

# Understanding The Key Elements and Outcomes of Walk-in Counselling Programs: A Scoping Review

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## Understanding the Key Elements and Outcomes of Walk-in Counselling Programs: A Rapid Scoping Review

According to *The State of Mental Health in Canada 2024* report, the mental health of Canadians was three times worse in 2024 than before the pandemic [1]. Findings from the *Mental Health and Access to Care Survey* suggested that of the more than 5 million Canadians experiencing significant mental health impacts, 36.6% reported that their needs, related to information, medication, and counselling/psychotherapy, were either partially (25.8%) or fully unmet (10.9%) [2]. Counselling and psychotherapy were the needs most frequently unmet. Oftentimes, there are long waiting times for mental health counselling in non-profit agencies [3] and other barriers related to affordability and accessibility of these services [4]. Non-profit agency-based mental health programs are critical avenues of support, especially for those who cannot afford private counselling services. However, with increasingly complex and rising rates of mental health issues, more strain is placed on non-profit agency programs to meet client needs, likely resulting in long waitlists, increased levels of unmet needs, and exacerbation of client issues. With the growing demand for mental health counselling, there is an increased need to explore how to best respond to clients who are seeking mental health counselling services.

Over the past 20 years, walk-in counselling (WIC) services have increasingly been adopted by non-profit counselling organizations to reduce waiting times and enhance accessibility for service users [5-7]. WIC is a service delivery model that typically offers single-session therapy, where each session is standalone, to individuals, couples, and/or families. Service users can attend the service without an appointment and are typically seen by a counsellor within an hour [8]. It is important to recognize that WIC can differ from single session counselling since not all WIC is a single session, and not all single-session counselling is WIC [5]. WIC has been identified as a promising approach to managing the increased demand for mental health services and long waiting lists for clients seeking such services [8,9]. Comparing two agencies in Ontario, one with a WIC model and one with a traditional wait list approach, Reimer et al.<sup>4</sup> found that clients presenting with more complex needs and mood issues seemed to benefit more from the WIC model compared to the traditional model, particularly during the first four weeks following the initial session. The accessibility of WIC is one of the most important elements of the WIC model, as clients can access services at the immediate time of need, capturing higher motivation and potentially preventing an exacerbation of issues [9].

While Family Services of Peel (FSP) has been operating a WIC program for several years to address concerns with growing waitlists and unmet client needs, the aftermath of the pandemic has indicated that the agency needs to strengthen the WIC program to meet the emerging needs of clients. However, to our knowledge, there is limited synthesized evidence on WIC interventions or services, their implementation models/strategies, and the resulting impacts on clients. Thus, there is a need to better understand the approaches taken to WIC in non-profit-based mental health and family counselling agencies to determine how FSP can strengthen their existing WIC program. To achieve these aims, we conducted a rapid scoping review of academic and grey literature on existing WIC models, frameworks, and approaches implemented in non-profit mental health and family counselling organizations. The objectives were as follows:

- 1) To identify and understand existing evidence on models, frameworks, and approaches used for WIC programs in non-profit mental health and family counselling organizations.

- 2) To characterize these WIC models, frameworks, and approaches according to the populations served, types of providers involved, therapy modalities adopted, delivery models used, and program impacts.
- 3) To identify and characterize best practices for WIC programs in community mental health and family counselling organizations.

## **Methods**

### **Study Design**

We conducted a scoping review to address our research question: “What evidence has been published on WIC approaches used in non-profit organizations or post-secondary wellness centres offering counselling services?” The protocol was registered a priori [10]. Our scoping review was guided by the methodological framework of Arksey and O’Malley [11] and Levac et al. [12], which involved several stages: (1) identification and clarification of research questions; (2) establishment of inclusion and exclusion criteria; (3) development of the search strategy; (4) study selection; (5) data charting; and (6) collation, summarization, and reporting of the results. The results reported here follow the Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR) [13].

### **Search Strategy**

We conducted a comprehensive search in the following databases, in accordance with the Peer Review of Electronic Search Strategies (PRESS) Guidelines [14]: Clarivate Web of Science, EBSCO CINAHL, Elsevier Scopus, Ovid APA PsycInfo, Ovid EBM Reviews - Cochrane Central Register of Controlled Trials, Ovid EBM Reviews – Cochrane Database of Systematic Reviews, Ovid Embase, Ovid MEDLINE, Ovid Social Work Abstracts, and ProQuest Social Services Abstracts. The search was limited to studies published from January 2010 to June 2025, as WIC became an increasingly utilized framework and model for service delivery during this time period. No restrictions were applied to publication language or geographic region. Grey literature was searched in Google Scholar via Publish or Perish [15] (first 100 results), ProQuest Dissertations and Theses Global database, pre-print servers and repositories, and websites of relevant organizations. Review articles (narrative, scoping, systematic, meta-analysis, and meta-synthesis) were excluded. Our search terms included “walk-in counselling,” “community mental health services,” “non-profit,” and “counselling,” as well as Medical Subject Headings (MeSH) terms. Boolean search operators were used to separate the keywords. The search strategy was adapted as needed for each database. We also manually searched (using a backward search approach) the references of relevant studies to identify additional sources.

### **Eligibility criteria**

We applied eligibility criteria to select relevant studies on WIC programs in non-profit settings.

### **Inclusion criteria**

Our scoping review included peer-reviewed academic publications (i.e., primary papers) and grey literature (i.e., reports, theses and dissertations) that had the following characteristics: (1) reported on a WIC program or service in a non-profit organization or post-secondary wellness centre offering mental health counselling; (2) published between January 1, 2010 and May 2025; and (3) published in English and French.

### ***Exclusion criteria***

Our scoping review excluded (1) abstracts, commentaries, guidelines, books (in full), protocol papers without reported findings, methodology papers, and review papers of any type (e.g., scoping reviews, systematic reviews, umbrella reviews), (2) research documents without the full text available (3) research published before January 1, 2010, and (4) documents not published in English or French due to language restrictions from the team.

### **Study selection**

The retrieved literature was uploaded to Covidence [16] and was screened against the inclusion criteria using a two-stage screening process. In the first stage, three members of the research team (SC, EF, and MS) independently screened the titles and abstracts. In the second screening stage, the same team members independently reviewed the full texts of the papers selected during the first stage to confirm their eligibility for inclusion in the final review. Any disagreements during the screening process were discussed and resolved by the researchers engaged in screening.

### **Charting the data**

We used the standard data extraction form in Covidence and tailored it to meet our study's data extraction needs. We extracted data on the following: author and year of publication, location, aim, study design and methodology, WIC program characteristics, main outcomes, and key limitations.

### **Collating, summarizing, and reporting the results**

We used a mixed method approach to analyze the extracted data. The data was synthesized and analyzed using frequency counts to outline the prevalence of the main characteristics of the WIC programs described. We also used a thematic synthesis approach [17] to analyze the findings and identify the main characteristics of the non-profit WIC models, including their key elements, delivery strategies, and key outcomes. Thematic synthesis involved three stages: (1) data familiarization, (2) coding the text, and (3) theme development.

## **Results**

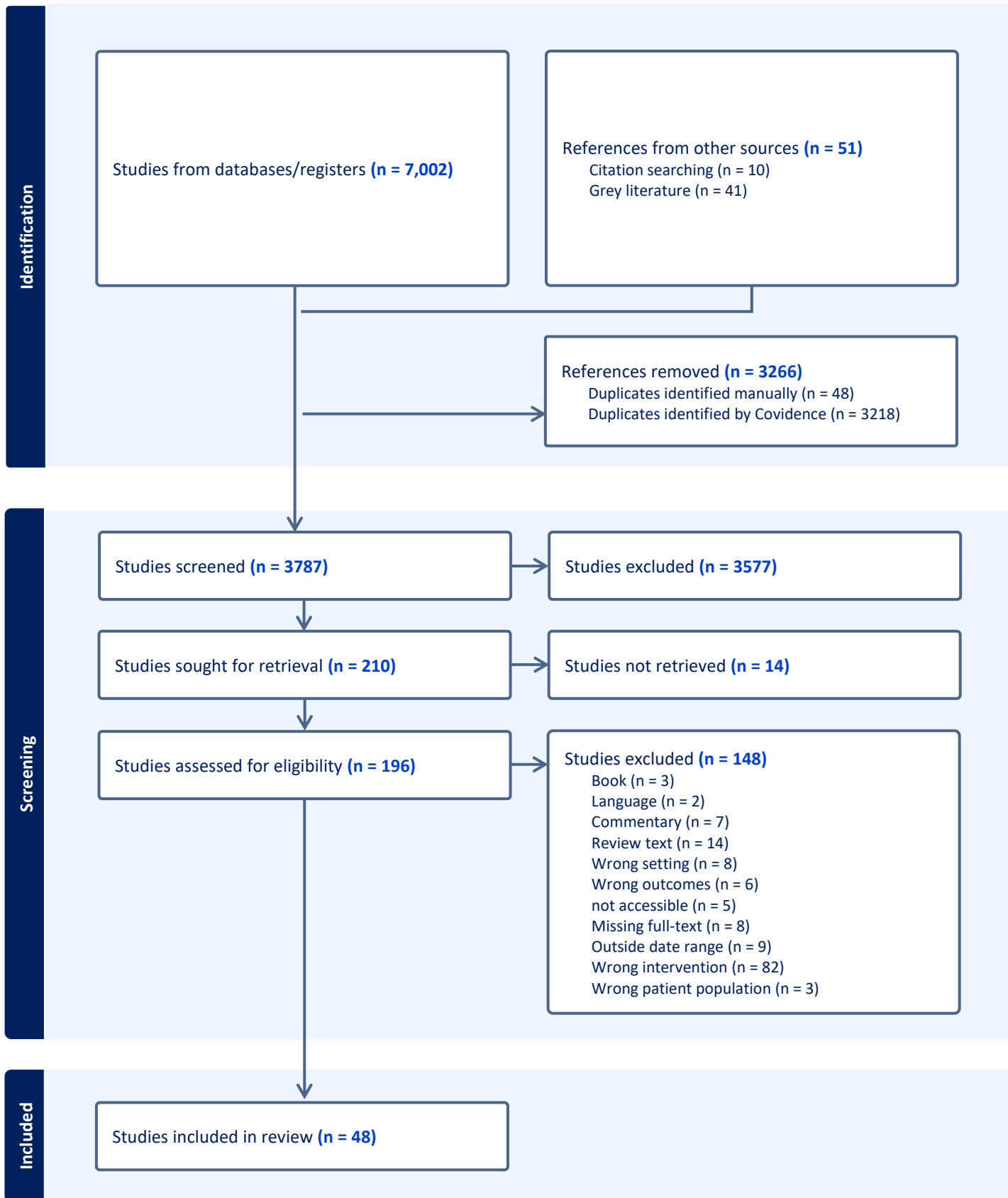
### **Screening results**

Our searches from 10 electronic databases, multiple grey literature search sources, and backward citation searches resulted in 7,053 records which led to a total of 3,787 potentially eligible studies once duplicates were removed. Following title and abstract screening, 3,577 studies were excluded, leaving 210 studies for full-text screening. Full-text screening resulted in the exclusion of 148 articles and inclusion of 48 articles for data extraction. Figure 1 shows a flow diagram of the screening results.

### **Characteristics of included studies**

The characteristics of the included articles are presented in Table 1, Table 2, and Table 3. All included studies described key elements and operations of WIC programs and/or reported evidence of WIC program evaluations. Across the 48 articles, 36 distinct programs and/or approaches were described. All included studies were published between 2012 and 2025. Most studies were published and evaluations conducted before the COVID-19 onset in 2020, with only eight articles [19,29, 30,31,46,59,60,62] comprising program descriptions and data evaluation

**Figure 1**  
Data screening flow diagram



**Table 1***Characteristics of included program evaluations*

<b>Author (date)</b>	<b>Location</b>	<b>Aim</b>	<b>Study Design</b>	<b>Approach</b>	<b>Program setting</b>
Barwick et al. (2013) [18]	Toronto, Ontario, Canada	(1) to describe the mental health characteristics of walk-in and usual care child and youth clients; (2) to compare the psychosocial adjustment over a 3-month period of time of walk-in clients with those accessing standard care; and (3) to describe the service utilization of walk-in clients prior to and following walk-in service delivery	Non-randomized experimental study	WIC-SST	West End Walk-in Counselling Centre, Yorktown Child and Family Centre, a community-based, non-profit organization
Cait et al. (2017) [5]	Kitchener-Waterloo, Ontario, Canada	To compare outcomes for clients of two family service agencies using two different models of service delivery. Qualitative phase: To explore the experiences of those who attended the WIC model compared to the traditional service delivery model	Mixed methods: Quasi-experiment and comparative case study	WIC-SST	KWCS, a multi-service, multi-funded, non-profit family counselling agency
Cait et al. (2025) [19]	Kitchener-Waterloo, Ontario, Canada	(1) To evaluate the effectiveness of the WIC-SST service model implemented at the university wellness centre (2) To understand the experiences of clinicians who chose to work in this model	Mixed methods	WIC-SST	University Campus Wellness Centre
Churisnoff et al. (2017a) [20]	Saskatchewan, Canada	To establish shared data collection among 5 family service agencies and evaluate their WICCs	Mixed methods	WIC-SST by appointment	WIC services offered by: (1) family service regina, (2) CFS Regina, (3) CFS Saskatoon, (4) SIGN Yorkton, and (5) Northeast Outreach and Support Services
Churisnoff et al. (2017b) [21]	Saskatchewan, Canada	To examine the possibilities for expanding the WICC at Family Service Regina through a pilot expansion	Mixed methods	WIC-SST	Family Service Regina
Cook et al. (2020) [22]	Kitchener-Waterloo, Ontario, Canada	To assess the outcomes and overall impact of the services offered through the OK2BME program.	Mixed methods	WIC-SST for crisis counselling	KWCS, a multi-service, multi-funded, non-profit family counselling agency

Dass-Brailsford & Hage Thomley (2015) [23]	New Orleans, Louisiana, US	(1) To describe the efforts of a volunteer organization to provide WIC services to the residents of the Ninth Ward of New Orleans following Hurricane Katrina. (2) To evaluate outcomes of participating in the WIC program	Pre- and post design	WIC-SST	The River of Hope – a volunteer grassroots program
De Boer (2017) [24]	St. Johns, Newfoundland, Canada	To identify short-term outcomes of a pilot WICC.	Mixed methods	WIC-SST	Right Here, Right Now Drop-in Counselling Clinic, located in a <b>Women's Centre</b>
Ellenbogen et al. (2019) [25]	St. Johns, Newfoundland, Canada	To assess changes in child and adolescent mental health difficulties among clients using the Change Clinic SST Service		WIC-SST SST by appointment	Change Clinic Counselling Service
Garbutt & Novik (2020) [26]	Saskatchewan, Canada	To evaluate SIGN's WICC in relation to client demographics, clinic use and outcomes, cost avoidance, and rural mental healthcare accessibility		WIC-SST	The Society for the Involvement of Good Neighbours (SIGN), a non-profit family service organization
Hair et al. (2013) [27]	St. Johns, Newfoundland, Canada	To pilot a brief counselling program, the Change Clinic		WIC-SST	The Change Clinic was implemented in the Janeway Family Centre
Harper-Jaques & Foucault (2014) [28]	Saskatchewan, Canada	To examine client satisfaction and clinical outcomes of WIC-SST To identify client and therapist factors most predictive of clinical outcomes	Pre-post evaluation	WIC--SST	South Calgary Health Centre
Harris-Lane et al. (2023) [29]	New Brunswick, Canada	To explain the process of implementing OAAT therapy in alignments with evidence-based implementation frameworks and strategies. To assess readiness for change among providers during implementation. To evaluate initial client and system outcomes.	Mixed methods	OAAT	Community addiction and mental health centres in NB
Harris-Lane et al. (2024) [30]	New Brunswick, Canada	To explain the process of implementing OAAT in New Brunswick <b>child and youth addiction and mental health services</b> . To assess readiness for change among providers during implementation. To evaluate initial client and system outcomes.	Mixed methods	OAAT	Child and Youth Addiction and Mental Health services in NB

Hartley et al. (2023) [31]	Australia	To (a) evaluate the feasibility, acceptability, and short-term effectiveness of walk-in telehealth family therapy, and (b) provide recommendations for the next steps of the WIT project	Mixed methods		The Bouverie Centre – family therapy institute
Horton et al. (2012) [32]	Kitchener-Waterloo, Ontario, Canada	To examine if WIC-SST generates economic benefits through reduced hospital and doctors use and more rapid return to work and usual activities	Economic evaluation		KWCS, a multi-service, multi-funded, non-profit family counselling agency
Lamsal et al. (2018) [33]	Kitchener-Waterloo, Ontario, Canada	To conduct a cost-effectiveness analysis of single-session WIC compared to being waitlisted for traditional counseling	Economic evaluation		KWCS, a multi-service, multi-funded, non-profit family counselling agency
MHCC (2023) [34]	Northwest Territories, Canada	To detail why the SC2.0 model was implemented, the approach to their system transformation, outcomes to date, and the way forward	Mixed methods	OAAT	Community Counselling Program  Part of a continuum of services
Pearce (2016) [35]	Saskatchewan, Canada	To evaluate a pilot WICC to determine if the clinic could enhance or expand current mental health and family counselling services in the Yorkton Region.	Mixed methods	WIC-SST	Society for the Involvement of Good Neighbours (SIGN) -- community-based agency
Reimer et al. (2018) [8]	Kitchener-Waterloo, Ontario, Canada	To explore whether there are certain client groups who benefit more than others from the WIC model by comparing two agencies	Non-randomized experiment	WIC-SST	KWCS, a multi-service, multi-funded, non-profit family counselling agency
Rogers & Novik (2019) [36]	Saskatoon, Saskatchewan, Canada	To detail the findings from a scan of mental health supports for older adults in Saskatoon. To evaluate counselling services offered at the Saskatoon Foodbank offered by CFS	Mixed methods	WIC-SST SST by appointment	CFS Saskatoon, a community-based counselling agency – services offered at a Foodbank
Stalker et al. (2012) [37]	Kitchener-Waterloo, Ontario, Canada	Pilot study of WIC (1) to learn more about the clinical effectiveness of WIC-SST, and (2) to determine how the quality of research on this model of service delivery can be improved	Mixed methods	WIC-SST	KWCS, a multi-service, multi-funded, non-profit family counselling agency
Stalker et al. (2016) [9]	Kitchener-Waterloo, Ontario, Canada	To compare change in psychological distress between clients receiving WIC-SST and clients receiving traditional counselling	Mixed methods	WIC-SST	KWCS, a multi-service, multi-funded, non-profit family counselling agency

Von Doussa et al. (2021) [38]	Melbourne, Australia	To evaluate a pilot project of one-off sessions for families on a waitlist for traditional services. (1) determine if one-off sessions are an effective way to address the waitlist, and (2) assess the feasibility and acceptability of this approach with families		One-off waitlist session	Bouverie Centre in Australia
Whitsell and Company Inc. (2019) [39]	St. Thomas, Ontario, Canada	To evaluate the operations of the Wellkin WIC mental health services	Mixed methods	WIC-SST	Wellkin Child and Youth Mental Wellness

**Table 2**

*Characteristics of included descriptive papers with case illustrations*

<b>Author (date)</b>	<b>Location</b>	<b>Aim</b>	<b>Study Design</b>	<b>Type of program</b>	<b>Program setting</b>
Barnes et al. (2018) [40]	Calgary, Alberta, Canada	To demonstrate the use of different therapeutic models in SST	Program description with case illustration	WIC-SST	South Calgary Health Centre, a multi-service community-based health clinic
Bedggood (2018) [41]	Kitchener-Waterloo, Ontario, Canada	To describe the process at KWCS for training new WIC-SST therapists	Program description with case illustration	WIC-SST	KWCS, a multi-service, multi-funded, non-profit family counselling agency
Bobele et al. (2018) [42]	San Antonio, Texas, US	To illustrate the teams' application of the single-session mindset.	Program description with case illustration	WIC-SST SST by appointment	Community Counselling Service offered through a university
Harper-Jaques & Simms (2015) [43]	Calgary, Alberta, Canada	To describe the SCHC WIC-SST program, noting key elements, evaluation results, and next steps.	Program description	WIC-SST	South Calgary Health Centre
Levin et al. (2018) [44]	Houston, Texas, US	To describe the Houston Galveston Institute WIC program	Program description with case illustration		Houston Galveston Institute
McElheran (2024) [45]	Calgary, Alberta, Canada	To describe the move from in-person WIC-SST to online format with the onset of the COVID-19 pandemic. To describe how the WIC and online SST sits as part of a hub of services	Program description with case illustration	WIC-SST SST by appointment	Eastside Community Mental Health Service (formerly Eastside Family Centre)
McElheran (2021) [46]	Calgary, Alberta, Canada	To describe the EFC WIC-SST program	Program description with case illustration	WIC-SST SST by appointment	Eastside Family Centre, a community based agency

McGuinty et al. (2022) [47]		To present a novel, single-session treatment protocol for Externalizing Metaphors Therapy for the clinical population of youth presenting with anxiety and/or depression.	Program description with case illustration		
McGuinty et al. (2023) [48]		To present an autism-specific model that is tailored to these clients using their unique preferred interests, presentations, and client-family strengths.	Program description with case illustration		
Rodriguez (2018) [49]	Mexico	To describe how the team used Collaborative Therapy stance to develop a WIC-SST program	Program description with case illustration	WIC-SST	Centro de Atencion a la Comunidad (CAC) Community-based counselling centre - not-for-profit organization
Scaletta et al. (2022) [50]	San Antonio, Texas, US	To describe the value of the single-session mindset within the Latinx community	Program description with case illustration	WIC-SST SST by appointment	Community Counselling Service offered through a university
Slive & Bobele (2012) [51]	San Antonio, Texas, US	To describe the WIC single-session form of service delivery.	Program description with case illustration	WIC-SST SST by appointment	Community Counselling Service offered through a university
Stewart et al. (2018) [52]	Calgary, Alberta, Canada	To describe the foundations of the Eastside Family Centre WIC-SST service	Program description with case illustration	WIC-SST	South Calgary Health Centre
Weeks & Zook-Stanley (2018) [53]	Minneapolis, US	To describe the model, values, and unique elements of the Walk-In Counseling Center	Program description with case illustration	WIC-SST	Walk-in Counselling Center, a community-based agency

**Table 3**

*Characteristics of other sources*

<b>Author (date)</b>	<b>Location</b>	<b>Aim</b>	<b>Study Design</b>	<b>Type of program</b>	<b>Program setting</b>
Crow (2016) [54]	San Antonio, Texas, US	To understand what clients, practitioners, and supervisors find most helpful in WIC-SST. To explore how WIC sessions can be used effectively. To promote the implementation of WIC	Qualitative	WIC-SST SST by appointment	Community Counselling Service offered through a university
Fang et al. (2018) [55]	Calgary, Alberta, Canada	To present preliminary findings of WIC at EFC	Policy brief	WIC-SST	Eastside Family Centre

Foundry (2024) [56]	British Columbia, Canada	To highlight lessons learned from developing WIC within an integrated youth services setting	Policy brief	OAAT	Integrated youth services setting
Josling & Cait (2018) [57]	Kitchener-Waterloo, Ontario, Canada	To describe KWCS, the two research projects conducted, and advocacy efforts	Brief	WIC-SST	KWCS
Mackenzie et al. (2021) [58]	London, Ontario, Canada	To investigate if weather effects the use of walk-in clinic services at one Canadian university.	Retrospective cohort	WIC-SST	King's College University
Sarmiento & Reid (2023a) [59]	Ontario, Canada	To better understand how mental health WIC use is related to the use of other services provided by agencies.	Retrospective cohort	WIC-SST SST by appointment	Two child and youth mental health agencies in ON
Sarmiento & Reid (2023b) [60]	Ontario, Canada	1. to explore how many mental health WICs are used by families (e.g., mean, mode, and median number of visits) 2. to document how often and how soon families returned for a second WIC visit and correlates of time to a second WIC visit	Retrospective cohort	WIC-SST SST by appointment	Two child and youth mental health agencies in ON
Wellspring et al. (2024) [61]	British Columbia	To better understand (1) the broad prevalence of mental health concerns among individuals accessing a walk-in mental health clinic (both before and during COVID-19), and (2) the ways in which the service was perceived by those who sought treatment.	Retrospective cohort	WIC-SST	University mental health clinic The Walk-In Wellness Clinic (WIWC)
Zehetmair et al. (2021) [62]	Germany	To assess the perspectives of refugees attending the psychosocial WIC	Qualitative	WIC-SST	State and registration center 'Patrick Henry Village'

**Table 4:***Modalities, approaches, and techniques used by WIC programs*

Article	Approach															
	WIC-SST	Strength-based	SFBT	Narrative	Intersession	Feminist	Trauma-informed	Culturally responsive	Therapist discretion	Milan 5-part model	SC2.0 with OAAT	CBT	Team approach	One way mirror/reflective team	SST by appt	
Barnes et al. [40]; Harper-Jaques & Foucault [28]; Harper-Jaques & Simms [43]	X	X	X	X	X					X		X	X			
Barwick et al. [18]	X	X			X				X				X			
KWCS Bedgood [41]; Cait et al. [19] Horton et al. [32] Josling & Cait [57], Lamsal et al. [33], Reimer et al. [8], Stalker et al. [37], Stalker et al. [9]	X	X	X	X					X			X				
Bobele et al. [42]; Crow [54]; Slive & Bobele [51]	X	X			X				X				X	X	X	
Cait et al. [19]	X	X													X	
Churisnoff et al. [20] #1; Garbutt & Norvik [26]; Pearce [35]	X	X	X					X								
Churisnoff et al. [20] #2	X		X													
Churisnoff et al. [20] #3	X		X													
Churisnoff et al. [20] #4; Rogers & Novik [33]	X		X						X							
Churisnoff et al. [20] #5	X		X													
Chursinoff et al. [21]	X		X						X							
Cook et al. [22]	X															
Dass-Brailsford & Hage Thomley [23]	X	X								X						
de Boer [24]	X			X		X	X									
Ellenbogen et al. [25]	X	X	X	X					X						X	

Fang et al. [55], McElheran [45], Stewart et al. [52]	X	X	X	X	X			X	X	X			X	X	X
Foundry [56]	X	X	X		X						X				
Hair et al. [27]	X														
Harris-Lane et al. [29]	X	X	X					X			X				
Harris-Lane et al. [20]	X	X	X					X			X				
Hartley et al. [31]	X	X			X								X	X	
Levin et al. [44]	X	X			X			X	X	X			X	X	
Mackenzie et al. [58]	X														
McGuinty et al. [47]	X	X			X										X
McGuinty et al. [48]	X	X			X										
Mental Health Commission of Canada [34]											X				
Rodriguez [49]	X	X							X				X	X	X
Sarmiento et al. [59,60] – Agency 1	X	X	X	X					X						X
Sarmiento et al. [59,60] – Agency 2	X	X	X	X					X						X
Scaletta et al. [50]	X	X	X												
Slive & Bobele [51]	X	X			X								X	X	X
Von Doussa et al. [38]	X														
Weeks & Zook- Stanley [53]	X	X	X		X				X				X		X
Wellspring et al. [61]	X	X	X									X			X
Whitsell and Company Inc. [39]	X														
Zehetmair et al. [62]	X		X						X						

**Table 5**  
*Characteristics of WIC programs*

Article	Dose		Population		Cost		Therapist		Days offered		Personnel			Intake	
	Unlimited return	Restricted return	Unrestricted	Restricted	Yes	No	Different	Same	1 day per week	Multiple	Therapist	Student	Clinical/medical	Yes	No
Barnes et al. [40]; Harper-Jaques & Foucault [28]; Harper-Jaques & Simms [43]	X		X			X	X			5 days	X	X	X	X	
Barwick et al. [18]				X		X				5 days	X				X
KWCS Bedggood [41]; Cait et al. [19] Horton et al. [32] Josling & Cait [57], Lamsal et al. [33], Reimer et al. [8], Stalker et al. [37], Stalker et al. [9]	X		X		X				X		X	X		X	
Bobebe et al. [42]; Crow [54]; Slive & Bobele [51]	X		X			X				X	X		X	X	
Cait et al. [19]	X			X		X				2 days	X	X		X	
Churisnoff et al. [20] #1; Garbutt & Norvik [26]; Pearce [35]	X		X			X				4 days	X			X	
Churisnoff et al. [20] #2	X		X			X			X						
Churisnoff et al. [20] #3	X		X			X				4 days					
Churisnoff et al. [20] #4; Rogers & Novik [33]	X		X	X		X				2 days	X	X			
Churisnoff et al. [20] #5	X			X		X				X					
Chursinoff et al. [21]	X		X			X				2 days	X	X			
Cook et al. [22]				X		X			X		X				
Dass-Brailsford & Hage Thomley [23]	X			X		X	X			3 days	X				
de Boer [24]	X			X						2 days	X	X		X	
Ellenbogen et al. [25]		X		X		X			X		X			X	

Fang et al. [55], McElheran [45], Stewart et al. [52]	X		X			X	X			6 days	X	X	X	X	
Foundry [56]	X			X		X				X	X				
Hair et al. [27]		X		X		X			X		X				X
Harris-Lane et al. [29]	X			X		X					X	X	X		
Harris-Lane et al. [20]	X			X		X					X	X	X		
Hartley et al. [31]	X		X				X	X	X		X				X
Levin et al. [44]	X		X			X				6 days	X	X	X	X	
Mackenzie et al. [58]	X			X		X				5 days					
McGuinty et al. [47]	X		X			X					X				X
McGuinty et al. [48]		X		X				X			X				
Mental Health Commission of Canada [34]		X		X				X			X				
Rodriguez [49]	X		X			X			X		X	X			
Sarmiento et al. [59,60] – Agency 1	X			X		X					X				X
Sarmiento et al. [59,60] – Agency 2	X			X		X					X				
Scaletta et al. [50]	X		X			X					X				
Slive & Bobele [51]	X		X			X	X				X	X			X
Von Doussa et al. [38]		X		X							X				
Weeks & Zook- Stanley [53]		X	X			X				X	X	X			X
Wellspring et al. [61]		X	X			X	X					X			X
Whitsell and Company Inc. [39]	X			X		X	X		X		X				X
Zehetmair et al. [62]	X			X		X				X	X		X		

results from post-COVID-19. The included studies were conducted in Canada (35) [5,8,9,18-22,24-30,32-35,37,39-41,43,57-61], the United States (7) [23,42,44,50,51,53,54], Australia (2) [31,38], Mexico (1) [49], and Germany (1) [62]. Two studies [47,48] described protocols for tailored WIC-SST approaches that were not applied to a specific geographical location. Of the included studies, 24 were peer-reviewed articles [5,8,9,18,19,23,27-33,37,47,48,51,58-62] and 24 were grey literature sources [20-22,24,26,34,35,36,38-42,44-46,49,50,52-57]. Further, 33 sources were primary research [5,8,9,18-39,54,55,58-62] and 15 were descriptions of programs [40-53,56].

The included primary research articles included evaluations of WIC program outcomes and impact (22) [5,8,9,18-31,34-38]; assessments of WIC program feasibility and acceptability (3) [29,30,38]; assessments of WIC program implementation (3) [29,30,34]; comparisons of WIC to traditional counselling (3) [5,8,9]; examination of WIC service use (2) [19,60], external community service use (3) [9,18,59], and mental health characteristics of clients attending WIC (2) [18,61]; examinations of economic benefits of WIC (2) [32,33]; evaluations of WIC program operations (1) [39]; examination of the impact of weather on client demand for WIC (1) [58]; and explorations of patient and clinician experiences with WIC (4) [5,31,54,62]. The descriptive studies offered overviews of WIC programs and protocols (14) [40,42-53,57], summaries of early findings (3) [37,44,55], and descriptions of training processes for WIC staff and students (1) [41].

Eight sources described the Kitchener-Waterloo Counselling Services WIC clinic [5,8,9,32,33,37,41,57], four described the Eastside Family Centre WIC services [45,46,52,55], three described the South Calgary WIC program [28,40,43], three described the CCS WIC program [42,51,54], three described the SIGN WIC program [20,26,35], two described the Catholic Family Services Saskatoon WIC program [20,36], two described two unnamed agencies located in Ontario [59,60].

### **Characteristics of WIC models**

Tables 4 and 5 summarize the characteristics of the 36 distinct WIC programs and approaches.

#### ***Approaches, Modalities, and Techniques***

Across the 36 programs, the only shared elements are that the services are offered or intended to be offered on a walk-in, drop-in, or immediate basis. Among all programs, it was indicated that the WIC services were based on a single-session or one-at-a-time approach. Single-session therapy (SST), used in 32 programs, is not a specific intervention or therapeutic modality, but an approach to service delivery in which each session is a whole therapy process [36]. Among four programs [29,30,34,56], it was reported that a one-at-a-time (OAAT) approach was used. A OAAT approach was identified as a term that is largely interchangeable with SST, as it is a delivery model that similarly involves treating each session as the whole therapy. The OAAT approach is often part of the SC2.0 framework, which involves a range of services that enables clients to choose what best suits their needs. The OAAT approach allows clients to attend as many counselling single counselling sessions as they want, without a long-term commitment.

To implement the WIC-SST approach, it was reported that a variety of modalities and approaches are used, illustrating how WIC programs can be used in a range of innovative and client-driven ways. Approaches, modalities, and/or techniques reported to be used included solution-focused brief therapy (SFBT) (18) [5,8,9,20,21,25,26,28,32,33,35-37,40,41,43-46,50,52,53,55-57,59,60,62], strengths-based approaches (17) [5,8,9,19,20,23,25,26, 28,31-33,35,37,40-46,49-57], narrative therapy (8) [5,8,9,24,25,28,32,33,37,40,41,43,45,46,52, 55,57,59,60,61], a reflecting team approach (8) [28,31,38,40,42-46-49,51-55], an intersession break (7) [28,31,40,42-46,51,52-56], the Milan Model (4) [23,44-46,52,55], culturally responsive approaches (5) [20,26,29,30,35,45,46,52,55,63], cognitive-behavioural therapy (CBT; 3) [4,8,9, 28,32,33,37,40,41,43,57,61], dialectical behavioural therapy (DBT; 1) [59,60], feminist-informed therapy (1) [24], motivational interviewing (1) [59,60], and a partnership approach (1) [59,60]. Moreover, it was explicitly stated among 12 programs [5,8,9,21,25,28,32,33,36,37,40-46,49,51-55,57,59,60], that therapists have the discretion to choose the therapeutic modality/approach/ technique that best meets the needs of the client being served. It is important to note that not every modality/approach/technique used in each WIC program was likely reported, as therapists likely use their judgement across all programs to determine the best fit for each specific client they serve. Ultimately, the review of the WIC programs illustrated that no single therapeutic framework is employed; rather, the focus of WIC service delivery is to utilize systemic and brief therapies that emphasize client resources, are pragmatic, and aim to provide a clear outcome for clients within a single session [18]. Table 6 provides detail about the various modalities and approaches used in WIC programs.

**Table 6**

*Modalities, approaches, and techniques used in WIC programs*

<b>Modality/Approach</b>	<b>Description</b>
Single-Session Therapy (SST) [51]	<p>SST is not a specific modality; rather, SST is a service delivery approach in which each session comprises a whole therapy session. SST can be conducted both in appointment and walk-in form. The SST approach recognizes that many clients choose to only attend one session, prefer brief therapeutic encounters, and know what is best for them. As such, the therapist begins each SST session assuming that it will be the whole therapy, that is, the client will not return. The focus of SST is not a single modality.</p> <p>Key elements of SST:</p> <ul style="list-style-type: none"> <li>• Each session is stand-alone</li> <li>• Sessions are goal-oriented and pragmatic</li> <li>• Sessions have a distinct beginning, middle, and end</li> <li>• The session is a collaboration between the client and therapist</li> <li>• The session is conducted using a strengths-based orientation</li> <li>• Clients leave the session with increased information and confidence in their skills.</li> <li>• Clients leave the session with a plan to address their problem.</li> </ul>
One-at-a-time therapy (OAAT) [34]	<p>OAAT is very similar to SST. OAAT is a delivery model where clients are invited to engage in as many counselling sessions as needed, without a need to make a long-term commitment to therapy. Like, SST, each OAAT session is treated as the whole therapy. The OAAT delivery model is part of the SC2.0 model. The SC2.0 is a model for delivering mental health and addictions</p>

	services, where the differences among clients are recognized. As such, a range of options are offered to ensure an appropriate match between service users and the level of care at the right time.
Solution-focused brief therapy (SFBT) [40]	SFBT is one of the most commonly used therapeutic modalities in WIC programs, as it requires the therapist focus on the presenting issue, target specific desired outcomes for therapy, and work towards a future free from that problem. The therapist works with the client to name a specific problem, develop a version of the client’s life without the problem, and develop small, practical steps that the client can take immediately towards the desired change.
Strengths-based	A strengths-based approach involved the therapeutic orientation to the strengths, resources, skills, and capacities that a client already holds and brings with them to the therapeutic encounter. The therapist works to identify these strengths and mobilize them as a resource to meet the clients goals.
Narrative therapy [40]	Narrative therapy is used to help people confront a problem by adopting a more valued-based and preferred way of living and thinking. A key assumption is that narratives shape an individual’s identity, becoming a dominant story. Externalization of the problem is key in narrative therapy, so that people can assess the effects, understand how it operates in their life, evaluate it, and determine how to relate to the problem. Through externalization, the therapist works with the client to co-author a new narrative.
5-part Milan model [46]	The Milan Model is a systemic family therapy approach that involves a five-part interview with the aim to help families develop new ways of thinking and form solutions to address presenting problems. The Milan Model is typically conducted with a therapeutic team.  The 5-part interview: <ol style="list-style-type: none"> <li>1. Pre-session – intake reviewed, therapists selected, and a preliminary plan is developed for the session.</li> <li>2. Session – establishment of the therapeutic alliance, completion of forms, and problem defined.</li> <li>3. Consultation break – the therapeutic team reviews the client’s strengths and resources, develops a plan to help the client move forward.</li> <li>4. Closing – the therapist provides strength-based feedback to the client, presents the plan, and closing assessments are completed.</li> <li>5. Debriefing – the team discusses what went well, what was learned, and other notes.</li> </ol>
Reflecting Team [42]	The reflecting team approach is very similar to the 5-part Milan Model. The reflecting team approach is a systemic approach to therapy. The basic principle is to be pragmatic and take the steps needed to help clients reach their goals in a single session. It comprises a therapeutic team whether one or two therapists conduct the session with the client, while the remainder of the team observes the session behind a one-way mirror. Like the Milan Model, the reflecting team approach follows a 5-part model comprising the same components.  The 5-part interview: <ol style="list-style-type: none"> <li>1. Pre-session – intake reviewed, therapists selected, and a preliminary plan is developed for the session.</li> <li>2. Session – establishment of the therapeutic alliance, completion of forms, and problem defined.</li> <li>3. Consultation break – the therapeutic team reviews the client’s strengths and resources, develops a plan to help the client move forward.</li> </ol>

	<p>4. Closing – the therapist provides strength-based feedback to the client, presents the plan, and closing assessments are completed.</p> <p>5. Debriefing – the team discusses what went well, what was learned, and other notes.</p>
Intersession break [42,46]	An intersession break is a specific service delivery technique that can be used as part of the Milan or reflecting team models, or on its own. It involves the therapist taking a break about two thirds of the way through the counselling session to consult with another counsellor on the client’s specific situation and to determine suggestions for moving forward post-session.
Cognitive behavioural therapy (CBT) [40]	CBT has been indicated to not typically be associated with a single-session WIC approach. However, it has been used in some WIC programs. The core premises of CBT are: (1) cognition affects behaviour, (2) cognition may be changed, and (3) behavioural change may be affected through changes to cognitive patterns. The use of CBT during a WIC session requires therapist discretion to determine its goodness of fit for the client.

***Number of WIC Sessions Clients Can Attend***

The number of WIC sessions clients could access was outlined for 35 out of the 36 programs and approaches [5,8,9,19-62]. Out of these, the number of WIC sessions clients could access was only restricted for five programs [25,27,38,53,61]. Among these, the WIC-SST sessions were restricted to one [38], three [25,27], four [61], and 10 [53]. For the remaining 30 programs, limitations were not put on how many WIC sessions clients may access. However, among studies that examined the usage of WIC sessions, most clients were found to access one or two sessions, with a minority attending three or more [6]. This suggests that even when restrictions are not placed on the number of WIC sessions clients can attend, the vast majority continue to utilize one or two sessions.

***Populations Served by WIC Programs***

Across the 36 WIC programs, 17 programs served unrestricted populations, including individuals, couples, and families [5,8,9,20,21,26,28,31-37,40-46,49-55,57,61]. The remaining 19 programs served restricted populations. Among these programs, 10 served children, youth, and their families [18,25,27,30,39,47,48,56,59,60], two served students [19,58], and one program each served women [24], the LGBTQ+ youth community [18], survivors/victims of violence [20], adults [25], hurricane Katrina survivors [23], refugees [62], and clients on a waitlist for traditional services [38]. The use of WIC to serve both specific and unrestricted populations demonstrates the flexibility and broad applicability of the WIC program format.

***Cost for WIC Sessions***

Only one WIC program was reported to have a cost associated with its use. At Kitchener-Waterloo Counselling Services (KWCS), clients pay on a sliding scale related to income ranging from \$0 to \$120 per session [5,8,9,32,33,37,41,57]. Most other programs indicated that their WIC programs were of no cost, related to the goal of enhancing accessibility to mental health services.

***Therapist Guarantee for Repeated WIC Sessions***

In the vast majority of papers, it was not stated whether seeing the same therapist for repeated WIC sessions is guaranteed or not. It was explicitly stated for seven programs that

clients using WIC services more than once were not guaranteed to see the same therapist [18,23,31,39,32,46,51,54,61]. Given the format of WIC, seeing the same therapist on multiple occasions is unlikely to occur. Seeing the same therapist would likely be guaranteed in programs where SST by appointment is available. However, there is not enough documented evidence to determine how therapist allocation occurs in WIC programs.

### ***When is WIC Offered?***

Across the 36 WIC programs, there was variation in the number of days per week that the service is offered. It was reported that nine agencies offered their WIC services one day a week [5,8,9,20,22,25,27,31-33,37,39,41,46,49,57], 17 agencies offered their WIC services multiple days a week [18-21,23,24,26,28,35,36,40,42-43,46,51,52,53,54,55,56,58,62], and eight did not indicate the number of days a week in which the WIC program is offered [20,29,30,34,59,60,61]. For three programs, the number of days the service is offered was not relevant, as McGuinty et al. [47] and McGuinty et al. [48] outline protocols for a WIC-SST service that would require implementation in a specific program, and Von Doussa et al. [38] offered their services to patients on the waitlist for traditional services, resulting in more variability in offerings. Among the 16 agencies offering WIC services multiple days per week, four offered the service two days per week [19,21,24,36], one offered the service three days per week [19], two offered the service four days per week [20,26,35], three offered the service five days per week [18,28,40,43,58], and two offered the service six days per week [44,45,46,52,55]. The other four agencies indicated that their WIC program was offered multiple days per week but did not specify an exact number of days [20,42,51,53,54,56,62]. Most WIC programs offered services into the evening hours, increasing service accessibility for clients who cannot attend during daytime hours.

### ***Personnel Involved***

As mental health-based WIC programs, all 36 programs are provided by psychologists, social workers, and/or psychotherapists. Among these agencies, 13 specified that they provided training opportunities to social worker, psychotherapist, and psychologist students [5,8,9,19-21,24,28,32,33,36,37,40-46,49,51-55,57,61]. Several of these agencies had partnerships with or are attached to post-secondary institutions in which the students are associated. Students played an integral role in filling capacity to run WIC programs, while the WIC programs also offered students a valuable learning and skill-building opportunity. For example, in the CCS WIC program, in which a team-based approach is used, students formed the majority of each therapeutic team, supervised by a psychologist [42,51,53]. Moreover, in six WIC programs, medical personnel, such as nurses, physicians, and psychiatrists comprise the team that support both WIC and full agency programming [28-30,40,43-46,52,55,62]. Lastly, three of the WIC programs were described as volunteer based. That is, the therapists that offer services volunteer their time to run the program [18,23,44].

### ***Intake procedures***

Intake procedures are typically an important element of counselling services, including WIC services. While the intake procedures for most WIC programs (22) were not indicated [18,20-23,27,29-31,36,39,49,50,56,58,60,61,62] and not relevant for three approaches [38,47,48], the intake procedures for the other 14 programs were described in brief

[5,8,9,19,20,24-26,32-35,37,39-43,45,46,51-55,57]. For three WIC programs, it was indicated that no intake was needed [20,26,34,35,53]. For six WIC programs, it was indicated that clients met with an intake worker to either complete the intake questions [5,8,9,19,24,25,32,33,37,39, 41,46,57], and for another three WIC programs, clients completed a set of intake forms [28,40, 42,43,45,51,52,54,55]. In one WIC program [44], it was noted that the therapist completed intake procedures themselves, and in one other program [59,60], the WIC program served as intake. It is possible that any of these intake procedural approaches were similarly applied in the programs for which this is not described. Whether clients met with an intake worker or completed intake forms, the information sought was very similar. At WIC intake, clients were asked questions regarding demographic information, distress levels, their present concerns, hopes for the session, and resources and strengths, and assessed for risk regarding suicidality, domestic violence, and risk of harm to others. In several studies this information was indicated to help with triaging service needs, ensure WIC was the best fit, and determine the most appropriate therapist for the presenting concern when possible.

**Evaluation tools**

Among the studies where the WIC program was evaluated, client distress and satisfaction were the most common measures. Client demographics were also commonly collected via demographic questionnaires. Harper-Jaques and Foucault [28], evaluating the South Calgary WIC program, also measured client’s hope using the Snyder State Hope Scale [63] and evaluators of the KWCS program [5,8,9,32,33,37,41,57] also measured client’s stage of change using the Stages of Change Questionnaire (SOCQ-18). Measurement tools for distress included the Outcome Rating Scale (ORS) [64], the Patient Health Questionnaire (PHQ-9) [65], the Generalized Anxiety Disorder questionnaire (GAD-7) [66], a distress thermometer, and the General Health Questionnaire (GHQ-12) [67]. Most agencies (9) used the ORS to measure distress [20,21,26,28,35, 40,42,43,44,51,54], while three agencies [20,26,28,35,40,43,45,46, 52,55] used a distress thermometer, two used the PHQ-9 [23,45,46,52,55], two used the GAD-7 [23,45,46,52,55], and one agency (KWCS) used the GHQ-12 [5,8,9,32,33,37,41,57]. The two studies measuring children’s distress used the Brief Child and Family Phone Interview version 3 (BCFPI-3) [18,68] and the Strengths and Difficulties Questionnaire (SDQ) [25,69]. To measure client satisfaction, measurement tools included the Session Rating Scale (SRS) [70], used by 10 agencies [5,8,9,20,21,26,27,32,33,35,37,41,42,44,51,54,57] and one used a program specific survey [28]. For the most part, there is overlap between the agencies that use ORS and SRS to measure client distress and satisfaction, as together these comprise the Partners for Change Outcome Management System (PCOMS) [71].

**Table 7**

*Measurement tools to evaluate WIC programs*

<b>Measurement tool</b>	<b>What it measures</b>	<b>Benefit for FSP</b>
Outcome Rating Scale [64]	A validated 4-item session-by-session measure that assesses a client’s overall well-being in four areas on a scale from 1-10: (1) individual well-being, (2)	<ol style="list-style-type: none"> <li>1. Client-centered feedback – prioritization of the client’s perspective regarding their progress</li> <li>2. Session-by-session monitoring – can track progress and make immediate</li> </ol>

	interpersonal well-being, (3) social well-being, and (4) overall functioning	<p>adjustments. Can track and evaluate progress over time, aiding to assess therapeutic progress</p> <ol style="list-style-type: none"> <li>3. Goal setting – helps clients identify changes they want to make, providing the therapist with information to support goals</li> <li>4. Scoring – a score can be calculated to get a better understanding of well-being</li> <li>5. Uses a visual scale, making it accessible for most clients</li> <li>6. Efficiency – 4-item scale that can be quickly administered to get a baseline.</li> </ol>
Session rating scale [70]	A validated 4-item questionnaire to measure a client’s feedback on the session and the therapeutic relationships. Clients rate their experience on a scale from 1-10: (1) experience of feeling heard, understood, and respected; (2) relevance of the session’s focus; (3) the therapist’s approach [goodness of fit], and (4) overall session quality	<ol style="list-style-type: none"> <li>1. Session-by-session monitoring: provides immediate, ongoing, actionable feedback for the counsellor, identifying any problems with the alliance</li> <li>2. Scoring – a score can be calculated</li> <li>3. Increased efficiency – better client-counsellor alliance can improve the efficiency and effectiveness of services</li> <li>4. Immediate feedback – can make immediate adjustments when scores are low</li> </ol>
PCOMS [71]	Comprises the ORS and SRS	<ol style="list-style-type: none"> <li>1. Identifies clients at risk of negative outcomes before treatment termination</li> <li>2. Provides quantifiable data on the effectiveness of providers and the system of care</li> <li>3. Uses reliable and valid measures, that are highly feasible to perform at each clinical encounter</li> <li>4. Provides a mechanism for consumer preferences to guide intervention choice.</li> </ol>
Patient Health Questionnaire (PHQ-9) [65]	The PHQ-9 is a validated self-administered 9-item instrument to assess depression.	<ol style="list-style-type: none"> <li>1. Validated tool for assessment of depression.</li> <li>2. Brief assessment tool.</li> </ol>
Generalized Anxiety Disorder (GAD-7) [66]	The GAD-7 is a 7-item self-administered screening tool for generalized anxiety disorder.	<ol style="list-style-type: none"> <li>1. Validated tool for assessment of distress.</li> <li>2. Brief assessment tool.</li> </ol>
General Health Questionnaire (GHQ-12) [67]	The GHQ-12 is a 12-item screening instrument to detect psychiatric disorders in community and non-psychiatric clinical settings.	<ol style="list-style-type: none"> <li>1. Validated tool for assessment of anxiety.</li> <li>2. Brief assessment tool.</li> </ol>

		3. Validated for use in community settings.
Snyder State Hope Scale [63]	The State Hope Scale is a 12-item tools that measures hope. Hope is defined as a positive motivation stated based on a sense of successful agency and pathways. The scale measures agency and pathways thinking.	1. Validated tool for assessment of hope. 2. Brief assessment tool.

***Implementation Approaches***

Only three articles [29,30,34] included details on the implementation processes of a WIC program, specifically OAAT therapy programs. To implement OAAT, and more broadly SC2.0 in the Northwest Territories, the project team reported using the Plan-Do-Study-Act cycle [34]. This framework supported continuous identification, problem-solving, and action to address implementation barriers. Harris-Lane et al. [29] and Harris-Lane et al. [30] retrospectively mapped the implementation process of OAAT therapy into adult, and child and youth addiction and mental health services in New Brunswick, respectively, onto implementation science frameworks. The implementation processes in New Brunswick retrospectively aligned with the Active Implementation Frameworks—Implementation Stages (AIF-IS) [73], Consolidated Framework for Implementation Research (CFIR) [74], and also utilized strategies promoted by the Expert Recommendations for Implementing Change (ERIC) [75]. Key implementation strategies included (1) ongoing monitoring of readiness to change and collecting stakeholder feedback for iterative improvement, (2) building a representative implementation team, (3) creating a comprehensive plan for implementation regarding staff training, communication, and system changes, and (4) supporting sustainability. While the implementation frameworks were applied retrospectively rather than being used to guide the process from the start, the findings demonstrated the importance of using a strong framework that involves continuous monitoring, facilitates a common language, and ensures rigorous measurement for practice change initiatives. The authors application of implementation frameworks can serve as a starting point for the application of best practices in implementation to implement WIC and other programs in community and non-profit agencies.

**Key Elements of Successful WIC Programs**

The thematic analysis revealed several key elements of WIC programs that contribute to the success of the WIC approach for clients, therapists, and organizations. These include (1) approach, modality, and technique, (2) therapeutic alliance, (3) client factors, (4) data collection and evaluation, (5) community and systemic factors, and (6) the therapeutic team.

***Approach, Modality, and Technique***

The approach, modality, and techniques used that are based on a pragmatic, strengths-based, collaborative, and client-centred orientation are a valuable aspect of WIC programs [5,8,9,23,27,28,29, 30,31,38,40,42,44,46,50,51,54,61,62]. Across several studies, clients reported that WIC sessions enabled them to gain insight, learn new skills and strategies, such as reframing and communication tools. The provision of practical support, informational support, and emotional support [27,28,29,31,61], as well as the collaborative, strengths-based and hope-based

approaches used in WIC programs were also perceived to be helpful [5,28,42,54]. The collaborative approach facilitates co-development of goals and strategies to address the client's presenting problems, promoting increased client engagement and motivation for change. The hope-based approach is similarly a key facilitator of motivation to change for clients. In addition, using culturally responsive approaches was identified as key, as this ensures approaches were adequately tailored for and respectful of all clients [18,34,42,46]. In developing the new ECMHS (formerly the Eastside Family Centre), the team hired staff with language and cultural diversity, enabling services to be offered in 10 languages other than English [46]. Finally, in the agencies that use a reflecting team approach, the provision of reflective feedback to clients was highlighted amongst these studies as important [42,44]. Reflective feedback, generated from the perspectives of active and observer therapists provides clients with a more comprehensive picture of the session, and may support the strengths-based and pragmatic orientation of WIC-SST. Overall, the findings from these studies show that the specific approach used by clinicians matters less than the client's engagement with therapy. This aligns with the broader understanding that the common factors of therapeutic approaches tend to benefit clients more than specific modalities.

### ***Therapeutic Alliance***

The therapeutic alliance between the client and the therapist was recognized to be important [22,26,28,29,30,31,35,42,44,50,51,52,54,61,62]. The findings of several studies indicated that building a strong rapport is possible within one session. This is important, as the therapeutic alliance impacts client satisfaction, the client's perceptions of whether their needs were met, and the change over time in client distress and well-being. In several studies, key elements of the therapeutic alliance reported by clients included feeling heard and respected, having someone willing to listen, the non-judgemental stance of the therapist, and the perception of feeling validated [28,29,30,31,52,54]. Moreover, based on reflections from several years of operating the KWCS WIC program, Bedggood [41] indicated that therapist philosophical skills and practice wisdom are critical elements to a successful therapeutic alliance. Philosophical skills involved the therapist being non-anxious, holding a single-session mindset, being comfortable with the unknown, and having an unconditional positive regard. Practice wisdom involved the therapist's skills regarding pacing and when to offer support versus concrete solutions.

### ***Client Factors***

The thematic analysis of key elements of WIC revealed that client factors can influence the helpfulness of WIC programs. We identified that client readiness to change and the meaning that clients attach to counselling services have an influence on the success and/or satisfaction with WIC programs [5,9,37,42,55]. While only discussed in a small minority of studies, it is important to be aware of how the client develops beliefs about therapy based on previous experiences and have varying levels of readiness to make changes in their lives, which can influence whether WIC sessions lead to positive outcomes and client satisfaction. Findings related to client readiness to change are important to understand, as a key element of WIC programs is how the immediate access can enable capturing client readiness to make change. Further research on the relationship between WIC models and client readiness to change may be

beneficial. Client beliefs about therapy are relevant, as past experiences with therapeutic encounters can impact how receptive clients are to the WIC model, their willingness to engage, and ability to make changes. Moreover, based on interviews with refugees who used a WIC service, Zehetmair [63] found that client factors acting as barriers included feelings of shame, internalized stigma, and language barriers. Thus, while the evidence surrounding client factors in relation to WIC services is minimal, there is some indication that client readiness to change, meaning of services, and beliefs play a role in client outcomes and satisfaction.

### ***Data Collection and Evaluation***

Regular data collection and evaluation of the WIC programs were indicated in several studies to be important [26,34,42]. Ongoing outcome measurement using validated measures can facilitate rigorous evaluation, strong data to provide funders, the ability to track changes over time, and address any concerns that arise over time more effectively. Our review showed that several different types of distress assessments are used and different types of information are collected across agencies (see Table7). When organizations use different assessment tools it can limit cross-organization comparison. However, it is important to choose tools that fit best for the organization and the clients. The organizations in Saskatchewan (Catholic Family Services Regina, Catholic Family Services Saskatoon, Family Services Regina, NEOSS, and SIGN) worked collaboratively to develop a shared outcome measurement framework that would enable these organizations to engage in comparison [20]. The five agencies collectively implemented PCOMS, a validated tool for measuring distress and client satisfaction. They showed the importance of a shared evaluation framework across agencies offering similar services, as it enabled more effective intra- and inter-agency evaluation and comparison.

### ***Community and Systemic Factors***

Across the included studies, community and systemic factors were identified as playing a key role in the success of WIC programs [20,24,26,29,30,34,62]. A few studies [22,26,34] suggested that increased community awareness is beneficial for WIC programs, facilitating demand, referrals from other social services to the WIC program, and client awareness of accessible and timely mental health services. The perceptions and buy-in of clients, providers, and organizations of WIC services was identified as important as well, as this supports service usage, acceptability and the efficacy of WIC programs [29,30]. Moreover, collaboration, both internal and external, was indicated as important for success. Partnerships with external agencies may enable enhanced referral connections, strengthen the program, and develop ways to serve rural and underserved communities [20,26,34]. For example, several agencies offered their WIC program at multiple locations in the community to increase accessibility. Catholic Family Services Saskatoon [20,36] and Catholic Family Services Regina [20] both offered WIC services at local foodbanks in addition to in-house. Family Service Regina [20] also offered their WIC program at the Regina Public Library two days a week in addition to two days at their agency. Moreover, partnerships were identified as critical to implementing OAAT, and SC2.0 more broadly in the Northwest Territories. By partnering with other mental health organizations, feedback could be sought from service providers, community organizations, and individuals with lived and living experience to bring in other perspectives [34].

### ***Effective Change Management***

Our analysis generated the understanding that effective change management plays an important role in successful implementation and change within WIC programming [29,30,34,]. While most WIC programs had existed for several years at the time of study publications, those reporting on new programs or changes to WIC formats illustrated that strong management of change and expectation related to change can help overcome resistance, build transparency and accountability, ensure information is effectively communicated, and make people feel valued and motivated. It was noted in a few cases, that staff were initially hesitant or resistant to the WIC format [19,21,29,30]. With effective change management in place, leaders can support their staff to make the change and increase acceptance of the change. Strategies for effective change management include use of evidence-based implementation frameworks, presence of engaged leaders (i.e., directors and managers), risk and readiness assessment for staff and organizations, ongoing open communication and engagement with stakeholders, sufficient training and education, and clear direction from leaders to services providers around implementation [29,30,34]

### ***The Therapeutic Team***

The therapeutic team was also identified as a key element of WIC programs [5,8,9,24,28, 31,32,33,37,40,41,42,43,44,45,46,52,55,57]. Collaboration among team members, including receptionists, intake workers, and therapists are important to ensure an effective flow of the clients through the WIC program. It was noted in several studies that team debriefing was important as this helps with skill development of less experienced therapists, determine how to best support clients, and maintain service cohesiveness [24,42,45,46,51,52,54,55]. Moreover, it was suggested that there is value in having a team lead for the WIC program. The team lead was indicated to coordinate the day or WIC shift and ensure effective service provision [24,28,40,43,45,46,52,55]. The team lead also acted as a source of immediate feedback for therapists using the intersession break or wanting to debrief following the end of the WIC sessions.

### ***Challenges to a successful WIC***

Alongside the identification of key elements of WIC programs, several challenges to operating a successful WIC program were identified across the reviewed studies [19,20,21,29,30,31,39]. A key challenge was instituting a WIC program within limited fiscal and human resources [20,21,29,30]. Without adequate funding and staff levels, WIC programs could not always meet demand or be offered beyond a limited number of days. Relatedly, concerns were raised about having to rely on therapist students to staff WIC programs, as demand may exceed paid staff availability and resources [21]. While WIC programs offer a beneficial training ground for students, the capacity to take on students is limited to the agency's capacity to provide necessary supervision for trainees. Other challenges included clients feeling that the limited sessions were not enough, staff resistance or hesitancy to adopt a WIC-SST approach [19,20,21,29,20], lack of adequate space [20,39], clients wanting to see the same therapist [61], and adapting to the different orientation of WIC-SST [19]

## **Client Outcomes**

### ***Presenting Concerns of Clients***

Based on the review of the studies, clients accessing WIC programs presented with a wide range of distress-inducing concerns. The most commonly reported primary issues of clients using WIC included mental health concerns, such as depression, anxiety, and post-traumatic stress disorder (PTSD) and relationship issues, such as family conflict, communication issues, couple issues, and separation/divorce [8,20,21,24,26,27,28,31,35,37,38,46,55,56]. Other issues reported by clients using WIC included trauma, stress, grief/loss, anger issues, addiction or substance use issues, domestic violence, probation, social phobias, sleep issues, managing child's mental or physical health, health/illness concerns, life transitions, and suicidality [8,18,21,24,26,27,28,31,35,38,46,55,58]. Across several studies, the presentations of clients were often classified as complex, as clients presented with co-occurring issues [37,38]. These findings illustrate that clients seek WIC services for a wide range of concerns.

### ***Client Satisfaction with WIC***

Most studies included in the review [18,19,20,22,23,26,28,29,30,34,35,38,55,61] examined client satisfaction with WIC programs. Overall, the findings from these studies demonstrated that the majority of clients were highly satisfied with WIC programs [18,19,20,22,23,26,28,29,30,34,35,38,55,61]. Clients reported that WIC services are a positive and helpful experience; the therapists are supportive, affirming, and non-judgemental; that they felt heard, safe, and validated; and that their concerns were addressed and met. Fang et al. [55] further examined the factors associated with client satisfaction. They found that post-session distress, level of improvement in distress, satisfaction with the approach taken, satisfaction with being heard, and working on what they wanted in the session were key factors mediated client satisfaction with the WIC programs.

### ***Changes in Client Distress Levels and Well-Being with WIC***

Most [8,18,19,20,22,23,25,28,29,30,31,34,35,37] primary research studies also examined changes in client distress and improvement in well-being due to attending a WIC session. These studies showed that clients consistently demonstrated clinically significant levels of distress before the WIC session. The findings demonstrated that the majority of clients experienced a significant decrease in distress following the WIC intervention, as well as reduced relationship conflict and improved well-being [8,9,18,19,20,22,23,25,28,29,30,31,34,35,37]. In a study using a quasi-experimental design to compare outcomes between WIC and traditional counselling programs, the findings showed that the WIC group demonstrated a steeper decline in distress compared to the traditional counselling group at the four-week follow-up point [8,9]. However, by 10-week follow-up, the change in distress was similar for both groups. Moreover, several studies found that clients with complex needs and those with mood issues benefited at higher rates from WIC, at least initially, illustrating the benefits of WIC for those in immediate and high distress. Similarly, in a non-randomized experimental study, Barwick et al. [18] found that the children in the WIC group had a steeper rate of decline in behavioural and emotional issues than the traditional counselling group. These findings disconfirm the idea that WIC would not lead to meaningful change after just one appointment. Fang et al. [55] further examined the factors associated with changes in distress. They found that post-session distress levels were mediated

by pre-session distress severity as measured by the PHQ-9, pre-session anxiety severity as measured by the GAD-7, previous counselling experience, satisfaction with services, readiness to change, and meaning of the service.

Beyond reductions in distress, the findings showed that clients also reported post-session improvements in well-being, communication skills, confidence to deal with their presenting issue, and increased hopefulness [27-31]. Moreover, while many clients reported that their mental health issues limited normal abilities to work and engage in normal daily activities, after attending a WIC session, clients saw improvements in ability to engage in these activities [32,37].

### ***Cost Effectiveness of WIC***

In some literature on WIC, there is an assumption that WIC may be more cost effective than traditional counselling. However, evidence supporting this assumption is quite minimal. Only two studies were found to have examined the cost effectiveness of WIC. Horton et al. [32] and Lamsal et al. [33] examined the cost effectiveness of the KWCS WIC program at two time points. To assess cost savings, both Horton et al [32] and Lamsal et al. [33] used published cost data and billing schedules related to the healthcare system and costs savings due to earlier return to work and reduced health service usage reported by clients at follow-up. They used the Incremental Cost-effective Ratio to calculate the cost savings. While they examined the same WIC program, the findings of the two studies were contradictory. Horton et al. [32] found small cost savings of \$21 per client for the first month over which outcomes were assessed. Lamsal et al. [33], on the other hand, found that while clients using the WIC program demonstrated a decrease in self-reported distress, the WIC program was not cost-effective compared to being on the waitlist for traditional counselling at one month follow-up. Given these limited and contradictory results, more research is needed regarding the cost effectiveness of WIC services.

### ***Sessions Used***

Several studies examined the number of WIC sessions used by clients. Most of these studies found that the majority of clients used one session, followed by two sessions [19,25,26, 28,29,30,59,60], even when examined over an extended time period. A smaller rate of clients used three or more WIC sessions. Moreover, Harris et al. [29] and Harris et al. [30] found that the implementation of OAAT resulted in large reductions to waitlists. These were the only studies that measured the change in waitlists over time with the implementation of a WIC service delivery model. Finally, von Doussa et al. [38] showed that the provision of a single-session therapy session to clients on a traditional service waitlist did not result in waitlist reductions. However, this model did reduce the subsequent length of treatment, with most families returning for one or two additional traditional counselling sessions.

### ***Service Use***

A few studies examined the relationship between WIC and the usage of other social and health services [8,18,31,37,59,60]. These studies showed that some clients presenting to WIC programs, particularly those with complex issues, accessed more community services following the WIC session [8,18,31,36,37,59,60]. These findings indicated that many clients may receive information of other community services and resources they can access, clients may be referred to other community services during WIC sessions, and/or that WIC services may not be effective

to fully address the clients concerns. Stalker et al. [37] also found that at follow-up, clients reported a decrease in health service post-WIC session. Understanding the relationship between WIC and other social and health service use is important for understanding how WIC fits in a larger integrated social service network.

### ***Negative Outcomes***

Despite the largely positive outcomes reported regarding WIC programs, several negative outcomes related to client satisfaction and distress were also identified. Negative outcomes included lack of perceived change by clients, the perception of needing more assistance beyond a single WIC session, client dissatisfaction with symptom and distress reduction post WIC session, the perception of needs not being met, and the service not being what clients expected [21,28,31,38,61]. These findings illustrate how WIC services do not work for every client, indicating that a range of service options must be available.

### **Benefits/Importance of WIC Programs**

Our thematic synthesis revealed three key benefits of WIC programs: (1) accessibility, responsiveness, and timeliness; (2) a key part of a mental health service continuum; and (3) benefits for certain groups.

#### ***Accessibility, Responsiveness, and Timeliness***

Our thematic analysis generated the understanding that WIC are highly accessible, responsive, and timely, enabling clients to get necessary support when they need it most. In a few studies, clients reported that they would not have otherwise sought help or they would have gone to their family doctor or the emergency department if the WIC program was not available [5,20,26,43, 56,57]. This supports the importance of WIC as a low-barrier, accessible, free service for people who do not know where else to turn or have limited options for other forms of support. Moreover, given that WIC services have no waiting list and do not require an appointment to be booked, clients can access service at their immediate point of need. This enables the ability to capitalize on client's motivation to change, which can lead to immediate changes and prevents the escalation of client issues and development of crises [5,20,57]. Additionally, some clients reported that WIC programs were helpful for interim support while waiting for more long-term and intensive support [24], as well as helpful for offering a booster session. Overall, the accessibility and timeliness of WIC programs was one of the most consistently reported benefit and elements of satisfaction for clients.

#### ***A Key Part of a Mental Health Service Continuum***

A key implication of several studies derived from their findings was that integrated, sustainable WIC programs are a key aspect of a mental health service continuum [5,8,9,18,20,28-30,35,52,54,59-61]. By adding such a program model alongside traditional counselling and other supports, clients can find the service best suited to their needs at the right time. Further, WIC was indicated to act as a bridge at times, as clients would be provided information about or referred to additional social services based on needs identified in WIC sessions [56,57,59]. Overall, the availability of WIC programs increases social service variety and flexibility.

### ***Benefits for Certain Groups***

WIC programs were highlighted in several studies to have benefits for certain groups, such as individuals with low income or living in poverty, those belonging to marginalized groups, individuals who have experienced disaster or displacement, and men. In studies that reported demographic data, several found that many clients using WIC programs identified as low income or living in poverty [9,21,26,31,57,59,60]. Since WIC programs are largely offered at no cost unlike most other counselling services, this program form is highly accessible for those of lower income status. Further, a couple of studies reported that compared to traditional counselling, more men accessed WIC, potentially making WIC an important resource for men [9,21,52,57]. WIC programs were indicated to particularly beneficial for diverse and marginalized communities [21,35,42,57,62]. For example, Bobele et al. [42], reflecting on years of service, have found that the WIC model was a particularly good fit for the Hispanic community they served. Moreover, Stalker et al. [9] found that higher rates of immigrants, men, and immigrant men used the WIC service compared to traditional services, indicating that WIC programming is a good fit for ethnically diverse communities and may have cross-cultural implications. Finally, two studies illustrated how WIC programming can be conducive to disaster and displacement setting. Dass-Brailford and Hage Thomley [23] found that a WIC service was of high benefit for survivors of Hurricane Katrina in New Orleans. Since these individuals were under high stress and not seeking a long-term commitment, a WIC program enabled this population to access support as they needed without appointments and previous commitments required. Zehetmair et al. [62] found that a WIC program was a helpful model to support refugees who had been displaced seek support needed to navigate the stress of this period.

## **Summary of Findings**

### **Characteristics of WIC Programs**

- **WIC approach/modality:** The review of the WIC programs illustrated that no single therapeutic framework is employed in WIC programs. While all programs used a single-session or one-at-a-time orientation to the program, treating each therapeutic encounter as a whole therapy process, a range of modalities are used in practice. The focus of WIC service delivery is typically to utilize systemic and brief therapies that emphasize client resources, are pragmatic, and aim to provide a clear outcome for clients within a single session. Approaches and modalities used include solution-focused brief therapy, narrative therapy, strengths-based approaches, an intersession break, the Milan Model, a reflecting team, CBT, DBT, and motivational interviewing.
- **WIC sessions allowed:** The review showed that the majority of programs do not limit or place restrictions around the number of WIC sessions that clients access. Only five programs had restrictions to one, three, four, and ten sessions. These findings align with Sarmiento and Reid [72] who conducted an Ontario-wide survey of WIC programs. They found that most programs did not restrict the number of sessions. Moreover, while most programs did not restrict the number of sessions available, most clients were found to utilize one or two sessions, with a minority using three or more sessions. These findings disconfirm the idea that clients may overuse WIC services.

- **Populations served:** The review demonstrated that WIC programs are used to serve both restricted and unrestricted populations indicating that the WIC format has high flexibility and wide applicability for clients. 17 programs served unrestricted programs, meaning they served individuals, couples, and families including children, youth, and adults. The other 19 programs served specific populations, such as children and youth, post-secondary students, women, refugees, survivors of violence, and hurricane Katrina survivors.
- **WIC service cost:** The review illustrated that only one WIC program had a cost associated with its services. The KWCS WIC clients pay on a sliding scale related to income ranging from \$0 to \$120 per session. As a sliding scale model, no client will be turned away due to not being able to afford the services.
- **Therapist guarantee:** In most papers, it was not stated whether seeing the same therapist for repeated WIC sessions was guaranteed or not. It was explicitly stated for seven programs that clients using WIC services more than once were not guaranteed to see the same therapist. This is likely the case for most WIC programs given the format being first come, first served. Seeing the same therapist repeatedly can only be guaranteed in instances where single-session therapy by appointment was also offered.
- **Time of WIC offering:** The review showed that there was variation in the number of days per week that the WIC services are offered. It was reported that nine agencies offer their WIC services one day a week, 17 agencies offer their WIC services multiple days a week, and eight did not indicate the number of days a week in which the WIC program is offered. Among the 17 agencies offering WIC services multiple days per week, four offered the service two days per week, one offered the service three days per week, two offered the service four days per week, three offered the service five days per week, and two offered the service six days per week. Five agencies indicated that their WIC program was offered multiple days per week but did not specify an exact number of days. Most WIC programs offered services into the evening hours, increasing service accessibility for clients.
- **Personnel involved:** All 36 WIC programs are provided by psychologists, social workers, and/or psychotherapists. Students of these professions played important roles in WIC programs, with 13 programs found to offer training opportunities. Six WIC programs also involved medical personnel, such as nurses, physicians, and psychiatrists. Finally, three of the WIC programs were volunteer based, with therapists volunteering their time to run the services.
- **Intake procedures:** In the majority of WIC programs (22), the intake procedures were not described. For the other 14 programs, three did not involve intake procedures, three used intake forms, six involved clients meeting an intake worker, one involved the therapist completing intake, and one WIC program served as intake. At WIC intake, clients were asked questions regarding demographic information, distress levels, their present concerns, hopes for the session, and resources and strengths, as well as assessed for risk regarding suicidality, domestic violence, and risk of harm to others.
- **Evaluation tools:** Among the studies where the WIC program was evaluated, client distress and satisfaction were the most common measures. Client demographics were also commonly collected via demographic questionnaires. Measurement tools for distress included the Outcome Rating Scale (ORS), the Patient Health Questionnaire (PHQ-9), the Generalized

Anxiety Disorder questionnaire (GAD-7), a distress thermometer, and the General Health Questionnaire (GHQ-12). The two studies measuring children's distress used the Brief Child and Family Phone Interview version 3 (BCFPI-3) and the Strengths and Difficulties Questionnaire (SDQ). To measure client satisfaction, measurement tools included the Session Rating Scale (SRS). The ORS and SRS were two most commonly used evaluation tools.

- **Implementation Processes:** Only three articles [29,30,34] included details on the implementation processes of a WIC program, specifically OAAT therapy programs. Key implementation strategies included (1) ongoing monitoring of readiness to change and collecting stakeholder feedback for iterative improvement, (2) building a representative implementation team, (3) creating a comprehensive plan for implementation regarding staff training, communication, and system changes, and (4) supporting sustainability. The authors' application of implementation frameworks can serve as a starting point for the application of best practices in implementation to implement WIC and other programs in community and non-profit agencies.

### Key Elements of WIC Programs

- **Approach, modality, and technique:** The collaborative, solution-focused, pragmatic, strengths-based, and client-centred approaches taken in WIC programs was widely found to be beneficial for and perceived positively by clients. Across several studies, clients reported that WIC sessions enabled them to gain insight, learn new skills and strategies, as well as receive practical support, informational support, and emotional support. The collaborative, culturally responsive, strengths-based and hope-based approaches used in WIC programs have been found to be helpful for promoting client motivation. The findings showed that the specific approach used by clinicians matters less than the client's engagement with therapy. That is, common factors of therapeutic approaches tend to benefit clients more than specific modalities
- **Therapeutic alliance:** The therapeutic alliance between the client and therapist was found to be key, as this impacts client satisfaction, the client's perceptions of whether their needs were met, and the change over time in client distress and well-being. In several studies, key elements of the therapeutic alliance reported by clients included feeling heard and respected, having someone willing to listen, the non-judgemental stance of the therapist, and the perception of feeling validated.
- **Client factors:** While only identified in a minority of studies, client factors including client readiness to change and the meaning that clients attach to counselling services were indicated to influence the success of and/or satisfaction with WIC programs.
- **Data collection and evaluation:** Regular data collection and evaluation of the WIC programs were indicated in several studies to be important. Ongoing outcome measurement using validated measures facilitates rigorous evaluation, strong data to provide funders, the ability to track changes over time, and address any concerns that arise over time more effectively. Our review showed that several different types of distress assessments are used and different types of information are collected across agencies.
- **Community and systemic factors:** Community and systemic factors were identified as playing a key role in the success of WIC program. These factors include community

awareness of the WIC program; perceptions and buy-in to the WIC model by clients, providers, and organization; and partnerships with other agencies in the community.

- **Change management:** While most WIC programs had existed for several years at the time of study publications, those reporting on new programs or changes to WIC formats illustrated that strong management of change and expectation related to change can help overcome resistance, build transparency and accountability, ensure information is effectively communicated, and make people feel valued and motivated.
- **Therapeutic team:** Collaboration among team members, including receptionists, intake workers, and therapists are important to ensure an effective flow of the clients through the WIC program. Strong coordination, effective client flows, and regular team debriefing and supervision are important elements for a strong therapeutic team.

### **Client Outcomes of WIC Programs**

- **Presenting concerns:** Client issues included mental health concerns (i.e., depression and anxiety), relationship issues (i.e., family conflict, communication issues), trauma, stress, grief/loss, anger issues, addiction or substance use issues, domestic violence, probation, social phobias, sleep issues, managing child's mental or physical health, health/illness concerns, life transitions, and suicidality. The presentations of clients were often classified as complex, as clients presented with co-occurring issues.
- **Client satisfaction:** Most studies examined client satisfaction with WIC programs. Overall, the findings from these studies demonstrated that the majority of clients are highly satisfied with WIC programs.
- **Client distress:** Most primary research studies also examined changes in client distress and improvement in well-being due to attending a WIC session. These studies showed that clients consistently demonstrated clinically significant levels of distress before the WIC session. The findings of these studies demonstrated that the majority of clients experienced a significant decrease in distress following the WIC intervention, as well as reduced relationship conflict, increased hopefulness, improved well-being, enhanced communication skills and confidence, and a return to work and normal daily activities.
- **Cost effectiveness of WIC:** Two studies were found to have examined the cost effectiveness of WIC. While they examined the same WIC program, the findings of the two studies were contradictory. Horton et al. [32] found small cost savings of \$21 per client for the first month over which outcomes were assessed. Lamsal et al. [33], on the other hand, found that while clients using the WIC program demonstrated a decrease in self-reported distress, the WIC program was not cost-effective compared to being on the waitlist for traditional counselling at one month follow-up.
- **Sessions used:** Most studies found that the majority of clients used one or two WIC sessions, with a smaller rate of clients used three or more WIC sessions.
- **Community service use:** A few studies showed that some clients presenting to WIC programs access more community services following the WIC session.

## **Promising Practices for WIC based on Scoping Review Findings**

Based on this scoping review of WIC programs and services, the following promising practices have been developed:

### **WIC approach/modality**

1. WIC therapists should use systemic and brief therapies that emphasize clients' strengths and resources, are pragmatic, culturally sensitive, and aim to provide clients with a clear outcome within a single session.
2. WIC therapists should be adequately trained in several systemic and brief therapies to enable appropriate use of discretion to use approaches that best fit for the client and their presenting concerns.
3. WIC therapists need to be skilled in operating from a single-session mindset to enable clients to leave the WIC session with a clear outcome or set of next steps to address their presenting concerns.
4. Team-based approaches to conducting WIC sessions, such as the reflecting approach can be beneficial. However, resource constraints likely make such an approach non-feasible in non-profit setting.
5. An intersession break may be helpful for therapists, especially students, to debrief with another therapist, as well as take a moment to reflect on the client's situation before providing specific resources and information.
6. The specific approach used by clinicians in WIC sessions matters less than the client's engagement with therapy. That is, common factors of therapeutic approaches tend to benefit clients more than specific modalities.

### **Therapeutic Alliance:**

7. To build a strong therapeutic alliance in a single session, therapists must be non-judgemental, willing to listen with an open-mind, and demonstrate respect for clients.
8. Building a strong therapeutic alliance is important for support positive client outcomes and client satisfaction.

### **Number of WIC Sessions Clients Can Access:**

9. WIC programs should be offered without restrictions on the number of sessions clients can access.
10. In instances where restrictions to WIC sessions is necessary, sessions available should not be less than three.

### **WIC Service Cost**

11. WIC programs in non-profit agencies should be offered at no cost to clients to align with the intention of WIC services to be highly accessible for all clients.
12. If cost for WIC service is necessary, clients should pay on a sliding scale related to income, with \$0 as the lowest price available.

### **Days WIC Services are Offered**

13. There is not a specific number of days that can be definitively stated to be the most appropriate for offering WIC services. The number of days WIC services are available will depend on staff levels, client demand, space capacity, and other relevant factors. The

most appropriate number of days to offer WIC services is program and community dependent. Organizations must account for relevant factors when determining how often to offering WIC services.

14. Offer WIC service hours in the evenings and potentially on the weekend to ensure broad availability and accessibility.

### **Personnel Involved in WIC Programs**

15. Well-trained social workers, psychologists, and/or psychotherapists comprise personnel who run WIC services.
16. WIC programs provide effective training environments for students of social work, psychotherapy, and psychology.
17. Strong training procedures, protocols, and processes are needed for staff and students who are new to WIC services [41]. This will ensure consistency in training and service delivery quality in WIC programs.

### **Intake Procedures for WIC**

18. At WIC intake, clients should be asked a brief set of questions regarding demographic information, distress levels, their present concerns, hopes for the session, resources and strengths, and be assessed for risk regarding suicidality, domestic violence, and harm to others.
19. Intake for WIC can be conducted by a well-trained intake worker or via brief intake forms.

### **WIC Program Evaluation Tools**

20. WIC program evaluation should be conducted using validated measures for client distress, well-being, and service satisfaction.
21. The ORS and SRS, which comprise PCOMS are a primary and effective evaluation framework for WIC services.

### **Community Connections**

22. Build strong partnerships with other community social services to generate demand, facilitate service referrals, and increase WIC program awareness.

### **Therapeutic Team**

23. Allot time for regular team debriefing.
24. Allocate a WIC program team lead to supports client flow from reception to counselling, coordinates intake, and supports debriefing as needed.

### **Implementation Processes and Change Management**

25. When implementing new programming or changes to existing programs and structures, use evidence-based implementation frameworks and strategies.

## **Recommendations for FSP**

### **WIC approach/modality:**

- Based on this review, no one specific approach, modality, or technique is recommended for FSP's WIC program.
- It is important that clinicians be trained in systemic and brief therapies that emphasize client strengths and resources, are pragmatic, and aim to provide a clear outcome for clients within a single session.
- It will be beneficial to operate from a single session or one-at-a-time mindset/orientation rather than applying a traditional counselling framework to WIC services.
- It is recommended that FSP continuously work to enhance cultural responsiveness and appropriateness of services. This could include exploring options to offer WIC services in other languages besides English.

### **Sessions allowed:**

- FSP's restriction of WIC services to three sessions is not supported by the findings of this review. Based on this review, it is recommended that FSP continue to offer clients at least three WIC sessions and not reduce WIC session availability. However, since most WIC clients only use one or two sessions, keeping the WIC program at three available sessions can help reduce attrition in ongoing counselling programs.

### **Population served:**

- The findings support FSP's offering of WIC services to all clients, as such no specific recommendations are needed.

### **WIC service cost:**

- It is recommended that WIC services continued to be offered at no cost to align with the intention to be highly accessible for all clients.

### **Therapist guarantee:**

- it is recommended that FSP continue to operate without a therapist guarantee, ensuring this information is effectively communicated to clients during their first session.

### **Personnel involved:**

- It is highly recommended that FSP develop a student and new staff training manual for WIC services to promote training consistency, high quality service delivery, and accessible information.
- It is recommended that FSP consider instituting a team lead for the WIC program day to support coordination, client flow, and support counsellors as needed.

### **Intake procedures:**

- It is highly recommended that FSP streamline WIC intake forms to be a brief package collecting information on key client demographics, distress levels, presenting concerns, hopes for the session, and resources and strengths, as well as risk regarding suicidality, domestic violence, and harm to others.

### **Evaluation tools:**

- It is highly recommended based on the reviewed programs that FSP consider the implementation of PCOMS, which comprises of the Outcome Rating Scale (ORS) and Session Rating Scale (SRS), into both WIC and ongoing CP. They are highly feasible, session-to-session measures for monitoring that can be implemented to track progress and satisfaction across a range of client problems and treatment approaches. By implementing PCOMS, PIRT can help FSP to monitor program outcomes in a systematic, reliable, and valid manner over time. This will provide rigorous data that will (1) support FSP counsellors to immediately respond to client's needs; (2) enable FSP counsellors to address gaps in therapeutic alliance immediately; and (3) support funding for the WIC and CP programs and applying for additional funding through calls for proposals.

### **Community Connections**

- It is recommended that FSP increase community connections and partnerships to generate demand for the WIC program. Community partnerships are a key element to WIC program success.

### **Change Management**

- It is recommended that FSP utilize evidence-based implementation frameworks and strategies when making any future changes to provide strong guidance, measurable constructs, and increase staff trust and motivation.

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