



Single-Session Consultations Delivered in a Gender-Responsive Clinic: A Case Series on Implementation and Lessons Learned

Clinical Child Psychology
and Psychiatry
2026, Vol. 0(0) 1–13
© The Author(s) 2026
Article reuse guidelines:
sagepub.com/journals-permissions
DOI: 10.1177/13591045261431344
journals.sagepub.com/home/ccp


Megan S. Irgens¹ , Jeanne McPhee¹, Alison Czopp¹, Elizabeth McBride²,
Margareth V. Del Cid¹, Erica Szkody³, Ian Sotomayor³,
Jessica L. Schleider³, Lauren Haack^{1,*} and Johanna B. Folk^{1,*}

Abstract

Single-session consultation (SSC) interventions are a promising approach for increasing access to timely evidence-based mental health care. This manuscript describes the early implementation, including feasibility and acceptability, of an SSC intervention delivered in a community-based gender-responsive mental health program at an academic medical center in the United States. Six clients completed a 45–60-minute SSC intervention that identified individualized goals, action steps, internal and external supports, and coping strategies. Pre- and post-session measures assessed psychological symptoms, hopelessness, agency, and satisfaction with care. Illustrative case studies are presented for two transition-aged youth. In both cases, the young women collaboratively completed the SSC and their post-session feedback indicated that they found the intervention helpful and aligned with their goals. Clinicians found the service easy to be trained in, viable to implement, and effective. Initial/preliminary results suggest the SSC intervention is feasible and acceptable for use in a free, community-based outpatient clinic serving young women and gender expansive youth. Findings highlighted increases in hopefulness mirroring findings from previous SSC studies. Implementation challenges included lower-than-expected uptake, including difficulty re-engaging youth who did not attend their SSC appointment. Lessons learned included the importance of flexible delivery, structured action planning, and intentional engagement strategies for successful implementation.

¹Department of Psychiatry and Behavioral Sciences, University of California San Francisco, Zuckerberg San Francisco General Hospital and Trauma Center, San Francisco, CA, USA

²Department of Educational Psychology, University of Wisconsin, Madison, WI

³Department of Medical Social Sciences, Northwestern University Feinberg School of Medicine, Chicago, IL

*Shared senior author.

Corresponding Author:

Megan S. Irgens, Department of Psychiatry and Behavioral Sciences, University of California San Francisco, San Francisco, Zuckerberg San Francisco General Hospital and Trauma Center, 1001 Potrero Avenue, 7M, San Francisco, CA 94110, USA.

Email: megan.irgens@ucsf.edu

Plain Language Summary

In this article, the authors describe using a type of single-session intervention called single-session consultation (SSC) with girls and young adult women who were on a waitlist for a community-based, gender-responsive therapy clinic at an academic medical center in the United States. The SSC was either facilitated by a trainee (who was under the supervision of a licensed provider) or a licensed provider. A total of 6 clients completed the SSC over the course of the 5-month period. The SSC lasted around 45–60-minute and during the intervention, the provider and client identified a singular problem to work on for that session. Together, they created an individualized goal, action steps, identified internal and external support, and coping strategies that the young person could use to cope with their identified problem. This paper presents two examples of the SSC and highlights the young person's identified problem, action steps, supports, and coping skills. In addition, the young person's psychological symptoms, self-reported hopelessness, agency, and satisfaction with care are also detailed. Findings suggest that SSCs are feasible to implement in a community clinic, acceptable to use from the viewpoint of providers and trainees, and young people find this intervention acceptable. This paper also details lessons learned to help future providers and clinics implement this intervention.

Keywords

single-session, consultation, intervention, feasibility, acceptability

Introduction

Youth mental health is a significant public health concern in the United States; in 2019, approximately 20% of youth ages 7–17 had a diagnosable mental, emotional, developmental, or behavioral disorder ([Agency for Healthcare Research and Quality, 2022](#)). Suicide rates have also increased among youth ages 12–17 in the United States ([Agency for Healthcare Research and Quality, 2022](#)). Mental health concerns that begin in childhood often persist into early adulthood, with 36% of young adults (18–25 years old) experiencing a mental, behavioral, or emotional disorder (Mental Illness - [National Institute of Mental Health \(NIMH\), n.d.](#)) Despite the significant need for mental health treatment for youth and young adults, there is a shortage of youth-serving treatment providers ([Thomas et al., 2009](#)); this shortage is especially acute in community-based care settings, which can result in long waitlists for young people to receive services. As summarized in [Kowalewski et al. \(2011\)](#), delays in receiving mental healthcare can lead to serious downstream consequences, including prolonging emotional distress and increasing risk of decompensation and suicide. Given this, there is a need for brief interventions that can meet the needs of youth quickly upon seeking care ([Schleider, 2023](#)).

Single session interventions hold significant promise for meeting this need, and Single-Session Consultations (SSC) offer a practical solution for the rising demand in community settings. A single, intentional session such as an SSC can offer a meaningful encounter for youth on waitlists. SSCs are structured, goal-oriented sessions that draw from Solution-Focused and Cognitive Behavioral Therapy to help clients address a single identified problem ([Schleider et al., 2021](#)). Clinicians can tailor their delivery using techniques such as breathing skills, visual imagery, or SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) goals, especially when clients present multiple concerns. SSCs promote skills-based coping, help manage waitlists, and have shown short-term effectiveness in reducing self-reported symptoms of hopelessness ([Schleider et al., 2021](#)).

There is growing evidence suggesting SSCs are acceptable to youth and feasible to implement. Yet, to our knowledge, no published literature has examined the acceptability and feasibility of SSC in a community-based gender-responsive mental health program at an academic medical center. Case-based descriptions of SSC delivery, adaptation, and reception are also limited. Such information may increase provider confidence in using this brief, solution-focused model to reduce wait times and improve care access.

The current study presents a case series of two young adults who received an SSC at a community-based gender-responsive mental health program at an academic medical center. This manuscript explores the feasibility and clinical utility of implementing a structured SSC service in a real-world community clinic setting. Based on previous work from [Schleider and colleagues \(2021\)](#), we hypothesized SSCs would be feasible to implement, as evidenced by at least half of youth who were offered an SSC expressing interest in participating and approximately 65% completing the intervention. It was also hypothesized that participants would find the SSC intervention acceptable, as evidenced by them recommending this service to their peers. This case series highlights key implementation processes, participant feedback, and lessons learned to inform future adaptation and scale-up of SSCs in similar community-based outpatient settings.

Method

This study was conducted in a community-based gender-responsive mental health program at an academic medical center in an urban setting in a U.S. western-coastal state. The clinic offered a range of outpatient services, including individual, family, and group therapy, case management, and SSCs. This study was approved by the University of California San Francisco Institutional Review Board (approval number: 25-45075). Adolescents and young adults (henceforth referred to as “youth”) referred to the clinic typically presented with mild to moderate clinically significant symptoms and a range of presenting concerns, including trauma-related, mood, and anxiety disorders. See [Table 1](#) for a summary of clinic demographic characteristics. Services were implemented by a multidisciplinary team of providers, including licensed clinicians and trainees working under the supervision of a licensed clinician.

Referral and Screening Procedures

Youth self-referred or were referred via established relationships with schools and youth-serving programs using an online referral form. All referrals, regardless of service type, underwent a brief yet thorough screening with a clinician to assess eligibility and need. Those needing more intensive care were referred to higher-level services. The screening clinician reviewed available options with eligible youth and young adults. Those interested in SSC and not already engaged in therapy were scheduled for in-person or telehealth sessions, based on preference and clinical factors. Prior to the SSC, youth and young adults provided consent following standard clinic procedures.

SSCs were scheduled for approximately 90 min: 30 min for the consent process and pre-session measures, 45 min for the consultation, and 15 min for post-session assessments and feedback. Participants were introduced to the SSC with an explanation that it was a 45-min session where the participant and a clinician work on Making a Plan in a Single Session (MAPSS) to help alleviate distress and that all participants would leave the session with an action plan. This protocol will be referred to as MAPSS from here on out.

Table 1. Demographics of Referrals to the Clinic During SSC Recruitment

Demographics	% of enrolled clients
Ages	
12–17 years old	70%
18– years old	22%
Missing	8%
Gender identity	
Cis-woman/Cis-girl	11%
Female	69%
Gender fluid/Genderqueer, transgender, other	6%
Missing	14%
Race/Ethnicity^a	
Asian	6%
Black	11%
Hispanic	44%
Multiracial	9%
Missing	13%
Other ^b	11%
White	6%

Baseline demographics data comes from the initial ($n = 192$) referral and intake.

^aYouth may also have self-identified as have more than one race/ethnicity.

^bOther race/ethnicity includes youth/young adults who identified as American indian, Native Hawaiian or Pacific islander, or other. Over a 5-month period in 2023 to 2024, when MAPSS was piloted in the clinic, a total of 31 youth were deemed eligible to complete the MAPSS intervention. Of the 31 eligible, twelve expressed interest (38%) in participating in MAPSS. Six youth completed MAPSS (50% of those interested). Gender identity categories reflect participant self-report. Although “female” is typically used as a sex category, this term was retained as reported by participants.

Participants

Over a 5-month period in 2023 to 2024, a total of 31 youth were deemed eligible to complete the MAPSS intervention. Eligibility criteria included being between the ages of 12 and 24 years, identifying as a young woman or gender expansive youth, presenting with mild-to-moderate distress, and not being actively engaged in ongoing individual therapy. Of the 31 eligible youth and young adults offered the opportunity to participate in MAPSS, twelve expressed interest (38%) in participating.

Six youth completed MAPSS (50% of those interested), two of whom were over age 18 and four of whom were minors. The two cases presented in this report have been de-identified to protect their privacy. These cases illustrate the variability in presenting concerns, session goals, and outcomes associated with the in-person delivery of the MAPSS intervention.

MAPSS Intervention Protocol

The MAPSS intervention was a structured single-session consultation delivering strengths-based, goal-focused support based on Schleider et al.’s SSC protocol (2020). Sessions were led by licensed clinicians or advanced trainees under supervision. Clinicians were encouraged to utilize online training materials for the protocol hosted on the Open Science Framework (see: <https://osf.io/xnz2t/files/osfstorage>) and/or attend a no-cost, live, virtual training hosted by the academic medical center

for providers in primary care and school-based settings statewide, during which experts in the field virtually trained providers on the same protocol. The consultation emphasized collaborative goal setting, guided by the participant's description of a "miracle day" (e.g., "Suppose while you're sleeping, a miracle occurs and the problem disappears... When you wake up, what's the first thing you notice that tells you the problem is gone?"; [Schleider et al., 2020](#)). Participants also identified internal and external supports, and developed a realistic action plan. After the session, they completed post-session assessments and a feedback form.

Measures

Youth completed standardized self-report measures during screening, pre-session, and post-session periods via REDCap. Measures were selected to align with previous SSC trials ([Schleider et al., 2020](#)).

Brief Symptom Inventory (BSI-18; Derogatis, 2001). The BSI-18 assesses psychological symptoms across three subscales: somatization, depression, and anxiety. Each of the 18 items is rated on a 5-point scale (0 = Not at all to 4 = Extremely), with higher scores reflecting greater symptom burden. Subscale scores were summed. One item from the depression symptom subscale assessing suicidal ideation was omitted; suicidality was instead evaluated verbally via a clinician-led risk assessment, consistent with the clinic's safety procedures. As a result, the depression symptom subscale and total score should be interpreted as indicators of general symptom burden. Participants completed the BSI-18 before their MAPSS session.

State Hope Scale (Snyder et al., 1996). This six-item measure assesses goal-directed thinking. Items are rated on a 9-point scale (0 = Definitely False to 8 = Definitely True), with higher summed scores indicating stronger present hopefulness. Participants completed the Adult State Hope Scale pre- and post-MAPSS.

The Beck Hopelessness Scale – 4-Item Version (BHS-4; Perczel Forintos et al., 2013). The BHS-4 assesses hopelessness using four statements about future expectations, rated from 0 (Absolutely Disagree) to 3 (Absolutely Agree). Higher scores indicate greater hopelessness. Participants completed it pre- and post-MAPSS.

Single Session Consultation Feedback Form (Schleider et al., 2021). This post-session measure includes five Likert-scale items assessing satisfaction, helpfulness of the action plan, hopefulness, and motivation to follow through. One optional open-ended item invited further feedback.

Data Analysis Plan

This study utilized a descriptive case series design to examine the implementation and outcomes of the MAPSS intervention. Pre- and post-session data were summarized at the individual level. Action plans developed during the consultation were reviewed to identify themes related to goal setting, internal barriers, and supports. Given the small sample, no inferential analyses were conducted; findings are presented descriptively to highlight individual trajectories and clinical takeaways.

Results

Case Summary: Participant 1

Participant 1 was originally referred to the clinic by school personnel for case management to support her pre-existing individual therapy in the community. Upon completing therapy with a community agency, she was referred back to the clinic through her case manager for group therapy. Approximately 4 months from the second referral, she requested an in-clinic individual therapist who was culturally responsive and trauma-informed; she also signed up to participate in a group offering. Upon completing the screening and triaging procedures by an individual therapist, re-current suicidal ideation was identified; she did not report any suicidal plans or intentions at the time of triage. She and the triage clinician completed a safety plan, after which she was also offered to participate in a group-based intervention while on the waitlist for individual therapy. She began participating in the group 6 weeks after this referral and was offered to complete the MAPSS intervention 2 weeks after completing group (due to the intervention not being available when she was first referred into the clinic, MAPSS was offered to her approximately three months after her triage appointment). She engaged in the MAPSS intervention 4 days after being asked if she would like to complete it. The intervention was delivered by a post-doctoral trainee under the supervision of a licensed psychologist.

Pre-Intervention Assessment. On pre-session questionnaires, her Brief Symptom Inventory subscale scores were 6 (Somatization), 13 (Depression), and 10 (Anxiety), suggesting depression and hopelessness were her most prominent symptoms. On the State Hope Scale, her score was 33 (range: 0–48), indicating she felt a moderate degree of agency to complete her goals. Her responses on the Hopelessness Scale (total score of a 6) identified she “somewhat agreed” that her “future seemed dark” to her and she thought “things won’t work out the way” she wanted them to.

Session Focus and Action Plan Development. At session start, Participant 1 said she wanted a structured daily routine to feel more productive and create an actionable plan. Her goal for the consultation was to create a realistic, actionable plan to support her.

In response to the miracle question, she envisioned feeling more hopeful, experiencing less dread towards her to-do list, perceiving herself as productive, and receiving fewer complaints from people in her life. She rated herself as a 5–6 out of 10 in proximity to this “miracle day” (with 10 being the closest).

During the session, the clinician introduced SMART goals to support skill-building. Participant 1 integrated this with existing strategies (e.g., list-making, prioritization) and identified three next steps: (1) convert her goals into SMART goals, (2) list weekly priorities, and (3) create a schedule. She specified when and where she’d complete these steps and named two support people.

As the session progressed, Participant 1 highlighted the need for new glasses (a new case management need) which allowed the provider to explore what else could be getting in the way, internally, of the participant from completing the action plan which she indicated was fear. Reflecting on prior successes (e.g., learning to drive), she generated an evidence-based coping strategy to counteract this fear. The clinician emphasized her ability to challenge automatic negative thoughts and reinforced her capability to succeed in new endeavors.

Post-Intervention Outcomes. Following the session, her agency score on the State Hope Scale decreased from 33 to 32. Her hopelessness score on the Beck Hopelessness Scale decreased from 6 to 4, suggesting an improved cognitive outlook on meeting her goals.

On the consultation feedback form, Participant 1 rated the session as “mostly” helpful in addressing her presenting concern and found the action plan “very much” helpful. She expressed she was “very much” hopeful that she would use the action plan and reported feeling “very much” motivated to enact it. She also indicated she would “very much” recommend this intervention to others.

Follow-Up Care. After the MAPSS intervention, Participant 1 continued to access case management services within the clinic and due to the clinic losing funding and closing, she was referred to the city’s mental health services for individual therapy to manage symptoms of depression and suicidal ideation.

Key Takeaways. Incorporating a single skill (SMART goals) that can be easily taught in a single session enabled her to mobilize her pre-existing strengths. Additionally, identifying a concrete barrier (e.g., needing glasses) allowed the consultation to address immediate case management needs and uncover an underlying emotional barrier, fear of failure, that was critical to her avoidance behavior.

The clinician, who was trained using online materials (see: <https://osf.io/xnz2t/files/osfstorage>), found MAPSS easy to implement, as it drew on familiar skills from other evidence-based approaches (e.g., SMART goals, problem-solving). They felt able to build rapport, address the identified issue, and explore underlying emotional content. The clinician viewed MAPSS as a valuable, scalable waitlist intervention for community settings.

Case Summary: Participant 2

Participant 2 was referred to the clinic by an outpatient health center for individual and group therapy to manage symptoms of depression and anxiety. The screening and triage clinician reached out to her and the referral source the day after the referral was made. Participant 2 completed the screening and triage interview 8 days after the referral and completed the MAPSS intervention 11 days after screening and triage was completed. The intervention was delivered by a post-doctoral trainee under the supervision of a licensed psychologist.

Pre-Intervention Assessment. Prior to the session, Participant 2’s BSI-18 subscale scores were 10 (Somatization), 11 (Depression), and 13 (Anxiety), suggesting she needed the most support with symptoms of anxiety. On the State Hope Scale, she reported a score of 33 (range: 0–48). Her responses on the Beck Hopelessness Scale (score = 6) indicated a moderate level of hopelessness.

Session Focus and Action Plan Development. At session start, Participant 2 said she wanted help managing stress. Her goal was to leave with three tools to cope with daily stressors.

In response to the miracle question, she described several behaviors she would engage in on her “miracle day,” including conducting research into the medical field to explore potential career opportunities, improving her memory by reducing stress, and feeling overall greater happiness. She rated herself as a 2 out of 10 in proximity to achieving this miracle day.

With the clinician, Participant 2 identified three steps: (1) trust her intuition in decision-making, (2) find joy by making her son laugh, and (3) use grounding techniques for in-the-moment stress. All were flexible, practicable skills.

When asked to identify supportive people to assist with these steps, she had difficulty naming individuals in her life. Instead, she relied on herself and used her phone and YouTube for guided breathing exercises.

As the session progressed, Participant 2 disclosed feelings of guilt related to prioritizing her own goals and well-being, fearing that doing so would make her a “bad mother.” The clinician and participant collaboratively addressed this cognitive distortion and developed a coping plan: when she experienced the thought “I cannot take time to de-stress because I need to care for my son,” she would reframe it by reminding herself that “taking care of myself helps me take better care of him.” The clinician provided a written message of encouragement, reinforcing Participant 2’s strengths and emphasizing the importance of self-care in achieving her goals.

Post-Intervention Outcomes. Following the session, her State Hope Scale score increased from 33 to 39, indicating greater perceived agency. Her Beck Hopelessness score dropped from 6 to 1, reflecting improved hopefulness. She rated the consultation and action plan as “mostly helpful,” and reported feeling “very much” hopeful and motivated to use the plan. Overall, she said she would “very much” recommend the intervention.

Follow-Up Care. After the MAPSS intervention, Participant 2 was referred to the city’s mental health services for individual therapy to manage symptoms, as the clinic’s waitlist prevented her from receiving services in a timely manner.

Key Takeaways. Participant 2 demonstrated the ability to leverage previously acquired coping strategies (e.g., breathing exercises) and creatively identified self-accessible resources to support her goals. Addressing underlying cognitive barriers related to self-worth and caregiving was a critical component of helping her move toward her identified goals.

This clinician was trained in the intervention through a no-cost, live, virtual training (see: https://www.youtube.com/watch?v=fgtPJXLXJo8&list=PLM2HLS9I3mKCZHze_IcQBdS-kUpCHTNZC&index=6) She found the intervention easy to use, flexible to meet the needs of the participants, and compatible with her clinical style. She appreciated how the session guided itself logically and allowed the participant to leave with a concrete and structured plan with an encouraging note. She also indicated this intervention is a valuable addition to services and was completely free to implement.

Discussion

This manuscript examined the feasibility and acceptability of a structured SSC service piloted in a community-based, gender-responsive mental health program at an academic medical center, using two case studies with different clinicians. Uptake was lower than expected: 38% of youth offered SSC expressed interest, and 50% of those scheduled completed the session. As implementation lasted only five months and this was a first-time offering, greater participation is expected over time. Several factors may have contributed to the modest uptake, including youth perceptions that a single session might be insufficient for addressing complex or longstanding concerns, the effort required to consent to a one-time intervention without an immediate therapy referral, and difficulty engaging

youth to schedule sessions after initial expressions of interest. Some barriers may be modifiable and worth targeting in future efforts (Schleider & Beidas, 2022).

Despite modest uptake, SSCs were well received by youth who completed them. As hypothesized, both participants rated the intervention favorably and said they would recommend it to peers. These findings align with prior SSC literature showing strong acceptability and satisfaction among youth (Schleider and Weisz, 2017; Sung et al., 2025).

Both clinicians in the case examples were trained online at no cost. Training took less than 3 hours, including material review and learning the clinic's workflow. Neither clinician was licensed or had previously used Solution-Focused Therapy as a primary modality, but the supervisor was comfortable with trainee delivery and provided group supervision. This also supported continuity for clients who transitioned to ongoing therapy, as clinicians could update assigned therapists on client presentation. The SSC model required minimal cost and training. Both clinicians independently found it acceptable to learn and deliver, reporting appreciation for the model's flexibility and the ability to adapt it to their style. This supports SSCs as a feasible, evidence-based option for unlicensed clinicians in community clinics (Schleider, 2023).

Feasibility and Clinical Utility

Across both cases, participants were able to collaboratively define meaningful goals, identify internal and external supports, and co-create action plans aligned with their values. Clinicians flexibly applied the structured protocol, meeting participants where they were, drawing from existing coping strategies, and introducing only a few new skills to avoid overwhelm. Post-session assessments indicated increased hope, reduced hopelessness, and high satisfaction, mirroring prior SSC findings.

Importantly, both participants accessed internal coping strategies and identified realistic next steps despite limited resources and ongoing stressors. The MAPSS structure helped translate complex concerns into manageable goals. Clinicians, including trainees, benefited from a clear protocol and supervision, supporting SSCs as a dual-purpose care and training model in academic clinical settings.

Implementation Lessons

Several lessons emerged during early implementation. First, setting clear expectations about the scope of a single session was essential, especially for participants with higher acuity or complex needs. Structured tools, such as the action plan worksheet, promoted consistency, clarity, and engagement. Integrating SSCs into triage and waitlist workflows may offer a scalable way to reach youth earlier in their help-seeking process, particularly those who might otherwise disengage before accessing ongoing care. Both participants reported increased hopefulness, which may boost willingness to pursue future services in the same clinic or elsewhere. For youth new to therapy, a helpful, low-barrier intervention can serve as a positive entry point into the mental health system.

Although brief, free, and accessible, SSCs still required intentional engagement strategies. More than half of eligible youth declined to participate, highlighting the need to build trust, clarify purpose, and present SSCs in a developmentally appropriate, strengths-based way. Future implementation should include training to address uncertainty from both providers and clients to improve uptake. Having tailored strategies are likely to increase uptake in a scalable way (Schleider, 2023).

Limitations

This case study was not designed to assess effectiveness and is limited by its small sample size and inability to conduct inferential statistical analyses. We also lacked long-term follow-up data to assess sustained impact. While six clients completed SSC sessions during the pilot, only two youth (adult-aged) were eligible to consent to the research portion (i.e., due to clinic policy about research consent restrictions for minors due to this being a brief intervention). It should be noted that Participant 1 completed the MAPSS intervention immediately following participation in group therapy at the same clinic, whereas Participant 2 did not receive services from this clinic prior to completing MAPSS. Differences in prior treatment exposure may have resulted in unequal baseline levels of coping or problem-solving skills, potentially shaping how MAPSS content was received and its observed effects. Both identified as women and received care in a clinic for young women and gender expansive youth.

Future Directions

Future research should explore reasons youth decline SSCs, including logistical barriers, understanding of the intervention, privacy concerns, or preferences for ongoing care. Studies should also examine the impact of in-person versus telehealth SSCs and how SSCs can complement other services such as group therapy or case management. Larger, more diverse samples are needed to refine implementation strategies and evaluate outcomes. This case series adds to evidence supporting SSC feasibility and acceptability, laying a foundation for continued adaptation in community settings.

Conclusions

This study presented a case series detailing the feasibility and acceptability of implementing a single-session consultation within a gender-responsive community clinic. While more rigorous evaluation is needed, our findings highlight SSCs as a feasible, acceptable, and promising model for expanding access to care in youth and young adult serving community settings. In addition, SSCs can be delivered by both licensed and non-licensed therapists and tailored to meet the individual needs of each client. This flexibility makes SSCs a valuable training opportunity, allowing clinicians to integrate their own therapeutic style while practicing core tenants of solution focused therapy and cognitive behavioral therapy. Continued exploration of tailored, brief interventions may help address urgent mental health needs among underserved populations.

Acknowledgments

We thank Cal-MAP for hosting the ECHO training through which the Lab for Scalable Mental Health provided provider training.

ORCID iD

Megan S. Irgens  <https://orcid.org/0000-0002-3568-8883>

Ethical Considerations

This study was approved by the University of California, San Francisco Institutional Review Board Institutional Review Board (approval number: 25-45075).

Consent to Participate

For the two cases presented, clients completed a research consent approved by the University of California, San Francisco Institutional Review Board Institutional Review Board, which authorized an additional research consent form for all clinical services in this clinic (approval number: 20-30902).

Author Contributions

All authors contributed to the development and review of the final manuscript. Megan S. Irgens led conceptualization, data curation, analysis, and drafting. Jeanne McPhee, Alison Czopp, and Elizabeth McBride contributed to project administration, investigation, and manuscript development. Margareth V. Del Cid supported analysis, methods, and writing. Erica Szkody, Ian Sotomayor, and Jessica L. Schleider provided methodological input and critical revisions. Lauren Haack and Johanna B. Folk served as senior authors, providing conceptual, methodological, and supervisory support.

Funding

The authors disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: This work was supported by a grant from the San Francisco Department of Children, Youth and Their Families (DCYF). Dr. Haack was supported by a grant from the Health Research Service Administration (HRSA). Dr. Irgens was supported by the NIDA T32DA007250 (PI: Satre) and Dr. Folk was supported by NIDA K23DA050798 (PI: Folk).

Declaration of conflicting interests

The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Data Availability Statement

The participants of this study did not give written consent for their data to be shared publicly, therefore supporting data is not available.

References

- Agency for Healthcare Research and Quality. (2022). Child and adolescent mental health. In *2022 National healthcare quality and disparities report*. U.S. Department of Health and Human Services. [Internet] Available at. <https://www.ncbi.nlm.nih.gov/books/NBK587174/>
- Derogatis, L. R. (2001). *Brief symptom inventory 18: Administration, scoring, and procedure manual*. NCS Pearson.
- Kowalewski, K., McLennan, J. D., & McGrath, P. J. (2011). A preliminary investigation of wait times for child and adolescent mental health services in Canada. *Journal of the Canadian Academy of Child and Adolescent Psychiatry*, 20(2), 112–119. Available at. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3085672/>
- National Institute of Mental Health. (n.d.). *Mental illness*. U.S. Department of Health and Human Services. Available at. <https://www.nimh.nih.gov/health/statistics/mental-illness>
- Perczel Forintos, D., Rózsa, S., Pilling, J., & Kopp, M. (2013). Proposal for a short version of the beck hopelessness scale based on a national representative survey in Hungary. *Community Mental Health Journal*, 49(6), 822–830. <https://doi.org/10.1007/s10597-013-9619-1>
- Schleider, J. (2023). *Little treatments, big effects: How to build meaningful moments that can transform your mental health*. Hachette UK.

- Schleider, J., Sung, J., Bianco, A., Gonzalez, A., Vivian, D., & Mullarkey, M. C. (2021). Open pilot trial of a single-session consultation service for clients on psychotherapy wait-lists. *The Behavior Therapist*, *44*(1), 8–15.
- Schleider, J. L., & Beidas, R. S. (2022). Harnessing the single-session intervention approach to promote scalable implementation of evidence-based practices in healthcare. *Frontiers in Health Services*, *2*, 997406. <https://doi.org/10.3389/frhs.2022.997406>
- Schleider, J. L., Dobias, M. L., Sung, J. Y., & Mullarkey, M. C. (2020). Future directions in single-session youth mental health interventions. *Journal of Clinical Child and Adolescent Psychology*, *49*(2), 264–278. <https://doi.org/10.1080/15374416.2019.1683852>
- Schleider, J. L., & Weisz, J. R. (2017). Little treatments, promising effects? meta-Analysis of single-session interventions for youth psychiatric problems. *Journal of the American Academy of Child & Adolescent Psychiatry*, *56*(2), 107–115. <https://doi.org/10.1016/j.jaac.2016.11.007>
- Snyder, C. R., Sympson, S. C., Ybasco, F. C., Borders, T. F., Babyak, M. A., & Higgins, R. L. (1996). Development and validation of the state hope scale. *Journal of Personality and Social Psychology*, *70*(2), 321–335. <https://doi.org/10.1037/0022-3514.70.2.321>
- Sung, J. Y., Sotomayor, I., Szkody, E., & Schleider, J. L. (2025). Provider hesitancy toward single-session interventions for mental health problems: Malleability and implications for adoption in routine care settings. *Clinical Psychology: Science and Practice*. Advance online publication. <https://doi.org/10.1037/cps0000274>
- Thomas, K. C., Ellis, A. R., Konrad, T. R., Holzer, C. E., & Morrissey, J. P. (2009). County-level estimates of mental health professional shortage in the United States. *Psychiatric Services*, *60*(10), 1323–1328. <https://doi.org/10.1176/ps.2009.60.10.1323>

Author Biographies

Megan S. Irgens, Ph.D., is a licensed clinical psychologist and National Institute on Drug Abuse (NIDA) T32 postdoctoral fellow in the Department of Psychiatry and Behavioral Sciences at the University of California, San Francisco. She earned her Ph.D. from the University of Arizona and completed her predoctoral clinical internship at UCSF in the Juvenile Justice Behavioral Health Lab. Dr. Her research focuses on developing, adapting, and implementing brief, scalable substance use and mental health interventions for legally involved youth from rural communities.

Jeanne McPhee Ph.D., is a licensed psychologist and an Assistant Professor in the Department of Psychiatry and Behavioral Sciences at UCSF. Dr. McPhee's research focuses on promoting positive outcomes for legally involved and underserved youth by adapting and implementing evidence-based treatment, policies, and practices for youth, their families and communities, and within the larger systems with which they come into contact. She has expertise in provision and implementation of therapy for youth, adolescent development, and systems-level interventions to support youth, including workforce development.

Alison Czopp, LCSW, is a licensed clinical social worker at UCSF/Zuckerberg San Francisco General Hospital (ZSFG) in the Juvenile inJustice Behavioral Health (JJBH) team. She graduated with her Masters in Social Work from University of Michigan. She has extensive experience in delivering mental health and substance use prevention interventions to underserved youth and families, particularly those with foster care, child welfare, and legal system involvement.

Elizabeth McBride is a graduate student in the School Psychology PhD program at the University of Wisconsin-Madison. Her research interests include developing and implementing school-based

supports for youth involved in the juvenile legal and child welfare systems. She aims to do community-engaged research that centers and uplifts the voices of youth and families.

Margareth V. Del Cid, Ph.D., is an Assistant Clinical Professor in the Department of Psychiatry and Behavioral Sciences at the University of California, Davis. Her research advances equity in youth mental health by centering community-informed approaches to address immigration-related stressors, systemic inequities, and barriers to care.

Erica Szkody, Ph.D., is a Research Assistant Professor in the Department of Medical Social Sciences at Northwestern University. Their research focuses on developing, culturally adapting, and evaluating digital mental health interventions for youth and underserved populations. They have expertise in single-session interventions, implementation science, and systematic approaches to behavioral health research.

Ian Sotomayor is a Clinical Psychology PhD student at Northwestern University's Feinberg School of Medicine, in the Department of Psychiatry and Behavioral Science, and he has been working in the Lab for Scalable Mental Health for about four years in developing single-session interventions, culturally adapting materials, and studying how moderating factors across individual and structural levels influence treatment outcomes. They are building a program of research studying trauma and stress, within subdisciplines of intervention and implementation science, in the context of colonization, genocide, and enslavement.

Jessica Schleider, Ph.D., is the Director of the Lab for Scalable Mental Health and the creator of the Single Session Consultation (SSC). Her research focuses on developing, testing, and implementing brief, digital, and single-session interventions to reduce youth mental health problems, particularly among young people facing structural barriers to care. She has led multiple federally funded clinical trials and published foundational meta-analytic and umbrella reviews establishing guidelines for single-session intervention research and implementation.

Lauren Haack, Ph.D., is an associate professor, clinical psychologist, and chief of the school-age youth division in the UCSF Department of Psychiatry and Behavioral Sciences. Dr. Haack's program of research is focused on 1) cultural influences to mental health conceptualization, assessment, and treatment, 2) accessible and culturally attuned evidence-based services for youth and families worldwide, and 3) provider experience, training, and consultation. Dr. Haack is involved in several current clinical research efforts, including projects funded by the National Institute of Mental Health and the National Institute of Health Fogarty International Center focused on improving family access to and engagement in psychosocial school-based treatment for ADHD domestically and internationally.

Johanna B. Folk, Ph.D., is a licensed clinical psychologist, Associate Professor, Associate Director of the Juvenile inJustice Behavioral Health Lab, and the Director of Research, Evaluation and Analysis in the Department of Psychiatry and Behavioral Sciences at the University of California, San Francisco at the Zuckerberg San Francisco General Hospital and Trauma Center.