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Toward responsive community services:
Consumer participation in a rural counselling service

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ABSTRACT. Designing services to meet communities’ needs requires understanding clearly what those needs are. Ideas about grassroots, community-based, decentralised or participatory development all promote active involvement of communities in developing services. More recently, ‘consumer participation’ has become a hot topic. Yet questions persist about the mechanics of encouraging participation, and how to ensure that it is both authentic and inclusive. This paper reflects on a case from rural Australia in which a community-based health provider has piloted a process for encouraging local participation in the ongoing development of its counselling service. The focus was on current, past, and potential users of this service (‘consumers’) from rural towns and properties of the region. The project developed a mechanism for consumers to provide comment and input, toward the goal of making the service as responsive as possible to community needs. This paper describes the participation process and reflects upon the outcomes and what was learned about the costs, benefits, and usefulness of implementing such a process.

Introduction

It is hard to challenge the proposition that local people know their own needs best. Designing services to meet communities’ needs requires understanding clearly what those needs are. This has been a longstanding challenge for policymakers, who repeatedly discover that good ideas at desk level can easily translate to ineffective policies and projects on the ground. The problems of top-down policy making, and the advantages of a more regional or local approach, have been noted around the world. In rural Australia, this has often taken the form of tension between urban-centric policy making and the diverse needs of non-metropolitan regions (Brown 2005, Eversole and Martin 2005). Decentralised, community-based services offer one solution.

Yet even decentralised services face the classic tensions between decision-makers and decision-takers. Locally based does not necessarily equate to responsive. A powerful local institution and its unempowered public can easily reproduce this same tension between the powerful and the marginalised, the desk-based decision and the unheard local need. Even decentralised, community-based services still serve a diverse clientele; how can they ensure that their service is truly meeting the needs of all community members?

Increasing the participation of people in informing the decisions that affect them is now a popular approach to remedying the power imbalance between decision-makers and decision-takers. There has been a push internationally for ‘development’ to become more participatory (thus the concept of ‘participatory development’) and for government and key organisations such as universities to become more ‘engaged’ with their region or community (thus ‘community engagement’ and ‘regional engagement’). It is increasingly becoming both a philosophical position and a policy mandate that the participation of the public be sought in ensuring that policies and services meet their needs. In health and community services, the preferred term is ‘consumer participation’, focusing specifically on service users.

Participation is not a very precise term, however, and the questions remain: what kind of participation, and to what degree? The degree of participation that is asked for, or really wanted, varies enormously. Generally it is limited, constrained by existing
agendas and institutional structures. Craig and Porter (1997) for instance, demonstrate how participation in development projects is ‘framed’ and limited within development organisations’ existing ways of doing things; White (1996) and others note that different kinds of participation can exist, from nominal to transformative; and Herbert-Cheshire and Higgins (2004) explore how, in rural Australia, apparent devolution of development leadership to communities can mask subtle ways of perpetuating central government control. The literature has also begun to acknowledge that one of the key issues of participation is how it actually articulates with existing governance models (Eversole and Martin 2005, Edwards 2001) – what kinds of mechanisms and institutional structures can make participation work, and what are the real costs and benefits of moving to more participatory models?

This paper explores these broad questions in the specific context of a case study of a participation process undertaken by a rural Australian community-based health service. Consumers, Communities and Counselling – Increasing the Contribution was a locally initiated, State-government-funded 12-month project in 2006 that trialled a process for encouraging local participation in the ongoing development of a local counselling service. The focus of the participation process was on current, past, and potential users of this service, from rural towns and properties of the region – these were the ‘consumers’ (actual and potential) of the service. The process provided an important learning opportunity for the service’s staff and demonstrated how a consumer participation process can be successfully implemented, and what sort of outcomes can result.

The counselling service

In December 2005 the Counselling Service at Frances Hewett Community Centre, part of the Western District Health Service (WDHS) in rural Western Victoria, Australia, received a grant from the Victorian Department of Human Services (DHS) to assist with the development of quality counselling services. The funded project was called Consumers, Communities and Counselling – Increasing the Contribution. In this project the term consumers was used to refer to the people who were current or potential users of the counselling service. This included children, young people, women, men, people from diverse cultural backgrounds and experiences, varying social circumstances, (dis)abilities, sexual orientation, and health or illness conditions.

The WDHS counselling service is located at the Frances Hewett Community Centre in Hamilton, a rural service centre of approximately 10,000 residents. It serves adults and adolescents from Hamilton and surrounding areas in the Southern Grampians Shire, a local government area with a population of 17,000 people. Over 50% of clients of the service come from Hamilton itself, with the remainder from other small towns and properties in the area. Overall, about 75% of clients are women and 25% are men. Clients are aged ten and up, with about half of clients being in the 40 to 59-year age bracket. Approximately 40% of all clients seen are women between the ages of 40 and 59.¹

¹ Demographic data on clients come from a sample of 228 clients seen over a two-year period.

Up to this date and currently, the Counselling Service is a free service that may be accessed via self-referral or referral from doctors or other health professionals. It has operated since 1999. The Counselling Service covers a wide area, often employing considerable flexibility in order to meet the needs of clients who may live an hour’s drive away from the Frances Hewett Centre, often in isolated rural settings, with very limited public transportation options. While after-hours service and home/farm visits were never advertised prior to or during the project, they had been offered in cases of need since the inception of the service. After the project, they were advertised and offered regularly.

Three counsellors are employed by the service to a total of two full time equivalents or 76 hours’ service per week. At any given time, about 50 clients are ‘active’, but about 700 clients have been seen over the history of the service. Generally, clients are seen fortnightly with approximately a fortnight’s lead time for appointments, unless the situation is urgent. Many clients only attend one or two sessions with the counsellor, as they only have a short-term need of the service. In a sample of 228 clients seen over a two-year period, over half (53%) had attended for only one or two sessions. Another typical pattern is cyclical use of the service. A client may attend counselling and resolve the issues at hand, then later return.
when faced with another crisis. Overall, 10% of clients in the sample had attended the service for 11 or more sessions.

According to the service’s Senior Counsellor, ‘the overwhelming reason’ that people access the service ‘is anxiety and depression following too much stress for too long and trying to cope without support in that situation.’ Relationship issues and grief and loss (including loss of employment) are among the other common reasons that men and women access the service.

Background to the consumer participation project

In the Victorian Department of Human Services (DHS) document Counselling in Community Health Services: Future Directions & Guidelines for Quality Counselling, consumer participation was flagged as being of key importance in ensuring high quality services (DHS 2005). Participation encourages people to speak up about their views on the services provided, and to be involved in decision-making about their own health care. The Western District Health Service Counselling Service recognises that incorporating consumer participation into all service delivery is vital to ensure it is relevant, accessible, and in tune to the needs of the community it serves. The focus on the importance of Consumer Participation is also in line with the work of the Health Issues Centre on consumer participation in health (see http://www.healthissuescentre.org.au/consumer_participation/index.asp). While this work has been aimed at the acute medical sector, it was seen as an imperative and an opportunity by the Frances Hewett Community Centre to follow through into the community health area.

Community participation was thus understood to be an essential part of ensuring that the service being provided was community-relevant. Consumers, Communities and Counselling – Increasing the Contribution (the Consumer Participation Project) thus developed and trialled mechanisms to involve diverse people from local communities in helping to ensure the service was best designed to meet their needs. The general purpose of the project was as follows:

- For consumers to be able to have a direct say in how counselling services are run in health centres through participation in focus groups or undertaking a confidential survey.
- For participants to help design the survey, to be distributed to all consumers of the counselling service.
- For a list of recommendations from the focus groups and surveys to be documented and assessed for trial implementation.
- For the recommendations to be trialled where possible or if not, reasons to be provided back to consumers.
- For the recommendations to become part of the ongoing improvements to DHS-funded counselling services throughout Victoria.

The Frances Hewett Community Centre had for some considerable time held a philosophy that consumers should be involved in saying how the services they used might be best managed. This was evidenced by a lively User Group Committee covering all aspects of the Centre’s activities and meeting on a quarterly basis. The Counselling Service in turn wished to establish further cultural change that actively supported and fostered an effective contribution from consumers. The Consumer Participation Project was seen as a vital link in achieving this culture.

Consumer participation methodology

The project was designed to provide the maximum opportunity for input by past, current, and potential future clients of the service. It involved a two-stage process: first, an open invitation to participate in focus groups or individual interviews (according to individuals’ preference), and then a mail-out survey to past and current clients based upon results from the first stage of the research. Focus groups and interviews were conducted by an external researcher not affiliated with the service, who also provided assistance with the design of the survey instrument.

In late January 2006, a Letter of Invitation was sent to 320 past and current users of the service (from the past four years), and an advertisement was published in the local newspaper, the Hamilton Spectator (21st January 2006). Both the letter and the advertisement invited all interested people to participate in the project in order to have a say in how the Counselling Service is run and how it might be improved. An individual did
not have to be a user (past or present) to participate.

Those who expressed interest were offered the option of either of two focus group sessions (one day and one evening) or an individual interview. An Information Sheet was developed to explain the project and its background in more detail to potential participants.

The goals of the focus groups and interviews were articulated as follows:

- To seek input on Counselling Service quality, service gaps and opportunities for improvement;
- To reflect on how to make the counselling service more accessible and relevant to the community;
- To generate specific recommendations for WDHS; and
- To flag key issues to follow up in the consumer survey.

The following basic principles were observed in the focus groups and interviews:

- Participation: Everyone’s viewpoint is valuable and can be influential, the study is part of an ongoing consumer participation process.
- Confidentiality: Participants will not be named in the study results, WDHS staff are not present to see who says what, and personal details are not discussed here.
- Volunteer Involvement: Participants are volunteers who may withdraw at any time.

A copy of the Focus Group Script is included (see Appendix 1); the same script was used as a guide for open-ended interviews.

Overall, about 25 people expressed interest in the project, and 16 people were able to attend the focus groups: 13 women and 3 men. As with the demographic profile of the service, the majority were women. Seven women and one man participated in the Monday afternoon focus group. Three women and one man participated in the Tuesday evening focus group. Three women and one man participated in individual interviews due to scheduling conflicts or personal preference.

The age of participants varied, but most were over age thirty. Younger clients were not represented in the first stage of the research, and it is important to note this as a limitation. While younger clients were actively invited and encouraged to participate, they chose not to do so. Some younger people expressed a view that they would be daunted by group sessions.

Based on the results of the focus groups, a consumer survey was designed (see Appendix 2). The survey, with a cover letter and reply-paid envelope, was posted out in April 2006 to 200 past and former clients (omitting those of the original group whose Letter of Invitation had been returned as ‘unknown at this address’). Some surveys were, however, still returned as undeliverable; often, clients move on and there is no record of their address. Thirty-six completed surveys were received, for a response rate of 18%.

After the receipt and analysis of surveys, a report was prepared and counselling service management and staff began the process of implementing recommendations. The twelve-month project concluded at the end of 2006.

**Key findings and outcomes**

Over the twelve-month span of the project, much was learnt about local consumers’ perceptions of the counselling service, its strengths, and suggestions for improvement, as well as the important role played by a rural counselling service and the cultural context in which it works. In addition to these content-focused findings, which are documented elsewhere (Eversole 2006), there were also important findings about the Consumer Participation process itself. These are the focus of this paper and are categorised into three main theme areas: the level of consumer involvement, the issue of limited information, and the specific outcomes which the process generated.

**Consumer involvement**

The project provided a formal, though flexible, structure for consumer participation. The formal process of focus groups, interviews and surveys gave consumers various potential avenues of input. Advertisement welcomed input from anyone in the community, though many current and past clients also received personal invitations from counsellors to participate.

Counselling by its very nature and association of stigma with mental health may have affected the response rates, which were low from the community in general. This reflects evidence that that rural people are much less likely to report unhappiness or
stress (AIHW 2002), and thus, that most people in the wider community would not likely categorise themselves as ‘potential’ users of the service. The level of stigma associated with persons attending counselling was also discussed in the focus group sessions. It is possible that this perceived stigma may have also discouraged some current or past clients from actively participating in the process.

Despite this challenge, there was an overt willingness on the part of many clients to assist the Centre and the Counselling Service. As indicated in focus group and survey results, the Counselling Service is clearly valued by those who use or have used it; this goodwill among users may have facilitated participation. Participation, therefore, may have been motivated as much by a desire to help out or do a favour for the counselling staff, than by a strong desire to have a say in the future directions of the service.

Over the year, initial interest in the project waned considerably, except for a small core group of clients who made it clear that they feel ownership of the Centre and goodwill toward the running of the services offered. Those clients who remained involved throughout the year worked effectively to put together a useful and focussed survey paper. The waning interest from others appeared, anecdotally to be because some of those involved did not feel that they had issues that needed rectifying and therefore could offer little of relevance.

One overall weakness in the representation of consumers was in the area of youth. In 2005 and 2006, 17% of the total consumer population seen by the Counselling Service were under 25 years of age but not one person in this age group agreed to be involved with the Consumer Participation Project, despite active encouragement to do so. Anecdotally, the main reason given by young people was that they did not feel that they had issues that needed rectifying and therefore could offer little of relevance.

Limited information

One issue that arose in the course of the Consumer Participation Project was that participants themselves had limited information about the service they were discussing. While participants could speak knowledgeably about their own experiences, they had limited information about the needs of others in the community, as well as about the larger context of the Counselling Service. Participants were often unsure what services were actually offered to different client groups (e.g. counselling for children; after-hours services), because their knowledge of the Counselling Service was limited to their own
experiences. This lack of knowledge was occasionally frustrating for participants, who recognised that a fair assessment of the service and the generation of recommendations required more information than they personally possessed. It also raised the need to distinguish between facts and opinions presented.

For instance, many of the clients made comments indicating that they liked the service in its current form but thought that others might want different services. As this was not evidence-based, it proved to be unusable: e.g. comments were made that the service should be available on Saturdays and Sundays, but there was no evidence that there was a target group of consumers who would use the service at those times. Even if a potential target group had been identified, consumers did not have the information necessary to evaluate the cost-effectiveness of offering this service, or to take into account other issues involved, such as security for clients and staff during times when the Frances Hewett Centre was unattended.

These experiences pointed to the importance of understanding that participants have limited information about both the community as a whole and the nature of the service under discussion, and the need to structure consumer participation processes to be cognizant of this. One group of consumers does not, and cannot be expected to, speak for the whole community. Nor can it effectively assist with plans and recommendations for a service provider without understanding the larger context in which this service provider works. Thus, it may be more advisable to implement consumer participation processes at different levels of intensity for different purposes; if high-level consumer input into decision-making is desirable, this could be charged to a more permanent group, which would be provided with the necessary data and information to inform effective decision-making.

Specific outcomes
The overall goals of the Consumer Participation Project were to seek input and recommendations from consumers to improve the responsiveness of one rural Counselling Service to local community needs. Following the collation of survey results and further discussion with focus group members, three recommendations stood out, relating to three main areas of service: the waiting area, the service hours, and the provision of written take-home information to clients. All three recommendations, as detailed below, are in the process of being implemented by the Counselling Service and/or by the Frances Hewett Community Centre as a whole.

Recommendation 1 – Waiting Room Area
The top recommendation made by participating consumers was in regard to the need to improve the current waiting area at the Centre. It was also acknowledged by staff that the waiting area was not the most appropriate or comfortable, being placed in a wide passage in a main thoroughfare of the Centre and creating a feeling of exposure. Consumers overwhelmingly stated that they would like that area to be improved. One consumer went to significant effort to come up with a design and change of location for the waiting area, and that person’s efforts were greatly appreciated. Unfortunately, the proposed change was impossible logistically as it involved removing the reception area from the front of the building, plus removal of vital communication and electrical equipment that is hard-wired into the building. Again, when generating recommendations, consumers did not have access to this kind of important contextual information.

Nevertheless, the key recommendation to remodel the waiting area has been taken on board by Centre management and staff, who are progressing this project in consultation with the chief executive officer. Issues such as security, sensitivity to consumer needs, privacy, safety and aesthetics have been taken into account in discussion with an architect and an interior designer who were engaged just prior to the end of 2006 to create a suitable waiting area. A design has been produced which includes the use of curves, fabric and differing heights to allow for people to choose the level of security, privacy and exposure they experience whilst waiting for an appointment. At the time of writing, the new waiting area was set to be installed within days.

Recommendation 2 – Extend Service Hours
Consumers recommended that the hours that the Counselling Service was available to the community should be extended to ensure that people with day-time commitments could access the service more easily. An ad hoc
The arrangement had already been in place since the inception of the service, whereby if a client did have difficulty in attending during normal business hours, an appointment later in the day or after official closing time would be offered. However, many of the consumers participating in the project were unaware of this arrangement. Importantly, it was felt that people in the wider community would also be unaware of this, and might be hesitant to approach the service as a result.

From November 2006, in response to this recommendation, the Service has remained available from 5.30-7.30 pm on Thursday evenings. This has been advertised in the media, at public meetings and people have been informed on a one-to-one basis. Safety for both counsellors and consumers had to be given due priority and therefore the service could only be extended when the Centre was open for other business and numbers of other staff were in the building.

This extension of service has been utilised to a small but significant degree, mostly thus far by working males, or couples where one or both partners are working during the day. It is anticipated that drought forums held locally may increase the numbers of farmers who attend after working (daylight) hours. The Western District has recently been granted temporary Exceptional Circumstance status from the Federal Government due to the current drought. In response to this situation, the Service is also working to increase its accessibility to farmers through a willingness to make on-farm visits where that is more convenient. Home visiting to frail, disabled or isolated people has occurred from the inception of the service, but this has now been extended to cover those farmers/ farm families where significant workload issues at this time of drought may cause additional stress.

**Recommendation 3 – Take-Aways**

A further recommendation was that consumers be given a copy of any action plan suggested by the Counsellor as a memory aid, and as a way to chart progress over time. Written action plans had already been used previously but only on an ad hoc basis where it was either felt by the Counsellor, or requested by the client, that such information be committed to hardcopy. Many participating consumers were unaware of this, however, and it was suggested that as a general practice it could be beneficial.

There were issues, however, about the counsellors having the facilities to do this on the spot, at the time of the counselling session. In response, the Counselling Service did some research into how other agencies dealt with this problem. It was felt, after some consultation, that an initiative of the Bouverie Centre, Family Institute, La Trobe University could be utilised by the WDHS Counselling Service. The Bouverie Centre uses a Takeaway Pad – an A5 duplicated pad with room for the Counsellor to write a dot-point action plan and other information for the client to ‘take-away’ whilst retaining a carbon copy for the client’s file.

Financial negotiations and copyright issues were discussed with the Bouverie Centre and they agreed to have modified Takeaway Pads printed with the WDHS logo and information. The pads were trialled from October to December 2006 and were well received by all consumers. An ongoing supply of Take-Away Pads with the service’s own logo have now been ordered.

**Summary and conclusions**

The Consumer Participation Project was an active learning process for staff and consumers alike throughout 2006, and led to some significant feelings of ‘ownership’ of the service by those people who participated, as well as recommending some useful ways forward for the Counselling Service itself. There was an affirmation for staff and management that the quality of the service is perceived as quite high, as well as specific recommendations for improvement, as detailed above.

From another angle, piloting this consumer participation process has enhanced the capacity of the service to reflect and to be more open about its scope and limitations. The counsellors and the organisation are to be commended in engaging with consumers and receiving full comments on suggestion for improvement. There has also been benefit from the interaction between the counsellors and a university academic, where new learnings and opportunities have opened up. This interface is seen as very positive from the perspective of the Director of Community Services, in terms of broadening staff understanding and appreciation of research skills, capacity building and consumer participation.
Consumer participation processes are not without cost, both for the organisations implementing them, and the consumers who are willing to participate. Nevertheless, the potential for learning and improved service provision is high. Further refinement of the process would see a range of consumer participation strategies implemented for different purposes and in response to different needs, in order to overcome some of the issues highlighted in this paper. For instance, not all consumers feel they have ‘something to say’ or are confident saying it; and not all consumers have the available time to dedicate to a formal participation process. Less formal and more creative ways may be needed to seek input from these consumers.

Similarly, some consumers are interested in taking a leadership role in generating recommendations to benefit their community, yet have inadequate information to do so effectively. Others simply have a point to make and are happy to leave the problem-solving to others. Thus, different degrees of consumer participation need to be recognised and accommodated within consumer participation processes. It is important to note that in the health context, the term ‘consumer participation’ often refers simply to involving consumers in decisions about their own health care (see e.g. Thistlethwaite 2005). Yet the consumer participation model piloted here sought consumer input into the content of a service for the entire local community. This project has demonstrated that this more ambitious, community-based approach to consumer participation is possible to achieve, and that it provides an important opportunity for dialogue and learning by everyone involved.

References

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Appendix 1: Focus Group/Interview Script

“Consumers, Communities and Counselling: Increasing the Contribution”

Welcome and Project Background
Including:
- Basic data and background on the WDHS Counselling Service
- The rationale, goals and funding source for this study
- The timeline of the study, including the survey and report-back sessions

Review of Objectives for the Session
- To seek input on Counselling Service quality, service gaps and opportunities for improvement
- To reflect on how to make the counselling service more accessible and relevant to the community
- To generate specific recommendations for WDHS
- To flag key issues to follow up in the consumer survey

Basic Principles
- Participation: Everyone’s viewpoint is valuable and can be influential, the study is part of an ongoing consumer participation process
- Confidentiality: Participants will not be named in the study results, WDHS staff are not present to see who says what, and personal details are not discussed here
- Volunteer Involvement: Participants are volunteers who may withdraw at any time

Part One: Assessing WDHS Counselling Service Access and Availability
- Issues and concerns
- Recommendations

Part Two: Assessing WDHS Counselling Service Quality, Sensitivity and Outcomes
- Issues and concerns
- Recommendations

Part Three: Other Key Issues and Recommendations

Summary

Thanks and Next Steps
Facilitator’s contact details available and she can be contacted anytime with questions or concerns.
- Note the opportunity to make an individual appointment if desired
- The Survey based on issues identified in the Focus Groups will be run over 6 weeks in April-May
- A report-back session to focus groups will be held thereafter (June?)
Appendix 2: Survey Instrument

“Consumers, Communities and Counselling – Increasing the Contribution”

Survey

During April and May 2006, we are asking all current and past users of the Western District Health Service’s Counselling Service to assist us by completing the following survey. This survey gives you the opportunity to say, anonymously, what you think of this Counselling Service and your ideas for how to improve it. This survey is part of a year-long Consumer Participation project funded by the Department of Human Services, Victoria. For more information on the project, please see the attached Information Sheet. Please return surveys by 15 May 2006.

- Please do not put your name on the survey – all surveys are confidential.
- If you do not wish to fill out a survey, you are not required to do so!
- Feel free to write on the back of the page or add an additional page with your comments
- Results will be presented and discussed at a public meeting Thursday 15 June, 4pm, at Frances Hewett Community Centre.
- Recommendations from the survey will be implemented on a trial basis later this year.

Part One: Consumer Profile

1. I would describe myself as a:
   - [ ] New user of the service (within the last month)
   - [ ] Regular user of the service – short-term (less than six months)
   - [ ] Regular user of the service – long-term (more than six months)
   - [ ] Occasional user of the service
   - [ ] Past user of the service

2. I expect to use this service again
   - [ ] Yes  [ ] No  [ ] Unsure

3. I am
   - [ ] Male  [ ] Female

4. My age is
   - [ ] 14-19  [ ] 20-29  [ ] 30-39  [ ] 40-49  [ ] 50-59  [ ] 60+

5. I am from
   - [ ] Hamilton
   - [ ] Another town in the area, with a population of 500 or more
   - [ ] A rural property or small town (under 500 people)
   - [ ] Other ___________________________
6. I came to this service via:

☐ Medical referral from a doctor
☐ Referral from another health professional
☐ A friend or relative suggested it
☐ My employer or school suggested it
☐ I knew about the service and chose to come
☐ Other ________________________________

7. I access the service at:

☐ Frances Hewett Community Centre
☐ Other ________________________________

8. I would be interested in being part of a Consumer/ User Group to help determine future directions for this Counselling Service:

☐ Yes ☐ No ☐ Unsure

9. I would like to continue to provide input in another way (please indicate or comment)

_________________________________________________________________________

_________________________________________________________________________

Part Two: Evaluating the Accessibility of the Service

10. Do you think that most people in your community are aware that this Counselling Service is available if they need it?

☐ Yes, most people would be aware of it
☐ Some people would be aware of it
☐ No, most people would not be aware of it
☐ I’m not sure

11. Did you know about this service when you first needed it?

☐ Yes ☐ No

12. How did you find out about the service?

_________________________________________________________________________

13. Do you think that there are obstacles that would keep people that you know from accessing this Counselling Service?

☐ Yes (Please describe):

_________________________________________________________________________

☐ No
14. Do you have any suggestions about how to overcome these obstacles?

________________________________________________________________________

15. Do you believe this Counselling Service is easily accessible to:

<table>
<thead>
<tr>
<th>Group</th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>Women</td>
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<td>Men</td>
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<td>Youth</td>
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<td>People with a disability</td>
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<td>People with young children</td>
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<td>People who work full-time</td>
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<td>Other _______________</td>
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Please comment: How could this service be made more accessible to different groups?

________________________________________________________________________

16. Are you happy with the location and layout of the current service?

☐ Yes ☐ No

Do you have any comments or suggestions for improvement?

________________________________________________________________________

17. Are you happy with the service’s opening days and hours?

☐ Yes ☐ No

Do you have any comments or suggestions for improvement?

________________________________________________________________________

18. Is this service available and accessible when you need it?

☐ Yes, always
☐ Usually
☐ Not always
☐ No, there are problems

Do you have any comments or suggestions for improvement?

________________________________________________________________________
Part Three: Evaluating the Quality of the Service

19. Please assess the quality of this service with regard to the following:

a) I feel comfortable talking with the counsellor
   ☐ Yes ☐ No

b) The counsellor is sensitive to my needs and feelings
   ☐ Yes ☐ No

c) I feel my privacy is respected
   ☐ Yes ☐ No

20. How helpful has the counselling service been to you personally?
   ☐ A waste of time
   ☐ Somewhat helpful
   ☐ Very helpful
   Comments?

21. Please indicate which of these words (if any) describe your experience of counselling here. Feel free to add other words of your own below.
   ☐ a chance to let off steam
   ☐ scary
   ☐ it wasn’t for me
   ☐ being listened to
   ☐ working through issues
   ☐ discouraging
   ☐ helpful
   ☐ positive
   ☐ encouraging
   ☐ embarrassing
   ☐ judgemental
   ☐ informative
   ☐ negative
   ☐ not helpful

   ______________________________________________________
   ______________________________________________________
   ______________________________________________________
22. Please indicate which words (if any) describe the outcomes of counselling for you. Feel free to add other words of your own below.

☐ taking control of my life
☐ acquiring skills (eg.________________________)
☐ acquiring information (eg.___________________)
☐ feeling better about myself
☐ resolving specific issues
☐ receiving a referral to another service
☐ developing coping strategies
☐ making decisions
☐ setting action goals
☐ changing my attitude or perspective
☐ no outcome

23. How might outcomes for users of this service be improved?

24. Has it been useful, or would it be useful, to have a written Action Plan to take away with you as part of the counselling process?

☐ Yes  ☐ No  ☐ Unsure

25. Would you be interested in our Counselling Service providing any of the following?

☐ A support/ friendship group (Please note preferred days/times)

☐ Information sessions (Please note topics of interest)

26. Please add any additional suggestions or comments (use back of page if needed).