Team Approach to Intake Procedure in a Community Mental Health Clinic

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IN CLINICS with long waiting lists there is need for constant attention to methods that will insure efficiency. Marks (*1*) found, for example, that many clinical predictions about children ordinarily derived from intensive interviewing could be made with no less accuracy, and in certain instances with more accuracy, using Minnesota Multiphasic Personality Index profiles of the children's parents. Even though psychometric techniques cannot answer all the questions raised with regard to planning for an applicant, such findings reflect much redundancy in present procedures. New procedures must be evolved, if possible with no decrease in quality and, ideally, with positive staff attitudes toward changes. A team approach to intake was developed with these aims in mind and was apparently successful.

As a multipurpose public clinic serving 1,100 patients a year the Henderson Clinic of Broward County in Fort Lauderdale, Fla., has gradually assumed a screening function that the community has come to expect from it. Its 20 new patients per week range from children with almost any mental or emotional condition, or suspected condition, to adults on posthospital care or, in rare instances, to those on probation from criminal courts. The diversity of cases and the constant need to refer to other sources in the community eventually suggested deviating from the standard case history, diagnostic testing, staffing, and treatment sequence that is traditionally used in many clinics. The staff consisted of four Ph.D.-level clinical psychologists, one acting as executive director, four psychiatric social workers with M.A. or M.S.S.W. degrees, and one part-time psychiatrist.

In the past, when the mother of a troubled child telephoned for an appointment, she was asked to come to the clinic for a preliminary 1-hour interview with the psychologist or social worker. Usually she had been referred by the family physician, minister, or juvenile court counselor, but she may have phoned on her own initiative. The mother's interview was duly recorded, but until the father was also interviewed and the child observed, no decisions were made. Staffing of the case waited until the needed workup interviews were completed and school and medical reports were received. In many instances, particularly if psychological testing or a psychiatric interview were required, several weeks elapsed because of the number of persons on the waiting lists for these special procedures.

All members of the professional staff, including the three or four who had had no contact with the patient, participated in staffing. The patient learned of staff decisions later at a disposition interview with one of the original interviewers.

This lengthy system, on occasion, resulted in a 3-month "workup" that culminated in referral, after careful consideration, to the Family Service Agency. This is an example of optimum inefficiency in intake procedures.

To shorten the various waiting lists which grew with amazing rapidity and to speed action on requests to the clinic for aid, the following

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procedure was initiated in the fall of 1961. This system is still in effect and has been used with more than 2,000 patients.

Telephone Screening

To avoid the expenditure of time on persons who should obviously be referred elsewhere, all new applicants or their relatives were carefully questioned over the telephone by an experienced staff member. At first clinic staff members alternated on the daily task of returning calls of persons who had requested service. This required skill and judgment, but getting such pertinent information as symptom duration, previous kinds of treatment, and name of family physician, necessary to make a decision, did not develop into the anticipated problem. This task was gradually assumed by one of the staff members, a social worker with wide knowledge of community resources. This step drastically decreased the number of patients seen for only one visit, since many of these could be adequately screened and referred before coming to the clinic. Clerical work was also reduced since no files were set up for cases closed the day after the interview.

Team Staff

For patients whose problems seemed to warrant clinic investigation (rather than county welfare investigation, for example) concurrent appointments were set up for the members of the family, typically for a child, his mother, and his father. Members of the intake team saw them for 30 to 35 minutes, using whatever interview method they preferred with the parents but aiming for the information included in a rather typical preliminary interview outline. Children were observed in the play room and waiting room, where their spontaneous expressions such as drawings could often be elicited and brought to the team staff meeting.

The staff meetings consisted of only the interviewing team members and the clinic psychiatrist who acted as consultant to each and who contributed to the tentative diagnostic impression and the recommendations to be made to the family. Immediately following this 15-minute "team staff," the patient or the parents were informed of the recommendations. In approximately 75 percent of the new cases the severity, chronicity, and general nature of the condition could be judged adequately. In the remaining 25 percent it was felt that a more intensive psychological evaluation, psychiatric or neurological examination, or complete social history was in order.

In all cases, however, an immediate decision was possible. Emergency cases were of course given immediate attention, with others being placed on the waiting list for treatment or referred whenever possible for private treatment.

The hour for a participating psychologist or social worker was typically divided as follows: one-half hour to observe patient, one-quarter hour for team staff, one-quarter hour for disposition. Since two teams operated concurrently, the staff periods were staggered to allow the psychiatrist to participate in two consecutive 15-minute staffs. Frequently he used the remaining time to see patients for whom medication might be recommended or whose acute distress suggested the possibility of hospitalization. If time allowed, he might also act as a member of an intake team observing a child or conducting an intake interview with an adult.

Results

It was the staff consensus that this system worked well; indeed it became routine in the clinic. On the average, the total number of staff hours devoted to intake for each new case was reduced by one-half. The old system had required a minimum of 4½ hours for cases needing no special procedures; the new system demanded only a total of 2¼ hours of staff time. For a weekly intake load of 20 cases, this 40-hour savings was equivalent to the addition of another staff member. More significant, however, was the fact that most cases were given this 2¼ hours of attention in 1 day rather than, as in the old system, receiving 4 hours of service over a period that might stretch to a month or more.

This procedure places a premium on having experienced, competent team members with excellent communication between them. Essential to its success were the absence among staff

members of semantic conflicts over diagnostic reference terms and the ability of the psychiatrist to make general judgments based on information given him by other staff members about patients he might not have seen.

Discussion

The facts regarding the team approach to intake are presented with a positive bias without making a systematic evaluation. Measuring the success of any intake process involves a many-faceted set of criteria. These include screening functions with diagnostic impressions adequate enough for the decision that must be made, correct decisions with regard to disposition of cases, a feeling of the staff that their system is workable, feelings by patients that their problems have been adequately appraised, and the broader effect a good procedure has on the community in general.

Furthermore, the therapeutic aspects of the intake process should never be ignored, and compressing a procedure as described may affect this. To the adult patient the intake procedure can be an enormously important event. Frequently, his troubles have been exacerbated immediately beforehand to such an extent that he has finally decided to "turn himself in," so to speak. A possible major change in self-concept is implied in finally giving in and deciding not to struggle alone with his life any more. Therefore, the intake is frequently a crisis point for an individual or a family, and the relief potential involved can be great. At this point a person can finally tell his story, let the truth be known, and, in fact, enter a kind of secular confessional. The fact that this is "good for the soul," or provides relief is consistently reflected in the verbalizations of patients. Such remarks as, "I feel a lot better now," and "I'm glad we finally told somebody about this," reflect the patient's relief in sharing the problem or perhaps in simple self-disclosure.

One danger in such a pouring out of the whole truth lies in the phenomenon experienced by some patients who feel anxious about having said too much and decide not to return. The possibility of the latter effect occurring is logically lessened by the compressed intake. On the other hand, the process of identifying and labeling the problem is enhanced by such a procedure. The patient has the immediate satisfaction of knowing that his problem has been experienced by others, is accepted by the staff without undue concern, and that there is a procedure designed to resolve it. While Marks and others may be able to make sophisticated predictions about patients from impersonal tests alone, one might ask how comforting an actuarial statement is to the anxious patient or mother.

It was the opinion of the staff that the simultaneous team procedure was able to satisfy these various criteria of an adequate intake process.

Conclusions

The use of telephone screening and a team approach in intake have been described as one way to make a traditional clinic procedure more efficient. If clinics are to try meeting broader needs in community mental health, such as prevention and early detection, their present time-consuming methods must be carefully appraised. To what better use, for example, could a well-trained and experienced social worker be put than compiling irrelevantly lengthy social histories? Is a psychologist with a Ph.D. best employed in routinely testing all clinic applicants, when testing frequently answers no questions not otherwise answered? Might not the social worker's knowledge of community organization and the psychologist's training in statistics and research design be applied to broader problems? Finally, how can the talents of a psychiatrist, with his community prestige and professional influence, be best spent to improve mental health in the entire community?

For the clinic that seeks an efficient, comprehensive program, the time has arrived for new approaches and the extension of little-used old ones. The real mental health need within a community is frequently not merely more staff to perform traditional functions but a broader approach to mental health problems before they reach the stage in which treatment is the only alternative.

REFERENCE

(*1*) Marks, P. A.: An assessment of the diagnostic process in a child guidance setting. Psychological Monographs, vol. 75, No. 3, 1961.