

A primer on single session therapy and its potential application in humanitarian situations

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Single session therapy is a specific form of therapy conducted by professionals who seek to use their existing skill sets and knowledge base to address clients' presenting concerns, within one session. The session takes place with the understanding that the session might be the only one. Such single session services are currently expanding in a number of high income countries. This paper calls attention to this therapy for potential adaptation to acute emergency settings, in low and middle income countries, where offering one session may be the only option. This paper describes: (a) single session therapy as adapted in recent emergency settings; (b) the single session model in high income countries; (c) its relationship with psychological first aid; (d) the development of the model and its evidence base; and (e) the model as an intervention and a service. While single session therapy holds promise for work in humanitarian settings, there is still a need for randomised controlled studies in humanitarian settings before this therapy may be considered as recommended, evidence based, humanitarian practice.

Keywords: evidence based, humanitarian emergencies, single session therapy

Introduction

In many emergency situations, the inability to offer multiple session treatment and follow-up for mental health and psychosocial concerns means a single session is often the only option (Urrego et al., 2009). This paper intends to familiarise humanitarian mental

health staff with single session therapy (SST) as an option for use as mental health and psychosocial support. The methods used to gain information to develop this paper are described in Box 1. SST is conducted by professionals, who use their existing skill sets and knowledge base, to address clients' presenting concerns with the understanding that the single session might be the only one. There has been extensive discussion of the single session model in non emergency settings (Slive & Bobele, 2011; Horten et al., 2012). However, in this paper, the authors highlight the potential application of this modality in emergency settings, where access to care can be poor and therefore a single session may be, in some situations all that is possible, presenting an appropriate environment for its application. Indeed, during the technical meeting on *Responding to the Psychosocial and Mental Health Needs of Sexual Violence Survivors in Conflict-Affected Settings*, SST was proposed as a potential model requiring further research (WHO et al., 2012).

In non emergency settings, in high income countries, mental health service providers increasingly choose to offer SST in specific environments. For example, when provided through a walk-in service, SST allows a distressed individual who is hoping for, and prepared for, change to immediately access professional assistance (Slive & Bobele, 2012).

Box 1: Methods

The following four methods led to the information described in this paper:

1. Consultation with 14 professionals, with experience providing single session services, mental health services in disaster settings, or mental health services in primary health care settings. (For a full list of those involved in the consultation, see *Acknowledgements*.)
2. Narrative review of the literature including: case studies; grey literature (informally published materials, such as reports from agencies); presentations; and historical papers.
3. Systematic review of randomised controlled trials.
4. Personal observations of walk-in single session therapy services in Calgary, Canada (seven shifts).

There are three main types of single sessions in discussed in the literature:

- (1) SST as a therapeutic approach or model: typically with defined principles and semi-structured questions in order to address the client's presenting concern (whatever that may be), with the understanding that the single session may be the only one (Bloom, 1981; Talmon, 1990);
- (2) manuals of single session protocols designed for use with specific problems: single session cognitive behavioural therapy (CBT) to address specific phobias (Ollendick et al., 2009); single session CBT to address posttraumatic stress disorder (PTSD) (Başoğlu et al., 2005; 2007); single session eye movement desensitisation and reprocessing (EMDR) for PTSD (Jarero & Uribe, 2011); single session psychological debriefing to diminish or prevent traumatic stress (Robinson & Mitchell, 1993); and motivational interviewing or brief interventions for substance use problems (McCambridge & Strang, 2004; Rutledge, 2007); and
- (3) early drop-outs from longer term treatment (Simon et al., 2012).

While manualized protocols for specific problems and early drop-outs are of interest, this paper focuses only on the first type: the SST as a therapeutic approach or model for any presenting concern.

Experience in recent emergency settings

In some recent emergency settings, including Hurricane Katrina (Miller, 2010), the ongoing, armed conflict in Columbia (Urrego et al., 2009), and the 2010 Haiti earthquake (Guthrie, personal communication, May 2012) mental health professionals have adapted SST as a framework to guide their practice.

Hurricane Katrina

In response to Hurricane Katrina, Miller (2010) found the strategies he previously used during walk-in single sessions in Calgary were applicable to mental health within a disaster setting. In both settings, Miller found that the professionals role was to acknowledge the client's concern, help them prioritise their goals, provide only the assistance asked for, and focus on their strengths and resiliency (e.g., support systems) (see Table 1). Working alongside disaster mental health workers in disasters in the emergency

centres, Miller was able to provide SST to those seeking professional support who had either walked-in, or were referred from a mental health worker. Miller created an opportunity for those affected by the Hurricane to discuss the loss, related feelings,

and difficulties, but only if initiated by the client. Miller believes that the act of offering a single session, in itself, may help to promote recovery and that long term, inexpensive, and in-depth treatment may not, therefore, be necessary. His viewpoint is that the

Table 1. Guiding questions and format for single session interventions in emergency settings

Introduction:

- Explain the service and the amount of time you will spend together.
- Welcome them to return to the service (if possible).
- Remind them that if they return, they will likely see another therapist.

What is the single most important concern that you have right now?

- Explore the most important type of help needed.
- Prioritise needs. Keeping the most immediate and critical needs a priority, yet still be mindful of other needs.
- Assess risk (e.g., immediate risk of suicide/self-harm. or harm to others).

People usually try to resolve a problem themselves. What things have you tried?

- Remind the client of their own strengths and resources through informing them that people who experience loss and traumatic events commonly:
 - learn something about their personal and interpersonal resources, strengths or resiliencies through previous losses;
 - start moving forward and rebuilding their lives, but additional encouragement and support may be needed to help sustain those processes.
- Explore what they have already tried to prevent them from continuing to try something that is not working.
- Recognize that exploring these questions are important to increase the client's level of hope, which can be the first step toward healing.

What inner strengths would it be useful for us to know about?

- Educate clients about key resiliency factors e.g., strong family relationships, positive outlook, spiritual convictions, sense of hope, feelings of personal control, creativity or humour.
- Explain the role of resiliency factors as crucial components of the process of moving forward, and rebuilding, their lives.

What would be the smallest change needed to show you that things are heading in the right direction?

- Help the client identify and prioritise their goals and problems.
- Understand that multiple problems and goals can overwhelm the client, or increase their feelings of a loss of control.
- To help increase the client's sense of control, help the client think smaller rather than bigger, and help them focus on the next step they can take (even if it is in the session).

(Adapted from Miller, 2010).

professional simply acts as a catalyst for change, allowing people's natural resilience and capacities to be the significant components in the healing process (Miller, 2010).

Columbia

Providing services in the midst of Colombia's internal armed conflict, within a specific area of the country, meant many of those affected could only access the Médecins Sans Frontières (MSF) Spanish mental health team on one occasion. Because of this, the MSF team could not plan, monitor nor follow-up over multiple sessions, so they adapted the SST model. The study, based on this intervention, found that more than half of all clients presented with depressive symptoms, or situational difficulties. In evaluating the approaches usefulness, the MSF team's study revealed 67 of 71 (94.4%) clients reported, immediately after the session, that the single session was helpful. Through the narrative (qualitative) component of the study, clients described that the single session *'helped to get out of the maze where they had been lost and had found no response, and helped one to feel stronger and see the capabilities one has'* (Urrego et al., 2009). The study's responses suggest that SST had its intended influence on *'positive redefinition, the mobilisation of individual resources, and finding solutions in the here and now'* (Urrego et al., 2009).

Haiti

In Haiti, Guthrie adapted the SST model in a medical clinic. He reported that each day, doctors referred about 15 cases of extreme distress to him, mainly PTSD or complicated grief. He saw no possibility of making further referrals to existing mental health services, so he adapted SST, acknowledging Haitian's assumed strengths and resiliency. During the single session, he reported

exploring the client's presenting issue and working towards progress with the person in distress (Guthrie, written communication, August 2012).

The single session model

The single session model's description, principles and processes differ, based on the service context. In 1981, Bloom defined SST as *'an encounter designed to provide a significant therapeutic impact in a single interview'* (Bloom, 1981). A recent book on single session walk-in therapy described SST as *'a complete therapy, in and of itself, clients present a concern and goals are constructed and it aim[s] for clients to leave with a sense that they've been heard, with hope, and with an increased awareness of their strengths and resources'* (Slive & Bobele, 2011). The Bouverie Center, which has been providing single session services in Australia since 1994, describes single session work as a service provision model (Young et al., 2012). SST is considered to be appropriate for those for whom psychological first aid is not enough, and who may benefit from brief professional psychotherapeutic support (Miller, 2010). This is relevant in acute emergency contexts where there are high numbers of people who need more than psychological first aid, and who have limited access to professionals who have not yet had the time to train and supervise paraprofessionals in offering effective psychological support. Of note, while SST can provide adjunct support to clients living with severe mental disorder and/or at imminent risk of suicide, such clients will require more extensive treatment.

Consistent with psychotherapy research findings that suggest most change occurs during the first couple of sessions of therapy (Howard et al., 1986; Seligman, 1995), the single session model proposes that many people receive sufficient support from (a) a

single session together with (b) the offer of future single sessions if needed (Bloom, 2001). Other authors (e.g., Slive & Bobele, 2012), use findings from the dose response and phase models literature or common factors research to support the basis of the single session model. Dose-response and phase models literature explores the relationship between the number of treatment doses or sessions and rates of change. Literature examining dose response and phase models suggest that most improvement occurs at the beginning of psychotherapy and decreases over the number of sessions (Hansen & Lambert 2003; Lambert & Forman, 2002; Wolgast et al., 2003). Similarly, research on common factors relates positive therapeutic outcomes to a strong therapeutic alliance that focuses on the client's motivations and needs; creates hope; continually gathers feedback from the client and focuses on resources and strengths (Duncan et al., 2004; 2010; Wampold, 2001). Within the single session, the professional seeks to positively influence future thoughts and behaviours, while recognising that many significant changes occur outside the planned therapy process (Bloom, 2001).

Single session therapy and psychological first aid: similarities and differences

'Psychological first aid [PFA] is a description of a humane, supportive and practical response to a fellow human being's suffering [in the immediate aftermath of exposure to serious stressors] and who may need support' (Inter-Agency Standing Committee (IASC), 2007). PFA and SST are both responses to those who are suffering and need support. Both models assess needs, or concerns, and assist people while respecting dignity, culture and abilities. Neither model

includes, unless requested by the client, a discussion of the event that caused distress. In both models, the helper assesses for level of risk, encourages positive ways of coping and links with other services and support, as necessary.

Different from PFA (as described by the World Health Organization (WHO), War Trauma Foundation (WTF) and World Vision International (WVI), 2011), SST's principles and semi-structured questions allow professionals to apply their, previously learned, psychotherapeutic techniques (see Table 1). So, unlike PFA, SST requires previous, in-depth training, and relies upon previous clinical experience and skill sets. In emergency settings, SST has the potential to be offered as part of a specialised mental health service. As such, the goal of SST is *'helping the clients adjust and deal with the range of new needs and emotions that emerge from the trauma'* (Miller, 2010).

Development of the model and its evidence base

Hoyt, Rosenbaum & Talmon (1992) made early contributions to SST's literature and development. In one of their seminal pieces, entitled Planned Single Session Therapy (1992), they discuss three historical, systematic studies of SST that related improved symptoms, lowered distress levels and decreased medical utilisation after a single session (Malan et al., 1975; Cummings & Follette, 1976; Rockwell & Pinkerton, 1982). Building on these historical studies, Rosenbaum, Hoyt & Talmon (1990) followed up with non emergency outpatients, after three to 12 months at the Kaiser Permanente Medical Group, a health care provider in the United States. From a sample of 60, 34 (58.6%) had one session. Of the 34 who had only one session, 31 (88%) reported improvement, and 23 of the 34 (65%) also

reported the session created positive ‘ripple’ effects.

Since the early 1990s, these findings have guided organisations in English-speaking, high income countries (e.g., Australia, Canada, and the United States) as they provided, developed and researched SST (Slive, McElheran & Lawson, 2008; Taylor et al., 2010). Health and community based organisations adapted the single session model to improve service delivery to various target groups and ages (individuals, couples and families, children and adolescents), cultures (Mexican Americans or Aboriginals) and various contexts (high or low income settings within high income countries) (Harper-Jaques et al., 2008; Bobele et al., 2008; Slive & Bobele, 2011). Providing single sessions as a walk-in service is expanding, and some health care services in Canada have begun to offer walk-in mental health services within primary health care clinics. The single-session literature also discusses hospital social workers who work from a strengths based approach with limited resources, who need to provide services to many clients, and who may only see their clients once (Gibbons & Plath, 2005).

The absence of an intake, triage, waiting list, or assessment, is key to the accessibility of single session services (Slive & Bobele, 2012). For many service providers in developed countries and other non emergency settings, adopting the single session model decreased their waiting lists, and authors inferred that they were also providing more cost effective care (Horten et al., 2012; Weir et al., 2008; Perkins, 2006).

Most of the research that emerged during the development of these services includes uncontrolled studies that explored the usefulness of a single session. Of the three Australian SST studies conducted in diverse settings, Boyhan (1996) noted 45–53% of

participants were content with SST, with the assurance they could return for another session. Furthermore, 63–78% of participants described high to moderate levels of improvement after SST. In 2004, Miller & Slive evaluated walk-in SST in Calgary. Of the study participants, 67.5% (29) indicated improvement in the presenting concern after one session, and 43% [of those?] (19) said one session was enough, when contacted three to six weeks after their single session. While lack of a control groups limit these studies, they do suggest potential.

More recently, Simon and colleagues (2012), explored satisfaction surveys from the Group Health Cooperative, a health care provider in the United States. Of the 2,666 who matched their inclusion criteria, 906 (34%) had only one session within a 45-day time frame. Of those 906 (34%), Simon et al., (2012) found *‘those who did not return were more likely to report care experiences at the positive (high satisfaction, strong therapeutic alliance, and large clinical improvement) and negative extremes (low satisfaction, poor therapeutic alliance, and clinical worsening)’*. In relation to humanitarian settings, this study could support single session therapy’s assumption that one session may be enough for some to be satisfied, while others may still require more long term treatment in order to achieve satisfaction.

To identify treatment efficacy, the authors conducted a search for randomised, controlled studies and used two approaches to identify such studies. As mentioned in the introduction, single session studies for specific problems (CBT for PTSD, motivational interviewing for substance use problems) were excluded.

The two applied approaches were:

1. Reviewing existing reviews. We found four unsystematic reviews (Bloom, 2001; Hurn, 2005; Cameron, 2007; Campbell, 2012) and, within these reviews, the

authors identified one randomised controlled study, and follow-up (Perkins, 2006; Perkins & Scarlett, 2008)

2. A systematic search was conducted in August 2012, in English. Search terms included (synonyms of) *'mental health', 'single session therapy',* and *'randomised controlled trial'* (further details available upon request). PubMed, Social Work Abstracts, Embase, Psychology and Behavioural Sciences Collection and Psych Info were the main databases searched, with an applied limitation of only English language studies. This search did not lead to the discovery of any additional, randomised controlled studies

Perkins (2006) conducted a randomised controlled study, including 216 people, aged 5 – 15, from an outpatient child and adolescent public mental health clinic in Australia. The study randomly assigned participants to either the treatment group, who received a booked single session within two weeks, or to a control group who were placed on a six-week waiting list. The SST involved a two hour, semi-structured assessment and solution focused treatment session with the child, carer and siblings. The session included the basic parts of a diagnostic assessment, focused on current problems, explored what they had previously tried, and created plans for moving forward. At the end of the session, the clinician and participants collaboratively decided if more interventions were necessary. Measures included parent, teacher and clinician standardised and multi-dimensional outcome measures, and pre and post rating scales. Other measures included: the Devereux Scales of Mental Disorders (DSMD), the Health of the Nation Outcome Scales for Children and Adolescents, and the Client

Satisfaction Questionnaire-8. In the single session, the clinicians diagnosed 73% (159) of clients with meeting the Axis I Disorder DSM-IV criteria, including: parent-child relational problems, oppositional defiant disorder, anxiety disorder, Attention Deficit Hyperactivity Disorder (ADHD), adjustment disorder with mixed disturbance of emotions, disruptive behaviour disorder, and separation anxiety disorder (Perkins, 2006).

The treatment group demonstrated, both statistically and clinically, significant improvements compared to the control groups, with the exception of the teacher rated DSMD. Perkins (2006) reports these findings as comparable to those that come from different types of therapy, and similar to the findings of aforementioned, uncontrolled SST studies (Boyhan, 1996; Price, 1994; Perkins, 2006). At the 18 month follow-up, Perkins & Scarlett (2008) explored the long term effects of SST. The study, however, does not include the number of clients who no longer met DSM-IV criteria at follow-up. Yet, the findings did suggest significant improvements among approximately 60% (129) of the clients who had had only one session of therapy. Furthermore, the study reported that clients maintained the positive changes recorded initially, during one month follow-up, after 18 months.

The single session model as an intervention and as a service

There is no single unifying theory for SST. Most of the literature suggests a strengths based model, building on the client's resources. While some authors discuss the therapy in terms of change, narrative or crisis oriented theories, brief solution focused therapy, post modern, social constructivist or systemic approaches, single session work is always meant to be

pragmatic, and based on the clients' presenting concerns (Slive & Bobele, 2011; Gibbons & Plath, 2005). To address these particular concerns, SST is meant to be a flexible and creative approach, where many different techniques and methods can be applied (Campbell, 2012; Talmon, 2012). Furthermore, SST focuses on problems as they currently exist, rather than exploring the client's history, or theories about their root causes (Slive & Bobele, 2012). As expressed by Campbell (2012), the client should leave a single session *'with a plan how to solve their problem, the confidence that they have the skills and resources available, and the knowledge that they can come back at any time for further work'* (see Box 2 for an example).

The authors will discuss single session therapy as in intervention and a service. When SST is discussed as an intervention, it is an individual interaction between the professional and person requesting assistance, or experiencing distress that is

examined. When SST is discussed as a service, it is the manner in which the intervention is provided (for example: as a pre-session component, follow-up, location, or use of a team) that is being explored. As the previous examples demonstrated, humanitarian settings may only allow for the provision of the intervention. In order to better inform readers working in humanitarian settings, the authors describe here both the single session intervention, and the service provision, as carried out in stable, high income countries. It is well acknowledged that this model would need to be adapted extensively for use in different contexts.

Consistent with the principle of integration, highlighted in the introduction of the *Inter-Agency Standing Committee Guidelines*, single session services are typically integrated within existing health or community based organisations (IASC, 2007). Single session services tend to be offered by teams who are multi-disciplinary, consisting of experienced

Box 2: *A single session story: assisting with sleep problems after an earthquake, using the client's own stress reduction techniques*

One therapist combined her previous skills and experience in narrative and solution focused therapy into a single session. Her client was a woman struggling with earthquake related anxiety as a result of previously surviving several earthquakes. However, this had occurred without any major influence on her daily life. Yet, two months prior to the session, an earthquake had occurred that resulted in both anxiety and insomnia. She sought evaluation, and during her single session the therapist adapted an inquisitive approach, and listened to the client's story. The therapist was able to help her recognise the beach as a place where she had previously felt safe. The therapist facilitated her by applying a visualisation strategy to address her current anxiety and insomnia by holding a shell and imagining she was at the beach while she fell asleep. During a brief follow-up, the woman reported an improvement in her sleep levels. This case example demonstrates how a professional applied a previously learned therapeutic model to the client's presenting problem, assisting the client in recognising their strengths and resilience, in order to create a plan to move forward within a single session.

(Phillips, 2002)

professional social workers, nurses, or therapists, with a diverse range of skill sets (Campbell, 2012). The team format creates an opportunity for support supervision and the training of students (Harper-Jaques et al., 2008). What is typically involved in stable, high income countries in single session services, and how this may be adapted for humanitarian settings are discussed below.

Pre-session (non emergency affected, high income country):

- A phone call or pre-session form helps the client's process of change by asking what brought them in, what they have already tried and what they hope to get out of the session. The forms may also include queries on: substance use, safety, well-being, and levels of support, distress or hopefulness.
- Often, the team reviews and discusses the forms before the client is seen. These discussions help the therapist begin to consider how they can be most helpful to the client, important areas to explore, and the client's potential level of risk.

Session/intervention (non emergency affected, high income country):

- For the session, the clients may be seen individually, with another person or within a small group for 60 to 120 minutes.
- The team may be involved in the session through video, a two-way mirror, sitting in on the session as a witness, or being available for consultation, as required. Some teams have the option of phoning in to the session.
- The session typically includes an explanation of the service, exploration of what brought the client in today, what they have already tried, their theory of the problem, and a review of their strengths.

- The therapist also addresses any risk issues, as needed. Clients who may be at risk for suicide, homicide, addiction or intimate partner violence may be referred to the appropriate services.
- Usually, the therapist takes a break from the session and consults with their team. During this break, the therapist might ask the client to complete a task, consider a decision, or practise an exercise like deep breathing.
- Following the break, the therapist may verbally acknowledge the client's strengths and resilience, ask additional questions, or explore different ways of thinking about the presenting problem. The therapist may further explore goals, resources or supports.
- Usually, the session concludes with the reminder that they are welcome to return for another, single session if needed.

Follow-up (non emergency affected, high income country):

Some organisations will follow-up with a phone call, a post session questionnaire, or evaluation. Part of the follow-up is to inquire if they require further support.

- To ensure consistency of care, the notes from the session may be sent to the client's doctor.

The single session model requires further study on how to incorporate components of the service into the various types of humanitarian contexts. Adaptation may depend on the context, including stability, of the humanitarian setting. Suggestions for potential adaptation are discussed below.

Pre-session (within a humanitarian setting):

In humanitarian settings, in low and middle income countries, it may not be possible to

use the phone call or pre-session form. However, community workers (e.g. community health workers) or, social work, psychology or nursing students from local universities (if available) may ask the relevant questions in order to prepare for the interview with the therapist. Using a pre-session component can help to identify who requires psychological services, and who requires immediate links to other services to help meet basic needs, or ensure safety.

Session/intervention (within a humanitarian setting):

In humanitarian settings in low and middle-income countries, it will unlikely to be possible, or appropriate, to use video cameras or two-way mirrors, but having another team member sit in as a witness should be a possibility. Additionally, it may not always be possible to invite them to return to another session if required, but the professional should work with the client to identify alternative sources of additional formal, or informal, support, whenever possible (e.g. doctor, family member, or community leader). If the client is in the process of forced migration, they can also be linked to services available in the area where they are migrating (Abaakouk, personal communication, 2012).

Also, as stated in the *IASC Guidelines* (2007), clinical treatment should be available alongside a range of non formal supports. In other words, SST should not be offered as the one and only service to address the diverse needs of emergency affected populations.

Follow-up (within a humanitarian setting):

In humanitarian settings, in low and middle income countries, community workers or students may offer possibilities for follow-up.

When adapting the single session model, continual attention should be paid in order to minimise the risk of harm. Important considerations for minimising the risk of harm include ensuring that severe mental disorders are addressed as adequately as possible, using the available resources (Harper-Jaques et al., 2008). Furthermore, single sessions should always be provided as an option, or a choice. For example, one should never pressure the client to have a single session only. Finally, as is well known, the evidence suggests that the single session time should not be used for interventions that are not recommended, such as psychological debriefing (Rose et al., 2002). The latter may be defined as promoting venting, by asking a person to briefly, yet systematically, recount their perceptions, thoughts and emotional reactions during a recent stressful event. [Open communication between the professionals providing single sessions, other members of the team, and those receiving single sessions should assist in minimising harm.]

Based on the literature, and interviews with experts (see *Acknowledgements*), the authors have composed a list of do's and don'ts for SST within humanitarian settings. This list may be used in the design of a trial on SST, and is available as Appendix A.

In humanitarian settings in low and middle-income countries, community workers or students could be possibilities for follow up.

Conclusions

The framework behind SST's intervention and service potentially allows for flexible, creative and dynamic responses to mental health and psychosocial needs. As single session services continue to expand in high income countries, careful attention should be given to its potential for adaptation to fit the needs of services in emergency settings

in low and middle income countries as well. This is especially true where only one session is feasible. As research continues to explore single session's potential to strengthen mental health services in high income countries, the potential to provide single session services in a manner that strengthens mental health services in emergency situations should also be explored. In the meantime, the current evidence base of SST is extremely limited and controlled research with follow-up data is needed within humanitarian settings before it may be potentially considered as recommended, evidence based, practice in emergency settings.

Appendix A: do's and don'ts in SST

Do's

Team

- Work with a team (if possible) to ensure accountability
- Work with adequate supervision and support

Therapeutic approach

- Build rapport quickly
- Start the session thinking that this is the only session
- Understand a single session has the potential to create a significant impact
- Take an inquisitive approach
- Be actively present with the client
- Work collaboratively and continually check in with the client
- Use various evidence based approaches and techniques that fit your training, skill level, experience and the client's presenting needs
- Ensure the approaches and techniques fit within the culture or context

- Keep the client focused on what is happening in the moment
- Recognise that a single session is good for some people, but not always enough for many

Service provision

- Allow couples, individuals and small groups to participate in a session together
- Help clients create a relationship with the service rather than the individual professional
- Consider how providing single session services can help strengthen the existing mental health care system
- Provide the service in an accessible location where those who need help can access it at the time of need (community halls, schools, information centres, etc.)
- Integrate your service into an existing service (primary health care, existing government, NGO or mental health services (if possible) (IASC, 2007)
- Ensure cooperation between single session service providers and professionals within the broader mental health care and psychosocial support system

Professionalism

- Use good communication skills
- Know the process of a single session well, and complete specific training in SST
- Take adequate rest and follow a self care plan
- Know the available resources and links
- Consider your own beliefs about the potential impact of a single session, e.g., how hopeful are you that a single session can create meaningful change?

Session/intervention

- Explain the service
- Explore exactly what brought them in today

- Explore their theory or explanation of the problem
- Explore what they have tried, strengths, formal and informal resources
- Find, explore and focus on the most salient issue, or the thing that will bring about the most change
- Explore level of risk if necessary
- Take a break and consult with a team or supervisor (if possible)
- Highlight areas where you notice the client's strengths and resilience
- Provide psycho-education and normalise where necessary
- Reframe as necessary
- Refer to resources or links (if possible)
- Discuss any recommendations or referrals (if possible)
- Assure them they can come back if they can, or if they require further information or assistance (if possible)
- Ensure appropriate care is taken to link to the appropriate service (if available and accessible) if they are at high risk for suicide, homicide, family violence or health risk (refer to police, social services or legal aid – if possible)

Don'ts

Training

- Do not provide single sessions without sufficient cultural knowledge
- Do not provide single sessions without sufficient background in counselling

Therapeutic approach

- Do not pressure the client to discuss traumatic events, do not offer psychological debriefing
- Do not take an advice giving approach
- Do not think that SST is right for every client, and every therapist

- Do not force someone to have a single session

Session/intervention

- Do not spend too much time on irrelevant topics
- Do not pressure the client to recall distressing events
- Do not communicate the message that one session should be sufficient, particularly for those who might require more assistance

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