



*Quality assurance at the walk-in clinic:
Process, outcome, and learning*

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With the emergence of walk-in counselling clinics throughout Ontario, Canada, the need for a measure of quality assurance and outcome has never been greater. This paper will share a post-session questionnaire for use at walk-in counselling clinics congruent with a brief narrative approach that serves to assess quality and outcome, and also further serves as a learning tool for clinicians.

Keywords: Brief narrative therapy, walk-in clinic, outcome and process

With the emergence of walk-in counselling clinics throughout Canada, there is an important call to develop outcome and quality assurance measures relevant to time- constrained single session service delivery models. Typical psychotherapy outcome measures take an extended view to measure the short and long-term goals of a program. Given the single session nature of walk-in clinics often there is not the luxury of time, continued contact, or staffing to elicit data other than immediately following the session. Longer-term outcome studies, when employed at walk-in clinics, are often achieved through funding grants, volunteer services, or as funded research studies. For most children's mental health clinics, similar to the one at which I work¹, the use of three and six month or one year outcome evaluations of the walk-in session is not a possibility. There is a 'lack of resources available for quality assurance and evaluation to measure and monitor program effectiveness and outcomes' (Children's Mental Health Ontario, 2013, p. 6). Base funding does not cover such initiatives and it is challenging to organise the necessary teams to apply for research funding. While many clinics utilise immediate post-session questioning to focus on determining whether people found the session helpful or had experiences such as friendly staff or easy access, these measures tell us little about people's experience of the conversation itself (quality assurance) and contribute little to the skill development of the therapist.

BRIEF NARRATIVE THERAPY

Narrative therapy is used at many walk-in clinics throughout the province of Ontario and is cited as used more often at walk-in clinics than a cognitive behavioural therapy approach (Duvall, Young & Kays-Burden, 2012). This brief narrative therapy is not a hurried therapy but rather complete and in harmony with the practices and ethics of longer-term narrative therapeutic practice. Brief narrative conversations can involve re-authoring conversations assisting people to identify and link the initiatives of their lives into stories in the making more fitting with their preferences for life and identity. Conversations can provide a venue for people to become more acquainted with, and share, their skills for living and wisdom associated with subordinate storylines. Conversations can also quickly begin the deconstruction of the taken-for-granted ideas or limiting discourses assisting people to develop a revised position on a problem, or further develop counter-practices to the oppression of problems. All these paths, as White (2006, 2007, 2011) has noted, provide the context in which people can begin to distance from the known and familiar of their lives in order to begin to move towards their preferences. When the material of these conversations is brought into proposals for action, the therapy stretches beyond the single contact and can prove quite useful to the people consulting to us.

Informed by brief narrative intention, a walk-in clinic organisational culture is fostered at the walk-in clinic that:

- Recognises the importance of how meaning is socially and relationally shaped and affects how people respond to the world.
- Employs practices that support the development of personal agency (a person's sense that they can do something about the problem) and increased options for proceeding (a person's sense of knowing what to do about the problem).

- Privileges insider knowledge (know-how) in that what the participants bring with them to the process is more richly described and utilised in addressing the concern, or in moving life towards their preferred direction.
- Is continually shaped by participant feedback throughout the conversation. This includes the practice of critical reflection (Fook, 2002), subjecting our practices to a critical gaze as a means to add to our practice experience.
- Collaborates in developing plans and next steps. These are co-developed and co-shaped building primarily upon participants' own knowledge and experiences.
- Serves to provide ways in which the conversation can be sustained following the visit such as through developing plans and next steps that are culturally and contextually relevant and archived in 'take-home documents' for people to review afterwards.

WHAT IS A SUCCESSFUL WALK-IN SESSION?

In examining outcomes we need to give consideration to how we define a 'successful' brief narrative single session. Brief narrative walk-in single session therapy is not a form of triage but rather a generative therapy in which meanings may find revision and next steps for addressing circumstances are co-developed with a plan for practice in the real world. The therapeutic task is to provide scaffolding to assist people to incrementally distance themselves from the known and familiar of their lives (White, 2011). At times, this may involve traversing quite a significant distance as people come to know themselves differently, develop a revised position towards the problem, or become more thoroughly acquainted with an alternate storyline with clear next steps in that unfolding narrative. At other times the distance travelled in the conversation may be smaller and reflect the beginnings of the development of a 'story in the making'². However brief, these narrative conversations also place an emphasis on considering how our practices may affect people in the real world (White 2011; Malinen, Cooper & Thomas, 2012). The measure then of a successful brief narrative single session is two fold:

- 1) Does the feedback of participants reflect that the conversation was useful, provided ideas about next steps, and left them with a sense of hope? (In other words, were the participants able to traverse the distance between the known and familiar of their lives towards what was previously not known?)
- 2) Was the experience of therapy in harmony with narrative relational ethics?

Given this, in examining brief narrative single session therapy we must examine the processes of the therapy in conjunction with outcomes.

PROCESS AS OUTCOME

The process of a therapeutic encounter '... includes everything that transpires between and within the participants when they are actually or virtually in each other's presence' (Orlinsky,

Rønnestad & Willutzki, 2004, p. 311). Narrative practice places an emphasis on attention to the process of therapy (how we do what we do together) alongside the outcomes of the therapeutic encounter (the effects and usefulness of what we do together). The single session time-constrained context of a walk-in clinic places great responsibility on the therapist to respect the relational ethics of narrative therapy given there may not be an opportunity to address any mishap through future follow-up.

In considering outcomes, admittedly there is no perfect therapy. Data suggesting positive outcomes in relation to a certain problem does not necessarily mean we have been exempt from facilitating a process that has been hazardous, flawed or incongruent with our intentions. From a narrative practice perspective, the process of therapy may be hazardous if it involves colonising practices, replicating the politics of culture/gender or heterosexual dominance, centres the therapist's agenda, participates in normalising judgement, privileges outsider knowledges, or obscures a person's sense of personal agency, just to name a few³. As a brief narrative therapist, resisting these sorts of acts of power is important to me.

Orlinsky et al. (2004) highlight the '... interrelations of various process facets with one another and ultimately with outcome' (p. 320). This notion relating process to outcome is relevant to efforts to develop quality assurance and outcome measures for walk-in single session therapy encounters. Resisting a process/outcome distinction and considering the time constraint of brief narrative single session therapy, how the person consulting us experiences the conversation provides the foundation for, and is intimately connected to, the outcome of the session. A measure of a single session is most useful when it provides information about the person's experience of the process as that is what's indicative of outcome in such time-constrained circumstances.

THERAPIST ACCOUNTABILITY AND LEARNING

Madsen points out that, '... what we attempt to measure and how we attempt to measure it have effects on clients, workers, and therapeutic relationships' (Madsen, 2007, p. 345). Indeed this is a point I wish to emphasise. Madsen also notes, 'such questions subtly organise our interactions with families' (Madsen, 2007, p. 350). The questions we ask in a post-session questionnaire, together with the responses to those questions, will shape the future practices of the therapist. They serve to orient the therapist to the execution of certain micro-skills and ways of practicing that are preferred or in harmony with specific practice ethics. Given this, post-session questionnaires can provide a learning tool for the therapist alongside data related to quality and outcome. The therapist can study the feedback as comment on their execution of the therapy process, thereby assisting them to learn from each encounter.

This provides a structure for critical reflection: '... an approach of subjecting our practice to a more critical gaze, at the same time allowing us to integrate our theory and practice in creative and complex ways' (Fook, 2002, p. 39). A critical reflection process '... serves to uncover power relations, and how structures of domination are created and maintained' (Fook, 2002, p. 41). This is a crucial practice in single session work as single session therapy absent of the scrutiny of process may unknowingly be

showing promising outcomes but achieving those outcomes through hazardous misuses of power, influence, or hierarchy.

DEVELOPING A QUESTIONNAIRE

In developing a post-session questionnaire I have gathered and crafted questions that provide feedback related to people's experience of a brief narrative conversation that also assists to shape the therapist's learning. I am looking at outcome, as much as it may be available following a single session of brief narrative therapy, but also the process of the therapy itself.

A collaborative ethnographic approach

The questionnaire is not intended to be a traditional research tool subject to multiple trials seeking reliability or validity for strict adherence in employment by agencies and private practitioners to justify outcomes to funders and policy makers. My project is much more of a 'collaborative ethnographic' (Lassiter, 2005) study. In part, the aim is to generate a cultural understanding of the session. I am seeking the 'insider's point of view' and an understanding of the experiences generated in the culture of brief narrative single session therapy. What emerges are comments on categories of practice. The participants' experiences of the conversation become more available for critical reflection by the therapist. This subjective sharing then holds the therapist accountable for the part they play in that ethnography.

Post-session questionnaires

'An array of process elements have been identified by therapy theorists and researchers ...' (McLeod, 1997, p. 107). The work of Barry Duncan, and Scott Miller over the past 15 years (Duncan, Miller & Sparks, 2004; Duncan & Miller 2000) has taken an empirically based quantitative approach utilising post-session questioning to elicit information from participants to shape therapist practices in future sessions.

Duncan and Miller developed the Session Rating Scale (SRS), a simple post-session feedback questionnaire completed by people eliciting their rating along a continuum of criteria including experience of acceptance, liking/positive regard, understanding, therapist honesty and sincerity, agreement on goals, agreement on tasks, smoothness of the session, depth, helpful/usefulness, and lastly hope (Duncan & Miller, 2000, p. 239). These elements orient us to pay attention to how the person may have experienced the process of the session and practices employed by the therapist. Their focus on the person's experience of the therapy and how that information could not only shape the therapy but also assist therapists in adjusting their practice opens important possibilities for assessing brief narrative single session therapy. Similar post-session rating based on a continuum has also been used in the Session Evaluation Questionnaire by William Stiles (2002), designed to measure post-session the value and comfort of a session of psychotherapy.

In Bill Madsen's review of measures in collaborative therapy (Madsen, 2007, p. 350), he proposes several questions eliciting participants' input that align more closely with my brief narrative practice intentions than the Session Rating Scale elements and phrasing. He proposes questions seeking feedback about therapists' efforts to understand the uniqueness of the person's life and what was the extent to which their 'abilities, skills and

wisdom were acknowledged' (Madsen, 2007 p. 350). Further questions seek to learn to what extent participants felt they were active participants in the work, asking about their experience of a collaborative process.

Where this meets my narrative ethics is in highlighting the processes with which desirable outcomes in therapy are achieved. Answers to these questions hold me accountable to those processes and how I go about doing therapy with people where the stakes are high given there is often no opportunity for apology or repair in future contacts.

The SSIFT

Adapting a post-session rating format (Duncan et al. 2000, 2004, Stiles 2002) and expanding upon Madsen's questioning, I have crafted the Single Session Impressions and Feedback Tool (SSIFT), a tool to elicit process/outcome information about brief narrative walk-in clinic conversations (see Appendix 1). As an acronym, the SSIFT lives up to its name assisting us to sort through the complexity of a single session conversation to elicit the participants' experiences. This is a post-session questionnaire that looks at outcome as intimately linked to and influenced by process. The questionnaire seeks the perspective of participants, aged 11 and older, immediately following the session, and is administered by the walk-in clinic receptionist. The SSIFT includes 8 contrasting items along a 7 point scale. One supplement question requires a written response. This tries to provide a balance to the control over the content to which attention is paid. Given that we have structured the initial questions, the content of those initial questions is controlled. Questions calling for a written descriptive response offer control over the content back to the participant.

QUESTIONNAIRE CRITERIA

There are many criteria that could be examined in a questionnaire, however, I want to examine those that are in line with my brief narrative practice, and that will assist in my skill development, as well as hold me accountable to my practice ethics. The following are criteria suggestions along those lines.

FOCUS

Brief narrative therapy is not a therapy in which goals are developed and pursued throughout the conversation as in other traditions of therapy. As a brief narrative conversation is a re-authoring conversation, or a conversation that provides the opportunity for people to more richly describe some of their skills for living and knowledges of life connected to alternate stories, the metaphor of 'exploring conversational territory' (White, 2007) is a better fit than goal pursuit. Together with the participants, I do however want to share in outlining the conversational territory for the limited time we have together. Early on in the conversation we discuss what would be most important to talk about to ensure the conversation remains as relevant as possible to the people consulting me.

Recognising conversational territory as opposed to employing practices of goal pursuit provides the freedom to explore less voiced alternate stories while maintaining a coherent process. Asking participants to rate 'Focus' as a priority on the questionnaire holds the therapist to a practice ethic to ensure the conversational territory of the conversation has remained relevant to the person consulting to us. We can ask people to discern on a continuum their experience of whether the conversation addressed what they wanted to talk about the most or seemed more focused on what the therapist wanted to discuss (Duncan et al. 2000). This is different from agreement on goals developed. Focus brings coherence to the conversation but allows for the conversation to explore many kinds of entry points to 'stories in the making' or on the margins of awareness.

INTEREST

I ask participants to provide a rating discerning between 'The conversation caught and held my interest' and 'The conversation interested me very little'. This consideration of 'interest' is not in the sense of entertainment value but rather a comment on questioning skills. The degree of interest caught and held in a session is a reflection of the therapists' ability to ask the kinds of questions that have people becoming curious about and interested in developing meanings and understandings about their life and identity. Hancock and Epston (2008) emphasise the learned craft and art of narrative inquiry. They discuss the art of crafting questions that 'intrigue, that work the mind, that touch the heart, and that render meanings that can orient people ... to new possibilities for change and development by making better use of insider knowledges' (p 491). Epston, sharing what makes a good question, stresses how they '... have a dramatic effect. They wake you up. They breathe life into you by revitalising and enspiriting all your senses' (in Hancock & Epston, 2008, p. 492). I strive to ask questions in this way, which stir interest about the more neglected territories of identity, future prospects for life, or invite deliberation about the significance of one's responses to life's difficulties.

Inquiring about 'interest' particularly assists my skill development when working with youth who may find many more things interesting than a walk-in conversation. In these conversations, I am challenged to find questions and '... ways of not disadvantaging youth' (Bird, 2004). This has led to the exploration of ways to bring poetics into my questions and take-home documents (Speedy, 2000), and ways, as David Epston has said, to 're-energize the narrative' in order to keep participants engaged.

YOUR SKILLS

Of great importance to a brief narrative walk-in process is the foregrounding of the skills, know-how and wisdom of the children, young people and adults who consult us. As a means to learn about how well I have performed that skill, I ask people to discern if the therapist learned about their skills, know-how and wisdom, or did not make that part of the process (Madsen, 2007).

Low ratings on this item inform us that we need to exercise our 'double listening' (White 2003) skills more, as well as our inquiry into what people bring to the process and how their knowledge can be used to address their concerns. This measure shapes our practice in orienting us to pay attention to ways that professional knowledge and local knowledge take up space in the conversation.

PARTNERSHIP

Partnership is an important aspect in our conversations. This refers to facilitating a process in which children and adults experience having a say and playing a part in contributing to outcomes. Attention to this skill pushes me to examine my de-centred influential posture (White & Morgan, 2006), and to scrutinise my ways of creating space for everyone's contribution, including young children. I give attention to practices that don't disadvantage children but rather engage them through art or play, or play-acting. I invite people to discern partnership, contrasting the experience of being an important partner in our work together on that day to feeling left out of the work (Madsen, 2007). Scrutiny of the ways in which I strive for partnership holds me to my relational ethic of striving to level the hierarchy.

FEEDBACK

Periodically throughout the conversation I will ask several questions seeking the person's feedback regarding

- a) how the conversation is going for them,
- b) if it has been useful to that point,
- c) what has or hasn't been useful,
- d) what stands out for them that we should talk more about, and
- f) whether I should be asking about a different topic.

This provides a means of shaping the conversation as it progresses and for checking if I am staying relevant to the expressed focus at the beginning of the meeting. Eliciting feedback invites accountability to the established project agreed upon at the outset and supports collaboration. Seeking feedback is an important therapist skill and I believe contributes to people's sense of feeling heard and understood. I invite people to contrast, 'Did your therapist ask for your feedback throughout the conversation' to, 'My therapist continued without checking in with me' (Duncan et al. 2000).

NEXT STEPS/PLANS

A priority in brief narrative work is to facilitate a process in which proposals for action and/or next steps become available for

people. This is in contrast to practices in which the therapist would provide advice, suggestions, recommendations, or interventions to the participant. My preference is for next steps and plans to come from the people consulting us as a means to guard against offering highly decontextualised ideas that may not be relevant to the person once they return to the context in which they live. This is important because in single session work there is a great risk that participants could experience disappointment in themselves if a prescribed task was not useful. A struggle to make changes despite carrying out recommendations could be storied as personal failure.

As a means to elicit feedback on this practice of co-developing or assisting people to come up with their own ideas, the questionnaire I have proposed asks people to distinguish between 'I played a large part in developing the plan and next steps', and 'I played no part in developing the plan and next steps'. Should they score their experience more towards not playing a part in developing the plan or next steps, it serves as an indicator to the therapist about the need for reflection. The therapist is invited to ask the following questions: What ways could I have invited the participants to come up with their own ideas? What might the possible effects be on their sense of personal agency when only I provide the ideas? What conversation could we have had that would provide for a rich well of ideas to turn into proposals for action after the session? Seeking answers to these questions has shaped my practice. It has particularly influenced my use of re-telling practices, and the crafting of questions that emerge from those sharings to assist people to re-contextualise the conversation into discernible proposals and next steps.

HOPE

For some time I have had a special interest in the concept of hope. I believe that the experience of hope plays a significant part in useful therapeutic conversations and that this significance has been under-represented in the literature. When I think about definitions of 'hope', I have been drawn to Snyder's hope equation (see Snyder, 1994). Simply, hope can be seen as a culmination of people's sense that they can do something about their concern (personal agency) and the formation of ideas about what to do about it (options for proceeding or pathways).

This representation aligns with my intent to facilitate brief narrative conversations that sponsor people's experience of personal agency as well as execute a process in which next steps are co-developed. For this reason, I have felt it important to ask after the session about people's sense of hope. Similar to Duncan and Miller (2000), I ask them to discern between 'I felt hopeful after the session', and 'I felt hopeless after the session'. Low scoring on hope cues me in two ways. First a low rating prompts me to check in with the participants to enquire about their sense of safety and if some safety planning needs to happen. Furthermore, a low rating invites me to reflect about the kinds of questions I could have asked that may have been experienced as fostering hope. This again is especially important in my context as I do not have the luxury of future sessions to address mishaps.

USEFULNESS

Finally I ask participants to indicate if they found the conversation useful, in contrast to not finding it useful. This is an outcome that is important to me and often important to funders, and governing bodies. I do not ask if the conversation was helpful. I prefer to ask if the session was useful as that is congruent with narrative intent. I resist a posture of helping people in favour of striving to be useful to them by facilitating a process. I resist a helping posture as in the context of a single session such a posture risks inviting practices that may erode personal agency by placing the therapist at the centre of change. Further it may be too soon to tell if the session was helpful for participants. Immediately following the session people will, however, have a sense if the conversation was useful in providing a different way of looking at things or new ideas for proceeding.

Assisting the conversation to endure

In my brief narrative practice I am always looking for ways to assist the conversation to endure long past the conversation itself. As a means to facilitate this, I include on the questionnaire the question, 'What are one or two things that stood out for you in the conversation that were useful and will stay with you when you leave?' In answering this question, participants are generating a specific idea, most relevant to them, for further consideration. The answer gives us a peek into what may stay with them following the conversation. When this is highlighted in combination with receiving a take-home document⁴, the endurance of the conversation is less vulnerable to fatigue.

CLOSING

This paper has shared the Single Session Impressions and Feedback Tool (SSIFT), a walk-in single session therapy process/outcome feedback tool congruent with the practice intentions of brief narrative therapy. When we link the process (how we do what we do) to the outcome (the usefulness of what we do) in single session therapy, our attention becomes focused on the process of therapy and the possible effects of those processes on people's lives. Furthermore, this tool seeks to shape the practices of the therapist by inviting critical reflection, accountability and learning. With the proliferation of walk-in clinic service models throughout Canada and abroad, the need for tools that provide data for funders, as well as for clinicians will continue to grow. The questionnaire presented, although more a part of a 'collaborative ethnographic' endeavour, serves to respond to the need for outcome measures of single session therapy while also ensuring a structure and procedure for critical reflection.

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NOTES

I am employed as a supervisor of the Child Clinical and Brief Services at Haldimand Norfolk REACH, a large multi-service agency in rural Ontario, Canada. The primary populations served include rural Caucasian, middle to low income families, First Nations, and Mexican Mennonite people.

This is a term that is well suited to single session therapy. The phrase 'stories in the making' refers to emerging storylines with gaps and loosely linked events that form tentative emerging storylines.

Finding ways to measure, evaluate and/or research whether the process of therapy has contributed to replicating these and other forms of dominance or privilege offers considerable challenges. The work of the Just Therapy Team (Waldegrave, Tamasese, Tuhaka, & Campbell, 2003) proposes forms of partnership accountability for this purpose.

The development of take-home documents at the walk-in clinic is common practice. These documents can include in-session crafted conversation summaries, letters, testaments, drawings, poems, etc. They serve to archive significant moments, understandings, or storylines, as well as co-developed next steps.

APPENDIX 1.

Single Session Impressions & Feedback Tool (SSIFT) © Adapted from Duncan & Miller, 2000, Stiles 2002, and Madsen 2007

Please share your feedback. Please circle the appropriate number to indicate your experience of today's conversation.

AGREE WITH THIS SIDE		NEUTRAL			AGREE WITH THIS SIDE	
FOCUS						
<i>My therapist focused on what they wanted to and my wishes didn't seem important</i>						<i>My therapist addressed what I/we wanted to talk about the most</i>
1	2	3	4	5	6	7
INTEREST						
<i>The conversation was uninteresting to me</i>						<i>The conversation captured and held my interest</i>
1	2	3	4	5	6	7
YOUR SKILLS						
<i>My therapist did not learn about my skills, abilities, or wisdom</i>						<i>My therapist learned about my skills, abilities, and wisdom</i>
1	2	3	4	5	6	7
PARTNERSHIP						
<i>I felt left out of the work today</i>						<i>I experienced being an important partner in our work together today</i>
1	2	3	4	5	6	7
FEEDBACK						
<i>My therapist kept going without checking in with me</i>						<i>My therapist asked for my feedback throughout the conversation</i>
1	2	3	4	5	6	7
PLANS/ NEXT STEPS						
<i>I played <u>no</u> part in developing the plan and next steps</i>						<i>I played a <u>large</u> part in developing the plan and next steps</i>
1	2	3	4	5	6	7
HOPE						
<i>I felt hopeless after the conversation</i>						<i>I felt hopeful after the conversation</i>
1	2	3	4	5	6	7
USEFUL						
<i>The conversation was not useful</i>						<i>The conversation was useful</i>
1	2	3	4	5	6	7

What are one or two things that stood out for you in the conversation that were useful and will stay with you when you leave?

1. _____
2. _____

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