Journal of Marital and Family Therapy
January 2004, Vol. 30, No. 1, 95–103

BREAKING DOWN THE BARRIERS TO CLINICAL SERVICE DELIVERY: WALK-IN FAMILY THERAPY

John K. Miller
University of Oregon

Arnold Slive
Woods Homes

This article provides a description of a unique walk-in family therapy service designed to overcome barriers to clinical delivery, as well as a survey of client experiences with the therapy. This therapy modality is aimed at providing an immediately accessible, affordable, nonstigmatizing, single-session-focused resource. The service operates from a systemic, collaborative, consumer oriented, pragmatic, non-pathology perspective. Follow-up telephone interviews were conducted with 43 clients 3 to 6 months after they received treatment. Generally, former clients reported satisfaction with the service. The majority (67%) indicated some level of improvement, and 43% of participants found their single session sufficient to address their concerns. At the time of the session, the majority (86%) of clients were rated by their therapists as "customers" regarding their motivational readiness for change.

INTRODUCTION

Issues Related to Current Clinical Service Delivery Systems

Accessibility to mental health services is a concern throughout the world. According to the first-ever U.S. Surgeon General report on mental health (U.S. Department of Health and Human Services, 1999), effective treatments exist for most mental disorders, yet one-half of those who would benefit from treatment fail to seek help. One finding of the report is that the complex and fragmented mental health service delivery system in the United States, financial barriers, and social stigma all help create barriers to a full range of services. The report proposes that the mental health field is plagued with more barriers to service than any other area of health and medicine. Currently in the United States, 44 million Americans are without health care insurance, and those who do have coverage often find that mental health benefits are insufficient to meet their needs (U.S. Department of Health and Human Services, 1999).

The cost of allowing mental illness to go untreated in the national and global economy is astronomical. In the mid-1990s the World Health Organization, the World Bank, and Harvard University researched the "burden of disability" associated with a full range of health problems faced by peoples throughout the world (Murray & Lopez, 1996). They found that the impact of mental illness on the overall health and productivity throughout the world is largely unrecognized, and that mental illness is the second leading cause of disability and premature mortality. In 1990 the indirect costs of all mental illness totaled nearly $79 billion in the United States alone (Rice & Miller, 1996; U.S. Department of Health and Human Services, 1999).

These reports point to a fundamental and costly problem in our paradigm of clinical service delivery. To begin to address this problem, the Surgeon General's report calls for an examination of alternative strategies to overcome stigmatization, limited access, and rising costs for quality services. The purpose of

John K. Miller, PhD, Marriage and Family Therapy Program, College of Education, University of Oregon; Arnold Slive, private practice, Wood's Homes, Calgary, Alberta, Canada.

Correspondence concerning this article should be addressed to John K. Miller, Marriage and Family Therapy Program, 5251 University of Oregon, Eugene, Oregon, 97403-5251. E-mail: jkmiller@oregon.uoregon.edu

this article is to provide preliminary information regarding walk-in family therapy, one strategy of service delivery designed to overcome these barriers.

A Walk-In Center as One Strategy for Overcoming Barriers to Service Delivery

In 1990, Wood's Homes, a large treatment agency in Calgary, Alberta, Canada, created a unique walk-in family therapy service at their Eastside Family Center to address the growing problem of barriers to service delivery. The main goal of this project was to provide more immediate, accessible, affordable and "user friendly" services. At that time, the east side of Calgary was an area of high ethnic diversity, high density, and low socioeconomic status. A single parent headed a majority of the families in this area. At the time of the center's inception, this area was described as in high need of clinical services. To compound the problem, the Alberta government was facing cutbacks in medical, educational, and social services (Slive, McElheran, & Lawson, 2002).

The basic philosophical principles that guided the development of the service were born out of a dialogue between representatives from Wood's Homes, service providers, and east side community leaders regarding the problem of decreased accessibility and rising costs for services (Miller, 1996; Slive, McElheran, & Lawson, 2002). These fundamental principles include accessibility, affordability, availability, service as a "safety net," community ownership, and an egalitarian approach to therapy.

Service should be highly accessible. To realize this goal, center hours are set at times convenient for families (Monday–Friday 1:00 p.m.–8:00 p.m. and Saturday 11:00 a.m.–2:00 p.m.). Services are open to everyone, without exception. The center is strategically located near a busy shopping mall within a short distance from public transportation.

Services should be affordable. A combination of government contracts, partnerships, fundraising efforts, and the efforts of a volunteer staff of community therapists make it possible to provide services at no fee (Miller, 1996; Slive et al., 2002).

Services are more useful if they are immediately available. To accomplish this, center services are delivered on a walk-in basis. Clients are seen at times at which they decide they are most in need. No appointment is required (or taken). Clients are typically in session 10–30 min after they enter the building. This is in stark contrast to clinical delivery systems that begin with an initial call for an appointment, followed by an in-take process before therapy actually begins.

The Center should serve as a larger "safety net" for the community. This is accomplished by providing a place for other community "helpers" (teachers, doctors, police, social workers, etc.) to refer someone and know that they will be seen immediately. In this way, the walk-in service subtly challenges the public notion that clinical services are far away and take time to access.

Fundamentally, the walk-in service should be "owned" by the community. A Community Advisory Council composed of community service agency representatives and citizens governs the administration of the clinic and approves new policies.

Services are based on an egalitarian approach to therapy. From this perspective, clients are viewed as equals, and therapy is viewed as a form of consultation. Therapists tend to focus on strengths and resources the clients bring to the therapy process and avoid taking an authoritarian stance in treatment.

With these fundamental principles in place, the Eastside Family Center opened its doors in 1990 and has been in continuous operation since. In 1994, the Westside Family Center, a sister agency, opened to provide services to the people of the northwest section of Calgary. Over the last decade therapists at the clinics have developed certain guidelines to increase the utility of the therapy in this unique therapy setting.

GUIDELINES FOR CONDUCTING WALK-IN SESSIONS

Therapy Begins When Clients Walk In the Door

The entrance, the reception desk, and the waiting area at the centers have all been designed to promote a non-anxious experience for the client. The entrance to the clinic is away from a main traffic area, which increases client confidentiality. The reception staff is friendly and respectful. The waiting room is clean, well furnished and suitable for both children and adults. The intake and informed consent forms are exceptionally

brief by design. The forms are nonintrusive and ask questions that stimulate solution-focused thinking. Examples of questions from the form include: What is the single most important concern that you wish to share today? Emotionally, who is most and least affected? What things have you tried to resolve problems? If you have attended counseling before, what was most and least useful? What inner strengths would it be useful for us to know about? What will be the smallest change to show you that things are heading in the right direction? If clients are unable or unwilling to complete all the items on the form, they are invited to leave them blank and discuss them with the therapist during the session.

Pragmatics versus Model

Although no one model of therapy is employed at the centers, the community therapists that provide services operate from a systemic point of view and tend to gravitate toward solution-focused, brief therapy approaches. One fundamental goal of the service is to provide clients a clearly identifiable outcome at the end of each session, not limited to assessment and referral. This outcome is often small and guided by the client's stated goal for the session. To accomplish this in a 50-min session, therapists at the centers have found that specific therapy models tend to be less important than attention to pragmatism (Amundson, 1996). Results are judged by their practical results on whether the session was able to provide the client with their stated goal, not on whether the problem was removed or solved.

This orientation to pragmatism is radically different from orientations that strive to promote "deep" characterlogical changes over an extended therapy relationship. To orient clients to this type of service, therapists have found that it is useful to provide a clear message at the beginning of the session. A typical orienting message might be as follows:

> Before we begin, I would like to take a minute to explain how we work. As you know, this is a walk-in counseling service; you can come as you have without the need for an appointment and there is no fee. We'll meet for about 50 minutes. After we've talked for half an hour or so, I'll take a break to consult with my colleagues about our conversation. Then I'll return and share our feedback and ideas about the questions that you have presented to us today. My hope today is that we can work together in the next 50 minutes to help sort out your difficulty. You are welcome to return to the center at any time, and although you may not be able to meet with me, another therapist here will be glad to talk with you. After our meeting I'll write a summary of our session that future therapists here can refer back to; in that way if you decide to come back at some time in the future you will not have to start over again at the beginning. What are your questions, if any, about this service?

The therapist completes the session summary immediately after the session. The summary includes a description of the presenting concern, the therapist's appraisal of the client(s) readiness for change, and any interventions delivered during the session. Clients do not routinely receive a copy of the summary, although it may be reviewed with them by their next therapist should they return for another session.

Over the last decade, the therapists at the centers have experimented with various "first questions" for the therapists to ask early in the session to help promote a solvable framing for the problem and the greatest efficiency in a 50-min session (Slive, McElheran, & Lawson, 2002). The following questions, common in brief and solution-focused approaches, have proven to be useful in that they do not focus solely on the problem, but on what pragmatically will work for the clients. These questions include:

> What do you need to get from the session today?
> How will you and I know at the end of our meeting that this has been useful to you?
> What will work for you today?
> How will you and I know that things are on the road to getting better?

These questions have proven useful in that they orient the therapist and the client toward a solvable framing of the problem with a clear direction to proceed.

More is not Better, Better is Better

Therapists at the centers have adopted a "consumer-driven" view of how to proceed in therapy. Simply put, the job of the therapist is to find out what the client wants, and give it to them. From this perspective, therapists avoid second-guessing the client's stated goal by looking for root problems or underlying pathology. Instead the therapist approaches the family as a "consultant," organized by "what the client wants." Often client goals are not clearly stated and require some processing early in the session to clarify. The therapist's task is to guide this process, paying special attention to avoid providing more help than is requested. For example, a client may not be looking for a solution, but simply for someone to talk with. This is accepted at face value. It is important to note that in certain situations the therapist will be guided first by the ethic of "do not harm." When a child is at risk or there is a risk of self harm or harm to others, the appropriate authorities are informed. When a woman is being assaulted by her partner, she is provided with information about the abuse cycle, its impact, patriarchal social structures, and the resources that may provide for her safety. Informed consent for treatment and research are reviewed by the therapist at the beginning of the session. This includes a description of the limits of confidentiality and the services provided.

Timing is Important

Walk-in therapy is unique in that the *clients* choose the time they wish to attend a session. This type of clinical delivery system offers certain advantages over traditional weekly outpatient treatment with regard to timing and the change process. Many family therapy theorists have posited that second-order change in therapy is more likely to occur when the timing of the therapy corresponds with the client's "motivational readiness" for change (Hubble, Duncan, & Miller, 1999; Prochaska & DiClemente, 1992). From a solution-focused point of view, clients entering treatment can be understood as fitting into one of three categories with regard to readiness for change, "customers," "surveyors," and "visitors," with "customers" being the group most likely to engage in the change process (Berg, 1989). Others, such as Minuchin and Fishman (1981) argue that at times a sufficient level of "intensity" is necessary for the client system to be receptive to therapist's attempts to promote change. By allowing clients to choose the times they will access therapy, it is more likely that they will enter treatment at moments of sufficient "intensity" and "motivational readiness" for change (Prochaska & DiClemente, 1992). Therapists at the centers embrace this notion of the importance of timing and work in session to capitalize on the opportunity for change.

Relationship with the Service Versus an Individual Therapist

The walk-in service at the clinic is designed to provide immediate and accessible services in times of need, as determined by the client. The trade off in this arrangement is that it is unlikely that a client will be able to see the same therapist should they return for another session in the future. Given this reality, the center staff focuses on promoting a relationship with the service versus the individual therapists who provide services. This type of relationship building is radically different from the mainstream therapeutic standard, that elevates the significance of the individual therapist/client relationship (Asay & Lambert, 1999; Hubble et al., 1999; Lambert & Bergin, 1994). The following case example illustrates one such client relationship with the service versus an individual therapist.

Case Example: A Family in Crisis

This example illustrates the use of the walk-in model to assist in family decision during a time of uncertainty, confusion, and upheaval. The session resulted in the opening up of dialogue between family members regarding an important decision that potentially affected the well-being of a 13-year-old girl and her family.

A mother and her 13-year-old daughter (Kim) arrived at the Eastside Family Center, filled out the intake forms, and were escorted into the interviewing room by the therapist. Following the therapist's brief description of how the Center works, the mother, appearing distressed, began to explain that her daughter was an only child and that she and the father had separated 1 month earlier. The mother, having indicated that she had been dealing with long-term health and mental health issues (she was currently seeing a psychi-

atrist) stated that the separation had been a good thing for her, and she expected it to be permanent. Kim, in a calm, articulate, and concerned manner, interjected comments to add detail to the mother's description.

At the time of the separation, Kim decided to live with her father. However, when her father began staying out all night drinking, Kim made her own arrangements to live with her aunt (mother's sister) and uncle and their two young children. There she felt comfortable and well treated and had been attending school and doing rather well in her life. In the meantime, Kim's mother had been encouraging Kim to live with her. However, one night while sleeping at her mother's home, Kim discovered her mother and mother's new female friend "having sex." Kim now refused to consider living with her mother. The mother wanted the therapist to help Kim to understand and accept her mother's recent "discovery that I am a lesbian" and to agree to live with her. Kim did not want to consider living with her mother. She wanted to remain with her aunt's family. However, she showed an interest in discussing her mother's "new life" with a counselor.

Following an intra-session team consultation, the therapist first complimented Kim on her maturity, as demonstrated by her ability to adjust to the enormous changes in her life, and then complimented the mother on the fine job she had obviously done in raising such a capable daughter. At this point, the mother noticeably calmed, perhaps realizing that she was not going to be negatively judged, and relieving her of some of her own self-blame for causing upheaval in Kim's life. The therapist then began to slowly discuss the notion of "time": The need to give family members time to adjust to new circumstances and to be open to creative solutions along the way. The mother was asked her opinion about whether the "healing of time" might best occur for her daughter while remaining "for a period" at her aunt's or whether she thought it best if Kim move back "immediately" to her mother's. As the mother considered this question, it was suggested that mother and daughter could return for another walk-in session to discuss mother's "new life." They seemed interested. They left the session agreeing to "go for coffee" and expressed confidence that they could resolve this "short term" question of where it would be best for Kim to live "for now." This session allowed mother and daughter to listen to one another's concerns and to take the pressure off the decision making process.

This case example illustrates several of the guidelines that inform the work at the center. First, the clients in this case chose the time to access therapy. For this mother and daughter prompt access to services seems to have been very important in that they were in the middle of making a decision that would affect several people. If they had had to wait for weeks to be seen by a therapist as is common in traditional practice, it is likely that the motivational readiness of the mother and daughter would have faded. Secondly, the therapist began with the notion that the clients themselves possessed resources to help resolve their concern. Intervention in this case was oriented first by what the clients were requesting, namely, help with making an important decision. Where some therapeutic orientations may call for more intensive intervention (e.g., further assessment, parenting skills training, relationship building), the orientation of the walk-in center is guided by the principle that the therapist should provide only as much help as is requested and that it is possible to provide some help in a single session.

PROGRAM EVALUATION

Previous research at the walk-in centers indicated that clients were generally satisfied with the service (Hoffart & Hoffart, 1994; Miller, 1996). To begin to gather more data about client experiences in treatment, the authors conducted a preliminary program evaluation of the walk-in service. In the program evaluation the authors asked clients about what, if anything, clients found useful, if they had improved, what clients remembered from the session, and what they would change.

Approximately 700 walk-in therapy sessions were conducted at the Eastside and Westside Family Centers during the 3-month period of initial data collection. All clients seen during this time were asked if they would consent to a follow-up interview regarding their experience with the service. The majority of clients consented to participate in the follow-up interviews. Of the clients who consented to participate, 50 cases were randomly selected for follow-up telephone interviews 3–5 months after their therapy session. The therapists participating in the study completed a brief protocol relating to client demographic information, therapist experience level, whether or not they used a team, and the presenting concern of the client.

Therapists were also asked to rate the "position" of the client (visitor, surveyor, customer) in reference to therapy and the clients' readiness for change (Berg, 1989).

Of the 50 cases randomly drawn for the initial sample, 43 completed the follow-up telephone protocol. The lead author conducted the interviews. The remaining seven (14%) could not be reached by phone or did not wish to participate at the time of the follow-up call. At the time of the intake, clients were asked who would represent the family when contacted for follow up (usually the person identified as the "symptom bearer," or a parent in cases where the "symptom bearer" was under 18 years of age), and this person was contacted for the follow-up telephone interview. The follow-up protocol was adapted from Talmon's (1990) "Follow-up Interview" protocol and included open and closed questions. Client responses were written verbatim. Specifically, clients were asked about the current status of the problem, what made change possible (for better or worse), their thoughts regarding the session, and any recommended changes.

Sample

The sample included a total of 43 client cases, 46.5% ($n = 20$) from the Eastside Clinic and 53.5% ($n = 23$) from Westside Clinic. Of these, 44.2% of the identified clients were male ($n = 19$) and 55.8% were female ($n = 24$). The majority (86%) were Caucasian ($n = 37$), with the remaining 14% ($n = 4$) Asian, Japanese, Chinese, or Native American. The mean number of days from the time of the therapy session and the follow-up phone contact was 87 days (range = 44–132 days). For 83.7% ($n = 36$) of the cases this was their first visit to the Eastside or Westside Clinics. The remaining 16.3% ($n = 7$) were return clients. More than one-half of cases seen (60.5%) presented as individual cases ($n = 26$), where an individual person presented for therapy. In 17 of the cases in the sample (39.5%), more than one person in the client system was present in the session. "Parent and adolescent conflict" and "family relationship issues" were the two most common categories of concerns for the sample, making up 62.8% of the total cases ($n = 27$). "Mental health issues" was the third most common category of concern, making up 16.3% ($n = 7$) of the total cases. The majority (86 %, $n = 37$) were rated by the therapist to be "customers" for treatment (Berg, 1989), indicating that the therapist felt that the clients were motivated for change.

Twenty-two therapists provided services for the 43 client cases in the sample. Therapist's self-identified models of treatment varied widely and included cognitive, feminist, brief/MRI, narrative, solution-focused, Milan systemic, and eclectic. Most therapists at the clinic were employed elsewhere as full-time clinicians and provide services at the Centers on a volunteer basis. A shift coordinator, who managed case assignments, therapy sessions, and team observations, oversaw all sessions. The shift coordinator was often an American Association for Marriage and Family Therapy Approved Supervisor or equivalent. Therapists recorded the type of interventions they employed in the session with each client case in the sample group. In each case some type of commendation/validation was given to the client by the therapist. In 42% of the cases ($n = 21$) the therapist offered some "reframe" of the client concern, and in 34% of the cases ($n = 17$) the therapist suggested a "doing or behavioral task." In 8% of the cases ($n = 9$) the therapist offered a referral to another agency or service. Other interventions included the miracle question (de Shazer, 1985, 1988), education/information, and problem solving.

Almost all of cases in the sample (90.7%, $n = 39$) utilized a treatment team format in which the therapist consulted with the team during a break in the session. This type of team participation included both the cases where the team is behind the mirror, and when the team is in the consultation room giving feedback via case report during the break in session. The team usually consisted of 2–3 other therapists and a shift coordinator, who also provided supervision.

Data Analysis

After entering the collected protocol data into a spreadsheet, inductive content analysis was utilized to identify themes, patterns, and categories that emerged from narrative responses to open-ended questions (Bogdan & Biklen, 1998; Laszloffy, 2000). Each narrative interview response was reviewed by the researcher to identify themes and patterns, and an initial coding system was developed. A second review generated a list of broad categories to organize responses. Responses were then grouped according to these initial categories. A final review consisted of a process in which new categories were created and refined,

until no new categories could be developed. Finally, responses to scaling questions, "yes/no" questions, and other quantitative data were tabulated and descriptive statistics were generated.

Client Ratings of Satisfaction and Change

A majority of the respondents reported general satisfaction with the service, with 74.4% reporting they were "satisfied" or "very satisfied" with treatment. None of the participants indicated they were "very dissatisfied," and four (9.3%) indicated "dissatisfaction." Seven of the participants (16.3%) indicated they were "neutral" regarding their satisfaction with treatment.

Many (67.5%, $n = 29$) reported some level of improvement after the session, indicating things had "improved" or "much improved." Things were "much worse" or "worse" for only three of the respondents (7%), and 11 (25.6%) reported that things were about the same. In 44.3% of the cases ($n = 19$) clients reported the single session was sufficient to address their concerns.

When asked about changes in thoughts, feelings, and behaviors since the session, more than one-half of those who indicated improvement identified changes in relationships with family, friends, or work situations. One client stated "My husband is spending a lot more time with our daughter, which really helps. We are unsure what happened, but we are now working together as a family to address the problem." Work relationship changes were typified by such comments as "I made a strong stand with my boss and am now sticking up for my rights" or "I found a new job through my computer that I really enjoy and am now caught up on my bills." Many other respondents credited improvement to increased insights about the problem, such as "it helped me to get some professional feedback and advice about coping mechanisms for me and my family" or "the therapist made me feel normal, not loony. He helped me to realize and face what had happened to me and deal with it."

Of those who indicated that things were about the same or worse, many reported sentiments such as "I felt a bit better after the session, but I needed personal therapy later to address my concerns" or "we needed to return to the center for additional support."

When asked what made the changes possible, respondents typically acknowledged one of two areas, their own resources, and assistance from the therapist. Statements such as "I decided to lay down some reasonable rules and structure with my children and stick with it" or simply "we decided to work on it by ourselves over time" were common for those who discussed their own resources as a major factor in the improvement. Those who discussed assistance from the therapist recognized factors such as therapist advice, useful information, and referral to other resources. Some clients commented "the therapist helped me identify what was wrong and gave me some good coping advice" and "the therapist helped me think more positively and gave me some other resources such as the YWCA and school services."

DISCUSSION

Implications for the Clinical Service Delivery Gestalt

As the field of mental health continues to explore various strategies to overcome the barriers to clinical service delivery, further consideration should be given to how walk-in, single-session treatment strategies may provide a valuable element in the overall treatment gestalt. Although few would argue that this treatment modality is appropriate for all clinical situations, it may help in addressing the problems of stigma, accessibility, and cost in the following ways.

Walk-in services described in the study are designed to minimize stigmatization by adopting a "consumer" driven orientation (Slive, McElheran, & Lawson, 2002). This orientation guides the therapist to focus on what the client is seeking from treatment, further promoting client motivation for change. With this orientation, the client is viewed by the therapist as an equal in the change process, as the therapist assumes a more "nonexpert" position. This approach also tends to begin with the assumption that people have strengths, are resilient, and have resources to solve their problems. From this perspective, therapy can at times be effective by simply providing a place for people to consult with a therapist and gain new information. In cases where a more traditional outpatient therapy would be helpful, the walk-in service provides a valuable new "gateway" to the world of clinical services in which people who would not access

traditional services can get a sense of what therapy can be like.

It is likely that many people who would not access traditional outpatient services will access a walk-in treatment service. The results of this investigation indicate that a majority (86%) of the clients in the sample were assessed by their therapist to be "customers" for treatment, indicating that their motivational readiness for change in the first session was high. This compares favorably to traditional therapies, where only about one-third of those seen are rated as "customers" for ongoing treatment by their therapist (Asay & Lambert, 1999; Hubble et al., 1999; Lambert & Bergin, 1994). This preliminary finding supports the notion that providing a walk-in service will capture the opportunity to provide services when the client is motivationally ready to receive them. As some researchers have suggested, change is more likely to occur when the timing of therapy coincides with the client's desire to take action (Hubble et al., 1999; Prochaska & DiClemente, 1992). Finally, overcoming the barrier of limited accessibility is furthered by the strategic locations of the centers near busy shopping malls adjacent to major thoroughfares.

Walk-in services may help with the problem of overall cost for services in several ways. Given that they operate largely on a volunteer basis, the cost to provide services is relatively low. As discussed previously, it is likely that many people who would not consider accessing traditional outpatient therapy services will access a walk-in service. If this type of service were implemented more widely in the United States, it is likely that the "morbidity" costs associated with untreated mental health problems would diminish. Given that the total "morbidity" cost of untreated mental health issues in the United States is $79 billion a year (Murray & Lopez, 1996), even a small increase in utilization of services could promote much larger savings in the overall economic system.

The walk-in service model may also provide cost savings by relieving pressure on existing traditional outpatient practices. As Talmon (1990) has noted in his research on single-session therapy, the modal length of traditional therapy is most often a single session. In the majority of traditional therapies the first session is oriented toward assessment and basic information gathering and has little intent to promote change. When a client attends only a single session, traditional therapy will most often regard this as simply a "treatment failure" (Talmon, 1990). In contrast, walk-in service is intentionally designed to make the most of these single-session opportunities.

Limitations and Future Directions

The investigation described was designed to provide preliminary data regarding walk-in single-session-focused family therapy. The relatively small size of the sample ($n = 43$) calls for prudence when generalizing the findings. As Gutek (1978) has pointed out, people seem to be satisfied with everything social scientists ask them about. This dynamic calls for careful consideration when interpreting positive findings.

Further investigations are needed to determine whether the implementation of this type of treatment modality would have an impact on the overall community with regard to reduced cost for care, decreased "morbidity" costs associated with untreated problems, utilization/accessibility, and stigma. The services described in this article were offered in a single city in Canada. The overall Canadian system of clinical delivery is notably different from other systems and it is unclear if the service would enjoy the same community response in other locations and other contexts.

One limitation of the service is that clients who return for another walk-in session may not be able to see the same therapist they had seen previously. This is one necessary trade-off given the nature of the walk-in service. Previous surveys of client response to the service indicate some would like the possibility of seeing the same therapist should the client(s) return (Miller, 1996). Depending on therapist availability, some clients may be referred to their walk-in therapist for more traditional outpatient therapy.

In this survey only 14% of the sample ($n = 4$) identified themselves as non-Caucasian. Further investigation is needed to determine if this finding is indicative of the overall client profile at the service, or if further measures are needed to invite people of color to the service.

Finally, of those respondents in the survey that commented about what made change possible (for better or worse), approximately half attributed positive changes to extra-therapeutic factors (Asay & Lambert, 1999; Lambert & Bergin, 1994). It is unclear if any of the extra-therapeutic factors respondents discussed are connected significantly to the single walk-in session or if the changes would have occurred even if the clients had not attended the session. Further investigation is warranted to determine possible links between the walk-

in therapy sessions and extra-therapeutic factors. One possibility is that in some situations the single walk-in session may serve as a well timed catalyst to support already present extra-therapeutic factors.

REFERENCES

Amundson, J. (1996). Why pragmatics is probably enough for now. *Family Process, 35,* 473–486.

Asay, T. P., & Lambert, M. J. (1999). The empirical case for the common factors in therapy: Quantitative findings. In M. A. Hubble, B. L. Duncan, & S. D. Miller (Eds.), *The heart and soul of change: What works in therapy* (pp. 23–55). Washington, D.C.: American Psychological Association.

Berg, I. K. (1989). Of visitors, complainants, and customers: Is there really such a thing as resistance? *Family Therapy Networker, 13*(1), 21–25.

Bogdan, R., & Biklen, S. (1998). *Qualitative research in education: An introduction to theory and methods* (3rd ed.). Boston: Allyn and Bacon.

De Shazer, S. (1985). *Keys to solutions.* New York: Norton.

De Shazer, S. (1988). *Clues: Investigating solutions in brief therapy.* New York: Norton.

Gutek, B. (1978). Strategies for studying client satisfaction. *Journal of Social Issues, 34,* 44–56.

Hoffart, B., & Hoffart, I. (1994). *Program evaluation of the Eastside Family Center.* Unpublished manuscript.

Hubble, M. A, Duncan, B. L, & Miller, S. D (Eds.) (1999). *The heart and soul of change: What works in therapy.* Washington, D.C.: American Psychological Association.

Lambert, M. J., & Bergin, A. E. (1994). The effectiveness of psychotherapy. In A. E. Bergin & S. L. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (3rd ed., pp. 143–189). New York: Wiley

Laszloffy, T. (2000). The implications of client satisfaction feedback for beginning therapists: Back to the basics. *Journal of Martial and Family Therapy, 26,* 391–398.

Miller, J. K. (1996). Walk-in single session therapy: A study of client satisfaction (Doctoral dissertation, Virginia Polytechnic Institute and State University, 1996). *Disseratation Abstracts International, 58,* 421.

Murray, C., & Lopez, A. (1996). *Global burden of disease: A comprehensive assessment of mortality and disability from diseases, injuries, and risk factors in 1990 and projected to 2020.* Boston: Harvard University Press.

Prochaska, J. O., & DiClemente, C. C. (1992). *Stages of change in the modification of problem behaviors.* Newbury Park, CA: Sage.

Rice, D. P., & Miller, L. S. (1996). The economic burden of schizophrenia: Conceptual and methodological issues, and cost estimates. In M. Moscarelli, A. Rupp, & N. Sartorious (Eds.), *Handbook of mental health economics and health policy. Vol. 1: Schizophrenia* (pp. 321–324). New York: John Wiley and Sons.

Slive, A., McElheran, N., & Lawson, A. (2002). Family therapy in walk-in mental health centres: The Eastside Family Centre. In M. M. MacFarlane (Ed.), *Family therapy and mental health: Innovation in theory and practice* (pp. 35-45). New York: Haworth.

Talmon, M. (1990). *Single-session therapy: Maximizing the effect of the first (and often only) therapeutic encounter.* San Francisco: Jossey-Bass.

U.S. Department of Health and Human Services. (1999). *Mental health: A report of the Surgeon General—executive summary.* Rockville, MD: U.S. Department of Health and Human Services.