

NORTH COAST  
AREA HEALTH SERVICE  
**NSW**  **HEALTH**



## RURAL COMMUNITY HEALTH INTAKE STUDY: CLIENT INTAKE FOR ADULT COUNSELLING IN RURAL COMMUNITY HEALTH

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## GUIDE TO THIS REPORT

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This document reports on research undertaken 2006-2008 under the auspices of the Institute of Rural Clinical Services and Teaching (IRCST) and the North Coast Area Health Service (NCAHS). The researcher identified a dearth of research or literature on intake although local reviews and re-organisation were known to be common. The research, while small, hoped to make some contribution to an understanding of what were preferable models of intake for counselling in rural community health.

The study was undertaken using two study sites in the NCAHS. One site used a dedicated intake worker to provide access adult counselling services (referred to as Dedicated Intake) and the second site used a roster of counsellors (Rostered Intake).

For those who may need some explanation of the different types of intake an appendix is supplied; Appendix 1 The Intake Territory.

## ACKNOWLEDGEMENTS

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Dr Michelle Wallace, Maxine Molyneux and Lee Dunn.

RHD 2008

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## MAIN MESSAGES

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Community Health Services are the sole provider of counselling for adults in some rural areas of NSW and the only fully funded ones in many others. Intake is the route by which people access community health counselling services.

The people with the highest risks will be the least likely to access services. Most people will only make one attempt to access the service. For this reason it is important to have qualified and experienced clinicians at intake. Intake systems should maximise accessibility and not inadvertently become a barrier to entry themselves. Reception is inherently a significant part of intake.

Intake for adult counselling services cannot be divided off from other services. Enquiries for mental health and sexual assault, for example, will inevitably come through intake sometimes. People who come to the Health Service may be in an acute emotional, psychological or social condition. Although Community Health is not a crisis service it does need to be able to identify and respond to people in crisis. It is not the responsibility of members of the public to know how Health Services are organised. It is the responsibility of the Health Service to be able to take enquiries and deal with them flexibly, compassionately, accurately and quickly. When a person walks in to or phones a Health Service they should succeed in accessing the health service they need.

The more visible Community Health is, the easier it is to access. The steps in the intake pathway should be as close to one (1) as possible, and ideally, there should be no separation of intake from service delivery. Intake workers should be the most qualified and experienced. Any dedicated intake staff, should be a part of the service delivery team and meet with them regularly to ensure understanding and communication between staff. People should stay with the same worker when possible. They should be welcomed to the service with consideration, and respect. Overall, no single model of intake is superior in all circumstances, but these identified features can be addressed regardless of which intake system is used.

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## EXECUTIVE SUMMARY

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Community health services are the sole provider of counselling for adults in some rural areas of NSW and the only fully funded ones in many others. Intake is the route by which people access community health counselling services. This report makes recommendations for accessible and responsive intake for adult counselling within the resource constraints of rural community health service resources.

The people with the highest risks will be the least likely to access services. Most people will only make one attempt to access the service. The first contact is often with a receptionist and the key role of reception in intake should be acknowledged and utilised. The most vulnerable people are least likely to proceed so it is important that intake systems maximise uptake and don't become a barrier themselves. It is also important to use the most qualified and experienced clinicians at the front of the service where the most therapeutic benefit will be gained for those who have the least contact. As primary health care has an important impact on health levels and costs, equitable access is a concern. Intake systems need to offer a variety of options to people of different circumstances to provide equitable access.

Intake for adult counselling services cannot be neatly divided off from other services. Enquiries for other services, mental health, or sexual assault, will come to community health centres. It is not the responsibility of members of the public to know how the services of the NSW Department of Health (Health Services) are organised at any point in time. It is the responsibility of the Health Service to be able to take enquiries and deal with them flexibly, compassionately, accurately and quickly.

Many people who come to the Health Service are in an acute emotional, psychological or social condition. Community health is not a crisis service. It does however, need to be able to identify and respond to people in crisis. When people walk or phone into a Health Service, they should be successful in accessing the Health Service they need.

### **Rural intake for counselling services**

Community health services in rural areas have regularly reviewed and adjusted their intake systems to accommodate local resources and needs. There is no public collection or record of these reviews. A common progression has been from counsellors taking referrals directly, to using either a roster of counsellors, or a person employed specifically to do intake. Two other approaches to intake are open days (also referred to as walk-in or Single Session Therapy), and call centres. Intake systems from two sites were used in this research; one using a Dedicated Intake worker, and the other Rostered Intake of counsellors. Resource constraints affected both during the period of research.

The present research canvassed the views of people from various positions: referral agents, clients, receptionists, counsellors and intake workers, local managers and senior managers. This elicited information on what the intake system looked like from inside and outside and what was important in intake depending on where the person sat in relation to the system.

The research found opportunities to: improve accessibility to community health services, better recognise the degree of vulnerability of clients contacting the centres and better utilise the role of reception in the intake process.

## Accessibility

Community health needs to be publicly visible. To be accessible, people need to know it exists. It particularly needs to be visible and accessible to people from low socio-economic backgrounds due to their higher level of risk and limited ability to take advantage of other more expensive counselling services. The two Community Health sites studied were well sited near their respective central business districts (CBDs). Nevertheless three of the four clients interviewed did not know the service existed before their referral.

The intake systems used were not self evident from outside the centres. People were regularly required to attend a different centre or make a further phone call to access a service. Reception staff believed from the demeanour of these people, that some would not make that further attempt. This highlighted the need for more flexible entry. One respondent was unable to identify the Centre by its signs and neither Centre has signs clearly identifying what services are provided.

## Vulnerability of Clients

Although community health services are not crisis services they are contacted by people in emotional, psychological and social crises<sup>1</sup>, sometimes for services provided at other locations. It is not up to the public to know they should have rung here or gone there. They come when they are in need and when they come to a Health Service they should be able to access health services, not be sent away, as is done at Community Health Centres in response to mental health enquiries.

**It is not the responsibility of members of the public to know how the services of the NSW Health are organised at any point in time. It is the responsibility of the NSW Health to take enquiries and deal with them flexibly, compassionately, accurately and quickly.**

## Role of Reception

Reception is an integral part of intake and should be acknowledged and treated as such. Receptionists make the initial decisions about where people will be directed (community health intake, drug and alcohol, sexual assault or to another organisation). Because reception is the first contact with the Health Service, receptionists are more likely to have contact with the people most likely to drop out of contact with the service. They are in a position to engage clients and establish a culture conducive to good intervention outcomes. They often deal with distressed or frustrated people and deserve the support of the organisation and their professional colleagues to develop their skills in this, and to be resilient to its impact on their own wellbeing.

## Context of the Research

This research was interested in the relative usefulness of different intake systems used to access adult counselling services in rural community health. Five approaches are noted: direct, open days, rostered, dedicated and call centre (Appendix 1). Aldridge and Kanowski (1998) characterised these as either local or central with the call centre (or centralised intake) as the only central model. Alternatively they could be characterised as those that incorporate intake with service delivery (direct, open days, rostered) and those that separate out these functions (dedicated, call centre).

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<sup>1</sup> One client interviewee reported waiting six weeks, having left a number of messages on an answering machine, for her daughter to access a sexual assault service regarding a past episode. During this time her daughter ceased going to work and started to self harm.

Literature on triage, call centres, dedicated intake and open days was identified but none was based on work in community health settings. Call centres have the advantage of: a highly publicised phone number, being a central point for data collection, and for interface of computer systems. They give an immediate phone response but require a large investment in technology or the privatisation of the intake function introducing a further, organisational gap in continuity between intake and service provision.<sup>2</sup>

Grimwade (2006) looked at a dedicated intake system in child and adolescent mental health which operated as a local area call centre. Dedicated intake workers can become knowledgeable about the full range of local services. Grimwade emphasises the cultural role of intake, either encouraging or discouraging people from engaging with the service. He also identified that a good intake experience increased the likelihood of positive intervention outcomes and sets the structure for the rest of the agency. As with a call centre this dedicated intake team provided a prompt phone response and functioned to sort and send. Grimwade observed some conflict between the intake and service delivery personnel with intake staff being scapegoated.

The Single Session/Open Days (Talmon 1990, Perkins 2006) literature is from child and family, and adolescent mental health settings. It identifies increased access for the socio-economically disadvantaged by providing an immediate response to walk-in enquiries including an initial intervention. It is also good for reducing or eliminating waiting lists.

All the systems have supporters and detractors. There are important features of good intake that can be incorporated in any of the systems. For example, it would be possible to have a call centre that is semi-local, accommodates phone and walk-in enquiries, is street front, undertakes an initial intervention, whose intake staff are the most experienced clinicians and are part of the counselling team. Similarly it would be possible to have a local direct system with a well advertised phone number and an integrated computer system to collect systematic data.

Intake systems have the potential to be a barrier to entry. We have probably underestimated the social and community role of a good intake service, and the therapeutic and preventative potential for the individual.

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<sup>2</sup> Whilst call centres are seen to be self evidently cost effective by senior managers they usually don't undertake the same suite of functions as local systems, so in the absence of a cost benefit analysis this cost effectiveness can be assumed for the front of the system only, not downstream, and not over time.

## Checklist for good intake practice:

- The Community Health Centre (CHC) is widely known in the community it serves
- The CHC is located in or near the central business district (CBD)
- The CHC is clearly and prominently signed
- The CHC signage indicates what services are offered
- People phoning or walking in to the CHC obtain an appointment on the spot for a time within 3 working days
- The person any client sees, or speaks to for an initial appointment is an experienced clinician
- Intake workers and counsellors are either the same personnel, or if not, meet regularly and are administratively in the same team
- Initial enquiries never go to an answering machine
- Specific arrangements resulting in an immediate response (as per the above) are made for incoming enquiries where clinical positions are not backfilled
- Reception staff who have any initial contact with clients are included in design and discussions about intake and are resourced for their role
- Initial interviews offer an initial intervention as well as undertaking assessment and prioritization
- People should not be sent away with a phone number. They should be put through or the number dialled for them.
- An inclusive and welcoming culture should be consciously cultivated by the CHC
- Referral agents should have direct access to a client's counsellor
- Any intake system should be flexible

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## THE LITERATURE

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### Introduction to Themes

The literature review did not identify previous research on the efficacy or comparative usefulness of different systems of intake for counselling services in rural community health, either in Australia or overseas. Search terms used were: health care delivery, community health services, evidence based practice, and intake systems in all EBM reviews, Ovid full text, Ovid Medliner, CINAHL and Google scholar. Also: community health, intake systems, client intake, client administration, primary health, client satisfaction, community health intake and social work in PsycINFO, Ovid full text, CINAHL and Google scholar. A Google search using 'access' and 'community health' found a Victorian government consultative document that used the term 'service access model', however this search term did not elicit any further material.

The literature on single session therapy at initial contact offers some commentary, as does some of the material on call centres (centralised intake) in health services. A PhD thesis on referral and intake in child and family mental health (Grimwade 2006) canvasses a number of important issues though limited to phone intake and in an urban setting. Literature on rural health services, on community health, equity and accessibility and barriers to entry, has relevance to intake systems.

Literature on health systems and reforms in health systems has contextual relevance: material on new public management in health services, discourse analysis in health and complexity theory. The following discussion aims to relate these elements to the question of the merits of different intake systems for accessing counselling in rural community health.

### Intake Systems

A Victorian government report on the introduction of 'Service Coordination' (KPMG 2004), notes three intake models being used in Community Health: dedicated (professional non-service staff), rostered service staff and staff doing intake within their own service. These are referred to as dedicated, rostered and direct. The report notes that each model delivers specific benefits with the dedicated system requiring less training and the rostered system 'encouraging staff to think outside of their service silos' (KPMG 2004 p6). The rostered system referred to involves clinicians taking enquiries including from outside their professional area, (not counselling staff answering counselling enquiries as used at study site for Rostered Intake in the present research). It acknowledges that both the dedicated and rostered system have capacity for a brief intervention at intake and cites this as a benefit; 'the ability to move toward single session therapy' (KPMG 2004 p9).

The Victorian review makes reference to Lean Thinking, a system of improvement based on the 'consumer's' needs and journey through the system<sup>3</sup>. However it appears that 'service coordination' is more about re-integrating fragmented services at the intake point, and improved information management and data collection systems than about the consumers experience. It is asserted that service coordination is in the interest of the consumer and expresses the hope that clients will not need to repeatedly give their details (KPMG 2006).

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<sup>3</sup> See Lean thinking for the NHS 2006 <http://www.nhsconfed.org/docs/lean.pdf>

Grimwade (2006) evinces a preference for the dedicated intake system. The system is the equivalent of a semi local call centre where dedicated staff take initial enquiries across a range of community health, drug and alcohol and child and family services and pass them on to the respective teams at various sites. This preference is by comparison to a rostered system. Grimwade's rejection of rostered intake is based in the experience of people working outside their area of expertise and is similar to that reported at the site using Dedicated Intake in this study when they had previously tried a similar approach:

"Clinicians hated them, they felt hassled by the work and not competent in the face of the knowledge needed, so the advantage of ownership was outweighed by the opportunity to hand on the tricky ones to the next rostered person." (Grimwade, personal communication 3.10.8)

In the KPMG (2006) report and the Aldridge and Stapleton (2006) review of telephone access lines in NSW there is a tendency to support a system with which there is an established association.

Grimwade (2006) notes the importance of 'culture' at the point of intake (see also the discussion on 'discourse' below) and notes the implications of this for engagement, or not. He discusses the cost to society of the failure to engage which, in the case of mental health clients and children tend to be those most in need (Grimwade cites Inman 1956 and Kazdin, Mazurick and Bass 1993). Intake is seen as structuring the agency and its design, and being capable of influencing both efficiency and clinical outcomes (Grimwade & Dean 2008).

Grimwade calculates 'over one hundred different tasks or functions' are undertaken by the telephone intake worker in a period of 20 – 30 minutes. He reports clients are tolerant of the bureaucratic processing, and that intake is relatively visible from outside the organisation compared to the counselling or therapy services. He identifies a gap in understanding between intake workers and service clinicians and notes the occurrence of conflict in which the intake team tend to be scapegoated.

### **Open Days /Drop In/ Walk In/ Single Session Therapy**

The Open Day or Single Session Therapy (SST) approach to intake has most commonly been used in Child and Family teams and Child and Adolescent Mental Health (Price 1994, Boyhan 1995, Young and Rycroft 1997, Perkins 2006). In this intake strategy, people can call in without an appointment and be seen by a clinician. Early Childhood clinics often function in this way. Clients receive a single session that involves both an assessment and an initial intervention. The literature (Talmon 1990, Price 1994, Boyhan 1995, Young and Rycroft 1997, Duncombe 1999, Perkins 2006) demonstrates that 30% of clients attend once only for counselling, irrespective of the therapeutic style or profession of the counsellor, and irrespective of the diagnosis. 70% of that group of once only attendees are satisfied with the service they receive. In the Open Day/SST approach all clients are offered an immediate appointment including intervention at intake rather than being booked for an assessment and then placed on a waiting list. Thus, about 30% of people will not proceed to wait and the remaining 70% who do, will wait for a second not an initial session. Clients are able to have further sessions.

Removing 30% of demand, on average, from caseload allocation or any waiting list means a shorter time frame for service delivery for clients and a shorter waiting list for clinicians (Duncombe 1999). The Open Day literature argues that an intervention at intake is important because that contact will be the only one with the health counselling system for 30% of people. Further, Young and Rycroft (1997) found some indication that the timeliness of the Open Day approach contributed to therapeutic efficacy. 'When compared to similar clients receiving longer term therapy, single session therapy clients show slightly more improvement and satisfaction' (Young and Rycroft 1997).

## Centralised Intake / Call Centre

Centralised intake (CI) systems, call centres, have been used in the USA since 1970 especially in relation to drug and alcohol services (Guydish et al. 2001). In San Francisco, 30 independent community based treatment agencies co-operated to introduce a centralised intake unit. Evaluation demonstrated no difference in outcome for clients. Both potential clients, and the various agencies benefited from having a phone centre able to match clients to appropriate agencies rather than having to make, or to experience, re-referrals. This benefit is specific to the circumstance of a group of unrelated service deliverers to a clearly defined target group.

CI has been used in health services in Australia since the mid to late 1990's (Aldridge and Kanowski 1998) for triage for mental health, and health information and advice. In Mental Health services it functions to triage, trigger emergency intervention and refer back to local mental health teams (Aldridge and Stapleton 2006). As a health information service, call centres can supplement the lack of services in rural and remote areas, encourage people to take greater responsibility for their own health, and deflect demand from Accident and Emergency Departments and General Practitioners (Silvestro and Silvestro 2003, McKesson 2006)

Common themes in the literature on Centralised Intake in health were: 'single point of entry', ease of access, standardisation, consistent and accurate information collection, timely response to clients, 'customer' satisfaction, triage accuracy, streamlining, low cost, and efficiency (Stier 1999, Bentley et al. 2005, Mohr and Bourne 2001, McKesson 2006, Silvestro and Silvestro 2003). It was not possible to establish from the literature located that access was improved for the most 'at risk' mental health clients, that 'customers' were satisfied, or whether any substantial improvements in service had been achieved. It is likely that the 19 minute turnaround time for initial phone contact (Aldridge and Stapleton 2006, Health 2008) is faster than in previous systems but no evidence was cited to indicate that this system is superior or more cost effective overall. Similarly it is possible that the ring count to pick up is faster, but again no evidence that this is more important than for example walk off the street access, is cited. No mention is made of the elegance, or lack of elegance with which the MHAL is able to interface with the local teams it refers clients to, or of any conflict in this regard as identified by Grimwade, though the author has heard such difficulties frequently discussed in the field.

Aldridge and Kanowski's (1998) preference for the centralised system and rejection of locally based systems was in respect of a rural mental health service. The centralised system was seen as preferable because: it could reduce variations in service quality and staff training and expertise, was easier to access via a well publicised phone number, was a 24 hour service, was associated with superior tracking of clients through its computer system, and was seen to free up staff at the local services. It did not canvas whether local services would lose staff or funding to supply the centralised service.

It has not been possible to locate evidence of a cost benefit analysis or effectiveness analysis for any of the centralised intake systems in NSW Health, nor any direct comparison to alternative systems that could provide evidence of superiority one way or another. A report prepared by ACIL Tasman for the Australian Health Ministers (ACIL Tasman 2004) states that Health Call Centres in Australia and overseas have been subject to extensive review processes and that these reports are 'well known to all jurisdictions'. As no evaluations of Australian health call centres have been found it is assumed the reviews referred to are in-house documents. The NSW Community Advisory Group on Mental Health advise that they have three documents on the mental health centralised intake (MHAL) supplied by the NSW Government but none of these are public documents and they were thus unable to provide access to them .

Centralised intake in three rural NSW Health Areas is now being used as the pathway for accessing community health counselling. It appears there are no evaluations of these in the public domain.

## **Primary Health and Community Health**

Primary health care refers to the first contact between a person and the health care system. The Community Health approach is directed at the whole person and the whole community (Australian Community Health Association 2000).

Community Health Centres were established in NSW in the 1970's and based on principles of community participation, prevention, self help, accessibility, local accountability, and team work (Health Commission of NSW 1977). Contemporary NSW Department of Health documentation (NSW Department of Health 2006) refers to access, equity, health and wellbeing, community engagement, responsiveness, collaboration and multi-disciplinary and evidence based approaches. The priorities identified within this are specifically the integration of primary and acute service delivery with the goal of enhancing hospital avoidance. The example given is that of a reduction of admissions due to cellulitis by 30% with monetary and bed day saving cited (2006 p7).

Community health is now seen as much in the light of how it might contribute to the reduction of hospital demands as on any commitment to community, health, and illness prevention per se. This is a philosophical shift within which the intake systems for counselling in community health systems now sit.

## **Rural Health**

The circumstances of rural community health services are characterised by: a lack of specialist staff, transport issues for clients, low population density, and low income compared to the wider Australian community (Crago, Sturmeay and Monson 1996, Alston 2000). For community health workers rural practice involves: professional isolation, high visibility, pressure to be all things to all people, a relatively conservative social environment, the need to operate as a generalist, and operating in 'strong tie' communities (Crago et al. 1996, Alston 2000).

Aldridge and Kanowski (1998) when looking at intake for mental health on the south coast of NSW, characterised intake as either local or central. A feature of the interviews and focus groups they did was that practitioners and clients alike had a strong preference to be able to contact a worker already known to them. The 'local' system facilitated this whereas the centralised system did not: "... the ability to make a referral to a known local worker... is a highly rated advantage and its significance in isolated somewhat parochial rural communities should not be undervalued." Nonetheless, this factor was not addressed in the eventual intake system recommended by the authors. The importance of relationship in primary health services is born out in the literature on access (see below).

The counselling and psychotherapy professions have evolved in weak-tie urban communities. Some of the rules that accompany these professions: not counselling friends, confidentiality, not socialising with clients, and other applications of 'professional boundaries', are dependent upon the urban context where it is possible to keep one's social and professional lives separate (Sturmeay in Crago et al 1996 p.65). Lynn (1990) argues that service delivery in rural areas needs to be compatible with rural life. This suggests that intake systems for rural community health that should validate the 'strong tie' community structure compatible with rural life. Others have argued the importance of networks and social capital for a relational approach to primary health in general and not just in the rural setting (Scott and Hofmeyer 2007).

## **Access, Equity and Barriers to Entry**

### **Equity**

'Equity' in health service delivery needs to be distinguished from 'equality'. Equality refers to uniformity, or sameness. In 'single point of entry' systems, all clients go through the same 'doorway' and the same process. This however may not be equitable. Information about health services is not universal, and ability to negotiate the systems is notably not so as the wealth of literature on the exclusionary effects of socio-economic indicators tells us (Esser-Stuart and Lyons 2002). For NSW Health reducing health inequities is stated to be core business. The goal of equity in health is about improving health for those who are worst off by reducing or eliminating inequities that are unreasonable or unfair (NSW Department of Health 2004). Intake systems may need to offer a variety of options to people of different circumstances to provide an equitable level of access into community health services.

### **Access and Barriers to Entry**

Since intake is the doorway(s) to community health services, accessibility is crucial at this point of the system. Primary health has an important impact on better health levels and lower costs, especially for children, making access to it a significant concern (NSW Department of Health 2004).

Failure to access health services (low levels of participation) is characteristically associated with low socio-economic status including in relation to rural status, age and/or disability, and minority populations. This has been referred to as the 'inverse care law' (Hart 1971, Watt 2002)<sup>4</sup>. Barriers to entry in rural areas can include the lack of specialist services, distance from available services, transport, and low income (Aldridge and Kanowski 1998, Alston 2000). NSW Health aims to improve accessibility to primary health, including community health, for those in most need through integrated planning, measures targeted at the disadvantaged and community participation (NSW Department of Health 2004)

Recent research that has sought to explore accessibility from the client perspective has identified the importance of relationship. Both in regard to adolescents accessing drug and alcohol services and women from minority cultures it has been reported that knowing a practitioner and having a trusting relationship made people more willing to access services (Bernard et al. 2004, Esser-Stuart and Lyons 2002).

Lack of knowledge of the existence of services and what they provided was a barrier to service in both the Bernard et al (2004) and Li (2006) studies on access for minority culture women and rural aged care respectively. This has implications for intake.

## **Organisational Issues**

### **Health Service Reform**

Intake for counselling services in community health sits within the organisation and culture of the wider health service. NSW Health in common with public service organisations in many English speaking western countries has shifted from 'public administration' for the public benefit, to management according to market and competition principles, or, a new public management approach (NPM) (Pollitt and Bouckaert 2004, Hood and Lodge 2004, Blaauw et al. 2003). The goal is to be more business like and improve performance; the typical critique being that historically, centralised bureaucracies had been bloated, wasteful and ineffective (Osborne and Gaebler 1992).

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<sup>4</sup> "The availability of good medical care tends to vary inversely with the need for it in the population served. This ... operates more completely where medical care is most exposed to market forces, and less so where such exposure is reduced." (Hart, 1971)

These changes have arisen alongside the rise of computerised information systems, and movement from direct service provision to contracted provision. They involve a shift of attention away from the process of service production, of regulating inputs, to measuring and rewarding outputs and outcomes. There is an accompanying movement toward having 'consumers' share accountability for decision making (Fine 2007, McDonald 2006, NSW Department of Health 2007).

The reforms intend to: increase efficiency; manage the problem of excess demand; reduce morbidity from the most common illnesses and most demanding on health resources (heart disease, chronic airways disease, renal disease, diabetes); and direct people away from tertiary services (emergency departments, hospital admission) when possible. The potential role of primary health care services in these 'hospital avoidance' strategies is noted (NSW Health 2006).

There has been criticism that health system reforms have been too frequent (Braithwaite et al. 2006), outcomes rarely and poorly evaluated, unintended outcomes not scrutinised, methodological issues in evaluations not addressed (Pollitt 1995), and that there is little understanding of what has led to success or failure (Hurley, Baum and Van Eyck 2004). Hurley et al (2004) cite the range of stakeholders with competing agendas, the difficulty in articulating a rationale where demand exceeds supply, the political context, and electoral cycles as some of the limiting factors on successful health reform.

Community health services, and counselling services are minor within the larger Health Service environment, and rural services are marginal due to size and geography. They and their intake systems, sit within, and are influenced by this context of organisational change.

## Discourse

Organisational discourse constructs the culture within any service via its organisational structure, built construction, IT and use of language. All of these contribute to discourse and influence practice, with the assumptions being relied upon often in the background (Iedema and Wodak 1999). The design of an intake system will itself contribute to and be influenced by the discourse within which a service functions. It can contribute to depersonalisation, the production of power, and the specifics of organisational interaction (Iedema and Wodak 1999). How an intake process treats someone will determine whether they experience a loss of power, and/or a loss of status, for example by being converted from a person to a 'client', or 'consumer'. This conversion need not be intentional on the part of an individual clinician but could arise from the design of an intake form and the methods required by the organisation for applying that form (Miller et al. 1998).

## Health Services and Complexity Theory

Evidence based practice (EBP) and best practice are amongst the discourse items that characterise the contemporary NSW Health service. They aim to ensure a protective level of service. Within this discourse it is accepted that if a procedure or approach has been validated by the Cochrane Collaboration or is otherwise designated best practice, this is *the* way to proceed. This approach can be seen as linear, or mechanistic in the style of general systems theory.

Primary health care delivery systems are better characterised as 'complex adaptive systems' (Litaker et al. 2006, Plsek and Greenhalgh 2001, Gatrell 2005) that involve a collection of agents with freedom to act in sometimes unpredictable ways and whose actions are interconnected and influence each other. From the perspective of complexity theory, EBP can construct an objectivity that has the potential to constrain practice. The attempt to impose uniformity is likely to undermine the development of local strengths and opportunities that contribute to innovation and quality improvement.

“While variation is sometimes viewed as problematic, its presence may also be highly informative in uncovering ways to enhance health care delivery when it represents unique adaptations to the values and needs of the people within the practice and interactions with the local and community health care system.” (Litaker et al. 2006)

A variety of systems for intake into rural counselling services, have evolved and this research was interested in the adaptations to local circumstances. According to Litaker et al (2006), improvements in the performance of clinicians have greater longevity where they are individualised to unique values, processes and practices, and where new practices have been identified by the practitioner stakeholders for incorporation into the local culture (Litaker et al 2006). As a corollary, the management literature focuses on managing resistance to change in health services (Miller et al. 1998). Miller et al see resistance arising from strategies that assume practitioners will respond in a linear fashion to new information.

## Summary

There is a lack of specific literature on intake systems in community health, rural or urban. This literature review has therefore also looked to areas of contextual relevance. The most directly related literature is that on intake and referral in child and adolescent mental health (Grimwade 2006), Open Days (Talmon 1990, Price 1994, Young and Rycroft 1997) and on Call Centres (Aldridge and Kanowski 1986, Aldridge and Stapleton 2006). Grimwade's (2006) work based on a dedicated intake system emphasised the potential for intake to set the culture and structure of an agency with implications for clinical outcomes. The Open Days literature indicated a value in immediacy, having a time available where people can be seen for an initial intervention rather than simply having data collected and then being placed on a waiting list. The Call Centre material indicated benefits for having a central number when a number of organisations are delivering service to the same client group, and for supplying health information out of hours and in out of the way places. It is used as a triage system in Mental Health but the author was unable to find material that substantiated its benefit for this by comparison to alternate systems.

The Community Health literature alerts us to the shift in philosophy from a community, health promotion and preventative focus to a hospital diversion and clinical outcomes emphasis as the context for community health intake. Rural health literature reminds us that we are working in 'gemeinschaft' communities where relationship is of key importance, including in the professional arena and may be one of the few advantages inherent in rural service delivery where there are financially poorer clientele, less services and inadequate transport. Attention to the importance of 'relationship' at intake is indicated.

Of the less direct material, that on accessibility and equity was of the most relevance. We are alerted to the importance of flexibility of entry to enhance equity as 'equality' or uniformity tends disadvantage some people. Imperfect knowledge of health services and low socio-economic status are barriers to entry. Accessibility is particularly important at intake to community health as it can reduce demand at the tertiary level.

The final area searched was organisational material including New Public Management, health service reform and the implications of discourse and complexity theories in understanding health services and their organisation. It found an extensive history of recurring reform and restructure based on a marketised approach to public service delivery. This has influenced the discourse in the shift from services to patients or clients to 'consumers', that is, on the economic or market aspects of service success (including risk management) rather than on wellbeing. This may come back to how we and our intake system treat and characterise people making an initial enquiry and how we frame ourselves and the services we offer. One aspect of discourse is Evidence Based Practice which can make it seem that there is one best way to undertake a service. Complexity theory in the health setting warns that this is unlikely to be the case because both the human system within which the client functions and the health system itself is, including staff, are too complex in terms of interactions and individual differences to indicate linear predictions and uniform practices.

Altogether there appears to be a suggestion of the importance of interpersonal relationships and flexibility in considering intake systems for rural community health counselling services.

The present research, while small, hoped to make some contribution to an understanding of what were preferable models of intake for counselling in rural community health.

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## THE METHODOLOGY

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Because of the lack of literature and theory on intake systems in community health, this qualitative research used a 'grounded' approach (Glaser & Strauss 1967). It aimed to collect and analyse the data in an unbiased manner using open ended questions. The research is grounded in the primary, everyday experience of the interviewees (collected as data), with concepts and themes being allowed to emerge and then be revised as knowledge of them developed (Sarantakos 1995). A central feature of grounded theory is that it is cyclical and iterative (Pope & Mays 2006).

The research began with a literature review and informant interviews. From these a list of themes was developed. It then collected the experiences and observations of participant interviewees from two study sites. The research was exploratory, using a cross-sectional design to explore the views of referring agents, clients, receptionists, clinicians, and managers of community health services. It identified the general terrain of client intake and the themes and issues that arose across the spectrum of participant interviewees.

Qualitative methodology helps to extend the knowledge of a social reality that is being described (Alston & Bowles 2003). This research used the qualitative technique, of semi-structured, in depth interviews, to collect the data. It is inductive research in that it moves from specific, interactions and observations, to identify general, ideas and theories. It was interested in understanding how people with a stake in intake systems in rural community health understand and/or experience them and through that, hopes to make some contribution to an understanding of what models of intake could be preferable for counselling services in rural community health.

### Research Design

The research was designed in two phases. Phase 1 began with a literature review and informant interviews. The informants were people who had some interest and experience in intake systems in rural community health, mainly in NSW but also in Queensland. They included an ex client, a receptionist, clinicians, local managers, and a senior manager.

The 15 informants were identified opportunistically, and continuously throughout the research and were not a random sample. From a review of these interviews, 15 themes were identified by the researcher, and separately by two colleagues as a check on the researcher's interpretation. The themes were used as the basis of the participant interviews in Phase 2.

Phase 2 consisted of participant interviews from two sites; the first, 'Dedicated Intake' using a dedicated intake worker, the second, 'Rostered Intake' used a roster of counsellors who were also the service providers. Both systems were operated by Community Health services within the NCAHS. In each case 8 participants were interviewed: 2 referring agents, 2 clients, a receptionist, 2 clinicians and a local manager. In addition, three senior managers were interviewed from the Network and Area levels. This was a total of 19 participant interviews. Literature searching and informant interviews continued alongside Phase 2.

### Sampling

Sampling was 'purposive'. A number of referral agents were approached and the two interviewed for each of the two cases were those who made themselves available. The clients were provided with a participant

information sheet by their clinician at discharge. Those who were willing to participate had a contact phone number and first name provided to the researcher who then made contact by phone. The researcher did not have identifying information about the clients. A key receptionist at each centre was interviewed. The clinicians were all social workers as all the adult counsellors at the two cases study sites were social workers. The four social workers comprised the counsellor and the dedicated intake worker from the Dedicated Intake site and two counsellors/rostered intake workers from the Rostered Intake site. The managers interviewed were the ones who held positions relevant to an interest in the community health intake system at the sites. One senior manager declined participation.

### **Data Collection and Data Analysis**

Data was collected by taped interview. Each interviewee was asked the open ended question; "What, from your point of view (as a client/ manager etc), are the features of a good intake system." The responses were then explored to add specificity and clarify meaning, for example, "What do you mean by accessible?" In each of these lightly structured interviews, the 15 themes from the informant interviews were raised with each participant introducing an iterative element.

Data was not collected to saturation due to the small size of the study. The informant interviews were transcribed for analysis. The participant interviews tapes were reviewed for key comments, and pertinent quotes. The material from the participant interviews was analysed using framework analysis (Ritchie & Spencer 2002). It was charted by site, category of informant and theme, allowing new themes to emerge. These were then explored for trends, associations, explanations, and concepts.

### **Reliability and External Validity**

The similarity of responses by clients and referral agents reported in the Aldridge and Kanowski (1998) study, and by clients and health workers in Bernard et al (2004) encourage the belief that the opinions elicited have validity. The present research used individual interviews only to achieve its results, Aldridge and Kanowski (1998) also used focus groups, indicating two methods coming up with the same results.

The researcher sought to enhance validity by using a check for researcher effects when eliciting the themes from the informant interviews (Sarantakos 1995). The independent identification of themes by two colleagues elicited similar results. Member checks were undertaken with participants prior to the completion of the research report and elicited no corrections.

### **Limitations**

The results of this research are limited in applicability by the small sample size, that the sampling was purposive, or opportunistic rather than random, and by the necessary exclusion of clients who don't make it into the Community Health service system. As a clinician, the researcher has a greater familiarity with the world view of the clinicians' and might consequently have represented those views more accurately or more fully than those of the other participant groups.

### **Ethics**

Because the case studies are small and rural, it has been necessary to be discreet about the specific positions held by interviewees. All interviewees were explicitly informed about the nature of the research, assured that participation would have no effect on them directly and that their confidentiality would be fully protected. The researcher believes these conditions to have been fully met.

Ethics approval for the research was granted by the NCAHS Population Health and Health Services Human Research Ethics Committee.

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## FINDINGS: RESPONDENT VIEWS OF INTAKE

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The data collected from the interviews was analysed, and is discussed in groupings: referral agents, clients, receptionists, counsellors/intake workers, local managers, senior managers. This discussion makes links back to the literature.

### Referral Agents' View

The referral agents comprised workers from two domestic violence (DV) services, a GP and a job network officer.

#### Direct referrals

The referral agents were concerned about the vulnerability of their clients, and their client's limited ability to negotiate complex organisational hurdles such as: being re-referred, being required to make a further call or reaching an answering machine. They expressed a preference for direct access; to be able to make direct referrals, speak to the counsellor their client will be seeing, and have discretion over who their client would see. These were effectively clinical concerns.

*"...sometimes you would get clients where you would say 'ring this number' but sometimes you get clients, that you know,... they are not going to ring it. They're not together enough."*

*"These people have short fuses, and their comprehension is not what yours and mine is."*

*"I'm dealing with people in crisis, I want to be able to give them something other than a person in Newcastle or Coffs Harbour so they feel as though something is happening for them."*

*"When you're able to speak to a clinician and make those referrals you are able to give them a lot better indication of where that person's at."*

*"I take pride in being able to help patients get to the right service, the one they need,... I would feel a bit powerless in ... just handing them over to a central intake point."*

These views are consistent with those reported by Aldridge and Kanowski (1998) "Referrers said they felt better referring to a particular known and trusted worker than an unknown, faceless 'mental health team' (p6).

This was a clinical concern for professionals who had known their clients for some time, had a good understanding of their needs and had built trust that they couldn't afford to put at risk. As with referrals to medical specialists, these referring clinicians would prefer to know who they were referring their client to and the skills of that person. They may want to give a full briefing. They didn't want to risk the client to an impersonal system, not knowing where the client would come out or whether they would make it through the system at all.

Another clinical concern was having their diagnosis and management plan disregarded. Referrals to a new Department of Housing call centre were reported to be refused at times by non-clinical Housing Department

officers based on policy guidelines and despite Department of Community Services' involvement, Centrelink Social Work assessment and the referral of a DV worker. Referral agents wanted to be able to engage with the personnel at the organisation they are referring to, and to have professional links on which accountable practice could be based.

### **Clear information and reliability**

Similarly the referral agents wanted clear information on the system, waiting times, and when the client would receive a call back:

*"Clarity about process through the system allays fears they may have."*

*"Knowing the appointment time is more important than knowing how long the weeks sic are."*

*"Time delay is the biggest barrier. After a day or two the opportunity is lost."*

*"DV clients have low self esteem; it's easy for them to dismiss their own needs. Making the initial call is really difficult."*

*"Call back (needs to be) what they've been told and relatively soon, within two weeks."*

### **Summary**

Concern to have clarity about the intake system, its processes and time frame was related to concerns for the clients. Knowing exactly what was happening and having an appointment within a couple of days made it more likely that vulnerable and poorly resourced people would make it through the system to the service. Given that the most at-risk are the least likely to access services (Price 1994, Esser-Stuart & Lyons 2002, Bernard et al 2004) there is a need to be fastidious about improving their likelihood of success when they attempt to. The referral agents wanted direct contact with workers, and to be able to make direct referrals, also because of their concerns for the wellbeing of their clients and the standards of their own practice.

### **Clients' View**

The story that emerged from the 4 client interviews (1 male, 3 female, two from each of the two study sites) was one of their vulnerability when they needed to access adult counselling. They needed promptness and compassion. These people were tolerant of the impediments they found in accessing community health systems<sup>5</sup> and appreciative of the experience, and warmth of welcome they received when they spoke with intake workers.

It should be noted that in this, as in other studies, interviews were not conducted with clients who failed to make it into the system. This missing information can be somewhat gleaned from the experiences of the successful clients but warrants future direct attention.

### **Vulnerability**

The interviewees were clear that their psychological suffering was acute when they were seeking access to community health. Vulnerability was also highlighted in two of the cases where parents were seeking help for

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<sup>5</sup> Discussions with clients, as with the other respondents, centred on their experience of community health intake but allowed them to comment on other experiences of intake they had too.

their children, one for an adult daughter <sup>6</sup> and the other a school child. Clients are not always able to negotiate the system themselves.

*"I had hit rock bottom"*

*"I was put into intake the next day, I needed that, I was very low"*

*"...stressful in the mornings getting him to school, I was hanging out"*

*"I had to phone for her, she's not good on the phone",*

*"When we finally got the call that was great but she had started hurting herself, burning herself, and here you are a frantic mum... where finally it's come out and she doesn't know how to deal with it and there was nobody we could say, 'help her now!' "*

## Tolerance

Despite their acute need two of these people were tolerant of frustrations they found in trying to access services (in one case despite delay leading to physical trauma as well as further psychological suffering) and grateful for the compassion and understanding they received when they did access a service.

*'...obviously Sexual Assault are very busy ... it took a lot of time, it wasn't sort of their fault, but getting people to ring back ..."*

*"The thing was that the main person was on holidays. The poor lady that was relieving was here this day and there that day ... she was on a thin line anyway. It goes back to the department, not enough funding for important services."*

*"They put me on through to the Tweed, the counsellor was pregnant, I was referred to Family Centre... there's circumstances you can't get round she was going to have a baby".*

The barrier to access in these two examples was the result of a failure to backfill positions where staff were on leave, examples of cost minimisation by service management. Other obstacles described by these respondents were: coming up against message banks, not receiving return calls, having no prior knowledge of the service, a lack of clear and accurate information about how to access services, and poor signage at the Centres.

The respondents accessed the Community Health adult counselling services quite easily (though one had to go out of area). The mother who was seeking a Sexual Assault service for her daughter found support more easily accessible for herself through Community Health.

The clients were clear about what would constitute a good intake system for them. They didn't want to have to make multiple calls and they appreciated it when things were made easy for them. They valued clear information about the system, and a prompt response. For this group of respondents that varied from 2 days to a week. They valued continuity of care when either – they were able to continue to see the same worker they did their intake interview with or, because their intake experience went so well that it inspired their confidence in the system. They valued workers (or the system) being reliable in doing what they had been told they would

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<sup>6</sup> The service sought here was not community health adult counselling, but a sexual assault (non-crisis) service. The distress was related to the onset of symptoms related to past abuse. This scenario however could easily occur for clients seeking adult counselling and highlights the degree of psycho-social suffering that may be being experienced by community health clients, not least the mother of this young woman watching her deteriorate into social retreat and self-harm. This client could have been referred to the Mental Health Access Line when she went back to her GP after her 4 week wait to hear back from Sexual Assault.

do, and in one case the pro-active efforts of an intake worker finding a counsellor in another area. What they were most effusive about was feeling heard and understood. This led them to experience hope, and confidence and affirms Grimwade's (2006) observation that good intake establishes the context for successful intervention.

*"I just felt so comfortable. She just seemed to understand more ... I felt relieved, it was like ah, 'I'm going to get somewhere'."*

*"She seemed to understand what my needs were, made me feel at ease and I was in the right place doing the right thing."*

*"I felt able to say what I wanted"*

*"Just getting recognised as an individual and getting the help that I needed"*

These responses related to having experienced clinicians on intake at both study sites. Comments such as: "appreciated that she was a skilled worker", "wouldn't have wanted to talk with an unqualified person", and "the materials she recommended were good", indicated confidence in the expertise of the worker. Positive intake experiences gave a sense of emotional relief, and confidence that the issues could be resolved. Having experienced clinicians at intake and a compassionate response are two of the National Standards for Mental Health Services referred to by Aldridge and Kanowski (1998) in positing 'best practice' features of intake systems.

The clients also appreciated the personal tone taken by the workers as evidenced by comments of having been recognised as an individual, for example, "A1 for going out of her way and ringing me back. That return call was wonderful ... my issues were important, I wasn't just a statistic...".

## Summary

The clients' view identified their vulnerability at the time they are looking for counselling. It indicated their tolerance with shortcomings of the service and appreciation for the experience and compassion of the clinicians operating the two intake systems used in this research. Their comments raise issues about the lack of knowledge in the community of Community Health and its services, the problems created by not backfilling positions and of having intake systems that go to telephone voicemail.

## Receptionists' View

One receptionist was interviewed for each of the two study sites. Their remarks revealed similar concerns and also reflect the different systems they were working in <sup>7</sup>. Receptionists are the front line, first point of contact for the Community Health Service. In their role, they: make initial decisions and referrals, manage enquiries from people in distress, use informal strategies to develop responses, and bear the brunt of people's frustration with the system. There is no specific training for acquiring these skills, or supervision to cope with any distress.

The feedback from the receptionists was consistent with the feedback from the referral agents and the clients. In the Dedicated Intake system problems arising from intake enquiries going to an answering machine were raised. In the Rostered Intake system problems arising from a shortage of intake appointments were reported.

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<sup>7</sup> At Study Site 1 clients seeking adult counselling are directed to phone a number in a nearby large town. This phone line is attended part time and goes to a message the remainder of the time. At site 2 receptionists make appointments for intake which is usually face to face, but can be arranged to be by phone.

## First point of contact

In both systems the receptionists did the initial sorting, deciding which enquiries to send to the Mental Health Access Line (MHAL), Drug and Alcohol services, Child and Family, Social Work, health services provided from other premises, or out of Health to relationship counselling, or other private services. The receptionist's input often occurred at the person's first attempt to access a service, either by walking in or by phoning.

*"Reception has to sort who to send to mental health – give MHAL number, by listening to what the people are telling us. We are (always making an assessment) because they say 'I need to speak to a social worker', then we've got to say 'Can you tell me a little bit...' to distinguish between mental health, D&A, sexual abuse recent or non-recent... I always like to ask questions, because what's the point of having someone who's in trauma making the wrong telephone call"*

*"Sometimes you have to probe a little about what people need. You can do that without people needing to give you all the details, you just need to know what area to point ...them in the right direction. It may not be appropriate for them to come to us... you have to choose your words carefully so they don't (tell you the whole story), to protect their privacy too. They don't want to come in (later) and think, 'Oh, that's who I told everything to, and they're sitting behind the desk there.'"*

## Inadequacies

The Receptionists' comments bear out the obvious shortcomings of the two systems. In the Dedicated Intake system enquiries for adult counselling were directed to a phone that went to an answering machine 50 percent of the time. In the Rostered Intake system the receptionist made the intake appointment immediately but if there was a shortage of available appointments this may not be for ten days or more. The receptionists were left to commiserate with or subdue clients who had difficulties with these shortcomings. There are other health services they received enquiries for too (sexual assault, aged care) and these may also require telling people to phone another number.

*"All we can say to them is 'This is our intake process', we give them the number of the intake worker, and they can ring ...that works fairly well in theory but she's a busy lady, she only works half the day doing that."*

*"People are ringing up in distress at times ... they've got to leave a message on the answering machine. And it could take a couple of days or so. She might ring back and they're not home, and then they ring us and say but you told us to do that and we haven't heard from her. And then they feel they're getting the run-around, and that's awful."*

*"Often people get upset... 'I ring and now you're telling me I have to ring another number!' I actually apologise to them when they react like that and I say, 'Yes, I know this is not a really great way to deal with it but this is what we have to do.'"*

*"This week has been busy and one of the rostered people is on leave and hasn't been replaced ... when there's only a few days a week when there's intake, and to lose one of them straight off like that..."*

## The 'front of house' role in intake

The receptionists sit at the 'front of the house' and provide the Health Service's first response, including for distressed people and those with mental illnesses and disorders. They are not specifically trained, supported or supervised for this. They learn on the job and are dependent on the goodwill of clinical staff in dealing with the brunt of people's distress or frustrations.

*"For reception (training), 'Listen to how we handle the calls and learn from that.'"*

*"(After many years experience) you get a sense of what's going on emotionally for a person, they're sad or depressed or suicidal, or they're going to blow up. You know, you can feel it around them, you know what's going to happen next."*

*"Some staff are really flexible, even if they're not on intake. You wouldn't call on staff for just anything but when you know someone needs help, and they need it now, and when there is someone around ... it means everything, because you feel supported ... and it feels more like you're working as a team to help someone. If you get a complete 'No', you think 'Great, ... in no mans land ... left to deal with a difficult situation which, we're not counsellors and its not satisfactory for the client."*

*"Certainly does! (puts pressure on reception) Heaps. We've learnt to cope with it through experience. ... I calm the person down and tell them what there is available and 'We understand you're distressed'... I tell you what I do, if I know that (a worker is available) I just go and get her. She will come out 'cos she knows if we come and ask then it's something that needs to be looked at straight away. But sometimes she can't do it."*

*"We (receptionists) just talk to each other (when it becomes distressing), we've got needle syringe exchange, we've got disgruntled people coming ...banging on the desk and you've got to deal with that as well."*

Shaw (1992) observed the pivotal role of receptionists in the intake process and the extent to which their responses influenced whether clients would engage with the agency or not. Whilst it may not be appropriate to put responsibility for intake onto receptionists they should certainly be supported and trained to the role in the intake process they fill by default. Receptionists observe the shortcomings of intake systems and know when people are deterred from engaging.

*"...and you sometimes wonder if they'll actually make the call."*

*"I ring you and now you're telling me I have to ring another number."*

### **The ideal intake**

From the Receptionists' perspective the best intake system would be one where there was a worker available throughout working hours, but a perception that this would be uneconomical. They acknowledge the need for and advantage of responsiveness and the role of an intake worker with expertise.

*"The perfect intake system would be to have someone on-site who is just there strictly for intake when you get your walk-ins and your phone calls for people in distress that need someone to talk to at that very minute"*

*"Sometimes she (intake worker), can nip things in the bud by giving information to people."*

*"Availability,... to be able to give a distressed person an appointment straight away. To have set times available helps to defuse the situation for the person ringing in, and less stressful from an administrative point of view."*

### **Summary**

The receptionists view was consistent with that of the referring agents and clients in reflecting on the vulnerability of people who approach the community health service and the barriers created by shortcomings of the systems. The receptionists' role as the first contact deserves support and a responsive hearing to their feedback. Their place in the intake system should be validated and their participation sought when altering or designing intake systems given they have information about its impact on clientele.

## Clinicians' View

Two clinicians were interviewed for each study site; the dedicated intake worker and the counsellor from the Dedicated Intake system and two counsellors who participate in the intake roster in the Rostered Intake system<sup>8</sup>. All were partial to the system they were operating in. All had been privy, over time to the development and adaptations in their present system<sup>9</sup>. Their comments fell into: what helped and hindered access and equity, belief in the importance of relationship both with clients and other practitioners, and made comments on what contributes to good and poor intake practice. The workers from the Rostered Intake system were strong in their belief in the value of intervention at intake, both for the client and in terms of cost efficiency.

### Access and equity

The Rostered Intake clinicians saw access as facilitated by having the option of phone and face to face intake, prompt response and being located in the CBD. A Dedicated Intake respondent cited the importance of being clear about process.

*"Very few people use the telephone option. It's (the centre) not out of the way, it's in town, so if you don't have a car, you've caught the bus ... or a friend has driven you into town, you just walk around to Community Health."*

*"Face to face makes it accessible – people are sick of talking on phones, sick of call centres, they find them impersonal."*

Barriers to access included phone problems (mobile phone black spots, having to make more than one call), and the profile of Health from outside the Department:

*"People are not aware of the difference between Mental Health and us – 'I have just told you all that'."*

*"Unless there is a number given out they do not have (the intake worker's) direct number"*

The service was not seen as equitable because it is culturally inaccessible for indigenous people, and other minority cultures, doesn't provide services in languages other than English, doesn't provide for childcare for mums with a number of children, cannot assist with transport and has limited ability to do home visiting. Thus people without transport, including people with disabilities and adolescents are less likely to use the service. This observation is consistent with the literature (Esser-Stuart and Lyons 2002, Bernard et al 2004).

### Relationship

Good relationships between professionals were seen as facilitative of the service, in the interest of clients, and as a recommendation for flexible entry.

*"(The intake worker and counsellor) have really made the effort to get to know one another's practice well, so we can have confidence in ringing one another and give some feedback"*

*"Doctors didn't want their clients to go through intake ... they wanted to say 'I know (worker x), I want to refer this client to (worker x). They don't like putting people through hoops. It's the relationship thing, 'I know this worker, I'm happy to recommend them'."*

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<sup>8</sup> Three of these four interviews were longer than the other interviews conducted and this is addressed as a bias issue in section 5 discussion.

<sup>9</sup> Both systems were subject to alteration during the study period, and no longer operate in the manner described.

*"I will accept that someone from Family Support knows who I am and what I do and that the referral they're making to me is appropriate."*

The establishment of a good relationship, and an approach the client experiences as personal can be useful in facilitating further sessions when a rostered intake worker will be the ongoing counsellor, or in conveying confidence in a counsellor the intake is referring on to.

*"You don't want to establish such good rapport that they end up being disappointed when you won't be seeing them ... it's important for them to feel that they have been getting the ultimate service every step of the way."*

*"People may burst into tears at that point, without having said a word. I'll always say, 'There's no rush'. It's a very human process."*

*(in face to face intake) "Non verbal stuff goes on too; the way people communicate. People perceive that they know the person they're talking to, particularly in a local area, you see them around the shops, you are a known person."*

*"Transfer thing hasn't been too much of an issue. If people are aware of the system up front ..., if it's a good intervention (with the intake worker) then they're all most happy with that."*

### **Intervention at intake**

Although it was more emphasised by the respondents from the Rostered Intake system where an intervention at intake was standard practice, both sets of counsellors believed a good intake could provide a positive outcome for the client and be cost effective as a result.<sup>10</sup>

*"... might be able to dispense with one on one counselling because the person has received what they need from the telephone counselling."*

*"If you do a good assessment and intervention on intake a lot of people don't come back for a second session, a lot of people that one session is enough to get the information, the clarification, the support or the referral, the whatever that they wanted, so they're out of the system, so they're not blocking they're actually freeing up the path."*

*"(intake worker) will go to a lot of trouble for people, that's why we have a lot of 'no further action' people."*

### **Comments on other systems**

One worker thought a direct referral system would be "too time consuming, and conflict with counselling commitments." At the Dedicated Intake site there had previously been a system where counselling and non-counselling staff had participated in a roster for all community health enquiries. This was seen as a mistake.

*"Having seen people who have no or little experience trying to do intake and then seeing someone who has the training and the skills, there's no comparison."*

Reservations about a call centre model included the loss of local information and relationships, a belief that people did not like call centres and the need to redirect clients as is presently experienced with MHAL clientele:

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<sup>10</sup> At Study Site 2 an initial intervention at intake is used as part of a prompt initial response. Any waiting is intended to occur after people have had their initial, intake consultation. The workers tend to take up new referrals immediately and when necessary increase waiting times between sessions for older clients who they know to be stable.

*"Also, how would a call centre work for adolescents, they walk into our centre and ask for a counsellor ... They're sent away to use a public phone, they might have no credit, they have to go and ring somebody, people don't always have phones that they can access. They're being sent away to phone another time. This was the energy they had built up to walk into that building and say 'I want to see a counsellor' and a young girl especially could be very nervous and stressed, she's done it and they've sent her away to make the phone call."*

Instead it was important to provide an expert service and to be accessible:

*"...providing a good service to the community, a service that people can easily access, where they're not fobbed off. I really like the system we've got because people have an (face to face) interview so if they're in crisis they have an opportunity to have a crisis intervention interview. They're dealt with, they're not put off for a week..."*

*"I can't overstate that (need for expertise at intake) too much, because I've seen when it hasn't happened and unskilled people haven't been able to discern the level of needs and safety for people. When you're seeing someone face to face you're assessing safety."*

## Summary

Whilst the workers had a preference for the systems they were working in there was agreement between them on the characteristics of better intake. Intake should be accessible, flexible, have a prompt response, be carried out by a clinician, and include an intervention. Poor access and equity for minority groups, those without transport, and people with children were noted. Specific issues were also noted around mobile phone black spots and 'phone tag'.

The clinician respondents had a strong philosophical commitment to the importance of relationship in good practice, both at the professional to professional level, and at the professional to client level. They saw this as being therapeutic in the latter case and facilitating good service delivery in the former. Thus communication and teamwork were seen as factors in a good intake system. The clinicians believed the intake worker should: be an experienced counsellor with a sound knowledge of local resources, a good allocation of time to do the intake, be respectful, use professional listening skills, discover the person's needs and relevant details, make appropriate referrals, do a good assessment, and prioritise if demand was high.

## Local Managers' View

The local managers were committed to flexibility believing it to be a principle of community health, but there were some differences about whether a walk-in response was affordable as a component of this. They valued the local as against any potentially more central response, and relationships were seen as important. These views concurred with the referring agents and the clinicians. Both local managers could see the value of an intervention at intake.

## Good and accessible intake

Accessible intake is easy. It should be quick, and use pathways that are obvious from outside the organisation.

*"... efficiency of slipping it through the system very smoothly, it gets to where it has to go pretty quickly."*

*"Easy access means they can ring up and get an appointment reasonably quickly. They don't go onto a waiting list to wait 2 months or 3 months."*

*"Currently they just pick out the number for Community Health, ring, walk in whatever, it's very obvious."<sup>11</sup>*

One centre had improved accessibility of the Community Health service by re-locating in the CBD near other human services. Both saw value in intervention at intake. In the absence of restrictive key performance indicators intake workers were seen to have the time available to complete a session there and then if that was feasible.

*"Clients are handled in an efficient manner and aren't put to further distress and channelled in the right direction. ... It's a screening thing, making sure that the right service gets the right client ..."*

*"Residents have access to clinicians with a variety of experience and backgrounds to meet their needs, a variety of appointments are available, are slotted appropriately and they see them in a timely manner, ... (we don't have any waiting lists normally), and that they feel satisfied."*

## **Expertise**

There was a commitment to having experienced clinicians undertaking intake and an understanding that this provides a quality response for the client and efficiently initiates an effective response.

*"...there's someone on the end of the phone who sounds like they know what they're doing, and can reassure the person that's coming in that they will be directed in the right manner, that's way beyond a need for face to face."*

*"We've got staff who've been there a long time who know their job and who are passionate about the process and who care about it so the quality, the standard people are accessing is really good I feel."*

## **Interplay between flexibility, a local response and the value of relationship**

Flexibility was seen as valuable and related to the importance of a local, and a relationship based approach. The local managers were generally happy for staff to take an individual approach as long as there was also consistency:

*"I don't like ... standardisation of assessment tools because people don't fit into boxes. You can fit so much into tick boxes and then you get missing information, why are they presenting is the main issue, .... standardisation is fine in some ways, but I think you've got to be flexible."*

*"Can have both (consistency and flexibility). There's consistency re what the person ... elicits from the call and how they may progress to helping the caller. ... You still can respond to what you hear and how you deal with that call even though you've got your set questions ... flexibility to continue the call as long as you feel necessary or have the flexibility to ring back. "How did that call go for you, were you happy?" There's more flexibility there in a local service."*

*"(system avoidance) is prevalent in most local sites because it is human nature to try to make things easier for people if they come in and are distressed. I think that has a lot of benefits in respect to remaining humane and respectful ... It maintains that human contact, reassures the public that there is someone there in a difficult time. In general staff will greet them in a respectful, very calm, helpful manner in that instance and support and they don't feel like a goose having walked in and having a cry. Making life easier by putting a call into some other service that might mediate that process for them. It isn't necessarily queue jumping, it's a case of recognising the distress someone's in and needing support more instantly than others who are pretty cool about their predicament."*

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<sup>11</sup> This is not however, how that system actually worked at the time, and nor are any Community Health Centres listed under Community Health in the phone book.

## Comparative intake

One of the local managers took up the theme of comparative intake systems and preferred that any system should accommodate local flexibility. Any key performance indicators (KPI) could be set centrally but operationalised locally.

*"I guess I'd have to be convinced that the need to have somebody just waiting for somebody to present with an enquiry, ... the number of people presenting ... would not warrant someone waiting in the background ... just in case someone pops in"*

*"I'd have to work out how would (centralised intake) that help the local community ... how do they decide whether to ring community health or to ring intake? How do we inform them that you actually ring intake you don't ring community health? ... it would have to be well described articulated and explained."*

The present system is better than the previous one<sup>12</sup>.

*"Speech therapist trying to deal with someone who had social issues ... was quite limited. 85% of intakes were in respect to social enquiries so we decided to have a social worker on intake."*

## Summary

The local managers were sympathetic with the value of a local response by experienced counsellors. They were clear that intake needed to be prompt and easy. Response could be flexible and include an intervention. There was a concern that having an intake counsellor available locally would involve having someone sitting around. Centralised intake was not an attractive option.

## Senior Managers' View

Three managers characterised as 'senior managers', were interviewed. They came from the Network and Area levels of NCAHS. They were more committed to the idea of some sort of centralised intake or single point of entry but also expressed sympathy with local and personal approaches. One senior manager was committed to uniform standardised assessment for equality of service and risk management reasons.

There was awareness that lack of information in the public arena could inhibit access for the most needy, and that our services were not culturally accessible for some.

*"People need to know what we do, and how to access"*

*"Sometimes I don't even know what we've got"*

*"Not equal information, the at risk groups, who are on the fringe of society ... often don't have the information and ability to get to them (our services) ... We try through outreach to get to them, but they don't have equality of access, ... provided that we're trying ... to make the access as equal as possible, that's what we have to do"*

*"Need to design services around what people feel culturally comfortable accessing"*

*"Advertising will increase the inflow of clients, in MH very few were inappropriate ones (calls)."*

So the understanding was there, as reported in the literature (Ensor and Cooper 2004, McDonald and Zetlin 2004) that those likely to miss out on a service will be the most needy.

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<sup>12</sup> Refers to the previous system where non- counsellors, were rostered to do intake and were unable to manage counselling enquiries

## Good intake

Intake should be available, approachable and expert. It should be easy, one number, and no push buttons. One senior manager respondent thought a good intake should be consistent across all sites.

*"..so that intake is done in the same way asking the same questions ... Going for standardisation across the networks. Clients should expect to receive a similar level of care no matter where they turn up."*

## Balance

There was an awareness of the need to find balance between competing factors, professionalism and warmth, flexibility and consistent quality, cost up front versus downstream. The senior managers tended to look at the question of intake as purchasers of the service reflecting experience with contracting for the Mental Health Access Line, and two of them commented specifically on aspects of the MHAL.

*"The bigger something gets, ... the more rigid it is in terms of being a bit rule bound but it does have the critical mass advantage then of having availability around the clock."*

*"And the clinician, knowing the intake worker has the credibility, ... if you're getting that from a central point where people don't have any knowledge of each other they are less likely to have that flexibility. The local one is probably more customised whereas the bigger one is probably more formulistic."*

*"It can be more friendly if you give that flexibility within the parameters you set. It becomes more robotic and formalistic if you try to get the calls through in a tight period of time... if there are time constraints on the list of things you have to do within say 3 minutes."*

*"Financially constrained, resources are not available. How do we deliver the greatest benefit for the greater good."*

One senior manager's comment showed an awareness of an issue that concerned receptionists, that people who were put off at their initial enquiry won't follow through.

*"The risk is, if you have a robotic, formulistic response, people may not follow through, may not have the confidence, the relationship developed, their health issue may worsen. When we come to treat them it costs us more money in terms of time."*

## Call Centres and Comparing systems

The discussion with senior managers tended to be about centralised intake in comparison to other systems. One manager commented on the increase in part time staff and its impact on the continuity of care. Centralised intake was seen as a possible remedy for this.

Centralised intake was seen to be well researched, to spread the workload equally and to be easier to advertise. Centralised intake "should just be someone who puts them through to the correct area". There was acknowledgement of the need for a "clear, streamlined, relationship between intake and clinician", an important issue with both centralised intake and dedicated intake systems where the intake function is separated out from the service response. In one instance this was seen as a plus:

*"I tend to agree that there should be a separation between the intake service and the actual treatment."*

*"...with the volume of work that comes in you can't afford to have people who are doing intake in addition to their normal duties. I think volume doesn't allow that to happen any more and also the legal ramifications, if you miss something you could end up in court."*

By comparison:

*"Direct referral – good old customer service, I'm a great believer in that. Health care shouldn't be like a bank, push 1, push 2, we don't have to go down that road."*

### Single point of entry

In general, 'single point of entry' is equated with CI though a dedicated system can also be a single point of entry in a particular locality. An advantage is "you have the critical mass to have the service around the clock". Though there is no suggestion that community health intake requires 24 hour service.

*"As a manager I prefer a single point of entry. The more flexible you are, I understand that may meet some specific needs of clients, but the more opportunities for accessing a service, the more likely you are to have mistakes and to have people falling through the gaps."*

*"..the distress fell back onto the client, that we weren't providing a quality service because certain people could jump the queue and have priority of access so we did see times when the Police would force their way in or a GP would bellow down the phone whereas, had they gone through the access line, the access line person would have done a quick ten minute interview and then applied a rating scale and then sent it through to us and we would have known exactly where that stood in queue." (Re MHAL)*

### Intervention

Whilst the clinicians and to some extent the local managers saw providing an initial intervention at intake as efficient, there was a different perception at senior management level.

*"My feeling is that if you try to do an intervention as well you can take an hour and in that time you've got 3 or 4 clients who've left messages and haven't been able to get through because the intake worker is on the phone doing interventions, then the intake worker has to be ringing those people back and if people aren't immediately available, telephone tag, whatever. It means the intake process might take longer."*

This reservation appears to refer to a centralised intake setting where there might be a number of calls each hour, by comparison to the local systems that receive a number of calls per day. The respondent acknowledged that,

*"Quality at front can cost more but save down the track, a balanced decision needs to be made."*

### Data

Data collection and management was more of an issue for the senior managers than the other respondent groups. The business requirements for data needed to be balanced against the core business of human service delivery.

*"Yes, make no mistake, we're running a business."*

*"As we move into the HACC data base, HACC version 2: what did the person come for, how long did you see them, what were the outcomes?"*

*"We can't afford to be collecting more information than the department requires. Because the more you collect the less clinical service you provide."*

*"Data is all important but the main game is patient care"*

## Relationship

Senior managers were happy for there to be a human and warm side to the professional response at intake, but they balanced this against other concerns. They were also familiar with the useful facilitation possible when professionals who know each other work together across organisations.

*"Most complaints are interpersonal in nature, the person didn't feel heard or the intake person was rude, or dismissive, didn't listen to them. Sometimes boils down to the individual's personality, sometimes workload. It wouldn't be unusual to have 15 to 20 referrals to come in a day and one person had to go through them. They didn't have the time to be nice, they didn't have the time to delve into the secondary layer of information like "Is your mother aware of this?" "Have you got someone to bring you food?" You didn't have time, if you did you could have someone dying at No 4 in the queue. It is a balancing act, you strive for a bit of both."*

*"Can be professional and warm."*

*"The advantage of a local access is that the intake worker knows the clinicians and can therefore tailor the information to work with the knowledge of the ... clinicians and what they would be looking for ..., and also knows the clinicians well enough to say "this one's more urgent, can you prioritise it up a bit in your day?" And the clinician, knowing the intake worker has the credibility, can rely on that whereas if you're getting that from a central point where people don't have any knowledge of each other."*

## Summary

Senior managers were familiar with many of the issues raised by the other groups of respondents but balanced these against efficiency, outcomes, throughput, systems and data concerns. They viewed issues more in terms of high volumes that are typical of urban, or centralised systems. This group was the most sympathetic with centralised intake and least sympathetic with the concept of an intervention at intake.

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## CONCLUSION AND RECOMMENDATIONS

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This research did not identify one approach to intake that was best for adult counselling in rural settings. It did canvass a range of issues that, across respondents, were found to contribute to better intake practice regardless of which model was used. The indications were that: community health must hold a high community profile, intake response must be prompt, intake response must be welcoming, intake must be flexible to ensure equity and accessibility, intake workers must be experienced counsellors, reception must be better used and supported in its intake role, and intake must allow for direct relationships between professionals within and across agencies.

### Findings related to the literature

The findings of this research were consistent in some respects with the findings of the previous research on intake systems examined. The Victorian document 'Service Co-ordination' (KPMG 2004) acknowledged benefit of a brief intervention at intake, as does the Open Days/ Single Session therapy literature (Talmon 1990, Price 1994, Young and Rycroft 1995). The present research indicated that an initial, if brief intervention was valued by clients and clinicians, and supported by local managers.

The advantages of Centralised Intake; providing 24 hour service and triaging for emergency response are not issues for community health and were not raised by any of the groups of respondents. The literature review didn't find evidence of cost effectiveness benefits that centralised intake might have for counselling in a rural setting. While Centralised Intake was not one of the models used in this research participants were encouraged to talk about intake experiences beyond community health. The referral agents in particular, and clinicians in their role as referral agents had experienced centralised intake at Centrelink and NSW Department of Housing as being barriers to entry.

Local and integrated intake was preferred by both the majority of respondents and the majority of groups of respondents, by comparison to centralised and segregated, that is, systems where the intake function was separated from the service delivery function. As in Aldridge's work (Aldridge & Kanowski 1998) and the literature on rural social work and on access for community health in general (Sturmey, in Crago et al 1996, Lynn 1990, Scott & Hofmeyer 2007, Bernard et al 2004, Esser Stuart & Lyons 2002) the respondents in this study, valued personal relationships as a mediator of good service delivery. For referring agents and clinicians this applied to the relationships between professionals, and for the clients it applied to their experience of the relationship with their clinician.

It has been acknowledged that the most needy may be the least likely to access services (Hart 1971, Watt 2002) and this research confirms these concerns and indicates that intake systems themselves can be barriers to entry for the least resourced and assertive people. Although the client participants made it into the service relatively easily one had significant trouble, (leading to physical consequences) accessing a sexual assault service for her daughter who was unable to act on her own behalf.

These client participants also confirmed the findings of other research (Bernard et al 2004, Li 2006) on lack of knowledge of services as a barrier to entry, with only one of the four having any prior knowledge of the existence of the service. The counsellor respondents expressed concerns about poor equity of access for minority and at risk groups also verified in earlier research. The more visible community health is in the community and the more intuitive and flexible the intake system is, the more likely it is that the neediest people will be capable of accessing services.

There was some difference in emphasis between the different groups of respondents with the senior managers more attendant to issues of systems and dealing with high volumes of demand with sympathy for a centralised approach that could deal with high volume as necessarily more equitable, a view that was at odds with the experience at the small local rural centres in this study and the literature on barriers to entry. This must be seen however in the context that these managers have been operating in a Health Service that has had a continual series of restructures driven by new public management principles over the last ten years or so, with its emphasis on risk management, and cost minimisation and that culture can be expected to influence their priorities and perceptions.

These differing concerns, for the vulnerability of clients on the one hand and the integrity of the system on the other, could be more or less mutually exclusive depending on the intake system used. That is, a local system that did not maintain consistent data and got blocked at the intake point would bear out the concerns of the managers but one that supported high throughput and maintained the integrity of data might satisfy both sets of concerns. A similar scenario could be created for centralised intake where flexible access, a personal approach, an initial brief intervention and integration with the counselling team could satisfy all parties.

## **Findings beyond the literature**

The further findings of this study are indicative only due to the small number of respondents, but they raise important issues that deserve to be acknowledged and further addressed. These include: the potential vulnerability of clients who attend community health centres, the central role of reception in intake, the need for flexible entry to ensure accessibility and equity, especially for the most disadvantaged social groups.

The referring agent, client and receptionist contributions highlighted the vulnerability of people when they are seeking adult counselling. This has not been adequately acknowledged in the design of intake and has major implications for clients and receptionists who experience the consequences. It is reasonable to predict that the cost of this is also borne by the Health Service and the wider society in the longer term. Any commitment to reducing demand at the tertiary level could reasonably be seen as an indicator for improving access at the primary care level.

In addition, at the site using a Dedicated Intake system there was feedback that warns against the use of answering machines, and at the site using Rostered Intake there was sometimes a lack of intake appointments.

The most positive accounts from referral agent, client and reception respondents were about prompt personal and compassionate responses that left people feeling heard and understood, and with a sense of having started to resolve their issues.

The conclusion of this research is thus, that the model of the intake system is not as important as its ability to deliver 'good intake practice' and that the factors that contribute to good practice should be more central to the consideration of intake design than the model or structure used.

As a consequence of the present research, the author would be interested to know more about the experience of people who fail to make it into the system, and more about the possibility of technology and telephony to provide better linkages between various health services, thus increasing the flexibility of access. These could be areas for further research, as would the much larger project of establishing the relative costs of the different approaches.

Following are the recommendations arising from the research, these are presented in the form of a 'Checklist for good intake practice'.

## Checklist for good intake practice:

- The Community Health Centre (CHC) is widely known in the community it serves
- The CHC is located in or near the central business district (CBD)
- The CHC is clearly and prominently signed
- The CHC signage indicates what services are offered
- People phoning or walking in to the CHC obtain an appointment on the spot for a time within 3 working days
- The person any client sees, or speaks to for an initial appointment is an experienced clinician
- Intake workers and counsellors are either the same personnel, or if not, meet regularly and are administratively in the same team
- Initial enquiries never go to an answering machine
- Specific arrangements resulting in an immediate response (as per the above) are made for incoming enquiries where clinical positions are not backfilled
- Reception staff who have any initial contact with clients are included in design and discussions about intake and are resourced for their role
- Initial interviews offer an initial intervention as well as undertaking assessment and prioritization
- People should not be sent away with a phone number. They should be put through or the number dialled for them.
- An inclusive and welcoming culture should be consciously cultivated by the CHC
- Referral agents should have direct access to a client's counsellor
- Any intake system should be flexible

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## APPENDIX 1: THE INTAKE TERRITORY

## **Models of Intake**

Access to counselling services in rural community health can occur in a number of ways; direct referral (direct), via a roster of clinicians doing intake duty (rostered), via a paid worker dedicated to intake (dedicated), via a single or initial session (initial session) or a via call centre (centralised intake).

It will be seen through the descriptions below that these typologies are not clear cut and appear in various incarnations.

### **Direct**

It was common for counselling services (child and family counselling, drug and alcohol counselling and adult counselling), to be accessed by direct contact with the relevant clinicians often via a receptionist. The clinician would then assess, prioritise, refer and/or treat at their professional discretion. This approach is still used in some areas. The direct system can respond to both walk-in and phone enquiries. It allows for an immediate therapeutic response if the clinician taking the call deems that necessary, and for interim intervention, for example the provision of initial psycho-education (say on grief, depression, or anxiety) or written material.

It may be immediate or, (depending on the success of phone call backs, case load and leave and backfill circumstances) delayed briefly or for rather lengthy periods.

It is more common in smaller communities and the worker will usually have good familiarity with appropriate parallel or alternative referrals. The direct system is consistent with rural community's preference for connectedness and service delivery via relationship. That is, medical practitioners and non-government agents can contact the worker directly.

### **Rostered**

Increases in population and service size can lead to the establishment of a roster of counselling staff to manage new enquiries. Rostered systems may be accessible by both phone and walk-in, or restricted to phone. They may be available throughout working hours on a first in first served basis or restricted to set appointment times.

A variation of the roster is to use staff from a range of professions to take enquiries for a range of services. This may have the problem of non-counselling staff being struggling to manage people in emotional distress.

The rostered system (counselling clinicians taking counselling enquiries) tends to encourage team communication as clinicians inevitably pick up enquiries for colleagues whilst on intake shift. Allocation may be mediated solely or partially through an 'intake' meeting. Changes in the structure of NSW Health have led to the discontinuation of a number of local rosters as mental health and drug and alcohol staff have been withdrawn due to the 'streaming' of these services. This can make maintaining a roster for response to community enquiries impossible due to an inadequate number of remaining staff. The rostered system can offer an initial intervention.

### **Dedicated**

In some places funding is allocated to a dedicated intake worker or team. In this system, the intake worker collects, assesses and sorts new enquires to refer out or pass these on to the appropriate team. This may involve a specifically counselling intake worker but commonly takes calls for a range of health services. The dedicated intake worker system has the option of collecting identifying information, using screening tools, providing an initial hearing and initial information, and prioritising. It has the potential to be phone only or to incorporate walk-in enquiries.

The transfer from a dedicated intake worker may be via an 'intake' meeting or electronic. A locally based dedicated intake system offered via a well publicised 1300 or 1800 number is similar to a call centre. Any intervention is likely to be information and referral only

### **Open Days/Single Session Therapy**

A less common intake approach; in this system the agency may use an 'open day' once a week to see all comers once for an extensive initial assessment and intervention. This is a walk-in system. People who require further service are referred to the appropriate team. The same workers provide both the intake and the ongoing service. The most responsive approach, it is believed to be more efficacious therapeutically by some (Young and Rycroft 1997) and to improve accessibility for vulnerable populations (Price 1994).

It would be possible to incorporate the initial intervention feature into a dedicated intake or rostered intake system where these included the walk-in option and where experienced counselling clinicians were used.

### **Centralised intake or call centre**

Centralised intake (CI) is usually based in a capital city or provincial centre, is highly technologically driven, and based on assessment tools that are applied uniformly. Referrals are advised technologically from the centre to the localities it serves. In Australia a number of these are privately contracted for example, the Greater Murray and North Coast Mental Health Access Lines contracted to Mckesson (Aldridge and Stapleton 2006). Unlike the other solutions it tends not to evolve from local problem solving, but from a central agenda.

Exceptions to this general description include Centralised Intakes such as Centrelink where there are a number of centres including throughout rural areas, or the NRMA where there is one number but the calls go to a local service provider.

Call centres that are contracted to private enterprise will be restricted by the 'scoping' negotiated in their contract and be driven by measures such as how many rings until the phone is picked up and how many minutes the call lasts. They may be staffed by professionals or by a combination of professionals and trained non-professional staff under supervision. The call centre may be providing service to a number of clients, for example a mental health service for one area, and a community health service for another, but from the same site and with the same staff.

Being centralised they do not have a relationship with local staff and allocation is e-mediated. It is commonly an assessment and triage only service though other referrals may be made. On forwarding to the local team further assessment and clarification is likely to be required. They are able to initiate an emergency response. Centralised intake is seen as self evidently cost efficient because 'you can't have someone on duty in every small town all the time', but of course you can in a central location. Either resources are re-allocated from the margins to the centre for this purpose or extra allocation is made for the call centre staff. Call centres also require significant electronic infrastructure. They have the ability to collect data uniformly, at a central, single point that is valued by senior management.

### **Scope of the Intake**

#### **Identifying data only**

Within these intake approaches it is possible to undertake intake at a number of levels. At its most basic, intake can simply gather identifying data, and a basic statement of service required. This type of intake will usually include scoping and referral to some extent, that is, the potential client will be advised if their enquiry cannot be addressed by the particular agency and basic further information given, for example, " You'll need to contact 'X.....' agency for that."

## **Assessment**

Intake usually includes assessment. Assessment can be standardised by using specific tools (eligibility for care services, CIARR or depression and anxiety, DAS), or can include a fuller psycho-social assessment and hear the person's story. This will be related to prioritisation and allocation.

## **Intervention**

Intervention may be limited to a responsive therapeutic conversation: warm and reassuring, use of active listening, validation of the clients' experience and make appropriate referrals to other sources of information and support. Alternatively it may also arrange to send specific resources and initiate some action. For example if an enquiry is about depression, printed material maybe sent, supportive web addresses given and an initial therapeutic conversation about non-medical interventions for low mood undertaken. The discussion would assist the person to initiate a therapeutic activity (changes to diet, exercise, social behaviours) during any wait for further service and alert them to other sources of support.

## **Follow-up**

There may or may not be any follow-up from the intake personnel. If there is it will usually be restricted to ensuring that the client has been contacted by the relevant clinician or agency referred to. It may involve the potential client being able to re-contact intake if contact has not eventuated. Where service delivery staff are the intake staff, the intake session can be the first of a series of contacts with the same worker.