Improving Access and Rapid Response: Recommendations for Expansion of the Walk-In Counselling Service at Family Service Regina

A Practicum Report Submitted to the Faculty of Social Work in Partial Fulfillment of the Requirements for the Degree of Master of Social Work

Faculty of Social Work, University of Regina

by

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Acknowledgements

I was given the opportunity to participate in a pilot of increased hours of the Walk-In Counselling Clinic at Family Service Regina in order to develop recommendations for further expansion of the service within current financial and personnel constraints as partial fulfillment of the requirements for the degree of Master of Social Work.

Kirk Englot, Director of Operations and Business Development, Family Service Regina, identified a need for more walk-in counselling for community members unable or unwilling to wait for traditional service due to multiple factors and barriers. He initiated and supervised this pilot project in order to gather data and develop recommendations for a sustainable increase in WICC hours to better meet the needs of the community FSR serves. Thank you Kirk, the community will benefit because of your diligence and drive to improve access to help.

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Abstract

This paper examines the possibilities of, and recommendations for, expanding the Walk-In Counselling Clinic (WICC) at Family Service Regina (FSR) within current budgetary and staffing constraints. In response to a Ministry of Social Services contract, FSR has operated a WICC one half-day per week since 2010 to improve accessibility and usage for the Ministry’s referrals and community members, including the marginalized. Data collected from Family Service Regina’s data management system demonstrated a positive societal impact; however, the WICC was underutilized. A review and expansion of the Walk-In Counselling Clinic was identified as an action plan item for the 2016-2017 funding year.

The review involved a pilot project in which the WICC hours were increased to two days per week in order to collect statistics to assess the value of an expanded WICC program in Regina and formulate recommendations for further program design. Data collected clearly showed expanded hours met a community need for clients at or below the poverty line and those without Employee Assistance Programs. With increased operating hours during the pilot, client visits increased exponentially, demonstrating the need for improved accessibility.

Using a conceptual framework of Appreciative Inquiry, interviews with Family Service Regina counsellors were completed to gain an understanding of practitioner perceptions about barriers to, and possibilities of, expansion of the service. Interviews with select local and national community agencies providing WICC services were also completed to gain an understanding of how similar agencies introduced and utilize their WICC as well as successes and challenges in doing so. Data analysis confirmed the need for a more robust Walk-In Counselling Clinic in this community and nine key recommendations were drafted to serve as a guideline for capacity building and future expansion of the WICC.
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Chapter One: The Project

Introduction

Due to a steadily increasing demand for mental health services and a continuous reduction in resources, individuals and families who experience adversity may also experience barriers accessing timely care. Waiting can exacerbate stress and delay return to usual function (Hymmen, Stalker & Cait, 2013). Service providers have had to re-devise and re-imagine existing counselling programs within fiscal restraints to meet the needs of the marginalized. Across Canada and internationally, Walk-In Counselling Clinics (WICCs) have proven to be an effective alternative to usual (multi-session) care (Hymmen et al., 2013). These clinics offer accessible, immediate help at the time when the client needs it. Research shows the brief interventions typically offered in WICCs and single session therapies can lead to meaningful change and reduce the burden of stress. The literature also confirms the vital role an accessible Walk-In Counselling Clinic plays in meeting the needs of all community members (Stalker et al., 2016; Perkins & Scarlett, 2008).

Counselling services within the community of Regina are not currently meeting the needs of community members. Although three community agencies in the city, including Family Service Regina, offer Walk-In Counselling Clinics, few clients utilize the service. Statistics gathered from Family Service Regina’s data base over the past six years determined the existing Walk-in Counselling Clinic, which was open one afternoon per week, was underutilized. An average of only 2 clients per week accessed the service. Interviews with the other two community agencies determined they have also experienced sparse use of their Walk-In Counselling Clinic. Despite evidence demonstrating Walk-In Counselling Clinics (WICC) reduce wait-times, Family Service Regina’s (FSR) wait-lists for general counselling remained
consistently longer than 7 weeks. This experience was vastly different from other affiliated agencies nationally and those discussed within the literature, where institution of a WICC dramatically reduced wait-lists (Cait et al., 2016). Based on existing research, it was speculated that limited hours, ineffective promotion, and location, likely contributed to barriers to service utilization (Young, Dick, Herring & Lee, 2008; Barwick et al., 2013; Cait et al., 2016). In response to these prior research findings, the Director of Operations and Business Development at Family Service Regina initiated a pilot project of expanded Walk-In Counselling Clinic hours to investigate the impact on the community.

To better see the ‘whole picture’ and develop innovative programming, a review of the Walk-In Counselling Clinic (in addition to a trial of increased hours) was identified as an action plan item for the 2016-2017 funding year by Family Service Regina. It can be difficult for individuals working on the frontline to always be able to immediately see the bigger picture, especially while already working at capacity within fiscal and personnel constraints. Thus, it was suggested a University of Regina Social Work graduate student be brought into the pilot project as a student counsellor and assessor within a practicum placement. When this position was offered to me, I jumped at the chance to participate in this exciting project which has implications for all stakeholders, not the least of which is Family Service Regina staff as they will ultimately drive future practice and services. An Appreciative Inquiry framework was utilized to guide the qualitative data generation and analysis, as well as identify strengths within the system and formulate recommendations for future processes.

**History and Context of the Agency**

Family Service Regina (FSR) is an accredited, non-profit community agency that offers a variety of supportive services including professional counselling, education, planning and
advocacy for vulnerable individuals and families within the community. FSR’s mission statement reflects their values:

“Family Service Regina strengthens individuals, families and communities through responsive leadership and innovative programs and services”.

(Family Service Regina, 2016).

In operation since 1931, FSR has been consistently committed to providing services and programs based on sound evidence and a high standard of excellence. All FSR’s services are defined by the agency’s six principles and values: “respect and dignity, diversity, empowerment, innovation, accountability and collaboration” (Family Service Regina, 2016, p. 3). The agency is committed to outcome based reporting to validate services and improve community impact, utilizing the Duncan-Miller Outcome Rating Scale and Session Rating Scale to measure pre and post overall well-being of clients. Last year, in order to meet the ever-changing community needs, FSR initiated several new programs and initiatives including: Coping skills for Domestic Violence survivors group, Teens ‘N Tots support group, and Art for the Heart group, and have hired a Domestic Violence Intake Counsellor position (Family Service Regina, 2016). These programs are a demonstration of FSR’s promise to continually evolve to ensure all community members have access to appropriate programming in their time of need.

Family Service Regina has a diverse social enterprise division that provides Employee and Family Assistance (EFAP) services to approximately 11,000 employees and family members in more than sixty public, private and non-profit organizations (Family Service Regina, 2016). The community counselling unit is a diversified program that offers therapy for a wide variety of problems and now includes substance abuse assessments and case management services. The success of this program is manifested by long wait-lists averaging more than 2 months. These
long wait-times mean that individuals in need of rapid response are not receiving the necessary help. Many clients have pressing needs that require immediate access to a therapist while others are not covered under EFAP and cannot afford service fees. This means a significant percentage of the public has been unable to access timely help. To rectify this issue, a Walk-In Counselling Clinic was established in 2010. However, the WICC was only utilized at half of its capacity, indicative of significant barriers to service (Englot, 2016). This was not in keeping with Family Service Regina’s mandate to meet the needs of all community members. Seeing the possibilities and potentials within a community lacking coordinated, barrier-free rapid response is challenging. To that end, an analysis of the existing Walk-In Counselling Clinic was undertaken as a major part of this practicum placement.

**Purpose of the Project**

As a non-profit agency, Family Service Regina relies on grants, donations and fundraising to cover operating costs. Competing with other agencies for funding requires FSR to have a robust strategic plan with a strong inventory of programs and services relevant to current community needs in order to sustain long term viability (Family Service Regina, 2016). Evidence-based research shows Walk-In Counselling Clinics can significantly decrease wait-times and improve outcomes by increasing timely access to services (Barwick et al., 2013; Cait et al., 2016; Stalker et al., 2016). Yet, despite having an established WICC, during the past 2 years, Family Service Regina’s wait-lists have remained long, averaging 2 – 5 months.

Wait lists are not unique to FSR. Nationally and internationally, vulnerable individuals are unable to access timely services for an emergent or acute need (Paul & Ommeren, 2013; Bloom & Tam, 2015; Cait et al., 2016). Research shows most individuals prefer brief therapy
and attend less than four sessions (Perkins, 2006; Slive & Bobele, 2012). In 2016, 77% of clients at FSR attended four or less sessions in a traditional counselling setting:

**Table 1: Number of Sessions Attended in Traditional Counselling**

<table>
<thead>
<tr>
<th>Percentage of clients Attending:</th>
<th>1-2 sessions</th>
<th>3-4 sessions</th>
<th>5 sessions or more</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>52%</td>
<td>25%</td>
<td>27%</td>
</tr>
</tbody>
</table>

Of equal importance, 27% of clients who had to wait for services did not initiate counselling (Englot, 2016). This data is consistent with research indicating that brief therapy is effective and preferable to multi-session counselling. Walk-In Counselling Clinics offer a complete session in a single sitting; however clients are not restricted from further sessions if necessary.

It was determined the Walk-In Counselling Clinic program at Family Service Regina was in need of change to ensure relevant and sustainable programming. The Director of Operations and Business Development for Family Service Regina was tasked with developing an evaluation and feasibility plan to reduce or negate the wait-list through expansion of the WICC and other progressive design strategies. A driving factor for this initiative was the long wait-lists for general counselling services. Research has demonstrated that WICCs reduce wait lists and improve timely services for vulnerable individuals (Paul & Ommeren, 2013; Bloom & Tam, 2015; Cait et al., 2016). It was critical to have an understanding and comparison of how the Walk-In Counselling Clinic has been, and will be, used in order to confirm its need for marginalized community members, those unable to afford fees, and those unable or unwilling to wait 2-5 months for help. This led to collaboration between the University of Regina and Family Service Regina to bring in a Masters of Social Work student to assess the existing Walk-In Counselling Clinic, operationalize a pilot project of an expanded WICC, and formulate recommendations for future sustainable processes. The purpose of the pilot was to increase the
WICC hours and gather pre and post data on the community impact. Ideally, the pilot would not only prove the need for expanded hours, but would also diminish or negate the wait-lists. In addition, the data and recommendations would be used in grant applications to secure funding for future programming.

This pilot project was a large undertaking in a short timeframe. A flexible work plan was necessary to manage time constraints and maintain consistency. The next chapter begins with a discussion of the practicum proposal, followed by discussion of the work plan.
Chapter Two: Project Proposal and Work Plan

Practicum Proposal

My practicum at Family Service Regina ran for a total of 450 full time hours from January 9, 2017 to April 18, 2017, although drafting the practicum proposal started three months earlier. Two objectives were identified in the proposal: 1) conduct an evaluation of the Walk-In Counselling Clinic at Family Service Regina, and, 2) gain counselling skills and provide Walk-In Counselling Services to the community. Several activities were required to achieve each objective. The first objective was to conduct an evaluation of the Walk-In Counselling Clinic at Family Service Regina including, but not limited to: current wait-list and capacity demands, human resource allocation, current FSR general counselling and WICC program design, accessibility issues, and statistical and outcome data from both the WICC and general counselling program. The completed evaluation was to include recommendations for progressive program design that would accommodate the growth and expansion of the WICC and facilitate a reduction in Family Service Regina’s General Counselling Program’s wait-list.

To achieve this objective, several learning goals and activities were outlined. An Appreciative Inquiry (AI) framework was chosen for the program evaluation. Its focus on strengths and abilities align with social work values that build on system and personnel capacities. A literature review of Appreciative Inquiry and its approach to program evaluation was conducted to help determine its appropriateness for program evaluation in a human service setting. It provides a unique framework for evaluating and facilitating change by focusing on the resources of individuals and organizations within their environment and building on those capacities (Busche, 2016).
The other activities identified to achieve the first objective centred on gathering information on the existing Walk-In and general counselling programs at Family Service Regina. An environmental scan of other available Walk-In Counselling Clinics and general counselling programs in the community of Regina was completed to situate available services within this city. It was quickly determined that the majority of counselling clinics in this city are for-profit private businesses and none advertised a WICC, likely because WICCs often either offer complimentary or sliding fee services. Thus, the environmental scan was limited to the two other community agencies in Regina that offer both a Walk-In and general counselling service: Regina Catholic Family Services and Mental Health Services Regina.

Following the completion of the literature review and environmental scan, interviews were conducted with four Family Service Regina counsellors as well as the intake counsellor to gain feedback on the challenges and successes of the current WICC and General Counselling Program. Individuals working with the other two local community agencies were also interviewed because they expressed interest in developing comprehensive and coordinated WICC programs with Family Service Regina to best meet the needs of the community. Finally, four national agencies affiliated with Family Service Canada were also chosen to be interviewed as they had fairly recently integrated Walk-In Counselling services into their agencies. Interview questions were designed to reflect the positive, generative process of an Appreciative Inquiry Framework (Busche, 2016). The interview questions can be seen in Appendix I. After analysis of the interviews, several themes were identified and are discussed in Chapter Six.

The final activity for the first objective was to identify gaps, deficiencies and achievements of the current WICC programming in order to develop a comprehensive program design that enhances utilization of the WICC and reduces wait-times for the General Counselling
Program without additional budgetary requirements. This activity involved examining Family Service Regina’s data from the past six years, keeping and evaluating data on the expanded Walk-In Counselling Clinic hours, reviewing interview results and identifying possible barriers to service.

The second objective was to gain clinical counselling skills within the WICC program focusing specifically on Solution-Focused and Single Session Therapies for the purposes of providing Walk-In Counselling services to the community. Brief therapies are the mainstay of Walk-In Counselling Clinics and Family Service Regina believes in an evidence-based strengths approach to meeting community needs (Cait et al., 2016). FSR therapists are encouraged to utilize the counselling model that best suits their client’s needs; however, the main model of care in the FSR Walk-In Counselling Clinic is Solution-Focused Brief Therapy (SFBT). A literature review confirmed SFBT is a proven modality across mandates of care (Kim, Brook & Akin, 2016; Dolan, 2015; Cape, Whittington, Buszewicz, Wallace & Underwood, 2010). Single Session Therapy is also an evidence-based approach recommended for brief sessions (Cait et al., 2016; Paul & Ommeren, 2013; Cape et al., 2010). The literature review served more than one purpose. As a regular counsellor in the WICC, it was critical to understand the theory and evidence behind the methods in order to best serve clients. The information was necessary to understand the relevance of brief counselling as part of the evidence-base for expanded WICC hours, and last, the evidence found in the review was used to inform recommendations for the Walk-In Counselling Clinic expansion.

The next activity was to observe WICC sessions by current counsellors at FSR with the knowledge and agreement of the client and counsellor. I sat in on two single session therapy sessions wherein each counsellor used Solution-Focused Brief Therapy as their model of care.
The counsellors I observed demonstrated excellent examples of how meaningful a single session can be and provided me with a solid foundation on which to build my skills. Following that, I engaged in the WICC as a student counsellor, providing counselling sessions during the newly expanded hours. Two other Masters (EdPsych) students and I covered the program almost entirely on our own with clinical supervision, and, with staff therapists assisting occasionally when increased client volume or unavailability of a student necessitated extra help. The activity afforded me the experience to work with clients with a variety of presenting problems. The experience was rich and rewarding and provided me with tools and skills I will use to work with clients in the future. It also confirmed that students can be a valuable resource for staffing Walk-In Counselling Clinics as part of their learning experience within community agencies.

Finally, I felt it was important to enhance my learning by participating in professional development opportunities as they became available during my practicum. While there were very few training opportunities available during that time which limited my ability to participate in any professional sessions, weekly peer supervision meetings at Family Service Regina greatly helped to enhance my learning. These sessions proved to be a wonderful learning opportunity as therapists openly shared information on challenging cases to gain insight from peers. Each week the topic was different. My favourite was the informal but extremely informative book club, where therapists brought their own therapeutic resources, summarized the content and offered to share the book. The books varied from workbooks on disorders like anxiety, to textbooks on drugs and psychiatry to self-help books that counsellors recommend to clients. On a personal level, I wanted to enable my own personal reflection and professional growth. To accomplish that I kept a diary of self-reflection and weekly notes on accomplishments, challenges and
successes. This journaling also served as a silent coach and guide that helped me stay on track during this large project.

**Work Plan**

A more detailed work plan to achieve the objectives summarized in the previous section of this document was drafted within the first two weeks of this practicum. The plan outlines five work objectives and several tasks to achieve the objectives as well as estimated timelines and desired outcomes. Because this practicum was a novel approach to achieve FSR’s goal of expanded WICC hours, a unique practicum that had never been done at FSR before, my supervisor decided the work plan was a desired guideline but had to be inherently responsive to the pilot as it unfolded. Thus the document as seen in Appendix II is a broad work plan rather than a detailed and scheduled disposition.

I followed the work plan as closely as possible, however as the project unfolded several modifications had to be made. One activity was to conduct a literature review of Walk-In Counselling service designs from other Family Service Canada Organizations to compare methods of operation. However, after the interviews with local and national organizations, it was determined only one agency utilized a service model significantly different from Family Service Regina’s operating model; the Community and Partnership Approach (CAPA). It was determined that the only research required was an overview of CAPA. That discussion of CAPA is included in Chapter Seven.

Included in objective two was development of social media advertising within Family Service Regina’s guidelines. However, FSR has an employee dedicated to communications and advertising. I did engage with her for the purpose of modifying promotions to reflect the Walk-In Counselling Clinic expanded hours and possibly increase social media presence; however all
changes to advertising were at her discretion. The use of intentional language was discussed with the intake and front desk personnel in order to inform clients about the WICC program. The work plan also included identifying options for data entry and filing. However, at FSR, receptionists enter the data from the intake forms and the information is in a folder accessible to all employees. It was not within the scope of this project to explore changes to duties defined by a job description.

An activity in objective 3 was to engage in weekly peer supervision. I did have weekly meetings with my supervisor to discuss the project in its entirety; however, formal supervision of my counselling duties was available and accessed on an “as needed” basis. Included in objective four was an environmental scan to determine counselling services available in Regina, fees, wait-times and how soft transfers between agencies are handled. As the pilot was focused on sustaining an expanded WICC, it was decided that determining fees for service in general counselling was not relevant. Soft transfers are client referrals between local agencies to ensure the individual’s needs are met by the most relevant service. A main activity in this objective was to identify how they are conducted. During the interviews with local agencies, it was identified that the soft transfers were welcomed amongst the stakeholders. However, right now soft transfers in Regina are realistically more of a concept than an established practice. Currently, local agencies refer clients to another agency that can best meet their needs; however, this practice is sporadic. Building intentional relationships would streamline services, could facilitate complementary programming and avoid gaps and duplication of services.

The final objective of the work plan was completion of the practicum including evaluation and final practicum report, as well as a detailed presentation open to all stakeholders to summarize the project findings and recommendations. As the data became available, the
comprehensive report on the WICC expansion was formatted and completed. The actual report titled “Growth and Renewal: Improving access and rapid response through expansion of walk-in counselling services” can be found in Appendix IV, however, it is also woven throughout the entirety of this paper. A final evaluation was completed with my supervisor on my last day, April 17, 2017 and the presentation was delivered on June 22, 2017.

The remainder of this paper discusses the details of the project starting with a literature review on Single Session Therapy and Solution-Focused Brief Therapy in the next chapter. Chapter Four discusses the framework for the project, Appreciative Inquiry, followed by methodology and data collection in Chapter Five. In Chapter Six the findings are presented and discussions on their applications to Family Service Regina’s situation are covered in Chapter Seven. Chapter Eight contains the nine recommendations drawn from the completion of the pilot project and the final chapter offers personal reflections, limitations of the project, and closing remarks.
Chapter Three: Literature Review

All organizations must undergo change to ensure they remain pertinent to the needs of the clientele they serve. This is particularly true of community agencies that rely on relevant, evidence-based programming to secure consistent funding in a competitive fiscal arena. In order to meet these changing community needs, Family Service Regina implemented a Walk-In Counselling Clinic to better meet the needs of the marginalized in the community and reduce wait-times for counselling. Yet, contrary to the experience of other Family Service Canada organizations and other programs discussed in the literature, historical data showed FSR’s Walk-In Counselling Clinic did not meet those original goals (Barwick et al., 2013; Cait et al., 2016; Stalker et al., 2016). Change was required to improve community impact. Managing the change successfully relies on supporting and equipping those individuals impacted by the change, and offering a sound evidence base for future practice (Lewis, Passmore & Cantore, 2016). This chapter discusses the literature-based evidence for Single Session and Solution-Focused Brief Therapy as useful modalities in a Walk-In Counselling Clinic.

Walk-In Counselling Clinics are frequently utilized in community-based and mental health agencies to reduce wait times and increase access to service (Stalker et al., 2016). The goal is to offer a complete session in one visit (Stalker et al., 2016). Family Service Regina currently encourages use of Solution-Focused Brief Therapy as a model for the Walk-In Counselling Clinic because it identifies and builds on inherent client strengths and abilities. However therapists are encouraged to use any therapeutic modality that best fits the client’s needs, and Single Session Therapy is a model of interest. Both of these models align with the Appreciative Inquiry framework utilized in this project, and discussed in the next chapter, as the
focus is on self-directed positive change. The following literature review demonstrates mounting empirical evidence that enduring client change need not involve in-depth, long-term counselling.

**Single Session Therapy**

Both Solution-Focused Brief Therapy and Single Session Therapy (SST) assume that change can occur in a single to relatively few sessions (Macdonald, 2011; Campbell, 2012; Slive & Bobele, 2012; Gingerich & Peterson, 2013; Laaksonen, Knekt, Sares-Jäske & Lindford, 2013). Traditional counselling usually focuses on assessment first and treatment plans and resolution later, while SST recognizes that individuals are cognizant of their issues and therefore aims to establish goals and plan interventions within one session (Perkins, 2006). While the goal of SST is to complete therapy in one session, it is important to note that most Walk-In Counselling Clinics encourage clients to return for further sessions if they feel the need (Young et al., 2008; Ollendick et al., 2009; Campbell, 2012; Slive & Bobele, 2012; Cait et al., 2016).

Single Session Therapy has four fundamental beliefs:

1. Improvement occurs rapidly in the initial stages then may slow.
2. Each session is considered a single entity whereby rapid help is offered.
3. The therapist has an active role in empowering the client to establish goals, plan interventions, and determine an agreed-upon conclusion for the session.

The mainstay of therapy within a Walk-In Counselling Clinic, no matter which model the therapist utilizes, is that a single session should have a significant influence on the client’s perception and behaviour towards the presenting problem (Perkins, 2006). The assumption that assessments must precede interventions and that enduring change requires multiple sessions has
gradually been challenged, and consistent evidence of the effectiveness of brief intervention delivered at the right time has accumulated in the literature. At the very least, a single brief session provides help when it is desired and may mitigate the harm of waiting (Ollendick et al., 2009; Macdonald, 2011). A compelling argument for Walk-In Counselling Clinics is their likelihood of reducing distress for those waiting for long-term therapy (Macdonald, 2011). If a single session is not enough, the assumption is that the client will at least have moved up on the waiting list (Macdonald, 2011).

Single session therapy has gained widespread use in Canada as Walk-In Counselling Clinics become the mainstay for rapid response. However, it is not suitable for all clients. Campbell (2012) notes that SST is suitable for motivated individuals who can identify a problem they are actively seeking to change. It is also necessary to have the capacity to quickly engage in the process, reflect on, and independently deal with, the presenting issue post-session (Laaksonen et al., 2013). Those with significant neurological or biological issues (i.e. major mental illness, dementia, etc.) are not likely to be well-served by brief therapy (Campbell, 2012). SST is not a therapeutic model; rather it lends itself to any therapeutic orientation that can be adapted to a single-session (Campbell, 2012; Barwick et al., 2013; Stalker et al., 2016). Effective SST should ensure the client leaves with skills, resources and a plan on how to implement behavioural change, as well as an awareness that they can return for further sessions if needed (Ollendick et al., 2009; Campbell, 2012). SST therapists must be able to utilize a range of interventions skillfully (Campbell, 2012).

A criticism of Single Session Therapy is the lack of controlled studies to measure the effectiveness of this model (Campbell, 2012). In 2001 a study by Bloom found a lack of evidence to substantiate or contradict the effectiveness of SST (Campbell, 2012). Nonetheless he
suggested uncontrolled studies indicated a 70 to 80% success rate with this modality (Bloom, 2001; Campbell, 2012). Four years later, Hurn’s (2005) review of the literature also determined there was a distinct lack of research to support the effectiveness of SST and concluded “it is difficult to decide or argue when SST should or could be used instead of multisession approaches” (Campbell, 2012, p. 17). A later literature review by Cameron (2007) also found a deficit in studies on SST, however suggested that Single Session Therapy may play a unique and critical role in walk-in or crisis models when only one session may be available (Campbell, 2012).

Miller’s (2008) quantitative study on the satisfaction of 417 clients with walk-in single session therapy found 81.9% of participants were highly satisfied, 16% were neutral and only 2% were dissatisfied. The greatest strengths identified were immediate accessibility and the therapist’s attitude of caring (Miller, 2008). For participants who were dissatisfied, the most commonly reported issue was inability to access the same therapist for ongoing counselling (Miller, 2008). This dissatisfaction may be representative of clients in need of more than single session therapy and highlights that both single session and multisession counselling need to co-exist.

A study done in 2013 in Calgary at a Walk-In Counselling Clinic and traditional core counselling program compared client outcomes at intake, post-treatment and three month follow-up (Barwick et al., 2013). All participants were children (age 4-18) and their parents (Barwick et al., 2013). Client satisfaction, service utilization, emotional and behavioural adjustment and functioning were compared (Barwick, et al., 2013). Despite more severe distress at intake, post-treatment outcome measurements indicated walk-in clients had steadier rates of improvement and exhibited fewer problems (Barwick et al., 2013). Client satisfaction was higher for
participants accessing the WICC, with ease and timeliness of service being identified as having the greatest importance (Barwick et al., 2013). Of note, the walk-in clients stated that a sense of urgency made the WICC more desirable, and stated that only a two week wait time or less was reasonable and acceptable (Barwick et al., 2013). In this study, more males accessed the Walk-In Counselling Clinic than traditional services (Barwick et al., 2013).

Cait et al. (2016) undertook a qualitative study comparing walk-in single session counselling with traditional counselling. The study elucidated evidence of client satisfaction with Walk-In Counselling largely due to reduced barriers to access and timely provision of service (Cait et al., 2016). Some individuals found that the emotional release and confirmation of personal strengths, as well as information on community supports, met their needs (Cait et al., 2016). Those uninterested in ongoing therapy benefited from a whole therapy in one session (Slive & Bobele, 2012; Cait et al., 2016; Stalker et al., 2016). In Single Session Therapy, individuals feel heard when they need to be, and with the help of a therapist can construct a self-determined pathway to meet their needs and goals (Cait et al., 2016).

The results were similar to the studies discussed above in a quantitative study which compared changes in psychological distress in clients at two counselling clinics in Ontario; one with Walk-In Counselling and the other with the traditional wait list (Stalker et al., 2016). Using hierarchal linear modelling, Stalker et al., (2016) determined “clients of the walk-in model improved faster and were less distressed at the four-week follow-up compared to the traditional service delivery model” (p. 403). An interesting theme that emerged from this study was that proportionately more males from all cultures than females accessed the WICC suggesting that men found accessing rapid response in the WICC more favourable than waiting for help (Stalker et al., 2016). For those with ongoing issues, participants indicated a single session in the WICC
provided a “booster” that significantly relieved distress (Stalker et al., 2016). As with Cait et al., (2016), this study found accessibility of the Walk-In Counselling Clinic and the ability to control how and when service was acquired, to be the most important factors identified (Stalker et al., 2016).

An important element of Single Session Therapy is the acknowledgement of individual strength; that people know when they need help. Therapy provided at Walk-In Counselling Clinics reduces barriers to timely service which can reduce anxiety and infuse hope (Slive & Bobele, 2012; Cait et al., 2016). Another critical element of SST is its ability to mitigate crisis in a timely and accessible fashion (Cait et al., 2016). The understanding that a single session may only be a starting point, a consultation, for those needing or wanting more in-depth counselling can serve as a beacon of hope (Cait et al., 2016). SST neither diminishes nor negates the need for on-going counselling (Cait et al., 2016). Rather it benefits people at the time they are in need and in some cases, prevents difficulties from festering (Cait et al., 2016). Another model of care that is perceived to be of benefit in brief therapy is Solution-Focused Brief Therapy, which forms the next discussion.

**Solution-Focused Brief Therapy**

Solution-Focused Brief Therapy (SFBT) has been utilized as a form of brief therapy since the mid 1980’s. SFBT is a goal-driven model that recognizes an individual’s perception of a problem and utilizes a therapist to assist the client to work towards their own vision of a solution within a single or very few sessions, usually less than six (Gingerich & Peterson, 2013). A hallmark of SFBT is the focus on a better future by concentrating on what has worked, and what is working, for the client, by inviting them to make positive changes by doing more of what works (Dolan, 2015). This strengths perspective is a framework for solving problems within the
client’s existing resources and unique social environment (Franklin, 2015). These humanistic qualities, emphasis on personal choice and collaborative empowering therapeutic alliance, make it a therapy of choice for social workers.

There is a considerable bank of evidence-based research, five randomized controlled trials, fifteen comparison studies and follow-up reviews on over 2100 cases, that illustrates SFBT is very efficacious (Gingerich & Peterson, 2013; Macdonald, 2011). A meta-analytic review of 1,421 participants in 2006 found that clients experienced positive outcomes sooner with SFBT than with other therapies (Gingerich & Peterson, 2013). However, despite numerous evidence-based studies, other reviews found that significant differences in outcome measures, population and variabilities in SFBT modalities prohibited generalization and consensus on the practical effectiveness of SFBT (Gingerich & Peterson, 2013). In order to synthesize the information into a format of practical value to therapists and policy-makers, Gingerich and Peterson (2013) conducted a systematic qualitative review of controlled outcome SFBT studies.

Overall evidence from 43 studies proved SFBT is an efficacious modality that consistently provided positive benefits to clients (Gingerich & Peterson, 2013). Several studies found particular benefit in depressed clients, where SFBT was found to be as good as, or better than, a variety of alternative treatments including some drug therapies (Gingerich & Peterson, 2013). Three large studies showed quicker improvements on all measures with brief therapy as compared to ongoing therapies (Gingerich & Peterson, 2013; Knekt et al., 2011). This comprehensive review indicates there is strong empirical evidence for the efficacy of SFBT for use in a wide variety of behaviour and psychological issues (Kim et al., 2016; Ilbay & Akin, 2014; Gingerich & Peterson, 2013). SFBT is proving to be useful for work with individuals and
families as well as within care systems such as schools, child welfare and mental health clinics, making it a useful modality for use in community agencies (Franklin, 2015).

The brevity of Solution-Focused Brief Therapy is of value to clients, agencies and health care agencies. For those not interested in long-term therapy, SFBT is more in line with clients’ desired timelines (Burwell & Chen, 2006). The quicker reduction in self-identified symptoms with short term therapy equates to a faster return to functional capacity (Cortes, Ballesteros, Collantes & Aquilar, 2016; Knekt et al., 2011). Research indicates outcomes compare favourably with longer therapies (Knekt et al., 2011; Burwell & Chen, 2006). Cost efficiency analysis with respect to social and unemployment costs indicates long-term therapy may cost three times more than brief therapy (Knekt et al., 2011; Maljanen et al., 2014). A recent follow-up study of 74 cases found that SFBT helped clients achieve goals in 86% of cases with an overall success rate of 86% at termination of therapy, leading to the conclusion that “SFBT reaches the ‘minimum efficiency permitted’ according to the general consensus of experts” (Cortes et al., 2016, p. S233).

A key goal of Solution-Focused Brief Therapy, and indeed all brief therapies, is change from maladaptation to adaption - rather than an understanding of the cause of the problem (Macdonald, 2011). SFBT emphasizes the client’s perceptions in their own language and, at the risk of over-simplifying the process, has one main requirement, that the individual do something different (Macdonald, 2011). SFBT has seven core assumptions:

1. The problem is relative only to the individual’s perception of it.
2. The focus is on the desired future; the past is not essential to the solution.
3. There are exceptions to every problem and times when its effect is less.
4. Therapists believe clients have the capacity to make meaningful change.
5. Small changes can lead to big increments of change.

6. Clients want to change.

7. The solution is unique to the client (Trepper et al., 2010; Lloyd & Dallos, 2008).

A hallmark of Solution-Focused Brief Therapy is the ‘miracle question’ which seeks to identify the client’s perception of what life would look like without the problem and serves to assist the individual and therapist in co-constructing goals (Trepper et al., 2010; Macdonald, 2011). However, in some situations such as bereavement, or chronic or terminal illness, when the miracle would be no death or disease, the question must be modified to reflect a preferred future while acknowledging current circumstances (Lloyd & Dallos, 2008). Scaling questions help the client rate the impact of the problem and the range of improvement within the continuum of their environment (Trepper et al., 2010; Lloyd & Dallos, 2008). This technique helps both therapist and client assess change and link behaviour to solution (Trepper et al., 2010; Macdonald, 2011).

The therapist-client alliance is central to positive outcomes within this brief therapeutic approach (Macdonald, 2011). The goal-focused nature and focus on self-possessed resources often gives rise to a positive therapist-client working relationship which may facilitate better, faster outcomes for motivated clients (Laaksonen et al., 2013). The non-blaming and non-pathologizing stance is empowering, can boost confidence and enhance feelings of self-efficacy (Lloyd & Dallos, 2008). One small study identified “the theme ‘making the best of it’ … [as] the essence of SFBT” (Lloyd & Dallos, 2008, p. 21). Overall, the strength of SFBT lies in its ability to help individuals identify, utilize and build on helpful coping strategies (Lloyd & Dallos, 2008; Trepper et al., 2010; Macdonald, 2011).

This literature review serves as an evidence-base for models of practice within a Walk-In Counselling Clinic and as a resource for practitioners. The framework for this project provided
the context for interpreting the findings of the evaluation and was the overarching theory behind the application of the findings into recommendations for future practice at Family Service Regina. The next chapter discusses Appreciative Inquiry as the framework of the project.
Chapter Four: Appreciative Inquiry as the Framework

The framework of a project gives direction to the methodology and is critical to the understanding and interpretation of the data (Bellinger & Elliot, 2011). Appreciative Inquiry (AI) was chosen as the overarching framework for this pilot project as its focus on strengths and building on the capacity of those involved support both a social work perspective, and the goal of the project, which was to expand WICC hours within existing fiscal and personnel resources (Bellinger & Elliott, 2011). Including and recognizing stakeholders’ experience within their environment is critical in engaging organizations in self-directed change built on the motivation of practitioners (Whitney & Trosten-Bloom, 2003; Bellinger & Elliot, 2011). This chapter includes a review of the literature on Appreciative Inquiry as the conceptual framework for this evaluation project, and discusses its advantages and limitations.

Appreciative Inquiry

Managing change successfully relies on supporting and equipping those individuals impacted by the change (Lewis et al., 2016). Appreciative Inquiry is a strengths-based model for assessing and initiating agency change that recognizes and appreciates the experiences of stakeholders and facilitates change by building on their capital. A review of the relevant literature indicates that Appreciative Inquiry is a good framework for this assessment project.

Appreciative Inquiry (AI) is a well-recognized method of change management that focuses on inherent strengths within an organization and encourages stakeholders to identify what is working well in order to facilitate positive change (Busche, 2016). AI tenets that all organizations do something that works well and collective change can occur when people focus on doing more of what works as opposed to targeting deficiencies and doing less of something that does not work well (Hammond, 1998; Whitney & Trosten-Bloom, 2003). Identifying the best elements and designing a future built on that capital facilitates positive change (Busche,
Appreciative Inquiry taps into an environment’s potential by engaging stakeholders in self-directed change (Watkins, Mohr & Kelly, 2011).

With its focus on strengths, AI is well situated within social work practice and as such, was an appropriate evaluation tool for use in this Masters of Social Work practicum. AI recognizes that practitioners have the capacity and resilience to undergo meaningful change that will benefit and enhance professional practice; yet to date this approach has been under-utilized in the social work arena (Bellinger & Elliot, 2011). Little research evidence could be found to support or refute its use in social work, however, there are considerable studies that evaluate AI in a variety of health care situations, many of which arguably parallel or synchronize with areas of concern for social workers and counsellors (e.g. mental health, child and youth behaviour). Trajkovski, Schmied, Vickers and Jackson (2013) undertook a review of methodological studies of AI in a variety of healthcare settings. The authors determined AI was a viable method for facilitating change in health care (Trajkovski et al., 2013). Most participants found using the model as a guideline for transformation was a positive experience that generated achievable change; however success could be compromised by organizational timelines and demands (Trajkovski et al., 2013). The most beneficial outcome noted was improved communication and standardization of practices amongst practitioners that was sustainable (Trajkovski et al., 2013).

The process of Appreciative Inquiry initially involved a cyclical, non-linear 4D model: “discover, dream, design and destiny” (Cooperrider, 2012, p.1). Watkins et al. (2011) added a fifth element to the model: define. The define phase refers to identification of the idea or plan of what is to be accomplished. “Discover” correlates with narratives and interviews that serve to appreciate participants’ stories and is the data-gathering phase. “Dream” is envisioning the future where-by participants share dialogue gathered in the “discover” phase and common, positive
themes emerge (Cooperrider, 2012). This would be considered the data-analysis phase. During the “design” phase, “provocative propositions” or plans that reflect the organization’s greatest potential for a chosen future are laid out (Watkins et al., 2011; Cooperrider, 2012). “Design” is an action phase, where recommendations are crafted. “Destiny” is that phase that focuses on sustaining the identified changes, or implementing the plan. In this phase, participants articulate how they will contribute to the realization of the “dream”, and commit to ongoing activities that sustain it (Cooperrider, 2012). Having identified the need for more Walk-In Counselling services in this community, Family Service Regina had completed the “Define” phase and this evaluation project would contribute to the “Discover, Dream and Design” phases.

Advantages

An advantage of this modality is respectful relationships, inclusivity and recognition of stakeholders’ experience within their environment. Focused on resourcefulness, not deficits, AI is a generative process (Whitney & Trosten-Bloom, 2003; Bellinger & Elliot, 2011). AI generates a co-constructed plan that improves practice built on the motivation and ownership of practitioners (Bellinger & Elliot, 2011). It is theorized to have application in organizations in need of positive energy where the process facilitates participants’ appreciation of their situation such that they are in a better position to take action toward positive change (Grant & Humphries, 2006; Stowell, 2013). As the “researcher”, Appreciative Inquiry proved useful as it allowed me to immerse myself in the organization and engage with clients and employees with minimum intrusion while practitioners were encouraged to be “part of the enquiry rather than objects of the enquiry” (Stowell, 2013, p. 28).

Appreciative Inquiry’s possibility versus problem approach builds trust in the change process and identifies possibilities for a shift toward a “new normal” in an organization (Busche,
2016). This is in contrast to a problem approach which assumes that something is broken and needs fixing, possibly making stakeholders wary of the change process (Boyd & Bright, 2007). This fear can contribute to defensiveness and resistance to change and makes it less likely to positively alter current norms or workplace culture (Boyd & Bright, 2007). An emphasis on possibilities places the focus on opportunities and encourages stakeholders to be creative, flexible, and more open to information on the change process (Busche, 2016). This shift towards a more positive work culture can lead to an awareness of group strengths and resources, encourage innovation, and increase motivation to move forward, which ultimately increases stakeholder resilience and ability to cope with change (Boyd & Bright, 2007).

With this method of inquiry, all stakeholders are engaged and encouraged to participate. This is of particular relevance in an organization such as Family Service Regina, where the number of stakeholders is small, and appreciating each individual’s experience is critical for buy-in to the change process (Boyd & Bright, 2007; Trajkovski et al., 2013). In small organizations, individual voices are much louder and can have a significant influence on group dynamics (Boyd & Bright, 2007). Appreciative Inquiry validates those voices and focuses on the opportunities they present as the catalyst for change. People who might otherwise resist the change process may be encouraged to join in when they feel heard. However, organizational change is a complex process and it is important to understand that Appreciative Inquiry, like all models, has limitations.

**Limitations**

While Appreciative Inquiry is a methodology that aims to invoke change by focusing on the ideal future, it has been criticized as creating change that is too brief to sustain in the long term (Messerschmidt, 2008). If utilized only during the “Dream” and “Design” phase, and not
during the “Destiny” phase, participants may not be able to maintain a positive outlook, reverting instead to a focus on any negative impacts of change (Egan & Lancaster, 2005). Ongoing support and encouragement of managers is critical in maintaining a positive outlook. In the same vein, for Appreciative Inquiry to be effective in any organization, leaders and agents of change must have the ability to see the positive in their staff and encourage widespread participation of all stakeholders (Messerschmidt, 2008). Leaders must also respect each participant’s point of view and avoid the pitfalls of criticizing prevailing negative attitudes (Egan & Lancaster, 2005). Failing to recognize relational limitations amongst leaders and staff may limit the effectiveness of Appreciative Inquiry as a method of change in organizations where managers are considered to be at the root cause of negative attitudes and practices (Egan & Lancaster, 2005).

As a method of change that focuses on possibilities, Appreciative Inquiry has been criticized for failing to address problems of real concern to stakeholders (Egan & Lancaster, 2005). It may be difficult for participants to fully engage in imagining and participating in a positive future when current negative factors are not handled to the stakeholder’s satisfaction (Messerschmidt, 2008). Difficulties may also arise during any phase of the change process when participant’s visions are in conflict, such that one individual’s positive may be another’s negative (Messerschmidt, 2008). This may become a pivotal point on which the change process stalls in small organizations, where participants identify fewer possibilities to outweigh recognized problems (Messerschmidt, 2008). In this project, Appreciative Inquiry was limited to utilization as a framework from which to gather data and the lens for data analysis and project evaluation. Due to the short timeframe of the project, there was no time to implement it in a change process at Family Service Regina.
Expansion of the Walk-In Counselling Clinic at FSR presents operational, fiscal and professional challenges for counsellors, leaders and all stakeholders. The Appreciative Inquiry framework was of particular relevance for evaluating the WICC program due to its focus on stakeholder strength and ability to build on the capacity of existing resources, not the least of which is staff. In keeping with this framework, data collection methods focused on identifying system strengths, rather than seeking out deficits. The next chapter discusses the methodology of the project and how the data was collected.
Chapter Five: Methodology and Data Collection

This project included research initiatives with the intention being to gather information to inform strategic planning by the agency. A mixed methods approach consisting of qualitative or subjective data and quantitative or statistical data gathering was used for this project. Three different data sets were utilized: 1) a review of the local WICC programs in Regina; 2) interviews with staff at FSR, local agencies, and national Family Service affiliated agencies and, 3) statistics from Family Service Regina’s data management system. Use of qualitative methods involved an environmental scan to determine the quantity of relevant WICC programming in the community FSR serves, and individual interviews with Family Service Regina counsellors, local, and national agencies, to generate data to better understand the human perspective of those involved with implementing and providing WICC services. For the quantitative method, statistical data was gathered to provide a picture of the past six years’ usage of the existing Walk-In Counselling Clinic, and a snapshot of the demographics of the WICC with expanded hours to allow for projections and recommendations for future use. This chapter discusses the methodology and each of these three data collection methods.

Methodology

To better understand the experiences of Family Service Regina, local, and inter-provincial agencies, subjective data was collected on the utilization and wait-times for both traditional and Walk-In Counselling services. In this project, qualitative data was obtained through an environmental scan that determined the prevalence of Walk-In services within this community to help ensure Family Service Regina’s path forward enhanced the public’s access to programming. Data was also gathered from focused interviews to understand and appreciate the experiences of agencies offering or planning to offer a Walk-In Counselling Clinic. The open-
ended questions created for the interviews reflected the capacity-building nature of Appreciative Inquiry by providing opportunities for me as interviewer, and the interviewee, to discuss topics in more detail. Due to the broad nature of the information being sought for this project, this method allowed me the freedom to probe the interviewee further for elaboration or clarification of a relevant area (e.g. elaborating on the nature of therapists’ resistance to a WICC). Statistical data was collected on the utilization and wait-times for both traditional and Walk-In Counselling services at Family Service Regina to determine the demographics of clients utilizing the service as well as identify any trends in attendance. Combining the two methods of data collection was complementary, allowed for a more complete assessment of Family Service Regina’s Walk-In Counselling Clinic, and validated the importance of expanded hours by facilitating a comparison of past and current use (Hussein, 2009; Braun & Clarke, 2014). Data collection methods focused on identifying existing resources.

Data Collection Methods

**Environmental Scan.**

An environmental scan is useful in capturing relevant information about an organization’s environment to facilitate informed decision-making during the change process (Champnoise, 2007; Guion, 2010). For this project, the purpose of the scan was to identify existing Walk-In Counselling Services within Regina in order to determine current services and project how FSR could contribute to, or improve, access to programming. As the project aimed to improve walk-in services to local clientele, the scan was external to the agency and limited to the community of Regina. Research indicates the most useful places to look for this type of local information are: Google, social media sites such as Facebook, newspapers, and the phonebook (Conway, 2009). An environmental scan was undertaken through Internet and social media
searches as well as searching the *Regina City Phone Book 2016, Yellow Pages 2016* and the local newspaper, *Regina Leader Post*.

**Interviews.**

Discussions with supervisors determined which local and national agencies held the most relevance for this project, and interview questions were composed. The questions were open-ended and framed to focus on possibilities without ignoring deficits. To reflect a wide variety of employee, local, and national experiences, interviews were subdivided into the categories of: internal agency staff, community stakeholders and interest organizations, and Family Service Canada affiliated organizations with Walk-In Counselling Clinics. Qualitative data was gathered from questions specified to the target group. The focus of the interviews was to:

a) Gain an understanding of front-line employee experiences with the WICC.

b) Gain an understanding of the experiences of similar local and national agencies as related to Walk-In Counselling Clinics.

c) Identify any delivery concerns and barriers to service.

Interviews with internal agency (Family Service Regina) staff included four on-staff counsellors (psychologists and MSW) and one intake counsellor (BSW), who currently work in Family Service Regina’s Walk-In Counselling Clinic. I conducted the interviews with individuals, in person, at Family Service Regina. Notes were taken during the interviews and were transcribed immediately after for utilization in the data analysis.

Two other local organizations, Catholic Family Services of Regina, and Mental Health Services, Regina, Adult Therapy Program were chosen to interview based on their similarity to Family Service Regina and because clients may be referred to or from these agencies. Agency
interviews were completed by the writer with clinical directors or managers by phone. During these interviews, results were transcribed by hand.

Four national organizations were chosen based on affiliation with Family Service Regina and Family Service Canada, and fairly recent introduction and expansion of a Walk-In Counselling Clinic. The four agencies chosen were: The Family Centre of Northern Alberta in Edmonton, Alberta; Family Service Ottawa, Ontario; Catholic Family Services, Calgary, Alberta; and Family Services Windsor-Essex, Ontario. My supervisor and I completed these interviews with clinical directors or managers by phone. Results were transcribed by hand.

**Statistical Data.**

Statistical data was drawn from Family Service Regina’s Data Management System to create a concrete picture of the population utilizing the Walk-In Counselling Clinic. Both historical and current data gathered during the project were examined. Family Service Regina had gathered data on utilization of both the Walk-In Counselling Clinic and General Counselling program usage for the past six years. These figures were utilized to establish the need for ongoing funding and confirm judicious use of resources (Englot, 2016). As the need for expansion of WICC programming was realized, the need for data specifically related to usage of the WICC such as gender, age, income, and presenting issue, etc. were identified as important to determine client demographics and track growth, therefore, statistics were gathered during the project to provide current data. This tangible snapshot helped to evaluate the population accessing services in order to formulate recommendations for further strategies that best meet the needs of the community. Findings of the data collection are presented in the next chapter.
Chapter Six: Findings

A great deal of data was collected from the environmental scan, gathering of statistics, and during the interviews. Although the data was gathered with a focus on resources; deficits, particularly in availability of Walk-In Counselling services in Regina, do exist. These deficits are not meant to be contradictory to the positive nature of the Appreciative Inquiry framework; rather their existence can be seen as an opportunity to focus on improvements that will build something better for the community. This chapter presents the findings of the data collection, beginning with the environmental scan.

Subjective data.

Environmental scan.

An environmental scan of Walk-In Counselling services in Regina was undertaken through Internet and social media searches as well as searching the Regina City Phone Book 2016/17, Yellow Pages 2016/17 and Regina Leader Post. The Regina City Yellow Pages (2016/17) had no listings under the heading of “walk-in”. Under “counselling”, 41 businesses were listed including Family Service Regina, however none of the listings or larger ads mentioned a Walk-In Clinic. This is testimony to the difficulty those without Internet or social media may have finding accessible services. An Internet scan of “Walk-In Counselling Regina” on Google brought up only Family Service Regina, Catholic Family Services, Canadian Mental Health Association and a link to “Crisis and Emergency: Saskatchewan: Mental Health Services”. The Family Service Regina site was very user friendly and the Walk-In Counselling Clinic information was easily visible. Catholic Family Services had a full-page ad clearly stating “Free Walk-In Counselling Service”, on Mondays from 2:00 – 3:30 pm; however, it was not up to date. The dates offered on the website were September 12 – November 28, 2016, and I was
looking at it in January, 2017. The location offered, Second Floor Board Room Cathedral Area Community Association with no mention of a street address, is also not up to date as Catholic Family Services currently operates their WICC out of the Regina Food Bank. To the side of that large advertisement, under the heading, “Recent Posts”, a very small post mentions Counselling Sessions at the Regina Food Bank. After clicking on the post, a large ad popped up stating there is a counselling service on Tuesdays from 1:00 – 4:00 pm but makes no mention of the service having a cost, being offered free, or otherwise.

The Canadian Mental Health Association required several clicks to get to the Regina site but offered no information other than a map. Clicking on the available link “Crisis and Emergency: Saskatchewan: Mental Health Services” brought up a list of crisis and emergency organizations, including child welfare contacts, crisis lines, Walk-In Counselling, hospital emergency, emergency shelters and women’s shelters. Under the heading, Walk-In Counselling, was a short description of the purpose of a WICC, with a citation stating there are no results for this heading. Other than Family Service Regina, Walk-In Counselling in Regina is poorly promoted on the Internet and a client with limited time or limited patience may be unable to find help easily.

A social media scan of Facebook using the search term “Walk-In Counselling” resulted in no available services in Saskatchewan. When the term “free counselling” was used, the only applicable link to Saskatchewan was a post from 2016 referring to the SIGN Walk-In Counselling Clinic in Yorkton, Saskatchewan, that was offered by a Masters of Social Work student during her practicum. After widening the search to “counselling in Regina”, links to several agencies appear. The Walk-In Counselling Clinic at Family Service Regina could be
found after scrolling half-way down the first page. No fees were listed with any of the agencies that advertised in the phone book, Internet and social media.

The *Regina Leader Post* was included in the environmental scan as it is a local paper where local businesses often advertise their services. Four editions of the newspaper were reviewed for information on any counselling services in Regina: January 14, 17 and 27, 2017 as well as February 6, 2017. The days were chosen to reflect beginning, middle and end-of-week information. None of the editions of the newspaper contained any advertisement or information on any counselling services in Regina. While Walk-In Counselling Services are available in this community, there are opportunities for improvement in how the services are advertised to the public, particularly to those without easy access to the Internet.

*Interviews.*

During the interviews, it was determined that all of the local and national agencies offer a free Walk-In Counselling Clinic, while general counselling services were based on a sliding scale. Wait-times ranged from 1 – 6 months; however those who had implemented a WICC had reduced wait-lists to around one week. The main accessibility barriers identified by all agencies (prior to WICC establishment) were location, hours of operation, wait-lists and cost. Location is a barrier at Catholic Family Services, where the WICC is not within walking distance of most residential areas and is hard to reach by public transit. In Regina, poor promotion is likely a barrier. All agencies interviewed identified the impoverished and marginalized as the main population that accessed their WICC.

In Regina, income data had not been gathered regularly enough to make a determination of the population accessing the WICC before 2017. Compared to service delivery and WICC hours at national agencies, notable gaps in service were identifiable in Regina. Here, WICC
programming before the pilot was offered on two afternoons per week for very few hours. Through conversation with directors at the other local agencies it was determined that Regina community agencies work together to attempt to offer some consistency in services. However, with limited promotion, a community member would likely see each agency as an island, with disjointed and isolated services.

In this section of the report, the data collected from the interviews with internal agency staff, community stakeholders and interest organizations, and Family Service Canada affiliated organizations will be discussed. As part of this discussion, individual and specific statements will not be shared to protect the privacy of the interviewees and to prevent bias on the findings. The interview questions can be found in Appendix I.

**Internal agency staff.**

Interviews with internal staff highlighted the strengths of Family Service Regina’s Walk-In Counselling Clinic and the role practitioners played in contributing to its operation. There were also concerns expressed by interview participants. An Appreciative Inquiry framework was applied and focused on appreciating each player’s situation and experience as a precursor to future pathways. Acknowledging the challenges identified by internal staff helped in the formulation of recommendations for expansion of the program that understands and builds on the organization’s capabilities.

A Framework Method for the management and analysis of qualitative data was used to interpret the subjective data (Gale, Heath, Cameron, Rashid & Redwood, 2013). This method is particularly useful for data gathered through multiple interviews, because the content, or themes of the dialogue, rather than individual comments, are of primary importance (Gale et al., 2013). In this project, transcriptions of the interviews were reviewed and dialogue was analyzed for
trends or codes (for example, statements referring to positivity or pride in service delivery, were coded as counsellor satisfaction), that reflected the positive, capacity-building nature of the Appreciative Inquiry framework (Gale et al., 2013; Braun & Clarke, 2014). Similar codes (for example counsellor satisfaction, ability or commitment) were then grouped into themes such as affinity for delivery of Walk-In Counselling. Several themes emerged from the interviews with internal agency staff: affinity for the program, sustainability, and professional capacity; and are discussed in more detail below.

1. Affinity for the program: All participants expressed some degree of affinity for the WICC and professional pride in providing services to a marginalized population. All respondents agreed that the program meets a need for rapid response within the community. The majority noted a WICC was necessary for the impoverished and those without employee benefit programs. Some agreed expanded hours could reduce wait times for general counselling services.

2. Sustainability: There was a definite concern expressed by each respondent regarding the ability to sustain an expanded WICC within current fiscal, personnel and spatial constraints. There was concern over staffing as there is a heavy reliance on students to maintain the expanded hours of the Walk-In Clinic. Students are usually available only for a few months at a time (during their practicum placements) so there is a definite possibility of an increased staff load for ongoing training and supervision. Funding is always a concern for everyone within a community agency, especially in the current fiscal landscape.

3. Professional capacity: Participants were very concerned about the possibility of a Walk-In Clinic ‘eroding’ general counselling services. Most were concerned that a
Walk-In Counselling Clinic might actually replace general counselling while others were worried it could become a ‘dumping ground’ for repeat clients with complex needs unable, or those unwilling, to survive the wait-list. Some were fearful that brief therapy puts clients at risk, and there was some discomfort surrounding caseload burden and having to ‘stretch’ schedules to staff the WICC. Most mentioned a worry over inadequate training and consistency amongst therapists when they are providing walk-in services.

These themes shed light on the current counsellor climate at Family Service Regina, where there are genuine concerns about how an expanded Walk-In Counselling Clinic may diminish current services and place an additional burden on counsellors already working at capacity. A major strength is a common affinity for the program. These themes present an opportunity for moving forward through the use of education to allay staff fears and build on existing strength and capabilities. Interviews with local community stakeholders and interest organizations revealed similar thoughts to those expressed by counsellors at Family Service Regina on Walk-In Counselling programming.

*Local community stakeholders and interest organizations.*

The two Regina community agencies interviewed, Catholic Family Services of Regina, and Mental Health Services, Regina, Adult Therapy Program, were fairly similar in their responses. A successful Walk-In Clinic was identified as a strength. Both agencies are currently operating WICCs but neither has been well utilized. A number of barriers were identified that informed areas for improvement in the recommendations found in Chapter Eight. Themes that emerged from these interviews were the same as those that emerged from the interviews with internal agency staff at Family Service Regina and will be discussed below.
1. Affinity for the program: There was consensus that brief therapy is valuable. Both respondents have had little success retaining clients for multi-session therapy. Each agency is committed to the idea that walk-in services are needed as an option for their clientele, and both agencies expressed strong interest in coordinating services with each other and with FSR as a strategy to reduce wait lists and better serve the community. Both noted that coordination would require a consensus on the operational model to ensure fluidity between organizations, and WICC hours at each should be coordinated to prevent deficiencies and overlaps in service.

2. Sustainability: The location of the Walk-In Counselling Clinic at one agency is hard to access and has very limited hours, however, altering physical space is not currently an option for them. Promotion of the program may not be appropriate for the population it is meant to serve. Both agencies have long wait lists of 8 weeks to 8 months for their general counselling services; however neither has found a reduction in wait times as their WICC has been underutilized. Funding is always a concern with community services vying for resources. Running or expanding a new program within the existing staffing complement is a concern.

3. Professional capacity: Implementation was considered an internal barrier. Both agencies felt program implementation took place quickly with little training, which strained staff and prohibited full commitment to the concept. Both found long wait lists put clients at risk as the longer the wait, the less likely the individual was to show up for help. Some clients have presenting problems that are not amenable to single session therapy. Neither participant agency kept usable statistics on the average
number of sessions clients utilized, thus have little reliable data to support changes in programming, and staff have had trouble accepting the role of a WICC.

Appreciating the experiences of both sets of interviewees has identified existing barriers with current programming and opportunities to capitalize on existing capabilities. In an AI framework, this information is imperative in planning the path forward. Interviews with organizations outside of this province revealed similar experiences to those in this community, and provided invaluable information on the positive end-points of a robust WICC program.

_National Family Service Canada affiliated organizations._

Organizations outside the province of Saskatchewan have had considerable experience implementing and sustaining a Walk-In Counselling Clinic. Most have been in operation for more than 5 years. All centers have significantly decreased wait times from an average of 4 - 6 months to consistently around one week, demonstrating the positive impact of a WICC on the community. The responses to interview questions were consistently positive with overall themes the same as with the other sector interviews. However because these national agencies have experience implementing and sustaining a WICC, two additional themes were identified: innovation and challenges.

1. **Affinity for the program:** Each respondent expressed that offering a WICC had a positive impact on both the community and their agency. Successes and strengths were identified as: provision of barrier-free counselling, reduced wait-times, reduction in emergency room visits, positive outcomes illustrated by clients’ expression of well-being, and pride of staff in meeting the needs of the community.

2. **Sustainability:** Funding was the universal theme from all respondents. All discussed ways to meet the continued and evolving requirements of funders while remaining
flexible and adaptable. All centers were concerned with sustainability of the Walk-In Counselling Clinic within a climate of dwindling funding, after the service had proven to be a necessary entity. For two agencies, new partnerships had to be developed to meet the need of reducing community barriers to care. Some agencies changed the length of their individual sessions from therapist-determined to standardized 30 to 80 minutes which may include intake. Standard single sessions ranged from 50 minutes to 1.5 hours. Most centers had to utilize more students in practicum placements in order to sustain the WICC.

3. Professional capacity: All agencies placed high emphasis on the importance of training, maintaining and supporting existing staff while supervising and training a steady stream of the students that are a necessary resource. Partnership with universities was considered to be of critical importance. Employees felt more supported because sustaining a strong WICC program meant placing time and effort on counsellor education, training, professional development and supervision. One agency developed a process manual for all sites to ensure the provision of consistent training and supervision. Another increased peer supervision to ensure quality services while also ensuring staff are well-informed and supported. Most now utilize orientation days and ongoing training for staff.

4. Innovation: Restructuring the intake process and redefining the screening process in order to develop a reliable WICC proved beneficial to both the organizations and clients. One respondent agency has implemented a CAPA model (Choice and Partnership Approach) in which clients and service providers work together to implement a care plan based on the client’s strengths. That same center has adopted a
narrative model and is now a trauma-informed agency. Two agencies worked alongside a Local Health Integration Unit to integrate services that improve patient access and experience. A need was identified to examine ways to work with partner agencies and students to continually adapt to the community’s changing needs.

5. Challenges: There were interesting discussions on challenges during this set of interviews. Each participant initially said staff were very excited, and saw the Walk-In Counselling Clinic as a great opportunity. However, as the conversations continued, most participants noted that mature staff was resistant, fearful of the change in focus, and afraid that general counselling services would be eroded. Some staff did not like the idea of a “free service” and wanted to implement a sliding scale or fee for service even though it does not ideally meet the WICC concept of rapid response for all, regardless of income. Some wanted to develop a screening process for the WICC, ostensibly to customize whom they were seeing and avoid presenting problems they were not comfortable dealing with. One agency believes some staff were actually physical barriers to the Walk-In Counselling initiative because of their resistance to treat clients on an as-needed basis. Most agencies experienced staff departures due to non-acceptance of the changes; however, this did not prove to be a barrier in the long term as they now have a team that is excited to be flexible and adaptable to this new opportunity. Evidence-informed programs require a lot of time on administration and many non-profit agencies do not have the staffing complement available to support this necessity. Partnerships can prove challenging when decisions need to be made that include all partners. Funding requirements frequently change and trying to keep up with appropriate service delivery while changing the structure is
difficult. Another challenge identified was staff operating from a medical model that identifies patients as problems instead of experts in their lives, however changing to a narrative model to fit client’s strengths was a success.

Data from the interviews provided useful information on successes and possible challenges that may be encountered during WICC expansion in this community. Subjective data provided a more complete picture of historical use of the counselling programs at FSR and demographic information gathered during the trial expansion of WICC hours.

**Statistical data.**

Descriptive data is discussed in this section of the report to illustrate the positive impact on the community by extended Walk-In Counselling Clinic hours at Family Service Regina. Data shows considerably long wait times for the community counselling service which does not meet the needs of clients with immediate concerns primarily due to the delay in service. Since the pilot of expanded hours, significant improvements were seen in the volume of clients accessing the program and the very high percentage of individuals whom attended only one session, ostensibly implying their needs were met within a single session. Collected data also demonstrated that the majority of clients accessing the WICC fall beneath the poverty line. This data clearly represents a need for Family Service Regina’s Walk-In Counselling Clinic.

Family Service Regina utilizes both the Session Rating Scale (SRS) and Outcome Rating Scale (ORS) to measure outcomes and inform practice. These scales are invaluable tools, designed to gather information on the client’s perception of the session (SRS) and their feelings on overall wellbeing (ORS) following access to the service. SRS measures the client-therapist relationship which is integral in achieving successful outcomes (Miller, Duncan, Brown, Sorrell, & Chalk, 2006). ORS measures interpersonal functioning and wellbeing to determine if the
trajectory of change is positive, which improves the likelihood of goal achievement (Miller et al., 2006). Both scales are short and to the point, making them very easy to incorporate into each therapeutic session, thereby increasing the information and feedback available to counsellors and agencies (Miller et al., 2008). SRS and ORS are validated, evidence-based scales that play an important role in achieving successful outcomes by reliably measuring therapeutic alliance between counsellor and client (Miller et al., 2006).

Outcome data from clients attending the general counselling program showed a high level of satisfaction with traditional counselling, however, more than half of the clients only attended two or less sessions, while more than three-quarters attended less than four. The long wait, as seen in the Table 2 below, proved too long for more than one-quarter of clients on the wait-list who did not start counselling at all. Local and national agencies reported the same experience with clients not initiating therapy after waiting for long periods of time. Family Service Regina’s original Walk-In Counselling Clinic had a capacity of 4 hours per week; however actual hours were only 1:00 – 3:00 pm Thursdays with two counsellors available for a total of 4 hours. At an average of only 2 clients per week, the WICC was found to be underutilized by 50%. There was no data to pinpoint exact reasons for the underutilization as that information had not been collected. This experience was not congruent with literature that indicates an accessible WICC reduces wait-times (Young et al., 2008; Cait et al, 2016). In Canadian research, hours of service, location, and cost of counselling have been found to be barriers to service for low-income earners. The existing WICC at FSR was free; therefore it was assumed limited hours possibly restricted accessibility (Cait et al., 2016).

Statistical data was gathered by looking at existing historical data, and through the gathering of data during the pilot of expanded WICC hours. The historical data identified WICC
utilization for the past six years prior to the pilot project. This data was gathered retrospectively. Family Service Regina had not gathered data in all categories studied in this project, therefore, some sections below do not have statistics for the entire six years.

**Historical data.**

While this section discusses the historical data collected from Family Service Regina’s data management system, it also includes more recent data collected during the pilot period from January to March 2017. Although the pilot period was short, it was important to demonstrate how changes to the WICC were impacting its utilization, as well as client issues and concerns. Research indicates the implementation of brief therapy as a practice can decrease wait times for counselling (Young et al., 2008; Cait et al., 2016). As Family Service Regina had only collected statistics for wait times for the past two years, wait times were examined from the last two financial periods.

**Table 2: Wait Times**

<table>
<thead>
<tr>
<th>Time Period</th>
<th>Average Wait</th>
<th>Longest Wait</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 1, 2015 – March 31, 2016</td>
<td>73 Days</td>
<td>142 Days</td>
</tr>
<tr>
<td>April 1, 2016 – March 31, 2017</td>
<td>54 Days*</td>
<td>204 Days*</td>
</tr>
</tbody>
</table>

*Does not include clients with pressing needs that were prioritized to be seen within 3 days.

Over the past two years wait times for general counselling have averaged from a low of 8 weeks to a high of 29 weeks. This illustrates the need for increased accessibility to rapid response, as those with pressing issues are not well-served by waiting. Research has shown that services that meet immediate needs may mitigate crisis and lessen the sequela of presenting issues (Cait et al., 2016). Given these long wait times, it was important to understand the
percentage of clients that utilized multi-session therapy as opposed to attending less than four sessions which is more characteristic of the brief therapy accessible in a WICC.

Table 3: Percentage of Clients Attending 4 or Less Sessions

<table>
<thead>
<tr>
<th>YEAR</th>
<th>2 or less sessions</th>
<th>3 – 4 sessions</th>
<th>Total attending 4 or less sessions</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>41%</td>
<td>18%</td>
<td>59%</td>
</tr>
<tr>
<td>2012</td>
<td>47%</td>
<td>24%</td>
<td>71%</td>
</tr>
<tr>
<td>2013</td>
<td>51%</td>
<td>19%</td>
<td>70%</td>
</tr>
<tr>
<td>2014</td>
<td>46%</td>
<td>22%</td>
<td>68%</td>
</tr>
<tr>
<td>2015</td>
<td>52%</td>
<td>24%</td>
<td>76%</td>
</tr>
<tr>
<td>2016</td>
<td>52%</td>
<td>25%</td>
<td>77%</td>
</tr>
</tbody>
</table>

In the past 6 years, more than half of clients (52%) engaging with general counselling services essentially utilized single session therapy by attending two or less sessions. Consistent with evidence-based research literature, the number of clients attending four or less sessions has increased to a high of 77%, which demonstrates that brief therapy likely meets the needs of the majority of clients at Family Service Regina. Given the significantly long wait times, more than half of clientele could be seen sooner with a more robust WICC program. This was confirmed by comparing percentages of clients attending a single visit and those utilizing repeat visits in the original Walk-In Counselling Clinic.

Figure 1: Percentage of Clients Attending Single Visit vs. Repeat Visits
Historically, of those clients attending the Walk-In Counselling Clinic in the past 6 years, 89-96%, did not return for further counselling, possibly indicating a high satisfaction rate with single session therapy. During this WICC pilot, results from the Session Rating Scale (SRS) and Outcome Rating Scale (ORS) indicated the majority of clients found one session met their needs and expectations. Yet during the 2017 pilot, only 65% of clients were considered complete after a single session by practitioners. This discrepancy could indicate a design flaw, error in capturing data, or historical system failure that did not encourage clients to return if they felt the need. It could also be indicative of therapists’ discomfort with single session therapy. There is little research available on this topic and it is an area that is in need of further exploration. A multi-site agency in Australia and New Zealand did find that counsellors were resistant to the idea of shortening therapy when Single Session Therapy was introduced into the practice (Young, Weir & Rycroft, 2012). Further information on this topic can be found below, in Figure 4.

In order to accurately capture the demographics of clientele accessing the Walk-In Counselling Clinic at Family Service Regina, it was important to examine any gender differences in attendance between the WICC and the General Counselling program.

**Figure 2: WICC Attendance by Gender (Percentage)**
On average, a higher percentage of males attended the WICC than attended the general counselling unit and the numbers are steadily increasing. This important trend identifies a community need and is consistent with Canadian research that has determined an increasing numbers of males are visiting Walk-In Counselling Clinics (Barwick at al., 2013; Cait et al., 2016). The next section of this report will look at current data generated from the pilot of expanded Walk-In Counselling Clinic hours at Family Service Regina.

**Current data from the WICC pilot from January 1– March 31, 2017.**

As discussed earlier in this report, the original goal of this pilot project was not only to confirm the need for expanded hours, but generate information on how and when the Walk-In Counselling Clinic was utilized to determine future programming needs. Data indicates that the WICC was utilized well on the days it was open with expanded hours of operation.

**Table 4: Utilization of the WICC per Weekday**

<table>
<thead>
<tr>
<th>WICC Day of the Week</th>
<th>Number of Clients</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monday</td>
<td>40</td>
<td>47%</td>
</tr>
<tr>
<td>Tuesday</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Wednesday</td>
<td>1</td>
<td>1%</td>
</tr>
<tr>
<td>Thursday</td>
<td>42</td>
<td>49%</td>
</tr>
<tr>
<td>Friday</td>
<td>3</td>
<td>3%</td>
</tr>
</tbody>
</table>
Before the pilot project, the Walk-In Counselling Clinic was open 4 hours per week with an average of 2 clients per week. Since more than doubling the WICC hours to 6 hours on Mondays and 4 hours on Thursdays, the number of clients visiting the WICC quadrupled to 9.3 clients per week. The majority of clients attended the WICC right when it opened at noon to “secure” a spot instead of a steady stream of clients attending throughout the opening hours. The reason for this trend is beyond the scope of this pilot project but is of interest for future monitoring to see if changing intake language or strategic promotion campaigns could influence visit times. Clients seen outside the Monday and Thursday operating days are the result of WICC clients booking a repeat single session visit with the same counsellor on a different day. In keeping with evidence-based practice of single session therapy, during the pilot counsellors at Family Service Regina’s Walk-In Counselling Clinic encouraged clients to return for further sessions if they felt the need. After compiling the data on the percentage of clients that are considered complete (i.e. not encouraged to continue with counselling), it is clear that brief therapy met the needs of most clients. The numbers illustrate few clients felt the need to access multi-session counselling.

**Figure 4: Status of Single Session by Percentage of Clients**

<table>
<thead>
<tr>
<th>Status of Single Session (% of Clients)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complete 65%</td>
</tr>
<tr>
<td>Placed on Wait List 27%</td>
</tr>
<tr>
<td>Referred to Community Resources 5%</td>
</tr>
<tr>
<td>Referred to EAP 2%</td>
</tr>
</tbody>
</table>
The majority of client sessions (65%) are considered complete after one counselling session, indicating a high rate of satisfaction with brief therapy provided in the Walk-In Counselling Clinic. Only 6% required or requested referral to other organizations while 27% were placed on a waitlist. This 27% may be indicative of those who prefer future meetings with the same counsellor or may reflect the current therapist climate at Family Service Regina. During the interviews, counsellors disclosed a fear of putting individuals at-risk with Single-Session Therapy. Literature on counsellor fear or resistance to brief therapy is scant; however, in their article discussing the state-wide implementation of Single Session Therapy at multiple clinics in Australia and New Zealand, Young, Weir and Rycroft (2012) described not only counsellor resistance to transitioning to this new model of service delivery, but hostility, and outrage, at the concept of providing less therapy. Young, Weir and Rycroft (2012) added that some of those counsellors expressed concerns over “increas[ed] stress associated with adopting a new way of working … [and] feeling pressure to provide one brilliant session” (p. 91). Some fear of initiating a new therapy may also stem from the change process, and further discussion on counsellor resistance can be found in the next chapter (Young et al., 2012; Juhila, Caswell & Raitakari, 2014). During this pilot project, it is possible the lack of confidence in brief therapy that counsellors disclosed may have influenced practitioners to encourage clients to consider multi-session counselling as opposed to returning to a Walk-In Counselling Clinic if needed despite evidence that demonstrates the vast majority of clients attend less than 4 sessions and may not be served well by waiting weeks or months for service (Slive & Bobele, 2012; Cait et al., 2016; Stalker et al., 2016).

As part of the data collection, it was important to capture information about client presenting problems to see if there was a commonality in the type of issue that brought clients to
the Walk-In Counselling Clinic. This data could assist Family Service Regina in determining future programming needs and ensure best practice for common or specific issues.

**Figure 5: Presenting Problems/Issues for Clients Attending the WICC**

The majority of clients attending the WICC identified relationship issues as their presenting problem. This would fit with information found in the literature which states that Saskatchewan has the highest rate of domestic violence (DV) in the provinces (Burczyka, 2017a; Burczyka, 2017b). DV survivors may seek help for their situation without identifying as a victim of DV due to trauma-associated distrust and vulnerability (Goodman et al., 2016). A trauma-informed agency approach ensures all clients are treated respectfully. Unfortunately, a clear picture of presenting problems within this pilot is muddied because the current data management system only allows one problem to be captured while many clients present with multiple problems. This leaves the data open to bias and is an area to be considered for future planning.

Determining the issues that caused individuals to seek rapid support is important for current and future planning. It was also important to identify what percentage of individuals who accessed
the Walk-In Counselling Clinic were already under the care of a counsellor as this is indicative of the need for rapid help even when traditional resources have been utilized, and underscores the multi-faceted issues a WICC can serve.

**Figure 6: WICC Clients Presently Seeing a Counsellor (Percentage)**

According to the data gathered, 91% of clients accessing the Walk-In Counselling Clinic are not currently under the care of another therapist. This is in keeping with research that finds Walk-In Counselling Clinics fill in the gaps for those in need of urgent assistance (Cait et al., 2016; Stalker et al., 2016). For the 9% that are currently seeing a therapist, literature demonstrates that a WICC can provide a “booster” that significantly relieves distress or helps with a new problem unique to, or not yet discussed in ongoing therapy (Stalker et al., 2016). This data confirms that a robust Walk-In Counselling Clinic is needed in this community. Canadian research has also shown that low-income and marginalized individuals attend accessible,
affordable WICCs (Barwick at al., 2013; Cait et al., 2016; Stalker et al., 2016). This trend was also found to be true in Regina.

**Figure 7: Yearly Income**

On the intake forms, 45% of clients did not complete the question focused on income. Of the 55% that did choose to declare income, almost 90% of clients utilizing the Walk-In Counselling Clinic live in poverty according to the Low Income Measure After-Tax (LIM) (based on a 3 person household). More than half of clients are more than $12,000 short of meeting a poverty level income (Gingrich, Hunter & Sanchez, 2016). This pilot project data clearly illustrates the WICC may be instrumental in reducing barriers to service and meeting the needs of low income individuals and families. Factors that may positively influence accessibility are the central location of Family Service Regina and increased hours of availability. Living in poverty does not always equate to unemployment. The next table indicates the source of income for client’s attending the WICC.
More than half of clients, 53%, indicated they are employed. Only 2% were referred to the EFAP program which may indicate the other 51% do not have an employer benefit program. A significant number of clients (43%) chose not to state their source of income, however considering almost 90% of clients accessing the WICC live below the poverty line, it can be estimated that a significant percentage have little to no income. Nearly one-quarter (23%) of clients are on financial assistance which identifies a potential necessity for continuing partnerships with the Ministry of Social Services or other community agencies to meet the needs of this population. Lastly, it was presumed that insufficient promotion created a barrier to optimal WICC utilization. The following data in Table 5 indicates how clients heard about the Walk-In Counselling Clinic during the trial of expanded hours.

**Table 5: How Clients Heard about the WICC**

<table>
<thead>
<tr>
<th>Source</th>
<th># of Clients</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referred by MSS</td>
<td>2</td>
<td>2%</td>
</tr>
<tr>
<td>Social Media</td>
<td>3</td>
<td>3%</td>
</tr>
<tr>
<td>Blank</td>
<td>12</td>
<td>14%</td>
</tr>
<tr>
<td>FSR Intake</td>
<td>15</td>
<td>17%</td>
</tr>
<tr>
<td>Other</td>
<td>54</td>
<td>63%</td>
</tr>
</tbody>
</table>
This data gauged how individuals are hearing about Family Service Regina’s Walk-In Counselling Clinic. The majority of clients (63%) chose “other” for the source of information on the WICC program; therefore, their source is unknown. Only 3% of clients chose social media on the intake form even though Family Service Regina’s WICC is promoted on the Internet and through social media. Word of mouth was not offered as a choice on the form and could be considered a possible source. This may be reflective of how clients hear about and access rapid response assistance. These statistics will help FSR form a strategic advertising campaign for the future. The bottom line is that the majority of clients attending the Walk-In Counselling Clinic likely do not have the means to afford general counselling. Without a WICC their needs likely remain unmet.

Figure 9: The Bottom Line

- **Access to EFAP or benefits?**
  - 79% of clients would have to pay for services on their own. Considering 90% of WICC clientele make less than $50,000/year this is a significant barrier to service.
  - A WICC increases accessibility for low income earners.

- **Attended WICC before?**
  - 83% have not accessed a WICC before.
  - In 2016, only 103 clients utilized the WICC. In the first 9 weeks of 2017, 84 clients have already attended, 70 of whom have never done so before.

- **Attended WICC in last 3 months?**
  - 76% of clients have not attended in WICC in the past 3 months.
  - Although the WICC has been operationalized for 6 years, few clients access the service more than once in a 3 months timeframe.
Given the high percentage of clients who had not accessed the existing Walk-In Counselling Clinic prior to the trial, the dramatic increase in WICC attendance is likely indicative of previous barriers to care, ostensibly infrequent hours and ineffective promotion. This data provides tangible numbers to confirm under-utilization of the existing Walk-In Counselling Clinic and increased usage during the trial of expanded hours.

The data gathered in this study clearly supports a need to move forward with an expanded, sustainable Walk-In Counselling Clinic at Family Service Regina. To understand the impact this information could have on future programming, an in-depth discussion of the findings is offered in the next chapter.
Chapter Seven: Discussion

Progressive, innovative programming designed to improve community access to rapid response needs to be an on-going process. As part of this research and pilot project, internal, local and national stakeholders have presented invaluable input to support the possibilities of moving forward with Walk-In Counselling Clinic implementation in this city. While national agencies have already implemented a WICC within their operations, Family Service Regina and local agencies are still in the planning phase. To move forward productively, the process needs to focus on learning about, and appreciating, each stakeholder’s situation and experience as a precursor to future pathways. Data that was gathered during this project was evaluated utilizing an Appreciative Inquiry framework to highlight inherent strengths in existing programs on a provincial and national level. Statistical data provided a picture of the population being served before and during the pilot expansion of hours in Regina, and stakeholder interviews highlighted challenges and successes locally and nationally. After data analysis, three critical themes: affinity, sustainability and capacity for a Walk-In Counselling Clinic, were identified and underscore the need to focus on the best elements, what works well, in order to build a future program based on that capital (Busche, 2016). Thematic analysis is particularly relevant in this project as the findings are “experiential and interpretive realities of the participants”, and can be used to complement the information garnered from statistical data (Braun & Clarke, 2014, p. 48). Analysis of the data was used to inform the recommendations as presented in the next chapter, thus, some of this discussion will include dialogue on, and justification for, some of the recommendations. The themes will serve as the format for the discussion in this chapter.
Affinity for the Program

The main strength of the existing Walk-In Counselling Clinic at Family Service Regina and WICCs elsewhere is practitioner affinity for the program. From internal agency members to national directors, all those interviewed embraced the WICC for its ability to meet the needs of the impoverished and vulnerable. The positive effect on the community was considered to be of high importance, and those agencies that had established barrier-free WICCs had outcome data that demonstrated improved client well-being. Locally, agencies agreed that a coordinated, cohesive WICC program was necessary to fill in service gaps and meet the needs of those unable or unwilling to wait for services, as well as those with no need or desire to engage in multiple sessions. Counsellors at local agencies expressed feelings of professional pride from providing services to an underserved population, and directors from national agencies noted their counsellors also expressed the same sentiment. This pride was critical in building and sustaining WICC programming at the national agencies. At Family Service Regina, capitalizing on that pride may be the pivotal point on which program delivery proceeds fluidly as it will help breakdown resistance to program expansion. Without therapist buy-in, service delivery would be a challenge.

During the pilot, statistical and demographic data was obtained in part from intake forms. Approximately 30-40% of intake forms were not completely filled in. The reason is unknown, and all data was reconciled based on known information. Nearly 90% of clients accessing the Walk-In Counselling Clinic during the pilot live below the poverty line according to the Low Income Measurement, and nearly one-quarter (23%) are on financial assistance (Gingrich et al., 2016). While 53% of the clients are employed, information from the intake forms found 77% of clients had no insurance or Employee and Family Assistance Program coverage and had to pay
for services on their own. More than half of clients do not have benefits and are impoverished, therefore likely unable to afford general counselling fees. These numbers are similar to the populations served by the national agencies, and are supported by research that has found WICCs are critical in meeting the needs of the vulnerable.

Research indicates introduction of a barrier-free Walk-In Counselling Clinic substantially reduced wait-lists, and all the national agencies interviewed had that experience (Young et al., 2008; Barwick et al., 2013; Cait et al., 2016; Stalker et al., 2016). Although we do not have data from this pilot to confirm the same would happen at Family Service Regina, given that increasing FSR’s WICC hours by 1.5 times resulted in a 4.5 fold increase in usage, there is reason to believe a more accessible, coordinated WICC would also decrease wait-lists in Regina. Other data that substantiates the value of the WICC in this community include:

a) In general counselling services, 52% of clients in the past 6 years attended 2 or less sessions and 77% attended 4, or less, sessions.

b) In the existing Walk-In Counselling Clinic before the pilot, more than 88% of clients did not return for another session while during the pilot, 65% were considered complete after one session.

c) The number of males accessing the WICC increased throughout the course of the pilot.

d) During the pilot, 91% of clients did not have a previously-established relationship with a therapist.

e) Only 103 clients accessed services in the existing WICC in the past year, while 84 attended in the first 9 weeks of the pilot.

f) Eighty-three percent of clients had never accessed a Walk-In Counselling Clinic before.
These numbers indicate more than 75% of clients wait 2 – 5 months for help, risking worsening symptoms, when help could be accessed rapidly with an expanded WICC program. The vast majority of clients accessed the WICC as a first-line of care for an immediate need and did not return for further counselling, possibly indicating high satisfaction with brief therapy. Literature indicates males prefer WICCs to general counselling, and this data shows the same trend. Expanded hours and enhanced promotion through social media, as well as changing the Walk-In Counselling Clinic at FSR to reflect the pilot project hours, likely contributed to a dramatic increase in the number of client visits.

An Appreciative Inquiry framework recognizes that organizations and practitioners have the capacity to undergo meaningful change when transitions are built on something that works well. Data shows the Walk-In Counselling Clinic pilot was instrumental in reducing barriers to service and meeting the needs of low income individuals and families. Internal and local staff and national agencies have identified professional pride as a strength that came from delivering services to a hard-to-reach population. This is the strength and resilience on which to encourage and sustain meaningful change at Family Service Regina. To benefit both FSR and the community, it is recommended that the expanded WICC hours are maintained with consideration of future expansion. Given the majority of clients are low-income; the service should remain free of fees. During the pilot, the WICC was attended equally on both days it was open (Mondays and Thursdays) however clients tended to ‘queue up’ at the beginning to secure a spot. This is an area for further exploration in order to determine whether operating hours are relevant to the population.

Given the considerable increase in the WICC utilization during the pilot and evidence from the literature that substantiates its value, it is not unreasonable to presume that an expansion
of the program would assist in the reduction of current wait-times at Family Service Regina. The reduction from 89% of clients accessing the WICC once in the past 6 years, to only 65% being considered complete by a therapist after a single session during the pilot, may indicate some attention is needed during intake. However, it may also reflect therapists’ fear of brief therapy which will be discussed later. National agencies indicated an overhaul of their intake procedures improved accessibility of the WICC. At Family Service Regina, redefining the current screening and pre-screening process could improve direction of clients to the Walk-In Counselling Clinic as a first line of response rather than placement on the wait-list. Even for clients with Employee and Family Assistant coverage, the WICC may be able to off-load those who only need a single session from the wait-list. Improving dialogue with the client during initial contact could help improve client flow because intake language is important in ensuring new clients receive the most rapid response warranted. It also helps clients choose which type of therapy, general counselling or brief therapy, best meets their needs.

**Sustainability**

With non-profit organizations, funding is always the main concern when considering sustainable programming. Addressing fiscal and budgetary issues is out of the scope of this project; however, one of the purposes of the pilot was to expand hours within current financial and personnel constraints. Family Service Regina employees were very concerned about the impact of expanded hours on therapists already working at capacity. This concern is real and echoed by national agencies as they maneuvered a WICC institution.

Walk-In Counselling Clinics do not usually charge a fee for service. Because of the absence of profit, they tend to be integral components of community agencies rather than private counselling businesses. Non-profit community agencies like FSR rely on funding and must find
innovative methods to implement new programming without additional resources. Canadian research indicates the majority of community agencies rely on university practicum students to staff their WICC programs (Barwick et al., 2013; Cait et al., 2016). During the interviews, national agencies indicated they relied on students to ensure their program was always staffed. This pilot was staffed primarily by practicum students including myself, and two Masters in Educational Psychology students. Social work and Psychology faculties and colleges are dependable sources of students, however, practicum students are defined by the period of their practicum so are time-limited. Ensuring a reliable and stable number of students are available to sustain an expanded WICC would in part rely on formalized partnerships with universities. These relationships should benefit not only the agency and community, but the students as well. Strategic partnerships could assist in the formulation and maintenance of adequate student training and supervision and ensure up-to-date evidence-based therapy is maintained.

Continuity of service requires not only dependable staffing, but consistency in service delivery. Processes aimed at defining the agency’s model of operation protects its values. Family Service Regina’s mission is to “strengthen individuals, families and communities through responsive leadership and innovative programs and services” (Family Service Regina, 2016). Development of a Walk-In Counselling Clinic manual would provide background information on FSR such that all staff, including students, are aware of its mission, values and principles. Information on the development, purpose, and role of both multi-session and brief therapy would highlight the similarities, differences, and need for both. Recommended models and tools for counselling, including research, studies, and resources on evidence-based therapies should be included in the manual to enable best practice. This information would provide a conceptual framework to inform therapy. Inclusion of the code of ethics for each respective profession is a
critical resource, especially as a readily accessible guideline for students to follow. This would also be the place to incorporate documents on client rights, confidentiality, service limitations and safe-workplace policy. Front desk protocols and procedures may be added to ensure standardization of the client experience. Examples of all forms including tracking sheets, sign-in packages and outcome measures, and where they are available, would complete the manual as a comprehensive reference.

In Regina, an integrated Walk-In Counselling Clinic program would best meet the needs of the community through coordination of services with other local agencies to ensure consistent, accessible, gap-free service. The WICC at Catholic Family Services is physically hard to access; however, its location at a Food Bank does provide a unique opportunity for community members to access services while also accessing food and programming. Both FSR and Mental Health Regina are in central locations, easy to access by foot and public transit. Coordinating the WICC hours with the other agencies would ensure clients have access to services in multiple areas of the city.

Local agencies frequently refer to and from each other, and the interviews revealed internal stakeholders feel each one operates as an island. Current programming is isolated and to some degree disjointed. Mental Health Services Regina is considering instituting a stepped-care model to improve client flow and maximize efficiency without having to increase staff, while the Director of Operations at Family Service Regina plans to move towards a trauma-informed model. An integrated Walk-In Counselling Clinic in Regina would require coordination of services, including hours and locations, and necessitate some convergence of an operational model; whether it is a stepped-care model, a trauma-informed (TI) approach, or both. Stepped-care focuses on the structure of care and how people access and move through the system,
whereas a TI model puts emphasis on the client’s experience, and how individuals are interacted with, within the system. It is not unreasonable to suggest all local agencies adopt a TI approach to consistently and respectfully work with the population, while the stepped-care model may be more of interest to a larger agency such as Mental Health Services that is closely associated with other health care providers such as physicians.

It is important to note a Trauma-Informed approach has no effect on waiting-lists whereas stepped-care can be integral in reducing wait-times. Research has shown a robust WICC decreases wait-lists irrespective of the operational model (Young et al., 2008; Barwick et al, 2013; Cait et al., 2016). In this community then, the model of care is less about structure and more about consistency. Reduction in wait-times may occur from implementation of a stepped-care approach in one agency that impacts other wait-lists through attrition. How people perceive the services and the ability for all the local agencies to provide respectful, seamless care requires cohesion. A literature search explains the roles of a stepped-care model and a TI approach, and is discussed below.

**Stepped-Care model.**

The Stepped-Care model is an interesting approach to care. This model was implemented to increase access and efficiency of mental health care with a primary focus on psychological interventions (van Straten, Hill, Richards & Cuijpers, 2015). Fragmented health care and social systems can complicate and delay access to care. Once counselling is offered or recommended, wait-lists can hinder timely treatment and waiting can increase the burden and sequellae of the presenting issue (Oosterbaan et al., 2013; Shedden-Mora et al., 2016). A stepped-care model offers services to the individual at the most effective but least interventional level and only ‘steps up’ care to more intensive and specialist services when clinically required (Watzke et al., 2014).
The tenet is that primary low-intensity treatments are sufficient for most clients and are deliverable at the time they are most needed. This integrated pathway ensures individuals do not sit on wait-lists for more specialized or intensive service unless necessary, reducing the wait-times for those who need them. Offering immediate low-intensity services such as brief counselling has been reported to reduce depressive symptoms and risk for occurrence of a clinical depression by approximately 50% (Watzke et al., 2014; Shedden-Mora et al., 2016). A systematic review and meta-analysis of outcome studies found better outcomes with stepped-care than with traditional care (Oosterbaan et al., 2013; van Straten et al., 2015). However data on long-term outcomes was insufficient to recommend it as a dominant model for organizations (van Straten et al., 2015).

When properly implemented, this model has the ability to offer services along a continuum of care. It is a strategic approach to maximizing efficiency in agencies at capacity, offering rapid services to individuals with mild to moderate symptoms in immediate need of an intervention, while offering greater resources to those with complex problems (Lorenzo-Luaces, DeRubeis, van Straten & Tiemens, 2017). The benefit of early intervention can be seen in reduction of chronic symptoms (Hermans, Muntingh, Franx, van Splunteren & Nuyen, 2014; Shedden-Mora et al., 2016; Lorenzo-Luaces et al., 2017). This equates to lower overall costs for the individual, the healthcare system, and society (Goorden et al., 2014). Stepped-care has proven to be cost-effective in a mental health setting (Goorden et al., 2014). However, consistent monitoring of clients is a necessity to ensure those who do not improve are not lost (Lorenzo-Luaces et al., 2017).

It is this monitoring piece that may not make this model suitable for Walk-In Counselling Clinics. While stepped care is designed to deploy resources strictly according to need, WICCs
rely on client preference for further participation. The primary step in stepped-care is guided self-help, usually suggested by a primary caregiver such as nurse or physician (Oosterbaan et al., 2013). In our healthcare system, physicians can be hard to access and it is unclear how the follow-up piece might consistently flow. With the reliance on students for sustainable WICC delivery, inadequate training, lack of structured support and supervision, and inexperience of students could place some clients at risk, especially those with complex needs (Lorenzo-Luaces et al., 2017).

Evidence for a stepped-care model in agencies that see a wide variety of clients and an even wider variety of presenting problems is lacking as studies have mostly concentrated on a singular disorder, anxiety. There is a need for research on its place in addressing other behavioural and emotional disorders. A hindrance to implementation in community agencies not directly associated with a physician group such as Family Service Regina and Catholic Family Services, is the requirement that a physician request step-up care if primary care is insufficient (Watzke et al., 2014). It is possible many clients access services at FSR at the request of their physician, however, continued counselling is usually at the discretion of the client and counsellor. Follow-up then, is driven by the individual’s desires in conjunction with the therapist. While follow-up with a physician may be suggested, it is not an integral part of the process. Stepped-care is designed to fluidly move clients through a system but does not address how they are acknowledged and responded to. A trauma-informed model of care guides how clients are interacted with at every step of the process.

**Trauma-Informed approach.**

Trauma is prevalent in our society and can increase feelings of anger, distrust and fear, with long-term mental and physical health consequences. Negative experiences in care systems
may further traumatize individuals and prevent survivors from seeking help (Muzik et al., 2013; Reeves, 2015; Goodman et al., 2016). Failing to recognize and address trauma may contribute to incomplete treatment and negative outcomes (Brown, Harris & Fallot, 2013; Muzik et al., 2013). Increasingly, human service agencies that work with survivors have found a trauma-informed (TI) approach improves outcomes (Goodman et al., 2016). A TI approach is centred on two tenets: “(a) any person seeking services or support might be a trauma survivor and, (b) systems of care need to recognize, understand, and counter the sequelae of trauma to facilitate recovery” (Goodman et al., 2016, p. 748). TI services create a treatment culture of nonviolence, learning, and collaboration (Brown et al., 2013; Goodman et al., 2016).

The four key principles of a TI approach are: 1) trauma awareness, 2) emphasis on safety and trust, 3) opportunity for choice and collaboration, and 4) focus on strengths and skill-building (Brown et al., 2013). In order to embed an understanding of trauma in service delivery, every individual at a TI agency, from the staffing at the front-desk to the directors, should be TI trained (Brown et al., 2013; Bateman, Henderson & Kezelman, 2014). The cost of inadequate services to the individual, community and society in terms of long-term health and economic consequences can be immense; while becoming a trauma-informed agency is not costly (Domino, Morrissey, Nadlicki-Patterson & Chung, 2005; Bateman et al., 2014). Rather it relies on a shift in culture and practice that involves alterations to policies and procedures to ensure client and staff safety and security; and most importantly, adopting language that is non-threatening, non-judgmental and empowering (Brown et al., 2013; Drabble, Jones & Brown, 2013; Bateman et al., 2014).

Compartmentalization of health-care, social services and mental health services including counselling agencies result in fragmentation of treatment strategies and poorer outcomes (Brown
Studies have shown that women who access services at TI agencies experience significantly more reductions in symptoms and sequelae of trauma compared with non-TI experiences (Domino et al., 2005). Trauma-screening of all clients is integral to the process, as well as flexible intake and assessments that engage clients in a safe non-judgmental environment (Drabble et al., 2013; Reeves, 2015). Acknowledging the client’s strengths, capabilities and self-awareness through collaborative decision-making and co-constructing goals ensures autonomy and builds trust (Muzik et al., 2013; Bateman et al., 2014; Reeves, 2015).

Saskatchewan has the highest rate of intimate partner and family violence amongst the provinces (Burczycka, 2017a; Burczycka, 2017b). It is likely then, that a considerable number of clients who access counselling services in Regina have been exposed to trauma. Data from this pilot project indicates 65% of clients declare “relationship issues” as a presenting problem at the WICC. Research indicates many trauma survivors are fearful to disclose and may minimize the problem, therefore, many of the clients at Family Service Regina may be seeking help without identifying the trauma (Goodman et al., 2016). Without an integrated TI approach, these individuals are at risk of re-traumatization and failure to seek or complete interventions (Muzik et al., 2013; Bateman et al., 2014). While a WICC is critical in providing an immediate service for these individuals, approaches that do not recognize trauma may negate any benefits.

An understanding of trauma is critical in a strengths-based, recovery oriented approach (Bateman et al., 2014). Moving toward a Trauma-Informed approach requires adoption of evidence-based TI practices, staff education, and a focus on outcomes. Collaboration amongst other agencies in the community facilitates articulation of shared values, information sharing, budgeting, shared training and parallel systems. The benefit to the client is improved outcomes which translate into benefit for service providers in terms of professional satisfaction and pride.
(Bateman et al., 2014). TI services consider the unique vulnerabilities of survivors and aim to mitigate barriers to service. Given the rates of violence in this province, the importance of a TI approach cannot be understated.

The recognition of trauma is a pivotal connection between delivery of services and evidence-based practice. It is feasible for Stepped-Care and Trauma-Informed models to work in conjunction with one another, provide consistency, and unite local agencies. Intake and front desk are the initial points of contact with new clients. In moving toward a TI approach, re-examination of Family Service Regina’s front desk procedures and protocols would inform development of relevant procedures and protocols. It would ensure all staff is appropriately and consistently trained in trauma-informed language and guidelines. An integrated community Walk-In Counselling Clinic program in Regina will depend on making the most of the strengths of each individual agency to create connections that assure sustainable, barrier-free programming.

**Professional Capacity**

In an Appreciative Inquiry framework it is imperative to recognize stakeholders’ experience within their environment. During the interviews internal agency staff, and to lesser extent local agencies, had a tendency to worry about deficits in the system rather than resources and possibilities. However Appreciative Inquiry is a generative process and as such, identified deficits were re-constructed as opportunities for improvement in order to build on the resourcefulness of the staff, the profession, and the agency.

During the interviews, internal agency staff and local agencies expressed concerns that integration of a WICC could erode traditional counselling services. These concerns are not unique to this community. During implementation and expansion of their WICCs, more than one
national agency experienced a staff exodus due to non-acceptance of the new programming. The reasons this happened were varied but most commonly included the counsellors’ fear that a WICC could replace traditional counselling. Employee resistance to change is well-documented in the literature and cannot be discounted as an impediment to change or advancement. However, this section will discuss therapists’ concerns as they relate to professional capacity and employee resistance to change will be discussed later in this chapter under the Challenges section.

Therapists’ concern over the erosion of general counselling may be rooted in a lack of knowledge on the effectiveness of brief therapy. Some respondents were concerned that brief therapy, especially one session, puts clients at risk. Literature confirms a “shift in thinking” is required for therapists trained in traditional counselling to accept that meaningful change is possible in a single session (Young et al., 2008; Lees & Dietsche, 2012; Cait et al., 2016). The data collected during this pilot indicates 27% of clients accessing the WICC were subsequently placed on the wait-list for further counselling. It is not known whether this represents the number of clients requesting further service or is reflective of the counsellor’s fear of the effectiveness of the single Walk-In session. Education of the staff on single session counselling is critical to both clients and therapists. Several of the individuals interviewed identified workload as a concern. In an agency such as Family Service Regina, where most of therapists provide traditional services and carry heavy caseloads, the additional responsibilities associated with a Walk-In Counselling Clinic may be problematic. More than one individual expressed discomfort at having to ‘stretch’ their schedule to accommodate new duties at an expanded WICC. This is not unfounded, as wait-lists indicate the agency is already at capacity. Once again, education is critical. It is imperative employees are informed as to how the WICC will be staffed (students, etc.) and what duties will be expected of everyone. Information and communication can lay fears to rest.
An interesting concern was mentioned by one individual and echoed by others during the interviews. Some participants anticipated the Walk-In Counselling Clinic would become a ‘dumping ground’ for clients with complex needs who were unwilling or unable to wait for counselling. The pilot project found 83% of clients accessing the Family Service Regina Walk-In Counselling Clinic had never attended one before; therefore this expressed concern is based in speculation rather than fact. One explanation for this line of thinking could be the therapists’ lack of confidence in their ability to effectively deliver brief therapy. Another is an unwillingness to fully commit to the concept of single session therapy. The purpose of a Walk-In Counselling Clinic is to meet the client’s needs at the time of their choosing without waiting or formal assessment (Harper-Jacques, McElheran, Slive & Leahey, 2008; Cait et al., 2016). Thus, intake processes that give therapists an idea of the client’s issues are typically not available. Of course some clients require more than brief therapy, however, considerable research has shown the majority of client’s prefer, and attend, less than four sessions (Perkins, 2006; Slive & Bobele, 2012). It is possible that counsellors who will not commit to the philosophy of brief therapy are disquieted by the idea of working with a client in the moment. More than one national agency disclosed they had staff that ‘chose’ clients based on their intake forms, avoiding those with complex needs. This could be indicative of a need for on-going education to build skills and it is an opportunity to establish a strong support system for all employees.

Those national agencies that had operated a Walk-In Counselling Clinic for more than two years discussed the importance of implementing programming slowly and methodically. Literature confirms strategic implementation increases the chance of program success (Harper-Jacques et al., 2008; Young et al., 2008; Cait et al., 2016). More than one national agency considered inadequate program implementation to be an internal barrier to the initial success of
the WICC. They recommended change occur over a period of no less than six months. Training of staff was critical to both therapist buy-in and successful implementation. Adequate training ensures consistency amongst staff which translates into better service for clients. These agencies also emphasized the importance of maintaining consistent outcome measurements and utilization data to support the role of the WICC and substantiate any future changes in programming.

Data collected during the pilot at Family Service Regina has indicated a Walk-In Counselling Clinic is needed in the community it serves. Staff and students need to be made aware of these findings; the role of education cannot be understated. Placing time and effort on professional development would help ensure that staff feels confident and supported. Regular peer supervision during which counsellors play an active role in disseminating information would facilitate learning, sharing of ideas and exchange of information. De-briefing, either during peer supervision, amongst therapists, or with managers should be considered critical. Education, training and supervision are necessary to ensure students are able to deliver consistent, quality care. Students could contribute to everyone’s benefit through regular presentations on the most current trends in research. For these reasons, the recommendations include suggestions for ongoing staff training, including orientation days.

Innovation

Innovation was a theme identified from the national agencies interviewed. Implementing a WICC required, and still requires, innovative ideas and programming. All four national agencies restructured and redefined their intake and screening process to ensure optimal client flow. Unfortunately no specific details were given as to how this was done. However, research confirms a Walk-In Counselling Clinic should be responsive to the client’s needs without the red tape of intake and assessments (Harper-Jacques et al., 2008; Young et al., 2008). At Family
Service Regina, this means examining intake language and how clients are directed, whether encouraged to come to the WICC or placed on a wait-list. One national agency reached out to partner agencies to examine cooperation and cohesion in order to continually adapt to the community’s changing needs. In Regina, the local agencies must communicate with each other to coordinate and streamline services.

Mental Health Services in Regina is considering a Stepped-Care model to deliver services, and it has been recommended all local agencies move towards a trauma-informed approach. An agency in Ontario has chosen a different model to improve patient flow. The Choice and Partnership Approach (CAPA) has been widely used in England and Australia in mental health settings. Although it has not been mentioned as a model of interest in this community, it is important to explore relevant models, especially when a national affiliated organization has chosen this path. A review of the literature clearly demonstrates that CAPA is an innovative design model worthy of consideration.

**Choice and Partnership Approach (CAPA).**

The Choice and Partnership Approach (CAPA) is a strengths-based model in which clients and service providers work together to plan treatments and interventions based on the individual’s goals and capacities. The words ‘choice’ and ‘partnership’ are meant to replace the words ‘assessment’ and ‘treatment’ typically used in traditional care. CAPA was developed as a model to reduce waiting times and improve access to care systems usually within a mental health setting (Robotham & James, 2009). Treatment plans are formed at two possible appointments, the Choice appointment and the Partnership appointment. During the Choice Appointment, clients choose how they want to work towards their goal, using community or mental health
services, group, or individual treatment. The Partnership Appointment is then booked with the appropriate service provider.

An evaluation of an implementation of the CAPA model in Child and Adolescent Mental Health Services in England found waiting lists did not significantly decrease for partnership appointments (Robotham & James, 2009). The main advantage was less waiting time to be initially ‘assessed’. Being seen quicker facilitated a more rapid response for clients not requiring more specialized treatment (Robotham & James, 2009). On the other hand, an Australian study found implementation of the CAPA model resulted in significantly reduced waiting times, and improved navigation through the system that resulted in children and adolescents being seen sooner than in usual care (Naughton, Carroll, Basu & Maybery, 2017). Flow through the system greatly improved and no negative clinical outcomes were reported (Naughton et al., 2017).

CAPA relies on adequate education and supervision of staff. This may prove difficult in smaller multi-disciplinary teams where the most senior employee of a discipline is the only staff member and there is nobody else to supervise (Robotham & James, 2009). This approach facilitates formal planning mechanisms and may be useful in large national organizations; its application in small centers has not been proven (Robotham & James, 2009). It is not necessarily able to reduce barriers to accessing partnership, or treatment appointments (Wallcraft et al., 2011). Entry into the CAPA system requires a referral from a physician which makes its applicability in a Walk-In Counselling Clinic program questionable. In addition, lack of commitment by service providers, accessibility of service providers already at capacity, and funding can complicate users’ flow through CAPA (Wallcraft et al., 2011).

This model may not be appropriate in this community at this time, however, it was important to explore based upon the data and information collected as part of this project. In
order to strategically institute a Walk-In Counselling Clinic, some national agencies had to innovate by adopting different therapy models than they had previous utilized, such as Narrative Therapy, which works well within a brief therapy setting (Young et al., 2008). Still others changed the time allotted for a counselling session, limiting it to 30 to 45 minutes so as to see as many clients as possible. These ideas are all possibilities and their relevance will unfold as the Family Service Regina WICC expands. In Regina, innovation will be needed to develop a strategic promotion campaign for the expanded hours. When asked how they had heard about the WICC, only 3% of clients answered “social media”, while more than 60% chose ‘other’.

Although Family Service Regina has a staff member dedicated to communications, underutilization of the existing WICC before the pilot indicates promotion could be improved. When doing the environmental scan, I found it difficult to find easy information on a Walk-In Counselling Clinic in Regina. During the pilot, myself and the other masters level students suggested changes to the social media promotion to make it more user-friendly. However, making changes was out of our scope as FSR has a dedicated employee for media relations. Still, a robust promotion campaign would reach clients without Internet, and development of a strategic advertising campaign is recommended.

Developing and maintaining an up-to-date reference list of community services, programming, program details, and agency contact information would help ensure counsellors have appropriate references for client referrals. This information should enhance the ability of the counsellor to provide seamless care in both brief and multi-session counselling. Creating a coalition with Family Service Regina and affiliated agencies would improve coordination of services. Locally, the coalition could have quarterly meetings to decide how soft transfers and referrals are conducted and managed, and avoid duplication of services. This group could share
information, outcomes, educational opportunities, coordinate and promote programs and services, and discuss successes and challenges. Provincially, the coalition could meet twice yearly to strengthen the existing Family Service Saskatchewan Working Group and explore opportunities for unified service provision. Nationally, a coalition could meet yearly to share information on innovative programming, sustainability, funding opportunities and forecasting.

**Challenges**

Challenges were identified as an additional theme from the interviews with national agencies as they have had a few years of experience with implementing and operating a Walk-In Counselling Clinic. Overall, national agencies tended to use positive language when discussing implementation of their Walk-In Counselling Clinic. However, when asked about any challenges, all four agencies noted staff resistance had been a major impediment during the WICC program implementation. The issues were similar to the ones expressed during interviews with Family Service Regina staff. Some employees at the national agencies were fearful of the change in focus toward brief therapy, afraid a WICC would replace general counselling services. Some opposed the idea of a “free service” and favoured a sliding scale fee for service. Others did not like the changes to the intake process, and objected to the absence of a screening process. Clinical directors at those national agencies surmised the resistance was reflective of prior behaviours in which counsellors’ customized caseloads based on intake information. At one agency, some staff refused to treat clients on an as-needed basis during the WICC implementation. Most national agencies lost staff members due to disagreement over the WICC implementation, and at some agencies the resistance was so significant that therapists were actually considered a barrier to service.
Interviews with Family Service Regina employees, local and national agencies revealed reluctance of staff, notably ‘mature’ staff, to accept the incorporation of an expanded WICC into their practice. A number of factors could contribute to this resistance, not the least of which is a lack of education on the necessity and effectiveness of Walk-In Counselling, and a lack of individual confidence on the ability to deliver optimal care (Young et al., 2012). A literature search found very little research on this type of resistance. Most discourse on resistance during therapy focuses on client resistance to care. However, the findings in this pilot project are similar those found during implementation of brief therapy at the multi-site Bouverie Centre in Australia and New Zealand, where counsellors felt changing service delivery threatened their preferred approach to therapy (Young et al., 2012). Resistance to the change created tensions and stress between counsellors and management, as staff was leery of the reason for the change, and suspicious that it was an attempt to “reduce services . . . or reduce resources to their service” (Young et al., 2012, p. 87). While education on brief therapy played an important role in mitigating the resistance and diminishing fear of failure, the authors report that diffusing the ‘clinician’s illusion’ that most clients prefer or require multiple sessions with statistics on the actual number of per client visits, had the most impact on counsellor attitude (Young et al., 2012). With this evidence, managers were able to reframe the change process from a perceived service reduction, to a method of maximizing service by providing good service to all clients, whether they choose to attend one or multiple sessions (Young et al., 2012). Acknowledging counsellor resistance and mitigating it with education, leadership and support helped the Bouverie Centre successfully incorporate brief therapy into their mandate of care (Young et al., 2012).
On the other hand, some employees are simply not comfortable with change (Al-Haddad & Kotnour, 2015). The concept of employee resistance to change is well-documented in the research, however to date there is no consensus on universal strategies to overcome it (Kuipers et al., 2013; Al-Haddad & Kotnour, 2015). There are, however, numerous theories and models on how to manage change and mitigate resistance. Research indicates people resist change because of the uncertainty, and risk for failure with new obligations (Hon, Bloom & Crant, 2014). It is beyond the scope of this paper and project to fully explore the concept of employee resistance because it falls within organizational change which is a whole other field of study. However, two interesting theories that focus on employee strengths during the change process were identified during the review of the literature as part of this project, and are briefly discussed below.

Nudge theory is a relatively new concept that accepts and facilitates employees’ attitudes, knowledge and capabilities and seeks to manage change through indirect encouragement and enablement rather than instructing and enforcing (Chapman, 2015). This theory is of interest in non-profit agencies because it offers a method of identifying, analyzing and re-shaping existing choices (Chapman, 2015). In the case of FSR, the ‘nudge’ would take the shape of the WICC report that informs, educates and offers evidence to employees of the reason for change, while encouraging their acceptance by referencing their invaluable input into the past, present and future process. Nudge theory builds on employee strengths.

An interesting report from the University of Toronto School of Public Policy and Governance discusses the incorporation of behavioural science into the process of change in organizations (Galley, Gold & Johal, 2013). While this report focuses on achieving change within government organizations, the theory behind it is applicable to a small organization such as Family Service Regina. According to Galley et al., 2013, during the process of change in an
organization, “the greatest challenge is creating the institutional culture necessary for new service delivery models to succeed” (Galley et al., 2013, p. iv). The authors contend that by making positive behaviours easier, positive impacts on the agency culture can occur and facilitate change (Galley et al., 2013). It is important for the agency to remain results-focused in order for staff to appreciate their role in positive outcomes. When employees are able to see the end result of their work, (in the case of a WICC, positive benefits to the community), professional pride flourishes and facilitates a “shift in thinking” that encourages positive changes on the agency culture. This is not entirely different from Nudge theory; it builds on employee strengths.

It is important to understand that front line staff are immersed in their role as service providers. Given the wait-list of 2 – 5 months at Family Service Regina, those therapists are likely working at capacity. Expanding the WICC hours requires additional therapist time commitment, yet the mandate is to expand the Walk-In Counselling Clinic within current fiscal and personnel constraints. Resistance to this change, therefore, is not surprising. According to Juhila et al., 2014 in their chapter on resistance in social work, when change is perceived to hinder client-counsellor care or limit professional discretion on care delivery, counsellors may challenge the necessity or validity of the change (Juhila et al., 2014). This behaviour has been called the “micro-politics of resistance”, where the target of resistance is a policy or a change in service delivery (Juhila et al., 2014). Professionals cannot reject a new policy and still remain employed in the organization, so they may display resistance through the use of subtle strategies such as criticism, challenging instructions, countering positive dialogue with negative, and dismissing ideologies, theories or practices as invalid (Juhila et al., 2014). Education that focuses on exposing the counsellor to sound research and evidence can help mitigate some of the
resistance (Juhila et al., 2014). Good communication between all stakeholders can make implementation of the change process easier (Young et al., 2012). According to Boohene and Williams (2012) in their study on factors that influence resistance to organizational change, communicating the need for the change to employees by offering external information about the rationale contributes to employee’s readiness for the change, and education and support are critical in mitigating resistance (Boohene & Williams, 2012).

The theme, then, is that education and communication is critical when instituting change. It is my understanding that the proposed changes in Walk-In Counselling Clinic expansion at Family Service Regina have been discussed with staff for more than one year. Communication has been ongoing, with discussions at some weekly peer review meetings. In addition, I presented an overview of the pilot project to staff during a staff meeting. The next important facet will be dissemination of the evidence gathered from this project, to educate and inform. The report not only presents clear statistics on the population the WICC serves, a population previously unreached, but includes literature reviews on Single Session Therapy and Solution-Focused Brief Therapy which will provide education on the effectiveness of these modalities. Hopefully the report and literature review will provide opportunities for collegial discussion, exploration into future possibilities, and self-directed change.

Another challenge the national agencies identified during the interviews was administrative burden. They found evidence-informed programs require a considerable amount of paperwork and not-for-profit agencies did not have the staffing complement to maintain it. I am not sure how this aspect would affect Family Service Regina; however it is good to be aware of the potential problem. As part of an innovative approach to implementing a no-fee Walk-In Counselling Clinic, most national agencies formed strategic partnerships with other community
agencies; and all experienced some difficulties in the group decision-making process because decisions should take into account the needs of all partners. Partnerships can be hindered by lack of clarity and competing interests on the issue of resource allocation (Al-Haddad & Kotnour, 2015). Creating a coalition with affiliated agencies locally, provincially, and nationally to manage inter-agency transfers, coordinate resources and share information and ideas on sustainability and innovative program design would help ensure those most in need are heard and receive a fair share of the resources.

Challenges are inherent in any change process. Appreciative Inquiry tenets that collective change can occur when people within organizations focus on what works as opposed to targeting deficiencies (Hammond, 1998; Whitney & Trosten-Bloom, 2003). The interviews have affirmed that the path toward expansion of the Walk-In Counselling Clinic at Family Service Regina will require a commitment to a ‘shift in thinking’ that focuses on meeting the needs of the community. This will best be accomplished by turning the identified challenges and deficiencies into opportunities to improve services through communication and education.

Data gathered in the pilot demonstrated the demographics of the population most likely to access a robust WICC include low-income individuals and families and males, a population currently underserved in Regina. The increase in hours during the pilot resulted in an exponential increase in WICC visits. From this data, statistics were drawn that helped inform recommendations for future processes. The recommendations, as discussed in the next chapter, tap into Family Service Regina’s potential and were designed to facilitate positive change that could contribute to the growth and sustainability of a more robust Walk-In Counselling Clinic in this city.
Chapter Eight: Recommendations

Successes, challenges and concerns identified in the interviews conducted during this evaluation of counselling services offer a picture of the front-line provider experience. In an Appreciative Inquiry framework, challenges and concerns become opportunities to draft recommendations that break down barriers and address issues so that employees and agencies can build on inherent strengths, not the least of which is affinity for the Walk-In Counselling Clinic. Statistical data demonstrated that an expanded WICC program meets the needs of the impoverished in this community, and internal agency staff, community stakeholders and inter-provincial community agencies have identified a WICC as a necessity as well as a source of professional pride. Data analysis from the pilot project served as the base from which recommendations were drafted. Future sustainability of an expanded Walk-In Counselling Clinic at Family Service Regina was a key component.

In total, nine recommendations were formulated:

1. Maintain expansion of Walk-In Counselling Clinic – The project illustrated expanded hours at the WICC was successful and has value for the community. Literature demonstrates that a WICC can provide a “booster” that significantly relieves distress or helps with a new problem unique to, or not yet discussed, in ongoing therapy (Stalker et al., 2016).
   a. The majority of clients accessing the WICC are low-income earners.
      Recommend the WICC remain as a complementary service to meet the needs of this population.
   b. The majority of clients attended the WICC when it opened at noon to “secure” a spot as opposed to attending in a steady stream throughout the opening
hours. Recommend FSR continue to monitor and explore traffic flow strategies to reduce waiting times.

c. Regularly monitor attendance and access times to ensure operating hours are relevant to the population.

2. Utilize the WICC to intentionally reduce the wait-list. Currently at 8 – 29 weeks, there is a clear need for increased accessibility to rapid response. Interviews with Family Service Canada agencies have shown that a WICC significantly reduces wait-lists and research confirms this (Barwick et al., 2013; Cait et al., 2016; Stalker et al., 2016).

   a. To improve service streaming, recommend restructuring and redefining the intake process. Examine the current screening and pre-screening process so as to ensure clients receive the most rapid response warranted (i.e. WICC as first line of response).

   b. Examine intake scripting for new clients with reference to service placement and encouragement with respect to accessing the WICC rather than placement on a wait-list.

3. Re-examine front desk protocols and procedures. Recommend further development of procedures specific to front-desk personnel including knowledge of crucial conversations, trauma-informed language and guidelines for client flow. Establish a primary coordinator for each Walk-In Counselling Clinic day.

4. Establish a strategic/formalized partnership with the University of Regina and University of Saskatchewan to ensure Masters level students are consistently
available to provide quality service. Establish improved and formalized relationships with other universities.

5. Develop a Walk-In Counselling Clinic manual that is relevant to students, counsellors, reception staff, and serves as part of an initiative towards development of a trauma-informed agency. The manual should include:

   a. The WICC – history and purpose. This chapter would provide background information on the development of WICCs locally and nationally and their relevance within communities. The role of Family Service Regina’s vision, mission, principles and values should be highlighted.

   b. Evidence-based therapies – This chapter should include tools for counselling, focusing on information on the three most commonly-used brief therapies, Single Session Therapy, Solution-Focused Brief Therapy and Narrative Therapy. Recommend including references to relevant recent research studies, case studies, free resources and worksheet examples.

   c. Ethics – In this chapter the Canadian Association of Social Workers Code of Ethics and Canadian Code of Ethics for Psychologists should be included. FSR’s confidentiality policy, client rights and limitations to service should be detailed as well as the safe-workplace policy (no abusive calls, etc.).

   d. Front-desk protocols and procedures – This would include samples of all forms including tracking sheets and client sign-in packages. Front-desk procedures for greeting and engaging clients should be incorporated.

6. Focus on Orientation and Professional Development – Develop policies designed to support staff and students.
a. Recommend strategic implementation of the WICC expansion. Data from the pilot has proven the necessity of the WICC; it is critical to provide staff and students with the evidence for increased hours and assurance traditional counselling services will not be eroded provided funding reductions and new pressures do not emerge. Adequately training staff will ensure both the community counselling unit and WICC work in harmony and build on employee strengths.

b. Recommend consistent weekly WICC supervision during which counsellors play an active role in coordinating client care, and disseminating information amongst peers and students to review the weeks’ successes, challenges and unique situations. This is a format for guidance and information sharing. De-briefing should be considered critical. In this forum, managing complex client needs, exploring, consulting and sharing ideas will ensure services are consistent, current, relevant and streamlined for the benefit of all. Orientation should be designed to encourage cohesiveness and consistency amongst staff and students.

c. Recommend incorporating regular professional development specific to brief therapy and Walk-In Counselling Clinics to ensure quality service. Ongoing orientation days or half-days are imperative. Ensure staff have access to a package of case studies and evidence-based research on relevant therapy modalities, kept up to date by both students and counsellors. Monthly student presentations on the most current trends in research would serve as continuing education for both counsellors and students.
d. Recommend development of strategic methods to strengthen staff and student skills with respect to assessments, goal orientation and roadmaps for clients. Co-constructing future plans with a client is critical when completing a single session. Currently WICC counsellors place 27% of clients on a wait list after a single session. It may be indicative of clients who request further sessions with the same counsellor or may reflect counsellors’ fear of putting individuals at-risk with Single Session Therapy. Evidence confirms the effectiveness of both Walk-In Counselling Clinics and Single Session Therapy, with the vast majority of clients attending four or fewer sessions.

7. Develop a strategic promotion campaign and create and maintain an up-to-date reference list of community services and programming complete with agency contact information and program details. The list should be maintained and updated quarterly and distributed to all FSR staff. More than 60% of clients chose “other” for how they heard about the WICC and only 3% chose social media. A robust advertising campaign that reaches those without Internet and includes information on all WICC programs in the community should be a priority.

8. Recommend Family Service Regina transition towards a Trauma-Informed (TI) approach to ensure every employee in the agency is guided by TI principles. Walk-In Counselling Clinics and solution-focused therapies both have the ability to meet immediate needs without pre-screening which is integral in a trauma-informed approach. A TI framework understands the impact of trauma and strives to minimize the vulnerability and disempowerment of survivors in order to facilitate recovery and improve outcomes (Goodman et al., 2016). Given that Saskatchewan has the highest
rate of both intimate partner and family violence among the provinces, a TI approach is recommended to best serve this population (Goodman et al., 2016; Burczycka, 2017a; Burczycka, 2017b).

9. Create a coalition with Family Service Regina affiliated agencies to ensure best practice and move toward an affiliation of like-minded agencies.
   a. Locally – recommend quarterly meetings to share information, outcomes, educational opportunities, promote and advertise programs and services, and discuss successes and challenges. The coalition can decide how soft transfers and referrals are conducted and managed. Discussions would help avoid duplication of services as well as availability of funding opportunities and strategies.
   b. Provincially – recommend twice yearly meetings with provincial counterparts to strengthen the current Family Service Saskatchewan Working Group, and explore opportunities for unified service provision, learn about grant and funding opportunities, and share successes and challenges.
   c. Nationally – recommend yearly meetings with like-minded agencies to discuss innovative program design, sustainability, funding opportunities, forecasting, successes and challenges.

Future sustainability of an expanded Walk-In Counselling Clinic at Family Service Regina was a key component in drafting the recommendations. Along with a report entitled “Growth and Renewal: Improving access and rapid response through expansion of walk-in counselling services” (Chursinoff, Englot & Novik, 2017), which delineated the results of the pilot expansion program, the recommendations helped serve as guideline and plan for next steps during the
process of securing funding for expansion. These recommendations should meet the needs of staff, community and the agency as Family Service Regina moves forward with strategic, innovative WICC programming. They were, however, drafted during a time when expansion of the Walk-In Counselling Clinic was a goal and not yet a reality. Thus, the necessity of reviewing the recommendations yearly and updating them as the program expands cannot be understated. This pilot project and evaluation was not without its challenges; balancing personal and professional skills required constant self-assessment and fine tuning. In the final chapter I reflect on my dual role as participant and assessor, discuss the limitations of this pilot, and summarize the project in the concluding remarks.
Chapter Nine: Closing Statements

Participating in a project of this scope and magnitude was a unique and exciting experience. Besides learning to become proficient in time management, I also discovered a lot about myself as a professional, balancing the comfortable, familiar role of child protection worker with the new and uniquely different role of a counsellor. In this final chapter, I share my reflections on my participation in this project, including the limitations of undertaking this large venture, and close with concluding remarks.

Personal Reflections

Completing this pilot project was an incredible opportunity. According to the Canadian Association of Social Workers Code of Ethics that guides our profession, “Social workers advocate for fair and equitable access to public services and benefits” (CASW, 2005, p. 5). To be at the ground level of an undertaking so critical to the impoverished and underserved community in Regina not only placed me at the intersection of practice and pursuit of social justice, it was an opportunity few students experience. There was a steep learning curve as I simultaneously immersed myself as a therapist, and evaluated, the Walk-In Counselling Clinic at Family Service Regina.

The experience was not without challenges. While my current professional experience as a Child Protection Worker has allowed me to develop finely tuned assessment skills and the ability to identify the most urgent issues very quickly, it was that very experience that created professional challenges in this new area of practice. Child Protective Services (CPS) is a fast-paced, high stress environment where decisions are made quickly and the role of the social worker can be somewhat authoritative as quick decisions have to be made in the “best interests of the child”. As a therapist I had to put aside my tendency to assess and react rapidly, and allow
the client to self-identify the most critical needs and goals. I had to adapt my assessment skills to this new situation. When a client presented with multiple problems, I could easily pick out the two most important issues to address in the first and possibly only counselling session, however, I had to quickly learn to slow down and help the client self-determine their path forward.

My immediate supervisor’s help was invaluable in helping me learn to shift my professional language from authoritative to strengths-based. Now, more than ever, I understand the impact of words and tone on a client’s perception of the professional relationship and ultimately themselves. My current professional experience has allowed me to be proficient at dealing with a significant number of issues in a very short period of time so I was comfortable in a brief therapy setting. However I had to quickly develop a working foundation of knowledge on Single Session Therapy and Solution-Focused Brief Therapy in order to best serve my clients. While the literature search on these topics provided strong evidence for their effectiveness, sitting in on WICC sessions with Family Service Regina counsellors was invaluable.

Personally, I had to focus on active listening skills and learn to be comfortable with silence. During therapy sessions, I had to concentrate on not allowing my personal thoughts to intrude on the client’s thought process. It was a challenge to sit quietly with a client and not fill the void with words. I had to develop patience. Sometimes the most relevant issue was immediately obvious to me but it took time for the client to determine it, and I had to focus on my facial expressions; at not displaying what I was thinking or feeling. I did this by reading my journals and through self-reflection. It was important to personally reconcile my different roles as CPS worker, therapist, and person overwhelmed with multiple responsibilities.

One of the recommendations that came from this project is to re-visit hours of the Walk-In Counselling Clinic to ensure it meets the needs of the community. During sessions in the
WICC, I noticed a general difference between common presenting issues on Mondays and Thursdays. Clients on Mondays were often motivated to access help by issues or crises that happened on the weekend. There was a sense of urgency for these clients, a motivation to change something they were doing. On Thursdays clients seemed to need help with ongoing issues, not less critical, but less acute. At my current place of practice, the trend is the opposite. As the week progresses, so do the crises. The populations at both areas of practice tend to be impoverished and marginalized. Sometimes it is hard to see the forest for the trees, but there is a connection. Helping clients on a Monday at Family Service Regina may prevent or mitigate crises on a weekend elsewhere. Yet until this pilot project, there was almost no barrier-free help for this population despite considerable Canadian research that has shown the value of a WICC in reducing barriers to service for the impoverished (Barwick et al., 2013; Cait et al., 2016; Stalker et al., 2016). It was a pleasure and an incredible experience to work on this project. It is my wish that Family Service Regina continues on this vital path to expand their WICC hours so everyone in the community has access to help when they need it the most. It is also important to recognize that this project had some limitations.

Limitations

While this pilot project has confirmed that expanded hours at the Walk-In Counselling Clinic hours at Family Service Regina has exponentially increased the number of visits, which necessitates an expanded service, the two main limitations were: time and numbers. Data collection for the project took place over a period of nine weeks. This short time frame cannot accurately project visit ebbs and flows which will affect staffing requirements throughout the months and years ahead. Outcome data and demographics of population were assessed from a total of 84 client visits which is a relatively small number from which to extrapolate community
needs. None the less, the data determined the population utilizing the WICC in this community is impoverished and marginalized which is consistent with research from across the country (Cait et al., 2016). While First Nations, Metis, Inuit and minority peoples are recognized as underserved populations, due to the short time frame of the project, we were unable to capture the ethnicities accessing the WICC. Additionally, intake forms were inconsistently completed leaving gaps in data. For example, as many people did not identify their source of income as those who did. My role was not only an evaluator, but participator as a therapist. I strongly believe in breaking down service barriers for the marginalized in Regina and hope this project proceeds; therefore it was difficult to have true objectivity. The interview questions were designed by me and my immediate supervisor, who has a vested interest in obtaining results that corroborate his proposal. In addition, the number of national agencies interviewed was very small and chosen by the Director of Operations based on prior professional relationships. The objectives of this pilot project were to conduct an evaluation of the Walk-In Counselling Clinic at Family Service Regina, to develop recommendations for program design that will accommodate the growth and expansion of the WICC, and to gain counselling skills for the purposes of providing Walk-In Counselling services to the community. I am confident the objectives were met within the confines of these limitations.

**Conclusion**

In an effort to reduce wait-lists and improve access to rapid response services, counselling agencies around the country have instituted Walk-In Counselling Clinics (Cait et al., 2016). Evidence-based research has shown them to be a vital and necessary component in addressing the social needs of community members, especially the impoverished. Data gathered during this pilot supports that need in Regina. Wait lists of 8 – 29 weeks at Family Service
Regina means that clients are waiting too long to get help for an immediate need which puts them at risk of increased stress and emotional burden.

The purpose of a Walk-In Counselling Clinic is to provide brief therapy, usually one session, however the client is encouraged to return if they feel the need. Research has shown that most clients utilize four or less sessions of traditional counselling (Gingerich & Peterson, 2013). For the past 6 years an average of more than 90% of WICC clients at FSR accessed only one session. With expanded hours, WICC utilization increased exponentially from 2 clients per week to 9 clients per week. The primary population accessing the service lives below the poverty line and 79% do not have benefits to cover service. There is room for improvement in promotion of the service and coordination with local agencies would be a benefit. It was these results that informed the recommendations.

Interviews with FSR staff and other community agencies point out some commonalities, strengths and challenges for the future. It is important to note that internal agency staff are front line employees and their experiences differ from those of the managers and directors charged with establishing and sustaining new programs. Each offers valuable input and together they offer a complete picture of the path forward. Identifying the best elements and designing a future built on that capital facilitates positive change (Busche, 2016). The main limitation to the pilot project was the short timeframe; however the data collected showed a clear need for expanded service.

An Appreciative Inquiry framework involves the elements of: discover, define, dream, design and destiny (Cooperrider, 2012). The need for expanded hours was defined as an action plan in Family Service Regina’s 2017 fiscal year. This project discovered and dreamt the future by gathering data, then assisted in designing the future by drafting a report and
recommendations. All that remains to be completed is destiny, or implementation of the plan and sustaining the changes. This pilot has highlighted a community need; hopefully the results of the pilot project will provide the evidence and suggestions for innovative program design. Now that the opportunity to move forward productively has been opened by this pilot project, it is vital to put into practice processes that focus on appreciating the roles and needs of all stakeholders to ensure future plans are reliable and sustainable.
References


Gingerich, W., & Peterson, L. (2013). Effectiveness of Solution-Focused Brief Therapy: A


Appendix I

Interview Questions

Internal Agency Staff.

Individual findings will not be shared to protect the privacy of the interviewees and to prevent bias on the findings. Several themes emerged from the questions proposed to the counsellors.

Question 1: *How do you feel about the current structure, setup and design of the walk-in clinic?*

Question 2: *What do you value most about the walk-in clinic?*

Question 3: *Are there any current challenges or limitations with the current structure, setup or design of the walk-in clinic? If yes, how would you like to see these challenges transform into achievements?*

Question 4: *How do you see Family Service Regina’s walk-in clinic addressing the needs of the community?*

Question 5: *What could be achieved short term and long term if FSR implemented an expansion of the current walk-in clinic?*

Question 6: *Explain what you think would need to change if FSR decided to expand the walk-in clinic and what possible challenges and successes do you foresee?*

Community stakeholders and interest organizations.

Question 1: *How do people connect with your agency for programs and services?*

Question 2: *What does your agency’s current wait-list look like and how is your agency looking to transform and implement strategies to reduce or eliminate the current wait-list?*

Question 3: *When Family Service Regina expands its Walk-In Clinic, how would this support both agencies regarding referrals and wait-list times?*

Question 4: *How would your agency see coordinating transfers and referrals with/to Family Service Regina?*

National organizations with Walk-in Clinics.

Question 1: *What was your organization’s process of identifying a need for a walk-in clinic?*

Question 2: *What processes and program design changes were developed and implemented within your organization to move forward with a walk-in clinic?*

Question 3: *How long has the walk-in clinic been operating for?*

Question 4: *How has this program supported the positive impact on the needs of the community?*
Question 5: What successes and challenges has your organization experienced with the walk-in clinic?

Question 6: Has your implementation of a walk-in clinic positively or negatively impacted wait times for counselling services? If so, what were wait time like prior to implementation and what are they now?

Question 7: What resources have been/will be required to continue to operate the walk-in clinic?

Question 8: How has your team responded to the development, implementation and delivery of walk-in services?
# Appendix II

## Work Plan

<table>
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<tr>
<th>Objective</th>
<th>Tasks</th>
<th>Timeline</th>
<th>Outcome/Updates</th>
<th>Status</th>
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| 1. Evaluate current WICC program, design and theory | - Review current wait-list and capacity demands  
- Examine human resource allocation  
- Review WICC program design, accessibility issues and statistical and outcome data  
- Literature review of Walk-In Counselling service design from other Canadian Family Service Organizations  
- Literature review of Solution Focused Brief Therapy and Single Session Therapy  
- Complete short term models of counselling training, and overall WICC program training with two FSR staff  
- Complete Intake training with intake counsellor  
- Observe current walk-in sessions | January 9 - February 20, 2017  
January 9 – April 21, 2017  
January 9 – January 30, 2017 | Provide a summary of evaluation of current WICC program  
Provide summary/discussion of literature reviews |  |
| 2. Pilot Expansion of WICC Program | - Develop social media advertising within Family Service Regina’s guidelines  
- Expand current WICC program with one additional day for services to be offered on Monday 12:00 - 7:00pm  
- Determine options for data entry, filing, additional staff, supervision, etc.  
- Facilitate Walk-In Counselling services during additional hours  
- Complete comprehensive report for expansion to | January 27, 2017  
February 6 - April 17, 2017 | Feedback from professional associate, academic supervisor and academic community member |  |
WICC program to include:
- demographic information and population served
- impact on wait-list times for general counselling program
- challenges and successes of additional walk-in clinic hours/day
- additional staff/student resource requirements
- recommendations for innovative community design

| 3. Counselor Process Engagement and Evaluation | - Develop Consent form to be reviewed and signed by participants/staff who will be approached to be interviewed
- Conduct interviews with four counsellors as well as the intake counsellor at Family Service Regina to determine:
  - Challenges and gaps with current WICC program
  - Successes and achievements with current WICC program
  - Counsellor goals for WICC program
  - Discuss program evaluation through an appreciative inquiry framework
- Engage in weekly peer supervision meetings with counselors to gain a deeper knowledge of demands and accomplishments of WICC program and general counselling program | January 16 - February 20, 2017 | Completed interviews with four FSR counselors and intake counselor
Provide summary of interviews to identified key partners

| 4. Environmental Scan | Review and summarize services currently available in the community of Regina regarding:
  - availability of counselling | February 6 - April 21, 2017 | Feedback from professional associate, academic supervisor and academic community member |
<table>
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<th>Services</th>
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<tr>
<td>- wait-time lists</td>
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<td>- fees for access</td>
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<td>- accessibility barriers</td>
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<td>- populations served</td>
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<td>- gaps in service</td>
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<td>- Examine current and possible systems navigations: referrals, soft transfers</td>
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<tr>
<td>- Conduct interviews with community stakeholders as well as other organizations with walk-in counselling clinics to inquire and examine their challenges and success</td>
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5. Evaluate Practicum and complete final practicum report

| - Provide final practicum report which will include program evaluation, literature reviews on the approaches of counseling and recommendations for WICC program expansion |
| - Conduct a presentation at the end of the practicum placement |
| Feedback from professional associate, academic supervisor and academic committee member |
Appendix III

Master of Social Work Field Practicum Proposal

Student
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Program of Study
Master of Social Work (MSW)

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Supervision: Kirk Englot (professional associate) will be on site at Family Service Regina for the duration of the practicum. In-person supervision will take place weekly for feedback and support. It is anticipated other Family Service Regina counsellors will contribute supervision as the occasion presents itself.

Practicum Setting: The primary focus of the practicum will be the Walk-in Counselling Clinic (WICC) at Family Service Regina, Suite 200, 1440 Broadway Avenue. Family Service Regina provides counselling services, domestic violence programming, teen parent support and educational and support groups.

Practicum Hours: January 9, 2017 – April 17, 2017. Monday to Friday 8:30 – 4:30pm with one day being dedicated to extended hours for WICC (walk-in counselling clinic).

Practicum Objectives:

1. To conduct an evaluation of the WICC program including, but not limited to: current wait-list and capacity demands, human resource allocation, current FSR General Counselling and WICC program design, accessibility issues, and statistical and outcome data from both WICC and the General Counselling Program. This completed evaluation will include recommendations for progressive program design that will accommodate the growth and expansion of WICC and facilitate a reduction in Family Service Regina’s General Counselling Program’s waitlist.

2. To gain clinical counselling skills within the WICC program focusing specifically on Brief Solution Focused and Single Session Counselling for the purposes of providing walk-in counselling services to the community.
Learning Goals and Activities

1) **Develop skills in program evaluation and conduct an evaluation of the current WICC program within a framework of Appreciative Inquiry.**

   a) Action one: Complete a literature review of program evaluation approaches within an appreciative inquiry framework.

   b) Action two: Complete an environmental scan to identify other local WICC’s and General Counselling Programs and wait-times for relevant services.

   c) Action three: Conduct interviews with a maximum of four FSR counsellors, as well as the Intake counsellor, in order to gain feedback on current WICC and General Counselling Program challenges and successes.

   d) Action four: Identify gaps, deficiencies and achievements of current WICC program in order to develop a comprehensive program design that enhances utilization of the WICC and reduces wait-times for the General Counselling Program without additional budgetary requirements.

2) **Develop a foundation of knowledge regarding Brief Solution Focused and Single Session Counselling methods for the purposes of delivering walk-in counselling services.**

   a) Action one: Complete a literature review on both Brief Solution Focused Therapy and Single Session Counselling methodology.

   b) Action two: Observe walk-in counselling sessions by current counsellors at FSR as agreed upon by the client, professional associate, and Family Service Regina.

   c) Action three: Provide counselling sessions during the WICC program’s expanded hours to gain clinical experience and a comprehensive understanding of the operation of the program.

   d) Action four: Participate in professional development opportunities such as training sessions and learning within the agency as well as the community as they become available.

   e) Action five: Engage in weekly peer supervision meetings at Family Service Regina as well as gathering feedback from the professional associate and academic supervisors. Enable personal reflection and professional growth by keeping a weekly log of tasks, challenges and successes.
Appendix IV

Evaluation Report

April 2017

Growing and Renewal: Improving access and rapid response through expansion of walk-in counselling services

Family Service Regina
Healthy Families Strong Communities
Acknowledgements

Lucie Chursinoff, BSW and graduate student was given the opportunity to pilot an increase in hours of the Walk-In Counselling Clinic (WICC) at Family Service Regina in order to develop recommendations for further expansion of the service within current financial and personnel constraints as partial fulfillment of the requirement for the degree of Master of Social Work. National and international research shows the absolute value and need for the immediate services provided by walk-in clinics to ensure all community members, especially the most vulnerable, can access care when they need it most.

Kirk Englot, Director of Operations and Business Development, Family Service Regina, identified a need for more walk-in counselling for community members unable or unwilling to wait for traditional service due to multiple factors and barriers. He initiated and supervised this pilot project in order to gather data and develop recommendations for a sustainable increase in WICC hours to better meet the needs of the community FSR serves. Thank you Kirk, the community will be better served because of your diligence and drive to improve access to help.

A special thank you goes to Dr. Nuelle Novik, Associate Professor, Faculty of Social Work, University of Regina who served as mentor and academic supervisor along with Dr. Daniel Kikulwe, Assistant Professor, Faculty of Social Work, University of Regina.

I would like to thank everyone involved in this project for giving me the opportunity to be at the ground level of an undertaking that is only going to grow in scope and magnitude. The potential for this project to reduce barriers and positively affect this community is unparalleled.

Authors:
Lucie Chursinoff, BSW, RSW, MSW (candidate)
Kirk Englot, BSW, MSW, Director of Operations & Business Development, Family Service Regina
Dr. Nuelle Novik, Associate Professor, Faculty of Social Work, University of Regina

Suggested Citation
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Summary

This evaluation report examines the possibilities of, and recommendations for, expanding the Walk-In Counselling Clinic (WICC) at Family Service Regina (FSR) within current budgetary and staffing constraints. In response to a Ministry of Social Services (MSS) contract, FSR has operated a WICC one half-day per week since 2010 to improve accessibility and usage for MSS referrals and community members including the marginalized (Englot, 2016). Data collected demonstrated a positive societal impact however the WICC was underutilized. A review of the WICC was identified as an action plan item for the 2016-2017 funding year.

The review involved a pilot project in which the hours were increased to two days per week in order to collect statistics to demonstrate the value of an expanded WICC and formulate recommendations for further program design. Data clearly showed expanded hours met a community need for clients at or below the poverty line and those without Employee Assistance Programs. With increased availability, client visits increased exponentially, demonstrating the need for improved accessibility.

Using a theoretical framework of Appreciative Inquiry (AI), interviews of FSR counsellors were completed to gain an understanding of practitioner perceptions on barriers to, and possibilities of, expansion of the service. Interviews of select local and national community agencies providing WICC services were also completed in order to gain an understanding of how similar agencies introduced and utilize their WICC as well as successes and challenges in doing so.

FSR currently utilizes solution-focused therapy as their main model in the WICC however understands that each session and each therapist is unique and any therapy that meets the client’s needs will be utilized. Included is a brief literature review of AI as a research methodology as well as two commonly-used brief therapies, Single Session Therapy (SST) and Solution-Focused Brief Therapy (SFTB) to validate the relevance of these modalities.

A summary of the findings is discussed and recommendations on expansion of the current WICC are offered.
Why Was This Project Done?

Wait-lists for general counselling at Family Service Regina average between 7 and 20 weeks. More than one-quarter of clients on the wait-list do not initiate therapy when their turn arrives. Yet the Walk-In Counselling Clinic at FSR was historically underutilized by 50%, despite the fact that WICCs offer services at the time they are needed most and can offer a whole therapy in a single session, which can significantly decrease emotional burden.

Family Service Regina (FSR) is an accredited, non-profit community agency that offers a variety of supportive services including professional counselling, education, planning and advocacy for vulnerable individuals and families within the community. FSR’s mission statement reflects their values:

*Family Service Regina strengthens individuals, families and communities through responsive leadership and innovative programs and services* (Family Service Regina, 2016).

FSR has a diverse social enterprise division that provides Employee and Family Assistance (EFAP) services including organizational health, counselling and wellness to approximately 11,000 employees and family members in more than sixty public, private and non-profit organizations (Family Service Regina, 2016). The community counselling unit is a diversified program that offers therapy for a wide variety of problems and now includes substance abuse assessments and case management services. The success of this program is manifested by long wait-lists averaging more than 2 months for community members without access to workplace benefits. However long wait-times mean individuals in need of rapid response are not receiving the necessary help. Many clients have pressing needs that requires immediate access to a therapist while others are not covered under EFAP and cannot afford service fees. To rectify this issue, a Walk-In Counselling Clinic (WICC) was established in 2010.

Limited to one half-day per week, the WICC averaged only two cases per week (8% of total counselling work) (Englot, 2016). Evidence-based research shows WICCs can significantly decrease wait-times and improve outcomes by increasing timely access to services (Barwick et al., 2013; Cait et al., 2016; Stalker et al., 2016). Yet during the past 2 years, wait-lists have remained long, averaging 2 – 5 months. Barriers of limited promotion and restrictive hours of access likely contributed to underutilization of the WICC.

Wait lists are not unique to FSR. Nationally and internationally, vulnerable individuals are unable to access timely services for an emergent or acute need (Paul & Ommeren, 2013; Bloom & Tan, 2015; Cait et al., 2016). Research shows most individuals prefer brief therapy and attend less than four sessions (Perkins, 2006; Slive & Bobele, 2012). *In 2016, 77% of clients at FSR attended four or less sessions of traditional counselling:*

<table>
<thead>
<tr>
<th>Percentage of clients attending:</th>
<th>1-2 sessions</th>
<th>3-4 sessions</th>
<th>5 sessions or more</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>52%</td>
<td>25%</td>
<td>27%</td>
</tr>
</tbody>
</table>
Of equal importance, 27% of clients who had to wait for services did not initiate counselling (Englot, 2016). This data supports brief therapy. Walk-in counselling clinics offer a complete session in a single sitting; however clients are not restricted from further visits if necessary. 

In response, Kirk Englot, Director of Operations and Business Development FSR, was tasked to develop an evaluation and feasibility plan to reduce or negate the wait-list through expansion of WICC and other progressive design strategies. To operationalize this plan, graduate student, Lucie Chursinoff, participated as counsellor in a pilot expansion of WICC hours on Mondays from noon to 7pm. Data was gathered and assessed, and recommendations for further expansion have been drafted.

Is there an evidence base?

Appreciative Inquiry is a strengths-based model for assessing and initiating agency change and is the framework for this evaluation project. Family Service Regina currently encourages use of solution-focused therapy as a model for their WICC because it identifies and builds on inherent client strengths and abilities. However therapists are encouraged to use any therapeutic modality that best fits the client’s needs, and Single Session Therapy is a model of interest. This literature review explores evidence-based research on this topic.

Appreciative Inquiry

Appreciative Inquiry (AI) is a well-recognized model of change management that focuses on inherent strengths within an organization and encourages stakeholders to identify what is working well in order to facilitate positive change (Bushe, 2016). AI tenets that all organizations do something that works well and collective change can occur when people focus on doing more of what works as opposed to targeting deficiencies and doing less of something that does not work well (Hammond, 1998; Whitney & Trosten-Bloom, 2003).

AI recognizes that practitioners have the capacity and resilience to undergo meaningful change that will benefit and enhance professional practice yet, to date, has been under-utilized in the field of social work (Bellinger & Elliot, 2011). Little research evidence could be found to support or refute its use in the field however there are considerable studies that evaluate AI in a variety of health care situations, many of which are transferrable into the social services arena (e.g. mental health, child and youth behaviour). Trajkovski et al., (2013) undertook a review of methodological studies of AI in a variety of healthcare settings. The review found it to be a viable method for facilitating change (Trajkovski et al., 2013). Most participants found using the model to be a positive experience that induced achievable change; however success could be compromised by organizational timelines and demands (Trajkovski et al., 2013). The most beneficial outcome noted was improved, sustainable communication and standardization of practices amongst practitioners (Trajkovski et al., 2013).

With its focus on strengths, and flexible framework AI is well situated within social work and as such, is a reasonable tool for use in this project. AI generates a co-constructed plan that improves practice built on the motivation and ownership of practitioners (Bellinger & Elliot, 2011). Under the guidance of Kirk Englot and Nuelle Novik, open-ended interview questions were drafted which reflect the positive and explorative framework of AI (see Appendix 1). Results
of the interviews are integral in identifying themes that identify possibilities and potential barriers to expansion of the Walk-in Counselling Clinic at Family Service Regina.

**Single Session Therapy**

The goal of single session therapy (SST) is to offer a complete session in one visit. A literature search of SST reveals mounting empirical evidence that enduring change need not involve long-term counselling. SST recognizes that individuals are cognizant enough of their issues and aims to establish goals and plan interventions within one session (Perkins, 2006; Slive & Bobele, 2012). SST has four fundamental characteristics:

1. Improvement occurs rapidly in the initial stages then may slow.
2. Each session is considered a single entity whereby rapid help is offered.
3. The therapist has an active role in empowering the client to establish goals, plan interventions and determine an agreed-upon conclusion for the session.

SST is not a therapeutic model; rather it lends itself to any therapeutic orientation that can be adapted to a single-session (Campbell, 2012; Barwick et al., 2013; Stalker et al., 2016). The mainstay of single session therapy is that one session should have a significant influence on the client’s perception and behaviour towards the presenting problem (Perkins, 2006). A single brief session provides help when it is most needed and can mitigated the harm of waiting (Macdonald, 2011).

Canadian studies have found SST to be of considerable value. A study done in 2013 in Calgary at a WICC and traditional core counselling program compared client outcomes at intake, post-treatment and three month follow-up (Barwick et al., 2013). All participants were children (age 4-18) and their parents. Post-treatment outcome measurements indicated walk-in clients had a steadier rate of improvement and exhibited fewer problems (Barwick et al., 2013). Client satisfaction was higher for participants accessing the WICC, with ease and timeliness of service of greatest importance (Barwick et al., 2013). Of note, males accessed the walk-in counselling more than traditional service (Barwick et al., 2013).

Cait et al. (2016) undertook a qualitative study comparing walk-in single session counselling with traditional counselling. The study demonstrated evidence of client satisfaction with walk-in counselling largely due to reduced barriers to access and timely provision of service (Cait et al., 2016). Some individuals found the emotional release and confirmation of personal strengths as well as information on community supports met their needs (Cait et al., 2016). Those uninterested in ongoing therapy benefited from a *whole therapy in one session* (Slive & Bobele, 2012; Cait et al., 2016; Stalker et al., 2016).

The results were similar in a comparative quantitative study of a WICC and traditional counselling clinic in Ontario (Stalker et al., 2016). The authors determined “clients of the walk-in model improved faster and were less distressed at the four-week follow-up compared to the traditional service delivery model” (Stalker et al., 2016, p. 403). In this Ontario study proportionately more males from all cultures than females accessed the WICC and for those with ongoing issues, participants indicated SST provided a “booster” that significantly relieved distress (Stalker et al., 2016). Accessibility of the WICC and the ability to control how and when service was
accessed was the most important factor identified (Stalker et al., 2016).

Important elements of SST are reduction of barriers to timely service and the ability to mitigate crisis in a timely and accessible fashion (Slive & Bobele, 2012; Cait et al., 2016). SST neither diminishes nor negates the need for on-going counselling, rather it benefits people at the time they are in need and in some cases, prevent difficulties from festering (Cait et al., 2016).

**Solution-Focused Brief Therapy**

Solution-Focused Brief Therapy (SFBT) is a goal-driven model that recognizes an individual’s perception of a problem and utilizes a therapist to assist the client’s work toward their own vision of a solution within a single or very few sessions. A hallmark of SFBT is the focus on a better future by concentrating on what has worked and is working for the client, inviting them to make positive changes by doing more of what works (Dolan, 2015). The strengths perspective is a framework for solving problems within the client’s resources and unique social environment (Franklin, 2015).

There is a considerable bank of evidence-based research, five randomized controlled trials, fifteen comparison studies and follow-up reviews on over 2100 cases, that illustrates SFBT is very efficacious (Gingerich & Peterson, 2013; Macdonald, 2011). A 2006 review of the literature found clients experienced positive outcomes sooner with SFBT than with other therapies (Gingerich & Peterson, 2013). Overall evidence has proved it is an efficacious modality that consistently provides positive benefits (Gingerich & Peterson, 2013). Particular benefit was found in depressed clients, where SFBT was as good as, or better than, a variety of alternative treatments including some drug therapies (Gingerich & Peterson, 2013). Quicker improvements on all measures were found with brief therapy as compared to longer therapies (Gingerich & Peterson, 2013). There is strong empirical evidence for the efficacy of SFBT in a wide variety of behaviour and psychological issues as well as within care systems such as schools, child welfare and mental health, making it a useful modality for community agencies (Gingerich & Peterson, 2013; Ilbay & Akin, 2014; Franklin, 2015; Kim, Brook & Akin, 2016).

A recent (2016) follow-up study found SFBT helped clients achieve goals in 86% of cases with an overall success rate of 86% at termination of therapy, leading to the conclusion that “SFBT reaches the ‘minimum efficiency permitted’ according to the general consensus of experts” (Cortes et al., 2016, p. S233). The brevity of SFBT is of value to clients and agencies. The quicker reduction in self-identified symptoms with short term therapy equates to a faster return to functional capacity (Cortes et al., 2016). Cost efficiency analysis with respect to social and unemployment costs indicates long-term therapy may cost three times more than brief therapy (Maljanen et al., 2014).

**Environmental Scan**

An environmental scan of walk-in counselling services in Regina was completed for this report. The Regina City Yellow Pages had no listings under “walk-in”. Under “counselling”, 41 businesses were listed including Family Service Regina, however none of the listings or larger ads mentioned a walk-in clinic. This is testimony to the difficulty those without internet or social media have finding accessible services. An internet scan of “walk-in counselling Regina” brought up Family Service Regina, Catholic Family Services and Canadian Mental Health Association. The FSR site was very user
friendly and the WICC was easily visible. Catholic Family Services required two clicks to find information on their walk-in. Canadian Mental Association required several clicks to get to the Regina site which offered no information.

A social media scan of Facebook using the search term “walk-in counselling” resulted in no available services in Saskatchewan. When the term “free counselling” was used, the only applicable link to Saskatchewan was a post from 2016 referring to SIGN Walk-In Counselling Clinic in Yorkton, Saskatchewan that was offered by a Masters of Social Work student during her practicum. After widening the search to “counselling in Regina”, links to several agencies appear. The WICC at FSR could be found after scrolling through the results.

How was data collected?

1. Statistical Data
   Statistical data was drawn from FSR’s Data Management System. Quantitative data was gathered in order to create a concrete picture of the population utilizing the WICC. This tangible snapshot helped to evaluate demographics of clients in order to formulate recommendations for further strategies that best meet the needs of the community.

2. Interviews
   Through a literature review of Appreciative Inquiry as a research method and tool for agency change, and meetings with Kirk Englot to determine which local and national agencies held the most relevance for this project, interview questions were composed. The questions were open-ended and framed to focus on possibilities without ignoring deficits. To reflect a wide variety of employee, local and national experiences, interviews were subdivided into the categories of: internal organization staff, community stakeholders and interest organizations, and Family Service Canada affiliated organizations with WICCs. Qualitative data was gathered from questions specified to the target group. The focus of the interviews was to:

   a) Gain an appreciation of front-line employee experiences with WICC.
   b) Gain an understanding of the experiences of similar local and national agencies.
   c) Identify any delivery concerns and barriers to service.

   Interviews with internal organization staff included four on-staff counsellors (psychologists and MSW) and one intake counsellor (BSW), who currently work in the WICC. Employee and Family Assistance Plan counsellors were not interviewed as they currently do not participate in the WICC. The interviews took place in person at FSR with Lucie Chursinoff as interviewer.

   Two local organizations, Catholic Family Services of Regina and Mental Health Services, Regina, Adult Program Section were chosen by Kirk Englot based on their similarity to FSR and because clients are often referred to or from these agencies. Agency interviews were completed by Lucie Chursinoff with clinical directors or managers by phone.

   Four organizations outside Saskatchewan were chosen by Kirk Englot based on affiliation with FSR and fairly recent introduction and expansion of a WICC. The four agencies chosen were: The Family Centre of Northern Alberta in Edmonton; Family Service Ottawa, Ontario; Catholic Family Services, Calgary, Alberta; and Family Services Windsor-Essex, Ontario. Interviews were completed by Lucie Chursinoff with clinical directors or managers by phone.
What did the data show?

Statistical data was drawn to illustrate the positive impact on the community of extended WICC hours at Family Service Regina. Data shows considerably long wait times for the community counselling service which does not meet the needs of clients with immediate concerns. Since the pilot of expanded hours, significant improvements were seen in the volume of clients accessing the program and a very high percentage of individuals whose needs were met within a single session. Data also demonstrates the majority of clients fall beneath the poverty line. This data clearly represents a social need for FSR’s Walk-In Counselling Clinic.

Wait-times for general counselling average from 2 – 5 months, yet 77% of clients utilized less than 4 sessions. In the Walk-In Counselling Clinic prior to the pilot, nearly 90% of clients utilized only one session. The percent of males accessing the Walk-In service are steadily increasing.

STATISTICS FROM FAMILY SERVICE REGINA FROM 2010-2016

Wait Times

Over the past two years wait times for community counselling have averaged from a low of 8 weeks to a high of 29 weeks which confirms the need for increased accessibility to rapid response. *This table does not include the small number of clients with pressing needs that were prioritized to be seen within 3 days.

<table>
<thead>
<tr>
<th>Time Period</th>
<th>Average Wait</th>
<th>Longest Wait</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 1, 2015 – March 31, 2016</td>
<td>73 Days</td>
<td>142 Days</td>
</tr>
<tr>
<td>April 1, 2016 – March 31, 2017</td>
<td>54 Days*</td>
<td>204 Days*</td>
</tr>
</tbody>
</table>

General Counselling - % of total clients attending four or less sessions:

In the past 6 years, more than half of clients (52%) in general counselling essentially utilized single session therapy by attending two sessions or less. Consistent with evidence-based literature, the number of clients attending fewer than four sessions has increased to a high of 77%, which demonstrates that brief therapy meets the needs of the majority of clients. Given the significantly long wait times, more than half of clientele could be seen sooner with a more robust WICC. Such a model could potentially lessen the sequelae of the presenting problem.
Percentage of Clients Attending 4 or less sessions

<table>
<thead>
<tr>
<th>YEAR</th>
<th>2 or less sessions</th>
<th>3 – 4 sessions</th>
<th>Total attending 4 or less sessions</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>41%</td>
<td>18%</td>
<td>59%</td>
</tr>
<tr>
<td>2012</td>
<td>47%</td>
<td>24%</td>
<td>71%</td>
</tr>
<tr>
<td>2013</td>
<td>51%</td>
<td>19%</td>
<td>70%</td>
</tr>
<tr>
<td>2014</td>
<td>46%</td>
<td>22%</td>
<td>68%</td>
</tr>
<tr>
<td>2015</td>
<td>52%</td>
<td>24%</td>
<td>76%</td>
</tr>
<tr>
<td><strong>2016</strong></td>
<td><strong>52%</strong></td>
<td><strong>25%</strong></td>
<td><strong>77%</strong></td>
</tr>
</tbody>
</table>

**Gender Statistics in WICC and General Counselling**

On average, a higher percentage of males attended the WICC than the general counselling program. This important trend has been identified in the literature and identifies a community need.

**WICC attendance by Gender (Percentage)**

**General counselling attendance by Gender (Percentage)**
Case Summaries of Initial (Unique) Enrollments and Repeat Visits in WICC

Historically, of those clients attending the WICC in the past 6 years, 89-96% do not return for further. FSR utilizes the Duncan-Miller Outcome Rating Scale (ORS) and Session Rating Scale (SRS) to measure pre and post overall well-being. During the WICC pilot, the majority of clients indicated the session met their needs and expectations. Yet during the 2017 pilot, only 65% of clients were considered complete after a single session. This discrepancy could indicate a design flaw, error in capturing data, or a historical system failure that did not encourage clients to return if they felt the need.

Percentage of Clients Attending Single (Unique) Visit vs Repeat Visits

Doubling the hours of the WICC resulted in quadrupling the number of client visits. At least 90% of clients who accessed the WICC are low-income earners and 79% have to pay for services out-of-pocket. More than half of clients identify relationship issues as the primary problem.
Statistics from the WICC pilot from January 1– March 31, 2017.

Utilization of WICC per weekday
Before the pilot project the Walk-in Clinic was open 4 hours per week with an average of 2 clients per week. Since doubling the WICC hours to 6 hours on Mondays and 4 hours on Thursdays, the number of clients visiting the WICC has quadrupled to 9.3 clients per week. The majority of clients attended the right WICC when it opened at noon to “secure” a spot. Clients seen outside the Monday and Thursday operating days are the result of WICC clients booking a repeat single session visit with the same counsellor on a different day. In keeping with evidence-based practice of single session therapy, during the pilot FSR WICC counsellors encouraged clients to return for further sessions if they felt the need. The numbers illustrate few clients felt that need.

<table>
<thead>
<tr>
<th>WICC Day of the Week</th>
<th>Number of Clients</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monday</td>
<td>40</td>
<td>47%</td>
</tr>
<tr>
<td>Tuesday</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Wednesday</td>
<td>1</td>
<td>1%</td>
</tr>
<tr>
<td>Thursday</td>
<td>42</td>
<td>49%</td>
</tr>
<tr>
<td>Friday</td>
<td>3</td>
<td>3%</td>
</tr>
</tbody>
</table>

Clients Presently Seeing a Counsellor
According to data gathered, 91% of clients accessing the WICC are not currently under the care of another therapist. For the 9% that are, literature demonstrates that a WICC can provide a “booster” that significantly relieves distress or helps with a new problem unique to, or not yet discussed in ongoing therapy (Stalker et al., 2016).
Primary Presenting Problem
The majority of clients who accessed the walk-in clinic identified relationship issues as the presenting problem. Saskatchewan has the highest rate of domestic violence (DV) amongst the provinces, excluding the Northern Territories (Burczyka, 2017). DV survivors may seek help for their situation without identifying as a victim of DV due to trauma-associated distrust and vulnerability (Goodman et al., 2016). A trauma-informed agency approach ensures all clients are treated respectfully. Further, a clear picture of presenting problems is muddied because the current data management system only allows one problem to be captured while many clients present with multiple problems. This leaves the data open to bias and is an area to be considered for future planning.

![Presenting Problems/Issues Pie Chart]

How Clients Heard of WICC
This data gauges how individuals are hearing about FSR’s Walk-in Counselling Clinic. For the majority of those that included this information on their intake form, their source is unknown. Word of mouth was not offered as a choice on the form and could be considered a logical avenue. These statistics will help FSR form a strategic advertising campaign for the future.

<table>
<thead>
<tr>
<th>Source</th>
<th># of Clients</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referred by MSS</td>
<td>2</td>
<td>2%</td>
</tr>
<tr>
<td>Social Media</td>
<td>3</td>
<td>3%</td>
</tr>
<tr>
<td>Blank</td>
<td>12</td>
<td>14%</td>
</tr>
<tr>
<td>FSR Intake</td>
<td>15</td>
<td>17%</td>
</tr>
<tr>
<td>Other</td>
<td>54</td>
<td>63%</td>
</tr>
</tbody>
</table>
Income
Of those that chose to declare income, almost 90% of clients utilizing the WICC live in poverty according to the Low Income Measure After-Tax (LIM) (based on a 3 person household). More than half of clients are more than $12,000 short of meeting a poverty level income (Gingrich et al., 2016). This clearly illustrates the WICC may be instrumental in reducing barriers to service and meeting the needs of low income individuals and families. Factors that may positively influence accessibility are the central location of FSR and increased hours.

Yearly Income

Source of Income
This data gives a snapshot of the population served at the Walk-In Counselling Clinic during the pilot. More than half of clients, 53%, indicated they are employed. Only 2% were referred to the EFAP program which may indicate the other 51% do not have an employer benefit program. A significant number of clients (43%) chose not to state their source of income, however considering almost 90% of clients accessing the WICC live below the poverty line, it can be estimated that a significant percentage have little to no income. Nearly one-quarter (23%) of clients are on financial assistance which identifies a potential necessity for continuing partnerships with the Ministry of Social Services or other community agencies to meet the needs of this population.
**Status of Single Session**
The majority of clients (65%) are considered complete after one session indicating a high rate of success with the WICC. Only 6% require or request referral to other organizations while 27% are placed on a waitlist. This may be indicative of those who prefer future meetings with the same counsellor or may reflect current concern in the FSR counselling unit. Counsellors disclosed a fear of putting individuals at-risk with single-session therapy. However evidence demonstrates the vast majority of clients attend less than 4 sessions and may not be served well by waiting weeks to months for service.

**Status of Single Session (% of Clients)**

<table>
<thead>
<tr>
<th>Status</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complete</td>
<td>79%</td>
</tr>
<tr>
<td>Placed on Wait List</td>
<td>6%</td>
</tr>
<tr>
<td>Referred to Community Resources</td>
<td>27%</td>
</tr>
<tr>
<td>Referred to EAP</td>
<td>6%</td>
</tr>
<tr>
<td>Referred to MSS</td>
<td>6%</td>
</tr>
</tbody>
</table>

**What did the people have to say?**

- **Access to EFAP or benefits?**
  - **NO. 79% of clients would have to pay for services on their own.** Considering 90% of WICC clientele make less than $50,000/year this is a significant barrier to service.
  - **A WICC increases accessibility for low income earners.**

- **Attended WICC before?**
  - **83% have not accessed a WICC before.**
    - In 2016, only 103 clients utilized the WICC. In the first 9 weeks of 2017, 84 clients have already attended, 70 of whom have never done so before.

- **Attended WICC in last 3 months?**
  - **76% of clients have not attended in WICC in the past 3 months.**
    - Although the WICC has been operationalized for 6 years, few clients access the service more than once in a 3 months timeframe.
**Internal Organization Staff**

Individual specific statements will not be shared to protect the privacy of the interviewees and to prevent bias on the findings. For breakdown of the finding by category and question see Appendix 2.

Interviews with internal staff highlighted the strengths of the WICC and the role they played in contributing to its operation. There were also concerns. An Appreciative Inquiry framework focuses on appreciating each player’s situation and experience as a precursor to future pathways. Acknowledging the challenges identified by internal staff helped in the formulation of recommendations for expansion of the program that understands and builds on the organization’s capabilities. Several themes emerged from the questions proposed to the internal organization staff.

1. **Affinity for the program**: All participants expressed some degree of affinity for the WICC and professional pride in providing services to a marginalized population. All agreed that the program meets a need for rapid response within the community. The majority noted a WICC was necessary for the impoverished and those without employee benefit programs. Some agreed expanded hours could reduce wait times.

2. **Sustainability**: There was a definite concern from each respondent regarding the ability to sustain an expanded WICC within current fiscal, personnel and spatial constraints. There was concern over staffing as there is a heavy reliance on students to maintain the expanded hours of the walk-in clinic. Students are usually available for only a few months at a time (during their practicums) so there is a definite possibility of an increased staff load for training and supervising. Funding is always a concern for everyone within a community agency, especially in the current fiscal landscape.

3. **Professional Capacity**: Participants were very concerned about the possibility of a walk-in clinic ‘eroding’ long-term counselling services. Most are concerned a WICC will actually replace general counselling while others are worried it would become a ‘dumping ground’ for repeat clients with complex needs unable or unwilling to survive the wait-list. Some are fearful brief therapy leaves clients at risk. There was some discomfort surrounding caseload burden and having to ‘stretch’ schedules to staff the WICC. Most mentioned a worry over inadequate training and consistency amongst therapists.

**Community stakeholders and interest organizations**

The two Regina community agencies interviewed were fairly similar in their responses. A successful walk-in clinic was identified as a strength. Both agencies are currently operating WICCs but neither has been well utilized. A number of barriers were identified that informed areas for improvement in the recommendations at the end of this report. Themes that emerged were the same as those from internal organization staff.

1. **Affinity for the program**: There was consensus that brief therapy is valuable. One agency has had little success retaining clients for multi-session therapy, and both agencies are committed to the idea that walk-in services are needed as an option for their clientele. Both agencies have a strong interest in coordinating services with each other and FSR as a strategy to reduce wait lists and better serve the community. Coordination would require a consensus on the operational model to ensure fluidity between organizations, and WICC hours at
each should be coordinated to prevent deficiencies and overlaps in service.

2. **Sustainability**: The location of the walk-in counselling clinic at one agency is hard to access and has very limited hours, however, altering physical space is not currently an option for them. Promotion of the program may not be amenable to the population it is meant to serve. Both agencies have long wait lists of 8 weeks to 8 months; however, neither has found a reduction in wait times as the WICC has been underutilized. Funding is always a concern with community agencies vying for resources. Running or expanding a new program within the existing staffing compliment is always a concern.

3. **Professional Capacity**: Implementation was considered an internal barrier. Both agencies felt program implementation took place quickly with little training, which strained staff and prohibited full commitment to the concept. Both found long wait lists put clients at risk as the longer the wait, the less likely the individual was to show up for help. Some clients have presenting problems that are not amenable to single session therapy. Neither participant agency kept usable statistics on the average number of sessions clients utilized, thus have little reliable data to support changes in programming and staff has had trouble accepting the role of a WICC.

**Family Service Canada Affiliated Organizations**

Organizations outside the community of Regina have had considerable experience implementing and sustaining a WICC. Most have been in operation for more than 5 years. All centers have significantly decreased wait times from an average of 4-6 months to consistently around one week. The responses to these questions were consistently positive with overall themes the same as with the other sector interviews. Because of their experience with WICC implementation, two additional themes were identified.

1. **Affinity for the program**: Each respondent found offering a WICC had a positive impact on both the community and their agency. Successes and strengths were found in: barrier-free counselling, reduced wait-times, reduction in emergency room visits, positive outcomes illustrated by clients’ expression of well-being and pride of staff in meeting the needs of the community.

2. **Sustainability**: Funding was the universal theme from all respondents. All discussed how to meet the continued and evolving requirements of funders while remaining flexible and adaptable. All centers were concerned with sustainability of the WICC within dwindling funding, now that it had proven to be a necessary entity. For two agencies, new partnerships had to be developed to meet the need of reducing community barriers to care. Some agencies changed the length of their individual sessions from therapist-determined to standardized 30 to 80 minutes which may include intake. Standard single sessions range from 50 minutes to 1.5 hours. Most centers had to utilize more students in order to sustain the WICC.

3. **Professional Development**: All agencies placed high emphasis on training, maintaining and supporting existing staff while supervising and training a steady stream of the students that are a necessary resource. Partnership with universities was considered to be of critical importance. Employees now feel more supported because sustaining a strong WICC program meant placing time and effort on counsellor education, training, professional development and supervision. One agency
developed a process manual for all sites to provide consistent training and supervision. Another increased peer supervision to ensure quality services while also ensuring staff are well-informed and supported. Most now utilize orientation days and ongoing training for staff.

4. **Innovation:** Restructuring of the intake process and redefining the screening process in order to develop a reliable WICC proved beneficial to both the organizations and clients. One respondent agency has implemented a CAPA model (Choice and Partnership Approach) in which clients and service providers work together to implement a care plan based on the client’s strengths. That same center has adopted a narrative model and is now a trauma-informed agency. Two agencies worked alongside a Local Health Integration Unit to integrate services that improve patient access and experience. A need was identified to examine ways to work with partner agencies and students to continually adapt to the community’s changing needs.

5. **Challenges:** There was interesting discussion on challenges during this particular set of interviews. Each participant initially said staff were very excited, and saw the WICC as a great opportunity. However as the conversations continued, most noted that the mature staff were resistant, fearful of the change in focus and afraid that general counselling would be eroded. Some staff did not like the idea of a “free service” and wanted to implement a sliding scale or fee for service even though it does not ideally meet the WICC concept of a rapid response for all regardless of income. Some wanted to develop a screening process for WICC, ostensibly to customize whom they were seeing in order to avoid presenting problems they were not comfortable dealing with. One agency believes some staff were actual physical barriers to the Walk-In Counselling initiative because of their resistance to treat clients on an as-needed basis. Most agencies experienced staff departures due to non-acceptance of the changes; however, this did not prove to be a barrier in the long term as they now have a team that is excited to be flexible and adaptable to this new opportunity. Evidence-informed programs require a lot of time on administration and many non-profit agencies do not have the staffing complement available to support this necessity. Partnerships can prove challenging when decisions need to be made that include all partners. Funding requirements are changing and trying to keep up with appropriate service delivery while changing the structure is difficult. Another challenge identified was staff operating from a medical model that identifies patients as problems instead of experts in their lives, however changing to a narrative model to fit client’s strengths was a success.

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**Identifying the best elements and designing a future built on an agency’s inherent capital facilitates positive change.**
What are the recommendations?

1. Maintain expanded hours in the WICC
2. Utilize the WICC to reduce wait-lists
3. Re-examine front desk protocols and procedures
4. Establish a partnership with the University of Regina
5. Develop a WICC manual
6. Focus on orientation and professional development
7. Develop a strategic promotion campaign
8. Transition to a Trauma-Informed approach
9. Create a coalition with FSR-affiliated agencies

In an AI framework it is imperative to recognize stakeholders’ experience within their environment. Successes, challenges and concerns identified during the interviews offer a picture of the front-line provider experience. When taken in a positive light, challenges and concerns become opportunities to draft recommendations that break down barriers and address issues such that employees and agencies can build on inherent strengths, not the least of which is affinity for the program. Data, in conjunction with the existing literature, has proven the need for an expanded Walk-In Counselling Clinic program, and internal organization staff, community stakeholders and inter-provincial community agencies identify a WICC as a necessity as well as a source of professional pride. Information gathered from the interviews served as the base from which recommendations that will meet the needs of staff, community and agency were formed in order to move forward with strategic, innovative Walk-In Counselling Clinic programming.

Recommendations were guided by themes discovered in the interviews:

1. **Maintain expansion of WICC** – The project illustrated expanded hours at the WICC was successful and has value for the community. Literature demonstrates that a WICC can provide a “booster” that significantly relieves distress or helps with a new problem unique to, or not yet discussed in ongoing therapy (Stalker et al., 2016).
   d. The majority of clients have income below the poverty line. Recommend the WICC remain as a complimentary service to meet the needs of this population.
   e. The majority of clients attended the WICC when it opened at noon to “secure” a spot as opposed to attending in a steady stream throughout operating hours. Recommend FSR continue to monitor and explore traffic flow strategies to reduce waiting times.
   f. To ensure operating hours are relevant to the population, it is important to regularly monitor attendance and access times.

2. **Utilize the WICC to intentionally reduce the wait-list.** Currently at 8 – 29 weeks, there is a clear need for increased accessibility to rapid response. Interviews with Family
Service Canada agencies have shown a WICC significantly reduces wait-lists and research confirms this (Barwick et al., 2013; Cait et al., 2016; Stalker et al., 2016).

a. To improve service streaming, recommend restructuring and redefining the intake process. Examine the current screening and pre-screening process so as to ensure clients receive the most rapid response warranted (i.e. WICC as first line of response).

b. Examine intake scripting for new clients with reference to service placement and encouragement of accessing the WICC service as opposed to placement on a wait-list.

3. **Re-examine front desk protocols and procedures.** Recommend further development of procedures specific to front-desk personnel including knowledge of crucial conversations, trauma-informed language and guidelines for client flow. Establish a primary coordinator for each Walk-In Counselling Clinic day.

4. **Establish a strategic/formalized partnership with the University of Regina** to ensure MSW and Psychology students are consistently available to provide quality service. Establish improved and formalized relationships with other universities.

5. **Develop a WICC manual** that is relevant to students, counsellors, reception staff, which serves as part of an initiative towards development of a trauma-informed agency. The manual should include:
   a. The WICC- history and purpose. This chapter would provide background information on the development of WICCs locally and nationally and their relevance within communities. The role of FSR’s vision, mission, principles and values should be highlighted.
   b. Evidence-based therapies – This chapter should include tools for counselling, focusing on information on the three most commonly-used brief therapies, Single Session Therapy, Solution-Focused Brief Therapy and Narrative Therapy. Recommend including references to relevant recent research studies, case studies, free resources and worksheet examples.
   c. Ethics – In this chapter the Saskatchewan Association of Social Workers Code of Ethics and Canadian Code of Ethics for Psychologists should be included. FSR’s confidentiality policy, client rights and limitations to service should be detailed as well as the safe-workplace policy (no abusive calls, etc.).
   d. Front-desk protocols and procedures – This should include samples of all forms including tracking sheets and client sign-in packages. Front-desk procedures for greeting and engaging clients should be incorporated.

6. **Focus on Orientation and Professional Development** – Develop policies designed to support staff and students.
   a. Recommend strategic implementation of the WICC expansion. Data has proven the necessity of the WICC; it is critical to provide staff and students with the evidence for increased hours and assurance traditional counselling services will not be eroded provided funding restrictions and new pressures do not emerge. Adequately training staff will ensure both the community
counselling unit and WICC work in harmony and build on employee strengths.

b. Recommend consistent weekly WICC supervision during which counsellors play an active role in coordinating client care, and disseminating information amongst peers and students to review the weeks’ successes, challenges and unique situations. This is a format for guidance and information sharing. Debriefing should be considered critical. In this forum, managing complex client needs, exploring, consulting and sharing ideas will ensure services are consistent, current, relevant and streamlined for the benefit of all. Orientation should be designed to encourage cohesiveness and consistency amongst staff and students.

c. Recommend incorporating regular professional development specific to brief therapy and WICC to ensure quality service. Ongoing orientation days or half-days are imperative. Ensure staff has access to a package of case studies and evidence-based research on relevant therapy modalities, kept up to date by both students and counsellors. Monthly student presentations on the most current trends in research would serve as continuing education for both counsellors and students.

d. Recommend development of strategic methods to strengthen staff and student skills with respect to assessments, goal orientation and roadmaps for clients. Co-constructing future plans with a client is critical when completing a single session. Currently WICC counsellors place 27% of clients on a wait list after a single session. It may be indicative of clients who request further sessions with the same counsellor or may reflect counsellors’ fear of putting individuals at-risk with single session therapy. Evidence confirms the effectiveness of both Walk-In Counselling Clinics and Single Session Therapy, with the vast majority of clients attending four or fewer sessions.

7. Develop a strategic promotion campaign and create and maintain an up-to-date reference list of community services and programming complete with agency contact information and program details. The list should be maintained and updated quarterly and distributed to all FSR staff. More than 60% of clients chose “other” for how they heard about the WICC and only 3% chose social media. A robust advertising campaign that reaches those without internet and includes information on all WICC programs in the community should be a priority.

8. Recommend FSR transition towards a Trauma-Informed (TI) approach to ensure every employee in the agency is guided by TI principles. Walk-In Counselling Clinics and solution-focused therapies both have the ability to meet immediate needs without pre-screening which is integral in a trauma-informed approach. A TI framework understands the impact of trauma and strives to minimize the vulnerability and disempowerment of survivors in order to facilitate recovery and improve outcomes (Goodman et al., 2016). Given that Saskatchewan has the highest rate of both intimate partner and family violence in the provinces, a TI approach is recommended to best serve this population (Goodman et al., 2016; Burczycka, 2017).
9. Create a coalition with FSR affiliated agencies to ensure best practice and move toward an affiliation of like-minded agencies.
   a. Locally – recommend quarterly meetings to share information, outcomes, educational opportunities, promote and advertise programs and services, and discuss successes and challenges. The coalition can decide how soft transfers and referrals are conducted and managed. Discussions would help avoid duplication of services as well as availability of funding opportunities and strategies.
   b. Provincially – recommend twice yearly meetings with provincial counterparts to strengthen the current Family Service Saskatchewan Working Group, and explore opportunities for unified service provision, learn about grant and funding opportunities, and share successes and challenges.
   c. Nationally – recommend yearly meetings with like-minded agencies to discuss innovative program design, sustainability, funding opportunities, forecasting, successes and challenges.

Conclusion

In an effort to reduce wait-lists and improve access to rapid response services, counselling agencies around the country have instituted Walk-In Counselling Clinics. Evidence-based research has proven them to be a vital and necessary component in addressing the social needs of community members, especially the impoverished. Data gathered during this pilot supports that need in Regina. Wait lists of 8 – 29 weeks at Family Service Regina means clients are waiting too long to get help for an immediate need putting them at risk of increased stress and emotional burden.

The purpose of a Walk-In Counselling Clinic is to provide brief therapy, usually one session, however the client is encouraged to return if they feel the need. Research has shown most clients utilize four or less sessions (Gingerich & Peterson, 2013). For the past 6 years an average of more than 90% of WICC clients at Family Service Regina accessed only one session. With expanded hours, WICC utilization increased exponentially from 2 clients per week to 7 clients per week. The primary population accessing the service lives below the poverty line and 79% do not have benefits to cover service. An increasing number of males prefer a walk-in counselling service to general counselling. There is room for improvement in promotion of the service and coordination with local agencies would be a benefit. It was these results that informed the recommendations.

Interviews with staff and other agencies point out some commonalities, strengths and challenges in moving forward. It is important to note that internal agency staff are front line employees and their experiences differ from those of the managers and directors charged with establishing and sustaining new programs. Each offers valuable input and together they offer a complete picture of the path forward. The main limitation to the pilot project was the short timeframe; however, the collected data showed a clear need for expanded service. For negation of wait-lists, this pilot has highlighted the community need and should offer insight for innovative program design.
Appendix 1

Interview Questions

Internal organization staff

1. How do you feel about the current structure, setup and design of the walk-in clinic?
2. What do you value most about the walk-in clinic?
3. Are there any current challenges or limitations with the current structure, setup or design of the walk-in clinic? If yes, how would you like to see these challenges transform into achievements?
4. How do you see Family Service Regina’s walk-in clinic addressing the needs of the community?
5. What could be achieved short term and long term if Family Service Regina implemented an expansion of the current walk-in clinic?
6. Explain what you think would need to change if Family Service Regina decided to expand the walk-in clinic and what possible challenges and successes you foresee?

Community stakeholders and interest organizations

1. How do people connect with your agency for programs and services?
2. What does your agency’s current wait-list look like and how is your agency looking to transform and implement strategies to reduce or eliminate the current wait-list?
3. When Family Service Regina expands its walk-in clinic, how would this support both agencies regarding referrals and wait-list times?
4. How would your agency see coordinating transfers and referrals with/to Family Service Regina?

National organizations with Walk-in Clinics

1. What was your organizations process of identifying a need for a walk-in clinic?
2. What processes and program design changes were developed and implemented within your organization to move forward with a walk-in clinic?
3. How long has the walk-in clinic been operating for?
4. How has this program supported the positive impact on the needs of the community?
5. What successes and challenges has your organization experienced with the walk-in clinic?
6. Has your implementation of a walk-in clinic positively or negatively impacted wait times for counselling services? If so, what were wait time like prior to implementation and what are they now?
7. What resources have been/will be required to continue to operate the walk-in clinic?
8. How has your team responded to the development, implementation and delivery of walk-in services?
Appendix 2

Interview Results

Internal organization staff

Individual findings will not be shared to protect the privacy of the interviewees and to prevent bias on the findings. For breakdown of the finding by category and question see Appendix 2.

Several themes emerged from the questions proposed to the counsellors.

1: "How do you feel about the current structure, setup and design of the walk-in clinic?"

All five participants expressed some degree of affinity for the program, ranging from answers of “helpful” to “I like that it provides immediate intervention for certain people”. With respect to the structure, all five expressed concerns. Two felt the structure has too few hours and is too limiting to the public, making it inaccessible to many. The more pressing concern was capacity and the ability of staff to stretch their schedules and cover an expanded WICC.

2: What do you value most about the walk-in clinic?

The responses to this question were overwhelmingly positive with respect to providing a service for those in immediate need. All participants valued its ability to provide immediate, no-cost access, and its ability to “fit into” the lives of users. Four made reference to the value of SST as a therapeutic modality. Interestingly, one counsellor queried its value for men.

3: Are there any current challenges or limitations with the current structure, setup or design of the walk-in clinic? If yes, how would you like to see these challenges transform into achievements?

This question was designed to elicit possibilities of transformation, from challenges into achievements, however only two employees were able to articulate possibilities: “good method of forecasting users and issues” and “it works for people without EAP”. Challenges and limitations universally related to staffing and caseload management. The main concern was having enough students present to ensure staff did not have to cut into their caseloads for the WICC. Training and consistency amongst counsellors and students was also mentioned by 4 employees. Ensuring consistent, quality service for users because of the transient nature of students was raised by 3 participants.

4: How do you see Family Service Regina’s walk-in clinic addressing the needs of the community?

All respondents believed the WICC increased availability of services and provided an “immediate intervention piece” that is currently missing. One participant noted more data could further demonstrate that a WICC is useful while two noted it “gives clients a taste of counselling is like” and reduces fear and stigma. More than half of the respondents were concerned that increasing WICC services eroded general counselling services.

5: What could be achieved short term and long term if FSR implemented an expansion of the current walk-in clinic?
All but one participant easily articulated short-term possibilities that included: reducing wait lists, meeting users’ short term needs and forming a safety net for community members. However long-term possibilities created more questions than answers. Respondents were concerned about the long-term impact on sustainability, availability of funding, screening of clients, and ongoing demand for the service. A theme reiterated by each participant was concern that WICCs will replace general counselling.

6: Explain what you think would need to change if FSR decided to expand the walk-in clinic and what possible challenges and successes do you foresee?

Spacing issues and funding were the two consistent challenges raised. Each participant expressed a concern over physical spacing and placement of counsellors and students. With respect to funding, the general theme was how to manage an increased program load within the current staffing limitations, burn-out of counsellors, monitoring of students and cost of running an expanded WICC. Only one success was mentioned: “more people would know about our services”.

Community stakeholders and interest organizations

1. How do people connect with your agency for programs and services?

Both agencies accept referrals from internal intake, government departments and healthcare organizations as well as assessing walk-in traffic for suitability for a WICC, either on-site or at another location. Both found their WICC was not well utilized for a variety of reasons. At one center, the WICC has only been operational for twelve weeks however is not well publicized and clients comment they are unaware of the service. The physical location is not conducive to foot traffic and is hard to access via public transportation. Intake also advises clients of FSR’s WICC and its more central location may divert people. At the other agency the WICC has been operationalized for years however the program was implemented with little training and advertising and staff did not buy-in to the program. Due to the nature of some mental and emotional presenting issues, some clients find it hard to follow a single session model. Referring physicians are resistant to the idea of single session therapy and have not supported the WICC. At both sites the clinical director feels if the program had been implemented in a more step-wise fashion with therapist training and buy-in, the program would flourish. It was interesting that one center had a majority of young males accessing the WICC.

2. What does your agency’s current wait-list look like and how is your agency looking to transform and implement strategies to reduce or eliminate the current wait-list?

Each agency initiated a WICC to deal with wait lists which vary from 8 weeks to 5 months and both found the longer the client waited, the less likely they were to show up for therapy. Both reported a “high incidence” of no-shows for traditional counselling although neither had specific figures to report. One agency believes solution-focused is the model to utilize for most clients as they have had little success retaining clients for long term therapy. At intake, the other agency will suggest WICC for clients to “get started” with therapy while they sit on a wait-list. This agency is also currently discussing adopting a stepped care model in which clients are offered the most effective treatment at the lowest level, only ‘stepping up’ to more intensive/specialist service when clinically required (Rivers, 2013).
3. When Family Service Regina expands its walk-in clinic, how would this support both agencies regarding referrals and wait-list times?

Both expressed strong interest in coordinating services and referrals with FSR through networking and promotion of the WICCs through social media and other client-friendly methods. It was felt that stronger and coordinated WICC program implementation would help reduce the wait-lists at all centers however the cost of maintaining a WICC is a concern for both agencies, especially with a dwindling funding landscape. Both also expressed concerns of “dumping” on FSR if one wait-list is reduced while the other agencies are at full capacity.

4. How would your agency see coordinating transfers and referrals with/to Family Service Regina?

Both agencies would like to see more fluidity in transfers and referrals between organizations however right now there is no consensus on the therapeutic model each operates under (i.e. trauma-informed model) and they believe efficient use of services requires some cohesion, much as health care all operates under a “medical model”. Both believe that for coordination of services to be optimal, WICC hours at all the agencies would have to be coordinated to prevent deficiencies and overlaps in service. Of interest, neither agency kept good statistics on the average number of sessions clients utilized, thus, they have little reliable data to support changes in programming, and staff has trouble accepting the role of a WICC.

Family Service Canada Affiliated Organizations

1. What was your organization’s process of identifying a need for a walk-in clinic?

The need for a WICC was identified as a way to reduce wait lists. For two agencies, the funding structure changed and the WICC was developed as a way to develop new partnerships that met the need to reduce community barriers for access to care and needs such as downloading from emergency rooms.

2. What processes and program design changes were developed and implemented within your organization to move forward with a walk-in clinic?

One agency developed a process manual for all sites in order to provide consistent supervision. Other sites discussed focusing on increased, consistent supervision, both regular and individual, to ensure quality services while also ensuring staff are well-informed and supported. Most now utilize orientation days and ongoing training for staff. All respondents examined wait lists to see if some clients could be shifted to the more rapid response WICC. All centers restructured their intake process to better meet the needs of the clients and a WICC. One respondent operationalized a CAPA model (Choice and Partnership Approach) in which clients and service providers’ work together to implement a care plan based on the client’s strengths. That same center has adopted a narrative model and is now a trauma-informed agency. Two agencies worked alongside a Local Health Integration Unit to integrate services to improve patient access and experience. Some agencies changed the length of their individual sessions from therapist-determined to standardized 30 to 80 minutes which may include intake while standard single sessions range from 50 minutes to 1.5 hours. One center now utilizes single session therapy as their main modality. Most centers had to utilize more students in order to make the WICC operational.
3. **How long has the walk-in clinic been operating for?**

Most respondents have been running their WICC’s for approximately 5 years.

4. **How has this program supported the positive impact on the needs of the community?**

All centers noted wait lists have been positively impacted. All mentioned the importance of a WICC in meeting the needs of the community and client’s expression of wellbeing. All mentioned that barriers are reduced because the service is available to everyone. One center has been informed that emergency room visits have been reduced. One center noted that most clients use an average of only 3 sessions while another noted their average client usage was 4-6 sessions.

5. **What successes and challenges has your organization experienced with the walk-in clinic?**

Successes: All respondents take pride in providing barrier-free counselling services. All found that restructuring the intake process and redefining and examining a screening process was beneficial to both the organization and clients. Placing time and effort on counsellor education, training and supervision and professional development is important for staff support.

Challenges: Evidence-informed programs require a lot of time for paperwork and many nonprofit agencies do not have the staffing complement. Partnerships can prove challenging when decisions need to be made that include all partners. Funding requirements are changing and trying to keep up with appropriate service delivery while changing the structure is difficult. Another challenge was staff operating from a medical model that identifies patients as problems instead of experts in their lives, however changing to a narrative model to fit client’s strengths was a success. Another center noted the WICC is small so if someone is sick it is challenging to keep it going.

6. **Has your implementation of a walk-in clinic positively or negatively impacted wait times for counselling services? If so, what were wait time like prior to implementation and what are they now?**

Each participant stated that implementation of a WICC had definitely positively impacted wait-lists. Interestingly, all centers now have a wait-list that averages around only 1 week. One center had reduced wait-times from an average of 4-6 months to an average of 1 week. Unfortunately the other centers did not have recorded data but “know” the wait lists are “significantly” less. One participant called their old wait lists “chronic” and related to “poor customer service” with significant barriers to access; some counsellors would avoid complex presenting issues.

7. **What resources have been/will be required to continue to operate the walk-in clinic?**

Funding was the universal theme from all respondents. All discussed how to meet the continued and evolving requirements of funders while remaining flexible and adaptable. All centers were concerned with sustainability of the WICC within dwindling funding, even though it had proven to be a necessary entity. A need was identified to examine ways to work with partner agencies and students to continually adapt to the community’s changing needs. All agencies placed high emphasis on training, maintaining and supporting existing staff while supervising and training a
steady stream of the students that are a necessary resource. Partnership with the university was considered to be of critical importance.

8. How has your team responded to the development, implementation and delivery of walk-in services?

This question drew interesting responses. Each participant initially said staff were very excited, and saw the WICC as a great opportunity. However as the conversations continued, most noted that the mature staff were resistant, fearful of the change in focus and afraid that general counselling would be eroded. Some staff did not like the idea of a “free service” and wanted to implement a sliding scale or fee for service which does not ideally meet the WICC concept of a rapid response for all regardless of income. Some wanted to develop a screening process for WICC, ostensibly customize who they were seeing and avoid presenting problems they were not comfortable dealing with. One agency believes some staff were actual physical barriers to the community because of their resistance to treat clients on an as-needed basis. Most agencies experienced a staff exodus due to non-acceptance of the changes; however this did not prove to be a barrier as they now have a team that is excited to be flexible and adaptable to this new opportunity.
References


Kim, J., Brook, J., & Akin, B. (2016). Solution-Focused Brief Therapy with substance-using


