Right Here, Right Now Drop-In Counselling Clinic

Program Evaluation

Catherine de Boer, PhD

November 2017

A Partnership Project between the
St. John's Status of Women Council/Women's Centre and the
School of Social Work, Memorial University

Right Here, Right Now Drop-In Counselling Clinic
Program Evaluation

Report 2017

This work was undertaken by the
St. John's Status of Women Council/Women's Centre
and the School of Social Work, Memorial University

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Listening creates a holy silence. When you listen generously to people, they can hear the truth themselves, often for the first time. And when you listen deeply, you can know yourself in everyone.

Rachel Remen, *Kitchen Table Wisdom*

It's time we made a place where
people's souls may be seen and made safe.

Jewel, *Innocence Maintained*

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Catherine de Boer
November 2017

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Executive Summary

I. Introduction

The *Right Here, Right Now Drop-in Counselling Clinic* was a six-month pilot program delivered by the St. John's Status of Women Council/Women's Centre (SJSWC/WC). The program ran two days a week, Mondays and Tuesdays from 12:00 Noon – 7:00 p.m. from September 26, 2016 to March 28, 2017. The six-month pilot was part of a larger initiative that included:

- the development of the therapy model used at the clinic,
- mapping out the processes associated with program delivery,
- training the counselling team,
- promoting the clinic,
- designing the evaluative framework,
- developing the data collection instruments,
- collecting and analysing program evaluation data,
- writing the program evaluation report, and
- communicating the findings through various venues.

The Right Here, Right Now Drop-In Counselling Initiative represents a partnership between the SJSWC/WC and the School of Social Work at Memorial University. Funding for the design and evaluation of the project came from Memorial's Office of Public Engagement; *Quick Start Funds* ($1000) were awarded in June 2015 and *Accelerator Funds* ($10,000) were awarded in February 2016. The SJSWC/WC provided the staffing and space for the clinic, including the funding of one new counsellor position. The School of Social Work and the SJSWC/WC shared in promoting the clinic and in training the counselling team.

II. Purpose

The purpose of the Program Evaluation was to identify the intended short-term outcomes of the six-month pilot of the Right Here Right Now Drop-In Counselling Clinic and to determine if the clinic achieved the intended results.

III. Methodology

The program evaluation is based on a logic model. Data collection included quantitative and qualitative data linked to each of the eleven short-term outcomes listed on the logic model.

IV. Summary of Results

A. Overview

- The RHRN drop-in counselling clinic is the Region's first and only drop-in counselling clinic operating out of a non-profit agency, and is the first such clinic to work exclusively from a feminist model and only with women.
- 78 women received single session counselling and 9 received crisis counselling.
- 156 counselling sessions were offered; 78 were first sessions and 78 were repeat sessions.
- That 64% of the women attended 1 session only and 86% attended either 1 or 2 sessions suggesting the clinic was utilized as a short-term counselling option.
- On average, 3 women attended per clinic day.
- The average length of service (intake + wait time + session) was 90 minutes.
- The primary concern of women coming for counselling was their mental health (e.g., anxiety, depression, PTSD), followed by concerns about feelings, relationships, and trauma.

B. Outcomes Specific to the Women's Centre

OUTCOME # 1: Increased Engagement of Women in the Community in Need of Mental Health Services

- 64% (n=50) of the women who received drop-in counselling had never accessed services at the Women's Centre before.
- After receiving drop-in counselling, 50% (n=25) of women "new" to the Women's Centre remained engaged by either returning for additional drop-in counselling sessions or by attending other programs at the Women's Centre.

OUTCOME # 2: Increased Service Compliment at the Women's Centre

- The drop-in counselling clinic broadened the demographic reach of the Women's Centre. A greater number of younger women, women of higher socioeconomic status, and more employed and professional women attended drop-in than is typical of attendance in other programs at the Women Centre.
- Drop-in counselling rounded out the array of services offered at the Women's Centre increasing the range of mental health concerns that could be addressed and the ways in which staff could help.
- Women who came to drop-in learned about other services at the Women's Centre and learned how to access them.

OUTCOME # 3: Provided a Stop Gap Measure for Women Awaiting Existing Mental Health Services

- 32% (n=25) of women who came to the drop-in clinic were on waitlists for "traditional" mental health services; the mean length of wait time was 15 ½ months.
- 11 waitlists were identified, including waitlists for psychiatry, psychology, residential treatment, group therapy, and individual counselling.
- 19% of women also accessed drop-in counselling as a post-service measure having received unsatisfactory or inadequate service elsewhere.

OUTCOME # 4: Successful Employment of Recruitment Strategies

- 31% of women heard about the drop-in clinic through social media, making it the most successful method of promotion.
- Only 5% of women heard about the clinic from helping professionals making community referrals the least successful method of promotion.

OUTCOME # 5: Increased Capacity of Staff at the Women's Centre to Meet the Needs of Women Served

- Members of the counselling team received specialized training with leading experts in the field of single-session counselling. They also participated in weekly in-house training and peer supervision referred to as "Single Session School".
- Training was considered useful when . . .
    - Members of the counselling team created and maintained boundaries between their "clinic work" and their other responsibilities at the Women's Centre, the knowledge gained from training would then have time to percolate,
    - Reinforcement of the learning happened through repetition (i.e., materials were reread, training sessions offered multiple times etc.), and
    - Members of the counselling team attended "Single Session School".
- Members of the counselling team increased their capacity by:
    - Moving from a "fix-it" approach to a non-expert stance,
    - Gaining confidence in their abilities to be useful,
    - Enhancing their focusing skills, and
    - Utilizing techniques broadly tethered to single-session counselling or more specifically to the Right Here, Right Now Counselling model.

C. Outcomes Specific to the Women Who Received Counselling Services

OUTCOME # 6: Drop-In Counselling Services Were Identified by Women as Being Useful

- Using a 4-point scale with 4 being "excellent and 1 being "poor", mean scores on the nine items on the *End of Session Evaluation Form* ranged from 3.58 to 3.99.
- 77% of the sessions were identified as helpful as per qualitative comments on the *End of Session Evaluation Form.*
- In *Post-Service Interviews* women were asked to rate their experience using a 10-point scale with 10 being "the service was extremely useful and met or exceeded expectations" and 1 being "the service was completely useless". The mean score was 9.3.
- Women found the following aspects of the counselling useful: learning new skills, gaining insight, having someone to talk to, having someone who listened and cared, and the co-development of a plan.

OUTCOME # 7: Women Felt Connected to the Women's Centre and the Counselling Team

- Women experienced a sense of connection. Words used to describe the connection included: kindness, caring, sincerity, honesty, positivity, being valued, and being treated with respect.
- Women felt a connection to their counsellor, the counselling team and the Women's Centre itself.
- Women felt they were active participants in the counselling process.

D. Outcomes Specific to the Therapeutic Model

OUTCOME # 8: The Therapeutic Model Was Able to Meet the Mental Health Needs of the Women Served

- Discoveries made with respect to the model included:
  - Comfort and competence in using the model took time,
  - Postmodern techniques were a gateway to feminist practice,
  - Women's feelings of connection extended the usefulness of the single session,
  - The process of service delivery allowed for a consistent honouring of women's voices,
  - Embedment of the model into the Women's Centre's broader service compliment allowed for greater service responsiveness, and
  - The model allowed for primacy to be placed on women's voices and being heard.

E. Outcomes Specific to the University

OUTCOME # 9: Social Work Students Advanced Their Clinical, Program Development and Research Skills

- Two Bachelor of Social Work students were hired as Research Assistants, one of whom was later hired as a counsellor at the drop-in counselling clinic.
- One Master of Social Work Student completed her Internship with the drop-in counselling clinic.

OUTCOME # 10: The School of Social Work Increased Their Ability to Offer Timely and Responsive Training Opportunities in the Community

- Two faculty members at the School of Social Work provided training to the counselling team.
- Through the Continuing Education Committee at the School of Social Work, two public training events specific to the drop-in counselling clinic were organized.

OUTCOME # 11: Connections Between the School of Social Work and the Professional Social Work Community Were Strengthened

- Funding through Memorial's Office of Public Engagement supported the partnership between the School of Social Work and the St. John's Status of Women Council/Women's Centre.
- The School of Social Work engaged key management and staff at the Women's Centre in the design of a therapeutic model specific to community need.
- A faculty member at the School of Social Work completed the outcome program evaluation.

V. Recommendations

Given the success of the six-month drop-in counselling pilot and the overall strength of the findings of the Program Evaluation, it is recommended that:

1. The Women's Centre continues to offer a drop-in counselling clinic at current capacity (10 sessions per week),
2. The Women's Centre develops a plan for the expansion of the drop-in clinic in the event numbers increase,
3. The Women's Centre maintains its positive relationships with community partners, such as Eastern Health, Iris Kirby House, and the School of Social Work in an effort to share costs, staffing, and the work load of running the drop-in clinic,
4. The Women's Centre continues its efforts to promote the clinic using social media, which has proven successful and it increases its efforts to promote the clinic to mental health professionals, physicians and community partners, who could then refer women to the clinic;
5. To prevent model drift and maintain the cohesiveness of the counselling team, a brief team meeting at the beginning of each counselling day and a debriefing session at the end of the day be re-established and "Single Session School" be reinstated;
6. For the counselling team, efforts are renewed to separate their drop-in clinic work from their other responsibilities at the Women's Centre; and
7. The role of the supervisor and the process of supervision is revisited, specifically efforts are made to have supervision align with the theoretical foundations of the model and its underlying assumptions.

VI. Conclusions

The six-month pilot of the Right Here, Right Now Counselling Clinic was a success. There was considerable service uptake that remained constant throughout the six months. Women who utilized the service found it useful, many of whom returned for repeat sessions or to engage in other programs offered by the Women's Centre. Members of the counselling team were invigorated by their involvement in the service and in their increased capacity to be useful to

women with mental health concerns. The drop-in counselling service provided a necessary stop gap for women awaiting traditional mental health services within the Region. The therapeutic model designed for the clinic was effective. The model enabled women to have a voice and counsellors to listen deeply. The emphasis placed on training, reflective practice and peer support enabled the drop-in counselling clinic to offer a useful, relevant and responsive service for women in the community.

Part One: Background and Design

I. Background

Since 1973, the Women's Centre (WC) run by the St. John's Status of Women Council (SJSWC) has offered a weekly drop-in program consisting of a light lunch, activities and information sessions. This flagship program, serving in excess of 1100 meals per year, provides an opportunity for women, who might otherwise feel marginalized, stigmatized and alone, to experience support, non-judgement, friendship and community.

In recent years the SJSWC identified a need for counselling services to be added to their program "menu". Although staff at the WC were able to provide supportive counselling during weekly drop-in, a need for more intensive services was recognized. Many of the women served at the WC have complex trauma, addictions, and mental health concerns. They face sexual and domestic violence, housing instability, and a lack of community and familial support. Long waitlists, a shortage of mental health services and skilled mental health professionals in the St. John's Region hinders timely access to appropriate services (for greater elaboration on the context of mental health services in the St. John's Region, see Section II, below).

It was speculated that a single-session drop-in counselling clinic might be a useful way to meet the immediate mental health needs of the women attending programs at the WC while they awaited traditional mental health services. The concern was that without timely therapeutic support, opportune moments for change were being lost. Women's situations were worsening leading to an increase in their vulnerability and ultimately greater and unnecessary demands on crisis services. In addition to offering support for women currently connected to the WC, it was also speculated that a drop-in counselling clinic would be of benefit to the community at large as the counselling services would be open to any woman in St. John's Region in need of free, accessible and immediate counselling.

In the fall of 2015, the School of Social Work at Memorial University partnered with the SJSWC to explore the viability of establishing a drop-in counselling clinic at the WC. *Quick Start Funds* ($1000.00) from Memorial's Office of Public Engagement (OPE) were used to prepare for and conduct a ½ day planning meeting in which the design, implementation and evaluation of a drop-in counselling clinic was discussed. The objectives of the meeting, held on December 10, 2015 were as follows:

1. To bring together key management and staff members of the WC with faculty from the School of Social Work to i) identify the unique counselling needs of the women utilizing existing services at the WC, and ii) to explore options in the

design, implementation and evaluation of a pilot drop-in counselling clinic to meet these needs;
2. To explore funding options for a pilot drop-in counselling clinic; and
3. Prior to the meeting, to have engaged social work students in conducting a preliminary literature review of single-session counselling approaches and methods of program evaluation.

Following this meeting, a decision was made to offer a drop-in counselling program at the WC on a six-month trial basis. To that end, an application for further funds from the OPE was submitted in January 2016 and *Accelerator Funds* ($10,000.00) were awarded in February 2016. These funds were used to sustain the partnership between the School of Social Work and the SJSWC with respect to three aspects of the project:

1. The development of a **therapeutic model** designed to specifically address the immediate mental health needs of the women served at the WC;
2. The design and delivery of **training** modules for the counsellors who would be delivering the drop-in counselling services, several modules of which would be open to the social work students, alumni and mental health professionals in the community; and
3. The completion of an **outcome program evaluation** including the development of a logic model, designing data collection tools, collecting and analysing data and completing the report.

It should be noted the costs and accountabilities associated with **program delivery** (i.e., wages for the counselling team, supervision, and the costs associated with the venue) were borne exclusively by the SJSWC as per the *Accelerator Fund* eligibility criteria.

The timelines for the project were as follows:

Date	Associated Tasks
PRE-PILOT May 29, 2015	• Submission of application for *Quick Start Funds* through Memorial's Office of Public Engagement
June 19, 2015	• Notice of acceptance of *Quick Start Funds*
Summer/Fall 2015	• Dana Warren (BSW student) is hired as a Research Assistant • Review of literature on therapeutic models including single-session, feminist and brief narrative therapies and trauma-informed practice • Review of models of program evaluation and data collection instruments • Preparation of logistics of ½ day meeting (date, time venue, agenda, facilitation etc.)
December 10, 2016	• ½ day planning meeting between School of Social Work and key management and staff at the Women's Centre
January 15, 2016	• Submission of application for *Accelerator Funds* through Memorial's Office of Public Engagement
February 22, 2016	• Notice of acceptance of *Accelerator Funds*

Date	Associated Tasks
March – June 2016	• Development of therapeutic model for the drop-in counselling clinic
June 9 and 10, 2016	• Several members of the counselling team receive training in *Brief Single Session Walk-In Therapy* from Scot Cooper, PT @Laurier University, Waterloo, ON
June – August 2016	• Development of logic model and data collection tools
August 4, 2016	• Several members of the counselling team receive training in *Therapeutic Writing* by Dima Dupéré at a School of Social Work Continuing Education event
September 2, 2016	• MSW student Sharon Samson begins her field internship with the drop-in counselling clinic • Dana Warren completes her RAship and is hired by the Women's Centre as a counsellor at the drop-in counselling clinic

September 6, 2016	• Drop-In Counselling Immersion day
	  ○ Counselling team receives training (therapeutic model and in the use of the data collection instruments) from Catherine de Boer, School of Social Work Memorial University
	  ○ Team building

September 6, 2016	• Counselling team receives training in *Brief Single Session Therapy* from Dr. Heather Hair, School of Social Work Memorial University
SIX-MONTH PILOT September 26, 2016 – March 28, 2017	• Provision of drop-in counselling services • Weekly "Single Session School" • Promotion of the clinic through traditional media, social media and mental health networks etc. • Data collection for outcome program evaluation • Development of spread sheets for data entry • Beginning of data entry and early analysis
October 14, 2016	• Presentation about the development of the clinic made by Catherine de Boer, Jenny Wright and Dana Warren @ School of Social Work Continuing Education event
February 20, 2017	• Counselling team receives training in *Using Scaling Questions in Single-Session Therapy* from Catherine de Boer, School of Social Work Memorial University

POST-PILOT
April – July 2017
	• Data entry and analysis (Catherine de Boer, Fiona Cunningham and Nicole Boggan)
	  ○ Nicole Boggan (BSW student) is hired as a Research Assistant (data entry and some thematic coding of qualitative data)
	  ○ Fiona Cunningham, B.Sc., M.Ed., C.C.C., conducts analysis of quantitative data

May 2017	• Sharon Samson completes her MSW Internship

Date	Associated Tasks
May 25 & 26, 2017	• Counselling team receives training in *Brief Single Session Walk-In Therapy* from Scot Cooper, PT @School of Social Work Continuing Education Committee and SJSWC co-sponsored public event
May 30, 2017	• Presentation made by Catherine de Boer and Dana Warren @ Canadian Association of Social Work Education (CASWE) Annual Conference
July – November 2017	• Report Writing ○ August 21, 2017 – Presentation of draft report to counselling team ○ September 15, 2017 – Preliminary report submitted to Jenny Wright for review ○ November 15, 2017 – Completion of Final Report

II. Context of Mental Health Service Realities for Women in the St. John's Region

In March 2017, a report by the All-Party Committee on Mental Health and Addictions was released by the Newfoundland government. The committee reported that long waitlists were impeding individuals from accessing the services they required (All-Party Committee, 2017, p. 1). They noted that particularly youth ages 16-25 transitioning from the child to adult healthcare systems faced difficulties accessing and navigating mental health and addiction services (All-Party Committee, 2017, p. 1). The All-Party Committee made a number of recommendations to address these issues. Specifically, they suggested the creation and implementation of single session walk-in clinics in order to reduce waitlists and provide counselling in the interim (All-Party Committee, 2017, p. 6). In addition to this recommendation, the All-Party Committee (2017) suggested the development of an action plan to reduce wait-times that was informed by the realities of individuals with complex circumstances who experience barriers in attending appointments (p. 6). The creation of single session walk-in clinics holds promise to address the latter recommendation by providing a framework in which individuals can dictate when they show up to clinics, thereby eliminating "no shows," maximizing clinicians' time and allowing more individuals access to services.

Another issue reported by the All-Party Committee were challenges with organizations communicating with one another and professionals working in silos (All-Party Committee, 2017 p. 13). The All-Party Committee made the recommendation that organizations create and reinforce partnerships with one another through strategic planning, keeping open lines of communication and "sharing education" (p. 10). Fostering the partnership between the SJSWC and the School of Social Work at Memorial University opened up the opportunity to develop, implement and evaluate a drop-in counselling clinic. Further, the public training opportunities facilitated through the Right Here, Right Now Drop-In Counselling Initiative

demonstrates a willingness to work closely with other organizations to strategize how to effectively address the needs of the community.

As indicated above (see Section I), the SJSWC identified a lack of woman-centred mental health services available in the community. The All-Party Committee (2017) echoed this concern in their report calling for the development and implementation of programs that examine the "mental health and addictions gender-based needs" (p. 9). In the report, the committee exemplifies the need for gender-based approaches through discussing differences in disclosure and diagnoses (i.e. women are more likely to be diagnosed with depression than men) (All-Party Committee, 2017, p. 44). Because of the WC's existing connections in the community and understanding of the complex, interlocking issues that impact women's lives, the Centre was an ideal organization to offer counselling services that are informed by the unique needs of the population.

III. The Right Here, Right Now Drop-In Counselling Model

The RHRN therapeutic model was designed after an extensive review of the literature on the efficacy of various models of single session therapy, narrative and feminist therapies and trauma-informed practice, followed by consultations with key management and front-line staff at the WC. The model blends empirical knowledge with practice wisdom in an explicit effort to meet the counselling needs of women utilizing programs at the Women's Centre. The model has three aspects: 1) theoretical underpinnings, 2) the service delivery process, and 3) the embedment of the drop-in counselling clinic into the broader program "menu" at the Women's Centre. Each will be discussed in turn.

A. Theoretical Underpinnings

As depicted in Figure 1 below, the therapeutic model is a unique blend of single-session, narrative and feminist therapies with trauma-informed practice. The heart of the model is connection – primarily the building and strengthening of the therapeutic alliance, but not exclusively so. The therapeutic alliance is nested within and intentionally aligned with the woman's broader relationships with the counselling team as a whole (i.e., including the receptionist and intake worker), and the Women's Centre itself. The value placed on connection is made explicit in the underlying assumptions of the model (see Section IV), specifically Assumption # 2, which states, "We do our best when we are connected to people who care." Not only does this assumption reflect an intended way to practice, it is also empirically sound. Studies confirm that a positive therapeutic alliance is one of the best predictors of positive therapeutic outcome (Orlinsky, Grawe & Park, 1994; Orlinsky, Ronnesta & Wullutzki, 2004). In designing the model, care was also taken to ensure it was consistent with the *Guiding Principles* of the St. John's Status of Women Council/Women's Centre (see Appendix N), specifically the following:

- Feminism – a commitment to provide accessible services to all women;

- Harm Reduction – a focus on keeping women safe, minimizing risk and working along side women in achieving their goals;
- Trauma-Informed Holistic Support – a striving to provide services that are welcoming, respectful, compassionate, supportive and appropriate to the needs of women affected by trauma, and
- Knowledge and Understanding – an investment in building and applying knowledge in service of positive change, a consideration of women being the experts on their own lives and a commitment to seek understanding (St. John's Status of Women Council, 2016).

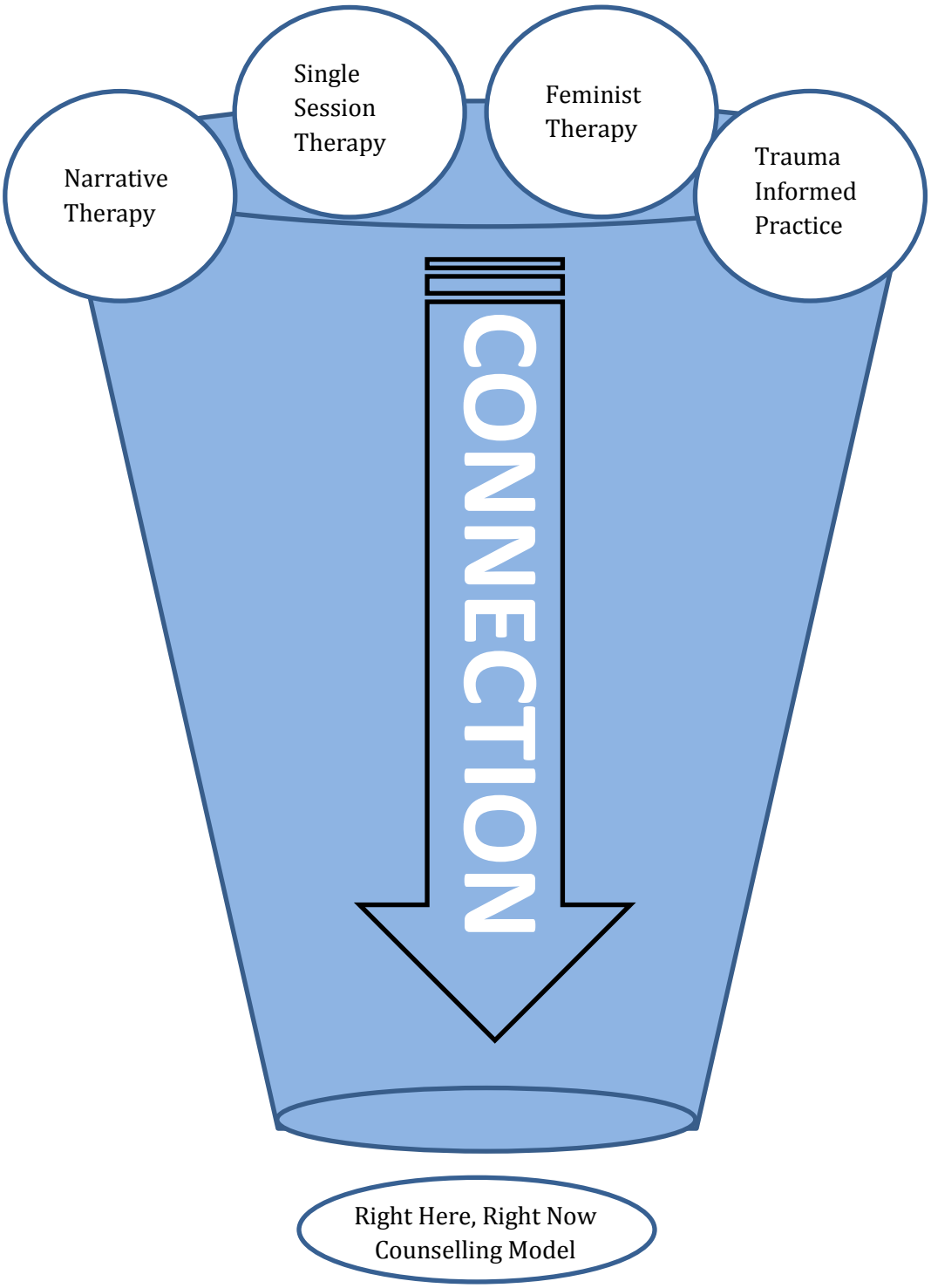
The model is **postmodern** in that i) it is present focused, ii) through externalization women are separated from their problems, and iii) women's knowledge is prioritized over expert knowledge. The **feminist** aspects of the model mean, among other things, that the counselling room is not a neutral space. Counsellors are explicitly and actively opposed to violence against women in all forms. When considered therapeutically relevant, counsellors encourage women to consider how sexism, patriarchy and misogyny in our society has impacted their mental health. Taking a feminist stance means women are believed; their stories heard and honoured.

The **narrative** aspects of the model allow priority to be given to women's stories while also emphasising the power women have to narrate their own lives to find both meaning and hope. Techniques associated with narrative therapy, such as scaling questions, externalizations, scaffolding, the development of the preferred narrative and the co-development of plans were incorporated into the RHRN counselling model. The narrative elements allowed for an understanding of women's concerns as impediments to identity development, meaning problems limit who women can be and who they can become. The focus on women's strengths and their resistance to both their own problem stories and the dominant societal stories that negatively shaped their self-understandings linked the narrative and feminist aspects of the model.

Trauma-Informed aspects of the model could be seen in the attention paid to offering the counselling in a safe and welcoming space. Women's safety and risk of self-harm were assessed during intake. Crisis counselling and the development of safety plans were enfolded into the intake process as needed. A woman's mental health concerns could be understood as adaptations she made to cope with and survive trauma. Recognizing triggers, calming oneself and remaining present were integrated into sessions, when appropriate.

Although the model incorporates aspects of **single-session** models, repeat sessions were possible. Each session was considered a stand-alone conversation but a woman could come back as often as she wished and in the repeat sessions she had the choice to discuss the same or a new concern. Like other single-session models, every session in the RHRN model had a distinct beginning, middle and end. Sessions focused on the facilitation of small change, which was considered generative. Sessions were goal oriented and pragmatic.

Figure 1: The Right Here, Right Now Counselling Model



B. Process of Service Delivery

Part of the model's design included mapping out the processes of service delivery (see Figure 2). We were intentional about how women flowed through the various elements of the service to ensure the overall experience for women was positive, welcoming and calm. Each member of the team had a specific role in the process and communication between each member ensured the process ran smoothly.

When women first came through the doors of the clinic they were warmly welcomed by Kayla, the receptionist at the Women's Centre. She would offer the woman tea or coffee and briefly explain the service process (i.e., the woman would first be seeing an intake worker followed by a counsellor). Kayla would let the woman know the approximate wait time before intake (usually less than 5 minutes). Kayla would then let the intake worker know that a woman had arrived and was in the waiting room.

An intake worker, either Natasha or Sharon, would then meet with the woman and take her into a quiet room. The intake worker would ask the woman what concerns brought her to the clinic, what her hopes were for the session and the strengths and supports she had. The purpose of the intake was threefold: 1) to ascertain if single-session counselling was indeed what the woman was hoping to receive, 2) to assess risk of harm to self and others, and 3) to help the woman begin to focus her broad presenting concerns into the select concern she wished to address within the session. The intake workers were skilled in providing crisis counselling, supportive counselling and service negotiation, if needed. Intake workers could help women develop safety plans and would make referrals for acute mental health services, if deemed necessary. After the intake was completed, the woman returned to the waiting room until a counsellor was available (usually less than a 10-minute wait).

The single session counsellor, either Dana, Sheila or Sharon, would first meet with the intake worker to get an beginning understanding of the woman's concerns after which the counsellor would meet the woman in the waiting room and bring her to a quiet counselling office. Each session was structured with a distinct beginning, middle and end. The beginning would focus on the presenting concern and the hope for the day. The middle would focus on a woman's strengths and her supports. Counsellors would be particularly interested in discovering the woman's skills and experiences that could inform the development of the final plan, which was the end portion of the session (see Appendix C). During the session, the counsellor would jot down important aspects of the session on the *Session Note* form. At the end of the session, the counsellor would ask the woman to complete the *End of Session Evaluation Form* (see Appendix D). While the woman was completing the form, the counsellor would photocopy the *Session Notes*, so the woman would have a copy to take with her.

Figure 2: Process of Service Delivery

C. Embedment

"Embedment" refers to something firmly fixed in place. When developing the model, it was our intention to have the drop-in counselling clinic both "firmly fixed" i.e., a stable program, and "fixed in place", meaning the clinic was located within the Women's Centre and intrinsically connected to the other programs offered there. There were many reasons why we paid such close attention to space and place. Most obviously, the desire to start a drop-in counselling clinic came from management and staff at the Women's Centre, so it made sense to have the program housed there. However, more purposely the model was designed to meet the specific mental health needs of the women already accessing programs at the Women's Centre. The model was "tailor made", so to speak, for the Women's Centre. We were also aware of the positive regard women in the Region held for the Women's Centre. Not only is the Women's Centre one of the longest running non-profit social service agencies in St. John's (45 years), the number of women coming through its doors (in excess of 400 each month) is exceptionally high. These numbers speak to the stability of the Women's Centre and the trust women have placed in the agency. Embedding the clinic within the Women's Centre allowed us to piggyback onto the positive reputation of the Women's Centre. Embedment, for us also referred to our intentions to "firmly fix" the drop-in counselling program within the Women's Centre's broader program offerings. In essence, by coming to the drop-in clinic a woman had access to all programs offered by the Woman's Centre. Likewise, women participating in other programs at the Women's Centre, such as the Safe Harbour Outreach Program (SHOP) or Empowerment Group could access the clinic.

IV. Underlying Assumptions

At the heart of the RHRN model are 10 assumptions that inform the work. These assumptions were drafted in April 2016 with input from the counselling team. After several revisions they were presented at the Immersion Day on September 6, 2016. The ten assumptions are:

1. Hope is essential for growth and change.
2. We do our best when we are connected to people who care.
3. Change is always happening.
4. Women's selfhood and experiences are honoured through our recognition of hierarchies within the service, our attempts to make the work as transparent as possible and by valuing women as the experts of their own lives.
5. Truth is subjective and there are multiple truths.
6. Women can do something about their concerns and they usually know what to do.
7. We are not trying to solve problems but facilitate a process that is useful.
8. Getting to know what the women bring to this process is what allows us to be the most useful.
9. Knowing all the details of a problem or the cause of the problem is not necessary for us to be effective. We are interested in the how and what of a problem, not the why.
10. We work with one foot in the problem and one foot in possibility.

Part Two: Program Evaluation

I. Introduction

The *Right Here, Right Now Drop-in Counselling Clinic* was a six-month pilot program delivered by the St. John's Status of Women Council/Women's Centre (SJSWC/WC). The program ran two days a week, Mondays and Tuesdays from 12:00 Noon – 6:00 p.m. from September 26, 2016 to March 28, 2017. The six-month pilot was part of a larger initiative that included:

- the development of the therapy model used at the clinic,
- mapping out the processes associated with program delivery,
- training the counselling team,
- promoting the clinic,
- designing the evaluative framework,
- developing the data collection instruments,
- collecting and analysing program evaluation data,
- writing the program evaluation report, and
- communicating the findings through various venues.

The Right Here, Right Now Drop-In Counselling Initiative represents a partnership between the SJSWC/WC and the School of Social Work at Memorial University. Funding for the design and evaluation of the project came from Memorial's Office of Public Engagement (OPE); *Quick Start Funds* ($1000) were awarded in June 2015 and *Accelerator Funds* ($10,000) were awarded in February 2016. The SJSWC/WC provided the staffing and space for the clinic, including the funding of one new counsellor position. The School of Social Work and the SJSWC/WC shared in promoting the clinic and training the counselling team.

II. Program Evaluation Framework

There are several program evaluation frameworks, the selection of which is dependent on purpose. According to Westerfelt and Dietz (2010), a *Process Program Evaluation* focuses on how an agency runs a particular program. The evaluation outlines what was done, what problems were encountered and what was learned as a result. The evaluation is of benefit to the agency seeking program improvements and may also benefit agencies, who wish to implement a similar program. By comparison, an *Outcome Program Evaluation* focuses on a) the identification of the intended outcomes of a program and b) the evaluation of whether or not the program has in fact achieved the intended results. This evaluation of the Right Here, Right Now Drop-In Counselling Initiative is an Outcome Program Evaluation. The five stages of the evaluation are outlined in Figure 3 below. Each Stage will be discussed in turn.

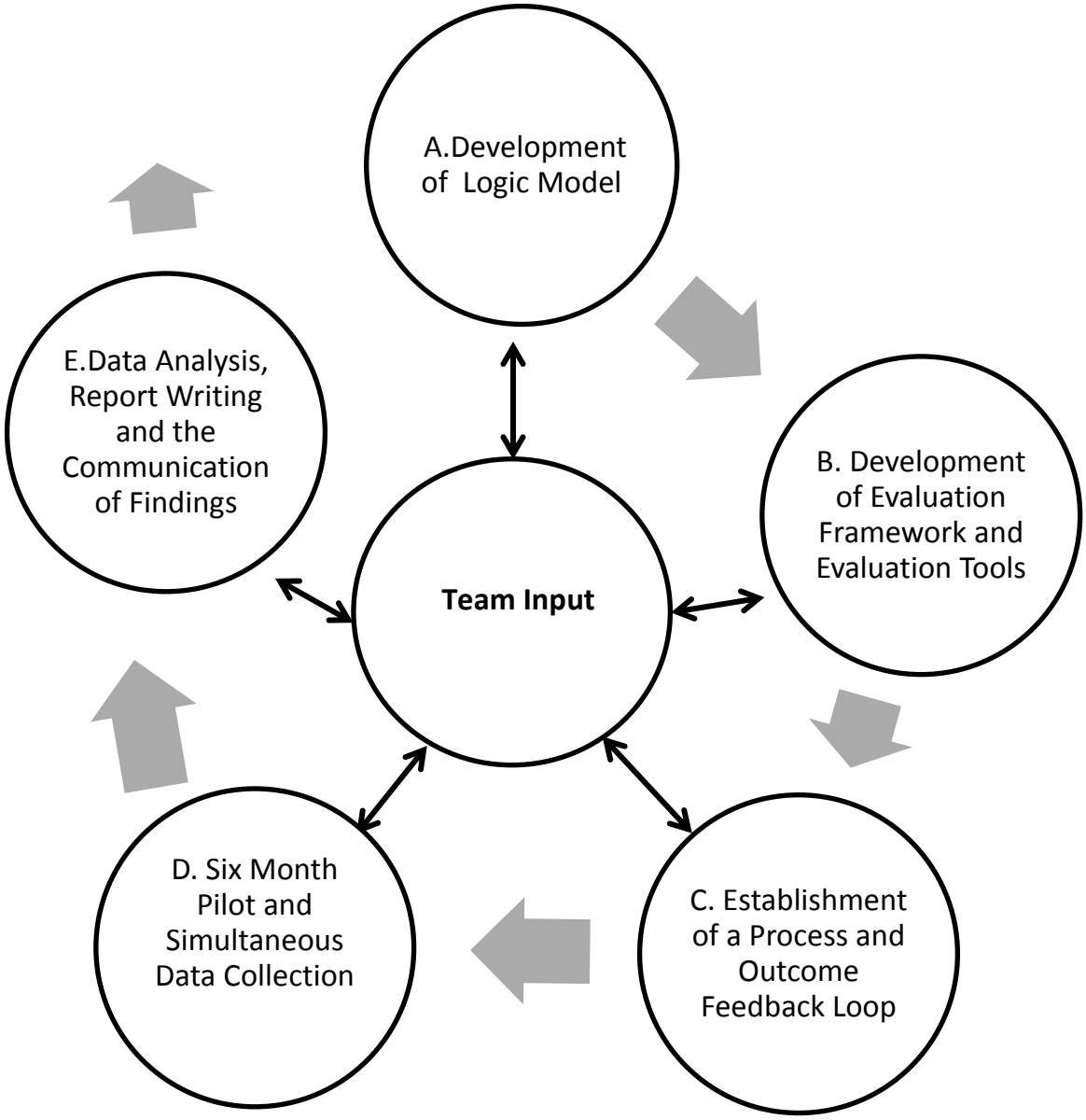


Figure 3: Model of the Program Evaluation Process

A. Development of the Logic Model

Figure 4: Logic Model

Situation - SJSWC/WC identified a need for accessible, barrier free counselling for women with challenging life circumstances, complex trauma, addictions, and mental health concerns, who are either not being served or are inadequately served by the existing mental health system

INPUTS	OUTPUTS		OUTCOMES – IMPACT		
	Activities	Participation	Short	Medium	Long
Funding Office of Public Engagement at Memorial University; SJSWC/WC **Staff** 1. Program Lead/Evaluator (1) 2. Supervisor (1) 3. Single Session Counsellors (2) 4. Intake/Crisis Workers (1) 5. Receptionist (1) 6. MSW Intern (1) 7. Research Assistants (2) **Training** Scot Cooper Heather Hair Catherine de Boer **Print Materials** Peer reviewed journal articles, texts and manuals; photocopies of evaluation tools, training and promotional materials **Facilities** Meeting Spaces (MUN and WC) Training facilities (MUN and WC) Counselling Space including reception area, waiting room, intake and counselling rooms (WC) **Admin. Services** Photocopying, filing, payroll, accounting	**Research and Development** Conduct a literature review of narrative, solution focused, feminist and single session therapies, and trauma informed practice. Develop the therapeutic model to be used at the RHRN Clinic Design evaluation framework and evaluation tools **Training** Develop and deliver training modules for counselling team **Initiative** Provide a six month pilot of drop in counselling services at the SJSWC 2 days per week Promotion **Program Evaluation** Data collection analysis, report writing. **Communication of Findings** Program evaluation report, media engagements, conference presentations, professional and academic manuscripts	**WC** Women who receive counselling services at the RHRN clinic; Drop-in counselling team **School of Social Work** Continuing Education Committee; BSW RAs; MSW Field Internship Program, MSW Interns **Community** Mental Health Service providers making referrals, and promoting the service	**WC** 1. Increase engagement of women in the community in need of mental health services 2. Increase service compliment at the WC 3. Provide a stop gap measure for women awaiting existing mental health services 4. Successfully employ recruitment strategies 5. Increase the capacity of the WC staff to meet the mental health needs of the women they serve	Numbers for drop-in counselling increase to full complement (10 sessions per day) Numbers in other WC programs remain steady or increase Findings of the program evaluation provide a foundation for successful funding applications	WC develops a robust clinical program with single and multiple session, individual, couple, family and group counselling offerings RHRN Clinic becomes a recognized and stable service within the broader mental health service community Existing gaps in the mental health service system begin to close Stable and adequate funding for the RHRN Clinic is secured
			Women Served 6. Drop-in counselling services are identified by the women as being useful 7. Women feel connected to the WC and the counselling team	Women who use the drop-in services return when needed and engage with other services offered by the WC Women's identified concerns are stabilized or improve as they await mental health services Women develop skills and a sense of personal agency that serve as protective factors against future mental health crisis	Women in crisis receive a timely, appropriate and useful service The community is better informed about the realities of women who face complex mental health needs and challenging living circumstances

INPUTS	OUTPUTS		OUTCOMES – IMPACT		
	Activities	Participation	Short	Medium	Long
			Model 8. Model is able to meet the immediate mental health needs of the women served	Model is refined and empirically tested Produce publishable manuscripts and conference presentations	Individuals trained and skilled in the model offer training, consultation and supervision.
			University 9. SW students advance skills (clinical, program development and research) 10. SSW increases its ability to offer timely and responsive training opportunities 11. Connections between the SSW, and the professional SW community are strengthened	Produce publishable manuscripts and conference presentations SSW is recognized for its role in the development of an innovative and empirically sound practice model SSW adheres to their mission of community participation Partnerships are made in the community with WC, MUN and others to explore next steps in service delivery	SSW Continuing Education program develops a curriculum that: a) includes partnerships with community agencies in the delivery of training modules b) Offers timely and responsive training opportunities RHRN Clinic becomes a recognized training Centre for MSW students and interested mental health professionals in the community

Assumptions
Every moment matters
Self-contained conversations
Not long term counselling
Basic needs must be met/considered
Safety planning is critical

External Factors
Lack of timely, appropriate mental health service
Women's distrust of the systems and services

B. Development of Evaluation Framework and Evaluation Tools

Table 1: Outcome Program Evaluation Framework
(As Related to Short-term Outcomes Outlined on the Logic Model)

Short-Term Outcomes	Evidence	Data Collection Tools (Tools specifically designed for the Outcome Program Evaluation are in Italics)
Related to the WC:		
1. **Increase engagement of women in the community in need of mental health services**	Tallied numbers of women attending the RHRN Drop-in Counselling Clinic	• *Intake Tally Form* (Appendix A)
	Documented times women recount a new (or renewed) involvement in WC programs after attending the RHRN Drop-In Counselling Clinic	• *Intake Form* (Appendix B) • *Session Notes* (Appendix C) • *Post Service Evaluation Form* (Appendix F)
	Antidotal evidence and qualitative interview data from the Women's Centre Coordinator and the Program and Advocacy Coordinator regarding the numbers of women entering WC programs after attending drop-in	• *Pre and Post Pilot Qualitative Interviews with the Counselling Team* (Appendix E)
2. **Increase service compliment at the WC**	Successful employment of recruitment strategies	• *Intake Form* (Appendix B)
	Antidotal evidence from the counselling team regarding how drop-in counselling fits in with the broader program of services available at the WC	• *Pre and Post Pilot Qualitative Interviews with the Counselling Team* (Appendix E) • Notes taken at team meetings
3. **Provide a stop gap measure for women awaiting existing mental health services**	Identify numbers of women who come to the RHRN drop-in counselling clinic awaiting other mental health services	• *Intake Form* (Appendix B) • *Session Notes* (Appendix C) • *Post Service Evaluation Form* (Appendix F)
4. **Successfully employ recruitment strategies**	Identify the recruitment strategies used	NA
	Women's accounts during the intake session about how they heard about the RHRN drop-in counselling clinic	• *Intake Form* (Appendix B)
	Unsolicited requests from service providers in the community for information about making referrals	NA
5. **Increase the capacity of WC staff to meet the mental health needs of the women they serve**	WC staff increase their knowledge base through reading, attending trainings, participating in peer learning activities (i.e., "Single Session School") and engaging in supervision and peer supervision.	• *Pre and Post Pilot Qualitative Interviews with the Counselling Team* (Appendix E)
	The counselling team's self-identified improvements in skills	• *Pre and Post Pilot Qualitative Interviews with the Counselling Team* (Appendix E)
	Reflective Practice	• Notes taken at team meetings • *Pre and Post Pilot Qualitative Interviews with the Counselling Team* (Appendix E)

Short-Term Outcomes	Evidence	Data Collection Tools (Tools specifically designed for the Outcome Program Evaluation are in Italics)
	Women identifying the intake workers and counsellors as having been useful	• *End of Session Evaluation Form* (Appendix D) • *Post Service Evaluation Forms* (Appendix F)
Re: Women Receiving Drop-In Counselling 6. **Drop-In Counselling Services are identified by the women as useful**	Women identify the drop-in counselling services as useful.	• *End of Session Evaluation Form* (Appendix D) • *Post Service Evaluation Forms* (Appendix F)
	Women's positive ratings of the helping relationship as a predictor of usefulness	• *End of Session Evaluation Form* (Appendix D) • *Post Service Evaluation Forms* (Appendix F)
7. **Women feel connected to the WC and the Counselling team**	Expression of a positive connection between the women and the WC and the counselling team	• *End of Session Evaluation Form* (Appendix D) • *Post Service Evaluation Forms* (Appendix F)
	Determining the nature and qualities of the helping relationship (i.e., connection and collaboration) experienced by the women	• *End of Session Evaluation Form* (Appendix D) • *Post Service Evaluation Forms* (Appendix F)
	Women, who as a result of feeling connected, return for repeat sessions of drop-in counselling services and/or participate in additional programs offered by the WC	• *Intake Form* (Appendix B) • *Post Service Evaluation Forms* (Appendix F)
Re: The Model 8. **The model is able to meet the immediate mental health needs of the women served**	Both women and members of the counselling team identify a fit between the model and the mental health needs the model was designed to address	• *Pre and Post Pilot Qualitative Interviews with the Counselling Team* (Appendix E) • *Session Notes* (Appendix C) • Notes taken at team meetings
	Women identify the drop-in counselling services as useful	• *End of Session Evaluation Form* (Appendix D) • *Post Service Evaluation Forms* (Appendix F)
Re: University 9. **Social Work students are provided with opportunities to develop skills in the areas of clinical practice, program development and research**	Two Bachelor of Social Work students successfully complete research assistantships with the project.	NA
	A Master of Social Work Student successfully completes a field Internship at the drop-in counselling clinic.	• Mid-term and Final MSW Field Internship Evaluations
10. **The School of Social Work increases its ability to offer timely and responsive training opportunities**	Members of the Counselling team deliver a Continuing Education Session at the School of Social Work on the topic of designing and delivering drop-in counselling services	• *Evaluation Form* for Continuing Education Session (Appendix H)
	A partnership is formed between School of Social Work and SJSWC/WC in the delivery of a two day workshop on Brief Single-Session Walk-In Therapy	• *Evaluation Form* for Training Workshop with Scot Cooper (Appendix J)

Short-Term Outcomes	Evidence	Data Collection Tools (Tools specifically designed for the Outcome Program Evaluation are in Italics)
11. **Connections between the SSW and professional social work community are enhanced**	The RHRN Drop-In Counselling Initiative provides opportunities for social work students and members of the counselling team to publish in professional and academic journals and present at professional and academic conferences.	• List of conference presentations and publications
	The RHRN Drop-In Counselling Clinic provides training and employment opportunities for students and alumni of the School of Social Work.	• List of training and employment opportunities

C. Establishment of a Process and Outcome Feedback Loop

Westerfelt and Dietz (2010) note that an "outcome evaluation is as much about the process as it is the final report" (p. 98). They argue, "What is learned in the course of doing an outcome evaluation can sometimes provide more useful information than the outcome data itself" (p. 98). As is typical of an outcome program evaluation, this particular evaluation was structured such that the team members delivering the services were simultaneously engaged in data collection. As per the advice of Westerfelt and Dietz (2010), a feedback loop was established whereby information about the process and outcome of the evaluation was discussed with the team and used to inform service delivery. Team meetings at the beginning of each clinic day provided an ideal opportunity for the feedback loops to occur. During the meetings, the team was able to ask questions about and tweak the data collection instruments, review the counselling delivery and team communication processes and most importantly make ongoing adjustments to the program to better meet the needs of the women served. Several examples of topics discussed in these meetings include: 1) the role of the receptionist in welcoming women and creating an accessible service, 2) the number of sessions a woman could receive and whether women returning for a repeat session would have the same or different counsellor, 3) the connection between a crisis counselling session completed with the intake worker and the therapy session completed with the counsellor and whether a woman could receive both in one day, and 4) ways to use the *End of Session Evaluation Form* as a therapeutic intervention while minimizing bias. At regular intervals, I attended the team meetings to provide updates on the outcome data and to hear from the team. As Westerfelt and Dietz (2010) conclude, discussions such as these "are indicators of a successful evaluation. They demonstrate that [team] members are engaged in reflective practice, and that they are making a connection between program and outcome" (p. 98).

D. Six-Month Drop-In Counselling Pilot and Simultaneous Data Collection

The six-month pilot began on September 26, 2016 and concluded March 28th, 2017. The clinic ran two days a week (Mondays and Tuesdays from Noon – 6:00 pm) for 26 weeks excluding the week over Christmas when the clinic was closed. Counselling was offered on 47 out of 52

possible clinic days as there were two statutory holidays (Thanksgiving on October 10th and New Year's Day on January 2nd) and three snow days (December 13, February 6th and February 14th) during the 26-week period.

Data for the program evaluation was collected by the counselling team using both qualitative and quantitative methods. In the week leading up to the six-month pilot, individual qualitative interviews were conducted with each team member using an interview guide approach. Team members were interviewed a second time at the end of the six-month pilot (see Appendix E). During the pilot, intake workers completed an *Intake Form* (see Appendix B) for each woman seeking service and they completed *Intake Tally Sheets* (see Appendix A) at the end of each clinic day. The counsellors on the team submitted *Session Notes* (see Appendix C) for each counselling session and they ensured that each woman was informed of the *End of Session Evaluation Form* (see Appendix D) and given an opportunity to complete it. During the intake process women were asked if they would be willing to participate in a post service evaluation interview at the end of the six-month pilot to discuss their experiences and any possible outcomes of the service. These interviews were conducted either face-to-face, by telephone or through an online survey (see Appendix F). For a fulsome description of the data collection instruments and how they were tethered to each of the short-term outcomes outlined in the Logic Model, see the Program Evaluation Framework presented in Table 1 above.

E. Analysis, Report Writing and the Communication of Findings

During the data analysis phase, measures were taken to minimize bias. These measures included: 1) the program evaluator not being involved in the delivery of single session counselling, 2) all data, with the exception of one Post Service Interviews and all the pre and post pilot interviews of the team members was gathered by the team members and not the program evaluator, 3) quantitative analysis was conducted by an outside party, and 4) in most cases the qualitative analysis was completed by several individuals to promote inter rater reliability.

Report writing began in July, 2017 after all the data had been collected and analyzed. A draft report was completed and reviewed by the team on August 21, 2017 after which the preliminary report was completed by September 15, 2017. The final report was completed November 15, 2017.

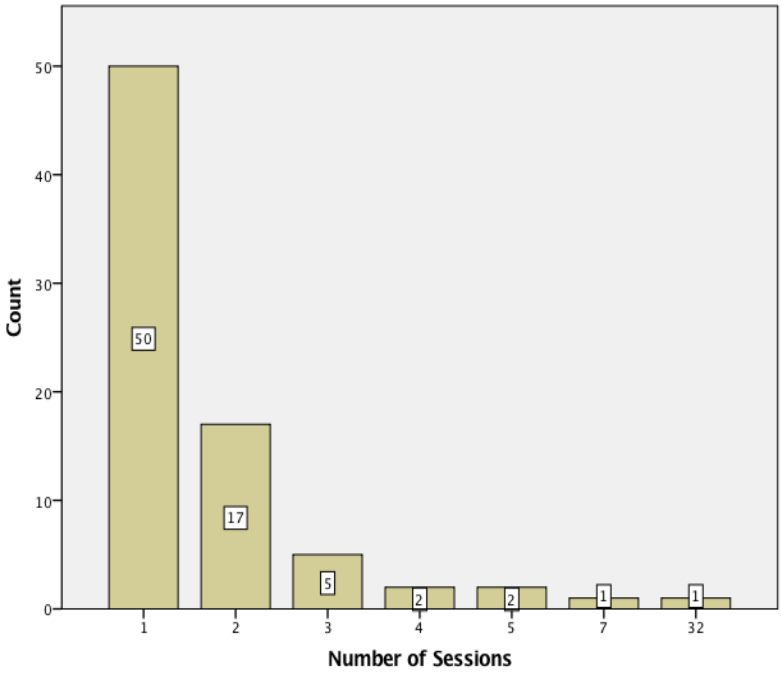
III. Program Evaluation Results

A. Overview

1. Number of Women Served and Number of Sessions Provided

Over the course of the six-month pilot, 78 women received single session counselling and 9 received crisis counselling. Of the 78 women, who received single session counselling, 50 attended one session only, 28 returned for repeat sessions. A total of 156 sessions were offered; 78 were first sessions and 78 were repeat sessions. The number of sessions attended by each woman is represented in Figure 5.

Figure 5: Number of Sessions Attended by Each Woman



As Figure 5 reveals, 50 women (64%) attended one session, 28 women (36%) attended more than one session. Of the repeat sessions, 17 women (21%) returned for one additional session, 5 women returned (6.4%) for two additional sessions, 2 women (2.6%) returned for three additional sessions, 2 women (2.6%) returned for 4 additional sessions, 1 woman (1.3%) returned for 5 additional sessions and 1 woman (1.3%) returned for 31 sessions.

The drop-in counselling clinic was designed to offer an immediate, accessible, and short-term counselling option for women. That 64% of the women attended 1 session and 86% attended either 1 or 2 sessions suggests that the clinic was indeed utilized as a short-term counselling option. As Figure 6 reveals, the median and mode of number of sessions attended was 1, and

the mean was 2. However, the mean was influenced by an outlier of 32 sessions attended by one woman, and with this number excluded (see Figure 7) the mean is 1.61 with a range of 6.

Figure 6: Number of Sessions with Outlier

N	Valid	78
	Missing	0
Mean		2.00
Median		1.00
Mode		1
Std. Deviation		3.615
Variance		13.065
Range		31
Minimum		1
Maximum		**32**

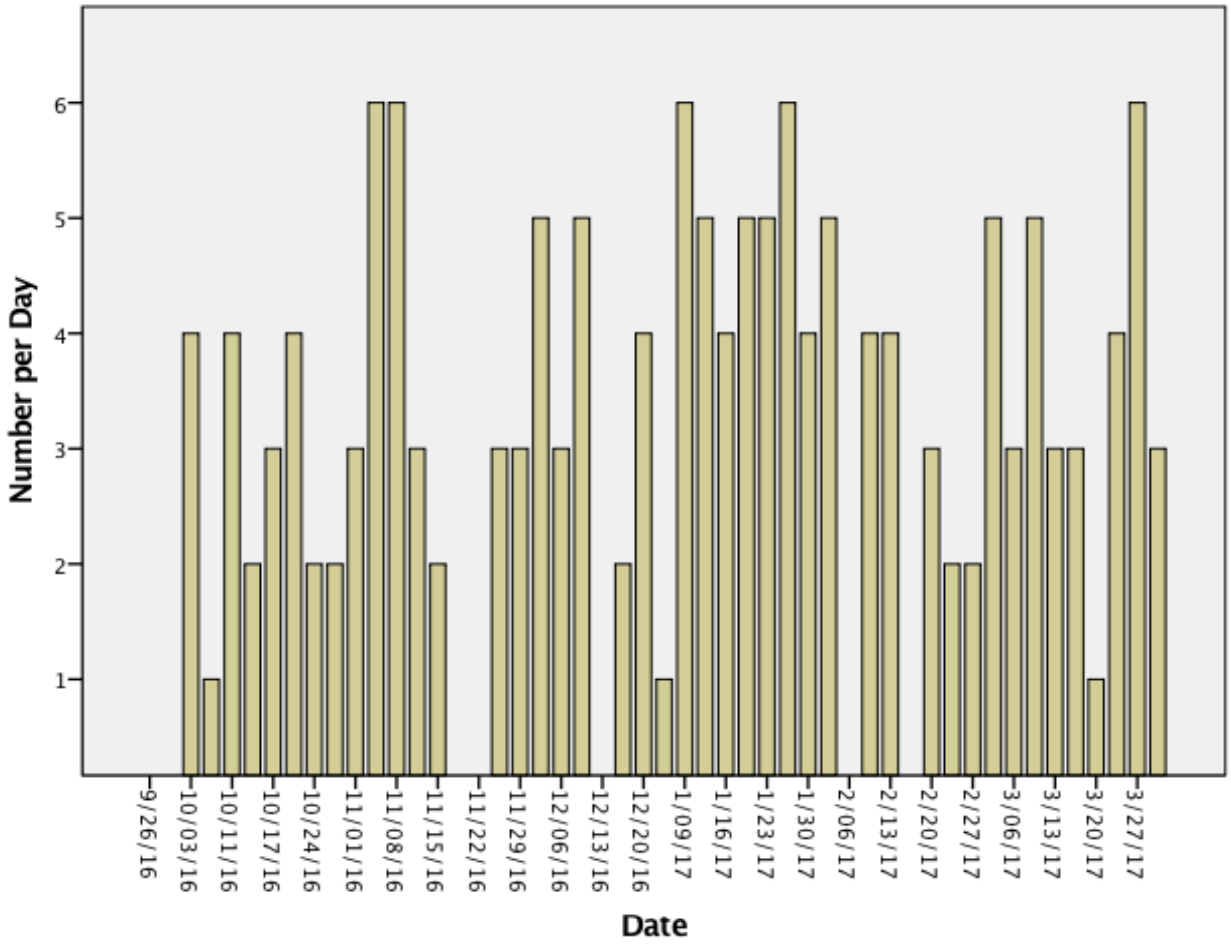
Figure 7: Number of Sessions with Outlier Removed

N	Valid	77
	Missing	1
Mean		1.61
Median		1.00
Mode		1
Std. Deviation		1.114
Variance		1.241
Range		6
Minimum		1
Maximum		**7**

2. Number of Women Attending Per Clinic Day

As indicated above, the drop-in counselling clinic ran for 26 weeks with a total of 47 clinic days. The number of women attending per clinic day is represented in Figure 8 below. There were several clinic days where no women came (September 26, 27, and November 22). Although one woman did attend on November 21st, the clinic day shows 0 attendees due to lost paperwork (n=1). It was anticipated that the numbers of women attending per clinic day would steadily increase throughout the six-month pilot due to the active promotion of the program (see Section B, 4 below) and word-of-mouth. In observing the bar graph (Figure 8), it is evident that the number of sessions per clinic day did not steadily rise and there is neither visual nor statistical evidence of a positive correlation between program length and the number of women served.

Figure 8: Number of Women Attending Per Clinic Day (Bar Graph)



As Figure 9 below reveals, the mean number of attendees per clinic day was 3.12, with a median of 3, a mode of 3, and a range of 6. The maximum number of women attendees on a clinic day was 6, which occurred on five clinic days.

Figure 9: Number of Women Attending Per Clinic Day (Statistics)

N	Valid	50
	Missing	0
Mean		3.12
Median		3.00
Mode		3
Std. Deviation		1.848
Range		6
Minimum		0
Maximum		6
Sum		156

It should be noted the drop-in clinic had the capacity to serve 10 women per clinic day. The maximum number of attendees per clinic day (n=6) represents 60% of the clinic capacity. There may be several reasons why the clinic never reached capacity during the six-month pilot. First, we know from examining the amount of time it has taken other programmes at the Women's Centre (e.g., Safe Harbour Outreach Program) to reach sustainable numbers, that a period of 1-2 years may be required before women trust the program and a positive reputation has been established. Second, we know anecdotally from comments made by the women, that their awareness of the program being a "pilot" versus a permanent program was perceived as a barrier. They seemed reluctant to participate in a program that may ultimately not be available. Finally, the relatively low numbers may indicate that persistent and more creative forms of outreach and promotion are needed.

3. Admission, Wait Times and Length of Sessions

The average, median, and mode wait time were all about 20 minutes. The average length of time a client spent with a counselor was 68 minutes, with a median of 65 and a mode of 60. The total length of service, from the time the woman first came through the door of the Women's Centre to the time the single session was complete (the addition of the Admission plus Wait Times plus Length of Session) was on average about 90 minutes, with a median and mode of 85 (see Figure 10). It should be noted that the average wait time was lengthened by several outliers. These outliers consisted of a number of women, who following their intake did not wish to have an immediate counselling appointment but instead requested an appointment for later in the day. In these instances, the length of wait time does not reflect the clinic's inability to offer services in a timely manner.

Figure 10: Admission, Wait Times and Length of Session

		Admission and Wait Time	Length of Session	Total Time of Service
N	Valid	155	155	155
	Missing	1	1	1
Mean		21.07	68.04	89.11
Median		20.00	65.00	85.00
Mode		20	60	85
Std. Deviation		13.558	14.121	17.144
Range		85	125	105
Minimum		5	15	45
Maximum		90	140	150

4. Presenting Concerns

The therapeutic model designed for the drop-in counselling clinic was intended to meet the unique counselling needs of the women, who utilized programs and services at the Women's Centre. Prior to the development of the model, researchers from the School of Social Work met with key management and staff members of the Women's Centre to become better informed about what these needs were. Staff identified the following: complex trauma, addictions (either that of the woman or her loved ones), mental health concerns, sexual and domestic violence, childhood abuse, lack of familial and community support, poverty, homelessness, difficulties accessing and engaging with helping professionals and mental health services. During the six-month pilot, we were able to identify the presenting concerns of the women attending drop-in, which enabled us to then compare their identified concerns with those the model had been designed to address. In essence, we were able to determine if, at least from a design standpoint, the model had met its mark.

The data pertaining to presenting concerns was collected during intake. The intake worker would begin the session by asking the woman an open-ended question such as, "What brought you here today?" or "What is the single most important concern you wish to talk about today?" The woman's answer to this question was recorded on the *Intake Form*. The purpose of this question was to elicit the woman's understanding of her concerns and to begin to focus the work that would be done later within the counselling session. The data collected on the *Intake Form* was then entered on a spreadsheet with each of the identified concerns listed and the number of times each concern was mentioned was tallied. The concerns were then grouped according to theme and content. For example, presenting concerns of "anxiety" and "depression" were grouped together under the theme of "mental health" and concerns of "domestic violence" and "child sexual abuse" were grouped under the theme of "traumatic life experiences". We were then able to determine that over the 156 sessions, 312 presenting concerns were identified. These 312 concerns fell into 11 categories (see Table 2 below). As is evident from these numbers, these are not mutually exclusive categories. Women often presented with more than one presenting concern. The themes and identified concerns are listed in descending order, with the most prevalent listed first.

Table 2: Presenting Concerns per Session

Theme	# Times Concern was Identified
1. Mental Health	**65 (Total)**
• Anxiety	25
• Depression	18
• Bi-Polar Disorder	6
• Addictions	5
• Post-Traumatic Stress Disorder	4
• Borderline Personality Disorder	3
• Obsessive Compulsive Disorder	2
• Asperger's Syndrome	1
• Eating Disorder	1
2. Concerns about Feelings	**53 (Total)**
• Stressed	11
• Overwhelmed	9
• Grief	9
• Detached/Disengaged/Flat	8
• Guilt/Regret	8
• Anger	5
• Fear	2
• Poor self-worth	1
3. Relationships	**47 (Total)**
• Stress, worry and concern related to partners, children, parents and friends	35
• Addictions of loved ones (e.g., partners and children)	8
• Communication difficulties with family members	4
4. Trauma (as related to. . .)	**38 (Total)**
• Domestic Violence	18
• Physical and Sexual Abuse experienced as a child	7
• Abuse experienced as an adult perpetrated by parents or children	7
• Unspecified events or expereinces	6
5. Transitions	**20 (Total)**
• Leaving a marriage	13
• Immigration	3
• Recent move	3
• Coming out as lesbian	1
6. Concerns about Behaviours	**19 (Total)**
• Hard to get motivated/move forward/get back on track)	12
• Hard to get out of bed	3
• Self-harm	3
• Hoarding	1

Theme	# Times Concern was Identified
7. Concerns about Thoughts • Negative Thoughts • Suicidal Thoughts • Ruminating or obsessive thoughts • Delusional or dissociative thoughts	**18 (Total)** 10 4 2 2
8. Job or School • Impact of job/school on mental health • Desire to get back on track work wise/school wise • Conflict at work/school	**17 (Total)** 12 4 1
9. Physical Health • Concerns related to recuperation from surgeries, hospital stays, illnesses, injuries, accidents, and disability	**13** 13
10. Involvement with Child Welfare • Children in Care • Unspecified	**11** 8 3
11. **Money** • Financial Worries • Homelessness	**11** 10 1

It should be noted that the presenting concerns listed above pertain to each session of counselling (N=156) not to each woman who came for counselling (N=78). Given that each session was considered a self-contained conversation, women who returned for a repeat session were explicitly asked by the intake worker if they wished to work on the same concern as their initial session or a different concern. Data pertaining to presenting concerns in the repeat sessions is presented below in Table 3.

Table 3: Presenting Concerns in Repeat Sessions

Presenting Concerns	# of sessions	% of Repeat Sessions	% of Total # of Sessions
Similar to those Addressed in Previous Session(s)	41	52.5%	26%
Different from those addressed in the Previous Session	10	13%	6.5%
Both Similar and Different	2	2.5%	1%
No Response	25	32%	16%

It should be noted that the data represented in Table 2 pertains to both first and repeat sessions. So, in the cases of the 41 repeat sessions in which the woman identified presenting concerns that were similar to those addressed in the earlier sessions (see Table 3 above), the presenting concern would likewise repeat on the list of presenting concerns (Table 2). This point is made for clarification and does not detract from our intention, which was to determine the presenting concerns identified for each session of counselling.

From the data represented on Tables 2 and 3, we can conclude that from a design standpoint the model met its mark. The presenting concerns identified by the women were consistent with the concerns the model was designed to address, most notably, trauma, mental health, domestic violence, childhood abuse, and poverty.

It is interesting to note the number of concerns the women had about themselves, specifically their feelings (N=53), behaviours (N=19), and thoughts (N= 18) as compared to their circumstances, such as living with domestic violence (N-18), poor physical health (N=13) or poverty (N=11). It is difficult to determine why this may be the case or what it may ultimately mean. However, it may be an important finding with respect to determining if, from a design stand point, the model met its mark. The model was designed to meet the immediate needs of women at a peak point of motivation. That women, who after taking the initiative to come for drop-in counselling, would then identify themselves as the foci of their concerns, may speak to their nascent understandings of personal agency. If this is an accurate understanding, then the active nature of the model (e.g., co-authorship of plans) is indeed be a good fit.

B. Outcomes for the Women's Centre

OUTCOME # 1 - Increased Engagement of Women in the Community in Need of Mental Health Services

During the course of the six-month pilot, the WC was able to engage 78 women, 50 (64%) of whom had never accessed services at the WC before. These 50 women, "new" to the WC confirm there was "increased engagement". Of these 50 women, 19 (38%) returned for repeat sessions, suggesting they had experienced sufficient connection in the first session to consider a second. In reviewing the *Session Notes*, an additional 12 of the "new" women, as part of their end of session plan expressed an intention to participate in programs offered at the WC. While it is impossible to confirm if these women actually followed through on these intentions, at a minimum we can conclude that by accessing drop-in counselling services, women were made aware of other programs offered at the WC and learned how to access them, when and if they needed to do so. Of the 18 women who completed the *Post Service Evaluations*, 6 (33%) indicated they had participated in programs at the WC, which they had not done in the past. When we add the confirmed numbers of "new" women who returned to the WC for either repeat sessions of drop-in counselling (19) and/or participation in other programs offered by the WC (6), we conclude that at a minimum 25 (50%) of the "new" women who came for drop-in counselling remained engaged with the WC beyond their single-session of counselling.

OUTCOME # 2 - Increased Service Compliment

This stated outcome, to increase the service compliment of the WC speaks to the desire of the SJSWC to provide services that are both relevant and useful. The organization has a history of initiating successful programs in response to community need. In 1981, they opened a transition house for battered women and their children, which after several years of

operation became its own stand-alone agency, the Iris Kirby House. More recently, in 2013 the SJSWC began the Safe Harbour Outreach Program (SHOP), a front-line service supporting women who do sex work. The RHRN Drop-In Counselling Clinic is the latest example of the WC increasing its service compliment in response to community need, in this case the mental health needs of women that are inadequately met by existing mental health services.

Usage of the program is certainly one measure of an increased service compliment. As stated above, we know that 78 women used the service, 50 (64%) of whom had never accessed programs at the WC in the past. These 78 women received a total of 156 sessions. Analysis of the *Post-Pilot Qualitative Interviews* with the Counselling Team, however, allowed us to move beyond the numbers to gain a better understanding as to how the drop-in clinic increased the service compliment at the WC. Two themes emerged.

1. Broadened the Demographic Reach

The drop-in counselling clinic broadened the demographic reach of the WC. By-in-large women, who actively participate in programs at the WC could be considered "marginalized", a term which, among other things, speaks to the extreme hardships and social disadvantages they have experienced. Many of the women, for example, have experienced poverty, abuse, and a lack of community and familial support. They can have complex trauma, addictions, and mental health concerns. We discovered that the drop-in counselling clinic was a) attracting "new" women, that is, women who had never accessed services at the WC before, and b) many of the women coming to the clinic were atypical participants. Specifically, the clinic was attracting a younger cohort of women, more employed and professional women and women of a higher socioeconomic status than was typical.

Jenny, for example, credited the drop-in counselling clinic with bringing "many more women into the Women's Centre." This sentiment was confirmed by Natasha, who noted the following:

> [The drop-in counselling clinic] put the Women's Centre on the map a bit more in terms of meeting the needs of younger women. I always envisioned a younger generation, between 18 and 30 coming in. That was always a very small demographic for us. But since the drop-in counselling program started we have seen lots of younger women coming in, which is really, really great.

Sharon and Sheila also made note of the broadened demographic. Sharon explained, "When I think about the Women's Centre, I think more often than not, of marginalized women accessing services. . . [the clinic] opened up the opportunity for more women to access services." Sheila concludes: "Sometimes the perception of the Women's Centre is that it is for women who are needy, you know that kind of thing? So it [the drop-in counselling clinic] broadened the base of the women who come here, and the different backgrounds."

2. Functioned as a "Wrap- Around" Service

The addition of the drop-in counselling clinic to the smorgasbord of services offered by the WC enabled the "new demographic" to avail themselves of additional service offerings and in some respects changed the ways in which WC services were accessed. Dana, for example, described drop-in counselling as a wrap-around service, meaning the women coming to drop-in received support from more than just the counsellor. They benefited from the range of skill sets on the counselling team (e.g., crisis counselling, service negotiation, advocacy) and could avail themselves of any of the programs offered by the WC. As Dana explains,

> I think that [prior to the six-month pilot], the counselling piece was missing. Now that the counselling piece is available, the Women's Centre has a full wrap-around service. . . When I am sitting in the chair [as a counsellor], I know I have a very narrow capacity as a counsellor, but I know outside of me, just on the other side of the door, is the rest of what the woman needs. . .I don't think that existed in quite the robust way that it does now.

Sharon as an intake worker had a similar observation.

> I think a lot of the women who came to the clinic and it was their first time coming to the Women's Centre learned so much about the programming that was available and they signed up for programming before leaving. . . I think the benefit is that for the women, who are in crisis or stuck, being at the Women's Centre and availing of programs may be helpful and beneficial. But having the drop-in counselling clinic there makes these programs even more accessible. I do believe . . .that counselling can change people's perspectives, so that what they take away from the programming can be of even greater benefit.

The impact of having the drop-in counselling clinic embedded into the broader program of services at the Women's Centre is measurable. In her role as the Women's Centre Coordinator, Natasha has seen an increase of women attending programs that is directly linked to the woman having first attended drop-in. At least 5 women who attended drop-in are now participating in the *Empowerment Group*, several have expressed interest in attending the *Helping Children Thrive Group* when it starts up again. Staff at the Women's Centre have also noticed an increase in attendance at the Thursday *Lunch-and-Learns* and *Morning Yarn*, by women who first learned about these programs through the drop-in counselling clinic. As Natasha concludes, by having the drop-in counselling clinic,

> we seem able to cover almost all possible needs that women have when they walk in the Women's Centre. It is a one-stop-shop. That is what I love about the Women's Centre right now, that we are a one-stop-shop. . . I think that is what helped the drop-in counselling clinic become successful, that women had more than just the clinic. They had all these different avenues to get support while they were here.

OUTCOME # 3 - Provided a Stopgap Measure for Women Awaiting Existing Mental Health Services

Over the years, women seeking services at the Women's Centre have expressed frustration accessing traditional mental health services due to a mental health system that is difficult to navigate, service offerings ill-suited to their concerns and long waiting lists. It was hoped the drop-in counselling clinic would serve as a stopgap measure for women on waitlists, offering them immediate and accessible services, and ideally preventing mental health decline while they waited. Although providing a stopgap measure was one of the stated short-term outcomes of the pilot project, women were never explicitly asked either during the intake process or within the counselling session itself, if they were on any waitlists. In fact, methods of tallying this information had not been considered. Clearly this was an oversight. As a result, the information collected about waitlists was garnered through a meticulous scan of the *Intake Forms* and *Session Notes* in search of women's unsolicited self-reports of being on waitlists. It is fair to deduce that if the women had been explicitly asked, the numbers of women who reported being on waitlists would be higher than numbers gathered through self-report. A corrective was made to the *Post Service Evaluation Form* with an item about waitlists added. These results were used to support the veracity of the self-report data.

Of the 78 women who received single session counselling at the drop-in counselling clinic, 25 (32%) were on a total of 36 waitlists for mental health services; 11 waitlists were mentioned. Several women were on more than one waitlist. Table 4 depicts the waitlists women identified.

Table 4: Waitlists for Mental Health Services

Waitlist	# of Women
Psychiatrist	5
Psychologist	3
Eastern Health Programs	
• **Residential Treatment Programs**	
○ Grace Centre	1
• **Group Therapy Programs**	
○ Trauma Group	7
○ Group for Concurrent Disorders	1
• **Individual Counselling**	
○ Le Marchant House	3
○ Terrance Clinic	2
○ START Clinic	4
○ Geriatric Psychiatry program	1
○ Program not Specified	6
Counselling (other than Eastern Health)	3
Total	**36**

Of the 25 women who revealed they were on waitlists, 10 likewise revealed the length of time they had been waiting. Due to the oversight in actively collecting this data (see above), the numbers depicted below cannot be considered generalizable or representative. However, the fact that 10 women waited an average of 15 ½ months for service speaks to the frustration and perhaps also the desperation many women experience while they await services. These numbers also reinforce concerns that the current mental health system fails to meet the mental health needs of women in a timely manner.

Table 5: Length of Time on Waitlists (Unsolicited Self-Report)

Waitlist	Length of Time
Psychiatrist	8 months
Psychologist	24 months

Eastern Health Programs
• **Group Therapy Programs**
  ○ Trauma Group
• **Individual Counselling**
  ○ Le Marchant House
  ○ Terrance Clinic
  ○ Program not Specified
	
	10 Months
	
	18 months
	24 months
	12 months
	2 months
	18 months
	18 months

Counselling (other than Eastern Health)	22 months
Average	**15.6 months**

A stopgap, by definition is designed to fill a gap, or meet an immediate need while a permanent fix or solution is in the works. That 32% of the women who received drop-in counselling services at the clinic were on waitlists suggests that the clinic was used as a stopgap measure. Qualitative data supports this. While on their respective waitlists, one woman referred to the counselling she received at the clinic as "maintenance", another as enabling her to keep her anxiety "under control" and a third as wanting "to stay on track". At least three women, who regularly accessed services at the clinic (i.e. came in for multiple sessions) stopped once they had moved up the waitlist and they could access the service. In addition, several women credited the clinic for informing them of other programs both within the WC and the community that likewise served as stopgap measures.

In addition to serving as a stopgap measure, data revealed that at least 15 women (19%) accessed the clinic as a post service or aftercare measure following their involvement with either traditional mental health services (n=8), or with social service agencies such as child welfare (n=5) and the Iris Kirby House (n=2) (see Table 6). In several instances, women indicated the traditional services had been inadequate. For example, one woman suggested the service she received had not been long enough, two others that the service had been "unhelpful", and a fourth that the service she received had been too intense and fast paced.

With respect to social services agencies, women expressed the need for longer-term support in dealing with domestic violence and child apprehension.

Table 6: Post Service and Aftercare Measures

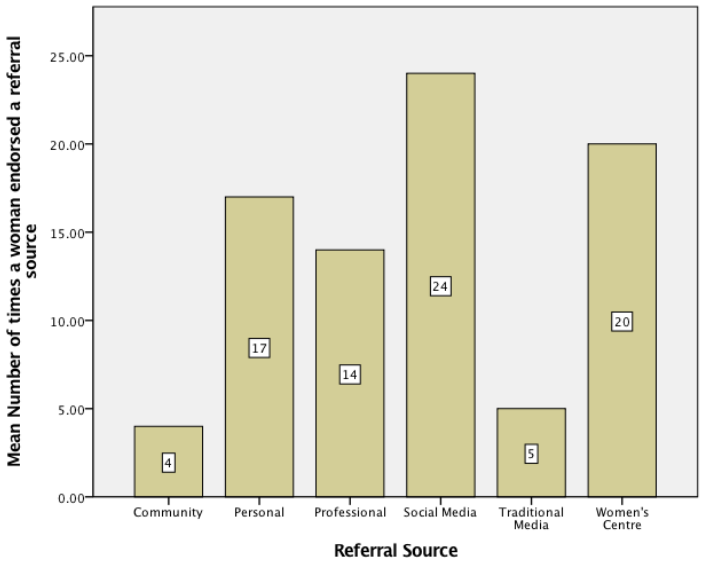
Service	# of Women
In-Patient Treatment at Waterford	1
In-Patient Addiction Program (Out-of-Province)	1
Therapy Group (Eastern Health)	1
Counselling (Community and School Based)	4
Psychologist	1
Iris Kirby House	2
Child Welfare	5

OUTCOME # 4 Successful Employment of Recruitment Strategies

During intake women were asked how they became aware of the drop-in counselling clinic. As is evidenced in Figure 9 below, six methods of awareness emerged. These methods were not mutually exclusive. Social Media (n = 24) was the most common method of awareness. Awareness was also created through other WC programs (n = 20) as the next most common method of awareness, followed by a referral by family or friends (n = 17). Referrals from professionals in the community, such as family doctors, teachers, and psychiatrists accounted for 14 referrals of women to the program. Traditional media, such as radio and television (n = 5) and community referrals (n = 4) through Child Youth and Family Service, Iris Kirby House, Native Friendship Centre, etc. were among the least identified methods of awareness.

That more women heard about the drop-in counselling service through social media than any other method, suggests this highly successful method of promotion needs to continue. By contrast, additional efforts to increase awareness of the service among mental health professionals and the community-at-large are needed.

Figure 11: Methods of Awareness



OUTCOME # 5 - Increased Capacity of Staff at the Women's Centre to Meet the Needs of the Women Served

The partnership between the School of Social Work and the SJSWC/WC enabled staff at the WC to take advantage of training and skill development, opportunities they might not otherwise have had. With the exception of Sharon Samson, the MSW Intern and Dana Warren, both of whom worked exclusively with the drop-in counselling clinic, the other members of the counselling team enfolded their clinic work into the broader roles they held within the organization. Jenny Wright, for example, the Executive Director of the SJSWC/WC became the supervisor of the drop-in counselling team. Natasha Bader Densmore, the Women's Centre Coordinator became the intake worker for the drop-in clinic and Sheila Ryan, the Program and Advocacy Coordinator at the Women's Centre became a counsellor at the drop-in clinic. Because of these dual roles, it was anticipated that the training and skill development the team received through the drop-in counselling initiative would transfer to the other aspects of their jobs thereby increasing their overall capacity to meet the needs of the women seeking services at the WC. This proved to be the case.

1. Training

The counselling team received training prior to the pilot beginning on September 26, 2017, throughout the six-month pilot and after the pilot was completed (as the drop-in counselling clinic continued beyond the pilot period). As per the partnership agreement between the School of Social Work and the SJSWC, several training opportunities were offered through the School's Continuing Education Committee. Training took several forms as depicted on the Table 7 below.

Table 7: Training for Drop-In Counselling Team

Training Received	Dates	Sponsor	Funding	Participants
Pre-Pilot *Brief Single Session Walk In Therapy* Facilitator: Scott Cooper, RT (12 credit hours)	June 9 & 10, 2016	Continuing Education Department, Faculty of Social Work, Laurier University	Accelerator Fund (Memorial's Office of Public Engagement)	Dana Warren Jenny Wright
Therapeutic Writing Workshop Facilitator: Dima Dupéré, MSW (5 credit hours)	August 4 & 5, 2016	Continuing Education Committee, Memorial School of Social Work	SJSWC/WC	Natasha Bader Densmore Sheila Ryan
Drop-In Counselling Immersion Day Facilitator: Catherine de Boer, PhD	September 6, 2016	SJSWC/WC	NA	Natasha Bader Densmore Sheila Ryan Sharon Samson Dana Warren Jenny Wright
Single Session Therapy Facilitator: Heather Hair, PhD (4 credit hours)	September 16, 2016	SJSWC/WC	Accelerator Fund (Memorial's Office of Public Engagement); SJSWC/WC	Natasha Bader Densmore Sheila Ryan Sharon Samson Dana Warren Jenny Wright
Pilot *Using Scaling Questions in Single Session Therapy* Facilitator: Catherine de Boer, PhD	February 20,2017	NA	NA	Natasha Bader Densmore Sheila Ryan Sharon Samson Dana Warren Jenny Wright
"Single-Session School" Facilitator: Jenny Wright (and members of the counselling team)	Weekly for the duration of the six month pilot	NA	NA	Natasha Bader Densmore Sheila Ryan Sharon Samson Dana Warren Jenny Wright
Literature Review Reading and discussing literature on topics such as single-session therapy, brief narrative therapy, trauma-informed and feminist practice	Ongoing	NA	NA	Natasha Bader Densmore Sheila Ryan Sharon Samson Dana Warren Jenny Wright
Video Review Team members watching therapy training videos	Ongoing	NA	NA	Natasha Bader Densmore Sheila Ryan Sharon Samson Dana Warren Jenny Wright
Role Play Activities Developing and practicing specific counselling skills through role play activities	Ongoing	NA	NA	Natasha Bader Densmore Sheila Ryan Sharon Samson Dana Warren
Session Debriefs Team members discuss and review each counselling session	Ongoing	NA	NA	Natasha Bader Densmore Sheila Ryan Sharon Samson Dana Warren Jenny Wright
Post-Pilot *Brief Single Session Walk In Therapy* Facilitator: Scott Cooper, RT (12 credit hours)	May 25&26, 2017	Continuing Education Committee, Memorial School of Social Work; SJSWC	Accelerator Fund (Memorial's Office of Public Engagement); SJSWC/WC	Natasha Bader Densmore Sheila Ryan Sharon Samson Dana Warren Jenny Wright

In addition to receiving training, as the pilot progressed several members of the counselling team shared their knowledge and experiences in various venues. See Table 8 below.

Table 8: Presentations and Training Provided by Counselling Team

Presentation/Training	Dates	Setting
Right Here, Right Now: A Women's Centered Drop-In Counselling Program Presenters: Catherine de Boer, PhD Jenny Wright, MSW Dana Warren, BSW (see Appendix G)	October 14, 2016	Memorial School of Social Work - Continuing Education Homecoming Event for Alumni
A Brief Time in History: How Our Involvement with a Drop-In (Single-Session) Counselling Clinic Informed Our Understandings of the Social Work Role in Canadian Society Presenters: Catherine de Boer, PhD Dana Warren, BSW (See Appendix K)	May 30, 2017	Canadian Association of Social Work Education Annual Conference

Training was an essential component of the drop-in counselling initiative. As the model was uniquely designed for the WC, members of the counselling team needed to be trained on how to use it (e.g., Drop-In Counselling Immersion Day, September 6, 2016). As the team had a range of educational and work backgrounds, receiving identical training ensured that team members started speaking the same language. By partnering with the School of Social Work, the SJSWC/WC could provide the team with specialized training (e.g., Brief Single Session Walk In Therapy, June 9 & 10, 2016, May 25& 26, 2017; Single Session Therapy, September 16, 2016) with leading experts in the field (e.g., Scot Cooper and Heather Hair), which otherwise might have been cost prohibitive.

Participating in training was an essential aspect of building the capacity of the staff at the WC. As the Region's first and only drop-in counselling clinic operating out of a non-profit agency, and as the first such clinic to work exclusively from a feminist model and only with women, members of the counselling team were determined to up their game. As a result, training sessions were well attended with team members actively engaged. The team considered the training, and indeed the drop-in clinic itself, as an opportunity to develop their skills, revitalize their work, and advance their careers.

However, it is one thing to attend training sessions and quite another to have the skills and knowledge "land" in such a way that one's overall approach to the work changes in a positive and fundamental way. Analysis of the qualitative data, specifically through a comparison of the pre and post pilot interview data, suggests that not only did these fundamental shifts

occur (see Section b, below), but that there were specific characteristics of the training that allowed them to occur. Three themes emerged.

a) *Boundaries*

First, the support of the organization at all levels (staff, management and board) in valuing the project and wishing it to succeed created space, both time and resource wise, for the training to occur and the cumulated knowledge to percolate. For the staff with dual responsibilities, a boundary was created around their drop-in clinic work and the other aspects of their jobs. This boundary was created in two ways. First, Janelle Duval, the Cultural Program Coordinator at the WC was assigned to cover all tasks associated with the WC on clinic day, allowing Sheila and Natasha to focus exclusively on their clinic work. Thus on clinic days, when not in session, they were able to read literature, watch training videos, participate in role plays and debriefing sessions. Second, Jenny in her dual role as Executive Director of the SJSWC/WC and supervisor of the counselling team was able to enforce the boundary. Sheila offers a good description of how the boundary was created and enforced.

> It was an overall organizational decision. Jenny used to poke her head into my office and see me at the computer and she would say, "You better be looking at something on single session," because at first I would try to sneak my other work in on clinic day. . .But she was on it, you know? We couldn't get away with it. She was watching us too. And even though we resisted it a little bit in the beginning, I still learned very quickly how important it was. We would get our morning coffee and head into the board room and we'd have these great discussions or we'd watch something or we'd read an article, we just did it. We just decided, if we are going to do this, we are not going to half-do this. We are going to do this in the manner in which it is meant, what it is set up for. And we did, because if not, we felt we were doing a disservice to it.

Unfortunately, within several months of the project, the boundary eroded. There was less focus on "Single Session School" and members of the counselling team, including Jenny were drawn back into doing the other aspects of their jobs on clinic days. The results of the boundary erosion were palpable. As Natasha, whose number one concern about the clinic was having "outside stuff come in", articulated, "My nightmare has happened". Sheila worried, "It is almost like an automatic pilot button is going to get switched on and I don't want it [the drop-in counselling program] to be on automatic pilot." Dana observed that as "single session school" waned, so did the team's adherence to the model. Team members lamented the erosion of the boundary and expressed a desire for it to be maintained. As Natasha expressed, "I want to be constantly going back to the material that we have and reading and looking at research and being in single-session school, but we can't. It is just impossible."

b) *Repetition and Reinforcement*

With respect to the increased capacity of staff, the famous lines penned by poet T.S. Eliot are particularly apt, "We shall not cease from exploration, and the end of all our exploring will be to arrive where we started and know the place for the first time." The team was provided with literature and had access to training videos prior to the six-month pilot, which throughout the pilot, they returned to repeatedly. Likewise, the Brief Single-Session Walk-In Therapy training led by Scot Cooper was offered before and after the six-month pilot. As Sharon explained, as the pilot progressed, "I found myself rereading articles I had just skimmed over initially. Picking out pieces from those articles that were important for me and reviewing that periodically was important. It was almost like the repetitive notion of that was big."

c) *Single Session School*

Single Session School was the inspiration of Jenny Wright and its effectiveness is closely tied to the two themes described above. At its best, single session school involved the team focusing on a specific topic each clinic day. The topic could be related to an article or training video, or could be one of the underlying assumptions of the model or a therapeutic skill associated with delivering single session therapy. For example, if the topic of the day was "externalizing the problem", the team would read about, watch videos on, practice and discuss externalization throughout the clinic day. Likewise, in the intake and counselling sessions conducted during that day, a concerted effort would be made to use the technique and discern its effectiveness. Jenny described single session school and its effectiveness in the following way:

> I found the in house learning that we did together to be the most effective and most powerful. So that would mean bringing in an article at the beginning of it that everybody read. It might have been bringing in one of the [underlying] assumptions and making sure, saying, "okay everybody, we are going to focus on this assumption today". Or it might be a structural part, like, "Let's really focus on how our co-planning is going. Are we waiting too late to co-plan? Do we need to start co-planning earlier in the session?" The team was incredible. They really allowed themselves to be vulnerable in that learning and it allowed them to say, "I don't know" or to share with the rest, "I did this and it worked". To me some of the most powerful learning happened when we curated it ourselves. It is imperative to the model that we keep that going.

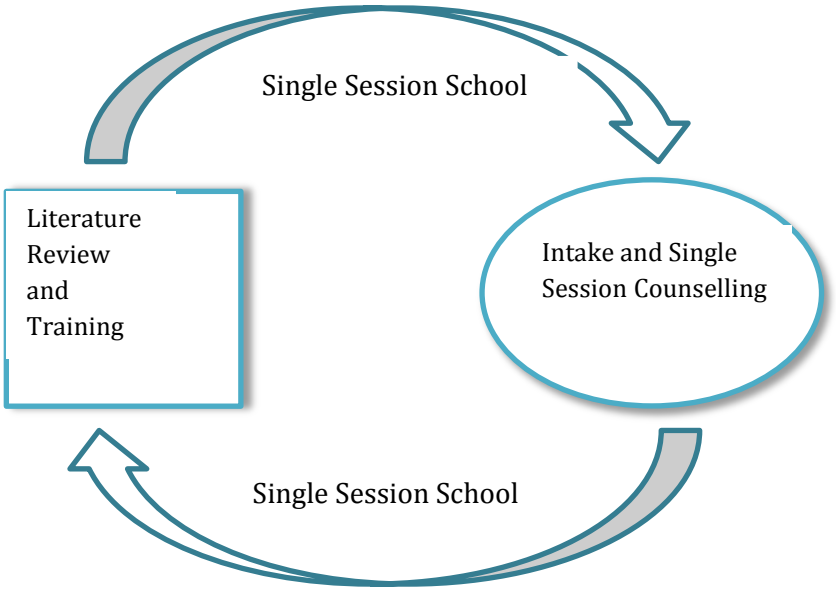
The team experienced single session school as a bridge between the formalized training they received and their direct experiences delivering the drop-in counselling. It proved to be an effective way to reinforce their learning. As Sharon explains,

> When we were in single session school there were many times we would talk about a particular issue and then four months down the road we would talk about it again. It was that reinforcement piece. I would always have a different relationship with that conversation later because my comfort level was increased and I was able to think

more critically about those pieces because of what my experience had been, so having that experience and then the reinforcement by having the same conversations later was purposeful learning.

As Sharon's statement and Figure 12 reveal, single session school created a circle of reciprocal influence. The knowledge gained from the literature and formalized training informed the delivery of drop-in counselling. Likewise, the skills and competency gained in providing the drop-in counselling allowed for new and richer understandings of the literature and a revisiting of the knowledge gained from training.

Figure12: Single Session School as the Bridge between Knowledge and Experience



2. Skill Development

That the training and delivery of drop-in counselling services was effective in increasing the capacity of the staff was evident in the post pilot qualitative interviews. Themes that emerged from the data are described below.

a) *New Understanding of the Counselling Role*

Members of the counselling team identified moving from a" fix-it" approach to taking a non-expert stance as a significant development. In the pre-pilot interviews, team members expressed a desire to learn new ways of being in the counselling role. Sharon, for example noted the following in her pre-pilot interview,

> The difference for me will be that in my current [place of employment] I always work within the prescribed mandate that limits me from allowing the individual to

> present their issue in its entirety. I always have the answer for somebody. I always have a support to offer them. I think it will be really interesting to see the support come from the individual woman and for them to direct the service.

By comparison, after the six-month pilot was over, Sharon concluded, "I now have a greater appreciation for not knowing and becoming almost completely vulnerable myself, to completely strip the conversation down to the bare basics and to say, 'Let's start from there'". Sharon experienced a correlation between her ability to ask better questions and her enhanced comfort in taking a not knowing stance. She noted,

> The skill to say, "Is this what you want to talk about?" or the skill to say, "Am I asking the right questions" is to not be the expert. I needed to be able to ask the women, "What do you want?" Then I had to accept what it was that they wanted to talk about and for them to take the lead in that role. So I wasn't giving the women information and I wasn't asking them questions about things they didn't want to touch on.

Sharon concludes that she is now "Okay with not knowing." She adds, "Whereas before I would be completely wrapped up with, 'Oh my God, I don't know' . . . now it is like, 'Does it really matter?' . . . there has been a huge shift in my acceptance of it being okay not to know." Compared to when the six-month pilot began, Sharon noted, "I see the world completely differently and I see the people I am working with differently. I listen differently. I accept things differently."

Likewise, Natasha acknowledged that one of the things she gained in being part of the six month pilot was "some skills around listening differently to women. . . making the switch in my head from trying to solve or be useful with everything they have coming in . . . to just stopping and being present in the moment". She added, "I do feel the shift in how we talk to the women now. Me anyways . . . it is a different conversation. I am using different words. I am asking different questions, so it feels a little bit more useful. We had chats before and I think they were useful too, but now it is a different kind of conversation". Natasha has observed other staff at the Women's Centre also making this shift. She added, now instead of having conversations that are "feeding the problem" or aimed at "trying to solve all the issues", staff are "just there to support and give women time, and have a different conversation."

For the members of the counselling team, taking a non-expert stance meant they prioritized the knowledge women had about their own lives and the women's understandings of the concerns they wanted to address within the session. They began to see themselves as facilitators of a process versus problem-solvers. As Sheila explains,

> I've always believed in women, but this whole notion of women being the experts in their own lives, I mean I always thought that, but never as fully as I do now. Like I think this has really enhanced the belief system that I already had. It's absolutely there, not matter what. No matter what's going on, they have all the things they need within themselves and just having that place to unpack it a little bit, or look at it in a new way for them, and we create that space for them to be able to do that.

b) *Confidence in One's Ability to be Effective*

Although it may seem a circular argument, the team spoke about how their confidence in the model and their own abilities to be useful, in fact, increased their usefulness. This sentiment is supported by the literature. Hubble, Duncan and Miller (1999) discovered that a counsellor's adherence to a specific model, regardless of what the model is, can account for 15% of change in the therapeutic process. Specifically, it is the counsellors' confidence in the theoretical orientation, their knowledge of the select model and their skill levels in using the techniques associated with the model that account for the therapeutic change. It is not so much the model itself that leads directly to therapeutic change but rather the counsellor's confidence in the model and his/her skills in using the techniques related to the model. In the quotation below, Dana remarks on not only her own but also the team's developing confidence in the model and how this lead to therapeutic usefulness.

> In the beginning as a team we all had doubts. There was one foot in the "It can't happen this way; there is no way we can just have one conversation with a woman and it be useful" and the other foot was in the "maybe it can be useful; I guess we can suspend our disbelief".

Dana compared her growing confidence with crossing a river. She said, "I feel like I have been on the other side of the river most of the time. I might have been in the shallow part at the beginning but I have always been the one [calling the team over by saying], 'Gang, it is over here where we have to be.'" Dana observed, "I have to say, most of the time, your own belief as a counsellor in the model makes the model work." She added,

> But this one [the model used at the drop-in counselling clinic] gives power to the conversation as opposed to the problem. I believe in connection . . . and I believe that happens the minute we meet a woman and you see the evidence of that right away. There is some lot of trust that goes into saying to a woman, "I want us to have a different conversation, one that is useful to you." You can see the change in a woman's face.

Whereas Dana drew a connection between her confidence in the model and her ability to be useful, Sharon noted that her confidence in her abilities was also an important factor. She noted,

> I have gained a sense of knowing that I supported people and knowing that it is something I would like to continue to do . . . just listening to somebody, knowing that I made them feel valued and important, that what they were experiencing was real and that I helped them figure out a way, guide their thought process so they could figure it out independently . . . to help women identify their strength, resilience and their amazing skills . . . For me, it was very, very powerful. Of course, I also have an increased confidence in my ability to be more effective and the knowledge that I want to do more of that.

c) *Focusing*

Often the women who came to the drop-in counseling clinic presented with concerns that were overwhelming for them, broad in scope and multi-layered (see Table 2 above). Members of the counselling team identified their abilities to focus conversations with the women, that is, advance a woman's presenting concern into a specific "hope of the day" as a skill they developed over the course of the six-month pilot. For example, Sharon recalls that at first she was struck by women's disclosures of their mental health diagnoses and the medications they were prescribed. She felt that in her role as an intake worker, it was necessary for her to relay this mental illness focused information to the counsellor before the session began. In the quotation below, it is possible to see how not only her focusing skills but also her approach developed over time.

> Initially we would repeat what a woman had shared with us at intake with the counsellor, what her diagnosis was and the medication she was taking . . . but I am okay now, more than ever with saying to the woman, "That is good information to know, but more important for me to know is, who are you? . . . What do you want out of this session? What do you want out of this relationship?

Sharon added,

> So many times women presented with so many issues. It was always interesting when that happened to have conversations with the women to support them as they prioritized what was the most important thing. This was a big learning piece for me as well. There was so just so much that people wanted to unload, but with all that, how could I be effective? It was almost like I needed to find a way to support them as they organized what was important for them right now. I hoped that when they walked away from the session they would be able to use that skill [of focusing] because they had just learned it and employed it in the session.

It is possible to find evidence of the focusing that occurred by comparing the concerns women presented at intake (See Table 2 above) with their identified "hopes of the day" recorded in the *Session Notes*. As indicted above, the presenting concerns were collected during the intake process, typically in response to the intake workers' questions such as, "What brought you here today?" or "What is the concern you would most like to discuss today?" During the intake process and the session itself, counsellors would engage the women in whittling down their broad concerns into a sizable issue that could be discussed within the 60-minute session. Counsellors would often do this by asking such questions as, "What would be most important for us to talk about today given that we have this one time together?" or "What do we need to do together over the next 60 minutes, so that you can leave here knowing that the session we had here today had been useful?" Table 9 below provides some examples of broad presenting concerns that were focused into specific hopes of the day.

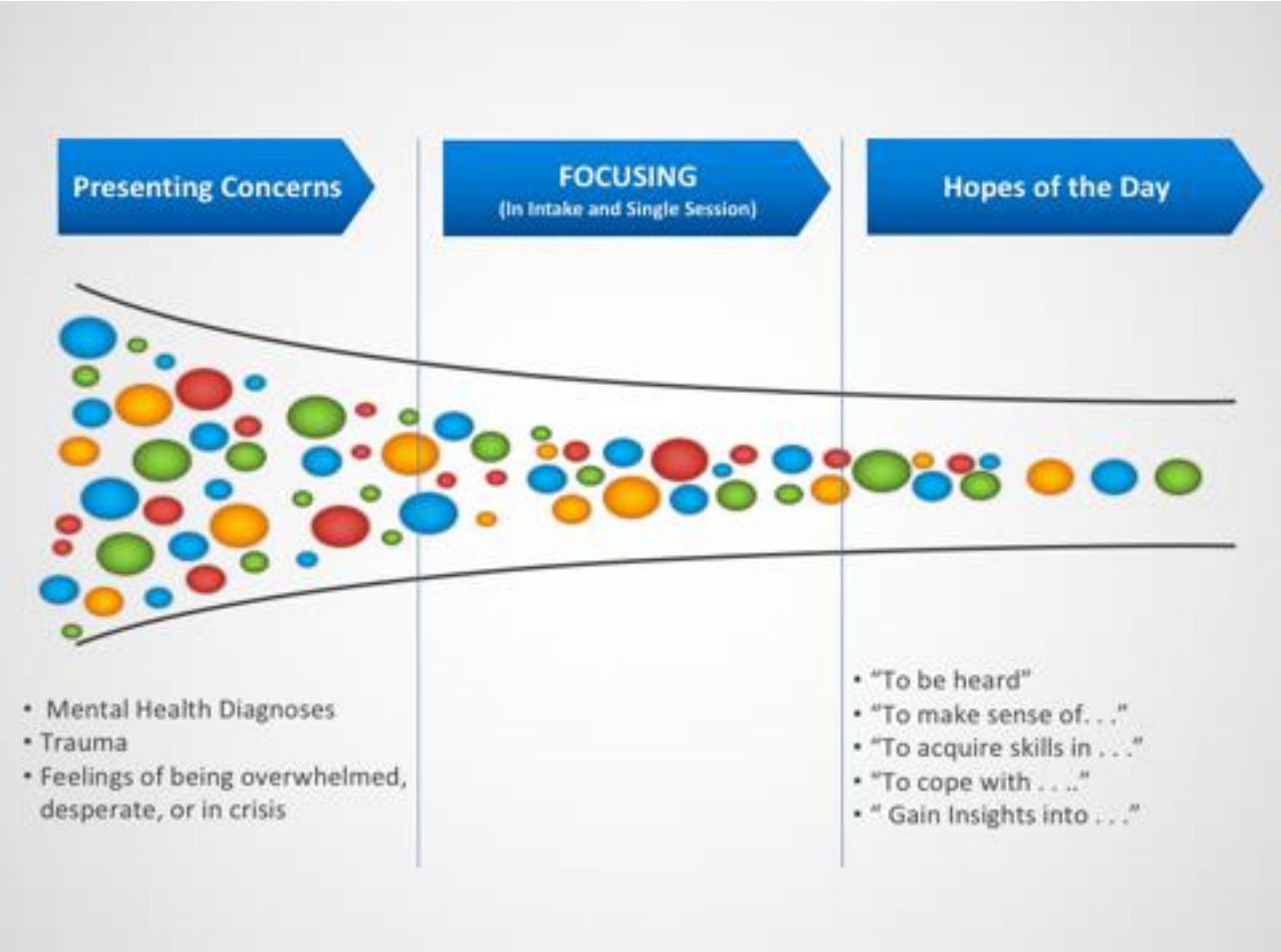
Table 9: Presenting Concerns Focused into Hopes of the Day

Presenting Concerns at Intake	Hope of the Day as articulated in Session
Left an abusive relationship of many years, bi-polar	"I would like to not be afraid to leave my house."
Have problems with a co-worker, makes it hard to get out of bed in the morning	"I need someone to believe me."
Experienced trauma as a child	"I would like to have better control over my constant crying."
Anxiety attacks, can't concentrate on anything	**"**To plan how I can talk about my mental health concerns with my family doctor."
Want to let go of men who are not good me.	**"**To stop second guessing myself."
How to deal with trauma from domestic violence	"To feel more confident about how to talk about boundary issues with a friend."
Anxiety	"To acquire skills to better respond to test anxiety."
How to work through the process of healing from child sexual abuse and all the associated feelings	"Get some strategies to help me get through the next day."
Concerned about my estranged teenage daughter who has just had a baby	"Learn how to support my daughter without her turning away."
Bad anxiety and I want to know why	"I may not be able to know why but learning about what is happening and what I can do about it now."
Negative and bad thoughts for the past couple of days	"I would like to communicate with my boyfriend about what I want to do over the Christmas holidays."

Following a qualitative analysis of all presenting concerns and tracing how each became focused into a concrete "Hope of the Day", it is possible to note several patterns with respect to a) how women presented their concerns and b) how the counsellors' focusing skills facilitated the usefulness of the session. As indicated above, women's presenting concerns were often trauma focused with frequent references made to mental illness diagnoses. Implicit in their narrative was the plea, "Please listen to me! Things are this desperate!" It is worth noting that given the shortages in mental health services in the Region and women's experiences of receiving only a limited amount of time to convey their concerns to a mental health professional, many of whom they may have waited months and even years to access, women coming to the clinic were prepared to reveal the breadth and severity of their concerns in the manner they felt would best legitimize their access to the service. Once women experienced being listened to and they discovered they could determine how the session would be utilized they were able to benefit from the focusing process. When analyzing the "hopes of the day" several themes emerged. Many of the hopes were to be heard, to be validated and to be believed. Beyond that the hopes were very concrete, specifically women wanted to a) develop skills b) gain insights, and c) make sense of or find

meaning in certain behaviours and experiences, and d) learn coping strategies. A depiction of the qualitative findings pertaining to the focusing process can be found in Figure 13 below.

Figure 13: Model of the Focusing Process



d) *Skills Specific to Techniques Associated with the Model*

Members of the counselling team made frequent reference to their growing confidence in using techniques that were either broadly tethered to single session therapies or were more specific to the model used at the drop-in clinic. These techniques included: scaffolding, listening with a brief ear, asking scaling questions, externalizing problems, and changing a woman's relationship with a problem. It is beyond the scope of this evaluation to describe each of these techniques and how they are to be employed. However, the fact that these techniques were identified by members of the counselling team as not only useful for drop-in counselling but transferable to other aspects of their jobs at the WC is indicative of their increased capacity to meet the mental health needs of women.

C. Outcomes for the Women

OUTCOME # 6 - Drop-in Counselling is Identified by Women as Useful

An *End of Session Evaluation Form* was designed to determine if women found the single session counselling they had received at the clinic to have been useful. The form was an adaptation of Miller, Duncan, and Johnson's (2000) *Session Rating Scale (SRS)* and included both quantitative and qualitative data. (For an explanation as to why we chose the SRS, please see Outcome # 7 below). We also conducted end of service interviews with the counselling team and with the women (n=18) after the six-month pilot was completed.

The *End of Session Evaluation Form* was completed for 142 of a possible 156 sessions (91%) and by 69 of the 78 women (88%) who attended drop-in. On the form they were asked to answer each of the 9 questions represented below on Table 10 using a 4-point scale with 4 being "excellent" and 1 being "poor".

Table 10: Results from End of Session Form - Quantitative Data

#	1	2	3	4	5	6	7	8	9
Question	How did you feel about your entire experience today?	Did you feel the counselling session was useful?	Did you talk about the things you wanted to talk about?	Do you have a better sense of your own strengths?	Do you feel more hopeful?	Do you feel more valued?	Did you feel you were a partner in developing the final plan?	If a friend was in need, would you recommend this service?	If you were in need again, would you come back?
Valid	135	142	135	132	142	126	128	133	135
Missing	7	0	7	10	0	16	14	9	7
Mean	3.848	3.92	3.90	3.625	3.697	3.579	3.719	3.99	3.97
Median	4.000	4.00	4.00	4.000	4.000	4.000	4.000	4.00	4.00
Mode	4.0	4	4	4.0	4.0	4.0	4.0	4	4
Std. Deviation	.3576	.268	.296	.5434	.5190	.5845	.4891	.087	.170
Range	1.0	1	1	2.0	2.0	2.0	2.0	1	1
Minimum	3.0	3	3	2.0	2.0	2.0	2.0	3	3
Maximum	4.0	4	4	4.0	4.0	4.0	4.0	4	4

1. Women Found the Service Useful

Even though mean scores varied slightly, the median and mode for each question is 4 out of 4. Mean scores ranged from 3.58 to 3.99. It is worth highlighting how exceedingly high these scores are. These scores suggest women found the service useful (see question # 2 with a mean score of 3.92 out of 4). That women indicated they would refer the service to a friend if she was in need (see question # 8 with a mean score of 3.9 out of 4) and would return themselves if they needed the service again (see question # 9 with a mean score of 3.97 out of 4) may also speak to how useful they found the service.

Of the 142 *End of Session Evaluation Forms* completed, 83 (58%) included qualitative data, meaning the women provided written comments on question # 10, which asked, "Is there anything else you would like to say?" Of the 83 responses, 64 of the responses reference the session as having been helpful; there are 29 expressions of gratitude, and 8 expressions of hope that the clinic remain open (Note these are not mutually exclusive categories). That women found the service useful is evident in the sampling of comments below.

> I found this service amazing and extremely helpful. I believe many women could benefit from this. Very impressed!
>
> It helped to have someone here. . .This saved my life today.
>
> This session gave me more hope in myself than I have had in months.
>
> Last session helped me so much, I came back for more.
>
> This is a valuable program. *Right Here, Right Now* works.
>
> Most helpful session I have ever had with any counsellor.
>
> I feel a wave of peace. Had I known counselling would make me feel good I would have done it years ago.
>
> I have had lots of counselling before but this today was really good.
>
> There is nothing like this. This needs to be a forever thing.

In the post-pilot interviews, members of the counselling team noted positive changes in the women from when they came in at intake to when they left at the end of session. Sharon, for example, in her post-pilot interview noted,

> I remember early on . . . seeing a difference from the time the woman came in for the intake to the time she left the session. [It was] that process of listening, allowing a

> woman to have a voice, acknowledging how difficult and challenging things are that made the difference. It was shocking for me to hear women say, "This is the first time anyone has acknowledged how difficult it has been and how this has impacted me."

Likewise, Jenny observed the following,

> You could also see it when women were leaving counselling. There was a change in everything about them. The way they held their bodies when they walked in was very almost small or stooped over. They were a bit frightened or nervous. But after going through the whole process of being greeted and meeting someone, I watched them come down the hallway and they would be standing taller and they would have a smile on their face and they would have a sense of purpose. I think that is usefulness in action. I think that is what I saw. . .They were leaving somehow changed by the process."

So while we may be able to conclude that immediately following the session a) women perceived the service to have been useful, and b) members of the counselling team likewise observed positive changes, we wondered whether the perception of usefulness was sustained over time. Hence, after the pilot was over, we were able to contact 18 of the 78 women (23%) who had come in for drop-in counselling. One of the questions we asked the women was a scaling question, "On a scale from 1 to 10, 1 being the service was completely useless and a waste of your time and 10 being the service was extremely useful and met or exceeded your expectations, where would you put this service?" After they assigned a number, we asked them to explain why they had selected that particular number. The women's answers are provided in Table 11 below.

Table 11: Results from the Scaling Question

N=18	Assigned Number	Reason for Selection
1	10	Comfortable, I am not always comfortable. I finally belong somewhere.
2	9	It wasn't long term therapy. It exceeded my expectations. No wait. I was extremely comfortable.
3	7	No Comment
4	10	I didn't want to go but I was encouraged to give it a try. I did. I was amazed, very pleased.
5	10	Very helpful, really cleared my mind, strengthened me. An incredible service to the community.
6	10	The experience was positive.
7	10	A lifesaving experience when I was at my lowest. I think I was meant to come. It is a great service for [mental health] emergencies.
8	7	Some parts exceeded expectation. But I guess I was asking for a miracle. I wanted more answers. I am still confused and lost. I want continuity and wish I could come more.
9	10	The therapist was useful in the way she approached me and my concerns.
10	8	Useful and was there when I needed it. I came at a time when I was open to receiving the benefits. What you get out of counselling is related to what you put in.
11	10	Service helped me through some bad spots.
12	7	I was in a dark situation and it was good to bounce my ideas off someone.
13	10	When I first heard about drop-in counselling I thought it would be a place where I could just go in and vent. But to have people who understood me? I didn't expect that. I was a non-judgemental space.

N=18	Assigned Number	Reason for Selection
14	10	I like that it is geared around women and women's issues. I walked out of those sessions with a way to think differently. I found it useful, just to put one foot in front of the other.
15	10	NA
16	10	NA
17	10	NA
18	10	From the moment I arrived I was made to feel very comfortable and the session was extremely helpful.

The mean score was 9.3 out of 10. Although the sample size is small and represents less than ¼ of the women who came to drop-in that perceptions of usefulness remained high and were sustained over time is affirming.

2. What Women found Useful

In their written comments on the *End of Session Form*, women also revealed what they had specifically found useful. Several spoke about learning new skills, gaining insight, and having someone to talk to. Others referenced the co-development of the plan as having been particularly useful. Some examples appear below.

> This is the first time I developed a plan to help myself and will actually use it.
>
> This really helped me. I have a plan. I know what to do.
>
> Helping me see the bigger picture. Keeping the pressure off.
>
> Focus, insight, helped gain clarity.
>
> Gave me a lot of perspective. It feels good to be listened to. You are the best!

In the *End of Service Evaluations*, women were specifically asked, "Now that some time has passed since your session, what happened at drop-in the drop-in clinic that was useful to you?". Of the 18 women who completed the *End of Service Evaluations*, 9 indicated it was having someone they could talk to, who listened, understood and cared for them that had been the most useful, 4 indicated they had gained some new insights, and 4 spoke about the new skills they had developed.

OUTCOME # 7 - Women Feel Connected to the Women's Centre and the Counselling Team

We wanted to use an end of session evaluation tool that would, among other things, allow us to measure the therapeutic alliance between the counsellors and the women coming to the clinic. According to Bertolino (2010), a therapeutic alliance contains two elements: 1) a bond or sense of connection, and 2) a collaborative partnership with respect to "processes (e.g., how to meet, when to meet), therapy directions, and goal establishment" (p. 41-2). In our case, we were interested in measuring the degree of connection women felt to the counsellors, specifically relational dynamics such as feeling heard, respected and valued, and the degree to which they felt they had contributed to the development of the final plan. We knew we wanted to measure these elements because the literature suggests that a positive therapeutic alliance is one of the best predictors of positive therapeutic outcome (Orlinsky, Grawe, & Park, 1994; Orlinsky, Ronnestad, & Wullutzki, 2004). For example, Horvath and Symonds (1991), in their meta-analysis of 24 studies on the quality of the helping relationship, discovered a correlation between the alliance and outcome of $r= 0.26$, which is a "medium sized effect that can be interpreted as saying that 7% of the outcome is associated with the alliance" (Wampold, 2001, p. 151). Furthermore, we knew that the women's ratings of the alliance would be a better predictor of positive outcome than the counsellor's ratings (Bachelor & Horvath, 1999). It is for these reasons that we designed an evaluation tool that the women rather than the counsellors would complete.

Miller, Duncan and Johnson (2000) designed a Session Rating Scale (SRS) to be completed by clients at the end of session to measure the therapeutic alliance. We were attracted to the scale because of its solid reliability, adequate validity and its simplicity. We kept the key elements related to feeling heard, collaboration, fit and experience of service. We added elements predictive of positive outcome (i.e., usefulness and hopefulness) and we added elements consistent with our underlying assumptions, specifically hope, connection and strengths. Lastly, we added a qualitative element.

Both themes, specific to the measurement of the therapeutic alliance (sense of bond or connection, and collaboration) were evident in the comments. With a further interrogation of the data with respect to each theme we were able to gain a richer understanding of the nature and quality of the therapeutic alliance within the context of the drop-in counselling clinic. This was an important analysis to undertake because as noted above, the quality of the therapeutic alliance is a predictor of therapeutic effectiveness.

1. Bond or Sense of Connection

Not only was it possible to conclude women did in fact experience a sense of connection; we were able to determine how the connection was experienced by the women. Specifically, women identified kindness, caring, sincerity, honesty, positivity, being valued, and being treated with respect. The following quotations from the women serve as examples.

Very welcoming and warm place. I felt like I could be myself.

I was treated with great respect.

You are all very positive. I didn't expect that.

I feel more hopeful and valued because you listened.

Gave me a lot of perspective - It feels good to be listened to.

So glad this service exists and the people who make it special.

I was so nervous and anxious when I first came. I feel so much better. Thank-you for your kindness.

It was also evident, as the following quotations reveal, that women felt a connection not only with the single-session counsellor but the counselling team as a whole and the Women's Centre, itself.

Way to go tag team!

This was a very warm and welcoming place.

I am so glad this service exists. The people make it special.

This is a wonderful program.

The system of support has wowed me.

2. Collaboration

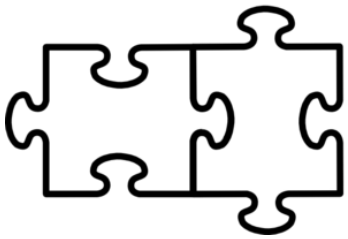
Collaboration, the second aspect of the therapeutic alliance predictive of positive service outcomes (as introduced above in Section 7a) was evident in both the quantitative data and qualitative comments presented by the women in the *End of Session Evaluation Forms*. Two aspects of collaboration were revealed: a) collaboration as "product", specifically the co-developed plans or "next steps", recorded by the counsellor on the *Session Notes*, photocopied and given to the woman, and b) collaboration as process, meaning, the women felt they were active partners within the session. Each aspect will be discussed in turn.

Collaboration as "product" - We had hoped women would associate the co-development of a final plan, which was a key feature of the model, with feelings of collaboration. This was indeed the case. The mean score for Question # 7 on the *End of Session Evaluation Form*, "Did

you feel you were a partner in developing the final plan?", was 3.7 on a four-point scale with 4 being "excellent" and and 1 being "poor". This high score suggests that women did experience high levels of collaboration with respect to the co-development of the plan. Qualitative comments that accompanied the numerical data likewise suggest that women found the plans (i.e., the product of the collaboration) to be useful.

> I always got guidance in the plan. I will always have the plan.
>
> You helped me understand what I need to do.
>
> This really helped me. I have a plan. I know what to do.
>
> I feel I can do the list [i.e., plan] for myself.

Collaboration as Process –Several themes emerged with respect to "collaboration as process", that is, women felt they were mutual partners in the counselling sessions. First, there was a noted dovetailing between women's experiences of having a voice in the session (i.e., the women as active agents in the session) and their experiences of being heard (i.e., the counsellor as active agent). These matching activities of speaking and listening can be seen in the following quotations, which fit together like puzzle pieces.



"Talking helped a lot." "Thanks for listening."

Second, women spoke positively about engaging with counsellors in a mutual process of digging for and discovering the next steps. For example, one woman commented, "You helped me understand what I needed to do." Another said, "It was so nice to have a professional help me work through my thoughts." It is evident from these quotations that the women saw themselves as active participants in the process. The counsellors helped facilitate the "working through" but the women did the work.

D. Outcomes Related to the Therapeutic Model

OUTCOME # 8 - Therapeutic Model Met the Immediate Mental Health Needs of the Women Served

As indicated above, the therapeutic model used at the drop-in clinic was specifically designed for the program. It had three aspects, 1) theoretical foundations (a single-session approach that combined aspects of narrative and feminist therapies with trauma-informed practice), 2) the mapping of service delivery processes, and 3) the embedment of the drop-in clinic within the broader service program at the Women's Centre. All three aspects had connection as the primary focus. We hoped the model would not only lead to the development of a positive therapeutic alliance (i.e., connection between the woman and her counsellor) but also that women would feel connected to the counselling team as a whole and more broadly to the Women's Centre itself. Data pertaining to the usefulness of the model was derived from the post-service interviews conducted with each member of the counselling team. Although It wasn't always possible to link the findings to each of the three aspects of the model, some common themes did emerge.

1. Gaining Comfort and Competence in Using the Model takes Time

Members of the counselling team noted that it took time to get comfortable using the model, in part, because they needed to switch from the fast-paced, "fix-it" approach characteristic of other aspects of their jobs. As Jenny explains, learning a new approach can leave one feeling vulnerable and awkward.

> I really thought the model was brilliant. It made sense and it was wonderful to watch it unfold as the counsellors, the intake workers and me, as we all became more and more confident. You start being really vulnerable, because you are working in a new way with folks and then week after week it was like, this is working, you know? It is happening. We were nervous but we did it, and it worked.

Part of the awkwardness, as Jenny goes on to explain, was related to moving from the familiar to the unfamiliar, in many ways a parallel process to what women experienced within the session itself.

> At first it wasn't comfortable. It was speaking in a new language. It was giving up the way of always doing something, and it would feel really strange and slightly vulnerable and awkward to ask women, "So what's your hope for the day?" We had to do that quite a few times before we realized that the women we were seeing quite liked the question. So there was a real awkwardness with the new way of engaging with women, a new set of questions, just a whole new way. It was really awkward but then it became comfortable and it made sense.

Dana also spoke about the model not being "easy" at first, but eventually getting to a point where it "clicked". She attributed aspects of the model, specifically taking a non-expert stance and the externalization of the problem to creating the "magic".

> I am so proud of this model. It has been the vehicle by which as a counsellor I am able to remain with a woman inside of what she needs and I say that because in the beginning it wasn't easy to step away from the fixing piece . . . but there came a point where it just clicked, I guess. And the clicking is about the person being the person and the problem being the problem. And when you can continuously ask questions using that lens, something magical happens really quickly.

Although difficult to do at first, like Dana, Sheila perceived taking a non-expert stance as contributing to the model's effectiveness.

> In the beginning, and I guess this tells you how much I have grown, I really sucked. I wasn't getting anywhere. But I was concentrating on getting somewhere. I realized after the fact what I had been doing. I had a set of rules for myself. . . and the ship wasn't steering in the direction I was putting it. But the problem was I shouldn't have been steering the ship. After I figured that out, it got much easier because it wasn't about me going anywhere.

2. Postmodern Techniques as the Gateway to Feminist Practice

In the quotations above, Jenny, Dana and Sheila reference specific aspects of the model they found to be effective, specifically asking women about their hope of the day, taking a non-expert stance and the externalisation of the problem. These aspects are typically associated with postmodern approaches to therapy and more specifically to single session and narrative treatment modalities, two of the constituents of the model used at the clinic. Interestingly, these techniques seemed to serve as the gateway to a third constituent of the model, that of feminist practice. As Dana explains, by externalizing the problem, she "had a better capacity to resist the influence of society that was showing up in the woman's conversation". By engaging in a feminist approach Dana was able to make connections between a woman's experiences and the woman's political and social contexts. She could then challenge the woman to consider the ways in which the dominant social narratives negatively shaped her self-understandings and constrained her problem-solving abilities. In the quotation below, Dana describes how the externalization of a diagnosis of anxiety created openings to critique negative societal influences on the woman's self-understandings and ultimately opened up conversations of resistance.

> I think once I got comfortable with the model I had a better capacity to resist the influence of society that was showing up in women's conversations in the "buts". Women would say, "But I do have this problem [e.g., anxiety]. It is mine. I have it. The doctor told me. This one told me. That one told me". So I would say, "Yes the experts tell us that you have a problem. And this [anxiety] is the problem, which you now wish for us to talk about in session." I think as I became more comfortable in the model, I could say things that would change that perspective. I wouldn't critique why

> they came. I would say, "Like your doctor told you, your anxiety is bad, and it does this to you and it does that to you". I don't downplay that. But then I get really curious and I say, "But what does anxiety really get up to in your life? How do you want to kick it to the curb? Why are you here today? What is that about? What is anxiety up to in your life that you are really tired of?" What I found really fantastic was that [after these externalizations] I could lens what society was up to. . . I could ask, "How is anxiety affecting your world? How is it affecting who you want to be?" and then there was another piece of "What does the world expect of you?" Based on this problem [of anxiety] what do you think is really going on?" Working from a feminist lens enabled me to bring all that in and let it live in the room. I didn't need to be neutral about that, which was really powerful. I think the model is fantastic.

Sheila drew the connection between taking a non-expert stance and the feminist perspective.

> I really liked the model . . . I think the thing I loved the most was just having some perspective on feminism. Women can easily show up and think that the situation they are involved in, an abusive relationship or the questions about "why me?" stuff, is because they are a target but they don't see that as women they have been placed there a long time ago. Just getting that perspective really helped women. I didn't have to belabour it but being able to make that connection for women, to help them see their place in the world, I found that to be very helpful and very strengthening for woman. . . it was this awakening almost of realizing it is not just them individually . . . I loved that part of it. I loved being able to bear witness to women's stories. It fit so well!

3. Connections Extend the Usefulness of the Single Session

As mentioned in other areas of this report, women indicated they felt a connection not only to the single session counsellor but to the counselling team as a whole and even more broadly to the Women's Centre itself. We know that these feelings of connection extended the usefulness of the single session. The model facilitated these broader connections in several ways. First, every woman coming to the drop-in clinic would interact with a minimum of three members of the counselling team: the receptionist, an intake worker and the single session counsellor. Second, when applicable intake workers and the single session counsellors would introduce women to other programs within the Women's Centre, either as part of service negotiation services or as part of the end of session plan. That the model facilitated these connections was seen as a strength and was credited to the model's third aspect, the embedment of the drop-in clinic within the broader service program at the Women's Centre. For example, in reference to a woman's comment in her post-service interview that she felt she related to the team rather than just one person Natasha noted,

> I like that she said that about the team because that is something I found really positive about having the clinic at the Women's Centre . . . we seem to cover almost all the possible needs of the women walking in to the place. It is like a one stop shop. That is what I love about the Women's Centre right now. It is a one stop shop. . . I

> think that is what really helped the drop-in clinic to be successful. They have all these different avenues to get support while they are here.

4. Process of Service Delivery Allowed for a Consistent Honouring of Women's Voices

Several members of the counselling team referenced the process of service delivery indicating it ran smoothly. As Natasha noted,

> In terms of the overall process from intake to the counselling session to the evaluation flowed very well. It worked nicely. . . Overall, I think when you honour women's stories, when you bring the intake and the single session together as one, you have a smooth process. Very, very few hiccups.

In the quotation above, Natasha associates the "smooth process" with the consistent honouring of women's stories that began in intake and extended into the counselling session. Similar to Jenny and Dana's comments presented under Section 7a above, Natasha indicates that learning to listen in a new way took time.

> When we were first getting a feel for this model, I found it hard to cut a woman off and stick to the questions [on the *Intake Form*] because I was trying to honour the story. Some women came in and they were in the midst of a crisis and I needed to do a mini-crisis intervention with them. . . I found I was listening with my Women's Centre ear and not my single-session ear. It took me a good month or two to really be able to get a feel for the flow and to have a woman spill her guts for 15 minutes and transition that into an intake and transition that into a drop-in counselling session.

For Natasha, working within the model necessitated the use of two seemingly incompatible approaches. On the one hand, she needed to be directive, guiding a woman's conversation so as to assess her suitability for single session counselling, prepare her for the session and begin the focusing process (referred to in Section 5b above). On the other hand, she sought to honour the woman's story, which was a seemingly non-directive process. Ironically, it seemed that the non-directive honouring of the woman's story provided greater continuity between intake and the counselling session and smoother service process than the accurate repetition of the content of the story itself (i.e., from the intake worker to the counsellor).

5. Embedment of the Clinic into a Broader Service Compliment Allowed for Greater Service Responsiveness

Part of deep listening meant that at times counsellors needed to adjust their approach to accommodate to the needs and intentions of the women seeking service. Fortunately, the model was able to support this flexibility. As Sheila explains, the model could be altered in response to women's needs rather than women having to shape their concerns to fit within a model.

> For the most part, [every session] had a beginning, middle and end. That was all stated upfront so there were no surprises. If it turned out to be anything different, we were able to step out and pull someone different in, if [for example] it came to a crisis situation, you know? That was the beauty of having it here [at the Women's Centre] and our model allowed us to do that. We tried to stick within what the pure single session was all about but we weren't rigid. I like that we followed it, but we weren't rigid, which I thought was wonderful. We could flow in and out a little bit, but the model was the guiding factor. We had room to play, which was neat. I don't think there is as much room to play in other [service] areas, but there is here [at the Women's Centre].

Unfortunately, through the course of conducting the program evaluation we discovered that with traditional mental health services, women often feel they have to shoehorn their needs into a particular model or service, just to receive help. For example, we discovered that some women were on the waitlist for a trauma support group when they hadn't experienced trauma but it was the only service available that came close to addressing their concerns. Likewise, women were waiting to see a psychiatrist when a less intrusive option may have been better but was unfortunately unavailable. That the model could be refined in response to women's unique needs was identified as a strength.

6. Voice

The narrative aspects of the model allowed for primacy to be placed on women's voices. Sheila associated deep listening and being "fully present" as useful elements of the model. She explains,

> You could see the impact in the room, if nothing else. Lots of times we don't know what happens afterwards, but just being fully present in the room with someone and being that sounding board, being a curious person and being interested in their lives and wondering, "Where does that [idea] come from?" and "How did you do that?" In asking questions that way women felt immediately that they had a place, someone was interested and curious about their lives, no matter what their struggles have been. By being listened to, it felt like they mattered. I mean how often did women say that the most important thing was just being heard?

E. Outcomes for the University

OUTCOME # 9 - Social Work Students Advance Skills (Clinical, Program Development, and Research)

Over the course of the project three students were directly involved in program development, program evaluation and program delivery.

1. Dana Warren

In 2015, using *Quick Start Funds* from Memorial's Office of Public Engagement, Dana Warren, a Bachelor of Social Work Student was hired as a Research Assistant (RA). As a mature student with counselling experience, Dana was a valuable RA. She conducted a preliminary literature review on single session counselling models, and trauma-informed, feminist and narrative therapies and she helped prepare for and she participated in the ½ day consultation between key management and staff of the SJSWC/WC and the School of Social Work. This meeting served as the culmination of the work funded by the *Quick Start Fund.* The purpose of the meeting was to 1) identify and understand the unique counselling needs of the women who utilized existing services at the Women's Centre, and 2) to explore options for collaboration in the design implementation and evaluation of a drop-in counselling service.

When *Accelerator Funds* from Memorial's Office of Public Engagement were secured in 2016, Dana was again hired as an RA. She assisted in the design of the theoretical model that was used in the RHRN Drop-In Counselling Clinic and she helped design the logic model and data collection tools that were used in the Outcome Program Evaluation. Using *Accelerator Funds*, Dana was one of four individuals who went to Laurier University in May 2016 to receive training in *Brief Single Session Walk-In Therapy* with Scot Cooper, RP.

In the fall of 2016, Dana graduated with her Bachelor in Social Work degree and thus could no longer work as an RA with the project. However, given her counselling experience, training in single-session therapy, and her familiarity with the project, Jenny Wright the Executive Director of the Women's Centre hired Dana to be one of the counsellors on the counselling team. Dana proved to be an excellent choice. She exercised leadership on the team and in her passion for learning and willingness to be vulnerable herself, inspired others to take risks and turn every session into a learning opportunity. Of the members on the clinical team, Dana was most familiar with the model and as such was able to guide and support the team in model application.

Dana also contributed in knowledge mobilization. On October 14, 2016, she was a co-presenter (with Jenny Wright and me) at a continuing education event at the School of Social Work (see Appendix G). In November 2016, she joined Jenny Wright and me in being interviewed by Barb Sweet, the resulting article appeared in November 8th edition of *The Telegram* (see Appendix L). In January 2017, she co-authored an article with me that appeared in *Connecting Voices*, the official publication of the Newfoundland and Labrador Association of Social Workers (see Appendix M). Finally, in May 2017, Dana and I co-presented (peer -reviewed) at the annual conference for the Canadian Association of Social Worker Educators (Appendix K).

That the RHRN Drop-in Counselling initiative enabled a highly competent Bachelor of Social Work student and RA to not only become immediately employed post-graduation but also serve as a valued and integral member of the counselling team confirms that, with respect to Dana Warren the outcome pertaining to the advancement of social work students' skills was achieved.

2. Sharon Samson

From September 2016 to May 2017, Sharon completed her Master of Social Work field internship with the drop-in counselling clinic. The joint supervision she received from Jenny Wright and me, worked well in that our unique skill sets and areas of expertise broadened Sharon's experience. In addition, the joint supervision emulated the partnership between the WC and the School of Social Work and was suggestive of how social work students' experiences can be enriched through community and university collaboration.

Over the course of Sharon's internship she moved from observing the intake process, to conducting intake sessions, and by mid-term, to conducting counselling sessions. Her involvement on the team likewise evolved. Using her own words, Sharon began by observing and "sucking up knowledge" and then moved into actively participating in the knowledge and skill development of the team.

As evidence of the advancement of Sharon's skills, a section of her final MSW Field Internship (cited here with Sharon's permission) is included below.

> The quality of Sharon's work was exemplary. She approached every aspect of the internship wanting to learn, participate, and experience whatever she could. She was prepared to step out of her comfort zone and often did. Most importantly, Sharon was "useful" – a word we talked a lot about over the [duration of the pilot project]. We wanted to develop a counselling program that was useful to women. In the session feedback forms and post-service evaluations we know that Sharon's work was effective. We can say with intuitive and statistical certainty that the women Sharon interacted with were well-served.

3. Nicole Boggan

Nicole was hired as an RA in April 2017 using the *Accelerator Funds.* Nicole was involved with the Program Evaluation in designing spread sheets, entering data and conducting some preliminary analysis. Her involvement with the qualitative analysis was critical to improving inter rater reliability. Nicole's organizational skills and quick mind proved to be an incredible asset to the overall evaluation.

The RHRH Drop-In Counselling Initiative afforded other students, not directly involved in the project, to likewise advance their knowledge and skills. The two public training events associated with the project (see below) were open to and attended by students.

OUTCOME # 10 - School of Social Work Increases their Ability to Offer Timely and Responsive Training Opportunities in the Community

The RHRN Drop-In Counselling Initiative enabled the School of Social Work to increase its ability to provide timely and responsive training in two ways: 1) by engaging select faculty in providing specific training to the RHRN counselling team, and 2) by organizing two public training events, open to both the counselling team and the community at large. With respect to training specific to the team, Dr. Heather Hair, lead a ½ day of training on brief therapy on September 16, 2016 and I lead a training session on the use of scaling questions within single session therapy on February 14, 2016. Prior to the six-month pilot, I also provided training to the team on the therapeutic model designed for the RHRN Clinic. It should also be noted that the *Accelerator Funding* from Memorial's Office of Public Engagement enabled three members of the counselling team (Jenny, Dana and myself) to go to Laurier University in May 2016 to receive training in *Brief Single Session Walk-In Therapy* with Scot Cooper, RP.

In the 2016-2017 academic year, the Continuing Education Committee at the School of Social Work offered two public training events that were directly linked to the RHRN Drop-In Counselling Initiative. The first was a Lunch-and-Learn held on October 14, 2016 (see Appendix G) and the second, *Brief Single Session Walk- in Counselling Training* led by Scot Cooper, RP (see Appendix I) was held on May 25 and 26, 2017. This second event was identical training to what the team had received in May 2016 (see above) but instead of going to Laurier University, we brought the training to Memorial. Each event was noteworthy. The Lunch-and-Learn had the highest attendance (21 attendees) of any lunch-and-learn in recent history. The Scot Cooper training was significant in that it represented the first formal partnership between the Continuing Education Committee at the School of Social Work and a community agency in training delivery. Comprehensive summaries of the participant evaluations of each public training event are included below.

1. Event # 1 - Right Here, Right Now: Continuing Education Session

Twenty-one participants attended the Right Here, Right Now: Continuing Education Session held on October 14, 2016. A copy of the evaluation form completed by participants can be found in Appendix H. The results from the evaluation can be found in Table 12.

Table 12: Summary of Quantitative Portion of Participant Evaluations
"Right Here, Right Now" Continuing Education Session

	Excellent	Good	Fair	Poor
Overall Session	19 (91%)	2 (9%)	0 (0%)	0 (0%)
Content of the Topic	20 (95%	1 (5%)	0 (0%)	0 (0%)
Organization of the Material	16 (76%)	5 (24%)	0 (0%)	0 (0%)
Usefulness of the Information	20 (95%)	1 (5%)	0 (0%)	0 (0%)
Method of Delivery	17 (81%)	4 (19%)	0 (0%)	0 (0%)
Knowledge of the Presenters	20 (95%)	1 (5%)	0 (0%)	0 (0%)
	Strongly Agree	**Agree**	**Disagree**	**Strongly Disagree**
I will Use the Information Gained Today	17 (81%)	4 (19%)	0 (0%)	0 (0%)
I Would Attend Future Continuing Education Sessions like Today's Session	16 (76%)	5 (24%)	0 (0%)	0 (0%)
There are Ample Training and Development Opportunities at Memorial's School of Social Work	1 (5%)	9 (42.5%)	10 (47.5%)	1 (5%)

The above table reveals that all 21 participants who attended the event ranked the presentation as either excellent or good in all categories. The categories that received the highest grades pertained to the quality of session overall, the content of the session, usefulness of the session and the knowledge of the presenters. Also noteworthy, 17 of the 21 participants (81%) indicated they "strongly agreed" and the remaining 4 "agreed" they would use the information they gained by attending the lunch-and-learn session. These statistics speak to the relevance and timeliness of the session.

The statistics pertaining to training and development opportunities at the School of Social Work were also revealing. Eleven participants (52%) indicated they "disagreed" or "strongly disagreed" with the statement that the School of Social Work was providing ample training opportunities. This statistic may speak to need of the School to continue its efforts to offer training opportunities that are both timely and responsive. Qualitative data from the participant evaluation forms offered some insight into what topics participants would like to see covered in the future. Of the nine participants who answered the question, 4 (45%) wanted to have a follow-up training session about the RHRN Drop-In Counselling Clinic.

2. Event # 2 - Brief Single Session Walk-In Therapy by Scot Cooper

Twenty-eight participants attended the *Brief Single Session Walk-In Therapy* workshop offered by Scot Cooper on May 25 and 26, 2017. A copy of the evaluation form completed by

participants can be found in Appendix J. The results of the evaluation can be found in Table 13.

Table 13: Summary of Quantitative Portion of Participant Evaluations "Brief Single Session Walk-In Therapy" by Scot Cooper

	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
Outcomes of the session were Clear	18 (64.3%)	9 (32.2%)	1 (3.5%)	0	0
Pace of the Presentation was Appropriate	19 (68%)	9 (32%)	0	0	0
Depth of the Content was Appropriate	20 (71.5%)	7 (25%)	1 (3.5%)	0	0
Ideas from the Session will be Useful to Me	21 (75%)	7 (25%)	0	0	0
Participation was a worthwhile use of my Time	22 (78.5%)	6 (21.5%)	0	0	0

The question pertaining to whether the ideas from the session would be useful, best speaks to Outcome # 10, that the School of Social Work increase its ability to provide timely and responsive training opportunities. As the above table reveals, 21 of the 28 participants (75%), "strongly agreed" and the remaining 7 participants (25%) "agreed" the session would prove useful. That the topic was both timely and responsive is further supported by the qualitative remarks on the evaluation form. Of the 27 out of 28 participants who included qualitative remarks, 9 (33%) indicted the session would have an immediate and positive impact on their current work, 8 (29.5%) credited the content as being particularly helpful, 7 (26%) felt they left with better skills. (Note these three categories are not mutually exclusive). Twelve of the 27 participants made reference to Scot Cooper's teaching strategies as being particularly effective. For example, 4 valued Scot's inclusion of videos, 3 the use of practice examples, 2, the group discussions, 2 the role plays, and 1 his modelling of the skills.

Another indicator of the timeliness and relevance of Scot Cooper's training, can be found in participant comments about what continuing education events they would like the School of Social Work to offer in the future. Of the 27 participants who included qualitative remarks, 15 (55.5%) hoped the School would offer more events on single-session counselling (SST). Of these 15 participants, 6 specified the sessions be on trauma-informed SST, 4 on crisis work and SST, 2 on narrative SST, and 3 did not specify. In addition, 6 participants indicated they would like future sessions on trauma-informed counselling in general and it need not necessarily be on trauma-informed SST, and 1 hoped for a future session on crisis work, again not necessarily SST crisis work. One could conclude from these remarks that not only did participants find the training useful, over ½ would like to see more of it in the future.

OUTCOME # 11 - Connections between the School of Social Work and the Professional Social Work Community are Strengthened

There are several ways in which the RHRN counselling initiative improved connections between the School of Social Work and the professional social work community. Several have been referenced above, so further elaboration is not required. These include:

- Funding through Memorial's Office of Public Engagement supported the partnership between the School of Social Work and the SJSWC/WC,
- The School of Social Work engaged key management and front-line staff at the SJSWC/WC in designing a practice model specific to community need,
- Two Faculty members at the School of Social Work provided training to the RHRN Drop-In counselling team,
- The Continuing Education Committee at the School of Social Work partnered with the SJSWC/WC in offering training that was open to mental health professionals within the broader community,
- The School of Social Work enabled a Master of Social Work student to complete her field internship at the RHRN Drop-In Counselling Clinic, and
- Faculty and Bachelor of Social Work Research Assistants (2) completed the Outcome Program Evaluation.

In addition, the knowledge and experiences gained by the RHRN Counselling team was shared in professional and academic venues. Dana Warren and I wrote an article for *Connecting Voices,* the official publication of the Newfoundland and Labrador Association of Social Workers (see Appendix M) and we co-presented (peer -reviewed) at the annual conference for the Canadian Association of Social Worker Educators (see Appendix K).

It should be noted, however, that there were also some barriers that made the connection between the School and the professional social work community difficult. For example, the School of Social Work was not an equal partner in promoting the RHRN Drop-In Counselling Clinic nor did they share consistent messaging with the SJSWC/WC. Also the nature of the Master in Social Work program will make a part-time internship, (i.e., two days per week) impossible for most students. This draws into question the feasibility of MSW students availing themselves of this opportunity in the future. Lastly, the Continuing Education Committee at the School of Social Work, as yet has not established any protocols that would either enable them to form future partnerships with community agencies in training delivery or in general, enable them to respond to community training needs in a timely manner.

IV. Recommendations

Given the success of the six-month drop-in counselling pilot and the overall strength of the findings of the Program Evaluation, it is recommended that:

1. The Women's Centre continues to offer a drop-in counselling clinic at current capacity (10 sessions per week),
2. The Women's Centre develops a plan for the expansion of the drop-in clinic in the event numbers increase,
3. The Women's Centre maintains its positive relationships with community partners, such as Eastern Health, Iris Kirby House, and the School of Social Work in an effort to share costs, staffing, and the work load of running the drop-in clinic;
4. The Women's Centre continues its efforts to promote the clinic using social media, which has proven successful and increases its efforts to promote the clinic to mental health professionals, physicians and community partners, who could then refer women to the clinic;
5. To prevent model drift and maintain the cohesiveness of the counselling team, a brief team meeting at the beginning of each counselling day and a debriefing session at the end of the day be re-established and "Single Session School" be reinstated;
6. For the counselling team, efforts are renewed to separate their drop-in clinic work from their other responsibilities at the Women's Centre; and
7. The role of the supervisor and the process of supervision be revisited, specifically efforts are made to have supervision align with the theoretical foundations of the model and its underlying assumptions.

V. Conclusions

The six-month pilot of the Right Here, Right Now Counselling Clinic was a success. There was considerable service uptake that remained constant throughout the six months. Women who utilized the service found it useful, many of whom returned for repeat sessions or to engage in other programs offered by the Women's Centre. Members of the counselling team were invigorated by their involvement in the service and in their increased capacity to be useful to women with mental health concerns. The drop-in counselling service provided a necessary stopgap for women awaiting more traditional mental health services within the Region. The therapeutic model designed for the clinic was effective. The model enabled women to have a voice and counsellors to listen deeply. The emphasis placed on training, reflective practice and peer support will enable the drop-in counselling clinic to remain useful, relevant and responsive to women's mental health needs in the community.

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