Effectiveness of Single Session Therapy Delivered in Walk-In a Counselling Clinic: A Program Evaluation

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Abstract

This paper explores the effectiveness of single session therapy (SST) delivered within walk-in counselling clinics (WICC). An overview of SST and walk-in counselling (WIC) is provided, along with relevant information regarding overall effectiveness. This paper will also include (a) an introduction to walk-in SST, (b) a review of the literature on the effectiveness of walk-in SST and other program evaluation results, (c) a review of what the literature states about predictors of success with this approach, (d) and finally, a program evaluation of a WICC in a mental health agency. The research indicates that there is a need for increased mental health services due to long waiting lists, and a lack of resources. Findings from a program evaluation at Children's Centre Thunder Bay and Thunder Bay Counselling support the efficacy of using SST in a walk-in mental health setting. Furthermore, recommendations for future mental health organizations implementing a WIC model will be provided to help improve effectiveness.

Introduction

In Canada, long waiting lists for mental health counselling services and a lack of resources for clients has become a rising concern (Bloom & Tam, 2015; Kowalewski, McLennan, & McGrath, 2011). Mental health and community based organizations have also been under increased pressure to provide cost-effective and brief therapy for clients to meet organizational, and client needs in an efficient manner (Perkins & Scarlett, 2008). Due to the high demand for counselling services, there has been an increased need for the development and innovation of new strategies to address the ability to offer these services (Cameron, 2007). In response, Single Session Therapy (SST), delivered in walk-in counselling clinics (WICC) has become a widely accepted approach implemented by community based and mental health organizations to help mitigate the increased need for services (Barwick et al., 2013; Cameron, 2007; Hymmen, Stalker & Cait, 2013; Slive, 2008). However, these organizations continue to struggle with managing the increased demands for counselling (Barwick et al., 2013). Furthermore, limited studies have been conducted on WICC effectiveness (Perkins, 2006; Stalker, Horton, & Cait, 2012). Therefore, further research must be undertaken to determine how the SST model can be appropriately utilized to reduce wait times and increase accessibility of services. Many WICC's offer services for a variety of issues, which include, but are not limited to mental health, psychosocial issues, financial concerns, relationship difficulties, and parenting. Therefore, for the purpose of this paper, mental health will include a broad definition of not only individual mental health, but also stressors related to relationship concerns, financial difficulties, and those of a psychosocial nature. Overall, mental health will be used as an umbrella term to address various client presenting problem areas.

The purpose of this review is two-fold. The first aim is to examine WIC effectiveness

through client satisfaction and outcomes; the second is to analyze specific client populations utilizing WIC. Program Evaluation findings from Children's Centre Thunder Bay and Thunder Bay Counselling will be examined, to determine recommendations for future mental health organizations implementing a WIC model.

It is important to note that throughout the literature, both WIC and SST are used interchangeably to describe counselling that involves a single session for clients. Therefore, each of these models highlights a form of service that allows clients to attend one session as the whole treatment process. SST has two forms, which involve either a structured format that has been scheduled or a walk-in method; however, for the purpose of this review, the focus will be on walk-in SST.

Research Strategies

Databases. The review of literature was conducted using the Lakehead University online library system. Databases included are: PsycINFO and Social Service Abstracts.

Search Terms. A variety of search terms were used for the purpose of this review. Within the literature examined, the following terms were commonly found, and therefore considered appropriate and significant to be utilized within this paper. The terms include, single session, walk-in, therapy, counselling, treatment, intervention, and social work.

Filters. Filters were applied to ensure relevant articles were being reviewed. Filters applied include: date range (2004-2018), peer-reviewed, English language and human subjects. Studies included were: empirical, qualitative, quantitative, longitudinal, clinical case study, and follow-up.

Rationale. Several articles are included to provide a comprehensive overview of the topic. Articles included are from the past 15 years. Most articles reviewed are Canadian;

however, three out of the twelve articles included are from the United States and Australia. All resources are cited throughout using American Psychological Association format and recorded in the reference list at the end of the paper.

Single Session Therapy and Walk-In Counselling

Throughout the literature, there are a variety of explanations on the differences and similarities between WIC and SST. Although most WICC's use a single session approach, it is important to understand the differences. "Walk-in and single session counselling can be different: not all single session counselling is walk-in and not all walk-in is single session" (Cait et al., 2017, p. 614). This information is important when untangling the two similar service delivery models. The literature highlights that some WICC's allow clients to return for another session, although, they are informed that the next session could be with a new counsellor (Cait et al., 2017). Therefore, even though most agencies advertise just one single session of therapy within their WICC, it is not uncommon for clients to return within the same year or years later for another session. Also, it is important to note that throughout the literature, both counsellor and therapist are used interchangeably to describe the individual performing the counselling session. Not all professionals conducting therapy are considered certified therapists. However, for the purpose of this paper each of these terms will be utilized.

Single Session Therapy

The basic premise of SST involves a counsellor working with a client, where one session is treated as a complete therapy process, with a beginning, middle, and end (Hoyt et al., 1992; Slive & Bobele, 2012). In addition, SST refers to a process where steps are planned in a single meeting to relieve the client's current suffering and distress (Bloom & Tam, 2015). This process involves both the client and counsellor working together to develop goals and increase the

client's understanding of their strengths and resources (Slive & Bobele, 2012). Overall, SST involves an "all-inclusive therapeutic encounter between therapist and client on either a walk-in or scheduled basis" (Bloom & Tam, 2015, p. 63.). Although SST can be offered within a walk-in setting, the scheduling of single-sessions by appointment can be another option within select agencies.

Within the past decade, SST has become a more prominent brief therapy approach across Ontario (Cait et al., 2017). The use of this therapeutic approach dates back to Sigmund Freud and his successful treatment of a client through one session (Hoyt, Ronsenbaum & Talmon, 1992). Many attribute the rise of SST to Talmon, another researcher who promoted the idea of SST (Harper-Jaques & Foucault, 2014). Talmon was one of the first researchers to thoroughly investigate SST in the late 1980s, and he soon discovered that just one session of therapy was the most effective model for most clients in his study (O'Neil, 2017). Talmon's original research indicated that following a single session of therapy, nearly 58% of clients indicated one session was sufficient, and 78% reported improvements in their presenting problem areas (Stalker et al., 2012; Talmon, 1990). These findings generated an increased popularity in single session work, where other professionals soon started to practice these methods.

Combined Walk-In Single Session Therapy

Walk-in SST is a new and innovative model of mental health service delivery that was developed in response to the rising problems associated with barriers to counselling services (Barwick et al., 2013; Miller & Slive, 2004). Consequently, WIC services have been increasing dramatically throughout Ontario (Stalker et al., 2012). The WICC model was first established in 2004 in response to the mental health crises and barriers associated with accessing community based and mental health services in Ontario (Bhanot-Malhotra, Livingstone & Stalker, 2010). As

of 2008, numerous mental health agencies started to develop WICC's, and by 2010, an online search revealed eleven WICC's developed nationwide (Bhanot-Malhotra et al., 2010). This number continues to grow, with over 20 WICC's existing in Ontario alone according to an online search for Canadian WIC (eMentalHealth, 2017).

WIC services provide clients with an easily accessible, timely, and immediate way to receive counselling (Slive & Bobele, 2012). Walk-in single session services refer to a process where no appointment is required (Bloom & Tam, 2015), and clients are given the opportunity to attend counselling without the long wait time (Slive & Bobele, 2012). Furthermore, WICC's offer clients counselling at a time that is completely decided by the client (Cameron, 2007). For example, during times of crises, WIC allows clients to be seen immediately, ensuring their need for counselling services is met promptly (Cait et al., 2017). Clients entering the WICC in crises have reported the clinic was there for them when they were in their most critical state, resulting in immediate relief and a regained sense of control (Cait et al., 2017). Overall, WIC is a form of SST that offers clients with counselling that is highly accessible and time-limited, with the goal of helping clients access other existing resources (Barwick et al., 2013).

Objectives and assumptions. Throughout the literature, it has been well documented that SST models challenge traditional psychotherapy assumptions and processes (Cameron, 2007). Walk-in SST has two main objectives: first, to provide clients with an alternative view of their presenting problem, and second, to help clients identify resources towards the resolution of their distress (Cameron, 2007). WIC plays an important role in the larger network of mental health, where these services may often become a starting point for clients to access other programs or resources (Slive & Bobele, 2012). Alternative resources might include family members, friends, and other members of clients' support network (Slive et al., 2008).

Connecting clients with alternative resources is important because clients can then begin to understand that they have the capacity and supports to resolve their own problems (Slive et al., 2008). Therefore, a key goal within the walk-in SST framework focuses on helping clients understand their problem and work towards finding their own solutions and resources to minimize presenting issues. Rather than taking an authoritative approach, the counsellor will empower their client to realize their strengths and capabilities as well as provide education on other relevant resources (O'Neil, 2017).

Approaches utilized by counsellors range from post-modernism to narrative, constructivist, and systemic therapies; however, the literature notes that no single approach is viewed as greater than another (Cait et al., 2017). Essentially this means that no approach is viewed as more beneficial to the success of therapeutic intervention. Within the walk-in model, a pragmatic perspective is important (Barwick et al., 2013). This means that approaches are customized according to client need, such that the most useful and those considered the best fit for a particular client are jointly prioritized (Barwick et al., 2013; Cait et al., 2017). For example, counsellors' self-identified methods for treatment might also include a combination of cognitive, narrative, solution-focused, systemic and eclectic approaches (Miller & Slive, 2004).

Basic foundational principles and assumptions for this model of treatment include: the assumption that clients can benefit from a single session; that it is more beneficial for clients and the success of therapy to engage with clients when they are ready and seeking out services; and finally, a collaborative partnership between client and therapist is required in working towards client-identified goals (Slive & Bobele, 2012). A specific WICC known as Reach Out Centre for Kids (ROCK) in ON, has a series of similar assumptions and guidelines for their program which include: that it is more beneficial for the therapeutic process to provide counselling to individuals

who are asking and receptive to change; that many clients can benefit from just one session and may not require further sessions; and many individuals will require additional support and resources via external referrals (Young, Dick, Herring, & Rock, 2008).

Counsellor's role. Within the walk-in single session framework, counsellors have a unique role that differs from practice in long-term counselling. Rather than utilizing an expert-driven approach, counsellors utilizing SST work towards actively helping clients develop concrete goals and plans to achieve those goals post-treatment (Bloom, 2001; Slive & Bobele, 2012). Counsellors that offer SST help identify and analyze specific problems, explore various solutions and resources to solve those problems, and motivate and encourage clients to work towards developing new approaches for managing distress (Cameron, 2007). The role of the counsellor is unique in the sense that they act as a guide rather than taking responsibility for the client's change process (Cait et al., 2017). Furthermore, counsellors often provide emotional support, with the hope of increasing client's sense of self-efficacy (Cameron, 2007; Harper-Jaques & Foucault, 2014; Young et al., 2008).

It has been argued that brief therapeutic processes that focus on a specific problem area are more efficient and effective in reducing clients' presenting concerns (Slive & Bobele, 2012). A key role of the counsellor then is to focus on the presenting problem, rather than using theories that examine deep-rooted underlying causes (Slive & Bobele, 2012). Overall, it is clear that counsellors utilizing this approach are more focused on the present moment and working collaboratively with the client to find solutions for immediate concerns.

Review of Relevant Literature: Walk-In Counselling Program Evaluations

Throughout the literature, the majority of program evaluations existing to date focus on themes such as client satisfaction measures, analyses of clients presenting problem improvement,

and clinical outcomes. Each of the program evaluations to date highlight differing program evaluation methods, such as, qualitative measures, pre- and post- evaluations, and follow-up data. The following review will highlight findings from relevant program evaluations, to demonstrate how previous evaluations can be utilized to understand the efficacy of walk-in SST services.

Review of Relevant Literature: Satisfaction and Outcomes of Walk-In Counselling

Satisfaction Measures

Throughout the literature, client's level of satisfaction was a common feature analyzed within walk-in SST program evaluations (Barwick et al., 2013; Harper-Jaques & Foucault, 2014; Miller, 2008; Miller & Slive, 2004). Miller & Slive (2004) conducted a program evaluation at the Eastside and Westside Family Center in Calgary, Alberta. The program evaluation examined approximately 700 walk-in counselling sessions and explored what clients felt was useful during therapy, whether they felt they had improved, and any changes they would have wanted (Miller & Slive, 2004). During an analysis of telephone follow-up interviews, the majority of client's reported general satisfaction with the walk-in service, where 74.4% reported being "satisfied" or "very satisfied" with the treatment process (Miller & Slive, 2004). Miller (2008), soon after conducted another evaluation, at the Eastside Family Center, utilizing a walk-in single session team therapy approach to determine the effectiveness of the program. Similar to previous results, out of 403 participants, 57.1% (n = 230) reported "very satisfied," and 24.8% (n = 100) were "satisfied" (Miller, 2008). More recently, another study that examined children and youth who utilized WIC services found higher levels of satisfaction compared to those who used more traditional services (Barwick et al., 2013). These results reveal the high level of satisfaction clients have with WIC services, indicating the success of this new service delivery model. In

addition to the previous literature, Harper-Jaques & Foucault (2014) conducted a program evaluation on the South Calgary Health Centre WIC service, and results indicated at post-treatment, 92.9% of clients reported that they were generally satisfied with the services they received. Overall, the previous evaluations on WICC indicate the effectiveness of these services, through positive satisfaction measure results.

Client satisfaction implications for positive outcomes. Many of the program outcomes of WICC's appear to be embedded within the client satisfaction component of the evaluations. These satisfaction measures demonstrate the effectiveness of the program through high levels of satisfaction with their counselling experiences. For example, several program evaluations highlight increased levels of satisfaction, and problem improvement from pre- to post-treatment (Barwick et al., 2013; Harper-Jaques & Foucault, 2014), demonstrating positive post-treatment outcomes and program efficacy.

Presenting Problem Improvement

Throughout the literature, a variety of WIC program evaluations examined client's level of presenting problem improvement, using pre- and post-evaluation surveys (Barwick et al., 2013; Harper-Jaques & Foucault, 2014; Stalker et al., 2016). One of the program evaluations indicated that clients' level of distress decreased post single session, and this level continued to decline after a one-month follow-up evaluation, where 44.4% reported that one session was sufficient in reducing presenting concerns (Harper-Jaques & Foucault, 2014). Therefore, clients displayed improvement in their original presenting problem areas. Similarly, Miller & Slive (2004) found that follow-up interview data from clients after attending WIC indicated that 67.5% reported some level of improvement in their presenting problem while only 7% of respondents stated their problem to be "worse" or "much worse" post-counselling.

In addition to examining pre- and post-surveys, an evaluation of follow-up data one to three months after WIC was conducted for select program evaluations. Specifically, follow-up measures examined whether or not clients experienced an improvement in their presenting problems. A study that examined the benefits of SST for both adolescents and children found that one-month follow-up benefits from treatment were maintained 18-months later (Perkins & Scarlett, 2008). Furthermore, 60% of clients made significant improvements clinically after just one counselling session (Perkins & Scarlett, 2008). Thus, the majority of clients using the WIC service reported long-term benefits.

Review of Relevant Literature: Effectiveness by Client Population

Predictors of Positive Outcomes in Walk-in Counselling Clinics

Within the SST literature, factors and predictors of positive treatment outcomes for single session WIC services have been examined. Talmon's research identified five ideal client characteristics for SST, including: (a) clients that have a specific problem that can be identified, (b) clients who seek therapy to determine whether themselves or others are functioning "normally," (c) clients that are able to reveal past exceptions or successes of getting past their problem, (d) clients that are wanting change and actively seek change and, (e) clients with strong support systems (Cameron, 2007; Talmon, 1990). Individuals with these characteristics may be more likely to benefit from WIC services and experience positive post-treatment outcomes.

Previous program evaluations also indicate that the severity of the problem the client is experiencing, and the client's motivation for treatment strongly impacts the level of client success in SST (Hymmen et al., 2013). Therefore, clients that enter treatment with more extreme or severe presenting problems may require more long-term treatment, rather than a brief single session. Client experiences also revealed that having a strong connection with the WIC therapist

who is actively listening to their stories is significant and helpful within this treatment model (Cait et al., 2017; O'Neil, 2017). Throughout the literature, the therapeutic alliance between client and counsellor in various therapeutic settings has been highlighted as vital for positive treatment outcomes (Leach, 2005). In fact, the literature states that nearly 70% of successful therapy is achieved through the development of the strong therapeutic relationship (Slive, McElheran & Lawson, 2008). Furthermore, a previous evaluation indicated that strong levels of support and validation from therapists in single sessions were frequently identified as helpful (O'Neil, 2017). Similarly, Miller (2008) reported that popular responses from clients regarding perceived strengths of the program included, having a therapist that understands them, listens well, and has a caring attitude. Therefore, having a counsellor that is willing to listen, empathetic, and genuine has been shown to improve the quality of WIC programs and increase positive treatment experiences.

Accessibility. In addition to measuring general satisfaction with WIC services, researchers have also collected qualitative data on client experiences and found that the accessibility and availability of services were highly associated with satisfaction (Cait et al., 2017; Barwick et al., 2013; Miller, 2008). Cait et al., (2017) conducted a more recent program evaluation using qualitative research methods to explore the experiences of those attending a WICC compared to other services with waiting lists. Results indicated that participant's satisfaction with services and positive outcomes highly depended on the accessibility of services (Cait et al., 2107). Another program evaluation found similar findings, where wait-times were linked to satisfaction rates (Barwick et al., 2013). Moreover, Miller (2008) revealed that when clients were asked to comment on the greatest strengths of the WICC, 31% reported that the accessibility, availability, and convenience of the program was paramount. In fact, Cait et al.,

(2017) reported that one participant provided valuable data expressing that the timeliness and availability of services was extremely helpful in preventing self-harming and suicidal behaviours. This evidence suggests that the convenience of the walk-in model can be extremely beneficial for those clients in crises needing immediate assistance.

A program evaluation examining qualitative data revealed that accessibility was found to be one of the most prominent factors that influenced client experiences (Stalker et al., 2016). Accessibility has been described as, facilitators and/or barriers that may impact or influence clients ability to acquire services (Cait et al., 2017; Stalker et al., 2016). The ability to easily access WIC appears to be a powerful influence on client's positive evaluation of WICC services. It appears that these results directly challenge the traditional models of counselling, which provide longer terms services, with lengthy wait-lists.

Presenting Concerns

The presenting issues and complaints that clients enter WICC's with have been examined by researchers to determine who is more likely to use the service, and whether specific client concerns are more likely to be satisfied over others (Miller, 2008; Miller & Slive, 2004; Harper-Jaques & Foucault, 2014).

Program evaluations indicated similar findings, where relationship issues, anxiety, depression, and family/parenting conflicts were the most common barriers amongst samples of WIC participants (Harper-Jaques & Foucault, 2014; Miller, 2008; Miller & Slive, 2004). Miller (2008) found that the most common presenting issue that clients entered with was marital and couple relationship conflicts (86%), with high ratings of general satisfaction post-treatment. In addition, satisfaction rates were highest for clients with sexual abuse/assault, child behaviour concerns, and issues with self-esteem (Miller, 2008). Similar results were found in a previous

evaluation, where parent and adolescent conflict and relationship issues were the most common presenting concerns, with a total of 62.8% of the sample (Miller & Slive, 2004). Overall, it is clear that clients with relationship issues and internalizing concerns are likely to utilize WIC services, revealing that specific interventions to target those populations would be beneficial in increasing positive outcomes and efficacy.

Defining Program Evaluation

Prior to examining the following program evaluation for CCTB and TBC's WICC in more detail, an explanation of what program evaluations include, and the purpose will be highlighted.

The Ontario Centre of Excellence for Children and Youth Mental Health (2013) describes a program evaluation as a systematic process in which data is collected about the program from several sources and then used for further adaptation, development, and improvement in the organization. Program evaluations have also been referred to as "the thoughtful process of focusing on questions and topics of concern, collecting appropriate information, and then analyzing and interpreting the information for a specific use and purpose" (Taylor-Powell, Steele, & Douglah, 1996, p.2). Therefore, program evaluations are a valuable tool to inform organizations of areas that need further improvement and restructuring. Furthermore, program evaluations may allow for organizations and other professionals to gain a deeper understanding of areas that are going well, and develop strategies for maintaining successful outcomes (Taylor-Powell et al., 1996).

A Program Evaluation: Walk-In Counselling Clinic, Thunder Bay ON

The following program evaluation was conducted on a WICC in Thunder Bay, ON. Thunder Bay Counselling (TBC) and Children's Centre Thunder Bay (CCTB) joined together to

collaboratively administer the WICC. The following information highlights the WICC program evaluation processes, results, and significant findings. The evaluation analyzed client satisfaction measures, through pre- and post-survey evaluation forms to determine if there were improvements in clients presenting problem areas after receiving a single session of counselling. Furthermore, specific client populations were examined to determine if there were differences in client outcomes.

Context of Organization

The WICC is held once per week at alternating locations for eight hours on Wednesdays. This counselling service runs on a first come first serve basis, with no appointments required. Therefore, people are able to access the walk-in as needed, and the service is completely open and accessible to the community.

How Services are Evaluated

Service Evaluation forms are filled out both pre- and post-counselling session to assess the main reason clients enter the walk-in, whether or not clients have improvements in reported symptoms, and their overall satisfaction levels with the service. To determine and measure the outcome of clients overall experiences and satisfaction levels within the WICC, questions inquire about stress levels, negative physical symptoms experienced, relationships, unhealthy coping strategies, confidence levels to fix the problem, understanding of what is causing the problem, and awareness of supports and resources to resolve the problem.

Procedure

Clients entering the WICC were asked to complete two Service Evaluations. Service Evaluation #1 (Appendix A) is completed prior to their counselling session, and Service Evaluation #2 (Appendix B) is completed post-session. Both Service Evaluations were

developed based on a specific program logic model (Appendix C). This model was formed collaboratively by the TBC and CCTB as a tool that would allow for the organizations to evaluate the WICC. The model specifically highlights what the counsellor should complete during the therapy process with the client. The Service Evaluation questions were then formulated according to the desired target outcomes. Each Service Evaluation is voluntary and not a mandatory requirement for accessing the WICC. However, the data from the Service Evaluations were paramount for understanding and comparing the effectiveness and satisfaction levels for the program.

Method

Participants

A total of 784 participants' data collected for the duration of one year (January 2017-December 2017), was included in this program evaluation. However, participants with missing survey data were not included, leaving a total of 499 participants for the final data analysis. Of these, 186 of the identified clients were male (37.3%), 310 were female (62.1%), and 3 were other (.6%). There were no selection biases for missing data for either gender or presenting concerns. However, age demonstrated some differences, where a high percentage of individuals with missing data were 45 years and older (45%). Participants included children, adolescents, and adults, with ages ranging from 9 to 80 years old. Participants' self-identified presenting issues were coded by the researcher into the following categories: suicidal ideation (n = 13), substance use (n = 32), externalizing behaviours (n = 18), internalizing concerns (n = 158), mental health trauma (n = 30), parenting/ family issues (n = 44), school difficulties (n = 10), workplace issues/stress (n = 12), relationship issues (n = 70), financial and living difficulties (n = 8), parental complaints with child and/or teen (n = 82), and other (n = 20). These categories

were developed afterwards based on client reports.

Measures

Service Evaluation #1. The first Service Evaluation has three key purposes. First, the evaluation gathers information on the clients presenting problem, which is used to help the team of counsellors determine who would be the best fit for that particular client. Second, the evaluation serves as a baseline of outcomes on clients symptoms, presenting problem, and stress levels, which are used for program evaluation purposes to compare these measures with the post-evaluation data. Third, the evaluation data allows counsellors to gain a clear picture of what the client's life looks like, giving them time to think of strategies to use ahead of time to bring into the session.

Seven different outcome questions are asked, where clients rate themselves on a scale from 1 to 10. Within the appendices, the reader will note there are differences between the scales for each question to ensure clients' are carefully considering their responses. Review the appendix for further details on each scaling question. The evaluation also includes two qualitative based questions, where clients are free to respond without a scale.

Service Evaluation #2. The second Service Evaluation is received immediately after the counselling session. This evaluation is similar to the first, for the purpose of comparing client results from before and after treatment. The second evaluation allows for clients to rate satisfaction and outcomes from counselling on a numbered scale. Four different outcome questions are asked, rated on a 1 to 10 scale, that are identical to questions asked on the initial evaluation administered. These questions explored: clients' stress levels, their understanding of the present problem, their level of confidence for fixing the problem, and the knowledge of supports and resources to resolve the problem.

Furthermore, the second Service Evaluation asks a question specifically about how satisfied clients were with the services on a scale ranging from “very dissatisfied” to “very satisfied.” However, for data analysis purposes, this question and the following were recoded with rating numbers on a scale from 1 to 6, with 1 indicating “very dissatisfied” and 6 indicating “very satisfied.”

Results

Demographic Information

From the total sample, age was broken down into different categories which include: 8 to 18, 19 to 24, 25 to 34, 35 to 44, and, 45 and over. The average age entering the walk-in was similar for both males (M = 34.03, SD = 14.45), and females (M = 32.38, SD = 12.83). To ensure there was no bias evident within the results, the analysis was conducted on clients who fully completed the Service Evaluations, and those who left answers blank (incomplete).The majority of the results were similar between each group. The following results include clients who completed both pre-treatment and post-treatment Service Evaluations.

“Internalizing concerns,” and “relationship issues,” were the most common presenting problems for the total sample. 158 clients entered the walk-in to address “internalizing concerns” (31.8%), and 70 clients identified “relationship issues” as their primary concern (14.1%). “Substance use,” “parental complaints about teen/child” and “parenting/family issues” were also top presenting issues. According to the results, 32 clients entered with “substance use” (6.4%), 44 clients identified “family issues” (8.9%), and 82 clients reported parental complaints (16.5%). Due to internalizing concerns, substance use, and relationship issues demonstrating a high percentage of participants and significant results, a more in-depth analysis was conducted on these areas. Further details on demographic information and presenting issues are shown in Table

1. Throughout the data analysis process, it was found that males and females had no significant differences; therefore results were combined for both genders.

Clients were asked to record where they would have gone if they had not gone to the walk-in. According to the data, the list of options included the following results: Family physician 76 (15.2%), walk-in medical clinic 27 (5.4%), emergency department 24 (4.3%), nowhere 296 (59.3%) and other 101 (20.2%). See Figure 1 for further information on where clients would have gone, if they had not entered the walk-in.

Initial Survey Outcomes

Experiencing Negative Physical Symptoms

The results from the initial Service Evaluation indicated that the client's average level of negative physical symptoms was 6.26 (*SD* = 2.58). Further analysis displayed that the results were similar when broken down for each age category (See Table 2). However, the results indicated that as age increases, negative physical symptoms also increase. Clients that were 45 years and over experienced more negative physical symptoms (*M = 6.84*, *SD* = 2.21), compared to the 8 to18 age category (*M* = 6.16, *SD* = 2.58). Furthermore, individuals entering treatment with internalizing concerns displayed higher levels of negative physical symptoms (*M* = 6.87, *SD* = 2.21), compared to both relationship issues (*M* = 6.24, *SD* = 2.67) and substance use concerns (*M* = 6.50, *SD* = 2.82).

Unhealthy Coping Strategies

The initial Service Evaluation also asked clients to report whether they were using any unhealthy coping strategies. According to the data reviewed, results were close to mid-range on the scale for individuals using unhealthy coping strategies such as drinking, eating too much, avoiding, crying, or sleeping too much (*M* = 5.41, and *SD* = 2.47). Further analysis indicated 19

to 25 year olds utilized the most unhealthy coping strategies compared to all other ages (*M* = 6.13, *SD* = 2.54). However, the 24 to 35 age category also displayed a large number of participants reporting unhealthy coping (*M* = 5.83, *SD* = 2.66). Further analysis indicated that individuals entering treatment with substance use as their leading presenting concern rated the highest for unhealthy coping strategies (*M* = 6.91, *SD* = 2.62) compared to both relationship issues and internalizing concerns. See Table 3 for other age category and presenting problem comparison results.

Relationships with Immediate Family

Clients entering the WICC reported the strength of their relationships with immediate family members (partner, children, and parents). For the total sample, results revealed a large number of participants had relatively strong relationships with their immediate family (*M* = 6.55, *SD* = 2.45).

Clients aged 25 to 34 years old exhibited the strongest relationships with their immediate family (*M* = 5.99, *SD* = 2.68), when compared to weakest, 8 to18 years old (*M* = 6.82, *SD* = 2.13). Further results are presented in Table 4. Individuals who entered treatment with substance use problems displayed the worst relationships with their immediate family members (*M* = 5.13, *SD* = 2.46). Meanwhile, individuals with relationship issues and internalizing concerns had similar and higher results for relationships with their immediate family members (*M* = 6.66, *SD* = 2.46) and (*M* = 6.63, *SD* = 2.30).

Comparison: Initial and Final Outcomes

Stress

Within both Service Evaluation #1 and #2, clients were asked to rate the level of stress the problem is causing for them. A Wilcoxon Signed-Rank Test was completed on all pre- and

post-questions to determine statistical significance. Effect sizes were calculated in order to determine the magnitude of the effect. Clients displayed a statistically significant results and had decreased stress levels from pre-treatment (M = 7.69, SD = 1.86) to post-treatment (M = 5.26, SD = 2.05), $p < .001$. Overall, the majority of clients reported an improvement in stress levels, N = 408 (81.8%). Further improvement results are displayed in Figure 2.

Age. Results indicated that ages 24 to 34 experienced the largest change in stress levels when comparing pre- (M = 7.92, SD = 1.51) and post- Service Evaluations (M = 5.04, SD = 1.99). Each age category experienced a large effect size ranging from (d = 1.08 to 1.81) and had statistically significant results, $p < .001$. See Table 5 and Figure 3 for further age comparisons.

Presenting concerns. Individuals that reported substance use as their primary concern improved the most in terms of stress levels from Service Evaluation #1 (M = 7.16, SD = 1.85) to Service Evaluation #2 (M = 4.69, SD = 1.66). Each presenting concern entering treatment (internalizing concerns, relationship issues, and substance use) indicated large effect sizes ranging from (d = 1.27 to 1.41) and displayed statistically significant results, $p < .001$. See Table 5 and Figure 4 for further results.

Understanding the Problem

Both Service Evaluations asked clients whether they understood what was causing the problem they were experiencing. Data from the total sample revealed statistically significant results for increased levels in understanding the problem from Service Evaluation #1 (M = 7.28, SD = 2.58) to Service Evaluation #2 (M = 8.47, SD = 1.87), $p < .001$. According to the total sample results, almost half of the participants reported an improvement in understanding their problem, N = 260 (52.1%). Further improvement results are presented in Figure 2.

Age. During the data analysis process, the pre- and post- Service Evaluation results were

compared by each age category to determine whether specific ages were more likely to understand what was causing the problem for them over others. Results indicated that the 19 to 24 age category had the largest change from Service Evaluation #1 (M = 6.96, SD = 2.18) to Service Evaluation #2 (M = 8.46, SD = 1.77) and the least understanding pre- treatment. However, in comparison, the 45 and over age category displayed the most understanding of what was causing their problem from pre-treatment (M = 8.32, SD = 2.63) to post-treatment (M = 8.78, SD = 1.71). Each of the age categories indicated statistically significant results, $p < .01$, excluding the 45 and over subgroup. Moreover, each age category revealed a moderate effect size ranging from (d = .56 to .76), except for the 45 and over age category which revealed a small effect size (d = .21). The 45 and over age category displayed low results for improvement in understanding the problem (26.7%), whereas results were higher for those who reported no changes in their understanding (49%). See Table 6 and Figure 5 for further analysis of the different age categories.

Presenting concerns. Individuals entering the walk-in with internalizing concerns as their primary problem presented the largest change in understanding what is causing the problem from Service Evaluation #1 (M = 6.91, SD = 2.49) to Service Evaluation #2 (M = 8.29, SD = 1.93). Clients that reported substance use as their presenting problem had the lowest change in understanding the problem post-treatment from Service Evaluation #1 (M = 7.75, SD = 2.46) to Service Evaluation #2 (M = 8.53, SD = 1.97) indicating a small effect size (d = .35). Each of the presenting concerns (relationship issues and internalizing concerns) had statistically significant results excluding substance use, $p <$ .001. See Table 6 and Figure 6 for further analysis of presenting problem comparisons.

Confidence to Fix the Problem

As clients filled out the pre- and post- Service Evaluations, they were asked how much confidence they had in fixing or resolving the problem they were entering treatment with on both surveys. The results from the total sample indicated statistically significant improvements in confidence levels from pre-treatment (M = 6.61, SD = 2.49) to post-treatment (M = 7.70, SD = 1.85), $p < .001$. According to the results for the total sample, 289 participants (57.9%) felt they had an improvement in levels of confidence for fixing the problem (See Figure 2).

Age. When the results from the Service Evaluations were compared by each age category, findings showed that the least amount of change in confidence levels was for those clients in the 45 and up age category from pre-treatment (M = 6.83, SD = 2.69) to post-treatment (M = 7.49, SD = 2.07), with a low effect size (d = .27). All other age categories indicated moderate effect sizes ranging from (d = .53 to .73). On the other hand, the 35 to 44 age category indicated the highest level of change, where confidence levels increased more than all other age categories (M = 6.62, SD = 2.20) to (M = 7.95, SD =1.33), with a moderate effect size (d = .73). Each of the age categories had a statistically significant result for increased confidence levels, $p < .001$ excluding the 45 and over age category. However the 45 and over category was still significant at the $p < .01$ level. See Table 7 and Figure 7 for further results.

Presenting concerns. The largest increase in confidence levels was for clients with internalizing concerns, with high levels of change from pre-treatment (M = 6.26, SD = 2.50) to post-treatment (M = 7.78, SD = 1.71). A moderate effect size (d = .71) was found for clients presenting with internalizing concerns. Individuals with internalizing concerns also represented the category of clients with the least amount of confidence to solve their problems pre-treatment compared to those with substance use and relationship issues (See Table 7 and Figure 8).

Meanwhile, clients at the beginning of treatment who reported substance use as their primary area of concern had the highest levels of confidence to resolve their problems (M = 7.78, SD = 1.90). Each of the presenting problem areas revealed statistically significant results excluding substance use, $p < .001$.

Accessing Resources

Each of the Service Evaluations highlighted previously asked clients if they understood or knew of supports or resources they could access to help resolve the problem. Results from the total sample indicated a statistically significant increase $p < .001$, from pre-treatment (M = 6.04, SD = 2.91) to post-treatment (M = 8.85, SD = 1.80). The results also indicated that when examining the total population, 374 participants reported an improvement in understanding where to access resources (74.9%). See Figure 2 for further examination of the results.

Age. The younger age categories (8 to 18) displayed the least amount of change (M = 6.23, SD = 3.10) to (M = 8.77, SD = 2.09), compared to the 34 to 44 age group (M = 5.75, SD = 2.97) to (M = 8.91, SD = 1.72), in terms of developing an understanding of available resources. However, the 25 to 34 age category entered treatment with the lowest scores for understanding where to access resources compared to all other age categories (M = 5.65, SD = 2.97). See Table 8 and Figure 9 for comparisons with other age groups. Each age category revealed statistically significant results $p < .001$, for the understanding of available resources from pre- and post-outcome measures.

Presenting concerns. Results indicated that individuals that reported substance use as their primary area of concern displayed the most change from Service Evaluation #1(M = 6.66, SD = 2.39) to Service Evaluation #2 (M = 9.47, SD = .88). Individuals with internalizing concerns reported the lowest level of understanding available resources and support pre-

treatment (*M* = 5.83, *SD* = 2.82), compared to both relationship issues and substance use (See Table 8 and Figure 10). Each presenting issue indicated statistically significant results $p < .001$, and large effect sizes (d = 1.15 to 1.56).

Post-Satisfaction Outcomes

In addition to measures that analyzed both pre- and post- outcomes for the same survey questions, a series of post-questions were distributed and analyzed. These questions focused on determining clients overall satisfaction with the services post-treatment. Data was pulled from four separate questions.

Satisfaction with Services

The first question asked clients how satisfied they were with the services they received. According to the data for the total sample, clients reported high levels of satisfaction with the services (*M* = 5.51, *SD* = .70). Overall, the results indicated that as age increased, the level of satisfaction with the services also increased revealing a positive linear trend. Results started with lower satisfaction levels for the 8-18 age category (*M* = 5.30, *SD* = .92), whereas ages 35 to 44 had higher levels of satisfaction (*M* = 5.65, *SD* = .52) along with the 45 years and over category (*M* = 5.60, *SD* = .60). Table 9 and Figure 11 provide further details on client satisfaction within each age category.

In addition to age, satisfaction with services was also examined by the presenting problem that clients entered treatment with. Results indicate that individuals who reported substance use as their primary presenting concern were the most satisfied with the walk-in services (*M* = 5.66, *SD* = .48), compared to individuals struggling with their relationships and internalizing concerns (See Table 9).

Addressed the Problem

Service Evaluation #2 also asked clients to report whether or not the session helped with addressing the problem they wanted to focus on. According to the data for the total sample, clients reported higher levels of satisfaction in addressing the problem areas they wanted to focus on (*M* = 1.53, *SD* = .79).

In addition, results indicated younger ages (8-18) were more likely to report that the problem was not addressed as highly as the other age categories (*M* = 1.70, *SD* = 1.01). In comparison, the 35 to 44 age category was more likely to rate that the problem was addressed at a higher rate than all of the other age categories (*M* = 1.33, *SD* = .51). See Table 10 and Figure 12 for further examination of these comparison results. Individuals who identified internalizing concerns as their presenting concern had the lowest scores on reporting that the service addressed the problem (*M* = 1.61, *SD* = .82), whereas individuals with substance use identified that the services helped them address their problem more compared to all other categories (*M* = 1.38, *SD* = .61) (See Table 10).

Feeling Heard and Listened to

Along with identifying if clients believed the service addressed their presenting problem, clients also rated whether they felt heard and listened to by the counsellor. The total sample results indicate that clients reported on average higher levels of satisfaction for feeling heard and listened to by their counsellor (*M* = 1.10, *SD* = .36).

Further findings revealed that the younger age category had the lowest scores for feeling heard and listened to (*M* = 1.15, *SD* = .51), compared all other age categories (See Table 11 and Figure 13). Furthermore, results indicated that 19 to 24, 35 to 44, and 45 and over age categories reported the highest satisfaction with regards to feeling heard and listened to, where each

category had the same result (*M* = 1.06, *SD* = .23). Individuals who identified substance use as their primary area of concern displayed the best results for feeling heard and listened to (*M* = 1.03, *SD* = .18), compared to relationship issues and internalizing concerns. See Table 11 for further presenting issue comparisons.

Feeling Welcome

The last rating scale question on Service Evaluation #2 asked clients to report whether they felt welcome at the walk-in clinic. According to the total sample results, clients on average reported higher levels of feeling welcome at the WIC (*M* = 1.10, *SD* = .34). However, the younger age categories felt the least welcome (*M* = 1.20, *SD* = .48), whereas ages 34-44 felt the most welcome (*M* = 1.04, *SD* = .19) See Table 12 and Figure 14 for all results and information. Further findings indicated that individuals who identified internalizing concerns as their primary presenting problem rated themselves as feeling the most welcome (*M* = 1.07, *SD* = .28), compared to those struggling with relationship issues and substance use. See Table 12 for further analysis of presenting problem comparisons.

Discussion

Ultimately, there are several significant findings from the CCTB and TBC WICC program evaluation that highlight the level of satisfaction with the services, overall effectiveness, and information regarding specific client populations entering treatment. The following discussion highlights significant findings from the Service Evaluations administered.

Client Satisfaction and Program Outcomes

As noted earlier, the literature supports what was found in the results regarding the link between program outcomes and client satisfaction. The evaluation indicated promising results for improving client's presenting problem areas, therefore validating the benefits of the WICC

services in Thunder Bay, ON.

Several findings were highlighted as important when comparing the outcomes from both the pre- and post- Service Evaluations. First, statistically significant results were found from the total sample for decreased levels of stress, increased understanding of the problem, increased confidence to fix the problem, and increased knowledge of resources and supports to resolve the problem. These results confirm the success of the program, where the majority of clients indicated improvements in the problem areas they were facing in just one single session. According to the previous program evaluation on the WICC for CCTB and TBC, similar results were found for improvements in stress levels, understanding of the problem, confidence to fix the problem, and increased knowledge of supports and resources (Morrison, 2010). These findings reflect the consistency and benefits of the WICC services further validating the effectiveness of this service over a ten year time period.

In addition to those findings, the total sample results displayed a large number of clients who felt their stress levels had improved post-treatment. However, close to only half of the participants presented an improvement in understanding what is causing the problem and their confidence levels to fix the problem. With such a substantial reduction in stress levels, there is still a large number of clients indicating they are not understanding their problem or how to fix their presenting concern. Therefore, this information reveals that the WICC has the ability to help clients in the moment reduce emotional intensity and stress. However, further changes in specific interventions and training may be required to adequately improve clients understanding, confidence, and ability to make sustainable changes post-treatment. This area may require additional research and study to better understand the meaning behind these findings. A qualitative study may be effective in examining this area more deeply, by generating

recommendations for further service delivery and training.

Further quantitative data confirmed the success of the program, where several clients reported high levels of satisfaction with walk-in services at post-treatment. Results indicated a large percentage of clients in each age and presenting problem category felt the program addressed their presenting problem, they felt heard and listened to, and they felt welcome. These results clearly demonstrate the efficacy of the program with the majority of clients displaying positive results in feeling they were accepted, welcomed, and understood post-treatment.

Client Populations

Some of the most significant findings from the initial Service Evaluation revealed the majority of clients entering the walk-in were female, and both males and females generated significant positive results. These findings indicate that the program is able to effectively target each gender equally, further highlighting the benefits of the service. Also, some of the most commonly found presenting issues were internalizing concerns, substance use, and relationship issues. Post-treatment, it was found that each of the presenting problem areas revealed high satisfaction rates, clearly demonstrating the walk-in's ability to target various presenting problems entering treatment. Similarly to other program evaluations, researchers found anxiety, relationship issues, and depression were the most common barriers amongst samples of WIC participants (Harper-Jaques & Foucault, 2014; Miller, 2008; Miller & Slive, 2004). Although the walk-in effectively targets various presenting problem areas and genders, there is room for further improvement. These results indicate that further training for staff to develop effective strategies to target these subgroups would be beneficial, due to the majority of clients struggling in these areas. Furthermore, therapeutic tools and screening processes targeting these subgroups would be valuable in addressing specific needs. Also, because the majority of the participants

were female, specific interventions tailored for this subgroup would be beneficial for improving services. The large difference between genders may be due to females feeling more comfortable coming forward with mental health concerns, highlighting the need for further interventions and training to address male mental health.

Interestingly, the results indicated that individuals in the 45 and over age category had the most understanding of what was causing their problem from Service Evaluation #1 to Service Evaluation #2. However, findings showed that those individuals had the least amount of change in confidence levels to resolve or fix their problem when comparing pre- and post-treatment results. This evidence indicates that individuals in older age categories already have an increased understanding of their problem due to previous coaching, or experience over the years. Furthermore, individuals in this age category had the least improvement in their problem areas post-treatment, due to previous understanding of the problem, leaving little room for increased change and understanding. Moreover, the older population had the lowest level of confidence to resolve or fix their problem post-counselling, revealing that individuals 45 and over are not developing increased skills or resources then what they had previously obtained. Therefore, further targeting of the 45 and over age population is needed in order to collaborate with these individuals in finding effective solutions. Further training for clinicians and research on supports for those in older age categories would be beneficial.

Further results indicated that substance use clients felt therapy addressed their problem more, and felt more heard and listened to when compared to clients with other presenting problems. Therefore, the program was successful in targeting individuals struggling with substance use, confirming the effectiveness of the single session model in treating clients with addiction. Furthermore, these findings are important because individuals struggling with

substance use may have more difficulty making change and finding supports (Clark, 2001).

Although the program has been successful in addressing clients' substance use problems, there are areas that require further examination. Other findings revealed that substance use clients were more commonly found to have poor relationships with immediate family members. Individuals with substance use difficulties may often push away their family support system, leading to a difficult post-treatment experience. This information is important for clinicians to understand when determining resources and strategies for this particular subgroup. These results highlight that clients entering treatment with few supports are exiting the service with high levels of satisfaction with the services they received. Clients entered treatment with strained support systems; however, at post-treatment client's felt heard and listened to. This evidence reveals that therapy provides clients with support they may not receive at home. Counsellor's also increased client's knowledge of supports and resources outside of therapy post-treatment. Therefore enhancing client's awareness of future resources they previously were not aware of. Counsellors must have a well-identified set of accessible resources for clients to turn to in these situations. Furthermore, providing supports for both family members and clients simultaneously, where they can collaboratively engage in a therapeutic environment may strengthen deteriorating relationships. Therefore, substance use was often associated with weakened supports and resources. However, the program was effective in producing high satisfaction within this population.

Further analysis from the program evaluation discovered that clients from all age categories displayed high levels of satisfaction with the walk-in services. These findings reflect the programs ability to target various age groups effectively. Although high levels of satisfaction were found for each age category, clients in the youngest age group (12 to 18) had the lowest

scores in terms of satisfaction outcomes. More specifically, individuals in this category demonstrated the worst scores when reporting whether the session helped with addressing the problem, how satisfied they were with the services, if they felt heard and listened to, and if they felt welcomed at the clinic. These findings may be due to younger clients' unwillingness to change, low levels of motivation, and external pressures to seek counselling. Previous research has revealed the importance of the therapeutic alliance for increasing positive treatment outcomes (Brener, Von Hippel, Von Hippel, Resnick, & Treloar, 2010; Leach, 2005; Schroder, Sellman, Frampton, & Deering, 2009). Therefore, increased skills and training for staff in the area of building rapport, engagement, and collaboration may be required to effectively target this particular group of participants. Further resources and training for clinicians would be beneficial in learning how to work with clients that are pre-contemplative or demonstrate difficulty understanding current stressors.

The majority of clients identified that if they had not entered the walk-in that day, they would have gone "nowhere." Previous research highlights how many clients valued the availability of the WICC and how the service prevented them from getting worse in crisis situations (Cait et al., 2017). This information speaks to the accessibility and convenience of the walk-in, and how many clients may have a limited understanding of other resources for them. These findings also highlight the importance of the WICC, further validating the benefits of the service as an easily accessible and valued resource in the community.

Limitations of Research

Overall, the program was successful with the majority of clients rating higher levels of satisfaction with the WIC services. Although the current program evaluation provided insight into WICC effectiveness, there are a series of limitations present. A large sample of participants

were included in this evaluation, however, almost 200 individuals did not complete their Service Evaluations. Missing data involved questions left blank and unanswered. The participants with missing data were not included for the total analysis process, leaving the possibility of potential bias within the findings. Another limitation included further missing data, where some of the client's ages were not recorded or available within the data set. For this project, age was manually entered and calculated. Therefore, those participants without recorded ages were not entered into the final analysis, leaving room for error and potential bias in the results.

Furthermore, because clients were able to freely record their own presenting problem on Service Evaluation #1, there was difficulty interpreting these qualitative results accurately. Consequently, responses varied from person to person. Presenting problems were recoded into different categories according to counsellor's interpretation, leaving room for error. Several clients came into treatment with various presenting problems, making it difficult to place individuals into one category. Clients often present with various life stressors, and it is unrealistic to place clients into a single category or problem area.

Future Directions

Although the purpose of this paper was not to determine alternative program evaluation methods, the following findings were deemed significant, and beneficial for future WICC analysis.

Future program evaluations should develop and research new processes that may reduce the level of missing data, to create a more comprehensive and accurate depiction of program evaluation effectiveness. Furthermore, initial Service Evaluations should require a section where clients can select their presenting problem(s), according to a series of options available which are previously categorized. However, if their presenting problem does not meet any of the options,

then clients may select “other,” and record more specifically their area of concern. Another option may be for clinicians to record the presenting problem with the client during the session. Both clinician and client may work together to fill out the criteria, to increase clarity and understanding.

Future program evaluations would also benefit from including follow-up data into their evaluation analysis. Results from one month follow-up telephone interviews would be valuable in determining how effective treatment is long-term. Therefore, a more in-depth analysis may determine what populations improve over others, and whether or not stress levels remain low over longer periods of time.

Conclusion

Client Satisfaction and Outcomes

In Ontario, the rising level of mental health concerns and long wait lists for counselling services require immediate attention. Previous research highlights positive outcomes associated with the uprising of WICC’s; an easily accessible alternative to traditional counselling services. Findings from the current program evaluation on a WICC found significant results highlighting the effectiveness of the service. Overall, clients were found to have high levels of satisfaction, and improvement in stress levels, confidence to fix the problem, their understanding of what is causing the problem, and understanding of resources and support.

Client Populations

Future directions in this area will be to further develop strategies for working with female clients, as they are more likely to use WIC services. Further examination and development of therapeutic tools targeting individuals in the 45 and over age category is required to increase levels of confidence and positive post-treatment outcomes. Similarly, it is imperative that

clinicians develop alternative methods for working with individuals in the younger age categories who were found to have lower levels of satisfaction with the WICC. Generating a more collaborative approach focused heavily on building rapport during SST is required.

Ultimately, the WICC demonstrates exceptional positive outcomes, however, further program evaluation analysis, and targeting of specific subgroups will only enhance the current mental health service delivery model. This in turn, will support the rapid changes in mental health today, while moving towards a more accessible, positive, and welcoming environment for service users.

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Appendix A

Service Evaluation - #1

Date: _____Name:_____

Gender: _____

Welcome to the Walk-In Counselling Clinic

One of our goals in the clinic is to provide the best service possible to you and others who attend. A second and equally important goal is to evaluate the effectiveness of our services.

As part of these commitments, we check to see if our counselling makes a difference in your life and if you are satisfied with the service you receive.

Please answer the following questions to the best of your ability. We will ask you similar questions at the end of the session and with your consent we may call you in about a month to ask us how we did.

Please know that participation in our evaluation is voluntary and that all information will be kept confidential. If you choose not to participate, this will not affect your ability to receive service from the clinic.

Thank you again for your time and assistance

If the Walk-In Counselling Clinic was not here, where would you have gone today?

- □ Family Physician
- □ Walk-In Medical Clinic
- □ Emergency Department
- □ Nowhere
- □ Other _____

1. What is the primary problem that has brought you to our Walk-In Counselling Clinic today?

2. From whom do you currently get support from (family, friends, professionals church, work, partner or other)? Please list.

For each of the following, please circle the number (1-10) that best represents your answer.

3. At this time, how much stress is **the problem** causing for you?

1	2	3	4	5	6	7	8	9	10
None			A little			A lot			Too much

4. Are you experiencing any negative physical symptoms (headaches, stomach troubles, sleep problems, weight gain/loss, etc) you feel are related to **the problem**?

1	2	3	4	5	6	7	8	9	10
None			A little			A lot			Too much

5. Are you using any unhealthy coping strategies (drinking too much, eating too much, avoiding, crying, anger, sleeping too much) that interfere with your life?

1	2	3	4	5	6	7	8	9	10
None			A little			A lot			Too much

6. How are your relationships with your immediate family (partner, children, parents)?

1	2	3	4	5	6	7	8	9	10
Poor			Not Good			Good			Very Good

7. Do you understand what is causing **the problem** for you?

1	2	3	4	5	6	7	8	9	10
No			A little			Sort of			Yes

8. How much confidence do you have to fix or resolve **the problem**?

1	2	3	4	5	6	7	8	9	10
None			A little			Some			A lot

9. Do you know where you can get support or resources to help resolve **the problem**?

1	2	3	4	5	6	7	8	9	10
No			A little			Sort of			Yes

Appendix B

Service Evaluation - #2

Date: _____Name:_____

Gender: _____

Now that we have finished our session, could you take a moment to help us evaluate our service and answer the following questions to the best of your ability? Please know that you do not have to participate and that all information will be kept confidential.

Please circle the number (1-10) that best represents your answer.

1. Following your counselling session, how much stress is **the problem** causing for you?

1	2	3	4	5	6	7	8	9	10
None			A little			A lot			Too much

2. Do you understand what is causing **the problem** for you?

1	2	3	4	5	6	7	8	9	10
No			A little			Sort of			Yes

3. How much confidence do you have to fix or resolve **the problem**?

1	2	3	4	5	6	7	8	9	10
None			A little			Some			A lot

4. Do you know where you can get support or resources to help resolve **the problem**?

1	2	3	4	5	6	7	8	9	10
No		A little			Sort of			Yes	

Please take a minute to tell us how we did in providing service to you.

5. How satisfied were you with the service you received today.

Very dissatisfied	Dissatisfied	Somewhat dissatisfied	Somewhat satisfied	Satisfied	Very satisfied

6. Did the session help you with the problem you wanted to address?

Yes Very much	Yes Sort of	A Little	Not really Not much	No Not at all	No

7. Did you feel heard and listened to by the counsellor?

Yes Very much	Yes Sort of	A Little	Not really Not much	No Not at all	No

8. Did you feel welcome at the walk-in clinic?

Yes Very much	Yes Sort of	A Little	Not really Not much	No Not at all	No

9. Any other comments you would like to make?

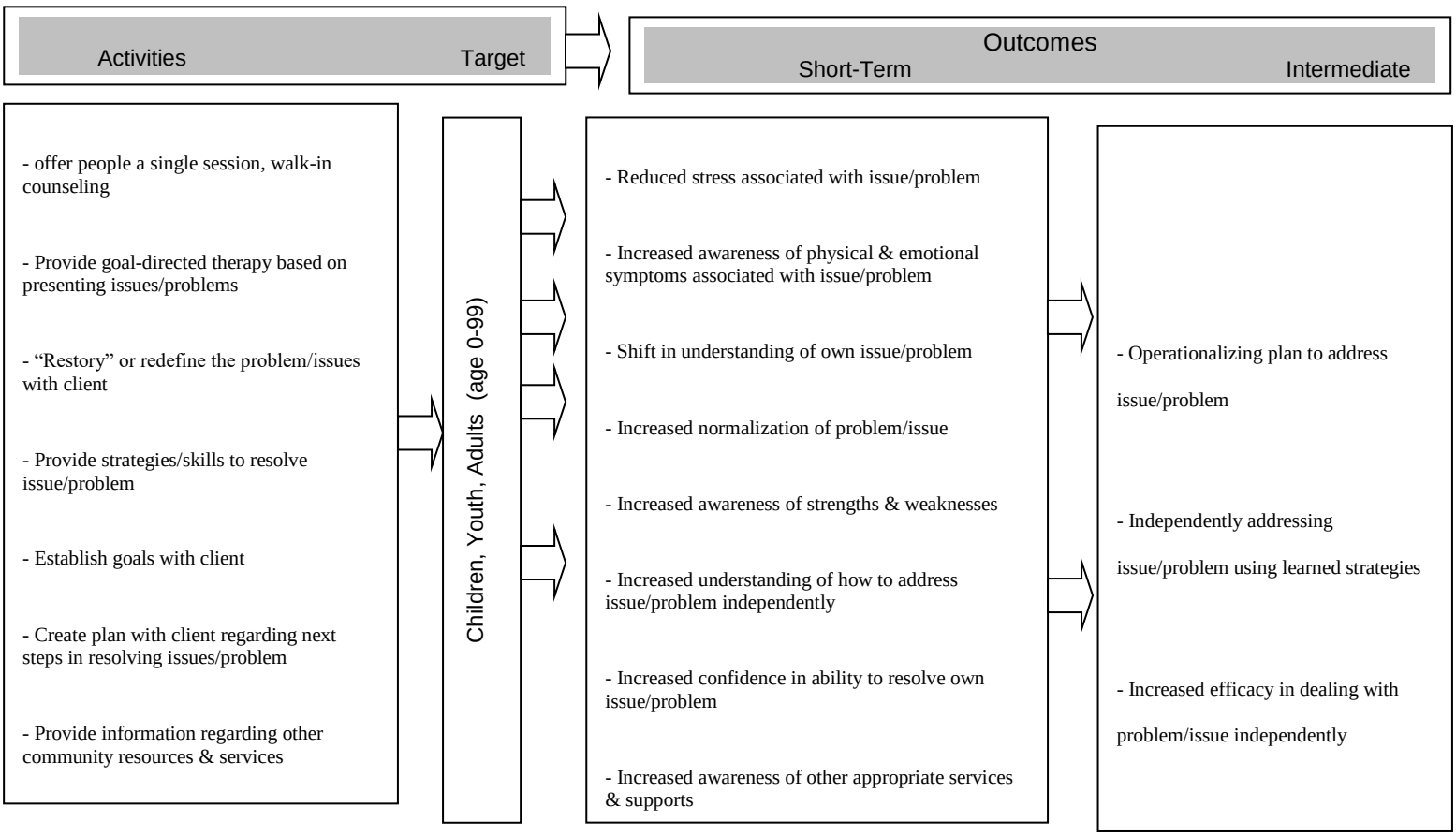
As part of our promise to improve our services, we might wish to contact you in about a month to see how you are doing. This contact would be specific to the service we provided and for evaluation purposes only. I consent to being contacted by the Walk-In counselling clinic.

_____ Contact Phone # _____

Signature

Appendix C

Program Logic Model: Walk-In Counselling Clinic Evaluation



Appendix D

Pre- and Post-Treatment Outcomes

Table 1

Frequencies of Age Groups in each Presenting Problem Category

Presenting Problem	N	8–18.99 N (%)	19-24.99 N (%)	25-34.99 N (%)	35-44.99 N (%)	45 and over N (%)
Suicide Ideation/ Attempt/ Self-Harm	11	4 (36.4)	2 (18.2)	3 (27.3)	1 (9.1)	1 (9.1)
Substance Use	31	1 (3.2)	8 (25.8)	10 (32.3)	3 (9.7)	9 (29)
Externalizing Behaviours	16	6 (37.5)	4 (25.0)	5 (31.3)	0 (0)	1 (6.3)
Internalizing Concerns	147	26 (17.7)	35 (23.8)	44 (29.9)	14 (9.5)	28 (19.0)
Mental Health Trauma	27	2 (7.4)	4 (14.8)	6 (22.2)	3 (11.1)	12 (44.4)
Parenting/ Family Issues	36	7 (19.4)	5 (13.9)	10 (27.8)	5 (13.9)	9 (25.0)
School Difficulties	5	4 (80.0)	0 (0)	1 (20.0)	0 (0)	0 (0)
Work place Issues/Stress	11	0 (0)	1 (9.1)	3 (27.3)	3 (27.3)	4 (36.4)
Relationship Issues	69	4 (5.8)	12 (17.4)	35 (50.7)	11 (15.9)	7 (10.1)
Financial and living difficulties	7	1 (14.3)	1 (14.3)	1 (14.3)	0 (0)	4 (57.1)
Parental difficulties/complaints with child or teen	30	0 (0)	0 (0)	3 (10.0)	13 (43.3)	14 (46.7)
Other	17	5 (29.4)	4 (23.5)	6 (35.3)	1 (5.9)	1 (5.9)

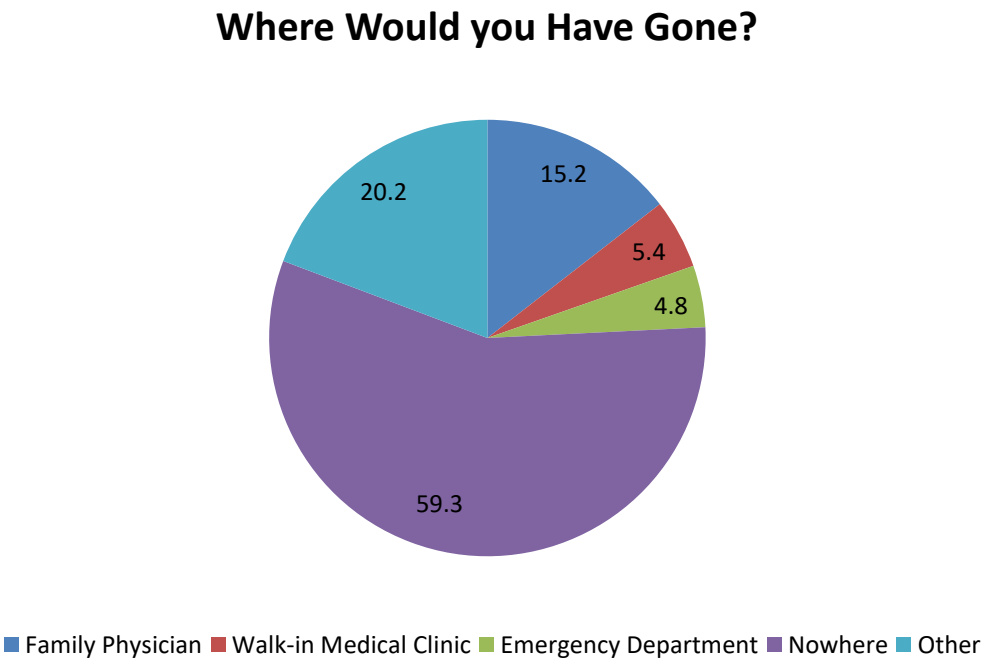


Figure 1. Pie graph showing frequencies of client responses to initial evaluation question: Where would you have gone if you had not entered the walk-in?

Table 2

Means for Age and Presenting Problem for Client Responses to Initial Question: Are you Experiencing any Negative Physical Symptoms?

Are you experiencing any negative physical symptoms (headaches, stomach troubles, sleep problems, weight gain/loss, etc) you feel are related to the problem?	N	Mean (*SD*)
Age		
8–18.99	61	6.16 (2.58)
19-24.99	76	6.18 (2.45)
25-34.99	127	6.43 (2.56)
35-44.99	55	6.49 (2.91)
45 and over	90	6.84 (2.21)
Presenting Problem		
Internalizing Concerns	158	6.87 (2.21)
Relationship Issues	70	6.24 (2.67)
Substance Use	32	6.50 (2.82)
Total	499	6.26 (2.58)

Table 3

Means for Age and Presenting Problem for Client Responses to Initial Question: Are you Using any Unhealthy Coping Strategies?

Are you using any unhealthy coping strategies (drinking too much, eating too much, avoiding, crying, anger, sleeping too much) that interfere with your life?	N	Mean (*SD*)
Age		
8–18.99	61	5.30 (2.55)
19-24.99	76	6.13 (2.54)
25-34.99	127	5.83 (2.66)
35-44.99	55	5.62 (2.73)
45 and over	90	5.44 (2.72)
Presenting Problem		
Internalizing Concerns	158	6.17 (2.58)
Relationship Issues	70	5.30 (2.60)
Substance Use	32	6.91 (2.62)
Total	499	5.41 (2.74)

Table 4

Means for Age and Presenting Problem for Client Responses to Initial Question: How are your Relationships with your Immediate Family?

How are your relationships with your immediate family (partner, children, parents)?	N	Mean (*SD*)
Age		
8–18.99	61	6.82 (2.13)
19-24.99	76	6.41 (2.10)
25-34.99	127	5.99 (2.68)
35-44.99	55	6.67 (2.37)
45 and over	90	6.56 (2.66)
Presenting Problem		
Internalizing Concerns	158	6.63 (2.30)
Relationship Issues	70	6.66 (2.46)
Substance Use	32	5.12 (2.46)
Total	499	6.55 (2.45)

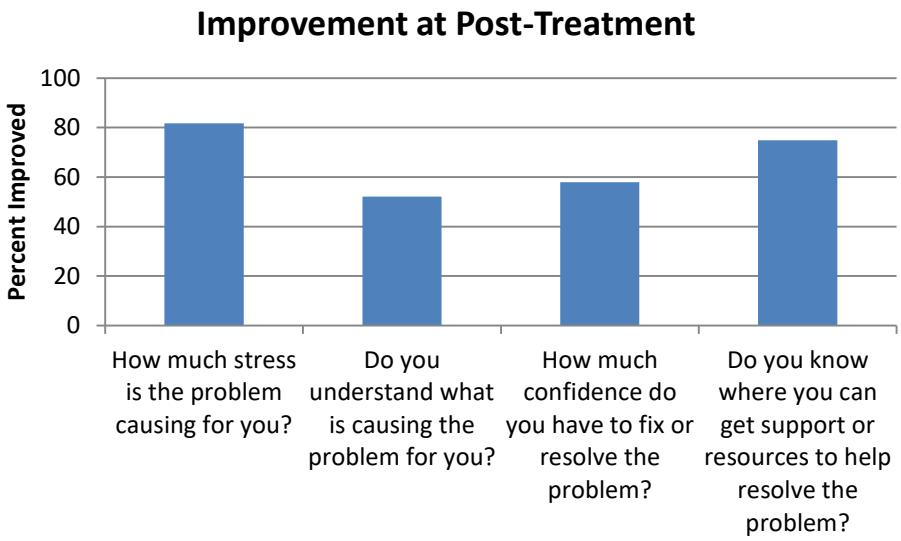


Figure 2. Bar graph showing percentage of total improvement post-treatment.

Table 5

Age and Presenting Problem Means, Effect Size, and Significance for Pre- and Post-Treatment Stress Levels

How much stress is the problem causing for you?	N	Pre-Treatment Mean (*SD*)	Post-Treatment Mean (*SD*)	Effect Size	Significance
Age					
8–18.99	61	7.10 (1.64)	5.07 (2.00)	1.11	.000***
19-24.99	76	7.67 (1.97)	5.08 (1.99)	1.31	.000***
25-34.99	127	7.92 (1.81)	5.04 (1.99)	1.51	.000***
35-44.99	55	7.96 (2.00)	5.75 (2.08)	1.08	.000***
45 and over	90	7.94 (1.76)	5.57 (2.02)	1.25	.000***
Presenting Problem					
Internalizing Concerns	158	7.80 (1.75)	5.28 (1.96)	1.35	.000***
Relationship Issues	70	7.84 (2.04)	5.16 (2.15)	1.27	.000***
Substance Use	32	7.16 (1.85)	4.69 (1.66)	1.41	.000***
Total	499	7.69 (1.86)	5.26 (2.05)	1.24	.000***

*p < .05; **p < .01; ***p < .001

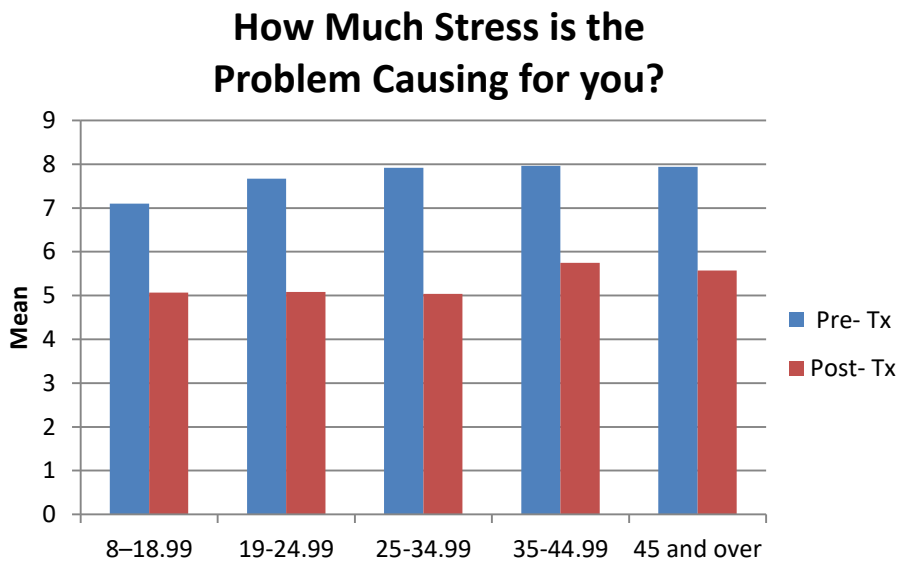


Figure 3. Bar graph showing age categories and stress level means at pre- and post-treatment.

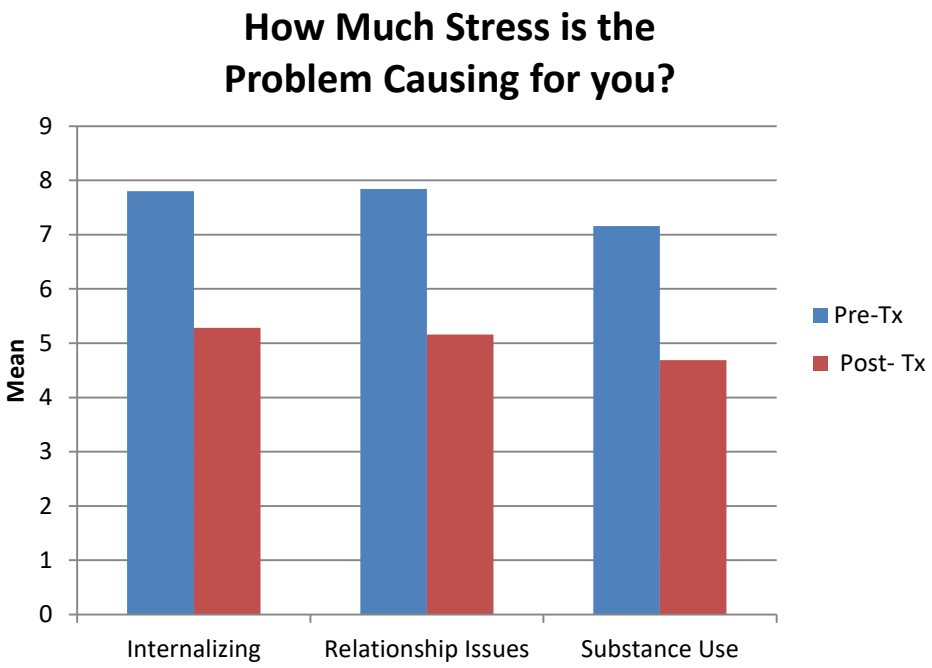


Figure 4. Bar graph showing presenting problems and stress level means at pre- and post-treatment.

Table 6

Age and Presenting Problem Means, Effect Size, and Significance for Pre- and Post-Treatment Understanding the Problem

Do you understand what is causing the problem for you?	N	Pre-Treatment Mean (*SD*)	Post-Treatment Mean (*SD*)	Effect Size	Significance
Age					
8–18.99	61	6.52 (2.91)	8.03 (2.41)	.57	.001**
19-24.99	76	6.96 (2.18)	8.46 (1.77)	.76	.000***
25-34.99	127	7.03 (2.34)	8.50 (1.70)	.72	.000***
35-44.99	55	7.20 (2.77)	8.49 (1.70)	.56	.000***
45 and over	90	8.32 (2.63)	8.78 (1.71)	.21	1.24
Presenting Problem					
Internalizing Concerns	158	6.91 (2.49)	8.29 (1.93)	.62	.000***
Relationship Issues	70	7.66 (2.21)	8.74 (1.55)	.57	.000***
Substance Use	32	7.75 (2.46)	8.53 (1.97)	.35	.080
Total	499	7.28 (2.58)	8.47 (1.87)	.53	.000***

*$p < .05$; **$p < .01$; ***$p < .001$

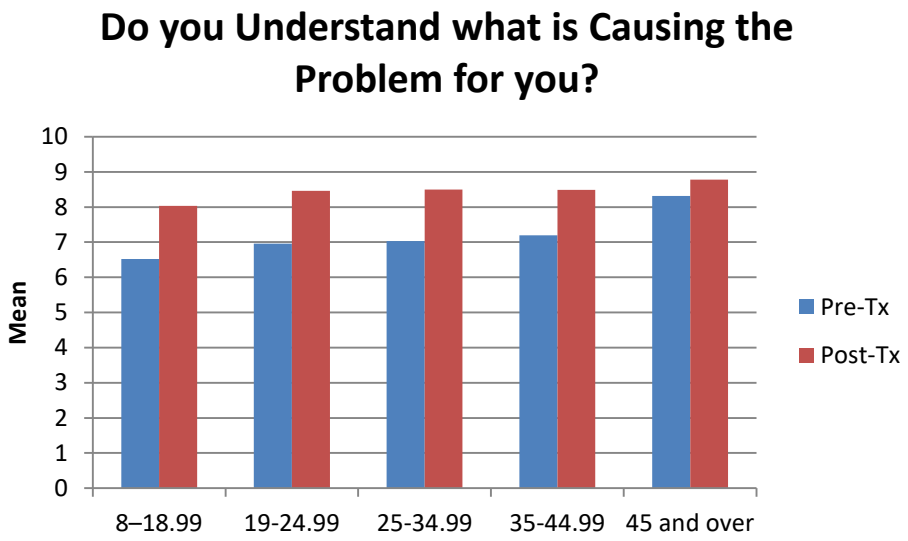


Figure 5. Bar graph showing age categories and understanding the problem means at pre- and post-treatment.

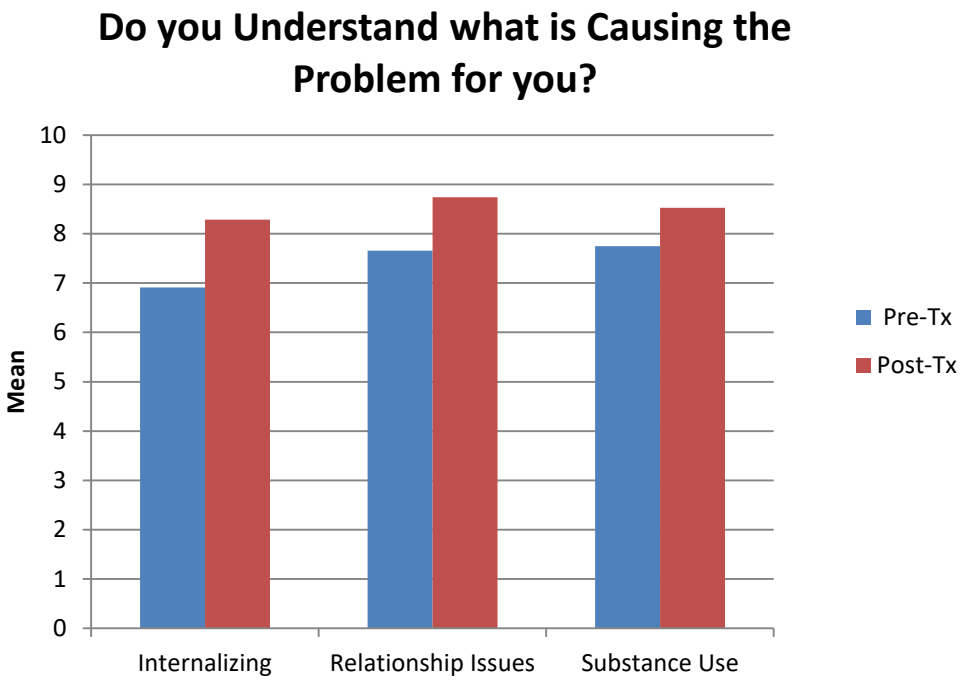


Figure 6. Bar graph showing presenting problem and understanding the problem means at pre- and post-treatment.

Table 7

Age and Presenting Problem Means, Effect Size, and Significance for Pre- and Post-Treatment Confidence Levels

How much confidence do you have to fix or resolve the problem?	N	Pre-Treatment Mean (*SD*)	Post-Treatment Mean (*SD*)	Effect Size	Significance
Age					
8–18.99	61	6.39 (2.51)	7.64 (2.22)	.53	.000***
19-24.99	76	6.57 (2.34)	7.86 (1.44)	.66	.000***
25-34.99	127	6.20 (2.61)	7.64 (2.02)	.62	.000***
35-44.99	55	6.62 (2.20)	7.95 (1.33)	.73	.000***
45 and over	90	6.83 (2.69)	7.49 (2.07)	.27	.004**
Presenting Problem					
Internalizing Concerns	158	6.26 (2.50)	7.78 (1.71)	.71	.000***
Relationship Issues	70	6.69 (2.56)	7.50 (1.96)	.36	.003**
Substance Use	32	7.78 (1.90)	8.25 (1.24)	.29	.152
Total	499	6.61 (2.49)	7.70 (1.85)	.50	.000***

*p < .05; **p < .01; ***p < .001

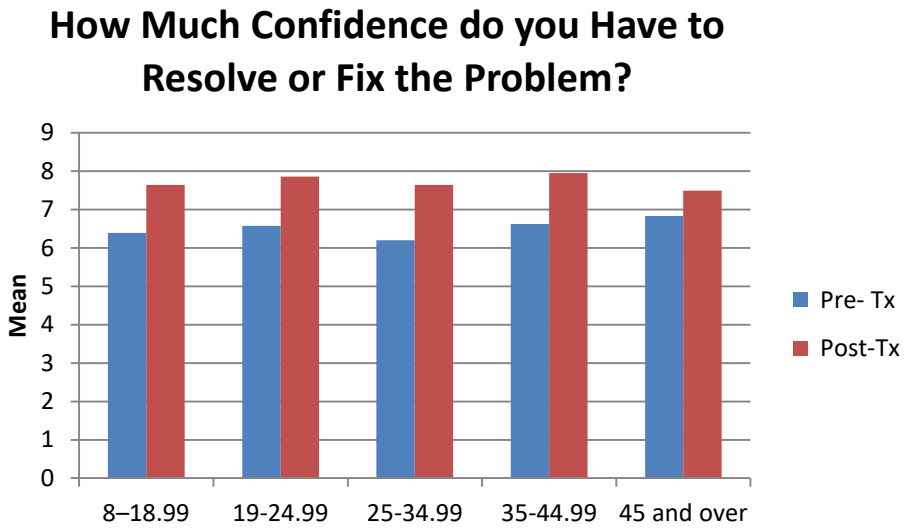


Figure 7. Bar graph showing age categories and confidence level means at pre- and post-treatment.

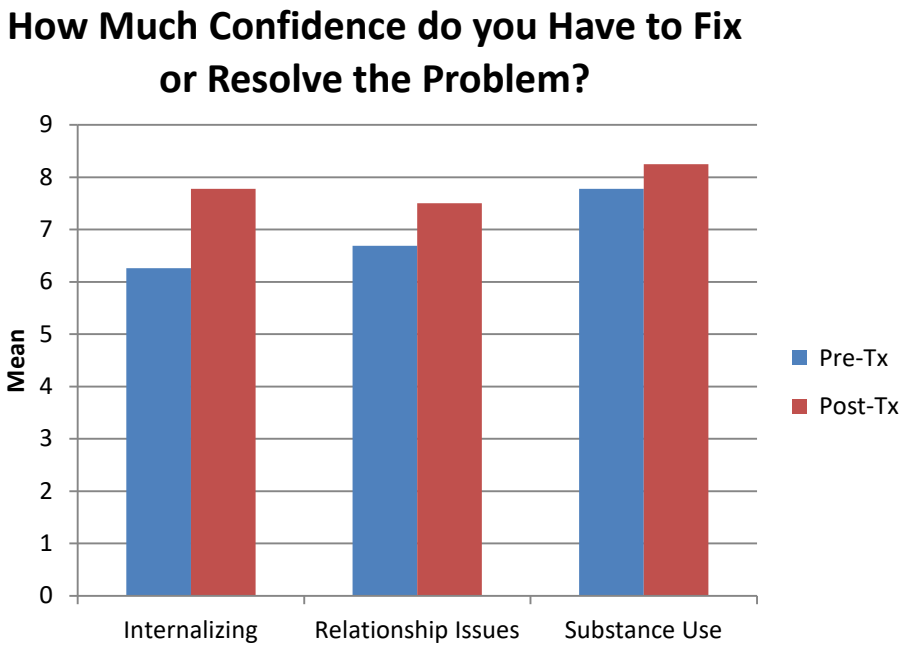


Figure 8. Bar graph showing presenting problems and confidence level means at pre- and post-treatment.

Table 8

Age and Presenting Problem Means, Effect Size, and Significance for Pre- and Post-Treatment Understanding of Support and Resources

Do you know where you can get support or resources to help resolve the problem?	N	Pre-Treatment Mean (*SD*)	Post-Treatment Mean (*SD*)	Effect Size	Significance
Age					
8–18.99	61	6.23 (3.10)	8.77 (2.09)	.96	.000***
19-24.99	76	6.05 (2.72)	8.87 (1.73)	1.24	.000***
25-34.99	127	5.65 (2.97)	8.97 (1.55)	1.40	.000***
35-44.99	55	5.75 (2.61)	8.91 (1.72)	1.43	.000***
45 and over	90	6.24 (2.97)	8.57 (2.26)	.88	.000***
Presenting Problem					
Internalizing Concerns	158	5.83 (2.82)	8.97 (1.55)	1.38	.000***
Relationship Issues	70	6.00 (2.91)	8.77 (1.78)	1.15	.000***
Substance Use	32	6.66 (2.39)	9.47 (.88)	1.56	.000***
Total	499	6.04 (2.91)	8.85 (1.80)	1.16	.000***

*p < .05; **p < .01; ***p < .001

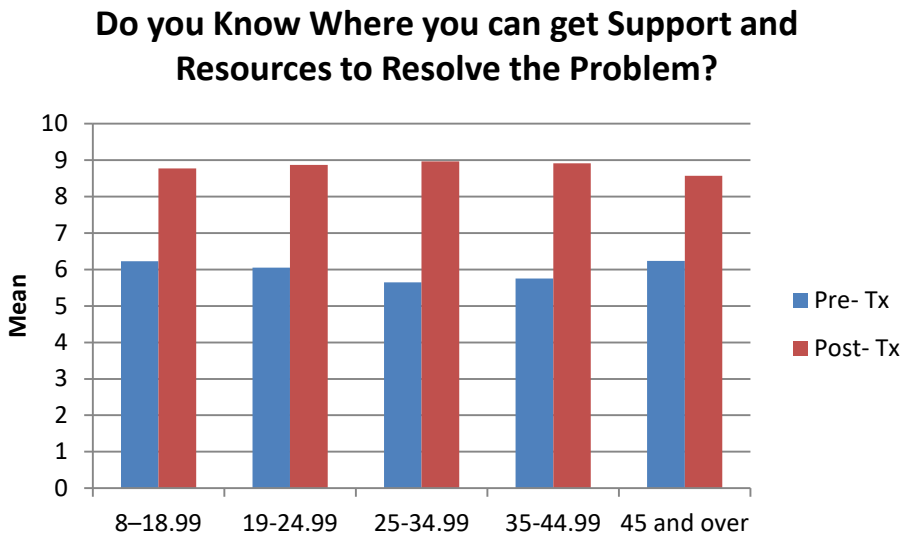


Figure 9. Bar graph showing *age categories and understanding of support and resources means at pre- and post-treatment*

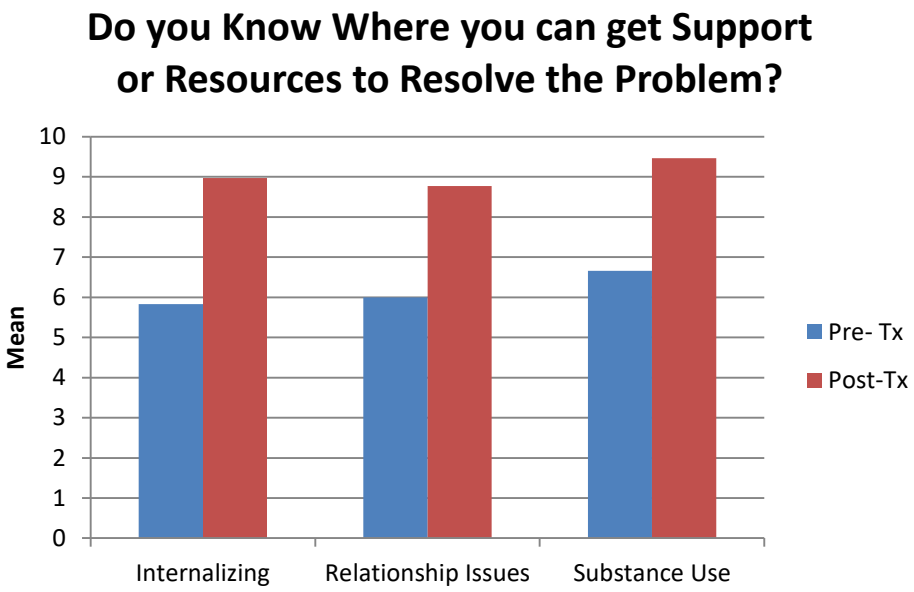


Figure 10. Bar graph showing presenting problem and understanding of support and resources means at pre- and post-treatment.

Table 9

Age and Presenting Problem Means for Post-Treatment Satisfaction

How satisfied were you with the service you received today.	N	Mean (*SD*)
Age		
8–18.99	61	5.30 (.92)
19-24.99	76	5.50 (.62)
25-34.99	127	5.53 (.78)
35-44.99	55	5.65 (.52)
45 and over	90	5.60 (.60)
Presenting Problem		
Internalizing Concerns	158	5.56 (.62)
Relationship Issues	70	5.57 (.63)
Substance Use	32	5.66 (.48)
Total	499	5.51 (.70)

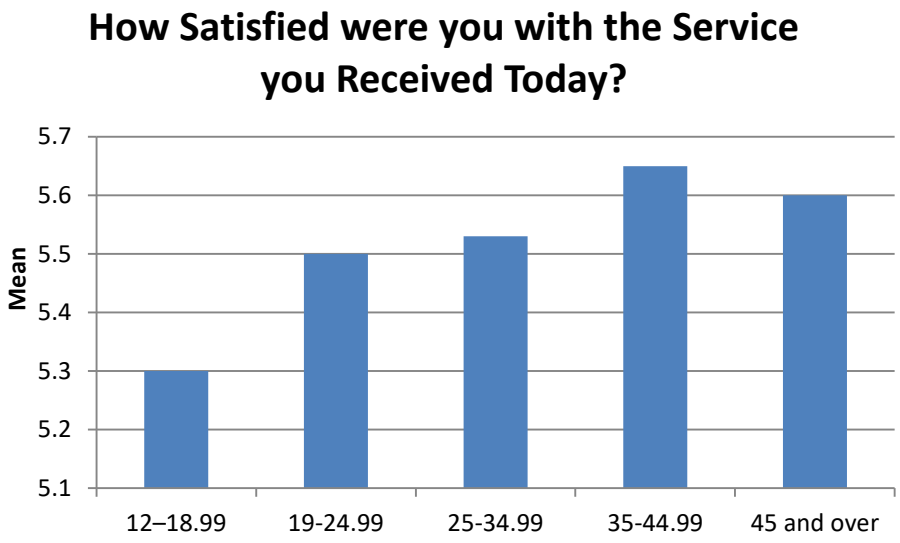


Figure 11. Bar graph showing age category means for post-treatment satisfaction.

Table 10

Age and Presenting Problem Means for Session Capacity to Address the Problem

Did the session help you with the problem you wanted to address?	N	Mean (*SD*)
Age		
8–18.99	61	1.70 (1.01)
19-24.99	76	1.57 (.60)
25-34.99	127	1.50 (.70)
35-44.99	55	1.33 (.51)
45 and over	90	1.49 (.92)
Presenting Problem		
Internalizing Concerns	158	1.61 (.82)
Relationship Issues	70	1.39 (.55)
Substance Use	32	1.38 (.61)
Total	499	1.53 (.79)

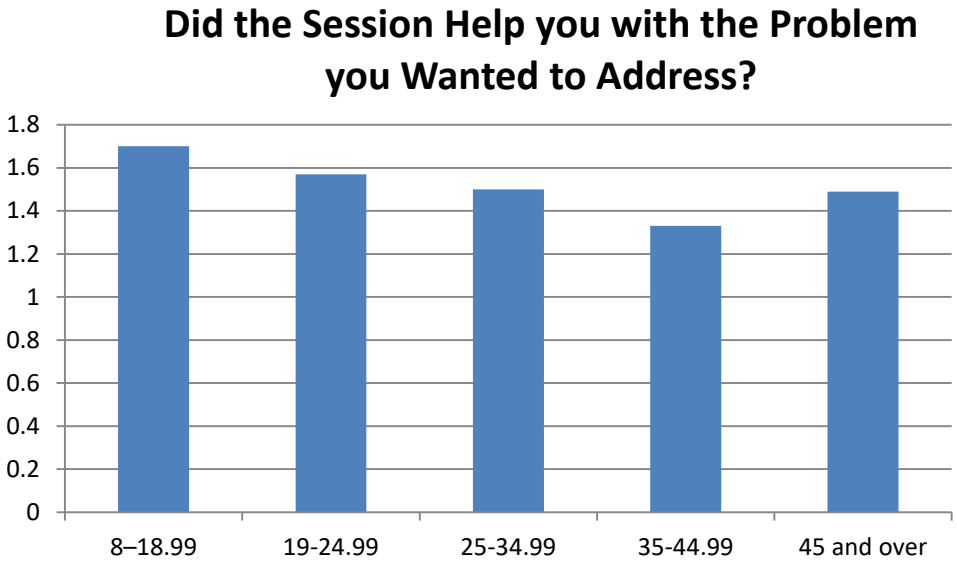


Figure 12. Bar graph showing age category means for sessions capacity to address the problem post-treatment.

Table 11

Age and Presenting Problem Means for Feeling Heard and Listened to Post-Treatment

Did you feel heard and listened to by the counsellor?	N	Mean (*SD*)
Age		
8–18.99	61	1.15 (.51)
19-24.99	76	1.05 (.23)
25-34.99	127	1.10 (.35)
35-44.99	55	1.05 (.23)
45 and over	90	1.06 (.23)
Presenting Problem		
Internalizing Concerns	158	1.05 (.25)
Relationship Issues	70	1.10 (.35)
Substance Use	32	1.03 (.18)
Total	499	1.10 (.36)

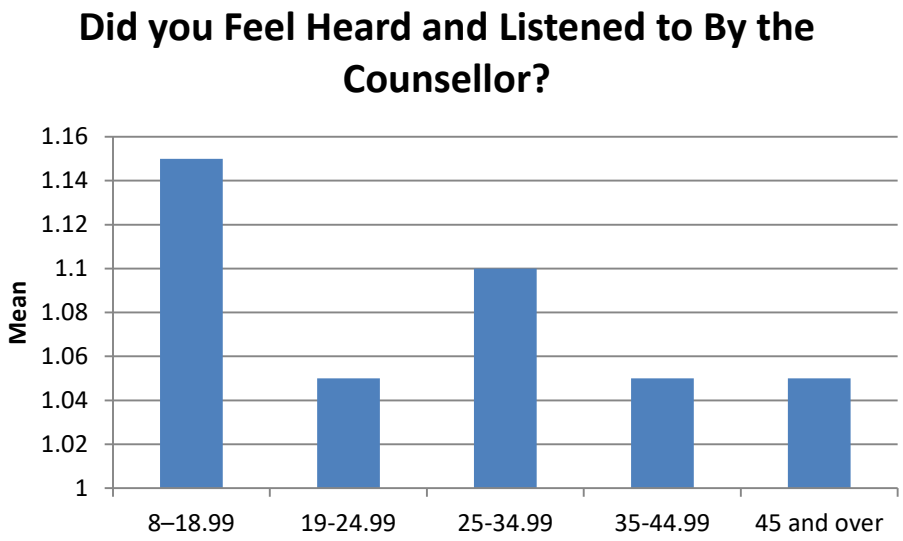


Figure 13. Bar graph shows age category means for feeling heard and listened to post-treatment.

Table 12

Age and Presenting Problem Means for Feeling Welcome at the Walk-in Clinic Post-Treatment

Did you feel welcome at the walk-in clinic?	N	Mean (*SD*)
Age		
8–18.99	61	1.20 (.48)
19-24.99	76	1.07 (.25)
25-34.99	127	1.11 (.34)
35-44.99	55	1.04 (.19)
45 and over	90	1.06 (.28)
Presenting Problem		
Internalizing Concerns	158	1.07 (.28)
Relationship Issues	70	1.10 (.30)
Substance Use	32	1.09 (.39)
Total	499	1.10 (.34)

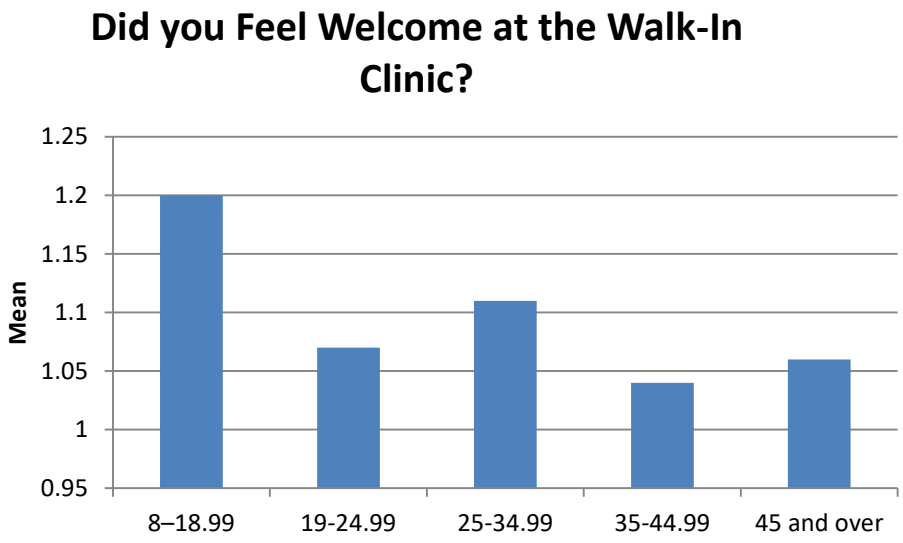


Figure 14. Bar graph showing age category means for feeling welcome at the walk-in clinic post-treatment.