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PRACTICES AND PERCEPTIONS: REFERRAL AND INTAKE TO CHILD AND ADOLESCENT MENTAL HEALTH SERVICES

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STUDENT DECLARATION

I, Jolyon Roderick Grimwade, declare that the thesis entitled, Practices and perceptions: Referral and intake to child and adolescent mental health services, is no more than 120,000 words in length, exclusive of tables, figures, appendices and references. This thesis contains no material that has been submitted previously, in whole or in part, for the award of any other academic degree or diploma. Except where otherwise indicated, this thesis is my own work.

I further declare that the ethical principles and procedures specified by the Human Research Ethics Committee of Victoria University, and, where relevant, those of the Human Research Ethics Committees of the Alfred Hospital, the Austin and Repatriation Medical Centre, and the Royal Children's Hospital, have been adhered to in the preparation of this report.

Jolyon Grimwade

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eleven years was simply essential: thankyou.

Jo Grimwade

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ABSTRACT

This thesis reports research into referral and intake to child and adolescent mental health services intended to illuminate a largely unnoticed but potentially powerful clinical phenomenon in service provision. Referral and intake to child and adolescent mental health services was demonstrated to be a complex process that shapes subsequent clinical interactions.

Three questions guided the present research. Why are the practices of referral and intake as they are and how have they been shaped, historically? What are the specific practices involved? What are the effects of these practices upon subsequent case consultations and outcomes? Four enquiries were conducted.

An extensive and critical literature review was directed toward the first question and demonstrated the historical roots of child and adolescent mental health services, elucidated the phases of the referral and intake process, clarified the many images of the parent in such services, and postulated the existence of three categories of service applicants, namely committed, containable, and crisis-reactive parent referrers.

A retrospective empirical enquiry addressed the second question and a prospective empirical enquiry addressed the second and third questions. A further, integrative and empirical enquiry addressed the practices, role, and clinical thinking of referral and intake workers. The empirical studies demonstrated that, when done well, referral and intake provides momentum toward change in subsequent clinical contact. The referral and intake worker was shown to perform nearly one hundred tasks within a 15 to 25 minute referral call. The committed parent referrer, who was distinguished from other referring parents, was characterized by hopefulness, determination, and often, emotional pain in gaining access or the active presence of another party opposed to the referral, in the

retrospective study.

The findings have major implications for the conduct of psychotherapy research and for the efficient and personable management of child and adolescent mental health services.

CHAPTER 1

MODELS OF PERCEPTION, MODELS OF SCIENCE, AND THE BANAL PSYCHOSOCIAL PHENOMENON OF REFERRAL AND INTAKE

The unexamined life is not worth living
Socrates in *The Apology* by Plato
(translated by Jowett & de Botton, 1871/1999)

Referral of a child is a necessary precondition for accessing child and adolescent mental health services. The practices of beginning through referral and intake, and the initiation of therapy, may potentially influence the quality of therapy contact and outcome. However, to date there has been no published attempt to explore these effects. The role of the referral and intake worker, along with the practices themselves, has been virtually unnoticed in the international literature. Also, there is no widely available documentation of the role of the parents when they seek help and refer their child-to-child and adolescent mental health services.

Referral and intake in this domain of clinical practice appear to have been considered ordinary, banal, taken for granted, and have therefore remained mysterious in their potentially powerful effects. By contrast, application for public services is an ordinary feature of Western living. Such lack of understanding may be inhibiting the development of programs of assistance to families. Research could help to identify more efficient practices and establish the role as a recognizable clinical specialty with specific responsibilities and skills.

1.1 The drama of referral and intake

When a parent telephones for public mental health assistance for a child or young person, a process of transformation may be initiated. Whether or not help is obtained by the parent, or for the child, is determined in ensuing months, but recognition of a problem and the need to act has been operationalized. This present research is focused on such voluntary referral, which constitutes the vast majority of referrals made to child and adolescent mental health services. Here, parents' perceptions provided the critical means to understanding the practices of referral and intake.

The referral and intake worker must address the parent's need for information and reassurance, while also addressing the institutional needs for accurate data collection, appropriate screening, and initiation of case allocation to a clinician for assessment. Listening, communication, and administrative skills are essential parts of the referral and intake worker's responsibilities. The quality of the referral and intake worker's work will impact upon the agency, and the capacity of the agency to take on new work will affect the capacity of the referral and intake worker to receive referrals efficiently and compassionately. The present research attempted to delineate the importance of referral and intake work as a clinical specialty.

1.2 The research questions and thesis structure

Three questions guided the present research. What, historically and pragmatically, has shaped the practices of referral and intake as they are? What are the specific practices involved? What are the effects of these practices upon subsequent case consultations and outcomes?

The thesis reporting this research begins with an extensive literature review. The literature enquiry has four foci. The first focus, explored in this chapter, is on methodology, addressing the problems of researching banal phenomena and the ethical and logistical problems of mental health research

with clients in therapy. The second focus, presented in Chapters 2, is on how other professionals and organizations perform referral and intake. The third focus, presented in Chapters 3 to 5, is on formal studies of psychotherapy, covering entry, beginning therapy, and discontinuance. The final focus of the literature enquiry is upon the roles and functions of referral and intake workers, as presented in Chapter 6.

Overall, the literature is fragmented, yet within the many narratives, the place of referral and intake work in the lives of citizens, in the functioning of clinics, and in the organization of societies can be appreciated. Much of the literature reviewing has been like the dusting and tidying of a forgotten archive, room by room. The dusting and tidying has produced inferences not made previously. The fragmentation exists at several levels, and between literatures that are on the same level but do not seem to overlap, despite seemingly natural confluences.

The thesis moves on to describe two empirical enquiries of staff and parents of clients concerning referral and intake experiences at child and adolescent mental health services. These are presented in Chapters 7 to 11. The method by which the data from the retrospective enquiry were collected and analysed is described in Chapters 8 and 9. The method by which the data from the prospective empirical enquiry of parents of clients were collected and analysed is described in Chapters 10 and 11. A further empirical overview of the data collected on the work of referral and intake clinicians is presented in Chapter 12.

The final part of the thesis entails discussion of all of the findings of the research in Chapter 13 and their implications for practice and further research in Chapter 14.

1.3   Approaches to observing the unseen and the ordinary

Historically the practices of referral and intake to child and adolescent mental health services were shaped by the development of certain professions, within certain Western societies. These

practices have remained largely overlooked by the field, as interest has focused on studying therapeutic outcome, rather than documenting the full range of activities of the clinical work involved. Administrative practices have often been considered banal and remained unseen. This research began by regarding the practices of referral and intake to child and adolescent mental health services important clinical activities, far from banal. The history of Western thought has involved both purposes for naming. A detailed analysis of how Western enquiry has made phenomena observable was required to underpin the research.

The curious mind is taken to phenomena, asks about form and relevance, and names. There are probably many ways to make enquiry, but Western history has been dominated, through documented time, by two basic approaches. From the time of the ancients to the beginning of the seventeenth century, the purpose of enquiry was understanding through contemplation, largely following the ideas of Plato and Aristotle (Smith, 1992). At the beginning of the seventeenth century, Bacon produced in direct challenge to Aristotelian ideas, *A new organon* (1620/2004), which shifted the focus of enquiry from contemplation to the practical application of knowledge for the production of technologies that enhanced living for the ordinary Western person. In more recent times, alternative ways of seeing have been brought forward through phenomenology and constructivism.

While the purposes of enquiry, contemplation or utility, were different, both produced ways of representing reality and these representations in turn created the possibility for other researches and innovations. The representational systems were more than just descriptions of phenomena, they constituted a new theory about how phenomenal characteristics were organized. The naming of parts or the description of functions could lead to inferences about how to represent the phenomena coherently. So, while the study of referral and intake might involve the study of parts and the mapping of functions, the two modes of enquiry can be combined to produce novel representations of previously unrepresented phenomena.

Visual metaphors correlate with ancient, modern, and contemporary Western approaches to enquiry. But values-based enquiry, exemplified by Socrates, preceded these three modes. The ancient emphasis was upon giving names and making phenomena understandable and Plato's Cave (Jowett & de Botton, 1871/1999) provided the visual metaphor for observation. More modern emphasis has been upon precise description of phenomenal functionality, as afforded in visual terms by the camera obscura (Crary, 1990; Draaisma, 1995/2000). In contemporary times, however, psychosocial enquiry has moved away from describing social entities and laws, to exploring psychosocial processes and their effects upon participants and contexts. Phenomenological enquiry of experience has been central. Knowledge has become contextualized and localized, with validity determined, analogically, by triangulation of data sources and analyses (Morse, 1991). The contemporary visual metaphor for enquiry might be collage.

Each of these means of perception have been developed to reveal unseen or unnamed phenomena. Referral and intake to child and adolescent mental health services involves practices that have been rarely, and only briefly, documented. There is a host of psychosocial, administrative practices that Simmel (Wolff, 1950) called banal. Simmel encouraged researchers to seriously examine the effects of these practices, as he believed some of these were constitutive of parts of social existence. Goffman (1961, 1968; Manning, 1992) took Simmel's lead to begin examining the practices of mental institutions in the 1950s.

The etymology of the word "banal" can be traced back to the thirteenth century where the common and the commanded were equated within feudal service (Makins, 1994). The idea of the negation of meaning within the commonplace or ordinary through commanded mechanism remains in contemporary usage. One sign of the negation of meaning is the lack of originality (Makins). At its worst, banality is a "curious, but quite authentic inability to think" (Arendt, 1978; cited in Assy, 1999, p.1), manifested in bureaucratic functioning.

Bureaucratic practices are banal in many ways, but they have two levels of purpose that correspond to two very different ways of pursuing enquiry. Bureaucratic practices are formal mechanisms for the addressing of public concerns. Control through documented procedures is exerted over access to resources. However, at another level or in an alternate, interpersonal space, the officer and the applicant for service can exchange meaningfully. Services are required and officers like to see applicants' needs satisfied. Within the bureaucratic function, then, the ancient task of naming is combined with the more modern task of data processing, while, at the same time, the contemporary task of locating meaningful experience occurs.

In the next section of this chapter, observation, the dominant models of science, and their visual metaphors are explored. Later, contemporary questioning of the models is presented, by pointing to the failures of quantitativism, Heidegger's phenomenology, case study research, and mixed qualitative and quantitative research approaches, including the clinical psychology assessment report.

1.4 First principles of observation

Observation is not a simple process, although it is often taken to be so. The words used to describe observation and its effects are tangled. The metaphors of Plato's Cave and of the camera obscura locate five characteristics of observing, namely frame of interpretation, the stance of the observer, the source of information, the means, and the purpose. All these affect the conclusions drawn from an act of observation.

1.4.1 Dictionary definitions related to observation

The dictionary has been a constant research companion and source of the wisdom of the language in the writing of this thesis. Important subtleties of meaning and of historical change are contained

within the large dictionary (Makins, 1994), subtleties often simply ignored by the bland application of quantitative method in psychological research, or the naïve use of participant language in qualitative studies.

For instance, words that seem almost synonymous, such as observation, evidence, experience, and empirical have small differences in meaning which lie in their etymology. "Observation", in its simple verb form, "to observe", has Latin origins in the word "to watch" (Makins, 1994). This has a connection to the word "to serve" which has, in turn, Latin connections to servant or slave. Makins (p. 1079) listed five different meanings of observe, all of which have relevance: "to see, perceive, notice", "to watch (something) carefully", "to make observations of (something) esp. scientific ones", "to make a comment or a remark" and "to abide by, keep, or follow (a custom, tradition, law, holiday, etc.)". "Evidence" derives from the Latin word "videre" which means "to see" (Makins, p. 539). But how does one "see" with scientific rigour?

Empirical observations have been widely accorded scientific status in the twentieth century. Empirical and experience share the same Ancient Greek root, 'peiran" which means attempt or trial (Makins, 1994). An experiment is a trial and is one definition of empirical provided by Makins. But it also accommodates two other definitions, one which has the empirical as based on experience rather than proof, and another which has the empirical as quackery because a theory is lacked. As philosophy "(of knowledge) derived from experience rather than by logic from first principles [or] (of a proposition) subject, at least theoretically, to verification" (Makins, p. 510). But, experience may be acquired and stored, may be immediate and subjective, and may be in process (Makins).

The contemporary post-positivist position regarding the empirical described by Guba (1990) places direct observation before theorizing, with observation conducted so as to be open to verification (Popper, 1965). Direct observation involves "attempting", as with Makins' Ancient Greek root

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given above, but such "attempts" or "trials" have delimited possible outcomes through the posing of the null hypothesis. According to Popper, such trials require a theoretical frame in order to be conducted validly. That is, thinking must precede testing, which almost turns this definition on its head. Augustine believed the empirical to be only possible once true understanding had been achieved (Blackburn, 1994), that is knowledge of God's role had to precede accurate perception of the world.

This tangle of meanings has existed for a very long time. Observation requires differentiation of the terms "frame", "stance", "source", "means", and "purpose". The following narrative of the history of Western thought will help to distinguish these several meanings.

1.4.2   The metaphor of Plato's cave as definitive of aspects of enquiry

Socrates, Plato's exemplar of the human enquirer, upset people with his constant probing of the practices they normally enacted in their daily lives (Jowett & de Botton, 1871/1999). He was searching out the values by which lives were lived. He could elicit the mistaken assumptions beneath a surface verisimilitude that was ordinarily undisturbed. By skilful questioning he uncovered contradictions in thought, and between thought and deed, and thus instigated an intellectual genealogy as follows:

- the value based examination of the commonplace activities of citizens (Socrates),

- the search within for ideal forms (Plato), and

- the need for direct and precise observation in the field (Aristotle).

Plato (Jowett & de Botton, 1871/1999) located the human enquirer, metaphorically, against a wall in a dark cave, and was bound, so observation was limited to the back wall of the cave. The cave was dimly lit from the outside by a large fire, far away and beyond a constructed causeway. When something moved between the fire and the cave opening, especially across the causeway, a shadow

was cast on the back wall. Such shadows were the only basis for knowledge of the outside world for those bound in the cave, enquirer or not. Careful observation might have revealed some of the nature of truth, but not until the enquirer broke free of the bindings and came into the sunlight could real enlightenment have occurred. But, it was the lot of the enlightened enquirer to return to live in the cave among the uninsightful (Jowett & de Botton). Plato's task for the enlightened was to see beyond the particular details of anything and to perceive and describe its ideal form.

Five parameters of observational; method are implicit to Plato's cave. The frame was the cave mouth and is more broadly defined as the range of purview. The stance concerned the position of the observer with respect to the data source, whether subjectively engaged or objectively removed, fixed in position, or mobile. The source concerned from where the information came, in Plato's cave the data arrived as externally projected shadows. The means concerned the lens used whether that of the cave wall or the eye. The purpose could include the accurate description, naming, experiential description, detection of mechanism, the search for ideal forms, or pursuit of value. That which is observation is dependent on all these possibilities.

However, the cave cannot account for data not received through the cave mouth or of insufficient illumination or contrast. The objectivity of the cave data relies upon an unchanging, non-emergent world. In such a world, the tasks of calibration of instruments can occur; lenses of insight could be developed.

However, peering grimly at dark shadows was not the preference of Aristotle (Lloyd, 1970). He ignored such constraints as the search for underlying truths, and made splendid and naïve descriptions of animals, birds, insects, and plants. For Aristotle, accurate description needed to precede conclusions (Casti, 1989).

1.4.3   The cave, contemplation, and the clash of Plato and Aristotle in the thirteenth century

The history of enquiry in the Christian era until the Renaissance was dominated by the Platonic 'search-within' and, to a lesser degree among Western scholars, the Aristotelian 'description-as-is' (Benoit, 1995; Benoit & Micheau, 1995; MacIntyre, 1990). These have remained important complementary tasks.

In the third century, Augustine incorporated a Platonic philosophy about ideal forms within Christian theology, whereby the aim of enquiry was to discover the deepest truth (Benoit, 1995; MacIntyre, 1990). This scholasticism held that without apprehending the Word of God, one could not perceive the particular, in its truth. The intellect only operated properly on objects through divine illumination. The will, untamed by scripture, diverted the operation of the mind away from the true stance and the true interpretation. Plato's cave was readily re-modelled as a cathedral.

Plato's idealism had been thought to be not just incompatible, but rather, incommensurable with the views of his student, Aristotle (MacIntyre, 1990). The incommensurability of Platonic and Aristotelian approaches became problematic when the ancient texts of Aristotle, recovered by Islamic scholars, began to be taught at the Augustinian University of Paris (MacIntyre) in the thirteenth century (Benoit, 1995; Benoit & Micheau, 1995). For Augustine, the will needed to be tamed in order for the empirical to be manifested. In the Aristotelian scheme, the will is unnecessary (MacIntyre), as one takes one's mind to the world in order to apprehend it, rather than to confirm a truth. However, Aquinas accommodated both positions by placing the ideas upon different levels. He proposed the enquirer as active, open, and without will (after Aristotle), but these capacities of the enquirer as having been derived from a singular God who could contain human will (after Augustine).

This resolution of the incommensurability of Aristotle and Augustine is echoed in contemporary science, the search for essential truth (Plato) is moderated by a method that does not prejudge outcome (Aristotle), but observes limits (Guba, 1990). MacIntyre used Aquinas' resolution of incommensurabilities to deal with contemporary divisions within the discipline of history in a way that might apply to the incommensurabilities in contemporary psychosocial enquiry between the objective and the subjective, the quantitative and the qualitative, and the meaningful and the mechanical. It is from this position that the questions posed in this research were framed.

1.5 From contemplation to utility: The pinhole camera as mechanical metaphor and its limits

Although Aristotle advocated the taking of the senses to the world, the combination of Aristotelian tradition within Augustinian scholasticism by Aquinas produced curious attitudes toward the empirical. The search for truth within, especially within published text, whether Augustinian or Aristotelian, produced a narrowing of intellectual and social activity that was challenged by the Renaissance, in very many ways. Four examples of the challenges to scholasticism are considered in this section, namely, the camera obscura, the Copernican Revolution, Bacon's new purpose for science, and Descartes' search for mechanism.

1.5.1 A new means for seeing

The *camera obscura*, also known as the pinhole camera, and meaning literally, "dark room" was an innovation characteristic of the artisans of the Renaissance. An upside down image could be projected onto the back wall of an empty box as light passed through a pinhole opening. Hammond (1981) presented a collation of historical references from fifth century BC China, to Euclid and Aristotle, and to Da Vinci. The name *camera obscura* was coined by Kepler who, in 1604, had a portable solar tent he used for astronomy and surveying (Hammond).

In a thorough presentation of the history of the *camera obscura* as cultural metaphor, Crary (1990) described " a new kind of observer" (p. 2) who was rational and rendered observed phenomena identically, as did the *camera obscura*. Vision was the rendering of light upon the retina and pure images became possible because of an objective, external reality. Seeing as a form of interpretation of experience had become explicit and objective. Other optical instruments were refined, such as Galileo's microscope and telescope (Casti, 1989) and focus was upon the order of the planets and how they affected the yearly holy days.

The metaphor of Plato's cave as metaphor of observational practice would seem to have been easily transmuted into the metaphor of the *camera obscura*. This also entailed another change, from the thought experiment to the technical device. This shift is evident in the assertion by Bacon (1620/2004), of science being for the manufacture of technologies to improve the wellbeing of human kind.

1.5.2   The Copernican revolution

Along with the sixteenth century interest in optical devices was an interest among Catholic scholars in solving the problem of the calendar (Baigrie, 2004). The problem was the accurate prediction of the Christian holy days, especially Christmas and Easter. Copernicus, a Polish monk, provided a mechanical solution.

In 1543, in the foreword to his treatise, *On the revolutions of the earthly spheres*, Copernicus (1543/2004) asserted that for the convenience of calculation of the annual dates of the holy days, it was necessary to regard the earth as moving in a circular orbit around the sun, which was in contrast to the complex system of circles that Ptolemy, in the second century AD, had so painfully documented to account for planetary movement (Casti, 1989). Orbital mechanism was placed on a collision course with biblical meaningfulness. Copernicus died soon after publishing his solution

and six decades later his convenient mathematics had become doctrinal heresy. In 1633 a Papal Commission was convened to examine Galileo's support for the Copernican proposition (Robinson & Garratt, 1999). Galileo was incarcerated but later released (Stengers, 1995).

1.5.3 Bacon's new purpose for science

When Bacon published, in 1605, *The advancement of learning* (Blackburn, 1994) a new purpose for scientific enquiry had been set down. Bacon proposed that science should assist people in their living, rather than be oriented to confirm past positions stipulated by religious text or, in other ways, to merely contemplate existence and give labels to phenomena. Bacon's direct challenge to the limitations of scholasticism was evident in the title of Bacon's other major work on science, *The new organon* (1620/2004), which sought to supplant the earlier work of Aristotle (Baigrie, 2004). This break with academic tradition had far reaching effects, especially as evidenced by technological innovations.

In tune with his times, Bacon, was an industrialist and a parliamentarian (Blackburn, 1994), wanted tools for living that changed actual circumstances in clear ways, rather than a learned meaningfulness that educated the values by which people lived. Bacon did not articulate the positivist approach to science, but his emphasis on the practical, the manifest, and the controllable, provided the first use of the term "mechanical" (Winchester, 2003), and certainly stimulated the direction of science toward positivism, technological application, and, especially through Descartes, the search for mechanical and mathematical explanations of the manifest.

1.5.4 Descartes: Spirituality, mathematics, mechanism, and dualism

The political fate of the scientist Galileo occupied the thoughts of Descartes, a mathematician, in the last decade of his life (Robinson & Garratt, 1999). Descartes considered, in some depth, what it

meant to be both a scientist and a Christian (Gaukroger, 1995). The result was the several *Meditations* of the 1640s and the famous dictum "cogito ergo sum" (Wilson, 1969). "I think, therefore I am" was not, to Descartes, a triumph of reason. Rather, it was the only possible, but miserable, conclusion to the baffling paradox of perceived experience. Without thinking, the self-awareness of the human would not be possible. Much has been made of the separation of mind and body implicit in this formulation, but this Cartesian Dualism arose with his wish to affirm his Catholicism.

Descartes separated all the three domains of experience, of the spiritual, the cognitive, and the physical, and placed them at different levels. The spiritual (Wilson, 1969) was the domain of the Church. The sceptic scientist's responsibility was to discover the mathematics of the manifest world and, following Bacon (Robinson & Garratt), the mechanisms by which phenomena functioned (Descartes, 1664/1972). For Descartes, as for Aquinas, the scientist, by enquiring about the mind and the body, could better render the magnificence of God's creation. But, subjectivity is inherently uncertain, or extensive in Descartes' terms (Wilson). Mensch (1996), in assessing the intellectual legacy of Descartes, observed a change from an ethics of value to an ethics of certainty.

The trajectory of Western science, since Descartes, has been to value the physical sciences and to remain confused or dubious about the sciences of the mind. The model of what it means to do science became the clear and verifiable mechanical sciences. Implicit was the hope that science could generate certainty, as Bacon had already identified and Newton's Laws demonstrated (Casti, 1989), but this formalization produced a space for subjective enquiry that mechanical science cannot map.

1.5.5   The limits of the grand positivist order in physics and social science

Enquiry has always involved the use of description and of representation. In his field studies, Aristotle picked up bugs, drew them, and tried to describe all anatomical features, along with each bug's apparent motivations (Lloyd, 1970). The scientific achievement of Copernicus was not just a description of planetary movement. He also generated a mechanical representational system or model that predicted observations, and which, with the refinements of Kepler (Casti, 1989), supplanted the representational system of Ptolemy. With Post-Renaissance science, various sorts of lenses were developed in the physical sciences (Crary, 1990) to see beneath the surface.

The interplay between the advances of representational art and medical science in the post-Cartesian world has been well demonstrated by Stafford (1991). Representational systems involve the looking inward to central organizing principles that are not obvious to simple inspection and description. Once well represented, understanding of function can be advanced, to the point where a new representation is devised (Stafford). The tension between the distinguishing of a phenomenon, and then the modeling or theoretical representing of its functioning, remains a central challenge for science that began in Plato's cave.

In the 1830s, Comte simplified enquiry by asserting that that which cannot be observed directly cannot be the proper object of science (Casti, 1989), almost banishing the problem of representation from the new science of sociology. This assertion of the positive, a foundation for positivism, was accepted as the way forward in science generally until the 1930s.

Physical science, with the advent of sub-atomic physics and quantum mechanics, became inferential, that is, representational, as direct observation was not possible. Russell and Whitehead (1911) saved the scientific status of both enterprises for a while with set theory and, later, Ayer (1936, 1940) bravely articulated the postulates of logical positivism. Set theory argued that any

attributes of a phenomenon can be arranged in a continuum and that any phenomenon cannot be both an attribute and a phenomenon at the same level. Once arranged in a continuum, the attributes and the phenomenon were subject to the rules of mathematics. This was adopted as the underpinning idea in all quantitative psychosocial research.

Ayer (1940), with his contemporaries of the Vienna Circle (Casti, 1989), re-cast science using mathematics, stating that if a phenomenon could be described by a mathematical formula in a predictive way, then study of that phenomenon was scientific. Lenses had evolved from Galileo's microscope and telescope to the electron microscope that made molecules and metal matrices observable, but the finest lens was considered to be statistical inference. The frame of interpretation was retained as objective. The stance of the observer was impartial. The source was external to the act of observation. The purpose remained the establishment of physical truths in order to benefit humankind through application of technology. But the exteriority of the observer had already been questioned.

Heisenberg (1929; Casti, 1989) tried to observe sub-atomic particles within an electron microscope by using the measure of scatter of sub-atomic particles. If the momentum of electrons could be determined, the actual location of the electron could not be specified. This was in direct contrast to Newton's law of momentum (Casti). Originally, this finding was thought to be a problem of technique and technology (lens), but Heisenberg (1971) came to propose the uncertainty principle as inherent to observation arising when the observed phenomenon was at the same level of abstraction as the means of observation. This is a problem of frame.

Godel (1931, cited in Casti, 1989) demonstrated a logical problem with the Russell and Whitehead's (1911) thesis. Godel's Theorem is that set theory can explain all gradations of quality within all sets, except for the set of all sets. If a phenomenon is distinguished as a set with a range of characteristics, necessarily this set is qualitatively different from all other sets. Thus the set of

sets cannot be arranged in mathematical form in the way that attributes within a set can be arranged. That is, the use of statistical analysis has as its limit, the quality of phenomena.

These limitations apply equally in social science, as well. However, the importance of Heisenberg's and Godel's ideas has proven difficult to register within the academic discipline of psychology. For example, Churchland's (1986) *Neurophilosophy*, which attempted to produce a generative discussion between philosophers of mind and neuroscientists, has a passing reference to Godel, and no mention of Heisenberg. Under known, specified, and controlled conditions, accurate quantitative observations can be made. This was Skinner's (1953) position, but the analogy of the behaviour of experimental pigeons to human action has not been sustained (Smith, 1992). Mathematics has a limit. The observer of human behaviour is always a human observer (Maturana & Varela, 1988).

Everyday banal phenomena do not have rigorous specifications, even if certain characteristics seem obvious. Banal phenomena do involve clashes between the observer and the observed, between the subjective and the objective, and between different frames and stances. Other ways of seeing need to be employed with phenomena such as the referral and intake practices of child and adolescent mental health services.

1.6   Ontology of the contemporary researcher and clinician

Ontology concerns the nature of being (Makins, 1994), or how one lives one's knowledge. The ontological position of the positivist has been well described. However, describing the ontology of the researcher has been problematic because of the inherent subjectivity that caused despair to Descartes (Robinson & Garratt, 1999). Can levels of rigour analogous to those of positivism be sustained with non-quantitative research? This was the ontological challenge for the psychologist

posed by MacDougall (1922, cited in Orasanu & Connolly, 1993; see lead quote to Chapter 7), and it extends to the enquiry conducted in clinical psychology practice.

1.6.1   Heidegger's phenomenology

Heidegger built his phenomenology upon an examination of the works of the ancients, especially Aristotle (Corradi-Fiumara, 1990). Heidegger made much of "logos", asserting that the Ancient Greek idea had become removed from current usage. He noted that contemporary intellectual exchange was dominated by talking at an audience without reciprocal engagement, whereas logos cannot be complete until the speaker has heard that the listener has understood (Corradi-Fiumara). Logos is a circular, reflexive concept based on listening and exchange. Logos is necessarily open-ended and could be extended, but does not have the inefficiencies that come from incomplete or partial understanding.

Logos, conceived so, allows for rendering of experience in ways that does not do violence to another's experience and is at the heart of Heidegger's phenomenology (Corradi-Fiumara, 1990). It is with the partial or segmented view of phenomena that Heidegger took issue with Aristotle. It is all very well to walk away from Plato's cave, with its editing apparatuses, into the true light of experience, but if the observer then overlays categories upon that which is experienced, phenomena are subject to the violence of observer-circumscribed observation.

The phenomenological then constitutes a fourth way of observing that, in some ways, leads back to the value based observations of Socrates described in Section 1.5.2 above, especially as articulated by Corradi-Fiumara (1990) in her *Philosophy of listening*. Glaser and Strauss (1967), the developers of the Grounded Theory method of qualitative research, owe a clear debt to Heidegger's wish to understand the meaningfulness of the moment and not to crowd this experience with a need for precise labels.

Heidegger's major work was *Being and time* (1928, cited in Collins & Selina, 1999) and involved much emphasis upon the nature of being. Time had been identified by Husserl as having three different phases, akin to past, present, and future, labelled retention, attention, and pretention. These are gathered together in the moment (Collins & Selina). In this compounded, non-linear, unquantifiable temporality, Heidegger located being as thrownness (past), fallenness (present), and projection (future) (Collins & Selina). We live as our past, present, and future.

However, abstruse and remote such discussion might appear, Heidegger's analysis has a curiously close connection with the qualitative exploration of phenomena like referral and intake. A referral call is not complete until each participant understands that the other has understood the circumstances that prompted the call and the processes that will occur after the call has concluded. This is the logos in action. Secondly, the three phases of time: before, present, and that which comes after, are significant to the adjustment of the parent and the functioning of the clinic and during the course of the referral call must be considered by the referral and intake clinician. The capacity to highlight and stay with the present is implicit in the art of qualitative interviewing and grounds all discussions (Glaser & Strauss, 1967; Henwood & Pidgeon, 1995; Strauss & Corbin, 1994).

For Heidegger, observational data were central to the experience. The frame of interpretation was the experience. The stance of the observer was of openness and embeddedness. The source was the experience. The means concerned the lens used, whether that of the microscope, the telescope, statistics, or counter transference. The purpose could include the accurate description, naming, experiential description, detection of mechanism, or pursuit of value. That which is observation is dependent on all these possibilities. Heidegger's position was completely foreign to the idea of psychosocial research as the analysis of shadows within the controlled environment of Plato's cave,

or as the transfer of image with an analogue *camera obscura*, or as the controlled environment of the positivist.

1.6.2   Rigorous enquiry when control is not possible: Naturalistic case study research

Gillham (2000), Stake (1994, 1995), and Yin (1989, 1993) were keen to demonstrate the rigour of case study method when control of variation was not possible. Applications of the method, of course, are ancient. Aristotle used case study method in his field studies (Lloyd, 1970), and case study was the basis upon which medical knowledge was built during the time following Descartes (Stafford, 1991). In the psychological sphere, case study allowed the building of differential diagnostic systems in psychiatry from the time of the foundation of the Medico-Psychological Association in 1841 (Berrios & Freeman, 1991). Case study was the basis for the development of psychoanalysis (Breuer & Freud, 1895/1974), for the application of Watsonian behaviourism to Little Albert (Watson & Rayner, 1920), and to the development of many family systems theories and therapies (Durrant, 1986 to date, *Case studies in Family Therapy*). Neuropsychology was established in the nineteenth century with the case studies of Broca and Wernicke (Churchland, 1986).

The legitimacy of case study method lies in the history of Western thought and the capacity to induct general theoretical principles from singular events. Yin (1989) has advocated the use of past sources to support understanding of a case study, to build external validity, and to deepen theory building through enquiry, but from the time of Bacon and Descartes great emphasis has been put upon mechanical knowledge and deduction. The rigour of case study has been questioned by this mechanistic history. For Gillham (2000), Stake (1994, 1995), and Yin, however, case study was simply useful.

Yin (1989) compared quantitative experimentation and case study research in terms of the degree of control able to be brought to bear on the variables under investigation. Both methods concern the testing of ideas in order to build theory. Both methods produce results that cannot be generalized to populations. Both methods require replication in order to confirm propositions. Yin was not arguing for the superiority of experimental approaches over case studies, but that in seeking to gather evidence, researchers should use the most appropriate model of research, and the highest possible criteria of rigour.

In a similar firm and clear way, Miles and Huberman (1994) provided both rationale and means for the rigorous analysis of qualitative data. The theory to be tested implied certain categories of data to be collected in interview. Through the interviews, these categories could be amended and final data codes could be generated. Then the codes could be used to reduce the data set to patterns of meaning. Miles and Huberman advocated the visual display of coding on multi-dimensional matrices to facilitate the interpretation of data. A parallel can be made here with the statistical analysis of a quantitative data set, whereby relationships are mapped in multi-dimensional space, according to frequencies and amplitudes.

Yin (1989) resolved some of the incommensurabilities of qualitative and quantitative methods by observing that the data sets derived by research strategies have shared criteria of validity and reliability, even though the data sets can be markedly different in frame, stance, source, and means of observation. Concurrent validity, internal validity, external validity, and reliability were used by Yin as tests of research design across all research strategies, pointing out particular characteristics for case studies and qualitative data. Research strategies can legitimately embrace different sorts of data and integrate them through the principle of external validity.

1.6.3   Mixed data sets

Creswell's (2003) articulation of mixed methods research in his third edition of his research methodology textbook was a pragmatic response to a growing body of practice. Takashori and Teddlie's (2002) handbook had documented many applications of mixed methods generated to answer questions in a wide variety of psychosocial settings. Creswell documented four epistemological motivations for mixed methods research; these were pragmatism, inclusiveness, valuing of different sorts of data without an hierarchy, and complementation and convergence of findings enhancing external validity.

The simplest articulation of the validity of mixed mode research was that of Morse (1991). She asserted that triangulation of qualitative data sources can occur at a higher level, whereby the convergence of different methods can strengthen the validity of conclusions. The data sets could be as diverse as psychometric measures and literature review, so long as there was unforced convergence. Convergence was a means for avoiding some of the problems of reduction within a particular paradigm.

Creswell (2003) provided several models for the conduct of mixed mode research, but usually, the data sets were compiled with different groups and at different phases of a research program involving separate research studies. The mixing of data sets was considered possible for the one sample, but an example of such research was not given. Either Creswell did not consider the clinical psychology assessment report to be research, or had not recognized this practice as a longstanding example of mixed mode enquiry.

1.6.4 A century of clinical psychology assessment

Clinical psychology practices from the seminal contribution of Witmer (1907) have developed to where the record of gestures and words can include data collected from parametric and projective testing. Sometimes clinical lenses have high acuity established by population studies and statistical manipulation. Sometimes the data involve hunches and counter-transference responses. There has, of course, been debate concerning the levels of validity of clinical observations made using these various means (for instance, Meehl, 1954) and John (1986, 1988, 1992, 1994) has been critical of the rhetorical claims for scientific method made by psychologists.

Groth-Marnat (2003), in the *Handbook of Psychological Assessment*, presented a careful description of the tasks and activities of the assessing clinical psychologist with special attention to reporting of findings:

> The psychological report is the end product of assessment. It represents the clinician's efforts to integrate the assessment data into a functional whole so that the information can help the client solve problems and make decisions. Even the best test results will be useless unless the data from them is explained in a manner that is relevant and clear, and meets the needs of the client and referral source. This requires clinicians to not merely give test results, but to also interact with their data in a way that will make their conclusions useful in answering the referral question, making decisions, and helping to solve problems (p. 619).

That is, the clinician needs to be aware of the frame of interpretation, the multiple stances taken when observing, the different sources of information, the means of the data collected and the purpose of the assessment and the purpose for reporting the findings. Clinical report writing is a discursive process (John, 1990, 1994).

Pragmatically, mental health professionals can use a variety of data sources to come to explanations of client predicament or to formulate plans for intervention. How this is done can be quite daunting

to analyse, but this has not prevented the attempting of the task, to some effect when applied. It would seem that the trained person is able to balance the data sufficiently well, despite its complexity. Conflict between different sorts of observation does not, in any particular case, preclude compelling assessment or prevent effective intervention.

1.7   The task: To name the obscured practices of referral and intake to child and adolescent mental health services in their mechanism, their meaningfulness, and their effect

In attempting this research exercise of documenting undocumented phenomena, different research models and several different sorts of research study were employed. This has had several implications. Firstly, the data collected and the analyses performed overlapped. This could appear to involve a large amount of redundancy, but it is implicit to information theory that redundancy increases precision (Wilden, 1979). Redundancy also requires length to elucidate the findings drawn from particular perspectives. The design has involved redundancy particularly through iteration over the course of literature, retrospective, prospective, and additional studies.

Secondly, different sorts of data were drawn from the same set of contacts with participants. Practices were described, as were perceptions, and in the prospective study, parametric measures were used to augment interview data. Definite events in the course of referral and intake contacts can be discerned and, therefore, can be handled as categorical data. Other data are just opinion and perception, but such opinion and perception may be formative of the definite aspects of the described processes. The methods can be complementary, rather than necessarily antagonistic.

Thirdly, the tension between models may only need to be recognized rather than resolved and, thereby, the tension might be generative of new understanding. In this thesis, that which can be counted will be counted. That which is impression will be rendered as impression. That which belongs in narrative will be presented as narrative, specifically, as case studies.

Fourthly, a novel method has been used to coordinate the several perspectives and studies and to map overlap of findings. In a quite formal way, expectations drawn from the literature, from first principles, and from experience were articulated. The intention was to honestly and openly set out the researcher's expectations before the research began. Such an approach has not been used in any other exploratory study with which the researcher was familiar. In providing coordination of the research data, much repetition occurred.

Fifthly, data has been so rarely collected with respect to the work of referral and intake, that any data that has been collected or became available through the research was used in analyses. In turn, the analytic strategy was one of data inclusiveness and avoidance of severe reduction into general themes or categories.

Finally, it is probable that the use of multiple models could have made the project unworkable in certain ways. The effectiveness of the multiple model approach will be a matter for discussion at the end of the thesis.

In summary, mixed methods research using a clinical attitude and a design that is alive to subtlety and emergence in a number of temporal frames is necessary to study the practices and processes of child and adolescent mental health referral and intake. Data can be collected in a number of ways but will need to be analysed in complementary ways and may require synthesis. Literature, interview material, and parametric tests are likely means for such a synthetic research project.

CHAPTER 2

HISTORICAL OVERVIEW OF THE PROFESSIONS OF CHILD AND ADOLESCENT MENTAL HEALTH SERVICES

In the beginning the Word ..
Gospel according to John, *Good News Bible*
(translated by Bratcher, 1992)

The practices of referral have been shaped by the history of certain mental health professions, the perceived place of the parent referrers, and some of the practices evolved to conduct the reception of referrals. This chapter looks to the history of triage, psychiatry, mental health nursing, social work, and child guidance to describe the professional context of contemporary referral practice, providing a stepping-stone in a sequence of narratives. These narratives are intended to frame certain aspects of referral work. As a whole, and by sequence, they comprise an integrated view of the collected wisdom relating to the structure and function of child and adolescent mental health referral and intake work.

The narratives described draw on published analyses of historical events, rather than primary sources. The history of each profession begins with the changes in social organization that swept across Western Europe in concurrence with the French Revolution, that affected the provision of health and social services, and their administrative and professional shape, in France, the United Kingdom, the United States, Australia, Canada, and elsewhere.

The French Revolution, for Foucault (Danaher, Schirato, & Webb, 2000), signified a change in the regulation of Western societies away from the authority of the crown toward the authority of the

parliament and the actions of the common person. Regulation of the masses moved from the direct gaze of the king and his soldiers to indirect regulation through the gaze of others upon others. The former regulation was direct and harsh, but if actions were unnoticed, no regulation occurred. The new style of regulation was milder, but pervasive and very regulatory through its pervasiveness. The new gaze brought new social phenomena into view, such as madness, and created new opportunities for the ordinary person to act decisively to solve local problems. In turn, new social institutions emerged at a rapid rate across Europe during the nineteenth century.

The history of war in the nineteenth and twentieth centuries punctuates the narratives below. The Napoleonic wars brought forth the practices of triage, the Crimean war brought forth the professionalization of nursing, and the American Civil War led to the profession of social work. Child Guidance appeared after World War One. The conclusion of World War Two saw mental health nurses entering child guidance, and re-defining of their place as mental health professions.

2.1 The gateway to psychiatry

In Europe, between late eighteenth century and mid-nineteenth century there were two moves in the social management of insane people. Methods of restraint and incarceration were replaced by approaches that allowed the troubled person refuge and the time to recover from the moral disharmony that was thought to be the source of madness (Smith, 1999). Through these moral treatments, psychiatry, as a modern profession, emerged in the asylums during the middle decades of the nineteenth century, across the Western world. Asylums were built in rural locations and soon became overcrowded (Scull, 1979). Moral treatment became replaced within the next decades with treatments for illness, and reasoning and refuge gave way to restraint as the major form of management (Shlomowitz, 1994).

Gaining entry to the facility was a major task for sufferers and their family and friends. Doctors were employed as ethicists to prevent the entry of malingerers (Foucault, 1961/1971), and control of the asylums passed from philanthropists, like Tuke the elder, to psychiatrists. Once a patient gained entry, care was provided by attendants who were undertrained, poorly paid, and overworked.

Concern about the conditions within mental asylums was recorded recurrently throughout the nineteenth and twentieth centuries, with wholesale closure of these institutions during the 1980s and 1990s. As the asylums closed, community residential and treatment facilities were opened. Many things changed due to the availability of better pharmaceutical and psychosocial treatments, but the need to have an entry policy and protocol remained.

2.1.1   Madness, the French Revolution, and moral treatment

Smith (1999) placed the many developments in care for those with mental health problems at the turn of the nineteenth century, into the eighteenth century context of British endeavours to provide asylum to needy people. Smith concluded that there was much overcrowding in the public institutions and little differentiation of the insane according to type of problem or its manifestations. For the rich, there were safe homes established by private carers, paid by commission to look after the mentally disabled. The Quaker Tuke, as reported by Smith, being horrified by the care provided in the public York Asylum set up in 1790 his York Retreat for those from the Society of Friends, who were troubled and required refuge.

Foucault (1961/1971) observed that eighteenth century treatments were mostly inadequate and had come to be characterized as an exercise in gathering and housing. Among those who were gathered were poorly differentiated groups of the mad, the criminal, and the politically active. The French Revolution brought the needs of the insane into public view in a violent way in France, as the

political prisoners were liberated from their chains. The needs for the insane to address their moral confusion were considered directly by the Robespierre government through Pinel, who re-organized the asylums at Bicetre, for men, and the Salpetriere, for women.

The highlighting of conditions in the public asylums, following the innovations of Tuke, led to British parliamentary reform through the Wynne Bill of 1808 (Smith, 1999). Tuke documented his approach to care in 1813, but already his principles had arrived in Australia through Governor Macquarie who established the first asylum outside of Sydney at Castle Hill in 1814 (Neil, 1992). Tuke's moral treatment became the major influence in the care of the mentally ill during the first half of the nineteenth century and invited an innovation that, according to Foucault (1961/1971), became formative of the modern profession of psychiatry.

Because asylums provided voluntary refuge, malingering became a problem. It became necessary to evaluate the motivations of those seeking refuge, to establish, if indeed, their need for shelter was an effect of moral confusion. This was a question grounded in ethics and, because few trained ethicists were to be found in rural England, doctors were appointed to the task of interviewing refuge seekers concerning their needs for entry. Prior to this, doctors had been providers of medical care for asylum residents, but henceforth they were able to determine the conditions of entry (Foucault, 1961/1971). According to Foucault this soon led to the formation of the British Medico-Psychological Association in 1841. In turn, practitioners of mental health treatment, who had been known as alienists, became psychiatrists. Berrios and Freeman (1991), along with Tantam (1991), Shorter (1997), and Stone (1997) were dismissive of Foucault's historical interpretation, preferring to see psychiatry as a steady set of advancements, rather than a revolution in the social construction of madness, but still regarding the formation of the Medico-Psychological Association as critical.

2.1.2   The rise and fall of the asylum and psychiatry today

The history of the asylum is the history of a wall, if not a gate, as Smith (1998) observed in the title of his account: *Behind closed doors*. The experience recorded in the accounts of life in asylums in Australia, from the Vagabond in 1876 (Anonymous) to the inquiry into Callan Park Hospital in Sydney of McClemens in 1961 (Cummins, 1976; Australian Broadcast Corporation (ABC), *Hindsight*, 2001), remain shocking in their descriptions, but even more shocking in their continuities over nine decades. Yet, status and relationships changed over the time of the existence of the walls for the three groups of people contained within the walls, the keepers, the psychiatrists, and the patients.

Historians of psychiatry, such as Stone (1997), have wanted to emphasize the steady progress of medicine. However, while psychiatry reached a zenith in the 1870s with the design of new facilities and the development of training courses for attendants, especially by Kirkbride in Boston (Shorter, 1997), the status of the emerging profession of psychiatry subsequently deteriorated relative to other medical specialties. Shorter noted that in 1853, the United States Asylum Superintendents, founded in 1844, refused affiliation with the "boil lancers and enema givers" of the newly formed American Medical Association. In the 1890s, the superintendents were criticized by neurologists for their lack of scientific contribution, and twenty years further on, were complimented for their management of buildings and groceries rather than their psychiatric practice (Shorter).

Psychoanalysis provided the first improvements to inpatient psychiatric treatment through the innovations of Sullivan and Fromm-Reichmann in the 1930s, with the delegation of responsibility to ward staff, who included Peplau. Developments in sociology helped bring psychiatric practices under public scrutiny and contributed to changes in ward management (Caudill, 1958; Goffman, 1961, 1968; Stanton & Schwartz, 1954) and underpinned the knowledge base of the consumer

movement that gained momentum in the 1960s. But, arguably the greatest changes to inpatient treatments were the new drugs developed in the 1940s and 1950s. Not only were patients' states of wellbeing improved, but many chronically ill and institutionalized people were able to return to wider society (Stone, 1997).

By contrast, child psychiatry was an extra-mural activity from its beginning with child guidance clinics in Britain and the United States. Specialist clinics, such as the Tavistock Clinic in London, the Philadelphia Child Guidance Clinic, and the Illinois Institute for Juvenile Research, were established that remain significant today. While, the history of child and adolescent mental health services is very different to that of adult psychiatry, as is demonstrated in Section 2.6 below, all these institutions had practices to regulate patient entry.

Ultimately, it was public and consumer advocacy that brought down the walls of the asylums. Psychiatry in the 1990s, and subsequently, has been largely an outpatient service involving maintenance drug treatments, and supported by psychiatric crisis management services and short stay public hospital wards (Dowling, Fossey, Meadows, & Purtell, 2001; Meadows & Singh, 2001). The walls have all but gone, but the processes of admission and the effects of these on the patients and on the courses of treatments remain inadequately documented. Mooney (2002) pointed to potential savings to be made at the doors of the community mental health services.

2.2   From keeper to independent nurse practitioner

Parallel with the development of psychiatry has been the profession of psychiatric nursing. Meanwhile, the name of the provider of direct care in mental health institutions had undergone at least four changes. In the late eighteenth century, family members and recovered patients were often the direct carers, although in the larger institutions the carers were gaolers or, following the name adopted in zoos, keepers. At some stage, the name became attendants and this name

remained for male carers until the early 1930s (Carpenter, 1980) in the United Kingdom, although as early as 1870 (Shorter, 1997), nurse training was being provided to asylum workers. Mental nurses became mental health nurses and acquired independent practitioner status with the innovations of Peplau (1952).

After World War Two, mental health nurses began to be employed in child and adolescent mental health in inpatient services and in community outpatient services to assist in the administration of drug treatments. The professional association of mental health nursing began in Australia in 1974 and by the end of the decade, a child and adolescent group had formed within the Victorian Branch. Over time, the professional experience and expertise of child and adolescent mental health services had broadened (Martyr, 1999) and when inpatient services began to be reduced, child and adolescent mental health nurses began occupying positions on outpatient treatment teams and in the role of referral and intake worker (Fleming, 1998).

2.2.2   The training of nurses

Attendants were an integral part of care programs for the insane from the time of the eighteenth century asylums for the insane (Smith, 1988, 1999). Untrained people of working class background, often strong men, usually occupied the role. Board and lodging was part of the remuneration. At the turn of the nineteenth century, attendants were sometimes recruited from the ranks of past residents (Smith, 1988).

During the nineteenth century, asylum care attendants were physical labourers with extensive time demands. Yet they were asked to do a job that involved a softness of heart and obedience to direction, with fines and dismissal as commonplace in nineteenth century Britain (Carpenter, 1980). Over time, this curious combination of the harsh, the mellow, the clock-regulated, and the boss-directed, laid the foundation of the work practices of the mental health nurse. In particular, a group

culture of solidarity developed between the attendants. This became more entrenched through the opportunities to share experience that training courses provided. Work practices like handover from shift to shift added to this fellowship (Mason, 1987).

An assertive profession of nursing emerged through Nightingale (Baly, 1997), following the Crimean war premised in the provision of care and with a clear gender critique of hospital practices (Carpenter, 1980). The first training courses for asylum care attendants, based on Nightingale's principles, were developed by Kirkbride in 1870 in the United States (Walk, 1961). Over the next several decades, a tradition of training was established in America and this facilitated the establishment of such courses elsewhere.

Nightingale's legacy for mental health nurses was a recognized specialist set of occupational activities, especially sanitary ones and a group orientation, "although Nightingale showed no desire to include asylums within the scope of her nursing reform" (Carpenter, 1980, p. 136). Training for attendants was advocated strongly by doctors in Britain, but the effect of the training courses, usually conducted within the asylum by the superintendent, was to attune the asylum to outside standards with the publication of the *Red Book* in 1885 (*The handbook for the instruction of attendants on the insane*; cited in Nolan, 1993).

While training remained within British hospitals until after World War Two (Walk, 1961), psychiatric nursing was establishing itself within United States universities during World War One (Nolan, 1993). United States mental health nurses (Peplau, 1952; Varcarolis, 1996) were most responsible for shaping the work of contemporary professionals employed in either adult or child and adolescent mental health settings (Heideman & Crabbe, 1991).

2.2.3 The independent practitioner and the profession of mental health nursing

In the 1930s, the American psychiatrists Fromm-Reichmann and Sullivan were developing inpatient psychotherapy services in which nurses were recognized as important therapeutic agents (Varcarolis, 1996), particularly through the use of the milieu of the ward in a form of ongoing group therapy. In 1952, the publication of Peplau's *Interpersonal relationships in psychiatric nursing,* in the United States, formalized therapeutic interaction with patients as the primary role function of the psychiatric nurse, and established independence in practice as the central goal for all subsequent psychiatric nurse education.

Peplau (1952) articulated the psychiatric nurse role as a professional one involving service to individuals. Custodial management through group, male culture, was to be superseded by responsible, caring, individualized professional activity. The change took somewhat longer than Peplau might have hoped and it took a great deal of public and consumer advocacy before the asylums and the old custodial culture receded. Peplau (1989) reflected upon her five decades of mental health nursing and predicted greater autonomy for mental health nurses with a wider range of professional roles.

Professionalization of mental health nursing was placed on the Australian national agenda with the First National Mental Health Nurses Congress in Melbourne in 1975 (Martyr, 1999). After three such conferences the first national body formed in 1977 as the Australian Congress of Mental Health Nurses (ACMHN). This became the Australian and New Zealand College of Mental Health Nurses in 1991. As early as the convention of 1980, Victorian child psychiatric inpatient unit nurses were seeking status as a special interest group of the ACMHN (Martyr).

2.2.4   The emergence of child and adolescent mental health nursing

The group culture of psychiatric nursing has never held its members captive. Trained psychiatric nurses have chosen to move into general nursing, child psychiatry, and a range of welfare related positions for decades. The re-definition of the psychiatric nursing role as interpersonal relating by Peplau (1952) liberated both nurses and patients. Within the asylum walls, sub-groups of staff advocated for patients' rights and the abolition of the institutions (Varcarolis, 1996; ABC, 2001). Community health and community mental health centres have facilitated the acquisition of the role of autonomous professional by many psychiatric nurses. For child psychiatric nurses, child guidance was the bridge to establishment of the specialty and then to professional status. In this sense, child psychiatry was instituted as a place to which psychiatric nurses could go, away from the constraints of asylum wards.

Heideman and Crabbe (1991) located the first American child psychiatric nurses as assistants to the child psychiatrists who administered pharmacotherapies to children in child guidance clinics following World War Two. Over time, and in line with Peplau's new description of interpersonal nursing, the space within child guidance expanded to include the nurse in a greater range of activities. The development of inpatient psychiatric services for children and adolescents saw the mental health nurse providing specialty services assisting children with new learning regarding themselves and their world, assisting children and their family with relearning of roles, relationships, and expectations, and assisting in restoring deprived aspects of living (Fagin, 1972; cited in Heideman & Crabbe, 1991).

The separate profession of child psychiatric nursing consolidated in the United States with the establishment of post-graduate courses in the 1950s, development of the specialty within the 1960s, publication of separate texts and the formation of a professional association in the 1970s, and the establishment of standards of practice and a professional journal in the 1980s (Heideman & Crabbe,

1991). Child mental health nurses now practice the full spectrum of psychosocial interventions provided in contemporary American child and adolescent mental health services.

In Victoria, Australia, child psychiatric nursing has been a recognized sub-discipline since the late 1970s, especially with respect to inpatient settings (Martyr, 1999), and from 1980 Victorian inpatient mental health nurses were seeking status as a special interest group within the then Australian Conference of Mental Health Nursing. Over time, a separate chapter of the professional association was established with members in all States, with independent practitioner status as a documented concern of the Association of Child Mental Health Nurses (ACMHN) from 1985 (Martyr).

2.2.5   Child and Adolescent Mental health nursing in contemporary Australia

Over the course of establishing child and adolescent mental health nursing as a separate professional entity in Australia, inpatient units throughout Australia have been closed down as expensive and as antagonistic to the treatment goal of having children reside with their parents. Mental health nurses have taken up positions in community child and adolescent mental health clinics, with responsibilities for case management and the provision of therapeutic services identical to those of other allied health professionals. Many referral and intake workers have mental health nursing backgrounds.

Child and adolescent mental health services referral and intake work offers the mental health nurse security of employment, associated with fixed hours of work and the handing on of responsibility at the end of the shift, along with the capacity to operate as an autonomous, decision-taking, daytime attending professional who provides care by listening and talking. There is a balance between functions of regularity and solidarity, and the functions of autonomy and care within ordinary working hours.

It is proposed here that the currently high prevalence of mental health nurses among child and adolescent mental health services referral and intake workers in Australia can be seen as emerging from the history of nursing outlined above. Firstly, nurses have wanted professional independence and sole practitioner status. Secondly, they did not want to work under direct medical control or to conform to the group nursing culture of the mental hospital. However, mental health nurses liked the security of regular hours and the handover of responsibility at the end of the shift. A third factor was that social workers gave up ownership of the role of community liaison built up by generations of psychiatric social workers. The latter sought to assert independence from doctors (Wood, 1996) by becoming clinicians, especially in the field of family therapy (Furlong & Smith, 1995), or by becoming social policy analysts and planners, as discussed below in Section 2.5.3. In turn, a niche opened for mental health nurses to leave inpatient work and move to become independent practitioners as referral and intake workers (Freestone, 1994).

The transformation of mental health nursing has been in parallel to the demise of the asylums, the change in social work's mental health paradigm, and the rise of mental health consumerism.

2.3   Mental health consumerism

Activism on behalf of mental patients has a long history. The establishment of Tuke's York Retreat was a direct response to the conditions at the York Asylum in the late eighteenth century. Dix (Shorter, 1997) was writing of appalling conditions in Boston and visited the York Retreat, in 1853, to find a better model for American asylums.

The first legal challenge to asylum care resulted in the 1871 Packard Laws in Massachusetts, in the United States, where a clergyman had had his wife incarcerated on grounds of insanity (Tomes, 1999). She fought for her release and for more stringent laws concerning involuntary admission

and retention of the right to communicate with others outside the institution (Tomes). However, the first grand movement was initiated by Beers, who endured a terrifying time as an asylum inpatient in 1901 in Pennsylvania, in the United States, following the suicide of this brother (Richardson, 1989). He dedicated his life to the amelioration of conditions for asylum inpatients, to the prevention of abuse, and, most importantly, to prevention of mental illness (Tomes, 1999). Gaining the support of the prominent psychiatrist, Meyer, and the prominent psychologist, James, Beers proposed the formation of a national movement for mental hygiene to parallel the successful physical hygiene of the previous decades (Horn, 1989). He sought the sponsorship of the new professions and of philanthropists to fund the necessary service innovations. In 1909 the National Committee for Mental Hygiene (NCMH) was launched. The NCMH gained influence and eventually founded the child guidance movement.

The United States Presidential statement on consumer rights in 1962 provided further impetus for the establishment of consumer rights among psychiatric patients (Tomes, 1998). The four consumer rights were given as the right to be safe, to be informed, to choose, and to be heard (Herrman, 1978). Already, the sociology of ward life (Caudill, 1958; Goffman, 1961, 1967; Stanton & Schwartz, 1954) had documented the trials of inpatient existence and the anti-psychiatry movement had begun (Szasz, 1960; Shorter, 1997). Some mental nurses, following the independent practitioner approach of Peplau (1952), were also moved to advocate for mental patients' rights (Varcarolis, 1996). The mental health consumer movement in the United States was aided by the evolution of the new psychotropic drugs, the movement for de-institutionalization, and the establishment in many States of community mental health centres (Tomes, 1999).

Similar shifts occurred in Australia. Committees for Mental Hygiene were founded during the 1930s (Lewis, 1988), but as with elsewhere, these were largely controlled by professionals, rather than former patients. Fifty years later, in line with international concern, the Australian Human Rights and Equal Opportunity Commission (HREOC, Burdekin, Guilfoyle, & Hall, 1993)

conducted a series of enquiries into psychiatric care in the late 1980s and made wide sweeping

recommendations for changes in practices. But Australian State governments did not wait and the

institutions in Ballarat and Ararat, Victoria, were being closed as the final report was presented

(Tobin, 1993). Mental health consumerism had been established in Australia.

In parallel with the implementation of the Burdekin et al. (1993) recommendations, discharged

patients formed action groups. In the State of Victoria, some discharged patients, together with

some researchers, embarked on an action research development (Epstein & Wadsworth, 1994;

Wadsworth & Epstein, 1996a, b, c; 1998) wherein participants in the mental health delivery system,

both clientele and staff, could meet and discuss shared interests, common goals, and differences of

perspective. These former patients firmly adopted the title "consumer". A term signifying that they

shared a set of experiences rather than having been confined by a system of labeling, yet having

had a diagnosis was a key defining criterion for being a consumer. It was important that a "patient

advocate" had to be have been a service recipient, but "patient" was a position of passivity that did

not apply to those voicing the objections and calling for change. The work of Epstein and

Wadsworth led to the involvement of consumer advocates for the appropriate care of new service

clients, and for the development of consumer friendly policies and practices.

Sozomenou, Mitchell, Fitzgerald, Malak, and Silove (2000) identified three ways consumer

participation positively affected lives. Policy changes enhanced wellbeing for those with mental

health diagnoses. Secondly, participation meant that consumers were moved out of the ordinary

passivity that accompanies such diagnoses. Thirdly, others could respond to the needs of those

diagnosed, enhancing the wellbeing of the whole community.

The adult mental health consumer movement in Australia has continued to grow resulting in a

government policy enunciating Best Practice Principles for consumer and carer participation in

mental health services (Mental Health Council of Australia, 2001). The document provides the

framework for the development of policy for particular service units. Of course, having such a framework, or even having developed a local policy, does not guarantee its implementation, as Stacey and Herron (2002) demonstrated.

Within this context, consumer advocacy has been applied to child and adolescent mental health services in Victoria (Luntz, 1997; Spink, 1997) and South Australia (Byas, Hills, Meech, Read, Stacey, Thompson, & Wood, 1999; Stacey, 1997, 1999, 2001; Stacey, Allison, Dadds, Roeger, Wood, & Martin, 2002; Stacey & Turner, 1998; Wallace, Higgs, & Marsland, 2001). These studies are presented in the context of an examination of the place of parents within child and adolescent mental health services in Section 3.4.3 of Chapter 3. Advocacy for people in need has had a long history and is at the core of the history of the profession of social work.

2.4   Careful caring from the Poor Law to the present: Social work as a profession

Trattner (1974) dated the origins of the social work profession with changes to the British Poor Law of 1835, when poverty was declared a crime against society. The response of social reformers to such legislation put in place a process of change that moved blame for poverty from the poor onto social processes. The end of the American Civil War revealed so much poverty among bereaved wives and liberated slaves that a coordinated response to the needs was required. The National Conference on Corrections and Charities was established to meet needs at both practical and policy levels (Richardson, 1989).

Among those who responded was Addams who established the Settlement House movement in Chicago for poor families on the move from other States and from Europe. Addams' contribution included activism, accommodation, and psychosocial family intervention and lasted well into the twentieth century, and embraced the establishment of university schools of social work. Social

work was an American invention (Goldstein, 1973), and it was not until the 1970s that United Kingdom social work was established within universities.

Social work in Australia took its lead from British Almoners, but by the mid-1930s was established within universities (Martin, 1990a, 1990b). By this time, the discipline of psychiatric social work had become an American training specialty in mental health clinics for adults and for children and adolescents. As has been noted above, social workers shaped the role of referral and intake within child guidance clinics.

2.4.1   Defining social work

Applied philanthropy (Richmond, 1897; cited in Wood, 1996) can be read to have several shades of meaning, but Richmond was not talking of the allocation of funds by rich benefactors. She was talking of how to make resources work in the interests of those for whom funds had been made available, and the skills of the agents employed to maximize the value of the resources provided through service delivery. For Richmond (1917), this was a professional role. The demise of voluntarism over the first three decades of the twentieth century did not involve the lessening of a desire to help, but rather indicated an emphasis on developing techniques that were efficient in servicing the needs, and rational with respect to how the many demands were met given resources available (Cantarow, 1980; Kunzel, 1993). Care was needed in how care was provided and this has promoted debate about the rationing of services.

Ife (1997) observed the heritage of social work incorporated six characteristics:

> providing *services*, it is located primarily within the context of the *welfare state*, it is seen as a *profession*, it is a *generalist* occupation, it is a *secular* occupation, and it involves the integration of *knowledge, skills and values*. (Ife, p. 4)

Social work has had three domains of action, namely social policy, welfare provision, and mental health services. Complementary to these characteristics and domains of social work, three themes can be located in its history, namely, caring care, refinement of practices, and paradigm shift. Whatever the work, social workers have consistently applied ideas of justice and sought to improve practice. New ways of working have emerged from time to time at the cost of relinquishment of past practices. These themes are evident in child and adolescent mental health services.

2.4.2   Social work and the child guidance movement

Work with families and children helped build the profession of social work (Addams, 1910/1966; Furlong & Smith, 1975; Luepnitz, 1988; Wood, 1966). Indeed, it is to these roots that contemporary Australian family therapists have gone to re-establish family therapy as a social work specialization (Furlong & Smith; Wood). Some of the motivation within the social work profession has been against the place allocated social workers within the first child guidance clinics (Furlong & Wood).

The shape of the referral and intake role was determined by a change in the purpose of child guidance following the identification of this need in 1909 by Healy (Horn, 1988). Originally, the interest of the American National Committee for Mental Hygiene in child and adolescent mental health services had been in the prevention of mental health problems through the treatment of delinquency, but such problems soon proved unresponsive to treatment. The attention of the psychiatrists and philanthropists, who designed the model programs in child guidance, turned to prevention of mental health problems in more amenable populations. The most important question at child guidance intake, therefore, concerned the likelihood of the child and the family to benefit from the therapy services offered.

Social workers, with child psychiatrists and psychologists were the professional staff of the child guidance clinics (Horn, 1989; Richardson, 1989). The role of psychiatry was in diagnosis and treatment. The role of psychology was with mental testing and treatment. The role of the social worker was with community liaison, parental support, and management of referral and intake processes. Differentiation of roles gave each profession the chance to build reputation and to constantly refine the practice base (Richardson) and document through publication.

However, an oral tradition in parent guidance developed whereby documentation of the work of parent consultation, liaison, and guidance seems not to have occurred. Rowntree (1994), in her review of literature concerning child-focused parent psychoanalytic psychotherapy, located Ferholt (1991) as the major contribution in the field at that time, even though, the parent guidance role in work with troubled children and their families was evident within American child guidance from its instigation, soon after World War One. One can only speculate as to why documentation of parent guidance did not occur, but the reasons are likely to be related to models of learning and of supervision in child psychoanalytic casework involving oral mentoring by experienced practitioners, who may not have been social workers. The experience in working with parents has been maintained in Britain at the Tavistock (Rustin, 1999, 2000; Tsiantis, Boethious, Hallerfors, Horne, & Tischler, 2000), but elsewhere has passed to other professions (Ferholt, 1991).

The professional place of social workers within child guidance, from which child and adolescent mental health services emerged, was formative of the task of the contemporary referral and intake worker in control of the intake process, research of the intake process, and in balancing immediate response with the instigation of long-term treatment strategies. Social work has contributed seven of the very important studies in the evaluation of intake to child and adolescent mental health and welfare services, chronologically, Feldman (1937), Inman (1956), Perlman, (1960), Ewalt et al. (1972), Hall (1974), Buckle (1980), and Sirles (1990). While five of these contributions concerned American child guidance, Hall looked at the reception function within British Social Services

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offices and Buckle overviewed the effects of the Seebohm reforms on the tasks of Social Services workers.

2.4.3   The themes in the history of social work

Reports of the new British Social Services Intake Teams, formed as recommended by Seebohm (1969), started appearing in the mid-1970s. At first, there was much enthusiasm for the new professional specialty (Gostick, 1976; Corrie, 1976; Gill & Boaden, 1976) and much effort went into the refinement of the emerging practices. But, with time, the sheer pace of work had made the Intake Teams difficult to run (Prodgers, 1979; Gostick & Scott, 1980). The Seebohm changes required the sorting of cases at the point of entry into those requiring long-term, short-term or brief response. This process was to be handled by the Intake Team and cases requiring shorter-term responses were to be effected by the Intake Team. According to Wardle (1991b), the new process was really a form of triage introduced to produce industrial change in the welfare sector.

The papers can be read as a series, going from enthusiasm to exhaustion, with the series stopping with the re-design of the system and the adoption of an alternate paradigm. It seems that documentation of their practice was more important to them than long-term research. Buckle (1980) tried to summarize what the whole project had achieved but there was little distillation of principles that might be applied elsewhere.

Paradigm replacement has been well documented in family therapy and with Freudian approaches to child guidance work. Burck (1978), in Britain, documented the shift from psychodynamic child guidance to family therapy. Family therapy has almost had to be re-invented in social work practice (Furlong & Smith, 1995; Wood, 1996). The expertise developed in parent guidance and referral and intake, which was not extensively documented, has had to be re-established without access to the past wisdom.

Furlong and Smith (1995) saw the professional structure in Australia as placing social workers lowest in the hierarchy (this was felt to be so by Royal Children's Hospital psychiatric social workers of the 1980s; Freestone, 1994). For these sorts of reasons, Australian social workers vacated the community liaison/intake worker space when family therapy and radical social work arrived in the mid-1970s (Furlong and Smith).

Caring care, refinement of practices, and paradigm replacement have characterized the history of social work. While the first theme has been a continuity of the profession, the tendency to replace one paradigm with the next has seen much effort put into refining one set of practices, only to be lost as new paradigm was pursued. The history of social work has been entwined with the history of child and adolescent mental health services.

2.5   Origins of child and adolescent mental health services

Nineteenth century publication on treatments of the child with mental health problems was rare, even though interest in childhood mental health problems arose not long after the establishment of the Medico-Psychological Association in 1841. Histories of the emergence of child psychiatry focus on the child guidance movement and Kanner's (1935) publication *Child psychiatry*. But Keir (1952) pointed to the British interest in human development and measurement from the 1870s, as the first source of the application of psychological methods and knowledge to childhood disorder, as then leading to the child guidance movement.

Child psychiatry was in the process of emerging as a discrete discipline just prior to 1900 (Wardle, 1991a). Wardle cited six factors as contributing to this emergence:

- "more positive and remedial approach to juvenile delinquency" (p.292) through the establishment of Children's Courts;

- universal compulsory education;

- clinics for multi-disciplinary response to children with psychiatrists and psychologists;

- the distinguishing of child and adolescent disorders from adult health problems;

- new ways of thinking about human functioning ("behavioural, psychodynamic, and psychobiological" (p.292)); and

- the application of scientific method and observation to children and their development.

The child guidance movement, however, was an effect of the first mental health consumer movement and the United States government's concern with juvenile delinquency. Over time, the specialist professions of psychologist, social worker, and child psychiatrist were developed within the child guidance movement. After the Second World War, mental health nurses were recruited to inpatient services and outpatient clinics. At the end of the twentieth century in Australia, the term child and adolescent mental health services has been adopted in most States to describe the work of a range of professions, including education consultants, speech pathologists, and occupational therapists (Fleming, 1998), who work in specialist teams and generically, providing a range of therapies with children, parents, families, and groups.

2.5.1   The mental hygiene movement, philanthropy, and the problem of delinquency

In 1909, the same year in which the National Committee for Mental Hygiene was launched, the First Presidential Meeting on childhood occurred and heard the presentation of Healy's research into juvenile delinquency. Two years earlier, Witmer had produced the first paper on clinical psychology practice with children. The coincidence of these events led the NCMH, under the particular influence of Meyer (Horn, 1989), to seek to prevent delinquency through the establishment of a clinical service. This clinical service had the same professional shape as Healy's research team with representation from medicine, child psychology, and social work.

Philanthropy was very important to the development of the child guidance movement by providing the funding that allowed for the development of expertise while protocols of response were being developed. Philanthropy had already made a great mark on health services in northeastern United Nations through the establishment of Johns Hopkins University and medical service (Richardson, 1989). This combination of research and practice became the model for other new institutions. The discovery of oil brought a new generation of entrepreneurs wishing to demonstrate their public virtues in ways previously done by industrialists. For example, the Harkness' Commonwealth Fund underwrote the child guidance movement demonstration projects.

2.5.2 From child guidance to child psychiatry

Initially demonstration child guidance projects were established (Horn, 1989). In the late 1920s, the program was widened across the United States and, finally, the programs became the responsibility of local government authorities (Horn).

The child guidance movement soon diverged from its aims as established by the NCMH. Expertise developed in helping children before they became delinquent, rather than after (Horn, 1989). Delinquency has remained a challenge for treatment agencies, worldwide. The original formulation of childhood disorders in terms of Meyer's psychobiological model became replaced with a broadly psychodynamic approach to childhood disorders by the early 1930s (Horn; Goldstein, 1973).

The professions were the other major beneficiaries of the philanthropists' funding (Richardson, 1989). As with Healy's (1909) research, roles were perceived for experts in disorders, educability, and social relations and physicians, child psychologists, and social workers filled the positions within the new child guidance clinics. With a secure funding base, these new professions could concentrate on building their skills, knowledge, and professional association (Richardson). In time, the profession of child psychiatry emerged and the specialty roles of referral and intake, community

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liaison, and parent work were established by social workers. The psychologist's role remained rather circumscribed to psychological testing within American child guidance, although in the United Kingdom the psychologist was involved a much wider range of interventions (Keir, 1952).

The Harkness' Commonwealth Fund supported international developments in Canada and at the Islington Child Guidance clinic, in London. As with many of the clinics established by philanthropy, these remain service-providing agencies, today. The first outpatient at the publicly-funded mental health clinic in London's Tavistock Square was a child in 1920 (Dicks, 1970). This clinic has grown into being one of the most significant child and adolescent mental health services in the world, the Tavistock Clinic.

Differences between Canadian and United States services were reported by Richardson (1989) with public control being a major difference. Similarly, in the United Kingdom, public-funding of child guidance produced a somewhat different shape to the child and adolescent mental health services. Of most importance was the division between community and hospital-based clinics, a division that still has psychologists and social workers having greater dominance in community settings than in the specialist hospital settings (Keir, 1952; Hersov, 1986).

Child psychiatry was announced as a new specialization by the publication of Kanner's *Child Psychiatry* in 1935. Later editions were produced in 1949, 1955, and 1973. Kanner was able to locate this specialty alongside biological psychiatry and in parallel with the expanding influence of Freudian thought in American psychiatry (Wardle, 1991b), it owed some debt to the Meyer's psychobiological approach. The medical director of American child guidance clinics was in a perfect position to build up the new specialty, although it was in hospital-based clinics that the profession of child psychiatry was built in Britain.

Among his many contributions, Kanner (1973) mapped out the history of child psychiatry. Wardle (1991b) provided an update on Kanner's historical view. For Wardle, innovation had been toward more complex and pro-active intervention. Mid-century "some professionals stopped doing things to and for their patients and started helping them to change themselves" (Wardle, p. 65). From the 1970s, "a shift of emphasis began, away from the search for problems, pathology, and negative factors in the patient and family, towards a search for assets and positive attributes to work with" (p. 66).

2.5.3   Child and adolescent mental health services in Victoria, Australia

Child guidance services began in Victoria in 1925 with the University of Melbourne clinic of Williams (1932, 1949; Lewis, 1988). In 1961, Dax documented the presence of the Children's Court Clinic, established in 1948, Travancore, the Observatory Clinic, both established in the early 1950s, and Bouverie Street Clinic, established in 1961. Bouverie has since become a centre for family therapy with Latrobe University, Travancore has merged with the Royal Children's Hospital mental health service, and the Observatory Clinic has become part of the Alfred child and adolescent mental health service. Little is known of the referral and intake practices of these services, beyond what was recorded from the memories of RCH psychiatric social workers (Freestone, 1994).

The annual report of the Alfred child and adolescent mental health services (Fleming, 1998) has provided a sound overview of contemporary practice in child and adolescent mental health in Victoria, Australia. Programs were described that have geographic responsibility with these clinical team services augmented by specialist programs in autism assessment, early intervention in psychosis, and educational adjustment. The report documented levels of referral, treatment, and outcome. The staff profile was presented. Clinic procedures were described, but referral and

intake was not described in detail. Beginning has been consistently overlooked in the reports of child and adolescent mental health practice, worldwide.

2.6   Triage agent as initial health consultant

The most widely documented practice of initial health consultancy is that of triage. Triage is the allocation of priority for access to treatment within an emergency medical service. Its origins were on the Napoleonic battlefield, where Jarrey, Napoleon's chief surgeon, instituted a means for getting the wounded, as quickly as possible, back to health and to the battle (Hinds, 1976). It is a common misunderstanding that triage has etymological roots in "tri" referring to three and meaning three categories for disposition of cases (Meredith, 1992). Makins (1994) located "try" as coming from the thirteenth century French word meaning sorting, "trier", with "-age" as a suffix referring to a process. Fredrickson (1988) translated triage as "sorting" (p. 11). Hinds' (1976, p. 33) preferred translation was "selecting".

According to Bracken (1998), three or four categories of response have usually been implemented in emergency departments. The original categories focused on the timeliness of response and distinguished non-urgent cases from urgent and emergent cases, that is emergency cases requiring immediate action. A fourth category has also been used, that of expectant cases, where the patient was expected to die. Bracken compared these with military classifications of expectant care, delayed care, minimal care and immediate care. As the term care was retained in both military and emergency department contexts, it would seem that the no care option of the Napoleonic battlefield has been discontinued.

The moral and ethical dilemmas a triage agent addresses in a medical emergency are complex. Triage involves a tension between accuracy of dispositional response and efficiency in the clearing of the emergency room waiting area. One solution has been to develop tight, objective criteria for

triaging, (Christopher, 1996) but subjective judgement has remained an important indicator of urgency and dangerousness (Cain, Waldrop, & Jones, 1996; Cole, 1997; Handysides, 1996). Waiting times are not just about efficiency and accuracy of triage criteria, as delays involve questions of staff availability, emergency department funding, and the allocation of funds for hospitals within overall government budgets. The availability and distribution of resources can be expected to affect the manner in which assistance is received most powerfully.

2.6.1   Triage for children

Thomas (1988), on the side of subjectivity and the establishment of paediatric triage as a speciality, provided a description of a paediatric emergency nurse triage assessment. Thomas concluded that "pediatric triage is a blend of good nursing assessment, careful consideration of the parent's observations and history, trust in 'gut reactions', and a focus on the *child* and not the *complaint"* (p.159).

When the principles of triage are applied to children, rather than adults, several sorts of difficulty arise, especially with respect to consent. Phillips, Rond, Kelly, and Swartz (1996) suggested new trauma triage criteria for children, to prevent under-triaging resulting from adult criteria. Children are different to adults in size, vital signs, metabolic imbalances, and developmental problems and impose medical constraints. Child abuse and neglect left specific markers and required psychosocial responses as well as medical ones. Interpersonal constraints of seeking parental permission, calming worried parents, and explaining procedures to children complicate the triage process, as well.

2.6.2 Psychiatric triage for adults and children

Triage has changed in its meaning in American adult psychiatry over recent decades with an ongoing tension between immediate medical management and the addressing of the context of care. In the 1970s, psychiatric triage (Muller, 1971) occurred at specialist inpatient units offering eclectic, short-term interventions and providing gateways to long-term actions. For Muller, there could not be a no-treatment option in psychiatry, as feedback to clients provided considerable psychosocial encouragement.

In 1980, Gerson and Bassuk argued for a "new evaluation approach for emergency psychiatric treatment" (p. 9) to replace severity and symptom based triage, with focus upon the context of care. Subsequently, Boren and Zeman (1985), Rosenzweig (1992), and Allen (1996) in contrast to Gerson and Bassuk's (1980) approach, which had placed assessment of psychosocial adaptation ahead of medical intervention. Boren and Zeman advocated for medical psychiatric triage with nearby location of liaison psychiatry services to emergency departments. Attention needed to be given to the immediate needs of the sufferer and to finding ways to make rapid effective communicative contact with potential patients.

Rosenzweig (1992) described cost-effective psychiatric triage. An executive approach to clearing the emergency department of psychiatric patients was advocated, following Boren and Zeman (1985). Rosenzweig described the processes of making contact and then handing on of patients as almost parallel to the formal triage process. The process was not simply sorting.

Allen (1996) argued that psychiatric emergencies should be met with "definitive treatment" (p. 247) as reducing symptom levels could minimize the social dislocating effects of psychiatric distress, thereby keeping the patient in touch with family and community supports. Evidence presented by Allen suggested that immediate drug treatment could reduce negative social effects.

Thus, efficiency in psychiatric triage would seem to have become more important over time and in tune with executive medical functioning. Even so, Handysides' (1996) presentation of psychiatric triage in the contemporary United States emergency department indicated that this specialty task of mental health nurses, changed the timeliness and focus of other triage activities, and involved intuition. Kevin (2002) presented a rural Australian view of telephone-based mental health triage, showing that context did change the way the triage task was enacted by non-medical staff, especially with respect to the dilemmas of subjectivity and objectivity.

Handysides discussed adult psychiatric triage in the same terms, but with two significant modifications. She highlighted a seated, relaxed, counseling-like location which encouraged the patient to talk with some expansiveness, and the conduct of a full Mental Status Examination rather than assessing vital signs.

Similarly, Kelley described the triage nurse's responsibilities when a child presented following child abuse and neglect (1998b) or sexual abuse (1998c). In such cases, the paediatric triage nurse needs to engage in psychosocial assessments using standard child and adolescent psychiatry methods, such as interviewing parents and obtaining drawings from children. Assessment of urgency may still be paramount with an at-risk child or adolescent, whether of abuse or suicide, but the means of assessment needs to slow events down and generally calm parents, child, and interested others.

Knox-Fischer (1998) described triage levels for paediatric psychiatric emergencies such as depression, suicidal behaviour, psychosis, and violence toward others or self, all where abuse was not the dominant concern, and mostly with reference to adolescents. Knox-Fischer addressed the roles and skills of the triage nurse, most of which were not about sorting or selecting. While, triage

criteria gauged level of urgency, the most important action seemed to be to get the presenting young person to a child psychiatrist.

The several nursing contributors to this literature endorsed triage as an occupational label. However, the action that is described as paediatric psychiatric triage has more in common with crisis counseling skills, with mental status evaluation skills and parent communication skills being very important. This literature would suggest, as a model, that the first health consultant contacted should listen, attend to context, and do very little sorting.

2.6.3   Remote location triage

There has arisen in the literature quite a lot of concern about the offering of telephone advice. Telephone advisors cannot see the ill person when a telephone call is made, and this has led to some strong warnings against offering advice on courses of emergency action over the telephone. Gobis (1997), a nurse attorney in the United States, saw much potential risk for the telephone consultant offering medical advice when the patient could not be seen.

However, Edmonds (1997) reported on five years' experience with a paediatric telephone advice line in an outer Melbourne, Victoria, hospital emergency department.

> Telephone triage nurses have to be able to communicate well both in writing and orally. They must have good interpersonal skills and be effective in public relations. They must have the ability to form rapport with the caller to obtain accurate, reliable information on which to base a plan of care … exposure to liability can be lessened if nurses communicate effectively and are made aware of the legal and professional limitations of this aspect of client care. Telephone triage is a function that will not go away and public enthusiasm is helping to make it an established part of the health-care system. (Coleman, 1997, p. 231)

All the issues associated with telephone advice and with the remote diagnosis of medical conditions apply, but in magnified form for the Australian Royal Flying Doctor Service (RFDS, 2004). The RFDS was established by Flynn in 1928 in Alice Springs and now provides Australia-wide coverage. The RFDS provides advice to remotely located persons with medical concerns for themselves, children, and employees.

The beginning of contact with the RFDS involves the determination of the need for the presence of a nurse or a doctor. In most cases, a concerned family member or co-worker, at a remote site, follows health practice advice. In situations of mental health crisis, the nurse does crisis line counseling or may have to visit to accompany the person to hospital. Parent guidance with behavioural problems has also been provided in a manner similar to other advice lines. For the RFDS, the idea of triage may be relevant in a small number of cases, but would be a substantial limit to the services needed by remote communities and travelers.

2.6.4   Comparison of triage and child and adolescent mental health referral and intake

Medical triage cannot be performed over the telephone, although advice can be given (Edmonds, 1997; Porter, Astacio, & Sobong, 1997; Robinson, Anderson, & Erpenbeck, 1997). Vital functions cannot be checked directly. Immediate intervention cannot occur except by the action, under instruction, of the caller. The triage professional is, therefore, not in charge. Attention has to be directed to the person's reports and state of mind, as the body is not visible. Intervention is through talking and aims for outcomes of reduced psychological distress and longer-term social support, rather than medical response, even when immediate bodily harm is at issue. Arguably, a psychiatric or psychosocial analogy of crisis intervention might be able to be performed over the telephone with a distressed person. Presumably, crisis telephone lines (Rosenfield, 1997) perform this function, but such intervention has more to do with counseling performed over time and may

not involve any consequent action. It may be a strong conclusion to make, but mental health triage of any kind cannot be performed over the telephone.

Freestone (1994), a mental health nurse, in an internal document for the Royal Children's Hospital, Melbourne, Australia, reviewed the intake and referral procedures of the newly integrated RCH Mental Health Services and the Health Department's Travancore services. The term triage was not used. She reported on practices from several services across Victoria and noted some similarities in the way child and adolescent mental health referral and intake clinicians aimed to impact case disposition, namely data collection, consultation, referral, networking, and supportive case transfer. Largely, referral and intake involved activities, which had been generated presumably from clinical good sense, in the absence of a research base, and involving minimal emphasis upon sorting. Decision-making about disposition was made in consultation with the appropriate clinical team leader. The report's major finding was for the establishment of a specialist, dedicated, telephone-based clinical referral and intake and information service.

The only mention of triage located within the social work opus, the largest single discipline source on child and adolescent mental health referral and intake, was when Meredith (1992) disputed the applicability of social triage, that is the loss of funding due to ineffectiveness in managing a social problem, to welfare resource distribution.

The triage agent has a specific set of duties in an emergency context. These duties are performed upon entry to the institution, but exist with a specific focus and brief time duration. The person seeking help has to trust to the triage agent's judgement. When the role has been adopted in other initial health consultancy contexts, the specificity of the triage duties has become less rigorous, the length of contact has been extended, the authority to act has been diminished, and the service receiver has been allowed much more discretion.

It emerges from the foregoing discussion that paediatric triage has many similarities with adult triage, but three major differences: the medical differences between adults and children, the decision-maker on behalf of the patient (child or adolescent) is not the patient (in nearly all cases), and the need to address the psychological consequences of trauma to a wider group of interested parties (the family). Psychiatric emergencies do not have a no-treatment option; presenting patients require, at least, a social response. Telephone triage is seen as legally more complicated, with the consumers of a telephone service less likely to want discrimination of service priorities than to be seeking advice and support.

Amid the steady re-definition of the triage role from battlefield to telephone adviser, many tasks of the telephone consultancy mental health intake worker have been articulated. The literature would suggest two key aspects of the role, namely recognition of the role as first contact, and the capacity to weigh options. The former of these aspects, which includes public relations and greeting, listening skill, knowledge of community resources and alternatives, the willingness to consult with others about key issues, knowledge of internal options for assistance and processes whereby such decisions are made (especially, computer loaded protocols and menus; Robinson et al., 1997; Simonian, 1996), is more likely to be recognized as belonging to the role of the receptionist. The evaluative, latter aspect is more commonly associated with a health professional. It appears from the literature that different clinical agencies have drawn different lines as to where administration becomes clinical work and whether the term triage applies to these duties.

Nevertheless, the term "triage" has traveled across nursing applications, along with the idea of making decisions at the beginning of contact with a patient (Handysides, 1996; Kelley, 1998a). There can be no doubt that triage has been part of the intellectual base of all trained nurses. Yet, the tasks of child and adolescent mental health referral and intake can be described without reference to triage (Freestone, 1994). Historical review and analysis of triage has suggested only

an occupational link between the term triage and nursing. By contrast, the term has had no occupational significance for social workers.

2.7   The professional role of the referral and intake worker within contemporary child and adolescent mental health services

The practices of child and adolescent mental health have been constructed within the contexts described above. Sometimes these practices have come from psychological theories like psychoanalysis, family therapy, or cognitive-behaviourism. Sometimes these practices have come from research projects concerning epidemiology, psychotherapy outcome, or sociology. Sometimes these practices have simply emerged from the common sense of those appointed to manage particular aspects of the overall work. Referral and intake have developed without documentation, and in response to all else that was happening, especially the needs of the referring parents and the availability of the telephone.

Social changes with respect to institutional care have caused changes in employments profiles and led to a large overlap of disciplinary responsibility and skill in recent times. The specialty of referral and intake as a dedicated role within child and adolescent mental health services emerged in Victoria during the early 1990s. But the documentation of the constitution the role, its enaction, and its effects are the subject of the empirical research to be reported in this thesis.

CHAPTER 3

ENTERING A CHILD AND ADOLESCENT MENTAL

HEALTH AGENCY

> The proud proponent [of psychoanalysis, treatment by persuasion, Christian Science and any number of other psychotherapeutic ideologies], having achieved success in the cases he mentions, implies, even when he does not say it, that his ideology is thus proved true, all others false. More detached observers, on the other hand, surveying the whole field tend, on logical grounds, to draw a very different conclusion. If such theoretically conflicting procedures, they reason, can lead to success, often even in similar cases, then therapeutic result is not a reliable guide to the validity of theory… At last the Dodo said, '*Everybody* has won and *all* must have prizes' (Carroll, 1865) ….
> (Rosenzweig, 1936, p. 412 & 415).

The parent's role within child and adolescent mental health services is multi-faceted. The several images of the parent within the field are discussed in this chapter from three sources of literature. Sociological researchers have documented the status changes upon entry to a program of personal change. Psychotherapy researchers have documented the methods for conducting programs of personal change. Various sources have documented the roles, capacities, and concerns of service users. However, a fourth potential source of information, research of the experience of making a referral and of receiving a referral, remains undocumented. This chapter presents entry as a task of the parent and the confusion that a lack of understanding of the parent's role produces in such agencies. The parent begins contact with a child and adolescent mental health agency.

3.1   The economics of service use and beginning

During the 1990s, with increased interest in evidence-based practice and economic evaluation of public service outcomes, there have been several attempts to quantify the costs and benefits of child mental health services and to re-design the way services are organized to both increase efficiency and to reduce inequity (Knapp, 1997; Bickman, Nurcombe, Townsend, Belle, Schut, & Karver, 1998).

When applied specifically to child and adolescent mental health services in Britain, economic evaluation, according to Knapp (1997) had to consider the questions of which treatment should be offered, under what conditions it should be applied, in which place, for whom and how it should occur. This required the development of new economic instruments and refined psychometric and outcome measures, as well as specification of treatments to allow measures to be applied across case and, thereby, to develop samples of sufficient size upon which quantitative research can be performed. Economic research required the existence of quality services and professionals committed to the process and the assumption that resources were indeed scarce. The focus upon outcome and efficiency met well with the push for empirically validated treatments (Barlow, 1996).

All government services involve the rationing of resources. Rationing, according to Kavanagh and Knapp (1995), can be a combination of rational, arbitrary, implicit, or covert distribution of resources. Meredith (1992) described rationing across government ministries, between programs, within agencies between the various services offered, and in the way professionals give emphasis to particular aspects of their overall job. Such potential for inequity has meant that, in mental health, strategies have been adopted to meet certain service priorities.

Efficiency through brevity and measured outcome, as advocated by health economists like Knapp (1997), was questioned by the *Consumer Reports* survey of psychotherapy consumers (Consumer

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reports, 1995; Seligman, 1995). Seligman and Barlow (1996) accepted the value derived from long-term psychotherapy by the surveyed consumers. In Australia, the social value of long-term access to publicly-available health insurance was emphasized by Halasz, Borenstein, Buchanan, Davis, Grant, Prager, Pring, and Prytula (1997; 1999), who criticized tightening of government health insurance program for mental health patients. Efficiency through brevity and measured outcome produced unmet needs.

The Australian government, in developing its overview of mental health policy that became the *National Mental Health Plan 2003-2008* (Department of Health and Ageing, 2003), sponsored research of unmet needs in psychiatry (Andrews & Henderson, 2000). Economists and bureaucrats contributed to the debate (Kessler, 2000; Rupp & Lapsley, 2000; Whiteford, 2000), with the overall conclusion that much more needed to be spent in order to avoid or prevent the costs of chronic mental illness. Getting the services to those in need through trained and accessible professionals was one of the proposed solutions. Areas of need identified were associated with social disadvantage within indigenous, remote, impoverished, and migrant communities. Prevention (Raphael, 2000a), early childhood psychiatry (Cottler, Reich, Rourke, Cunningham-Williams, & Compton, 2000), and child and adolescent psychiatry (Sawyer & Patton, 2000) were also considered to be areas of unmet need.

In the United States, Kataoka, Zhang, and Wells (2002) found that 21 per cent of the population of children and adolescents have mental health service needs, but only seven per cent of this population utilize such services. If this one in three access ratio applies to Australian children and adolescents, and the best estimate of need in Australia for these age groups was 19 per cent (Zubrick, Silburn, Gurrin, Teoh, Shepherd, Carlton, & Lawrence, 1995), then barriers are likely to prevent certain population groups from gaining access. Mooney (2002), another health economist, pointed to indigenous and rural Australians as likely to face barriers not encountered by others, especially in access to experienced, trained professionals.

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Mooney (2002) analyzed opportunities for increased efficiency in the Australian mental health system and argued that the emphasis upon improved treatment methods was unlikely to reduce the costs of mental health care. However, he located three areas for improved service delivery and stressed the importance of values and engagement in assigning mental health priorities. Mooney cited the study of Pescosolido, Gardner, and Lubell (1998) to demonstrate that, at the practice level, consideration of how an applicant presented, whether by choice, coercion, or "muddling through" (p.275), affected how well the services were used and thereby the outcomes gained. Mooney also looked to studies of doctor-patient relationships (Bensing, 1991; cited in Mooney) and to consumer participation in mental health decision-making (Bowl, 1996; cited in Mooney) as issues active at the time of presentation that would affect outcome. As an economist, he located the processes of beginning contact, and especially the attitudes toward services that service applicants brought with them, as affecting, up front, the distribution of mental health resources.

Mooney's (2002) argued that conventional evaluation practices based on outcome could effectively increase barriers to access. He proposed a model for economic reform of mental health services involved the setting of priorities for quality, accessible services and then adjusting efficiencies attendant to, but not disruptive of, the delivery of quality services. Details of access and beginning of contact have more than marginal implications for service effectiveness at the national level.

3.2   Entry: Socio-clinical perspectives

Commenting upon United States systems, Levinson and Astrachan (1976) described three regulatory tasks of what they called the entry system, that is the referral and intake procedures, namely, to receive and deal with the applicant population, to provide a link between the entering patient and the treatment system, and to serve, along with other boundary structures, as a link between the mental health centre and its communities. The management of the interface can lead

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to community connection or isolation from the community, and isolation has had dangerous consequences in the past. The walls of many public institutions have come down, but mental health services still screen applicants for appropriateness to use the services (Brown, 1993).

Levinson and Astrachan (1976) described the consequences of a mental health service not managing its external boundaries in a manner that promoted exchange with the community. They distinguished between "bringing in" and "letting in" and advocated a proactive stance to the various communities and citizens served by the centre. Levinson (1969) had earlier considered the lack of community connection through intake in community mental health sector, which he claimed accounted for the high rate of attrition of applicants, noting a search for 'good patients', extensiveness of diagnostic procedures, and mistrust and misunderstanding between applicants and staff.

3.2.1   Entry as policy

Reports of mental health service intake policy in the literature have been rare. Opinion has varied about the degree of openness of specialist services to referral and to the community. For instance, Rooney and Miller (1955), commenting on the situation in the United States, were community oriented:

> It is in the operation of the intake policy that we view the prime relationships of the clinic, for this intake policy determines the relationship of the prospective individual patient to the clinic, orients the allied professional groups such as health and social agencies, clergy, schools, etc., to the functioning of the clinic, and defines for the lay community the role of the clinic as one specialized facility within the community's total resources. (Rooney & Miller, 1955, p. 392)

For Anderson and Dean (1956), the key intake policy question concerned the appropriateness of applicants to receive service. They demonstrated that problems referred to the Los Angeles child guidance service with specific descriptions (for example, thumb sucking or enuresis) were easier to treat than problems described in generalities (for example, unhappy, bossy, insecure). Anderson and Dean (1956) concluded that as only one fifth of the applicants were appropriate, as a matter of intake policy, there needed to be screening of all referrals.

By contrast, Gordon (1965) asked if the right patients were being selected by child guidance intake. He used several sources to demonstrate that "agencies with the most qualified workers also tend to 'discover' the most 'unmotivated' clients and the most 'clients who are not yet ready for service'" (p. 134). Gordon listed further problems:

1. child guidance clinics see only a small proportion of the children who need help (perhaps, 5 per cent, if that many),

2. that the decision as to who is to become a patient is often arbitrary, and

3. that a great many of the patients 'handpicked' by the clinic do not complete treatment. (p. 134)

Gordon's (1965) views fit well with Levinson's (1969) conclusions about the search for good patients. Too often, intake policies meant that those in most need would not be seen, in part because of "patient resistance and alienation nurtured by such policies" (p. 134), demonstrated in attrition rates. Levinson, Merrifield, and Berg (1967) had noted that there were rules for selection of applicants, but no rules for rejection, just waiting at several points in the acceptance process that meant that many applicants, sooner or later, excluded themselves.

Levinson (1969) identified exclusionary referral and intake policy as:

one of the major failures of the mental health system as a whole. The sources of this failure are manifold: rivalries between agencies and disciplines; deficiencies of leadership;

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inadequate understanding of mental health as a community problem; and commitment to

short-term professional and organizational vested interest rather than to meeting societal

needs. (p. 91)

Levinson (1969) regarded exclusionary policy as a scandal. He observed with respect to United

States community mental health programs:

There are few unreluctant seekers of help. In most applicants the personal suffering and the

wish for help are counterbalanced by various opposing forces: fears of the psychiatrist; fears

of actually being 'crazy' and of being stigmatised by others as 'crazy'; coercive pressures,

direct or indirect, exerted by family, employer, or social authorities; preference for certain

kinds of help and aversion to other treatment modalities. (p. 89, 90)

For Levinson, the pragmatics of policy enaction, selected out applicants in need. By contrast,

Silverman (1970), who interviewed both applicants and intake workers at a United States

community mental health centre, found that lack of understanding of the purpose of mental health

assistance filtered access to services.

Lefebvre, Sommerauer, Cohen, Waldron, and Perry commented "Intake policies and the benefits or

drawbacks of the waiting list system have been highly controversial issues during the past twenty

years" (1983, p. 387), but their references suggested the debates occurred mostly within Canada.

Family therapists have been alive to the negative effects of intake policy, even when cases were

accepted. Stierlin, Ricker-Emboden, Wetzel, and Wirsching (1980; cited in Shaw, 1992), in

Germany, and Gurman (1981; cited in Shaw) and Nichols (1988; cited in Shaw), in the United

States, (cited in Shaw), noted that some administrative procedures set up the family to believe that a

symptomatic family member was the problem. On the other hand, Street, Downey and Brazier

(1991) in Britain noted the insistence on family attendance did deter some families from attending.

Gray and Perry (1986) reported on an Australian family therapy team innovation for the positive

recruitment of families. An open day strategy provided means for access and for the enacting of initial case processing without focusing upon a particular child as the problem.

It is apparent from the scant research that referral and intake policy, whether by explicit inclusion or exclusion criteria, or by subtle processes of selection, affects different applicants for service differently.

3.2.2   Entry as status changing

Intake provides a connection with the community that a citizen can make. The institution has a physical presence and location, but the institution may or not have a recognized place in the life of the community (Weissman, Epstein, & Savage, 1983). Entering a building is just one aspect of gaining assistance. Studies by Germain (1978) and Seabury (1971) showed that architecture and formal appointments of the welfare office deterred adolescents and other clients from seeking help, as entering implied acceptance of the regulated purposes.

Some sociological studies of adult psychiatric hospitalization have focused upon life on wards (Caudill, 1958; Stanton & Schwartz, 1954) and, in one study, the difficulties of getting free from the ward and from diagnoses (Rosenhan, 1973). Documentation of the actual processes of admission has been conducted in the United States, but in only a small number of studies (Brown, 1993; Levinson & Astrachan, 1976; Levinson et al., 1967; Pescosolido et al., 1998).

While Goffman (1961) did not map the actual process of admission, he did examine the changes to identity that occurred with adult admission to a mental hospital, considering the career of being mentally ill, survival within the institution, and the contradictory role of superintendent as custodian and treater. He demonstrated that in the lead up to admission, certain patient behaviours had come to be interpreted by family and associates as indicative of mental disturbance, and that

presentation for admission involved the family convincing the patient of the value of admission. Goffman was not arguing that the person was not mentally ill. Rather, he considered that the disturbances of behaviour that might be attributable to illness were indistinguishable from the effects upon the patient of the interpersonal behaviour of the family that was intended to convince the patient of their illness. Once inside the hospital, ward life was designed to confirm the status of the illness. Largely, Goffman studied processes of perpetuation of diagnosis.

Levinson et al. (1967) studied experience of entry to a community adult mental health clinic and found three different types of applicant, namely, those that sought diagnosis, those that sought relief from distress, and those that sought psychotherapy. They proposed that selection of patients at the community mental health centre was actually a process of negotiated consensus, which was heavily weighted in favour of the psychotherapy-seeking patient who could tolerate delays. Applicants presenting with more immediate or other concerns ended up in other services or with no assistance at all. Entry was an active process for the applicant, but was structured to select a certain sort of applicant.

Brown's (1993) study of community mental health intake, where entry was likened to a detective mystery narrative, suggested that entry has become more complex, with stigmatization remaining an issue. Perceptions of stigma have been shown to deter applicancy (Leaf, Bruce, Tischler, & Holzer, 1987; Stefl & Prosperi, 1985) among adults. However, the actual practices of entry were not found to cause the status change, but rather it was the act of gaining entry to the institution that caused the acquiring of the institution's definitions (Brown). Hence, this is a sociological effect disguised as procedure.

Pescosolido et al. (1998) studied the experience of first time adult entrants to the community mental health system. They were able to distinguish among applicants for service, three different positions of approach, namely choice, coercion, and 'muddling through' (p. 275). Service satisfaction and

perceived ease of delivery was different for applicants of the three types with those who chose being the most positive and those who were coerced by family, friends, or professionals the most negative. Those who muddled through did so from a position of need and lack of knowledge about how to get the need met, and some ambivalence about the receiving of service from a mental health institution. Pescosolido et al. argued that evaluation of service delivery outcomes could not be equated across these three applicant types, as the perceived barriers to receiving quality service were very different. Clearly, greater resources would be needed to achieve effective service outcomes for someone who was mentally ill and feeling coerced to attend.

The changes of status attendant on entry are mediated by degree of choice, perceptions of those in the person's immediate context, and goal in help-seeking.

3.2.3 Entry as placebo

Entry into a mental health treatment agency has demonstrable effects upon status as a person and as a citizen. In Goffman's (1968) terms, the patient's identity as a person can be spoiled by induction and the patient may perceive this despoliation. But an alternative, perhaps parallel, construction can be placed upon entry. An act of trust is involved, whereby the patient places faith in the healing powers of the consulted professional and expects to be healed. Such trust or expectancy has been studied in various healing contexts, and demonstrated to have positive, and sometimes curative, effects. This is the literature of the placebo effect.

Placebo effects have a long history. Western anthropologists have studied Shamanism in many parts of the world (Frank & Frank, 1991) and found surprising therapeutic effects in the application of the unseen tricks of a very tricky trade (Levi-Strauss, 1962/1966). The same effects have been demonstrated in connection with the therapeutic practices of Western medical doctors. Beecher

(1955) wrote of "the powerful placebo" (p. 1602), its prevalence, and its effects on medical intervention.

The term placebo derives from the Latin "I shall please" (Makins, 1994) and includes flattery as part within its semantics (de Deguileville Guillaume in 1426; cited in Macmillan, 1996). Shapiro and Shapiro (1997) defined the placebo effect as "the nonspecific, psychological, or psychophysiologic therapeutic effect produced by a placebo or the effect of spontaneous improvement attributed to the placebo" (p. 12). The effect might be positive or negative, and that the active part of the placebo could be the chemical or the procedure by which the chemical was received in the body, or the perception that the chemical or procedure produced.

Shapiro and Shapiro (1997) observed that the placebo effect was widely manifest. Studies cited by Shapiro and Shapiro placed the range of measurement of the placebo effect between 25 to 65 per cent in any treatment. The effect was in the deemed authority of the treater, the treater's communicative capacities, and the enacting of a ritual of healing (Shapiro, 1971). Rituals included physical examination, writing of a prescription, provision of little white pills, and referral to psychotherapy. Surgery had marked placebo effects in a range of ailments, but the ethics involved with respect to sham incisions has precluded double-blind experimentation. Drugs were one of the few therapeutic aids that had been systematically tested for their efficacy above and beyond the placebo effect, because of the development of double blind testing. However, even within this process, patients, treaters, and family and friends were likely to actually guess whether the person was on the therapeutic agent at a rate near 70 per cent (Shapiro & Shapiro). Such guesses were indicated by improvement in the condition and by the presence of side effects, some of which were manifested well before the therapeutic effect was manifested.

Shapiro and Shapiro (1997) were willing to conclude that psychotherapy was almost wholly placebo, in that entering therapy designed to remove symptoms or enhance wellbeing produces the

desired outcome, irrespective of technique. Frank (Frank & Frank, 1991) first suggested in 1959 that psychotherapeutic healing might be a placebo effect, or an effect of one sufficiently integrated compassionate personality interacting with another, with an agreed purpose to do with the psychological state of the consultee. Experimentation is simply not possible in psychotherapy and comparisons between psychotherapy methods have not revealed any signs that one particular method has superiority over another. A conclusion can be drawn that would not please many academic clinicians or their students, as they struggle to teach or to master the complexities of a therapeutic approach, but it is a possibility. Put simply, attending for a period of time will give clients symptom relief, irrespective of the approach or capacity of the therapist.

White, Tursky, and Schwartz (1985) gathered together most of the contributors to research on placebos over the previous 25 years (psychoanalysts, behaviour therapists, sociologists, anthropologists, and biomedical researchers) to provide a forum for the elucidation of the central issues. Definitional problems were rife (Grunbaum, 1985; Brody, 1985; Borkovec, 1985), many perspectives were displayed, but no consensus was reached. Twelve years later two conferences attempted to build on White et al.'s findings, but the conclusions concerning the placebo effect were similarly indefinite.

Fisher and Greenberg (1997), with colleagues, unsuccessfully attempted to establish the biomedicine of the placebo effect. Harrington (1997) located a conceptual problem, with placebo at the 'crossroads' between the research strategies used in determining meaning ("cultural or hermeneutic sciences"; p.7) and those research strategies used in determining mechanism ("so-called natural sciences"; p. 8). Both Fisher and Greenberg and their contributors, and Harrington and many of her contributors, were looking for the placebo effect as an outcome. Harrington observed that the effect has always been described as an effect of process, even if estimates of the effect size have been made, and that qualitative research methods were better adapted to the study of processes.

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The colleagues of Harrington (1997) discussed "that healing happens when we tell a story" (p. 229). No doubt, there are potent discursive practices manifested in any consultation, but perhaps it is the discourse with others before consultation that is more important, or perhaps the placebo effect flows, even more simply, from getting one's feet to move toward the consultation suite.

If the placebo effect occurs intrinsically with the process of consultation, it is straightforward to presume it is operative, as did Fish (1972; cited in Pentony, 1980). If the placebo effect is an effect of entry into a treatment program, the differences between the sociologically observed effects of identity despoliation upon entry into mental health services, and the treatment effects of placebo, become differences of emphasis rather than of kind. That is, entry into treatment involves changes of status, and these changes can be perceived positively or negatively by the person and by the society. The subsequent impacts upon the person would be determined by the net effect of these perceptions. In this context, the policy and practices of referral and intake are highly relevant.

3.2.4 Entry via receptionist

Hall's (1974) ethnographic study of receptionists in four different British Social Services offices in 1969 described the context dependence of welfare service reception work. Reception is a different role from intake, but, for each of the five receptionists, context shaped their work role and the priorities of their work tasks. In fact, in most of these circumstances, the duties of receptionist were considered so obvious, within the context, as to not require a documented job description.

Hall (1974) demonstrated that there were many ways to arrange the positioning of the receptionist within the physical space of a British welfare office. Hall's receptionists were able, by virtue of office geography, to exert control over casework contacts and the distribution of professional resources. Whether such influences continue into the clinical room and over time needs to be

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researched, but Hall has provided a view of the complexity of influence that front of house functions can have.

Shaw's (1992) list of receptionist tasks at an Australian family welfare and therapy service corresponded to the tasks described by Hall (1974), namely, being the public face of the agency, by greeting, listening, and transferring calls, administrative tasks, such as typing, mail and petty cash, and some duties related to client registration, such as provision of information to referrers and clients, explaining procedures, and receiving basic information. An attitude of welcoming, rather than gatekeeping was advocated and skill and discretion were required. The potential, ambivalent client was to be encouraged to continue contact, not by exhortation, but by thoughtful listening and pleasantness. This study, published in 1992, is the only account of a formal training program for welfare agency receptionists.

Consumer research (Spink, 1998a, 1998b) noted the potential for adverse and for helpful influence of receptionists upon parents. Parents enter services where the social juxtaposition of waiting room, receptionist, and clinician has been set. Similarly, the relationships between receptionists, intake workers, and clinicians have been defined geographically, organizationally, and interpersonally. These pre-existing conditions of clinic life shape the quality of the beginning of clinical contact.

Clinic managers and clinician researchers have tried many strategies to make mental health services more accessible and efficient, many of these are reported in Chapters 4 and 5. In the United States, several models as to how best to fund and run child and adolescent health services have been proposed over the last two decades (Bruns, Burchard, & Yoe, 1995; Burns, Goldman, Faw, & Burchard, 1999; Paccione-Dyszewski, 2002; Roberts, 1994). Friedman and Street's (1985) advocacy for a continuum of care, led to the establishment of the Fort Bragg Demonstration project (Bickman, Guthrie, Foster, Lambert, Summerfelt, Breda, & Heflinger, 1995; Bickman, 1996a,

1996b, 1996c). The project had a single point of intake, but this was not evaluated and, subsequently, questions have arisen as a result of these innovative measures about how to design the point of first contact (Bickman, Karver, & Schut, 1997; Mordock, 1997a, 1997b). The way the first point of contact relates to other areas of an organization affects how resources are distributed internally and with respect to the various clinical services.

3.3   Entry: The missing element in psychotherapy research

Two major criticisms of the Fort Bragg Demonstration program were the lack of research of the effects of the intake system and the lack of control over the therapeutic models applied by the therapists. The need to get the project up and going meant the rapid employing of many professionals from diverse disciplines, often young, inexperienced practitioners. Supervisors were intended to provide quality control of treatment. The range of potential treatments with diverse models of treatment within such a large program was expected to accommodate variations in effectiveness. This approach was in marked contrast to other projects where psychotherapy has been studied over the past two decades. Much psychotherapy research has focussed upon efficient implementation of therapy with measurable outcomes.

3.3.1   Contemporary child and adolescent psychotherapy research

For much of the modern history of medicine, therapy has meant active treatment of diagnosed clinical entities with specific means of intervention for specific, intended outcomes and, usually, with known side effects. The practice of medicine has transformed the word from accompaniment in distress (Makins, 1994) to targeted outcome. Such usage makes little distinction between drug treatments or psychological treatments, and little distinction between treatments that involve cure, or aim merely to secure maintenance of health status, or aim to palliate. All are therapies.

In contemporary usage, the term therapy implies a process leading to measurable outcomes. The value of being with the patient is not recognized, if symptomatic change is not effected. In other words, the purpose of therapy is outcome rather than understanding, but Kazdin (2003) called such an emphasis a weakness of current research practice. This is the distinction between the Baconian conception of science as control as against the Aristotelian idea of contemplative science (Smith, 1992), that was a central focus of Chapter 1.

Along with the distinction of personal contemplation from measured outcome goes a disenfranchisement of many therapists as researchers. Elliott (1998) distinguished between behaviourally-oriented therapists and interpersonal therapists. The former group includes cognitive therapists and biofeedback therapists who Elliott believed have the primary aim of removing symptoms. The latter group is far more diverse and includes Rogerians, psychoanalysts, Gestaltists, and many other practitioners who believe that therapy is process-based, relational, and emergent. The interpersonal therapist certainly wants to remove symptoms, but as part of a process of personality change and personal understanding. This is a much less precise therapy goal and is likely to include aspects that could never have been predicted beforehand.

The therapy debates have been almost silent on referral and intake. The only places where conditions of entry are rigorously observed are in those clinics conducting controlled research. Such rigour has been used to make sure only committed clients with single and clear diagnoses are treated. This sort of approach configures the referral and intake process as a client screen. There is clearly much more to referral and intake in actual clinical practice, and the expectancies and other effects established as the beginning of therapy is negotiated, deserve serious exploration.

Schools of thought about psychotherapy research were brought together in a 1998 edition of the international, refereed journal *Psychotherapy Research*, to debate the value of empirically validated or empirically supported treatments (EVTs or ESTs). All of the cognitive-behavioural contributors

supported the development of manualised treatments that met the American Psychological Association's criteria for EVTs. Among the psychodynamic and humanist contributors, there were three positions presented: relational therapies can be EST, relational therapies cannot be and should not try to be EST, and relational therapy research is better directed to process rather than outcome and diagnosis. The EVT debate continues, and as Kazdin (2003) observed, a focus on outcome and technique limits the scope of psychotherapy research, even if exemplary treatments can be identified.

Kazdin (2003) provided an update on the map for the development of research in child and adolescent psychotherapy, first articulated with Kendall (Kazdin & Kendall, 1998). The map was refined by Kazdin in 1999 and in 2000, when he identified the two phases of psychotherapy research that preceded his proposed research agenda.

Actually, there had been a phase of research that preceded Kazdin's (2000) designated phases. This is the phase of model development, which was characterized by the publication of case study reports. Case studies (Breuer & Freud, 1895/1974; Kaffman, 1987; Watson & Rayner, 1920) have been vital in the development of technique and in the training of practitioners, yet quite often are not considered to constitute legitimate research.

Kazdin's (2000) first phase was instigated by Eysenck's (1952) review of outcome reports of psychoanalysis, which involved 52 published case studies. Paul (1967; cited in Kazdin, 2000) instigated the second phase, with investigations of what works with whom (Seligman, 1994; Roth & Fonagy, 1996; Fonagy, Target, Cottrell, Phillips, & Katz, 2002). Kazdin (2003) asserted that although generative of much study, involving 550 forms of therapy and 200 DSM-IV (American Psychiatric Association (APA), 2004) disorders, this research approach would involve an inordinate amount of time and would prevent clients from getting the help they greatly need in a timely way. Further, "[t]he question [what works with whom] is crassly empirical, with no explicit

effort to understand how and why therapy works and how and why some factors influence outcome" (p. 830). Consequently, research has focused upon symptom removal, with little focus on covariates or factors that mobilize change.

An alternate summary of psychotherapy research was provided by Lambert (1993), who documented four sources of effect or change. Extratherapeutic effects, those factors that promote adjustment within the person and within the environment, accounted for 40 per cent of client change. Expectancy effects, also called placebo effects, were estimated to account for 15 per cent of the change. Specific techniques were credited with 15 per cent of the effect. Finally, factors common to all psychotherapies accounted for 40 per cent of the change. This last category included empathy, support, acceptance and many other characteristics of sound clinical practice that related to the therapist, the venue, and the arrangements of the therapy. Lambert's pie chart of change was not intended to be definitive, but rather indicative of the relative strength of influences and downplayed the role of specific techniques. Kazdin and Kendall (1998; Kazdin, 2000, 2003) attempted to shift the research agenda to Lambert's 85 per cent of non-technique influences in psychotherapy.

Kazdin (2003) was clear that child and adolescent mental health practice should be evidence based. However, like Seligman (1995), he observed the difficulties of transferring academic laboratory clinic based research to community clinic settings. University clinic based research, with great capacity to recruit committed parents and children with pure syndromes, has demonstrated that treatment can be efficacious, while studies of treatment in the field show no positive effect. Kazdin (2000) described the reasons for this situation, mostly in terms of the less than optimal conditions in community clinics with respect to control of relevant variables, and the prevalence in field settings of psychodynamic clinicians.

Kazdin (2003) suggested that there might be a small number of mechanisms of change that would be likely to include rehearsal and practice of behaviour or thought, catharsis, and the "mobilization of hope" (p. 264). It was surprising that Kazdin noted catharsis as capable of alleviating "symptoms through expression and release" (p. 264). Even more surprising was the inclusion of hope as a change principle. Neither hope nor catharsis was credited as having been empirically validated.

Kazdin has been among a group of child psychology researchers (Weisz & Weiss, 1991; Weisz, Weiss, & Donenberg, 1992; Durlak, Wells, Cotton, & Johnson, 1995; Kovacs & Lohr, 1995; Krahn, Hohn, & Kime, 1995; Weisz & Jensen, 2001) who have sounded their dissatisfaction with child and adolescent psychotherapy research in the past decade. These researchers have advocated that research should be overall more inclusive with particular emphasis on parental and developmental effects, and should embrace a wider range of research methods including case study and qualitative interviewing. The dissatisfaction extended to disenchantment with the militancy often-expressed in debates about therapy models.

Kazdin (2003) described an overall plan for child and adolescent psychotherapy research that involved six steps for the development of effective treatments:

- Theory and research on the nature of the clinical dysfunction;
- Theory and research on the change processes and mechanisms of treatment;
- Specification of treatment;
- Tests of treatment outcome;
- Tests of moderators; and
- Tests of generalization and applicability (p. 265).

It is important to note that boundary conditions were re-classified by Kazdin (2000), and re-located (2003) among the moderator variables.

The size of the change achieved by psychotherapy has never been documented as particularly large (Kazdin, 2003). While differences between models have been difficult to detect, even if studies have shown that some therapy is better than no therapy (Weisz et al., 1992), the commonalities concerning mechanisms of change remain strong and the search continues. But the most common feature has not been highlighted, namely, that therapy begins.

3.3.2   Efficacy versus effectiveness: The consumer's view

The ground of the psychotherapy research debate changed with the publication of the results of a consumer survey of therapy clients (Consumer reports, 1995; Seligman, 1995), although the findings of the survey took more than three years to be registered as significant. They were not mentioned in the special 1998 edition of *Psychotherapy Research* discussed above. By 2003, Kazdin was quoting Seligman and the *Consumer reports* articles, to draw the distinction between therapeutic efficacy (in academic settings) and therapeutic effectiveness (in clinical field settings).

Seligman (1995) joined the consultants' panel for the survey of adult psychotherapy consumers by *Consumer Reports* because of his work entitled *What works and what doesn't* (1994), which was critical of the minimally documented efficacy of most relational therapies. Seligman made an important concession regarding the value of long-term psychotherapy, and its capacity to produce emergent effects, by distinguishing between efficacy and effectiveness. He observed that most outcome research in psychotherapy concentrated on efficacy and this demonstrated that brief therapies were superior to longer term ones. Yet, the *Consumer Reports* survey respondents were clear that the more therapy the respondents had, the better they felt they were. Longer-term therapy was more effective from the consumer point of view. Outcome research had largely concentrated on efficiency of symptom relief, rather than on the value of more fundamental changes experienced by consumers. Seligman concluded that previous research designs had obscured a range of effects

valued by the consumers, especially, unexpected changes and changes beyond immediate symptom relief, that can sustain symptom relief.

Evidence-based efficacy research within university clinics provides the practitioners with the belief that therapeutic changes are direct effects of practitioners' efforts. Evidence-based practice is based upon edifice-based evidence. That is, if change occurs and a particular approach or set of techniques was applied, then it is likely that the person who presents the research will locate the cause of change within the approach or techniques.

However, it is clients who attend and clients who change. Techniques and approaches may facilitate change, but may not be the causative factor. Similarly, it is clients who discontinue and this may have little to do with the quality or model of the therapy offered. Patient satisfaction with longer-term therapy reflects not just effectiveness, but also patient involvement in the process. If this is so, the way therapy is initiated may set up the parameters of effectiveness, and most of the initiating events occur before therapy starts and outside of the influence of the therapist.

There are many clinicians who have commented upon the value of successful beginning. Console, an American psychiatrist and psychoanalyst, made first sessions a professional specialty. In *The therapeutic encounter* (Console, Simons, & Rubinstein, 1993) the importance of everything that occurred in and before the first session has been closely observed. Michaels and Sevitt (1978) discussed these same issues in adult psychotherapy and Coleman, Short, and Hirschberg (1948) in child psychotherapy.

Haley's (1975) *Problem solving therapy* was premised upon not doing what has failed to resolve the problem in the past. By this means, a line could be drawn across the past and a new beginning could occur. For Talmon (1990; Budman, Hoyt, & Friedman, 1992) each single session is an

opportunity to bring forth issues and have the clients attempt to resolve them. Each session has a new beginning with the details of the beginning important for the whole session.

These four different practitioners found that brief contact was sufficient for the patient to begin the work of change, without subsequent contact. But brief is not necessarily better, as Console and Winnicott (1971) remained long-term therapists, even while they valued brief and timely intervention. The thing that is common between all is that they knew of the value of sound beginning.

The simple importance of beginning has not been considered in psychotherapy research. Researchers have had preoccupations, such as with mechanism and not meaning, or with meaning and not mechanism, and including militant attitudes to other therapy models, that have precluded examination of beginnings. The importance of boundary conditions had been highlighted by Kazdin and Kendall (1998), but in Kazdin's (2003) revision of the child psychotherapy research agenda, beginning was only a moderator variable. Evidence for the influence of the beginnings needs to be sought in other places.

Clinic-based psychosocial research on referral and intake processes has been sporadic, even though it was identified as an important issue during the early period of the American child guidance movement (Feldman, 1937). Similarly, research of contact discontinuance has been frequently reported but has been inconclusive as to the causes and meaning of the discontinuance.

3.3.3   The beginning of referral and intake research

Of the few studies of referral and intake procedures at a child and adolescent mental health service, possibly the very first, that of Feldman (1937), remains one of the most instructive. Feldman

revealed that clinic procedures, including intake, were implicated in attrition from child guidance treatment. Systematic analysis by Feldman (1937) of 45 "resistive" cases (30 boys; 15 girls) was conducted.

Feldman (1937) offered the conclusion that those who declined treatment were "emotionally deprived children who were kept from making use of the clinic largely by factors within their own or their parents' personalities" (p. 98). In the end, for Feldman, discontinuance was an effect of a child or parent problem, but other factors were implicated. For instance, the fit between agency and family was poor in nearly all these cases. Importantly, too, some caseworkers were all too willing to blame themselves for the discontinuance, as Pekarik (1985a) later found. Most of these issues, however, pre-existed the current referral as agency characteristics or family characteristics. The coming together of family and agency had provided an opportunity for change that was ultimately resisted. It was not clear if the agency policy caused such poor agency-client fit. All these factors were present upon entry.

3.4   Images of the parent and the significance of entry

To enter a child and adolescent mental health service, a parent of good will needs to make a referral, take the child to the service, and actively participate in the service provided. However, parents may be diffident about seeking help or for some reason limited in their capacity to parent. Further, the parents' capacity to participate in and cooperate with assessment and treatment may influence the capacity of a child to be assisted.

The commonplace definition of parent within the child and adolescent mental health clinic is that the parent comes with the child with the problem, but this is inadequate and misleading. In the clinic, the term parent coincides with the terms referrer, transporter, cause of the child problems, and part of the means to recovery. Rarely is the parent considered a person, and no reference has

been found in the relevant literature to the parent as citizen. Integration of these many images of the parent might be possible if the parent is seen as a person, who needs greeting as a citizen, but who needs professional understanding of the multi-level problems confronted daily, and may be compromised by a lack of information, illness, or his or her own childhood experiences.

Many images of the parent of a child with mental health needs are presented in this chapter. The images are often in conflict and this seems not to have been recognized by clinicians, parents, or in published literature. The parent is a social position upon which is projected a particular conception of special interest groups or lone persons. This projection is apparently presumed to be so obvious that the existence of other potential images is precluded.

One image is of the information deficient parent. Parenting books and other information services exist because parents feel in need of the supplied information. The parent is ignorant but curious, defective but capable of learning, and self-sufficient but in need of support. The image has been serviced in several ways (Gold & Eisen, 1994; Green, 1984). Professional parent guidance consultation goes back to Adler (Dreikurs, 1964). Apart from mental health clinics and books, parenting information can be sourced from self-help groups, professional associations, and government departments and services, most of which are available on websites.

Another image is of the unwell parent in need of assistance with a troublesome child. Indeed, as discussed in Section 2. of Chapter 2, there have been sustained research programs that have linked reduced parental wellbeing with referral of child behavioural problems (Bailey & Garralda, 1989; Boyle & Pickles, 1997a, 1997b; Brody & Forehand, 1986; Chi & Hinshaw, 2001; Graham, 1985; Jensen, Bloedau, Degroot, Ussery, & Harry Davis, 1990; Richters, 1992; Wolpert and Fredman (1994, 1996). There has also been much research on children of parents with mental illness (Cowling, 1999, 2004).

Research is dominated by a clinician's eye view of the parent and this narrows the options of a referring parent to a rational committedness, that may not be available to most referring parents. This section explores images of the parent from the beginnings of child guidance and as represented in disparaging metaphors, as mental health consumers, and as ambivalent persons with troubling children.

3.4.1   Early American child guidance clinics and the parent

In early American child guidance, the primary focus of the work was the child. Parents, and the processes of getting children into treatment, were given secondary or incidental attention. According to Horn (1989), parents were regarded both as the cause of a child's problem and as responsible for taking all possible action, including referral, to correct the problem. The terms "cause" and "correct", as used by Horn, underlined the judgements that parents would have felt as they began contact with a child guidance clinic. The place of parents in the various subsequent forms of child and adolescent mental health services has been coloured by this mixture of blame and judgement, and the expectation of responsible action toward the child's recovery.

3.4.2   Metaphors of disparagement and blame in child and adolescent mental health

The place of parents within child and adolescent mental health services is multi-faceted, but not easily described. This descriptive problem exists from before the time when a referral is received at a service, as some or all of the family, family doctors, schoolteachers, or welfare agents might be concerned about the mental health of a child. Pragmatically, professionals may not have felt the need to define what a parent is because, in their work, the parent is the automatically located in terms of the registered child client. However, the multiplicity of potential views of what a parent or mental health service user is, permits descriptions that could distort the relationships between publicly employed professionals and a service-seeking

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member of the public. Descriptions of mental health service users have suggested ambivalence among clinicians about the status of service users. Commentary in this area has largely sprung from research concerning those people who do not continue with clinician-recommended clinical regimes.

The following analysis of metaphors demonstrates how the subjects, parents and their children as persons, are removed from the phenomenon under study. The relatively new research strategy known as discourse or text analysis (Pennebaker, Mehl, & Neiderhoffer, 2003; Smith, 1976) can be applied to the way categories of person are described. Naming as a privilege (Smith, 1990) comes with the capacity to hide the subject behind another phenomenon, and therapy discontinuance provides such a hiding place. Chapter 5 is an extensive examination of discontinuation from child and adolescent mental health services. It can be presumed that the discontinuers were parents in the following examination of metaphors, but sometimes it was the child who stopped attending the clinic.

In the literature, the person who contacts an agency commonly has been entitled "the applicant" (Perlman, 1960). "Referrer" has sometimes been used, but this can confuse a referring professional with the parent. The person is deemed to have needs by virtue of the contact. A simpler label has been "caller", since the advent of the telephone. There is a social boundary that is crossed at the time of contact, a phenomenon explored in greater detail in Section 3.2 above, but the status of the person at the time of initial contact is indeterminate or, at least, undescribed. Levinson et al. (1967) preferred to describe the state as "applicancy". It is unclear whether the person is a potential recipient of services or not. One paper acknowledged the transitional nature of contact in its title, "Do we have a customer?' (Gray & Perry, 1986), but rendering the potential relationship in commercial terms does not seem to do justice to the personal endeavours of those in treatment, or to the professional work of clinicians.

The initial contact, presumably, will result in clarification of the person's status, but the person as "citizen" and "choice maker" has not been mentioned in the literature. Perhaps the metaphor closest to "citizen" has been contained in the term "consumer" for those who use adult mental health services. Consumer (Sozomenou et al., 2000) can carry negative connotations, but avoids the troubles associated with "client", "patient", and "user".

Feldman (1937) used metaphors of discontinuance differently to many later commentators. Feldman's cohort was "resistive" and they "discontinued". Mostly, elsewhere, this client group has been referred to as "drop outs"(Pekarik & Finney-Owen, 1987; Sirles, 1990; and many others). "Attrition" was used by Inman (1956), Levitt (1957), Singh, Janes, and Schectman (1982), Plunkett (1984), Armbruster and Fallon (1994), and many others across the past five decades.

The labels chosen to describe those who discontinue vary from the accusatory and patronizing to the dispassionate and descriptive. Cooper and Lynch (1979), Cottrell, Hill, Walk, Dearnaley, and Ierotheou (1988) and Nimgaonkar and Farrall (1988) wrote of "nonattendance". In positive terms, Farley, Peterson, and Spanos (1975) and Epperson, Bushway, and Warren, (1983) wrote of "client self-termination" and Ewalt et al. (1972) discussed the phenomenon in terms of "treatment acceptance". Less positively, Duehn and Proctor (1977) described "premature discontinuance". Similarly, Kazdin (1990) and Kazdin, Holland, and Crowley (1997) described "premature termination".

Perlman (1960), politely, distinguished between "applicants" and "clients", as she emphasized the importance of intake procedures that facilitate the transition from interested enquirer about services to a person contracting to receive a service. Plunkett (1984) classified the applicant who did not attend for interview as "closed not seen", with those "who dropped out during"

evaluation labelled as "rejecters", and those who continued to treatment being labelled as "acceptors" (p.373).

Judgemental tones have been evident across the decades. Levitt's (1957) "remainers" and "defectors" (p. 316) echoed in Ross and Lacey's (1961) "terminators and remainers" (p. 420) and in Shapiro and Budman's (1973) description of defection, termination and continuation. The "no shows" of Lefebvre et al. (1983, p. 387), may have been ironic usage, but this was not true of how Lowman, DeLange, Thomm, and Brady (1984) distinguished between service "users and teasers" (p. 253). In much the same way, Gould, Paulson, Daniels, and Epps (1970) identified a group of clients who "flirt with treatment" (p. 166).

These various metaphors have sometimes entailed methodological problems. In 1989, Garfield wrote about giving up on dropout research because continuers attending for six sessions in one study could be considered discontinuers in another. Pekarik (1985b), Weisz, Weiss, and Langmeyer (1987), and Zuk (1986) had noted the same problem (Section 12.4).

The metaphors become less weighted, however, when differences are distinguished between early and later discontinuers. Pekarik (1986) clarified "termination status" and Sirles (1990) differentiated dropout from intake, diagnostics, and treatment. Orme and Boswell (1991) studied the "pre-intake dropout" (p. 375) and Reiher, Romans, Andersen, and Culha (1992) studied clients "who don't return following intake" (p. 473).

More recently, studies have apportioned less blame to the client, and other associated factors have been more closely observed, such as clients' reasons for dropping out (Pekarik & Finney-Owen, 1987), psychotherapists' attitudes and beliefs relevant to client dropout (Pekarik & Stephenson, 1988), adult and child client differences in therapy dropout (Plunkett, 1984), parents' treatment expectations and child attrition (Pekarik, 1991), and problem children's

treatment attrition and parents' perception of the diagnostic evaluation (Singh et al., 1982). It should be noted that in each of these studies the words 'parent' and 'child' were used.

Nevertheless, on the whole, descriptions of those who discontinue before they are expected to do so by the clinician carry negative connotations, while those who terminate in mutual collaboration with the clinician are positively connoted.

Inman (1956) commented, "It is rather disconcerting to the professional person in the field of social relationships to consider these 'lost' families" (p. 34, 35). Feldman (1937) and Pekarik and Stephenson (1988) found that caseworkers blamed themselves for the children being resistive. Elsewhere, the discontinuer has been considered a waster of clinical time (Pekarik, 1985a; Perlman, 1960). Not knowing as to why discontinuation occurred (Hershorn, 1993; Pekarik & Finney-Owen, 1987; Richardson & Cohen, 1968) has also concerned clinicians. This overall negative attitude toward the rejecting applicant might be, in part, a corollary of the change orientation of child and adolescent mental health professionals. In other words, clinicians might expect parents to want change, but might conclude that the discontinuers do not share this expectation.

One of the least helpful, pervasive, and most troublesome aspects of mental health work with children and families has been the tendency to blame parents for child psychopathology. Feldman (1937) eventually concluded that discontinuance was about resistive parents and their personality problems, despite much evidence for a range of other causes. One of the many criticisms of the family therapy movement (Haley, 1958) of psychodynamic child guidance was the supposed blaming of parents. The distinction between addressing parental participation in a child's troubles and blaming has remained difficult to draw, whatever the therapeutic approach adopted by a clinician.

Part of the difficulty with parent blaming is, of course, that parents do participate in their child's troubles, and some probably do actively cause the child's disturbance. However, this is not a useful place from which to begin therapeutic work. It can be one of the fears of the referring parent (Cohen, 1966; Richards, 1990).

It is hard to know when such attitudes among clinicians became institutionalized, but Horn (1989) felt that parent blaming was part of the 1930s American child guidance movement. A capacity to blame lies with privileged groups in society (Smith, 1990), and most social institutions in the West come from the activities of the privileged, even when working on behalf of the disadvantaged, as was the case with child guidance.

British child guidance was much influenced by the work of Melanie Klein, who developed psychoanalytic object-relations theory (Parry-Jones, 1989). Luepnitz (1988) felt that object-relations theory, with its emphasis on "the pre-Oedipal period probably has resulted in more blaming of mothers for disturbances of children" (p. 178). Similarly, Bowlby's attachment theory (1953/1965; 1988) has been used to blame mothers. Bowlby (1953/1965) documented the effects of maternal deprivation and described various reasons "why families fail" (p. 86), including economic hardship and death in the family, and stated:

> Considering that personality disturbances, especially mothers, almost certainly play the principal part in the majority of cases coming into permanent care in Western communities today, it is remarkable so little attention has hitherto been given to them. (p. 89)

Mother blaming was a not just a position taken by psychoanalytic therapists. Luepnitz (1988) systematically analysed the practices of many practitioners in her critique of family therapy. She exposed various family therapists as taking this same position, namely Ackerman, Bowen, Minuchin, Moynihan, Satir, and the Milan associates (for example, Selvini-Palazolli, Cecchin, Boscolo, & Prata, 1978), even though she was able to identify aspects of their work that were

commensurate with a feminist view. Luepnitz advocated a re-thinking of what it means to be a parent and to live in relationship to another adult and with children.

Both clinicians and researchers have used these metaphors, evidently wanting active, motivated, but compliant parent clients. Their attitudes toward the discontinuing parent seem negative, but the general attitude toward the parent remains obscured. Mental health consumerism offered a way out of this bind for parents.

3.4.3   The parent as mental health consumer

The rhetorical strength of the term "consumer" comes from its recognition that a person is more than a diagnosis and more than a passive recipient of applied expertise. It was clear form the *U and I* project (Epstein & Wadsworth, 1994; Wadsworth & Epstein, 1998) that "consumer" allowed those with mental health diagnoses to find a position from which to voice their objections to mental health practices. Voice, as speaking one's mind, when removed as a political option, can have mental health repercussions. The history of mental health practice has been to confuse political voice with syndromal talking. "Consumer" asserts the political in a mentally healthy way.

In the United Kingdom, according to Stacey and Herron (2002), the term "user", has been adopted. Sozomenou et al. reluctantly accepted the use of "consumer" in Australia and felt "user" to be linked to the idea of drug usage. The term "consumer", according to Sozomenou et al. (2000), has been widely criticized, as an inappropriate commercial import into a field where the idea of exchange of services, and of the idea of a choice made from a range of potential providers, could never apply. Yet, the term has stuck in Australia.

Consumerist research in child and adolescent mental health in Australia has been rare. Two consumerist studies (Luntz, 1998; Spink, 1998a, 1998b) were conducted in Melbourne, Australia,

informed by the work of Epstein and Wadsworth (1994). Raphael (2000b), in a federal government policy paper, considered consumerism an important part of health promotion and prevention. Stacey has been involved in several projects in the State of South Australia (Byas et al., 1999; Stacey et al., 2002; Stacey & Turner, 1998; and AMIGOS (Addressing Mental Illness and Giving Others Support; Wallace et al., 2001) and has published on youth partnership accountability (Stacey, 1997, 1999, 2001) and consumer participation in mental health service delivery (Stacey & Herron, 2002). However, Stacey's work has remained within the mental health consumer research paradigm and focused upon the adolescent former inpatient, or upon the adolescent child of a mentally ill person. These consumer studies have been effective but her work has not questioned the consumer model's applicability to outpatient child and adolescent mental health services.

There has been much Australian work with children and families where a parent is mentally ill (Cowling, 1999, 2004). Often such initiatives have come from the adult mental health sector, on behalf of the parent consumer, or from the welfare sector on behalf of the child, as with AMIGOS (Wallace et al., 2001). This group of children does have legitimate claims upon society's resources, but usually cannot access these as consumers of child and adolescent mental health services, as they do not have referable mental health problems. Nor can their mentally ill parents access such services for their children.

Luntz (1998) researched needs of non-English speaking background (NSEB) parents, adolescent clients, and referral agents for the access to Victorian child and adolescent mental health clinics. Luntz's (1998) emphasis was upon "cultural competence" of professionals and agencies, which involved an awareness of, and openness to, cultural practices, especially those relating to personal distress and to parent-child relations. Luntz reported that changes in service delivery were needed to accommodate the many languages that potential child and adolescent mental health services clients and carers used at home. Translated pamphlets and the use of interpreters were necessary. Ethnic community agency workers had reported that the term "mental" was aversive to some ethnic

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communities who to equate child and adolescent mental health services with those available through adult mental health services. Similarly, "aspects of the intake process were criticized for their formality and complexity" (p.14). Even the need for clients to attend set appointments was seen as a cultural barrier. There was also a need for a more appropriate crisis response.

The consumer project conducted at Travancore Centre of the Royal Children's Hospital Mental Health Service (RCH MHS; Spink, 1998a, 1998b) was instigated through the *U and I* project collaborators Epstein and Wadsworth (1994) and their colleagues. Advocacy had been suggested to be extended to child and adolescent mental health services (Spink, 1998a). Two consumer consultants were employed, part-time, at Travancore. One of the consultants had been an adult mental health consumer and had also had experience as a parent of consumers (her three children), and she was asked to bring a parent's perspective to the project. The second consultant had been an adolescent inpatient and was asked to bring a teenager's view.

Much detailed parent and adolescent experience of the service was reported by the two consultants and through the evaluator (Spink, 1998a). Yet, the outcomes were not deep and broad in the way consumer consultancy had affected adult mental health services (Wadsworth & Epstein, 1998; Wadsworth & Shaw, 1997). Many people were consulted. Some issues of introduction to the service could be identified. The waiting room was re-invigorated. Some of the reception staff were praised as models, while the behaviour of other receptionists was moderated. However, issues related to the ongoing conduct of casework were barely reported. Despite battles by the consumer consultants to define their roles, establish their relevance both to the clinicians and to other consumers, as well as to mutually collaborate, consumer consultancy was advocated to become a full-time role within the service.

Spink's (1998a) findings pointed to problems of conception of the project and of the applicability of the term to "consumer" to child and adolescent mental health services. Firstly, the application of

the *U and I* framework did not fit with the culture of the service, and became a constraint for the consultants. Secondly, the idea of the child, adolescent or parent as a service consumer, was not meaningful for the consultants, the service providers, or the service clients.

One member of the project's Reference Group pointed directly to both these issues:

> This is very different to the adult service context which has a focus on working with psychoses in a culture where crisis management predominates and a high proportion of treatment involves medication and hospitalisation. …In the final analysis, the requirement for adherence to the *U & I* model became somewhat of a constraint to creative exploration of new strategies . . [utilising] those features which are relevant, while adapting the model to the particular needs of young consumers and parent consumers in the context of CAMHS. In particular it may be important to broaden the base for training and support beyond the base of adult mental health service consumers, given CAMHS are as much about preventing mental illness as they are on maintaining a focus on young people diagnosed with mental illness. (Reference Group member; cited in Spink, 1998a, p. 94, 95)

The only reported satisfactory consultations were with an occasional child or parent in the waiting room, the inpatient unit teenagers, residential carers, and school staff (Spink, 1998a). The waiting room meetings were productive, but were recognized as unrepresentative of most service consumers by the consultants. The inpatient unit clients responded in ways similar to adult consumers battling the loss of sense of self on the hospital ward and the concomitant feelings of stigma. The residential carers, generally, could advocate for child needs and service changes because they had a specific commitment that transcended the particulars of contact with respect to any one child. Similarly, school staff could comment beyond specific case issues. The views of carers and school staff were generated from without the mental health service and suggest a conception of the parent and the child not narrowed to patient or consumer.

In critically reading Spink (1998a), it can be concluded that young people and adults, including parent carers, using outpatient child and adolescent mental health services (Spink) did not regard themselves as consumers, and had only a passing interest in the service. Consumerism implies a stability of relationship toward a service organization that can change some practices, but does not change the narrow range of needs that are serviced. The stability of adult mental health diagnoses and problems of management may not apply to child and adolescent mental health services in many or indeed most cases.

Byas et al. (1999), in South Australia, demonstrated the value of collaborative research involving professionals and consumers and provided implications for delivery of child and adolescent mental health services. Continuity of therapist was important, as was the need to explore expectations of the therapeutic relationship, specifically:

> therapists need to be proactive in (a) attending to the most important concerns for clients; (b) seeking mutual understandings, rather than assuming they exist; (c) honoring expertise brought by parents/families; (d) developing agreements on how therapy will occur; and (e) providing feedback on the process. (Byas et al., 1999, p. 80)

These findings, articulated as desired outcomes for consumers, are ordinary standards for sound clinical practice. However, the identity of the consumer was merged as a composite of "family", "parent", "child", "client", and "consumer".

While consumerism may not have a ready and simple place within the outpatient services of child and adolescent mental health, the work that has been completed would suggest that service users do think about how they are received into services. The label "mental" has deterred ethnic groups (Luntz, 1998). Waiting rooms can be improved, as can the practices of receptionists (Spink, 1998a, 1998b). Public awareness and public image are important (Byas et al., 1999). Continuity of personnel is important (Byas et al.). These are issues that impinge most at the beginning or re-

commencement of contact with a service, but referral and intake processes were not identified as having consumer importance. Parents begin these processes.

3.4.4   Psychodynamic child psychotherapy and work with parents

Working with parents has rarely been presented in the child psychotherapy literature (Rowntree, 1994; Rustin, 1997). As with many mental health practices, wisdom accumulated through practice has usually been made available orally to others, by mentoring or by apprenticeship. But the image of the parent at the beginning is not clearly described. In all this psychodynamic literature, the image of the parent as person is seen to emerge only after therapy has proceeded some distance.

Ferholt (1991) attempted to avoid the accusatory search for cause and responsibility by helping parents understand how interactions in the family, limited as these were to parental images of interaction patterns within their families of origin, had come to cultivate maladaptations in children. Frick (2000), Horne (2000), and Rustin (2000), in the volume of Tsiantis et al. (2000), all described ways of working with the parent that kept the child in mind. Each advocated the aim to produce psychotherapeutic change in the parent in a way that does not do damage to the child or to the child's therapy, that enhances the parent's experience of his or herself as a person, and that enables more thoughtful action as parent. These are all admirable aims, but are predicated upon parents accepting their inadequacy, their place in their child's pathology, and the need for therapy. Horne concentrated upon the means by which a parent can be prepared to accept therapy, as none of these aims can be achieved without the parent being enabled to accept these are reasonable and responsible aims. Through this beginning process, the problems of felt blame can be addressed and a working alliance established.

Daniels and Jenkins (2000) approached the task of undertaking psychoanalytic child psychotherapy from a children's rights and legal issues perspective. Cases were presented where child protection

and divorce have affected the child. Special attention was paid to the role of the parent in consenting to therapy for the child under such adverse conditions. While in such cases it may be desirable for each of the parents to be undergoing psychotherapy for issues which impacted upon the child, often the parent is not willing or ready to participate in such a way, yet will still need to consent to child therapy. Daniels and Jenkins described a difficult role for the therapist as mediator between various social institutions and the parents, while maintaining confidentiality and security of the therapy relationship. In this situation, the parent was configured as an ally in the work, yet as being a potential obstacle to treatment.

3.4.5 Respect for the parent in the child and adolescent mental health clinic

Parents might be considered as active initiators of help-seeking who find services, make referrals, transport the child, agree to treatment regimes, decide to discontinue, and evaluate their satisfaction. Most commonly, however, parents figure in these studies in positions of passive acceptance of professional advice. The child psychoanalytic psychotherapy literature (Tsiantis et al., 2000) accords dignity to parents who can recognize themselves as having therapy needs. As persons, parents, in these clinic-based studies, have been only described in their vulnerability or in their infirmity.

In these studies the parent has been configured as referrer, as transporter, as setter of expectations about the service, and as judge of appropriateness. The parent, as active participant, has rarely been described. The idea of the parent as co-participant in a helping process, which seemed to be the ideal for adult consumers and carers, has been difficult to discern. In contrast, the tone in which parents have been mentioned in the literature has often been derogatory. Indeed, more generally, the metaphors applied to users of mental health services have often been negative.

Buscaglia (1994) asserted the dignity of parents as persons by identifying a hierarchy with the person first, then the parent, and then the special task of being a parent with a disabled child. This might suggest attitudinal problems among counseling professionals in the disability field toward parents, but at least the ideas have been clearly and firmly articulated.

Similarly, Cunningham and Davis (1985) stressed the need for addressing parents from a respectful position and applied a partnership model to the long-term work of optimizing a disabled child's development. In this model the parents are legitimate therapy assistants, as well as people coping with a set of life problems, while remaining responsible parents for their children. Both Buscaglia (1994) and Cunningham and Davis emphasized the long-term project of child development and the varying needs of parents, over time. The parent occupies a dynamic yet stable position in relation to the tasks of the professional. There is stability of effort in relation to the child's changing needs. As will be seen, stability of diagnosis enables the emergence of certain stable roles and expectations in adult mental health, as well as in disability services. Parents and clinicians in outpatient child and adolescent mental health clinics do not expect such stability.

The image of the parent is just one of a number of factors with which the consideration of the initiating circumstances of child and adolescent mental health service confronts the validity of the findings of past research into psychotherapy processes and their effects, the subject of the following chapter.

3.4.6   The parent in the eye of the clinic

The place of the parent within child and adolescent mental health services would appear often to be dealt with pragmatically, as the person who is the parent of the referred child and of the child in need of treatment. Such pragmatics set up an interesting confusion for the referral and intake worker at referral. By the above definition, the parent, at referral, is the referrer of the referred

child, but, more likely, the parent will make contact as a parent in need of help with a troubled or troubling child. Which parent is accepted into the service?

Further, which parent is accepted into treatment, the parent of child who needs treatment, or a parent in need of treatment because of the signs displayed by their child? Or, some other conception that places both parent and child in a family context and which configures the tasks of therapy in specific ways? These are not issues for idle speculation and pragmatics has not made the issues go away.

Appreciating the parent as a person with needs, troubles, responsibilities, and a range of priorities would appear to be a challenge for child and adolescent mental health services professionals. There is a question of the social legitimacy of the help-seeking parent that goes quite deep. Parents, who seek mental health assistance for their child, at least at face value, are claiming responsibility for assisting their child in recovery, in assisting their child in getting to the clinic, and in accepting their part in their child's difficulties. Yet, the seeking of help for a child with mental health needs might have the parent perceive that professionals do not recognize the parent's right for respect as a citizen or as a person with needs, who still exercises the right to make decisions.

This difficulty in appreciating the position of the parent must create difficulty within the course of the first contacts and might be attributed by the parent to a bureaucratic process or a judgmental attitude on behalf of staff members contacted. Practicing clinicians need to consider how they define a parent, his or her roles, rights, and responsibilities, and how such definitions affect direct interaction with parental ambivalence about help-seeking.

It is proposed to use, as a working model of the parent, a person with two motivations, potentially at different levels, of a wish to seek help and of a wish to not need help. The term ambivalence could be used, but these wishes are rational and legitimate, rather than unconscious. This is a

person who has troubles and hopes and other life difficulties and resources. This person is a seeker of help rather than a consumer, but who exercises discretion in making choices with respect to child and adolescent mental health services contact.

The relative strength of the two motivations may well determine the outcome of the motion towards a child and adolescent mental health services service and could result in the decision to continue or discontinue with a professionally recommended course of action. Ahead of such a decision, a referral and intake worker might have a sense of intentions. Clinicians who had established a working alliance with the parent might also be aware of intentions to discontinue, but without a conception of the parent as somebody exercising decision-making, it might be difficult for the clinician to discuss intentions to terminate with timeliness.

3.5   Conclusion: Entry marks a change of status for service seekers

A referral for mental health consultation involves a number of processes being activated by that very fact, but which lie outside the consciousness of the client and often of the clinician who eventually sees the client. Mostly these have been considered to be sociological factors concerning stigma, diagnosis, and processes prior to and after entering the service. To these, in the case of child mental health intake, Feldman (1937) added some psychological factors, especially concerning the parents, which were echoed over half a century later by Kazdin, Mazurick, and Bass (1993). This list of factors included the forbiddingness of the architecture, the transformation of citizen status that entering entails, processes of applicant selection, the placebo effect, intake policy, other procedures, including the design of the reception function and its enaction, staff relations, and the communicative interface between clinic and community through referral and intake procedures.

Entry, for some people, involves many disincentives. Electing not to enter withholds understanding of these disincentives from clinicians, except as evidence for diagnosis, or by retrospective account should the client return. To seek greater understanding of these issues, adult and child mental health clinics in many parts of the world have conducted small-scale research projects into attending and discontinuing. In Chapter 4 empirical research concerning clinic processes that facilitate attending is considered. In Chapter 5 clinic factors implicated by empirical research on discontinuance are surveyed.

CHAPTER 4

EMPIRICAL STUDIES OF ACCESSING CHILD AND ADOLESCENT MENTAL HEALTH SERVICES

Nothing so difficult as a beginning
In poesy, unless perhaps the end.
(Byron (1832/1958) *Don Juan, IV*).

Every facility has a variety of means, formal and informal, by which prospective patients are selectively referred to it and are then selectively screened for admission as patients or clients. Not all persons-in-need within the community are referred to a service; not all who are referred actually apply to it for service; and not all who apply are offered it … the boundary processes of a facility serve to restrict severely the size and psychosocial composition of its clientele. These processes are rarely acknowledged in official policy statements and their consequences are rarely examined by staff. One means by which an organization exerts control over the inflow of patients is its referral and intake system (Levinson, 1969, p. 88, 89).

Access to publicly-funded child and adolescent mental health services involves a willing parent telephoning a service that can respond in a timely manner. Funding, location, community need, parental motivation, service utilization, referral pathway, and protocols for greeting and promoting attendance have all been the focus of publication. This chapter documents many reports, mostly from child and adolescent mental health clinics, in the United States, Britain, Canada, New Zealand and Australia, to address the resource and opportunity wastage that non-attendance can represent.

4.1   Studies of need and access

Making contact and asking for mental health assistance concern factors that exist well before contact is made. Children are referred because professionals and parents detect mental health

problems, but the likelihood of referral is moderated by other factors. These factors are need, access barriers, and parental motivation.

4.1.1   Need: Symptomatology, epidemiology and utilization

As noted in Chapter 2, the history of child guidance in the United States began with community concern about rates of juvenile delinquency (Richardson, 1989), which led to clinic-based interventions for troubled, rather than troubling, children under the auspice of the preventative endeavours of the mental hygiene movement and its philanthropic sponsors. Clinics in North America and Britain provided the base for development of systems of diagnosis and treatment, but disquiet grew in the 1960s and 1970s (Gordon, 1965; Hansell, 1967; Shephard, Oppenheim, & Mitchell, 1966; Weiss, Freeborn, & Lamb, 1973; Wolff, 1961, 1967) as to whether clinic services were being used by those most in need. In turn, questions of population incidence of mental health problems and clinic utilization were raised.

Over time, the rate of child and adolescent mental health needs in epidemiological research of Western populations has converged on 20 per cent. Kataoka et al., (2002) reported that although seven per cent of American children used mental health services, the actual rate of need was nearly three times, at close to 21 per cent of the population, with the usage rate at one-fifth for Latino children with mental health needs. Earlier, Rutter (Rutter, Tizard & Whitmore, 1970; Rutter, Cox, Tuping, Berger & Yule, 1975) had found rates of child psychiatric disturbance among ten year olds from an "inner London Borough" and an urban rate of disturbance (25.4%) more than twice that of the rural rate (12.0%) from the Isle of Wight, in otherwise similar samples. In Canada, those who conducted the Ontario Child Health Study (Offord, 1987; Offord, Boyle & Racine, 1989; Offord, Boyle, Szatmari, Rae-Grant, Links, Cadman, Byles, Crawford, Blum, Byrne, Thomas & Woodward, 1987) estimated the prevalence of disorder in the age range of four to sixteen years to be 18.1 per cent. Similar estimates have subsequently been made in Australia too (Sawyer,

Meldrum, Tonge, & Clark, 1992; Sawyer, Sarris, Baghurst, Cornish, & Kalucy, 1990; Zubrick, Silburn, Burton, & Blair, 2000; Zubrick, Silburn, Garton, Burton, Dalby, Shepherd, Carlton, & Lawrence, 1997; Zubrick et al., 1995).

Epidemiology cannot predict service utilization. The problem of determining population risk and rates of actual use by sub-populations has been an ongoing task for health planners. In child and adolescent mental health a small number of important studies have been reported. Stevens (1954) and Maas (1955) looked at the geography of Chicago to map socio-cultural factors that affected different aspects of referral and intake to child psychiatry services. Levy and Rowitz (1971) found that higher clinic utilization was associated with higher rates of poverty and unemployment. African Americans more often than Caucasians were referred in one study (Rembar, Novick, & Kalter, 1982), whereas more Caucasians and fewer Latinos were referred in another study (Novack, Bromat, Neill, Abramovitz, & Storch, 1975; Kataoka et al., 2002). In the United Kingdom, Wolff (1967) differentiated the rates of referral for psychiatric assessment for boys and girls with similar psychopathology. In Canada, the prevalence rate was 18 per cent (Offord et al., 1987). Later, John, Offord, Boyle, and Racine (1995) found that usage was related to the linking of such factors as prior service use and negative school performance, with child disturbance and with parental willingness to tolerate symptoms.

Jensen, Bloedau and Harry Davis (1990) reported on their study of clinic utilization by children of United States military families. Symptomatology explained 28 per cent of the variance associated with clinic use, but 13 per cent was associated with factors tangential to symptoms such as family size, divorce, stress and parental psychopathology. As with Pfeffer, Plutchik, and Mizruchi's (1986) comparison of inpatients, outpatients, and non-patients, troubling child symptoms drove referral, but troubled family times were needed, as well.

4.1.2   Barriers to service access

In the 1980s, referral discontinuance began to be conceived as a general problem of access, rather than of procedural purpose. Physical and social barriers to use of public welfare offices had been documented in terms of appearance and placement of buildings, and ineffective signage (Hall, 1974; Weissman et al., 1983). In the United States, cost and perceived stigma were major barriers to those for whom services were most needed (Leaf et al., 1987; Leaf, Livingston, Tischler, Weissman, Holzer, & Myers, 1985).

Stefl and Prosperi (1985), in the United States, distinguished mental health needs from barriers to utilization and from amount of utilization. Barriers involved availability (knowing of services and their location), accessibility (transport, availability of a companion), acceptability (stigma of being looked down upon by staff or by friends or relatives), and affordability (cost of services, costs incurred in attendance, for example, a day off work). Associated with the study was a risk assessment of not accessing services. Mental heath service user participants were sorted into groups of "no risk" (66 per cent), "possible risk" (24 per cent), and "probable risk" (10 per cent, comprised of outpatients (8.4 per cent) and inpatients (1.6 per cent)). Affordability was the highest barrier, availability the next, accessibility the next, with acceptability, that is stigma, the least powerful of the barriers. The group with "no risk" of not accessing services rated barriers as higher than those in need and those using services. Users, rather than those in need, were clearer about the actual affordability issues, but were very much more aware of the accessibility difficulties.

Leaf et al. (1987) found community attitudes toward mental health services in an American sample, contrary to expectation, were very positive about mental health services, while among users, attitudes were less positive. "Overall, the poor, less-educated, and young adult members of this community are the least disposed to use mental health services" (Leaf et al., 1987, p.283). These people were also the "most sensitive to the reactions of others" (p. 282). There was a real

difference between the idea of service and actually using one, with those who were reluctant having felt the effects of perceived stigma. Further, when reluctant consumers used services, continued use was less likely. Nevertheless, stigma has been shown to be less important for users of child mental health services than for users of adult mental health services (Pekarik & Stephenson, 1988). Parental capacity to tolerate symptoms (John et al., 1995) and parental upset (Jensen et al., 1990) have been found to also affect referral.

4.1.3 Parental motivation and state of mind at referral

Confirmation of a referral by a parent has been documented, as far back as 1955 by Rooney and Miller, as a precondition of acceptance of a referral to that service, especially when a general practitioner or a welfare agency initiates the referral. Making or confirming a referral requires parental willingness to make contact with an appropriate state of mind, probably influenced by the state of domestic harmony. Research has demonstrated conditions under which referral is more likely to be made by a parent.

From Ross (1972; cited in Brody & Forehand, 1986) to Chi and Hinshaw (2002), United States researchers have noted a connection between referral of a child with behaviour problems and maternal depression. However, Richters (1992) concluded that depressed referring parents could accurately perceive a child's need for professional attention, rather than the behaviour being an effect of the parent's state. The choice to refer, then, following Jensen et al. (1990) and John et al. (1995), would appear to involve both a wish for help with their child and themselves and a wish to avoid social judgement upon parenting.

Graham (1985), reviewing research into parental health status using Goldberg's General Health Questionnaire (Goldberg, 1978), found that behavioural troubles in addition to maternal illness prompted referral. Similarly, Garralda and Bailey (1987) reported ill health in both parent and

child increased the likelihood of referral to child and adolescent mental health services. Graham also found that referral for mental health assistance could be acceptable to a parent who was feeling unwell. Feelings of personal responsibility for causing the disturbance could be reduced by seeking referral, thereby attributing the sense of failure in managing a child to maternal illness.

The problem of social and psychological barriers to referral of troubled children was crystallized in the United States as the need for a continuum of care for their families across the range of their potential difficulties (Friedman & Street, 1985). This need was examined by the uniquely comprehensive Fort Bragg demonstration project (Bickman et al., 1995).

4.1.4   The continuum of care at Fort Bragg

The evaluation of the Fort Bragg demonstration project represented a coming together of all the expertise accumulated by seven decades of child guidance work. Diagnosis was refined (DSM-IV, APA, 1994), treatments were refined involving least restrictive environments, and these treatments could be made available in a coordinated and comprehensive way. The potential for economic and social savings through optimal community services through the provision of a continuum of care (Friedman & Street, 1985) deserved exploration. The continuum of care concerned how restrictive the environment of treatment needed to be, stretching from outpatient services to various forms of day program, residential service, therapeutic fostercare through to inpatient hospital treatment. The continuum was also about the range of services that a disturbed child might need, including paediatrics, special education, speech therapy, occupational therapy, and particular training. Recovery in one domain needed to be complemented by recovery in other domains if adjustment was to be achieved in any of the domains. The continuum of care deserved rigorous, independent evaluation (Bickman et al., 1995; Bickman, 1996a, 1996b, 1996c). This research was referred to in Section 3.2.5 of Chapter 3.

The Fort Bragg Demonstration Project (Bickman et al., 1995) bore the hallmarks of the development projects funded by philanthropists in the first part of the twentieth century (Horn, 1989; Richardson, 1989), except that in this case, the benefactor was also the recipient of services and a government agency. There had been concern in the United States army that military families were subject to greater levels of social discomfort than other families because of the recurrent changes of address in military life, the closed communities to which the families belonged, and the threat of danger implicit in military occupations. In summary, Bickman (1996a) reported that "more is not always better" (p. 689). Comparisons made with two other ordinary military mental health services indicated, despite the far greater range and intensity of services provided at Fort Bragg, the service delivered at all sites was of a similar quality and effectiveness. Friedman and Burns (1996), Lane (1996) and Paris (1996), in their reviews of the Fort Bragg research were impressed that such a detailed and rigorous evaluation had occurred as much research methodology knowledge had been gained.

Mordock (1997a) criticized the project on three grounds. Firstly, the Fort Bragg population was unique in both composition and mildness of disturbance. Secondly, over-servicing occurred because of the "clinician's illusion" (1997b; Cohen & Cohen, 1984), that all problems deserve a clinical response. Thirdly, the means of referral and intake and its effects had not been studied. It was unclear from the Fort Bragg reports how assignment of cases at referral and intake to the several available programs occurred. In response, Summerfelt, Salzer, and Bickman (1997) repudiated criticisms concerning population and over-servicing, and added that they knew of no study that rigorously examined the effects of referral and intake on subsequent psychiatric treatment. Subsequently, in a separate study, Bickman et al. (1997) examined clinician judgements concerning appropriate allocation of presenting cases to services, and found a range of clinicians in allocating cases to programs were later established to have performed at little better than chance. Although allocation to programs at Fort Bragg was organized through a central intake service, with clear admission criteria, one of the issues of concern at the outset in the continuum of care debate

(Friedman & Street, 1985; Friedman & Burns, 1996), returned as a limit on the findings of the whole project. The rigour of practices of beginning has been an issue in many small, clinic-based studies.

4.2	Studies promoting attending the first appointment

There has been considerable effort by mental health clinics throughout the English-speaking world to reduce the number of missed initial appointments. Prompting has been the most usual strategy (Burgoyne, Acosta, & Yamamoto, 1983; Carr, 1985; Turner & Vernon, 1976). The purpose of such efforts has involved the dual imperative, to prevent resource wastage, and to get assistance to vulnerable people in danger of not pursuing such help (Pekarik, 1985a). Consideration of the vulnerable state of the referring parent has been addressed through information provision and by strengthening service links.

4.2.1	Expectations and knowledge of the agency at referral

Attending at a child and adolescent mental health service involves a lot more than just a willingness to appear at the clinic at the appointed time. Informed expectations can facilitate entry, while lack of information can be detrimental. Expectations and knowledge of service are brought to the clinic by the would-be patient, but these are influenced by the advice, suggestions, and support of others.

A positive state of expectation of, and satisfaction with, the help being offered may promote first appointment attendance. Frank, Gliedman, Imber, Stone, and Nash (1959) suggested that psychotherapy might work by means of the positive activation of patient expectations, rather than through specific technique, if not placebo (Frank & Frank, 1993; Shapiro & Shapiro, 1978).

Gould et al. (1970), in the United States, had found that lack of definition of the problem at time of the referral was related to non-attendance at the first appointment. This lack could have resided in the patient, in the referrer's information provision, or in the referral and intake workers' practices. Gould et al. recommended that referral and intake workers clarify both the problem and the agency's role.

Burck (1978) conducted a qualitative study of ten British families' experience of family therapy referral, and found both a low rate of effectiveness and a large difference between parental expectations and the experience actually encountered. Burck recommended that referrers, primarily general practitioners, should be better informed about the service to which they were referring, and should convey this information to the parents. Burck's consumer informants complained about the failure of treatment to address the main problem. But most of her comments were directed to clinic practices and the need for clinicians to elicit expectations early in the contact, especially with respect to family attendance for family therapy, an issue noted by Street, Downey and Brazier (1991), also.

Bailey and Garralda's (1989) study of referral expectations was part of an ongoing research effort to understand the bases of general practitioner referrals of children with child psychiatric needs. The past impetus for such research came from Ryle (1967; cited in Bailey & Garralda), Gath (1968), and Garralda's experience with inpatient child psychiatry referrals (Garralda, 1983; Garralda & Bailey, 1986a; Garralda & Bailey, 1986b). Ryle had suggested that general practitioners refer only a small proportion of those in need. Gath had surveyed 50 referring doctors to the Maudsley Hospital Children's Department in London, and Bailey and Garralda (1989) decided to repeat Gath's study with an expansion to include the views of parents.

Bailey and Garralda (1989) found that attending the general practitioner was initially motivated by concern for their own state and concern for the child's wellbeing, each at 39 per cent. The

remaining 20 per cent attended on the recommendation of the school (and in two cases, a pre-school professional). The general practitioners had responded, usually in the same consultation, with referral on the basis of a range of reasons, with parental anxiety (65 per cent of cases) and parental request (59 per cent of cases) exceeding the severity of the child's problem (47 per cent), and family disturbance (33 per cent), as main reasons for referral. Other agencies influenced the decision to refer in 18 per cent of the cases. Failure to respond to treatment by the general practitioner caused referral in a further 18 per cent of cases. Parents were satisfied with the role of the general practitioner in three-quarters of the cases, but the majority of parental informants reported receiving inadequate information about the child psychiatric assessment process and what to expect from the assessment.

Nearly half of Bailey and Garralda's (1989) sample expected that help for the child would result from the referral. Similar numbers of parents expected an explanation of the child's behaviour, and advice and reassurance about what to do. Other expectations varied from a miracle, and the wish for the child to change attitude, to ambivalence about seeking help, to no idea at all. Even though specific steps and procedures might be known ahead of time, the experience was something different, and was difficult to describe ahead of time. Only three of Burck's (1978) ten parents had a realistic understanding of what was to occur, and this was because these had past referral experience, but only one of these families actually achieved a satisfactory treatment outcome. Burck had called for British general practitioners to give more accurate information, as had Cohen and Richardson (1970) in the United States, but, in Britain, Garralda and Bailey showed this had not occurred.

In summary, then, parents present at child and adolescent mental health services, possibly not feeling well themselves, with expectations that may be ill informed and understood only afterwards, when the referral may be in serious jeopardy. However, getting parental expectations clear and realistic before the referral is made would seem to be logistically problematical.

4.2.2   The influence of the referral pathway on attendance

Gath (1972), following up previous research on the referral patterns of British general practitioners to child psychiatry (Gath, 1968), found that severity of presenting problems, although important, was not the only reason for referral. Another major reason was the parental state of anxiety or protectiveness, with referral made in the hope of treatment for the parent. Garralda and Bailey had picked up this thread, with the study of child and family factors associated with consultations in primary medical care (Garralda & Bailey, 1987) and with referral to private child psychiatrists (Garralda & Bailey, 1988). Psychological factors were implicated in the presentation of 17 per cent of seven to twelve year old children to their family doctor. Psychosomatic symptoms such as asthma, bed-wetting, rashes and headaches, along with greater use of medical services, were recorded. Among the families of these children were higher rates of surgery, maternal illness, and stress. These children's parents were more concerned about their child's schooling.

Garralda and Bailey (1988) compared children (7-12 years) with psychiatric diagnosis in the referred and in the non-referred population, with further comparisons between those without diagnoses in both referred and non-referred populations. Garralda and Bailey found an attunement in the referral pathway to certain forms of presentation. Referred children had parents who reported high anti-social behaviour in their children, difficulties for parents in controlling the children, high levels of associated stress, and relative social disadvantage. Of these referred children, those with diagnoses tended to have severe problems, to be older, and to be from families with high stress levels, maternal mental problems, and a comparative lack of external supports. Among the non-referred but diagnosed community sample, were a greater percentage of girls, and a tendency for the mothers to present their children with physical rather than psychosocial symptoms. Comparisons between the two psychiatrically healthy groups indicated that parental concern about stress (especially socio-economic and housing-related), parental concern about ability to control their children, and relatives with histories of legal problems, were more common in those referred.

Ryle (1967; cited in Bailey & Garralda, 1989), Gath (1968, 1972), and Garralda and Bailey (1988) had thereby demonstrated the connections within British medicine for response to the child with mental health problems.

Weisz and Weiss (1991), in the United States, attempted to address referral patterns directly, by developing a Referability Index (RI), which represented the frequency of referral for a particular problem relative to the frequency of the problem in the general population. The RI was applied to child and adolescent samples in two countries, with the finding that problems of undercontrolled behaviour in children and adolescents were more likely to be referred for mental health assistance in the United States than in Thailand. In a subsequent report of the application of the RI (Weiss, Jackson, & Susser, 1997) the co-morbidity of externalizing and internalizing symptoms in an inpatient adolescent sample was studied. Here, Weiss et al. demonstrated that parents tended to refer in response to either internalizing or externalizing behaviours, but not to both. The usefulness of the RI has yet to be demonstrated, but the distinction between population incidence and the frequency of clinic referral of particular problems seems an important distinction to make, although it begs the question of the point at which the difference in rate occurs, with the parents, with other professionals who refer, or in the conduct of the person who receives the referral. These are all points on the referral pathway.

More recent research in Britain (Wolpert & Fredman, 1994; Wolpert & Fredman, 1996) addressed the question of who is referred more broadly, in order to strengthen the referral pathway and to decrease rates of non-attendance at child and adolescent mental health services. Wolpert and Fredman (1994) developed a flow diagram for referral with four levels of recognition of a child problem. The first level was the psychological disturbance of the child, which could lead to parental concern at the second level, or lead others (health, education, welfare, or community agents) to note the troubles at the third level. At the fourth level was the child mental health professional who may have received the referral from the parent or a third level professional.

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Wolpert and Fredman (1996) sought to test this model against the increased likelihood of referral that had been noted in the literature (Gath, Cooper, Gattoni, & Rockett, 1977; cited in Wolpert & Fredman; Garralda & Bailey, 1988) for children who were older, for those whose presenting problem involved anti-social behaviour, and for boys. Parents, psychologists and general practitioners in the same health district were asked to rate their level of "worry", and their likely referral response toward four cases presented in vignettes. The vignettes were distributed in alternate sets of four to allow for gender and age balance. The gender hypothesis was not supported, but the age hypothesis was sustained (Wolpert and Fredman). Disturbed three year olds were less worrying to parents and psychologists, but not to general practitioners. However, general practitioners were more willing to refer the older child. Parents were more likely to consult a general practitioner about an emotionally troubled child than one with conduct disorder, but general practitioners were more likely to refer the one manifesting conduct disorder. Thus, Wolpert and Fredman concluded "the pathway to psychological care may be more permeable, at certain stages at least, to 10 year-olds than 3-year-olds, and to children presenting with conduct disorder than to those presenting with emotional disorder" (p. 101).

Similarly, Jensen et al. (1990), as already reported, studied the risk factors associated with utilization of United States military child mental health clinics. The study balanced out effects for age, gender, and income among the clinic sample and community controls, ranging in age from six to twelve years. The likelihood of referral was increased when a symptomatic child was in a family under stress, when the mother was disturbed, and when factors associated with past marital relationships were active (direct conflict, shared parenting, acceptance of step-parents), but not necessarily associated with divorce per se. The study demonstrated that while upset mothers were more likely to refer, but the level of child symptoms was associated with disturbance in either parent. The findings of Forehand and colleagues (for example, Brody & Forehand, 1986), Bailey and Garralda (1989), Graham (1985), and John et al. (1995) converged with those of Jensen et al.

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Overall, it can be concluded that upper primary age, anti-social boys with upset and developmentally unknowledgeable mothers of disrupted marital backgrounds are more likely to be referred than other disturbed children. However, as Kazdin et al. (1993) demonstrated at the Yale University Conduct Disorder clinic, poor and under-educated parents were among the most likely to have children who discontinued. This last finding suggests that how a child comes to be referred may contain the seed of discontinuance.

4.2.3   Predicting attendance at the time of referral

The choice to discontinue after the first contact may indicate strong, pre-existing ambivalence on the part of the parent, or it may indicate dissatisfaction with what transpired during, and subsequent to, the first contact. Two studies have involved predictions based on the initial telephone or other referral contact (Ewalt et al., 1972), and predictions made following the first interview (Sirles, 1990).

Ewalt et al. (1972) surveyed 253 United States parent referrers on 56 family variables, and found a distinct pattern whereby continuation with a referral to the acceptance of at least six treatment sessions could be predicted. They concluded that the testing of five indicators at referral and intake allowed the referral and intake worker to make a prediction of likelihood to proceed to six sessions of contact. These indicators were:

1. Child's age less than **or** greater than 5 years

2. Mother's education level less than **or** greater than year 5

3. Worry about child **or** worry about other authority

4. Child not stubborn **or** stubborn

5. Referrer wanting help for self with child **or** don't know/just for child. (p. 860)

Each indicator was rated as "1" if the first part of indicator applied. The sum of these ratings could then be compared to a probability chart that provided a percentage rating of likelihood of proceeding to six sessions. A score of five carried the likelihood of 72.5 per cent, a score of four indicated a likelihood of 69.5 per cent, and fewer than four indicated likelihood below 50 per cent. Use with adolescents was not predictive of continuance, but 70 per cent of adolescents with scores less than three were predicted to discontinue. At referral, then, continuance can be envisaged by the clinicians through consideration of demographic and referrer motivational factors that might create barriers to access. Elsewhere literature support for the model has been supportive. Although Kazdin et al. (1993) found that mother's lower educational level (below Year 12) inhibited continuance, Feldman (1937) had noted that wanting help for the child only was likely to inhibit continuance. No subsequent reporting of the success of the model has been found.

Sirles (1990) found that the clinicians who conducted intake interviews were the best predictors of continuance beyond the evaluation phase. The accuracy of all other clinicians involved with a case in its early stages was little better than chance, but the receiving intake worker seemed to be able to discern certain qualities in the parent that suggested continuance. That this result has been reported is interesting, given that virtually no literature exists about the skills of the referral and intake worker. Alternatively, or in complement, the parent at first contact has given priority to thinking about how much time and energy would be available for the upcoming processes of assistance. The parent may be able to convey this level of commitment, possibly indirectly but with some clarity, to the referral and intake worker. Perhaps this clarity fades as other clinical processes begin, or the priority given to evaluating or communicating personal commitment changes.

4.2.4   First appointment non-attendance

The first appointment represents the first time that non-attendance can occur and follows the acceptance of a referral by the agency. Non-attendance has been described as resource

wastage. British general practitioners had objected to this (Oppenheim, Bergmann, & English, 1979) and a government minister had railed in the British parliament against such wastage (Russell, 1984). Subsequently, paediatricians, Andrews, Morgan, Addy, and McNeish (1990), stated, "failure to keep outpatient appointments is common. It wastes health service resources, disrupts clinic appointment systems, and may affect the patients' health." (p. 192). Andrews et al. (1990) reported that 23 per cent of children did not appear for their first paediatric appointment and 35 per cent missed subsequent appointments.

Non-attendance and the quality of the referral transaction would seem linked. Fischer and Turner (1970) looked at the problem in terms of orientation to seeking professional help. Feister, Mahrer, Giambra, and Ormiston (1974) considered that discontinuance reflected the shaping of the clinical population by clinic practices. More recently, Farid and Alapont (1993) provided some evidence that non-attendance was likely to be linked to inappropriateness of referral.

Following up of mental health service applicants goes back, at least, to Inman (1956), but most studies have concerned the applicant who attends some number of the initial sessions. No doubt some of the issues that apply to the assessment phase discontinuer apply to those who never attend, but there are differences. Gould et al. (1970) referred to "the silent population" as "patients who flirt with treatment" (p. 166). Hershorn (1993) renamed this "silent" group as "elusive" (p.49). Morton (1995) called the phenomenon "an enigma" (p. 47). These metaphors of discontinuance were discussed in greater depth in Section 3.4.2, above.

Gould et al. (1970) had set out to explain a two-year pattern of 20 to 30 per cent non-attendance at the UCLA outpatient psychiatric clinic. In a study of 24 non-attending applicants, compared with the 58 who did attend, referral information discriminated five main reasons for discontinuance: "non-specific feelings of discomfort .... blames others for present difficulty, ... crisis or situation moving toward a crisis, ... intolerable emotional pain … [and] … medication [wanted]" (p.167).

The original hypotheses of clinic bias against non-psychologically minded applicants, or an applicant's pattern of behaviour toward authority, were put aside.

Gould et al.'s (1970) second reported study was conducted one year later, over a two-month period during which 175 applicants attended and 58 applicants did not. Measures of waiting time (2-14 days), socio-economic status, and state of crisis did not discriminate attenders from non-attenders. Thematic analysis of the referral and intake data yielded six patterns among those who had attended ("shows") and four patterns among those who had not attended ("no shows"). A continuum was described of preparedness for treatment, with clarity, activity, and acceptance of the patient role at the most prepared end, and with unclear, passive, but emotionally pained people at the least prepared end. High preparedness predicted attendance at the first appointment. Gould et al. concluded that lack of definition of the problem at the time of referral was the key factor in not attending. Thus, Gould et al.'s (1970) work demonstrated that referral and intake was important in encouraging attendance, with passivity on behalf of the parent and lack of clarity on behalf of the agency also important. Discontinuance was not associated with simple demographic factors. Gould et al. reported that subsequent procedural changes, including telephone follow-up, did facilitate continuance.

In Canada, Lefebvre et al. (1983) contacted non-attenders by telephone, six months after they had failed to attend. Forty of 44 such cases from a six-month period were contacted, which was a low, 13.6 per cent of the total referral population. Demographic differences were small but children attending were on average a year younger, and more likely to be male, but non-attenders were more likely to be poor. Twenty-two families gave the reason that the projected wait of six weeks was too long and 19 families had decided to seek alternate treatment. Twenty-seven of these families reported improvement or problem resolution, 18 having had no intervention at all.

Lowman et al. (1984) compared attenders with non-attenders at a United States child psychiatry service. One hundred consecutively referred "teasers" (p. 253) (inquiry group) were compared with 100 consecutively referred "users" (client group), all of whom had the same intake worker, the same application processes, and the same forms completed. This study, among all those reviewed here, most adequately controlled referral and intake conditions. The non-attending children and parents were older than the attending children and parents. The non-attending children had demonstrated their problems at an earlier age, and these problems were more behavioural and less personality based than for the attending group. There were more girls than boys in the inquiry group, as with Lefebvre et al. (1983). Nearly half the inquiry group had gained help elsewhere, through a medical source (34 per cent), school (26 per cent) or other agency or professional (37 per cent). Twenty-nine per cent of the inquiry group were said to have recovered and 20 per cent found application procedures unsatisfactory, especially the application form, but also the waiting time and the fee.

Lowman et al. (1984) made recommendations about research methodology and service refinement. They had found non-attending families as no less willing to inform about their experience than the client families, and encouraged researchers to include non-attenders in future studies. Service refinements concerned referral and intake practices that were brief and facilitative, but that could detect those who were not likely to attend. They had found telephone follow-up to be more reliable than follow-up through the mail.

Cottrell et al. (1988) studied non-attendance at child psychiatry outpatient clinics in south London. A sample of 100 consecutively referred cases was followed, with five referrals not being offered initial appointments, and 14 families not attending the first appointment. An active opposition of parents to referral was significantly linked with non-attendance at the first interview. Six cases were discharged after one interview, with 21 cases not attending the next appointment. Forty-one of the remaining cases had completed or were continuing with treatment. Six cases were late

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discontinuers. Continuing cases were distinguished by the children having a state of general anxiety diagnosed at assessment. No other factors discriminated between continuing and discontinuing clients.

Nimgaonkar and Farrell (1988) followed soon after Cottrell et al. (1988), with a similar clinic demographic. Nimgaonkar and Farrell noted parental disinclination to attend as a likely cause of discontinuance. These two studies suggest that the parental view of referral, and perhaps knowledge of the clinic, can have profound effects upon attendance for older referred children, in accord with Wolpert and Fredman (1996).

While there are differences between adult therapy discontinuance and child therapy discontinuance (Pekarik & Stephenson, 1988), a United States study of adult pre- intake discontinuers highlighted the issue of crisis in precipitating contact. Orme and Boswell (1991) undertook their study "with the assumption that treatment begins with the patient's initial scheduling of mental health services" (p.375). They were responding to the challenge contained in the title of an earlier paper by Kirk and Frank (1976; cited in Orme & Boswell, 1991) concerning those who attended "zero interviews". There was a difference between zero attendance rates for those adults with children (39 per cent) and those adults without children (25 per cent). Waiting time affected discontinuance rates, with fewer discontinuers when the waiting time was less than four days or greater than twelve days. Orme and Boswell concluded that this pattern suggested two types of applicant, the one in urgent need of being seen, and the other willing to wait for service.

Hershorn's (1993) American study highlighted the need to respond to crisis applications for help in both adult and child mental health. Hershorn compared 29 non-attenders at first appointment with 27 attenders who returned a questionnaire sent to a pool of 189 referred adult and child clients of a community health centre. There were no differences between the groups with respect to gender, age, ethnicity, educational attainment, income, public assistance, and marital status. Most of the

mental health variables showed no differences, but attenders were more likely than non-attenders to have been referred by a mental health source. The many differences included non-attenders being more likely to have been married more times, to have been out of work or to have been a shorter time in work, to have had more jobs and residences, and to have been at their current address for a shorter period. Hershorn concluded that all these risk factors might be combined into a general indicator of risk for non-attendance, namely, stability in life.

4.2.5   Improving first appointment attendance

Non-attendance at the first appointment may be due to current concerns and priorities of the parents at the time when the initial appointment occurs, rather than when the referral was made. Many agencies have tried various strategies to increase first appointment attendance rates, such as adjusting referral and intake procedures, telephone and letter reminders, mailed out questionnaires, and forms to be filled by visiting the centre prior to the first appointment.

Two aspects of this uncoordinated research program stand out. Firstly, all strategies have been reported as effective, but the side effects of the changes have often not been examined. Secondly, researchers have accessed the literature to provide direction for their own study, but to a limited degree. It is likely that cross-fertilization among these studies would have improved experimental design generally.

An early study (Rooney & Miller, 1955) documented the effects of a change in referral and intake procedures at a public mental health clinic after an extended examination of the functions of referral and intake within a clinic and within a community. The referral and intake policy set "the prime relationships of the clinic" (p.392). Nearly fifty years ago, then, a systems conception of the community was provided, and the implications of such a view for clinic functioning, and interface with other service providers, were clearly stated.

The old policy had been to accept all applicants, the new policy involved consultation with a referral and intake worker to assess appropriateness of referral and priority for service. After implementation of the new policy, Rooney and Miller followed up non-attenders. The pattern of improvement without contact but with consultation elsewhere, was repeated in later studies, as was the presence of cases that had become worse or were not sure about what to do.

Krause (1966) compared the effects on continuance of four experimental intake procedures at a United States community health centre and involved referrals for parent-child difficulties, marital difficulties, or personality problems. Four different telephone referral interview protocols were evaluated. The first protocol emphasized the benefits to be reasonably expected from the centre. The second protocol emphasized understanding the client's request for assistance. The third protocol explained the "sorts of demands using the service *may* make on" the client (p. 516). The fourth protocol attempted to understand the difficulties that the client anticipated in using the services. Krause encountered many difficulties in implementation of the complex design of this study, especially, the training of referral and intake workers to include a willingness to explore issues in a creative manner within the framework of the set protocol. Few differences were found. Overall continuance to first appointment (54 per cent) and to subsequent sessions (75 per cent of attenders attended up to three sessions) was the same as it had been prior to the experiment. A particular referral and intake worker with a definite style (undescribed), using the fourth protocol, which explored barriers to service use, lowered the rate of discontinuance from 44 per cent to 27 per cent. Anticipation of potential difficulties in using the service was proposed by Krause to pre-empt a tendency to discontinue among some clients. Much later, Hershorn (1993; Hershorn & Rivas, 1993) suggested that factors that inhibit attendance should be addressed at the time of referral.

Another strategy for the reduction of first appointment non-attendance was attempted and evaluated by Turner and Vernon (1976), who used postcard reminders at their United States community mental health clinic. At clinics elsewhere in the United States, Folkins, Hersch and Dahlen (1980) reduced waiting times with reminder letters, and Kluger and Karras (1983) sent information packages. Telephone reminders have been researched in adult mental health centres, but Burgoyne et al. (1983) doubted the value of the innovation, whereas, Carr (1985) and Hochstadt and Trybula (1980) used reminder telephone calls to decrease incidence of missed initial appointments at adult community mental health centres. Gariti, Alterman, Holub-Beyer, Volpicelli, Prentice, and O'Brien (1995) demonstrated positive effects of an appointment reminder call with substance using adults in California. Examples from the child and adolescent literature recorded positive advantages of telephone reminder (Gould et al., 1970; Lowman et al., 1984). Pre-therapy orientation sessions were employed by Day and Reznikoff (1980), and Larsen, Nguyen, Green, and Attkisson (1983), and Zwick and Attkisson (1985), at their child and family clinics.

Overall, it is not clear from the various studies if there was long-term value in the reminder call. Reminding people may get them along more, initially, but it was unreported if more contact over the therapy period resulted. The consequences of innovations with respect to initial attendance have rarely been measured through to effects on therapy contact.

4.2.6   Seven exemplary studies of clinic innovation to promote attendance

Close examination of seven clinic studies of attendance innovations has demonstrated how adaptation of referral and intake procedures at child and adolescent mental health services, specifically, can have both predicted and unpredicted effects. Each of these studies accessed past literature to design the evaluation. All measured base rates and most used non-innovation control groups. All demonstrated effects upon rates of referral and rates of attendance. However, most of these have not considered the effect that the innovation has had upon the total pool of referrals.

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Sometimes the innovation seemed to have lowered rates of missed first appointments by having potential appointment non-attenders deterred by the referral innovation.

Then first of these exemplary studies to be reported was that of Swenson and Pekarik (1988) who used mail-based interventions with potential clients (50 adults and 30 children) assigned randomly to one of four conditions for the reducing of missed initial appointments at a United States community mental health centre. Two variables were manipulated, namely period of warning about the upcoming appointment (one day's notice or three days notice), and the content of the pre-appointment letter (appointment reminder alone or with a written orientation statement about the centre and its programs). There was also a control group who received no notice of their initial appointment that had been made at the time of referral. Three of the four reminder conditions did not produce significant differences in attendance rates from those of the control group, which was 43 per cent. However, those who received the reminder and the orientation letter one day before they were due to attend, had a missed appointment rate of only 17 per cent. The effect upon total rate of referral was not reported.

MacLean, Greenough, Jorgenson, and Couldwell (1989) wanted to lower a rate of missed initial appointment of 21 per cent at their Canadian child mental health clinic. This figure was already unusually low in comparison to similar services in many other parts of the world. They augmented the usual mail-based reminder strategy and used an experimental design, in which 75 cases were allocated to groups receiving one of four pre-appointment letters. These were the usual clinic reminder, a change-slip reminder (which asked clients to send back a slip at the bottom of the letter if an appointment time change was needed), a warning reminder letter (that warned clients about losing their place on the waiting list if they did not attend), and a change slip and warning reminder letter (a combination of the previous two strategies). Unfortunately, no measure was made of waiting period for the appointment.

No significant differences were found between any of MacLean et al.'s (1989) experimental groups for rates of arrival at the first appointment, changed appointment (including cancellation), or "no-show". However, the rate of non-attendance for the experimental groups overall was only 7 per cent, which was significantly less than the rate of 21 per cent for the clinic during the time of the study. During the four months after the experiment, when the measures were no longer in place, the "no-show" rate rose to 23 per cent.

A separate part of MacLean et al.'s (1989) experimental design involved parents who had received an information form that took 30 minutes to complete about the referral problem, family membership, and related medical, school and developmental details. For those who did not receive reminder letters, the rate of non-attendance fell to a highly desirable 1.5 per cent. More impressively, all those who received the form and an experimental reminder letter attended their initial appointment. So successful was the use of forms, that the clinic adopted the use of forms for all referrals, and the non-attendance rate subsequently fell to 0.5 per cent for the following 18 months (immediately prior to publication of results). However, those who did not return the form would previously have belonged to the 21 per cent of before experiment missed appointments, so it is unclear how many of the potential non-attenders were recruited by means of the act of filling out the form.

In a similar study, Kourany, Garber, and Tornusciolo (1990) found similar trends. Using an experimental design, 41 patients to a United States university child mental health clinic were randomly assigned to one of four conditions for prompting first session attendance. One group of participants received a reminder telephone call one to two days prior to the appointment that was scheduled when the referral was made. A second group received "a letter describing what would happen at their first visit to the clinic" (p. 658) a few days after the appointment had been negotiated. Another group received both the information letter and the telephone prompt. The

fourth group were not contacted between the time the appointment was made and the appointed time itself.

Kourany et al. (1990) did not cite MacLean et al. (1989), but like them found the effect that contact of any sort, with the first three experimental groups, lowered the rate of non-attendance, with no particular intervention emerging as significantly more effective. It was not clear if the overall rate of referral had decreased during the experimental period, but rates of non-attendance and cancellation were examined in relation to waiting periods for the appointment, which had not been done in MacLean et al.'s study. Non-attenders had to wait a mean of 46.8 days, cancellations 40.8 days, and attenders 28.6 days. These were highly significant statistical differences. Further, other demographic characteristics (age, gender, race, birth order, referral source, referral question, number of siblings, parental marital status, or welfare status) did not differentiate these three groups. However, those families who had had prior contact with the service were more likely to attend.

Kourany et al. (1990) followed up 68 per cent of the non-attenders by telephone several weeks after the missed appointment. The parents were asked what had prevented attendance, and asked to rate the applicability of 24 possible reasons for non-attendance. The most common reason for non-attendance concerned the difficulties of attending given the parents' work schedule (72 per cent). Sixty-four per cent reported improvement in the child. Fifty-four per cent cited the cost of the service as a factor. Fifty-two per cent had sought help elsewhere. Forty per cent did not think the child had a problem. Forty per cent discontinued because of the lengthy waiting period. Thirty-nine per cent had transportation difficulties. Twenty per cent of the replies reported child refusal or spouse refusal to attend.

Deane's (1991) study of an innovation at a New Zealand child mental health clinic was similar to those of Swenson and Pekarik (1988), MacLean et al. (1989), and Kourany et al. (1990), but

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simpler. Parents were asked to come into the clinic and fill out the Achenbach Child Behavior

Checklist (Achenbach & Edelbrock, 1980) and, having done this, were given the time of the first

appointment. The journey to the centre prior to the first appointment

> enabled the parents to prepare for the initial interview by encouraging them to structure and
>
> specify the problem, while also providing valuable assessment information for the clinician.
>
> (Deane, 1991, p. 47)

The innovation addressed the following issues:

1. It immediately conveyed the message that some parental cooperation and involvement
   in addressing the 'child's problem' was preferred.

2. It required the parents to exert more effort than just making a telephone call in order to
   obtain an appointment, verifying their initial motivation and commitment to continue.

3. It ensured that the children had some means of getting to the clinic.

4. It provided a relatively non-demanding, non-threatening and structured initial contact
   with staff at the clinic, increasing parent and client knowledge of the clinic and its
   services and potentially decreasing initial anxieties about attendance.

5. It provided an immediate response to the request for help. (p. 47)

Deane (1991) first collected base-line data for five months prior to the year long trial of the

intervention. There were no differences between the base-line group and the experimental group

on measures of age, gender, referral problems, referral source, and waiting period. During the

base-line period, the "broken appointment" (p. 49) rate was 37.7 per cent. During the intervention,

the rate was 26.5 per cent, a statistically significant improvement. Sixty-seven per cent of referrers

attended to complete the forms on the same day as referral, with the remaining 33 per cent coming

to the centre within an average of 2.7 days. All parents completed the forms, therefore, the

innovation did not increase attendance rates by adversely affecting the referral rate, as happened in

Wenning and King (1995).

A pre-therapy intervention involving attendance was used by Wenning and King (1995), among other concurrent strategies, to reduce the waiting period of four to six weeks, including a requirement for the clinic to take on a minimum number of new cases per month, the hiring of staff to conduct referral and intake interviews, and the adoption of a briefer treatment model. As with Day and Reznikoff (1980), Larsen et al. (1983), and Zwick and Attkisson (1985), mandatory, pre-treatment, parent orientation meetings were introduced. The meetings involved no cost and were held weekly, for one hour after lunch on a Friday, and were attended by a range of three to 15 parents.

> The specific goals of the orientation meeting were to screen parents based on level of motivation, educate parents about the evaluation and treatment process, correct unrealistic parental expectations about the clinic, and motivate parents to attend therapy sessions regularly. (p. 831)

Wenning and King (1995) compared attendance rates for an eight-month period in 1992, with the same period in the previous year, pre-intervention. Thirty-five inactive files from each year were randomly selected to see if the effect of reduced rates of missed appointments occurred within the subsequent the treatment phase. Statistical significance tests seem not to have been performed, but the rate of non-attendance at the initial appointment fell from 26 per cent to just 7 per cent. However, subsequent missed appointment rates did not change from 28 per cent, even though the number of appointments for the two groups of 35 inactive cases halved (913 to 457), in line with the briefer treatment model. Wenning and King were proud to report that the overall package of changes reduced the waiting period to between five and ten days.

Wenning and King (1995) reported the results of a preliminary follow-up of those who did not attend the orientation meeting, an extra piece of research, within their concluding paragraph. Telephone contact was made with 17 of 85 parents, and all "reported that they had missed the orientation meeting for a variety of reasons unrelated to the meeting itself" (p. 833). As in Kourany

et al.'s (1990) study, most of the reasons given for non-attendance were not related to the specific appointment.

Wenning and King (1995) obscured referral rates in their findings. Six hundred and sixty-two families contacted the service in 1992, and, of these, 227 did not attend the orientation meeting. This was just over one third, with a further 22 families who attended the orientation meeting not proceeding to the first appointment. Wenning and King claimed this to be evidence of resources saved, as no clinical service as such was provided. However, the rate of not getting to a first appointment was 34 per cent, which was greater than the pre-intervention of rate of 26 per cent. Also, the quantity of first appointments offered in the two eight-month study periods fell by more than 25 per cent from 1991 to 1992. This major decline in such a short time suggests a high possibility that the innovation of the orientation meeting actively excluded some of those in need of help and, thereby, lowered the overall rate of initial appointments drastically. The closest Wenning and King came to observing this trade-off of clinic efficiency with parental reluctance was:

> some families will view a mandatory parent orientation meeting as a barrier to care.
> However, the vast majority of parents who call do not express concern about having to
> attend this meeting. (p. 833, 834)

Seeking clinic efficiency can be a barrier to service, particularly when parents are ambivalent about attending. Stallard and Sayers (1998) and Wiseman and McBride (1998) found that requiring parents to confirm attendance at an appointment prior to attendance greatly improved attendance rates. Stallard and Sayers' first appointment non-attendance rate dropped from 27 per cent to 5 per cent, but nearly half of the applicant families were not seen at all.

Similarly, Wiseman and McBride (1998) demonstrated a much higher rate of first appointment attendance when confirmation of attendance was required, with no differences between those who received a reminder letter of the upcoming first appointment and those who received no other

contact than the letter of appointment that was sent within four days of referral. However, eleven per cent of the confirmation group did not make contact and, therefore, did not have a confirmed first appointment that they could not attend. The actual numbers in each experimental group were not reported, but it is likely if the non-confirming group were considered as referring non-attenders, the differences between the groups may not be significant. While they concluded that choosing to attend through confirming the appointment helped prevent appointment wastage, Wiseman and McBride remarked that such a system cannot work if there is not four weeks between first contact and appointment, as the mail out of appointment and then request for confirmation all have lead times and periods requiring timely response from the applicants. Implicitly, Wiseman and McBride recognized that such systems do create barriers.

The evidence concerning these many strategies for promoting attendance at initial appointments has been mixed. Overall, however, there does seem to be a group of applicants who are positively susceptible to strategies promoting first appointment attendance and another group who are unresponsive. The strategies can work to reduce missed appointments, but would seem to exclude some callers, although researchers have often not estimated the numbers of those excluded. Those who do not attend may require alternate handling to secure their attendance for the first interview and subsequent intervention.

It would appear that current practices of referral and intake can be improved and might promote attendance among a larger group of families, but there is a smaller group of families with delicately balanced commitments or priorities who do not get to the help they need because of these priorities. Kourany et al.'s (1990) list of reasons for non-attendance illuminate some of these issues. However, there would seem to be another group of non-attenders whose personality difficulties or crisis-ridden lifestyle makes attendance anywhere unlikely unless an immediate crisis response is offered. This issue is pursued further in section 5.3 in Chapter 5, below.

4.2.7   First appointment attendance and waiting time

Reports of a number of studies have suggested that a major reason for first appointment non-attendance is the length of time between the referral call and the first appointment. In the child and adolescent mental health field, longer waits mean lower rates of first appointment attendance and this has mostly been considered undesirable (Cohen, 1960; Gould et al., 1970; Lowman et al., 1984; MacLean et al., 1989; Kourany et al., 1990; Rooney & Miller, 1955; Wenning & King, 1995). By contrast, Robin (1976) had considered waiting as an effective filter on uncommitted patients. The experience of waiting, the time sensitivity of those who wait, and the rate of seeking help elsewhere have also found to be influential. That waiting time period can vary from clinic to clinic suggests that the decision not to attend occurs relatively close to the appointed time.

For instance, Orme and Boswell (1991), at an American adult community mental health centre, found that waiting affected some clients with urgent needs, but did not affect those who felt they could wait. Morton (1995), at an American adult group work service, reported a mean waiting time of 19 days for adults who did not attend, yet those who attended had waited just four days less. Stallard and Sayers (1998), in Britain, found that attending families waited an average of 5.5 months, while the wait of families who did not attend had been 6.1 months, at time of allocated first appointment.

By contrast, Stern and Brown (1994) reported on the experimentally controlled introduction of a waiting list to an urban United States child psychiatry clinic. The waiting list was introduced to cope with increased rates of demand for services by sorting at referral and intake urgent cases from waiting list cases. Compared to the previous year, waiting time for the first appointment, which had been a mean of 19 days prior to the innovation, was reduced to 17 days for the urgent group, but increased to 56 days for the waiting list group. Stern and Brown did

not comment on the reduction of the referral rate by 5 per cent from the previous year, which may have been an ordinary fluctuation, or the waiting list procedure deterred referral sources or filtered clients. Stern and Brown were concerned by the adverse effects of the waiting list changes, but chose methods other than reversing the innovation to improve efficiency in service delivery. A similar outcome was recorded by Chiesa (1992) with a referral and intake innovation at an adult psychotherapy clinic designed to reduce waiting periods by assessing urgency. Sorting according to urgency did not significantly improve access for those in urgent need, but severely affected those deemed able to wait, which sounds a procedural caution to the adoption of Hershorn's (1993) recommendation for making services more available to those in urgent need.

4.2.8 Procedural barriers to attending the first appointment

The innovations found to improve attendance at first appointments in child and adolescent mental health clinics all have involved procedural changes. As procedural changes can increase aspects of efficiency, procedural barriers must have been present, but what these might have been have usually only been reported in the context of innovations.

Strategies for engaging families during waiting periods have made the wait time more productive for families with the introduction of orientation meetings (Wenning & King, 1995) or the filling out of questionnaires (Deane, 1991; MacLean et al., 1989). Attempts to reduce the long waiting lists occurring in child and adolescent mental health services have had little success. Only three published studies have recorded successful strategies. Wenning and King involved the employment of extra temporary staff to do short-term therapeutic work. MacLean et al. achieved a near zero rate of missed initial appointments using reminder letters and questionnaires. Stallard and Sayers' (1998) system of requesting parents to confirm attendance by telephone produced better appointment attendance and shorter waits than the pre-innovation

time of six months, but nearly half the applicant population were not seen at all as they did not confirm, and thereby freed up earlier appointment times for those who did. These procedural changes seem to have affected overall referral rates negatively, with crisis referrals most likely to not pursue applicancy.

Procedural means have been reported that were designed to actually decrease clinic accessibility in two studies. Robin (1976), in Britain, vigorously asserted the use of waiting times as a means of filtering clinic workload. Frankel and Simmons (1992) reported use of referral and intake procedures to control referral rates to an American university clinic that provided parental behaviour management programs. However, University clinics are set up with three purposes other than service delivery, these being access to cases suitable for beginning clinicians, implementation of controlled research programs, and provision of service in a way that fits in with the teaching program and accommodating periods of intense activity and of no activity whatever.

The service access filtering effect of procedures has rarely been studied in depth. Those studies that do exist only incidentally note the effects of procedural changes other than those being directly studied. Mostly these procedural changes have been enacted in the referral and intake period. Initial interactions with clinic staff have also been found to be important.

4.2.9   Initial interactions and subsequent attendance

Initial impressions of therapists and clients and other interpersonal factors have been shown to be important to subsequent attendance. Beer (1991, 1992) found that for a pre-school child psychiatry service, completion of assessment was more likely when the initial appointment was longer and the clinician had more than one year's experience. Sirles (1990) had noted that more experienced clinicians were more likely to engage families within the initial interviews.

Attractiveness of client (Sharf and Bishop, 1979), attractiveness of therapist (Sharf and Bishop, 1979; Tryon, 1992), severity of problem (Bishop and Sharf, 1980), confidence of intake worker (McGuff, Gitlin, and Enderlin, 1996), and the quality of the perceived relationship with colleagues, (McGuff et al., 1996) have all been found to influence the conduct of the first interview and subsequent rates of attendance. This small and diverse group of studies have placed importance on what happens between the interviewing referral and intake clinician and service applicant. Starting well clearly has a range of factors associated with it, including attractiveness, but a consistent theme has emerged of clinician skill, experience, confidence, and capacity to engage the client.

Effective early transactions have been shown to enable accurate predictions of subsequent attendance (Sirles, 1990; Tryon, 1992). An initial negative impression of child and adolescent mental health service was hypothesized by Beckham (1992) to precipitate discontinuance, but parents attributed discontinuance to practical problems affecting access, as indicated by Kourany et al. (1990) and Hershorn (1993). All these results indicate a need to document more closely the subtle external influences and the interpersonal micro-practices of beginning.

4.3   From contact to attendance at child and adolescent mental health services

Making contact and then attending at an adequately resourced child and adolescent mental health clinic involves moving past many barriers. Clinics have been inventive, but uncoordinated, in their endeavours to ensure the applicant becomes a client. Mostly these efforts have been initiated at individual clinics, where the researchers have used literature to find support for the changes they proposed. The many studies mentioned in this chapter have reported the effects of the change upon the targeted phenomenon, but have rarely considered co-variates or effects upon other aspects of the processing of applicants, especially, reduced referral rates. Often, a wider survey of relevant literature might have attuned the researchers to the potential negative side effects of the innovations, or to the general lack of understanding of the effects of beginning at such a clinic.

Nevertheless, these separate attempts to provide better service do suggest useful strategies to improve services that might be applied without adversely affecting rates of referral. There is a body of knowledge from which to design referral and intake work practice. However, whatever the improvements, it also appears that applicants for service still terminate or discontinue contact before completing the program of assistance offered. This phenomenon, and its relationship to referral and intake, is explored in the following chapter.

CHAPTER 5

EMPIRICAL STUDIES OF DISCONTINUANCE
FROM MENTAL HEALTH SERVICES

Look in my face; my name is Might-have-been.
I am also called No-more. Too-late, Farewell.
(D. G. Rossetti (1871) A superscription. *The house of life*)

The primary question about these families who are lost by agencies concerns whether or
not their needs are being met. In the case of a family lost by a child guidance clinic, one
wonders what sort of adjustment the child is making and if he is getting better or worse.
If he is getting worse, not only the community is threatened, but the child's happiness and
that of his family and successors is endangered
(Inman, 1956, p. 35).

Perlman (1960) described the problem of the client discontinuing contact from mental health

agencies as:

> 'the case of the third man'. Of every three persons given the time, attention, and
>
> beginning casework help at the agency's referral and intake desk, one drops out before
>
> the second interview. (p. 171)

The phenomenon is international, and appears to be multiply determined. Australians, Sawyer

and Patton (2000), stated that "a large proportion of children and families who attend mental

health services *discontinue after a couple of appointments"*(their emphasis, p. 340). Clinic-

based research has studied procedures designed to lower the rate of dropout, but as shown in

Section 4.2 of Chapter 4, has found that these changes can have unintended and unmeasured

consequences on rates of referral. In this chapter, the pattern of discontinuance after the first

interview, as identified in published literature, is explored.

Despite the variations in the rates of discontinuance, Perlman's (1960) "third man" is a consistent citizen of referral lists to mental health clinics. Baekeland and Lundwall (1975), in a lengthy massing of published studies of dropping out, concluded that very few generalizations could be made concerning demographic or other reasons for discontinuance. The evidence that has gathered across clinic, country, context, and age group, and from the beginning of documented time (Feldman, 1937), continues to generate unanswered questions concerning the meaning of discontinuance and the action required to address the questions. Partial answers have been provided in the literature, but the separate studies do not provide an integrated picture of this field of research.

Discontinuance has several concerning implications. Where clients do not avail themselves of help they once considered necessary, they may remain in need of help, staff time is wasted by unattended appointment times, and the overall effectiveness of the service is reduced.

In this chapter, discontinuance is examined in terms of the phase of initial engagement with a child and adolescent mental health service. Discontinuance is perceived differently by the client, and differently again by the clinician, if it occurs before assessment, after assessment, or during psychotherapy and before mutual termination. The analysis of the accumulated discontinuance studies presented here suggests that there are at least three types of applicants to mental health services.

5.1   Phases of contact and discontinuance

The analysis of metaphors used to describe discontinuance in Section 3.4.2 of Chapter 3 showed that the descriptors of discontinuers have been less negative when phase of discontinuance has been highlighted as an issue (Orme & Boswell, 1991; Pekarik, 1986; Reiher et al., 1992; Sirles, 1990). Discontinuance can occur at different points in the management of

cases, and the profile of the discontinuer at referral, at referral and intake, at evaluation, and

later in the therapy phase, appears to be different (Armbruster & Fallon, 1994; Pekarik, 1992a;

Sirles, 1990). This was first noted by Tuckman and Lavell (1959).

Analysis of the evidence in this area is aided by considering discontinuance at each of the

phases in terms of the structure of clinical contact at child and adolescent mental health

services. Figure 1, below, shows a timeline passing through the phases of initial contact

(including the waiting period), assessment, and therapy, and provides a map of clients'

progress. The phases of contact are differentiated with shading.

PHASE OF CONTACT	*PROGRESS OVER TIME*	*agency boundary*	CIRCUMSTANCES OF CONTACT OR EXIT
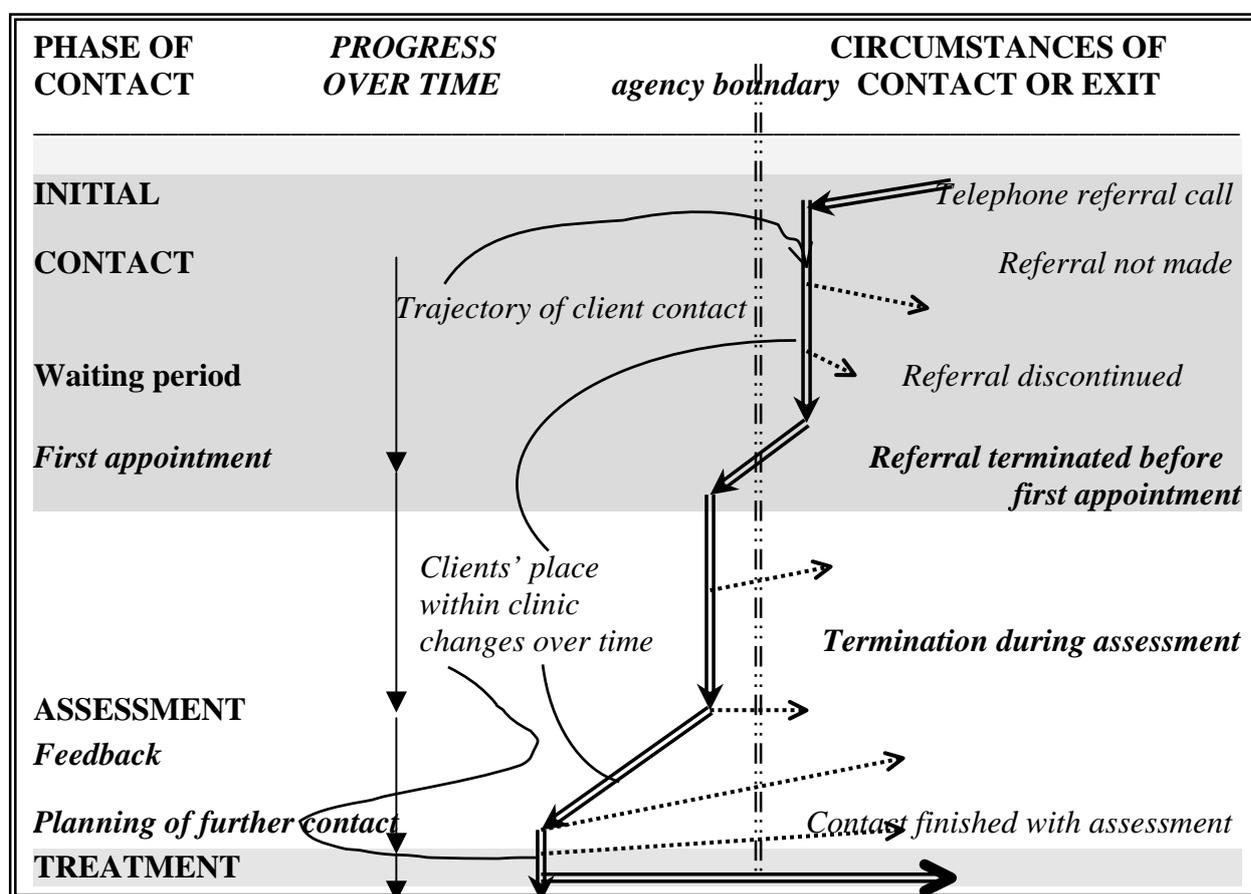
Figure 1: Representation of phases of contact with a child and adolescent mental health service
and the timing of discontinuance.

For the initial period in Figure 1, the client is outside the agency. Entering for the assessment

phase, the client may or may not proceed within the agency to treatment. Treatment with a

designated clinician occurs for a period of time that may be specified or open-ended. The double line indicates the trajectory over time of a client who completes therapy and terminates mutually with the clinician. Clients can discontinue at various times during contact. The thin-dotted lines pointed to the right indicate potential paths of discontinuance and are labelled at the right hand side adjacent to the exiting arrow. Discontinuance at these various points in time probably carries different meaning, and these differences are discussed below.

The clients' place and embeddedness in the life of the agency is also represented in Figure 1 with the first contact being made from outside the agency. The assessment occurs within the agency, but outside of its programs of assistance. When therapy begins, the clients are more deeply within the life of the agency. Termination has the clients leave the agency. The depth of feeling for the agency or the clinician cannot be easily represented, but the circumstances of termination would become more idiosyncratic the longer the client attended the service, as leaving would have more complex internal and external relational ramifications.

5.1.1   Phases of discontinuance

Tuckman and Lavell (1959) evaluated the progress of 1548 child patients of eleven Philadelphia child psychiatry clinics in the calendar year of 1955. Thirty-one per cent of these referrals were terminated by parents prior to assessment. One thousand cases proceeded to the assessment phase, with terminations during this phase of 15 per cent by the patient and eleven per cent by the clinic. Seven hundred and two cases moved into treatment, with treatment subsequently terminated by the patient (42 per cent) or the clinic (26 per cent) before mutual termination had occurred. Clinic terminations included improvement of 16 per cent, referral elsewhere, (5 per cent), and other reasons (5 per cent). Overall attrition rate for 1955 was 59 per cent. The attrition rate varied from clinic to clinic, with a range of zero per cent to 45 per cent at referral and intake, and two per cent to 34 per cent at the assessment phase. These were

wide variations with local contextual origins, such as "type of clientele, length of waiting period, fee schedule, and clinic policy and procedure" (p. 35).

Tuckman and Lavell (1959) analyzed a range of factors that might have affected rates of discontinuance across the three phases of referral and intake, diagnostics (that is, assessment), and treatment. Gender, ethnicity and age were not found to be operative factors in any of the phases. Those cases with three or more problem types were more likely to have terminated during the treatment phase, while in the diagnostics phase those with fewer problem types were more likely to have terminated.

Over the next thirty years, only Cohen and Richardson (1970) considered discontinuance with respect to phase of contact. Their extensive analysis of many cases, revealed a paucity of factors that differentiated between those who continued and those who terminated. Within the "pre-therapy" discontinuing sample, three variables were significantly related to discontinuance, namely greater elapsed time between initial contact and the eventual closure of the unseen case, the referral source having inadequately prepared the parent for the service, and the family and child displaying "gross ignorance or lack of sophistication" (p. 81). Among the "therapy" discontinuing sample, antisocial behaviour as a presenting problem of the child was found to be higher in the "attrition" group than in the "controls".

The phasic quality of clinic contact described in United States studies by Tuckman and Lavell (1959) and Cohen and Richardson (1970) was revived by Sirles (1990). Sirles proposed three phases of contact, which were phenomenologically and administratively discrete, and which she called, following Tuckman and Lavell, "intake, diagnostics, and treatment" (p.345). Sirles regarded the tendency to "project responsibility for dropout onto the child" as "short-sighted" (p. 346). In her literature review, Sirles found no uncontradicted findings of child variables differentiating continuers from discontinuers at any phase, except that children with chronic

problems were more likely to continue. Similarly, Sirles found only contradictions in the findings of past studies of discontinuance with respect to descriptive aspects of the family, including socio-economic status, parental level of education, and referral source.

In her study of 321 children and adolescents (and their families) in a United States university-based, outpatient child guidance clinic, Sirles (1990) found there was an even rate of self-termination (~22 per cent) from each of three phases of contact (intake, diagnostics, and treatment), with a total self-termination rate of 68 per cent. Mutual-termination (total of 32 per cent) increased across phase, with a fifth of the mutual terminations in the intake phase, a third of the mutual-terminations in the diagnostics phase, and nearly a half of the mutual-terminations in the treatment phase.

Sirles (1990) believed there to be a lack of commitment by some clients during the referral and intake phase, which was shown by a cancelled or missed appointment. Sirles felt this was associated with less severe problems, with clients able to accept the input received in a productive way, or simply coming to regard the problem as not very severe. Sirles saw appointment cancellation rate as a "weak predictor of dropout" (p. 353), but subsequently, Beckham (1992) found missed appointments to be linked to discontinuance.

While length of waiting time discriminated continuers from discontinuers, Sirles (1990) reported that variables associated with self-termination were different at each phase. At the referral and intake phase, along with duration of the problem and father's age, were three clinical process variables. Trainee clinicians incurred more self-terminations. Fewer terminations occurred when the family and the child were interviewed, rather than child only or family only. The interviewing clinician made more accurate predictions of the likelihood of discontinuance, than others involved in a case.

For the diagnostics phase, Sirles (1990) found that self-termination was related to problem severity, psychosocial stressors, number of interviews, and the staff position. For this phase, trainees were more successful than permanent staff at promoting continuance. Internalizing disorders, as compared to externalizing disorders, were associated with continuance, as was a high level of psychosocial stressors. The average number of diagnostic sessions for self-termination clients was 3.8, with continuers having had an average of only 1.8 sessions. This greater length of the assessment was attributed to the extended assessment being therapeutic and sufficient, rather than due to the diagnosis being difficult to determine or a drawn out diagnostic process because of conflict or client dissatisfaction.

Self-terminators during the treatment phase were found by Sirles (1990) to be discriminated from those who mutually terminated by one variable, only. Higher educational achievement in the mother predicted mutual-termination. Similarly, Ewalt et al. (1972) and Kazdin et al. (1993) associated likelihood for discontinuance with lower maternal educational achievement.

Sirles (1990) felt that the rate of dropout indicated that clients were able to take what they needed from brief contact and, thus, that "more immediate intervention strategies" (p.359) might be more beneficial than focusing on the implementation of long-term treatments. Since Sirles' publication, the phasic quality of discontinuance has become a standard parameter of discontinuance research (Armbruster & Fallon, 1994; Kazdin & Mazurick, 1994; Pekarik, 1992b).

5.1.2   Discontinuance after assessment

When child and adolescent mental health assessments have been completed, researchers have been able to examine closely the reasons for discontinuance. Feldman's (1937) pioneering study involved systematic inspection of case files following psychiatric and psychosocial assessment. Using telephone interviews, Inman (1956) documented the reasons for discontinuance among those

who had completed their evaluation at the Institute for Juvenile Research (IJR), Illinois, and had attended for the appointment to begin treatment, following a period of waiting of about six months. Without the aid of psychometric instruments or interview protocols, Inman painstakingly analyzed the content of the telephone interviews by inspection.

Inman (1956) was able to distinguish three themes in her findings, namely the effect of waiting, the state of the child, and the parent's choices about treatment. The length of time in waiting did affect the uptake of treatment, but not to the degree expected by the researcher. Although many of the parents complained about the wait, several had sought help elsewhere, and in many cases the child had recovered or significantly improved. These latter were trends also noted in research concerning missed initial first appointments, as reported in Section 4.2.4 of Chapter 4.

Inman's (1956) second theme concerned the state of the child.

> Improvement seems to be reported [by the interviewed mothers] more frequently in severely disturbed children than in moderately disturbed children; there is a higher probability that parents of severely disturbed children go elsewhere than parents of moderately disturbed children; and mothers of girls tend to seek help more often than mothers of boys (p. 68)

There were no significant differences in the sample when compared with the general demographic composition of the clinic referrals.

Inman (1956) was concerned to understand what discontinuing parents had done about their child who had needed treatment. In fact, half had done nothing because the child had improved. Some parents did go elsewhere, but only some of these found the alternate assistance helpful. Later, Inman explained these remissions in terms of the usefulness of the psychiatric treatment (therapeutic assessment), the unburdening of the worried mother through the taking of the social history, and growth manifested as ego integration.

Inman's (1956) study was conducted during Levitt's leadership of the IJR. Levitt (1957) conducted research comparing 132 "remainers" and 208 "defectors" at the IJR, and found no differences between those who did not commence treatment and those who stayed for 20 or more treatment sessions. Levitt attributed the lack of difference to the therapeutic value of assessment. This study was followed up by an in-home case review interview of 142 cases seen in the decade prior to 1954 (Levitt, 1958). The interviews were held two to twelve years after contact, with a mean time interval of just over seven years. Levitt (1958) noted that ten per cent of the sample discontinued because of the long wait before being seen, and 18 per cent of parents claimed they were not contacted by the agency a fact contradicted by inspection of clinic records. Dissatisfaction with the clinic was registered by only three per cent of the sample. Family resistance to the treatment amounted to 24 per cent of the reasons for not seeking treatment (mothers 14 per cent, fathers 6 per cent, children 4 per cent). Improvement was noted in 14 per cent of cases (spontaneous 4 per cent, environmental change 4 per cent, diagnostics 6 per cent). Circumstantial interference with treatment arrangements accounted for 17 per cent of reasons for not having treatment.

Sirles (1990) found, as noted above, that discontinuation after assessment was connected with a less severe problem, fewer stressors, and longer periods of assessment, and that one third of the terminations were mutual between client and clinician. Indeed, Inman (1956), Levitt (1957), Cohen and Richardson (1970), and Sirles all noted the therapeutic value of assessment. In other words, terminations after assessment may actually include treatment successes.

On the other hand, the assessment phase may be experienced unfavourably. Silverman's (1970) interviews with post-assessment discontinuers of child and adolescent mental health services suggested that, to many applicants, talking things through with another person was not apparent as a potential solution to troubles. It is likely, of course, that there are different sub-groups in the applicant population, such that assessment is therapeutically valuable for some and not for others.

Late discontinuance in child and adolescent mental health services has also been researched. Pekarik (1986, 1991, 1992a) has documented the effect of client expectations of the duration of therapy. Later terminations were more likely to be mutual, but the differences between early and late discontinuations were not great. Satisfaction with the therapy was greater if the duration of therapy was closer to the original expectations of the client. For clients, satisfaction with the therapy, and priorities in other aspects of their lives, were more important than questions of technique and model. However, psychotherapy researchers are not likely to appreciate this view of clients.

5.1.3   Kazdin: From therapy model to barriers to treatment participation

Kazdin's Yale program of treatment and research in behavioural psychotherapy with children, begun in 1987, had only been underway for a relatively short period of time (for example, Kazdin, 1988, Kazdin, Siegel, & Bass, 1992), when premature termination and treatment completion rates became a strong theme in his publications (Armbruster & Kazdin, 1994; Armbruster & Schwab-Stone, 1994; Kazdin, 1990; Kazdin, 1996; Kazdin, Holland & Crowley, 1997; Kazdin, Holland, Crowley & Breton, 1997; Kazdin & Mazurick, 1994; Kazdin et al., 1993; Kazdin, Stolar & Marciano, 1995; Kazdin & Wassell, 1998). Kazdin et al. (1993) found that premature termination of attendance by anti-social children and their families was associated with younger mothers, single parents, minority groups, socio-economic disadvantage, lower educational achievement, adverse life events, adverse child-rearing practices, and antisocial behaviour in the childhood of the parent. They also found that the children who terminated prematurely were experiencing more severe difficulties than those who remained in the program, had greater academic problems, had a greater breadth and history of problems, had more anti-social peers, and had multiple diagnoses. Clearly, work with this group is difficult as the problems are trans-generational, economic, cultural, and political, rather than simply psychological.

Attrition as a characteristic of a family unsuitable for treatment had been highlighted by Feldman's (1937) study. Kazdin (1996) noted Wierzbicki and Pekarik's (1993) meta-analysis of dropouts and the lack of clear differences between those who remained and those who discontinued, which had been noted by many previous studies (Lefebvre et al., 1983; Levitt, 1957; Ross & Lacey, 1961; Pekarik, 1983a, 1983b; Plunkett, 1984; Shapiro & Budman, 1973). Armbruster and Fallon (1994) recast discontinuance as having risk factors in all cases. Incomplete treatment became a matter of relative risk involving the incidence of certain obstacles. Kazdin, Holland and Crowley, (1997) and Kazdin, Holland, Crowley, and Breton, (1997) presented their Barriers to Treatment Participation Scale (BTPS) which, when used with a clinical sample, revealed that there were many legitimate reasons for discontinuance.

Kazdin's research focus has shifted from therapy model (1978), to outcome (1988) and, then, to beginnings (Kazdin et al., 1997), and from theoretical formulation to client problems and, then, to social barriers to treatment. In contrast, Pekarik's contribution started with concerns about discontinuance (1983a) and moved toward consideration of how best to do therapy (1996).

5.1.4   Pekarik: From wastage of clinical resources to consumer views of therapy

Pekarik's initial concerns were with wastage of valuable clinical resources (Pekarik, 1983a, 1985a). Pekarik (1985a) suggested ways for therapists to cope with discontinuers and later (Pekarik & Finney-Owen, 1987) demonstrated psychotherapists' tendency to blame themselves for client discontinuance, which was first noted by Feldman (1937). But, he had realized that client discontinuance did not necessarily signify failure, as the follow-up adjustment of clients could show improvement (Pekarik, 1983b). Employing different termination classifications produced different views of outcome (Pekarik, 1985b; 1992b), as Garfield (1989) also noted.

This conclusion led Pekarik to consider what therapists thought about discontinuance and what effect expectations of duration had on outcome for adults and children. Pekarik's treatment duration research revealed that termination status could be used as an indicator of improvement (Pekarik, 1986: Pekarik & Wierzbicki, 1986). However, when Pekarik (1991) compared differences in expected and actual duration of treatment for adult and child mental health work, expected number of visits correlated with actual treatment for adults, but not for children. Similarly, Pekarik and Stephenson (1988) observed differences between adults and children in continuance rates, with therapist experience and referral source related to parental continuance, but none of the examined potential variables distinguished child continuance.

The shift from a concern for resources to a concern for clients was evident in studies that looked at post-treatment adjustment for early and late discontinuers (Pekarik, 1992a) and satisfaction relative to discontinuance status (Pekarik, 1992b). In turn, Pekarik (1993) boldly suggested that psychotherapy research should go beyond effectiveness to use consumer-oriented criteria in defining treatment success. Pekarik seemed to have pre-empted the results of the *Consumer Reports* (1995) report on psychotherapy (Seligman, 1995).

Meanwhile, Wierzbicki and Pekarik (1993) completed a comprehensive meta-analysis of discontinuance and found little to distinguish discontinuers from continuers. Pekarik returned to the question of resource management when he wrote *Psychotherapy abbreviation: A practical guide* (Pekarik, 1996), but it was the resources and the needs of the consumers that were foremost. In the same year, a further study confirmed consumer data on satisfaction and outcome to be of foremost value (Pekarik & Wolff, 1996) in assessing adult therapy outcome.

Just as Kazdin did not acknowledge Pekarik's ongoing contribution to a field of research that would become important to him later, Pekarik and Kazdin have not reported the work of Hershorn (1993; Hershorn & Rivas, 1993).

5.1.5   Hershorn: Access to services and domestic stability

Hershorn (1993) assembled the findings of the long list of studies on client factors in attrition, to construct one factor, namely stability in life over the previous two years (Hershorn, 1993). He then studied adult and child referrals to several community health clinics, and found several indicators of instability among those individuals or families who discontinued contact. Discontinuers, when compared to those who had continued in treatment during this period, were more likely to have changed address, to have had more jobs, to have been longer unemployed, to have had adult relationships that were shorter, and to have had a greater number of adult relationships. Sole parenting was more common and child discontinuers had changed schools more often. For every social phenomenon that might be related to a difficulty in accessing services, the discontinuers were more likely to have had increased difficulties caused by increased turmoil at home.

Hershorn and Rivas (1993) examined data from several community health centres and demonstrated that premature termination from such services was much more common in households undergoing instability. A range of risk indicators involving address, employment, adult relationships, and schools measured instability. Hershorn and Rivas (1993) did not put their conclusions so simply, but it would seem that attendance for therapy has more to do with being well organized, or obsessional, especially domestically, than the need for therapy. In turn, Hershorn (1993) came to a conclusion similar to those of Kazdin (Kazdin et al., 1993) and Pekarik (1996), that agencies accepting referrals from people in turmoil need to respond to the immediate need for an appointment and for support. On this basis, the opportunity for more enduring therapy contracts might arise. Without immediate attention, applicants might reject the agency as a possible source of long-term assistance.

5.2   At least three types of applicants

In Section 5.1.2, a difference was noted concerning the reason for child and adolescent mental health assessment often leading to the discontinuance of contact. Levitt (1957) and Sirles (1990) attributed therapeutic value to detailed clinical assessment, which led to mutual termination. However, Silverman (1970) felt that some parents discontinued because the value of talking about problems had not been demonstrated. These different views could represent differences of sampling or methodology rather than a simple contradiction in findings, and a closer inspection of studies in the present review of literature has revealed systematic differences between samples related to phases of contact.

Hershorn (1993), Kazdin et al. (1993), and Pekarik (1996) all noticed a group of applicants to mental health services who needed urgent attention, if discontinuance was to be avoided. However, the available research overall can be interpreted to distinguish at least three groups of applicants, namely those who are crisis reactive, those who reluctantly seek help but are containable, and those who fit well with the service to become committed. It is suggested that this classification may have both practical and heuristic value with respect to the referral and intake processes of child and adolescent mental health services. These are presented in Table 1.

The three applicant groups can be distinguished by the timeframe within which applicancy and contact can be envisaged by them, the degree of commitment to contact over time, the likely phase of discontinuance, and the likely outcomes of the application for mental health service.

Table 1

Applicant types and features of contact behaviour

Features of contact	*Crisis reactive applicants*	*Containable applicants*	*Committed applicants*
Time frame focus	Brief	Brief, short-term, long-term	Brief, short-term, long-term
Commitment to change at time of contact	More against than for therapy; unlikely to commit	Ambivalent; may become committed through process	Mostly for therapy; committed from outset
Likely phase for discontinuance	After first contact or first appointment	After assessment	After assessment, during therapy, or at mutual termination
Outcome types	Never attend, but may re-contact	Seek short-term therapy, or seek long-term therapy. Circumstance reactive, but complete assessment. Circumstance reactive, turned off by procedures or staff	Assessment as therapy. Finish after long time, mutually. Finish when client comfortable

Research on applicants to mental health clinics for children (Kazdin et al., 1993), children and adults (Hershorn, 1993), and students (May, 1990, 1991) has identified, firstly, a group of service applicants who contact in a reactive or crisis-driven way. These referrals may not be followed through to the first appointment. These "crisis-reactive" applicants contact and request immediate service but do not show commitment to maintaining contact and may never actually attend the first appointment. They may be likely to make several attempts to engage with the agency over a period of time.

The second applicant group is located among those who discontinue contact after assessment. Those who respond to the processes of assessment and recover by this means, as identified by Cohen and Richardson (1970), Tuckman and Lavell (1959), and Sirles (1990), would be among this subgroup of applicants. There are also some in this group who find the assessment process to have been too onerous or confronting, who may correspond to the sample of discontinuers interviewed by Silverman (1970), and who discontinue after assessment. These are applicants who, at first contact, are "containable". These applicants can entertain the prospect of extended contact, but may be ambivalent about such a commitment.

Committed applicants refer with the expectation of long-term contact and seek secure outcomes. This is the group that agrees to cooperate with professionals both in agencies and in research. These people have commitment to the purposes and processes of assessment and treatment, but not necessarily to the timelines deemed appropriate by the clinician involved. When committed applicants discontinue will depend on life circumstances, but could involve abrupt termination due to change of address or could involve mutual termination. This reflects the lack of differences found in the literature between late terminators and therapy completers. So, among the committed subgroup are those who have shorter term and focused aims, as well as those who had longer term and emergent hopes.

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An estimate of the size of each of three applicant groups is difficult to give with precision, but Perlman's (1960) location of the third man, suggest that crisis-reactive applicants are of the order of one-third of all applicants. Stallard and Sayers (1998) stated that half of their applicants became clients. This would suggest that committed clients were at most fifty per cent of applicants. This would leave at least one sixth of the applicants in the containable category. These figures are intended as a guide to magnitude, only.

The applicant groups can be further broken down. Crisis-reactive applicants would include applicants who are predominantly socially compromised, some who are predominantly psychologically compromised, and some who are a combination of both. It would be expected that crisis-reactive applicants could be detected at referral and intake, along with some understanding of the extent of their social and psychological difficulties.

At least three subtypes of containable applicants can be proposed. Some of these applicants become committed long-term therapy seeking clients, some become committed short-term therapy clients, and some are reactive to circumstances. This last subtype would include those who, through an apparent period of focus and problem quiescence, actually do complete assessment, but remain vulnerable to discontinue when circumstances change. These circumstance reactive, containable applicants might also have experienced the beginning procedures of the clinic as aversive and then choose not to continue. Applicants deterred by procedures would seem likely to have genuine complaints about the procedures, but do not continue because of their reactivity.

The committed applicants group is comprised of those who are committed to short-term focused outcomes, those who seek longer term changes, and those whose commitment to treatment is constrained by the presence of other factors but who stay in treatment long enough to achieve sufficient resolution or adjustment, even if it is less than what the clinician estimates could be achieved if therapy continued.

This taxonomy of applicancy to mental health services is open to future research and to use by referral and intake workers to test out its utility within the processes of referral and intake.

5.3   Implications of discontinuance studies for referral and intake procedures

Referral and intake are activities often separated from the tasks of assessment and of the tasks of treatment. These phases, referral and waiting, assessment, and treatment, filter applicant aspirations in a predictable way that mirrors the phases of client discontinuance identified by Sirles (1990). Research on the effects of referral and intake upon subsequent contacts at a child and adolescent mental health service needs to observe the differences between these phases of contact. Stability in life (Hershorn, 1993) has specifically been found to be linked with discontinuance in the first phase of contact.

After many years of consideration of discontinuers as recalcitrant (Kazdin et al., 1993; Pekarik, 1985a), research has demonstrated that the difference between a continuer and a discontinuer has more to do with circumstances of living (Hershorn, 1993; Hershorn & Rivas, 1993) than client malfeasance or therapy failure. Turmoil in households lowers the priority given to attendance for therapy. The efforts of a clinic to moderate this rate of discontinuance can be worthwhile (MacLean et al., 1989), but, inadvertently, can create access barriers to attendance (Wenning & King, 1995; Stern & Brown, 1994), which exclude those in turmoil.

Application to a mental health service can be seen in terms of three different types of applicant, namely, committed, containable, and crisis reactive applicants. The differences between applicants suggest the need to develop ways to respond to applicants that facilitate the uptake of therapeutic assistance at some stage. The work of Kazdin, Pekarik, and Hershorn has demonstrated the need for clinical practices at referral and intake that facilitate acceptance of assistance by some urgently

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needy people. Rooney and Miller (1955), Krause (1966), Ewalt et al. (1972), and Sirles (1990) all demonstrated that the referral and intake worker has a special position in the understanding of the uptake of services. Yet, this position has not been adequately documented.

The preceding three chapters of this literature review have located the referral and intake worker at the point of entry to child and adolescent mental health services (Chapter 3), have documented how attending is connected with the various practices of beginning at a clinic (Chapter 4), and have discriminated the phases of contact discontinuance to reveal three different types of service applicant (Chapter 5). Chapter 6 draws together the disparate and barely connected literatures concerning the practices of referral and intake work in child and adolescent mental health services.

CHAPTER 6

THE PROFESSIONAL DOMAIN OF THE REFERRAL AND INTAKE CLINICIAN

> It is the belief of our referral and intake workers that defection is most closely related to clients' being unmotivated for treatment. They are able to accurately predict which clients will defect, based upon their telephone impressions of the client's motivation. They state that clients who sound motivated to get help for their child will make the necessary arrangements to show for the evaluation (Gaines, 1978, p. 60).

Referral and intake work in child and adolescent mental health services is hidden by its obviousness. It can be described in mechanistic, bureaucratic terms, but such banal description, as discussed in Chapter 1, can screen observation of the value of the interpersonal interaction involved. The person who applies for assistance wants personalized service that provides particular meaning. Usually the referral and intake worker wants to convey reciprocal meaning.

A split between description of mechanism and description of meaningful interaction is demonstrated in the literature on child and adolescent mental health referral and intake. Almost nothing has been documented concerning meaning, and the mechanisms are usually only set down in manuals. Occasionally, in the course of research on continuance and discontinuance of client contact with child and adolescent mental health services, as documented in Chapters 4 and 5, important information about referral and intake work has emerged. For instance, Gaines (1978, cited above) noted that referral and intake workers seemed to know which applicants were going to continue.

This chapter brings together three distinct bodies of literature that are pertinent to the role and tasks of child and adolescent mental health referral and intake workers. Firstly, the accumulated

knowledge of referral and intake policy and procedures is surveyed, and put into contemporary

context with the internal report (Freestone, 1994) for the Royal Children's Hospital Mental Health

Service (RCH MHS) of Victoria, Australia. Secondly, the decision-making role of the referral and

intake worker is addressed, through consideration of the literature on decision-making in health and

real life contexts. Thirdly, the documented skill base of telephone-counselors is reviewed, in order

to discriminate the tasks of the referral and intake worker from other telephone health and welfare

consultants. Conclusions from these spheres are then brought together to provide a basis for further

research concerning referral and intake work and workers.

6.1   Commentaries on referral and intake policy and procedures

Explicit reports of referral and intake policy and procedures have been rare in the international

literature. Clinics around the world have attempted to address the processes of referral and intake

in order to make service more accessible to clients. As described in Chapters 4 and 5 the research

field has largely failed to integrate the published wisdom through subsequent citation.

In their typical study, Rooney and Miller (1955) concluded "referral and intake policy determines

the relationship of the prospective individual patient to the clinic" (p. 392), seeing the clinic in the

context of its community. Rooney and Miller then adjusted their clinic policy to provide a clinical

interface and described two steps for acceptance of a referral. Firstly, a referring professional had

to discuss the referral with a clinical staff member, and then the potential patient had to make

contact. Contemporary child and adolescent mental health agencies have this as a common practice

(Freestone, 1994), but this has rarely been put in writing (Department of Human Services (DHS),

1998), and has not been cited as coming from past research.

6.1.1 Descriptions of referral and intake practices and procedures

The role and tasks of the child and adolescent mental health referral and intake worker have been described in a small number of incidental commentaries with respect either to the mechanisms or to the meaning of the practices. For example, Williams and Pollack (1964), in their study of referrals to the Illinois Institute for Juvenile Research, observed that "selection of treatment cases is much more a function of clinic policy than of individual choice" (p. 154), but went no further. The following chronological review assembles past commentaries of this kind, many of which have been reported in preceding chapters.

Krause (1966) studied four different stances from which to conduct telephone referral and intake work and the effects of these stances upon rates of attendance. These stances relating to the meaning of the work, were (a) bearing in mind the benefits to be reasonably expected from the agency, (b) understanding the client's request for assistance, (c) making clear the demands upon the client of using the service, and (d) understanding the difficulties that the client anticipated in using the services. Subsequent rates of attendance did not vary according to referral and intake stance, although one clinician, using the fourth approach, seemed to be much more successful in securing attendance. This approach involves meaningful exchange between applicant and referral and intake worker, as against the other approaches that are mostly directional transfers of information.

Gould et al. (1970), as mentioned in Section 4.2.4 in Chapter 4, described a continuum of preparedness for treatment with clarity, activity, and acceptance of the patient role at the most amenable end and with unclear, passive, but emotionally pained people at the other end. These differences of meaning could be detected at referral and intake. Procedures were changed such that the referral and intake workers spent time clarifying the problem, defining what the agency could help with, and seeking agreement to attend. Similarly, Lowman et al. (1984) compared service "teasers" with service "users", as mentioned in Section 4.2.4, and concluded, as did Gaines (1978),

that brief and supportive telephone referral and intake practices could detect those who were less likely to attend. The findings of Gaines, Gould et al., and Krause (1966) carry the implication that referral and intake mechanisms need to be meaningful.

Plain, mechanistic descriptions of procedure, like the Canadian one of Lefebvre, Weiss, Cohen and Waldron (1981), have been rare in the literature, too.

> During the first telephone interview with the parents, the worker obtains information about the presenting problem and relevant medical and psychiatric history and socio-economic data; this information is recorded on an intake sheet. (p. 183)

The obviousness of these tasks seems to have precluded publication of these procedures in a refereed journal, but at least one government manual has been located which documented the same range of practices.

The manual for child protection workers of the Victorian Department of Human Services (DHS, 1998) in Australia provided a listing of the work of child and adolescent mental health services "Duty and Referral and intake" staff. The list indicated the many tasks of referral, intake, and assessment as focusing upon:

- Presenting problems

- Why the person is presenting (or being referred) now

- Psychiatric history

- Physical history

- Past and current involvement with other services

- Family/living situation

- Major social or psychological stresses, both current and past

- Developmental issues and family functioning

- Mental state examination

- Formulation of provisional diagnosis and intervention plan

- Urgency of intervention

- Assessment of risk to self and others

- Preferences for services from staff in terms of gender, ethnicity, previous contact and

  location. (p. 13)

No indication was provided concerning the priority of each task for child and adolescent mental health services, and no details of each task were given. The child and adolescent mental health services referral and intake workers were expected to be able to receive referrals and undertake mental state assessments over the telephone using third party information. These guidelines, with their emphasis upon the many tasks that need to be achieved, would seem to overreach the capacities and the context of telephone-based consultants.

The research of both Hall (1974) and Shaw (1992) demonstrated that wherever mechanisms of greeting exist, the context would encourage such interchanges to have meaning for the participants. Hall's (1974) study of welfare worker officer receptionists showed much variation in the interpersonal enacting of the tasks of reception. Because receptionists had a special role in greeting, Shaw provided special training, such that the mechanisms of the work could be enacted in a welcoming way.

Changes of clinic mechanisms and policy contexts have been documented, but as was shown in Section 4.2.6 in Chapter 4, many clinic procedural changes adversely affected referral rates (Deane, 1991; MacLean et al., 1989; Stallard & Sayers, 1998; Wenning & King, 1994; Wiseman & McBride, 1998) without these effects having been explored. A policy innovation to use waiting time to promote attendance at New Zealand child mental health clinic was reported in detail in Section 4.2.5. Deane showed that the new practice did promote attendance among those who attended to fill out the forms, but it was unclear which part of the innovation was the most important. As in many other studies with an emphasis upon an innovation, other parts of the beginning procedures, such as the telephone referral and intake workers' procedures, may also have

been relevant and but were not explored, even though a closely considered rationale for the innovation had been developed.

Most reports of referral and intake work have reported live referral and intake interviews with families concerned about their children (Beer, 1991, 1992; Sirles, 1990), and with adults (Brown, 1993; Helstone & Van Zuuren, 1998; Lazare, Cohen, Jacobson, Williams, Mignonoe, & Zisook, 1972; Lazare, Eisenthal, & Frank, 1976; McGuff et al., 1995; May, 1990; Sharf & Bishop, 1979; Tryon, 1992), using practices that could only be described accurately in terms of endpoints. A major focus of some of the adult research (McGuff et al.; May; Sharf & Bishop; Tryon) has been perceived physical and psychological attractiveness of the client and therapist, rather than the referral and intake practices. Reports of telephone referral and intake practices have been rare, indeed, and reporting has been minimal (Gaines, 1978; Krause, 1966; Lefebvre et al., 1981).

The aggregate of specific literature on child and adolescent mental health services referral and intake work is small, diffuse, and fragmented. The specific aim of documenting the practices of child and adolescent mental health services referral and intake seems not to have been attempted.

6.1.2   Referral and intake as an organizational communication node

The most comprehensive report of referral and intake policy and procedure found to date pertains to Melbourne's Royal Children's Hospital's Mental Health Service (RCH MHS). This report (Freestone, 1994) surveyed the several models of referral and intake to child and adolescent mental health services in the State of Victoria, Australia. The purpose of the project was to facilitate integration of two different clinical cultures, the RCH-MHS and the Victorian Health Department's Travancore child psychiatry service, within a new combined service through the re-design of the referral and intake system.

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Freestone's (1994) report first collated information about other child and adolescent mental health referral and intake services. Secondly, staff were interviewed concerning their views and experience of referral and intake services. Thirdly, the consultation and implementation processes were documented demonstrating the care that was involved in making sure the process of development of a new referral and intake model was supported by the staff. Finally, a design for the new referral and intake service was presented within the context of the new, integrated child and adolescent mental health agency.

Freestone (1994) provided flowcharts, role descriptions, and referral forms from several Victorian child and adolescent mental health services, concluding that the tasks of referral and intake work were relatively similar across services and the initial data collected was similar. Telephone-based information provision and acceptance of referral had been an established norm in Victoria for sometime. Referral and intake work was presented by these services in mechanical terms, as a necessary community interface, or the first point of clinical contact. Several services had switched from referral and intake systems based on rostered duty to dedicated referral and intake worker positions in the early 1990s.

Within the combined Travancore and RCH MHS staffs were clinicians who had seen a range of the basic designs of referral and intake systems. It was the RCH psychiatric social workers who had taken the role of referral and intake workers at the hospital psychiatry service in the past, in line with longstanding child guidance practice (Freestone, 1994). "The PSWs [Psychiatric Social Workers] complained 'duty' had low status, the centralised 'referral and intake' and waiting list meant [clinical] staff were protected from having to reconsider their work practices, and the general service response was seen as inefficient by outsiders" (p. 53). There was much "responsibility that rested on duty workers['] shoulders for having to carry waiting lists and be caught between the community and the agency' (p.45). Anxiety "pervade[d] ... due to the nature of having to make difficult decisions over the phone and often in isolation [which amounted to] inherent uncertainty

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of dealing with phone work" (p. 74). Further, referral and intake was not given equal status to face-to-face work, as telephone contacts were "not counted on stats sheets" (p. 37). Another concern was "the possibility of an referral and intake worker's style, opinion or judgement having an undue influence upon the overall types of referrals accepted/rejected" (p. 45). These were issues mostly associated with the role and did not greatly differentiate the duty work of the rostered clinician from that of the dedicated clinician.

Overall, respondents expressed concerns about the responsibility and flexibility of the work (Freestone, 1994). The dedicated role was preferred, but not without reservations. There was a lack of confidence in referral and intake work as a professional activity, and a preference for a much tighter set of criteria and protocols. Referral receiving clinicians wanted to know that an accepted referral was appropriate, and wanted to control the actions of the referral and intake worker to almost mechanical, flow-charted processing of referrals.

Dedicated referral duty positions were established in the merged service, which were distinguished from the intake function. Intake involved client registration and was the task of the designated clinical team member (Freestone, 1994). Duty was "seen as the first point of clinical contact and evaluation [required] specific skills to accurately assess the needs of clients and the appropriate initial response and thus acts in a screening or gate keeping capacity" (p.39). Further, "Duty also has an information providing and counseling function that assists clients to make their own decisions about what may be the best possible course of action and therefore duty is not purely a mechanism for taking referral details" (p. 39). Freestone's recommendation for a dedicated referral duty service was based on the premise of the dedicated worker developing specialist knowledge of service networks, and maintaining continuity for the referrer over the period of waiting for the first appointment.

The re-designed RCH-MHS TIS (Telephone Information Service) was an information and telephone-counseling service only (Freestone, 1994). Procedurally, the TIS was located between the receptionist, who greeted service users, and the clinical teams who performed the referral and intake function as part of the first interview. The TIS responded to enquiries about services, provided telephone-counseling, and took minimal information regarding requests for referral.

Freestone (1994) listed the two tasks of referral duty as screening and information provision. Screening involved brief assessment of needs and circumstances, assessment of urgency, determination of appropriate internal team or external service, consideration of minority group needs and involved a variety of techniques of telephone and face-to-face interviewing and liaison and written information. Key issues were eligibility criteria and the matching of client need for best service, given specific staff skills and service priority.

The information-giving task of referral duty involved other services or orientation to the service as a client and the processes to be encountered. Freestone (1994) documented the many ways that sectors and participants within the service interacted and how external agencies interacted with each internal sector and participant. Freestone (1994) listed various connections between parts of the organization, but did not demonstrate how these connections were patterned in an overall sense. Therefore, the present researcher constructed an information flow diagram on the basis of her listing. This is presented as Figure 2 on page 162 below. It shows the place of the Telephone Information Service (TIS). Figure 2 illustrates that much of the interaction between agency and the RCH-MHS was mediated through the TIS. Connections, formal or casual and informal, existed between external agencies and the Director, internal sectors, and particular staff, but these connections cannot be easily represented. The major information pathway involved referring families contacting the TIS, then to the clinical team, then to intake interview, and finally to clinical outpatient services.

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In this inferred diagrammatic scheme, a major, if not the foremost, node of communication within

and outside the service is the TIS. Connections between sectors of the diagram varied in their

strength and direction. The flow from the TIS was often strong, but the feedback to the TIS was

often weak. The weak feedback connections affected the capacity of the TIS to conduct the tasks

of advocacy for particular referrals and to check upon the resource effects of dispositional

decisions. Team leaders distributed cases and, thereby, clinical resources.
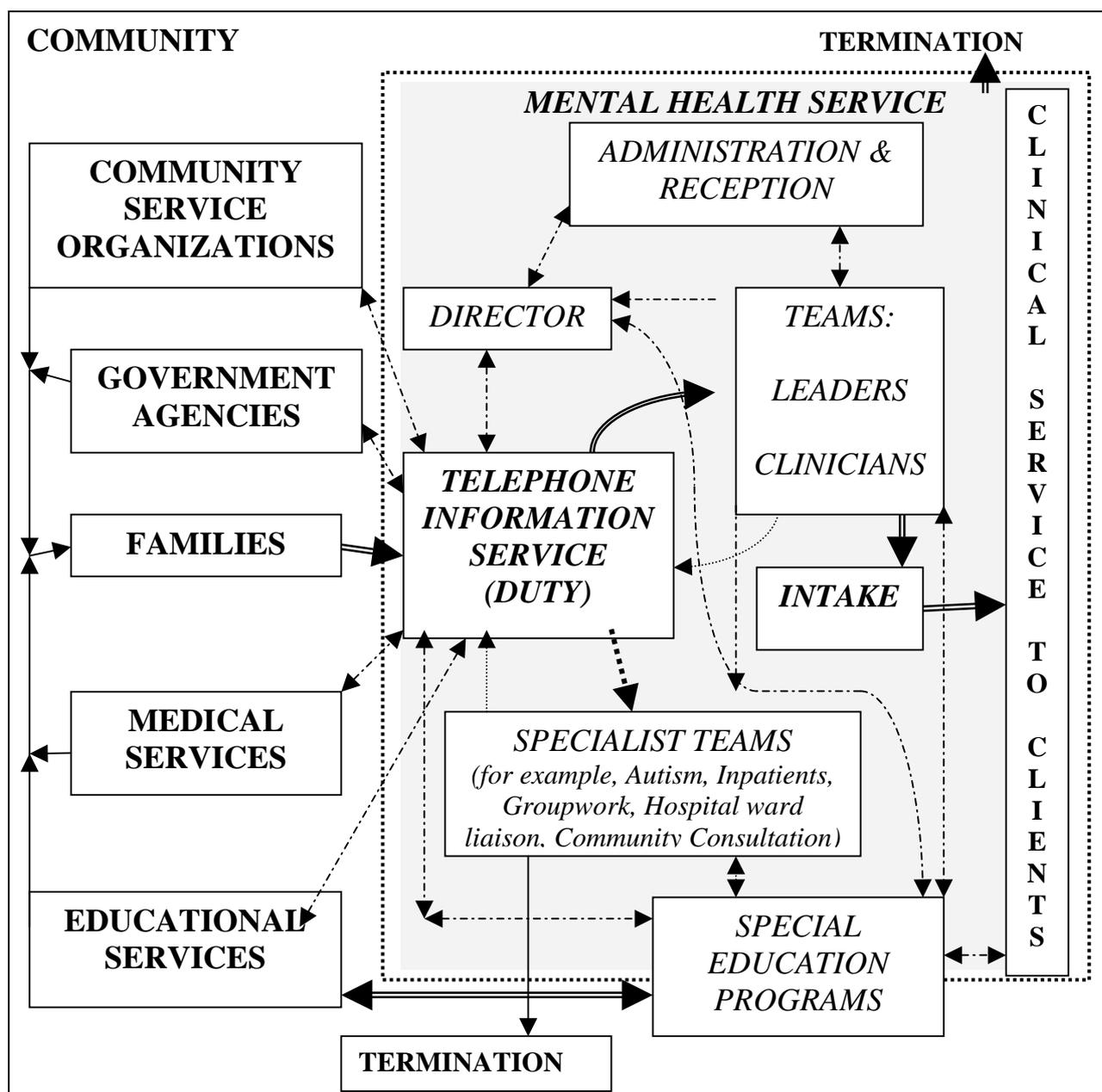
Figure 2: Organizational flow diagram of the new RCH Mental Health Telephone Information
Service, as inferred from Freestone (1994).

The scheme would appear to be inherently unstable when the volume of information to be communicated is large, yet, as inferred from the descriptions of other child and adolescent mental health services provided by Freestone (1994), other services have a similar organization. Staver and LaForge (1975) pointed directly to the ease with which the centrality of the referral and intake function could lead to referral and intake being made the scapegoat for other organizational and relational problems within a clinic, especially given the lack of knowledge of the function and practices of referral and intake work. Problems with attendance of clients were usually not considered to be problems with therapeutic alliances. The importance and expertise of the referral and intake role could be undermined within the perceptions of clinicians by an imbalance of organizational visibility with the prominence of the interface function based on decisions to accept referrals contrasted with the privacy of the task of listening to referring parents.

6.2   Child and adolescent mental health referral and intake work and decision-making

Freestone (1994) placed emphasis on the decision-making role of referral and intake work within the communication network of a child and adolescent mental health service. Applications of the decision-making literature to health contexts have been rare. As Barrows and Feltovich (1987) stated, "clinical problems are ill-structured and ... reasoning is built around a temporal unfolding of information" (p.86). Yet, the effects of decision-making are concrete and visible to the community and to other parts of the health system.

Decision-making has often been studied in contexts where errors can have grave implications, such as medical (Barrows & Feltovich, 1987), military (Klein, Orasanu, Calderwood, & Zsambok, 1993), and fire-fighting contexts (Omodei & Wearing, 1994, 1995). Bobevski and McLennan (1998) applied the Omodei and Wearing (1994) model to understand the decision-making processes

within telephone-counseling sessions. But, generally, the relevance of such research for decision-making in child and adolescent mental health referral and intake work seems limited.

The contribution of Gigerenzer and colleagues (Gigerenzer, 2000; Gigerenzer & Goldstein, 1996; Gigerenzer & Todd, 1999; Hoffrage & Hertwig, 1999; Rieskamp & Hoffrage, 1999) seems promising for application to child and adolescent mental health referral and intake work. Most decisions are made, according to Gigerenzer and Todd, under circumstances of incomplete information, unclear endpoints, and with constrained time for reflection. A number of heuristics or strategies of decision-making have been identified that comprise "fast and frugal rationality" (Gigerenzer & Goldstein, p. 650). This research has documented how decision-makers can reliably cut corners and seems widely applicable to health applications where the visibility of the work may only be the effects of the final decision.

More concretely, child and adolescent mental health referral and intake workers, in their decision-making, might well implement the principles of search, stoppage, and decision (Gigerenzer & Todd, 1999). Admission criteria can only be inspected by searching for informational cues (Reiskamp & Hoffrage, 1999) until a case is rejected, that is stopped, by the failure to meet the admission criteria or when the criteria are exhausted and the case is, thereby, accepted. Hoffrage and Hertwig's (1999) description of hindsight bias would seem to apply to the ability of referral and intake workers to learn from experience and adapt their practices to novel referral circumstances.

Clearly referral and intake workers are employed to make decisions that affect families and the clinic. Brown (1993) demonstrated how the detective story models the process of referral and intake that occurred within an adult mental health clinic, with data slowly collected and options for further action considered. Clinical data is structured in process and could be rendered as a narrative. By such process, the eventual outcome becomes inevitable as referrer and referral and

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intake worker work through the range of pathways to the completion of the call. By contrast,

Freestone (1994) listed the tasks of the referral and intake worker in terms of what they should aim

to achieve. The list of endpoints is valuable, but no description of the means to be used by an

referral and intake worker to get to these end points were given, other than by using exclusion

criteria.

Brann, Willsher, and Meares (1998) investigated decision-making in urban and rural Victorian

child and adolescent mental health services using information derived from a set of actual referrals

previously received at Brann et al.'s child and adolescent mental health service. Brann et al.

provided ten referral scenarios in order to determine the acceptance and rejection practices of the

referral and intake workers. Sixteen of the 17 Victorian CAMHS participated with replies from 12

urban and 17 rural referral and intake workers. It was clear that the scenarios were like those that

presented across all services. Brann et al. focused upon the inconsistencies between the workers,

with agreement on acceptance of a referral moderate (0.49) on a yes/no basis for all ten scenarios.

There were differences between the agencies that seemed to reflect different professional contexts

and availability of other services, and differences between co-workers. But there were three cases

almost unanimously accepted, and one almost unanimously rejected. Of the remaining six cases,

three were strongly yes, or probably yes, and three were at about fifty per cent likelihood of

acceptance. The study was about the outcomes of the decisions and littler about how the decisions

were made, although factors such as lack of information, protective concerns, family issues,

availability of alternate services, not mental health, and not fitting with inclusion criteria (rather

then exclusion criteria) were identified as central to decision-making. It was not clear if exclusion

occurred because of failure on one issue, or as a balance of several issues, or in what order such

factors were considered. The surveyed referral and intake workers took the task seriously and

reported the exercise as professionally useful to the thinking about their application of inclusion

and exclusion criteria. The result was a valuable contribution to a very sparse literature, but the

exercise was performed without the real demands that come from live referrals.

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While decision-making would seem an important part of the referral and intake work, it was found to be only one part of the work (Brann et al., 1998). Many clinical activities involve ongoing decision-making with respect to the current context, but as Bryans and McIntosh (1996) noted with respect to community nursing practice. Other aspects of referral and intake may be more important, but may be less measurable. Continuity in referral and intake work is very important to referring parents (Freestone, 1994).

6.3   Referral and intake work as telephone consultation

Studies of telephone consultation are rare. This may be due to the invisibility of all forms of consultation over the telephone, due to the separateness of location and the confidentiality of the contact, relative to the visibility of the decision-making of the child and adolescent mental health referral and intake worker. The largest pool of studies belongs to telephone triage with crisis line services, providing few systematic publications of their work beyond the manuals supplied to trainee telephone counselors. However, the literature that does exist allows for the discrimination of some of the skills, the contextual constraints, and style of the child and adolescent mental health referral and intake worker.

6.3.1   Telephone-counseling as a skill source for child and adolescent mental health referral and intake workers

The link between child and adolescent mental health referral and intake work and telephone crisis counseling practice was made only weakly by Freestone's (1994) respondents. Telephone-counseling skills were seen as desirable but not necessary for the efficient receiving of a referral. Part of this lack of connection between sets of practices may be due to the administrative light in which referral and intake work has been cast. The sparse literature upon telephone-counseling is

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constituted by textbooks concerning telephone-counseling, service manuals for telephone counselors, and a limited body of empirical research on its processes.

Telephone-counseling has a history of over forty years (Rosenfield, 1997), but little has been published concerning the specific techniques of telephone-counseling, beyond service specific manuals. Byrne and Byrne (1996) listed the skills of the telephone-counsellor as attending, listening, being motivated to listen, clarifying problem situations, things to listen for, and intervention skills of the telephone-counsellor, much of this was good sense that would apply in all counseling. . Rosenfield added that, the telephone counsellor required "sensitivity, stability, compassion, caring and a relaxed manner" (p. 42), with "skilled application of tone and pitch and the use of pauses" (Rosenfield, p.44) to compensate for the lack of gestural cues. Heightened intimacy was identified as a unique phenomenon of telephone-counseling by Rosenfield. This was evident in brief but intense and direct consultations, with a twenty-minute session being relatively long. Also, the expression of strong emotions such as grief, anger, and sadness is facilitated by the telephone (Rosenfield). This was linked to the heightened sense of confidentiality that aural connection provided.

The manual of the telephone-counseling agency, Personal Emergency Services (PES, 2001), in Victoria, Australia, placed emphasis upon the range of skills needed for a crisis-counsellor with the particular constraints of telephone contact. The task has to be performed under the distinctive circumstances of reduced time length, increased time pressure, diminished sources of feedback about the state of the caller, confidentiality, and near absolute anonymity. Information giving was minimized. Telephone-counseling could be rendered thus not so much as a series of skills, but as a willingness to apply empathic listening to an unidentifiable talker without obligation for further contact on the caller. Paradoxically, the ambivalences of the caller seemed to add up to a major opportunity for timely intervention, as identified by Rosenfield (1997).

Empirical research has described the attributes needed by health consultants for effective listening on the telephone. In a series of papers, Bobevski and McLennan (1998), Bobevski, Holgate, and McLennan, (1997), and McLennan, Culkin, and Courtney (1994) found telephone crisis counseling tended to be more brief, involving more problem-solving, than face-to-face counseling, although these may have been effects of the contact being for only one session. The results of the three studies suggested that an active, structuring, systematic, practical and empathic approach, aimed to modify the client perspective and include an effective summary when closing, is useful to a counsellor providing brief consultation. Effectiveness was enhanced when the counsellor was experienced, was willing to be emotionally involved at an appropriate level, and felt effective in the work.

The work of Porter et al. (1997), better described as telephone-based early intervention mental health consultation than as telephone triage, documented the helpful role of a crisis hotline in reducing suicidality through accurate assessment and appropriate support. Conte, Fisher, Callahan, and Roffman (1996) articulated the skills of the telephone research recruiter as having five interpersonal functions, namely warmth, receptiveness, focus, informativeness, and a willingness to be decisive. Telephone listening can be unhurried, accepting, and non-intrusive, yet alive to clarifying meaning and intentions. The major difference between telephone-counseling and child and adolescent mental health referral and intake work would seem to be that referring parents cannot retain their anonymity, and associated with this is that referral and intake workers aim to recruit the callers into programs of help.

6.3.2   Telephone-counseling in comparison to child and adolescent mental health referral and intake work

Mental health referral and intake workers have been demonstrated to be able to listen closely to client material such that reliable predictions of subsequent attendance can be made. This listening

has been shown to occur over the phone at a family therapy clinic (Gaines, 1978) and live in child and adolescent mental health referral and intake interviews (Sirles, 1990), as well as in student counseling referral and intake interviews (May, 1991), and in referral and intake interviews for adult psychotherapy (McGuff et al., 1996; Helstone & Van Zuuren, 1998).

The telephone mental health consultant listens to the caller who may often be upset, uncertain, and fearful of blame or fearful of others. The application of listening skills within a specialist context with clear limits, allows for such affect to be contained, useful decisions to be reached, and information regarding access and future contacts to be provided. The narrative of the transaction is open for the caller to help construct, and, thereby, remain in some sort of control. However, child and adolescent mental health referral and intake work can be seen to differ from telephone crisis counseling in five critical aspects:

- the caller to child and adolescent mental health referral and intake service is not anonymous;
- two-way information provision is central to the task of child and adolescent mental health referral and intake work;
- while the crisis line caller is not required to make any commitment to further contact, the parent contacting a child and adolescent mental health is assumed to be open to further participation in a service;
- while the crisis caller may benefit greatly from deep emotional release within the intimacy of the telephone call, child and adolescent mental health referral and intake work involves respect for depth of feeling but conducted through minimal and sufficient data collection; and
- the clear aim of child and adolescent mental health referral and intake work is to arrive at a decision to accept or reject a referral.

6.4   Signposts for further research on child and adolescent mental health referral and intake work

This thesis, so far, has outlined and evaluated published research deemed relevant to referral and intake in child and adolescent mental health services in Western countries. The importance given to referral and intake policy by commentators external to clinics, such as Levinson and Astrachan (1976) and Brown (1993), and researchers internal to clinics, such as Rooney and Miller (1955) and Deane (1991), has been reported in this chapter but such publication has not resulted in clinics publishing their policies for wider professional consumption. While local manuals of procedures undoubtedly exist, the tasks, skills, and role demands of referral and intake work require documentation and discussion in the field at the most basic level.

Past chapters have noted the fragmentary nature of relevant literature, and pointed to the need for investigation of a range of aspects of child and adolescent mental health referral and intake work. Training and occupational background, professional visibility, role innovations, applicant types and referral and intake practices, and continuity of service have all been identified as relevant variables.

Facilitation of client entry is a role of the child and adolescent mental health referral and intake worker that is visible to agencies and to clinicians. Two contrasting professional profiles of child and adolescent mental health referral and intake workers have been identified in Chapter 6 and deserve exploration. Firstly, there is the external profile of the gatekeeper at the community interface, recognized as prominent, important, and executive. However, some outside might regard such power to be inappropriately exercised by a person perceived to have clerical duties. Secondly, there is the internal profile of the clinical specialist, but clinicians would appear almost blind to the actual work of referral and intake, except when things go wrong. The clinician may view the role as clerical, as well. The evaluative part of referral and intake work is invisible, while the administrative and executive functions are visible. Between these profiles lie a range of

professional responsibilities and skills that need to be documented, with respect to both their

mechanism and their meaning.

CHAPTER 7

IMPLICATIONS FOR EMPIRICAL STUDY OF REFERRAL AND INTAKE IN CHILD AND ADOLESCENT MENTAL HEALTH

> Science has no royal road ... If lab experimentation involves any essential disturbance of
> the phenomenon, the psychologist must lay aside his plans of formal simplification and
> study the event under its natural conditions accepting whatever complications the change
> introduces into his problem
> MacDougall (1922; cited in Orasanu & Connolly, 1993, p. 12, 13)

From the wide-ranging review of relevant international literature presented in Chapters 2 to 6, a series of propositions was developed, providing a platform from which to explore practices and perceptions of referral and intake to child and adolescent mental health services. The next five chapters present the rationale, design, and findings of two consequent empirical studies. Chapter 7 first presents a crystallization of the propositions that emerged from the themes and findings of past research, and goes on to describe how these formed the basis for planning a qualitative, retrospective enquiry and a mixed methods prospective enquiry. It articulates the design and analysis of the proposed empirical work. Finally, it sets out the expectations guiding the empirical studies that were planned in the present research.

7.1   Propositions drawn from past study of child and adolescent mental health referral and intake

The first six chapters of this thesis discussed the results of research pertaining to the first research question posed in Chapter 1, namely: what, historically and pragmatically, has shaped the practices of referral and intake as they are? Each of the first six chapters presented either a domain of social and professional activity or specific research studies relevant to child and adolescent mental health referral and intake work. These chapters established propositions that could be used in describing

referral and intake or could be explored in empirical research, now brought together to build the rationale for further empirical research.

7.1.1 Professional backgrounds and the practices of child and adolescent mental health referral and intake workers

In Sections 2.3 and 2.5 of Chapter 2, mental health nurses and social workers were shown to have come to child and adolescent mental health referral and intake work from rather different directions. Section 2.6, on child guidance and child psychiatry, described the historical development of the referral and intake role within child and adolescent mental health services and the place of the professions within this history.

Themes in the history of mental health nursing relevant to the role of referral and intake worker were found to be the group culture with structured employment hours, counterbalanced by the seeking of professional autonomy through individual case responsibilities, and the opportunity provided for mental health nurses to move from wards to the referral and intake service of the community clinic. The group culture of mental health nursing is well aligned with practices that maintain institutional integrity and coherence and to monitoring the processes of entry.

Social work developed as the professionalization of the wish to assist those with social needs, particularly families, balanced with a need for equitable resource distribution. Social work had a long and productive relationship with the child guidance movement that helped establish the profession's uniqueness. Social workers had specialist roles within child guidance clinics providing parental support and community liaison, which included referral and intake work. The centrality of the referral and intake role within the profession receded with the expansion of policy development and family therapy as social work specialties in the 1970s. Nevertheless, social workers remain important to staffing child and adolescent mental health services referral and intake

and to orienting child and adolescent mental health services to the needs of families, parents, children and adolescents.

The differences between the two professions of mental health nursing and social work, with respect to work focus and institutional openness, may bring a balance to the practices of referral and intake work at any particular child and adolescent mental health agency. The practices of specific referral and intake workers would be likely to involve a balance between receptiveness and gatekeeping, which may or may not be linked to profession of origin. How these differences are manifested in the actual work was explored through interview in the present research.

Historically, nurses have been aligned with the practices of the initial health consultant known as the triage agent, as discussed in Section 2.7 of Chapter 2. Triage was the first set of practices developed to guide the immediate action of first line health consultants. However, triage operational principles are not necessarily an appropriate source for professional practices for child and adolescent mental health services referral and intake workers. The roles of the triage agent and of the referral and intake worker are superficially analogous. Both involve trained health professionals sorting presenting problems. However, there are differences in urgency and focus, with the parents of the presenting child participating differently in the planning and receiving of care.

Firstly, the various emergency circumstances that require the attention of a triage agent reveal urgency in decision-making and a focal range of immediate outcomes. Mental health referral and intake involves more complex data collection, more responsiveness to issues of social support and less time-precious activity, having more in common with early intervention work than prioritising of treatment needs. Secondly, despite the shared characteristics of paediatric triage and child and adolescent mental health services referral and intake work, such as consideration of the parents' consent and concern, the need to supply information, and to support parental understanding,

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paediatric triage is still enacted with respect to the child patient's immediate needs. Child and adolescent mental health services, having a longer-term and more inclusive view, consider parents and children as clients, and offer support in a time extensive way that is just not appropriate in an emergency situation.

Nevertheless, expectations of a triage role may be brought to the child and adolescent referral and intake work from past training or employment in adult mental health services, general nursing, or other occupation. It is these expectations of the referral and intake role that were explored empirically in the present study.

7.1.2   The experience of parents applying for child and adolescent mental health service

On the other end of the referral call to a child and adolescent mental health referral and intake worker is the parent applicant. As discussed in Section 3.4 of Chapter 3, a number of images have been projected onto parents by professionals in this field, but the images are not coherent with each other and do not seem to convey respect for the parent as person.

Section 3.2 of Chapter 3 noted that the many professional activities associated with mental health began with the appointment of medical doctors to have responsibility for the entry of patients into asylums. Section 3.2 demonstrated how such notions of entrance remained important when describing the place of mental health treatment within the lives of families and communities. Contacting child and adolescent mental health services by telephone concerning a troubled child involves both recognition of a child's difficulties and a willingness to enquire about assistance. Acceptance by mental health services as a referral involves a transformation of an adult from citizen to patient. With respect to a referral to a child and adolescent mental health service, changes may be experienced in the child, parent, or other family members due to placebo, or policy, or specific procedures. These changes occur unconsciously, but may be felt concretely, as

they occur independently of the particular case. Section 3.2 underlined the importance of a sociological view to usage of mental health services and how acceptance for mental health treatment can affect social identity. In this research parents may be able to provide insights into the changes of identity, of which clinicians would seem unlikely to be aware.

The images of the parent of a child with mental health needs, as conceived from within child and adolescent mental health services, include the parent as referrer, transporter, cause of the child's troubles, a patient in need of help in his or her own right, and as the person responsible for facilitating the child's recovery. A negative view of parents can be seen in the metaphors used by clinician researchers to describe discontinuing clients of mental health services.

The premises for consumer advocacy in adult mental health services do not seem to apply to child and adolescent mental health services. Firstly, the parent clients of child and adolescent mental health services generally expect, along with the clinicians, to move on from their problems in a relatively short period of time. Change in terms of recovery is anticipated and expected. Secondly, as the contact is often conceived to be brief, client families are less likely to want to make contacts and develop ongoing relationships with other parents with problems.

The characteristics of referring parents have been researched, and reluctance to make contact is a seemingly universal characteristic, even though many do attend, at least initially. Referral to child and adolescent mental health services has been shown to be more likely when the parent is not physically well, which suggests that child behaviour can be more difficult to manage in times of parental ill health, with the added needs of the parent providing the impetus to seek help. Low family cohesiveness also has been implicated in increased rates of referral. However, the most potent reason for referral has been concern for the child and the child's behaviour, with internalizing behaviours and older age of the child leading to higher rates of referral.

The picture of the parent revealed in these various studies is of one who has concerns, lacks certain knowledge about self and child development, and is having difficulty coping. Referral to a child and adolescent mental health service is not a desired option, but somehow it becomes necessary. Section 3.4.6 provided an heuristic for apprehending the parent of a child with mental health needs. The parent was conceived to be as strongly for the assistance as against it, in other words to be ambivalent to seeking help. These propositions concerning the characteristics of parents could be researched in the present studies.

7.1.3 The beginnings of contact at child and adolescent mental health services: Continuance and discontinuance

Psychotherapy research has been compromised by the lack of reporting of the initiating conditions of client contact. Yet, outcomes of psychotherapy may be attributable to the initiating conditions, rather than to the highly developed techniques of skilful therapists, as claimed by the field and presented in Section 3.3 of Chapter 3.

Hundreds of clinic-based research studies were scanned in Chapters 4 and 5 to establish the following key conclusions concerning the outcomes of continuance and discontinuance of attendance, some of which are open to direct empirical enquiry:

- there are many influences upon and barriers to participation in child and adolescent mental health services;
- the referral pathway, state of health of the parent, family cohesion, and child behaviour are key factors in referral;
- the stability of life factor of Hershorn (1993) was proposed as resolving the multiplicity of contradictory results concerning non-attendance and demographic factors;

- distinct phases of contact have been identified, marked by the respective patterns of discontinuance and the arrangement of clinical activity into referral and intake, assessment, and program of assistance; and

- three applicant types to mental health services were postulated by the present researcher.

First, studies of mental health service discontinuance have pointed to many influences that can occur in the initial period of contact and, indeed the trend in the field, as exemplified in the research of Kazdin (at least 14 relevant publications) and of Pekarik (at least 16 relevant publications) has moved towards study of initiating conditions. The list of influences that has been generated is long, as completing treatment requires attendance, and attendance can be affected by a host of factors involving the referral source and network (personnel, information giving, pathway), parental health, parental expectations of service, family cohesion, stigma, waiting times, prompting appointment attendance, demographic factors (gender, age, diagnostic features), changes in life circumstances that influence stability in living, legal problems, phase of treatment, therapist characteristics, service characteristics, and referral and intake worker practices. There appear to be many barriers to participation that cannot be associated with theories of psychological change. The stability in life factor requires clear, operational conceptualization if it is to be studied.

Another finding of the critical analysis of the discontinuance literature was presented in Table 1 in Chapter 5. Three applicant types were identified and described. It is possible, in theory, that each type of applicant could be detected at referral and intake. Crisis-reactive applicants referred during crisis were found to be unlikely to follow through if not seen immediately. Containable applicants display a range of interest and aversion to help and the ambivalence could lead to long-term or little contact. The third group of applicants were committed to either short-term or long-term work.

Applicant type would be open to research so long as each type is amenable to participation, but this does not seem probable with crisis-reactive applicants and some containable applicants. An

alternate research path would involve interviews with referral and intake workers to establish the categories, clearly, and then documentation of the types of applicants who call, over a period of time.

The final finding of the clinic-based research chapters of the literature review was documented in Section 5.5. An historical flow towards studying the initiating conditions of therapy was identified within the research opuses of Kazdin and Pekarik, whose persistence and productivity is outstanding in the field. Although both were interested in helping adults and children through cognitive-behavioural therapy, they have not ignored the range of factors that influence the uptake of therapy that are unrelated to their model of change. Along with the integrating contribution of Hershorn concerning the stability of life factor, these series of papers point away from technical descriptions of psychotherapy toward a conceptualization of significant aspects of therapy as the gathering of a momentum toward change for long enough, such that the termination of contact can be made at a time suited to the clients' life demands. If therapy is a gathering of momentum, how this momentum is gathered becomes crucial to the conduct of therapy. If the initiating conditions can be shown, in the present research, to be linked to the perceived quality of subsequent contacts, a new avenue for psychotherapy research will have opened up.

7.1.4   The referral and intake worker role

With respect to the many factors that influence applicancy for child and adolescent mental health service, the referral and intake worker role itself has remained in the shadows. Chapter 6 attempted to summarize the research concerning this role and produced a series of linked, but unintegrated, observations concerning tasks, functioning, and organizational relationships relevant to the role. It can be concluded that referral and intake workers, when taking a referral, have several tasks that have to be worked through with brevity and precision, yet with a listening attitude. How such work can be done is open to enquiry. Other aspects of the role could be documented, as well.

The literature revealed the following:

- policy and procedures have been considered important in child guidance from the outset, with recurrent publication interest, but with few details published;

- the referral and intake service can be used as scapegoat for clinic organizational and interpersonal troubles;

- continuity of contact in the early phases of contact was considered important;

- referral and intake workers can predict continuance through the early phases of contact;

- there are lists of tasks for receptionists and referral and intake workers which have correspondence, and may be part of the task repertoire of referral and intake workers;

- decision-making processes and heuristics were described, but these were remote from the tasks of referral and intake work;

- decision-making was only a small part of the overall job;

- the telephone-counseling literature helped identify referral and intake worker person characteristics, job description, and a list of key skills;

- referral and intake work is not crisisline counseling or triage;

- referral and intake work involves a special type of listening that has yet to be adequately described;

- referral and intake work involves the emergence of a narrative over the course of the contact; and

- clinicians do not really notice or give much importance to referral and intake work.

Referral and intake workers liaise with community agencies, referral and intake workers liaise, internally, with service leaders and other staff, and referral and intake workers may advocate for certain clients to gain service access. But the literature has been almost silent on the practices and values of referral and intake work itself. What is it like being an referral and intake worker? What

are the rewards and burdens of the job? What recognition of the value of the work is achieved? Do referral and intake workers regard themselves as professional clinicians? Do other clinicians regard referral and intake work as legitimate clinical activity? These gaps in knowledge about the referral and intake worker role could be explored empirically.

7.1.5   .Implications for further exploration in the present study

The sparseness and diversity of the relevant literature suggests that the phenomena to be studied have been difficult to enquire about, even when concerted effort has been applied. Mostly, information about the mechanisms of referral and intake has not been published, even if written in organizational manuals. Only two studies were found on the meaningfulness of referral and intake. One focused upon the meaning offered by the agency in telephone referral, rather than the meaning gained by the parent (Krause, 1966), while the other concerned the co-construction of meaning in the course of an referral and intake interview (Brown, 1993).

The dearth of specific publication, and the two studies of the meaningfulness of the referral and intake transaction suggest, that difficulties in access to informants might have precluded such research. For Brown (1993), researcher access was made possible by virtue of the referral and intake interview occurring under observation by a clinical supervisor, behind a one-way screen. Clinical research, in general, has not given any importance to the meaningfulness of referral and intake upon later therapeutic events, other than to screen out clients who were inappropriate to the stringent requirements for evidence-based practice research, and to gain secure consent for the course of therapy. The key research access issue would seem to be that of gaining participant consent.

One of the strengths of Brown's (1993) study was that it followed the process of service contact prospectively. Prospective study of referral and intake had been undertaken by Cohen and

Richardson (1970), who studied large numbers of referrals and reported disposition at the beginning and end, and the reasons for discontinuance, such that meaningfulness was not reported upon in any depth, other than the description of two phases of contact, namely pre-therapy and therapy. They advocated more prospective study, but only Joshi et al. (1985) was identified as taking up this methodology. Again, the sampling of 100 cases by Joshi et al. did not allow for detailed study of the importance of referral and intake to the clients, and did not differentiate the three phases of clinical contact first identified by Tuckman and Lavell (1959) and, later, confirmed by Sirles (1990).

How contact with child and adolescent mental health services begins affects how service is received, and how families make use of the allocated contacts. The referral and intake role is an important clinical specialty, buried in history by its ordinariness, which requires documentation of the practices and of the skilfulness involved with the role, without avoiding the confusion and mystery inherent to these practices. Direct enquiry of parents and of referral and intake workers would fill in many of the gaps in knowledge identified.

However, the lack of sufficient signposts to the effects of referral and intake upon subsequent clinical events, suggests that before prospective study could be commenced, a retrospective mapping of the important influences that come from the beginnings, needs to occur. The prospective study could then occur with enquiry directed to tracing the course of the located important influences.

In summary, the following propositions concerning the circumstances of referral that could be pursued in empirical enquiry; referral source, child behaviour, parental wellbeing, family cohesion, stability in life, phases of contact, discontinuance factors, waiting period, and applicant type. Other factors may, of course, be relevant. Some of the factors, especially stability in life, would require

the development of standard format data collection instrument incorporating all other relevant demographic details.

7.2   Underlying methodological principles: The demand for qualitative enquiry

In Chapter 1, it was argued that ordinary but obscured phenomena can be illuminated by exploratory case study research. Case study is an observational technique useful for the development of theory. In the first instance, this exploratory process needs to be qualitative, but with theoretical development, the explorations can be augmented by parametric measures within a mixed-methods research design.

Although a vast and varied literature has been reviewed, there is much that is not known about referral and intake to child and adolescent mental health services. Observational work, with a variety of frames, stances, and means, is required to describe the many task and functions of the referral and intake worker role and how it affects parents and subsequent clinical contacts. Direct enquiry of informants is needed. In Section 1.8.2 of Chapter 1, the parameters for rigorous enquiry of psychosocial phenomena when control is not possible and knowledge limited were described, following the argument of Yin (1989, 1993). Qualitative, case study research is required to help build the knowledge base about referral and intake work and to assist in the systematizing of its practices and effects.

Referral and intake to child and adolescent mental health services is both procedurally mechanistic and interpersonally meaningful. Names need to be given to the practices. The effects of the practices need to be discerned as they emerge.

The basic question to be asked throughout the proposed enquiries would be: given how contact with a child and adolescent mental health agency started, what effects of the contact remain at this point in time?

7.3 Design: Development of the research questions and aims of the present study

The retrospective study was conceived as a mapping exercise of the territory of referral and intake and its subsequent effects. With such a map, it was envisaged that cases could be followed, prospectively, to discern any ongoing effects of referral and intake. However, it was proposed that the prospective study would need only to demonstrate that the initiating conditions remain relevant to case disposition throughout contact, rather than show demonstrable effects.

The reference points for the mapping, in the retrospective study, were the points of first and last contact with a child and adolescent mental health service, and the phases of contact inferred from Tuckman and Lavell (1959) and confirmed by Armbruster and Fallon (1994) and Sirles (1990), to which was added the pre-contact phase. These reference points were discussed in Section 5.1 of Chapter 5.

7.3.1 Overall research strategy

The mapping of the practices and their effects was seen as having two important aspects. Firstly, the practices were to be identified and labelled. Secondly, the effects of these practices were to be measured. A two-stage, iterative strategy was planned.

In each stage, participants will be asked to report on referral and intake experience at termination, but also after assessment, after the first interview, and after the first telephone contact. Participants would be recruited to provide such reports at these points in their contact.

7.3.2   Aims of the present study

The research questions posed provided a framework for the aims of the research, namely to explore the effects of referral and intake processes upon contact with child and adolescent mental health services. Referral and intake processes were expected to influence the course of clinical contact at child and adolescent mental health services. Accordingly, this research aimed to:

1.   document the tasks, functions, and procedures of the referral and intake worker;

2.   establish the place of referral and intake processes within the work of the clinics;

3.   document the importance of the process for parents; and to

4.   indicate how the referral and intake process influences subsequent clinical contact.

These four aims were addressed within two empirical enquiries, the more specific aims of which are presented below in Section 7.6.1 (retrospective enquiry) and Section 7.6.2 (prospective enquiry).

7.4   Structure and expectations of the present study

Through a two-stage qualitative design, the first involving retrospective and the second prospective enquiry, findings were anticipated, as detailed below. It was expected that the findings of the retrospective enquiry would generate further expectations for the second prospective stage of the research.

7.4.1   Retrospective study

The specific aims of the retrospective enquiry were, then, to document:

1.   the processes of referral and intake;

2.   the effects of the processes of referral and intake on parents; and

3. the effects of the processes of referral and intake on the overall progress of cases.

These aims were then interrogated to generate a list of reasonable expectations of the proposed enquiry. It can be noted that the aims are nested, with the processes of referral and intake (first aim) open to discernment by parental views of case conduct (second aim) and within the context of case progression (third aim). The following list of expectations goes from the broader aim of effects on case progression, toward the more specific aim of documentation of practices, tasks, and procedures. These expectations were then used to design the interview questions asked of participants. These expectations were not designed for the testing of prediction, but rather to prompt discussion by the participants. Even where the answer to the question may seem categorical, the aim was to have participants consider how an effect was manifested over time, or how a description of someone might be different to how they perceived themselves. That is, the expectations were designed to focus the attention of the participant, without predicting the content of the answer.

Referral and intake processes were expected to affect the overall progression of child and adolescent mental health services cases (Expectation R1).

- The extent of this effect over time was expected to diminish, but remain important (Expectation R1.1).
- It would be considered a sufficient criterion of success, that parents described an effect during the therapeutic phase of contact, in some cases (Expectation R1.2).

More specifically, the study aimed to document the practices of the referral and intake workers (first aim), to document how parents perceive these practices (second aim), and to document how these practices affect subsequent events (third aim).

A second set of expectations concerned more specific parental perspectives (second aim) upon the practices and effects of referral and intake:

- Parents were expected to report ambivalence about seeking referral for help (Expectation R2.1).

- Parents were expected to report lowered health at the time of referral (Expectation R2.2).

- Parents were expected to report decreased psychological problems in their children over time (Expectation R2.3).

- Parents were not expected to regard themselves as service consumers with needs for the sharing of experience with other parents of child and adolescent mental health services clients (Expectation R2.4).

Staff of the child and adolescent mental health services were expected to give a different view of the referral and intake process from that of the parents (Expectation R3). With respect to the directors and the clinicians (first aim):

- Directors of services were expected to give a clear overview of the policy and procedures and an understanding of why the current referral and intake system was adopted given experience at the service and elsewhere (Expectation R3.1).

- Clinicians were expected to give a clear overview of the policy and procedures and an understanding of why the current referral and intake system was adopted given experience at the service and elsewhere (Expectation R3.2).

- Clinicians were expected to give a clear account of a case, its current status, and its circumstances of beginning (Expectation R3.3).

- Clinicians were expected to regard the case as beginning from either the time of clinical commencement or the time of referral (Expectation R3.4).

- Clinicians were not expected to have noticed how the beginning has continued to affect the current status of a case (Expectation R3.5).

- Clinicians were not expected to give a clear understanding of the status of the parent as client or as citizen before referral, the parent will thought of in terms of the referred child (Expectation R3.6).

With respect to referral and intake workers (first aim), it is expected that, through interview, referral and intake workers would give a full and clear account of their work and be able to describe the many practices (Expectation R4).

- It is expected that referral and intake workers would be able to give a clear overview of the policy and procedures and an understanding of why the current referral and intake system was adopted given experience at the service and elsewhere (Expectation R4.1).

- It is expected that referral and intake workers would be able to gain from each referrer a clear basis for accepting or referring elsewhere all cases (Expectation R4.2).

- It is expected that referral and intake workers would have a sense, at time of referral, of the likelihood of cases to progress beyond assessment (Expectation R4.3).

- It is expected that the experience of referral and intake work would be described in a manner consistent with Brown's (1993) mystery analogy (Expectation R4.4).

- It is expected that referral and intake work would be conducted using discernible decision-making strategies (Expectation R4.5).

- It is expected that referral and intake work will share a skill base with commonalities to receptionists, telephone counselors, and health advice line consultants, but not triage (Expectation R4.6).

- It is expected that referral and intake work is not perceived to have the same status as clinical work within services (Expectation R4.7).

- It is expected that referral and intake workers will vary in their receptiveness (inclusiveness and extensiveness of listening) in ways linked to their original professional training (Expectation R4.8).

Phase of contact effects will be discernible through the manner of the parent at first contact and at subsequent continuance or discontinuance (Expectation R5).

- Parents will be able to report on differences between phases of contact and the importance these phases had upon their progress (Expectation R5.1).

It is also expected that, as the study is exploratory, there will be novel and unpredictable factors (first aim) that will be detected (Expectation R6).

7.4.2   Prospective study

The specific aims of the prospective enquiry were to:

1. document in more detail the tasks and practices of referral and intake identified in the retrospective study

2. document the effects of referral and intake practices on the unfolding experience of parents,

3. document the effects of the processes of referral and intake on the progress of cases,

4. investigate the measures of parental wellbeing, child behaviour, family cohesion, parental hopefulness, stability in life, and access barriers within the context of case studies, and to

5. write case studies of the experience of change over the course of a year following referral of a child to a child and adolescent mental health service.

As with the retrospective enquiry, these aims were nested. It was expected that in the writing of the case studies (fifth aim), the quantitative measures would be evaluated (fourth aim), as would case progression (third aim), the impacts of the practices of referral and intake (second aim), and the closer documentation of the practices of referral and intake (first aim). The research expectations that were used to develop the interview schedule are, therefore, presented to show this nesting, below. Many of the expectations from the retrospective enquiry are listed below, but there are some differences, especially with respect to the quantitative measures.

Referral and intake processes were expected to affect the overall progression of child and adolescent mental health services cases (Expectation P1). These are the same as for the retrospective study.

- The extent of this effect over time was expected to diminish, but remain important (Expectation P1.1).
- The effect of referral and intake upon the therapeutic phase of contact would be noted by parents, in some cases (Expectation P1.2).

The literature survey suggested a number of influences that may be present, but given the two stages of enquiry, it was unclear how the findings of the retrospective enquiry would lead to the formulation of the second enquiry. Nevertheless, a second set of expectations concerned parents (first and third aims) that paralleled expectations of the retrospective study:

- Parents would be expected to report ambivalence about seeking referral for help (Expectation P2.1).
- Parents would be expected to report lowered health at the time of referral (Expectation P2.2).
- Parents would be expected to report decreased psychological problems in their children over time (Expectation P2.3).

- Parents were not expected to regard themselves as service consumers with needs for the sharing of experience with other parents of child and adolescent mental health services clients (Expectation P2.4).

- Parents would be expected to report increased barriers to participation in the first phases of contact, the perception of which will then decrease over time (Expectation P2.5).

- Parents with more indicators of instability in life would be more likely to discontinue contact (Expectation P2.6).

- Families with lowered cohesiveness, as reported by parents, would be more likely to seek referral (Expectation P2.7).

The director of the service would be expected to give a clear overview of the policy and procedures and an understanding of why the current referral and intake system was adopted given experience at the service and elsewhere (Expectation P3).

With respect to referral and intake workers, it was expected that, through interview, referral and intake workers would give a full and clear account of their work and be able to describe the many practices (second aim) (Expectation P4). These correspond to the same expectations for the retrospective enquiry.

- It is expected that referral and intake workers would be able to give a clear overview of the policy and procedures and an understanding of why the current referral and intake system was adopted given experience at the service and elsewhere (Expectation P4.1).

- It is expected that referral and intake workers would be able to gain from each referrer a clear basis for accepting or referring elsewhere all cases (Expectation P4.2).

- It is expected that referral and intake workers would have a sense, at time of referral, of the likelihood of cases to progress beyond assessment (Expectation P4.3).

- It is expected that the experience of referral and intake work would be described in a manner consistent with Brown's (1993) mystery analogy (Expectation P4.4).

- It is expected that referral and intake work would be conducted using discernible decision-making strategies (Expectation P4.5).

- It is expected that referral and intake work would share a skill base with commonalities to receptionists, telephone counselors, and health advice line consultants, but not triage (Expectation P4.6).

- It is expected that referral and intake work was not perceived to have the same status as clinical work within services (Expectation P4.7).

- It is expected that referral and intake workers would vary in their receptiveness (inclusiveness and extensiveness of listening) in ways linked to their original professional training (Expectation P4.8).

Parents would be able to report on differences between phases of contact and the importance these phases had upon their progress (Expectation P5). The prospective study included two further aspects to the corresponding expectation in the retrospective enquiry.

- Families who discontinue prior to the first interview would be different to those who discontinue during assessment, or who discontinue during therapy (Expectation P5.1).

- It is expected that three types of applicants for assistance would be discernible by referral and intake workers and from other data sources: crisis reactive, containable, and committed (Expectation P5.2).

It is also expected that, as the prospective study is exploratory, there would be novel and unpredictable factors that will be detected (Expectation P6). This is the same expectation as in the retrospective enquiry.

7.5 Presentation of the empirical studies

The methodology of the first empirical enquiry is presented in Chapters 8. Chapter 9 reports the findings of the retrospective enquiry. The latter provided direction for the prospective enquiry, the methodology of which is outlined in Chapter 10. The findings of the second enquiry are then presented in Chapter 11.

CHAPTER 8

RETROSPECTIVE ENQUIRY METHOD

Study the past, if you would divine the future.
Confucius (551-479 BC). *Analects.* (Leys, 1997).

This chapter presents the method that was planned for the implementation of the exploratory retrospective enquiry into the processes, practices, and effects of referral and intake to child and adolescent mental health services. As outlined in Chapter 7, the purpose of this enquiry was to gain, through a series of qualitative interviews, a map of the overall process as viewed by parents, clinicians, referral and intake workers and service directors. It was planned that the findings of this enquiry could then be used as a basis for the design of the prospective study, using quantitative measures, of the process from point of first contact until twelve months after the first contact.

The chapter outlines the plan of this stage of the study by describing its aims, the sample to be recruited, the interview protocol, the data collection procedure, and the proposed means to analyse the qualitative interview data.

8.1   Aims of the retrospective study

The aims of the retrospective enquiry were, as outlined in Section 7.4.1, to document, for two child and adolescent mental health service agencies, perceptions of the mechanisms and meaning of:

1. the processes of referral and intake;

2. the effects of the processes of referral and intake on parents; and

3. the effects of the processes of referral and intake on the overall progress of cases.

Perceptions of the processes, their effects, and of case progression were to be obtained after the event, through the reports of parents and clinicians. These perceptions would augment overviews of the formal policies and procedures provided by the directors and coordinating referral and intake workers of the services involved.

8.2   Sample of informants

Two child and adolescent mental health service agencies in Melbourne, Victoria, Australia, were approached and requested to provide access to potential informants. Twenty-four parents, their corresponding case-managing clinicians, the coordinating referral and intake workers, and the directors of each service were invited to participate.

While the term "participant" was used on the research information and on the informed consent forms, in line with standard research ethics terminology (see Appendices A4, A5, A6, C1, C3, and C4), the role of the research participants, once recruited, was to describe their perception of the referral and intake process. The role of these people was thus to inform the researcher. For this reason, the term "informant" was adopted to more accurately reflect the position to be taken with respect to the data collected.

Parent informants were to be recruited by clinicians at specific points in the case contact process, namely, mutual termination, upon completion of assessment, after first interview, and after first contact. At each of these data collection points, three parents and their clinicians were to be interviewed, at each of the two services. This would result in the conduct of a total of 52 interviews with 24 parents, a maximum of 24 clinicians, plus four interviews with directors and coordinating referral and intake workers. Individual clinicians, directors, and referral and intake workers would participate more than once if they recruited more than one parent.

8.3   Interview protocol design

The expectations listed in Section 7.4.1 of Chapter 7 were directed toward the documentation of policy, practices, and procedures as perceived by directors, coordinating intake workers, clinicians and parents, but also allowed for the emergence of unexpected factors, and for the emergence of factors indicated in the literature, such as stability in life, family cohesion, and parental wellness. The interviews were designed to explore these expectations. The interviews with the directors and coordinating intake workers occurred prior to those concerning cases. Interviews with the directors and coordinating intake workers covered similar policy issues as the interviews with clinicians, but the former had greater depth and breadth with respect to policy. Interviews for parents and clinicians covered the same issues, but from the perspective of the particular informant.

Two forms of semi-structured interview were designed, namely,

- a foundational interview protocol for use with service directors and coordinating referral and intake workers, to provide basic understanding of philosophy, policy, and practice procedures of referral and intake (see Appendix A8), and

- a specific case-oriented interview protocol for use with parents and clinicians, that would also leave room for the respondent to comment, as desired, on philosophy, policy and procedural issues pertaining to referral and intake (see Appendix A9).

Interviews would be semi-structured as it was anticipated that not all questions would be relevant to all informants, in all interviews, and the order of questions could be varied in accordance with each informant's responses as these developed over the course of the interview.

8.3.1   The foundational interview concerning policy and practice

The protocol for the semi-structured foundational interview is presented as Appendix A8. The purpose of this interview was to gain a sense of the service agency's attitudes toward the referral and intake process, and how informants perceived these to be reflected in service policies and procedures. All informants were expected to have opinions, but the perspectives of service directors, referral and intake workers, parents, and clinicians were expected to be different from each other, especially with respect to policy issues and agency history. Those who had experienced referral and intake procedures at other services, or in other forms at the same service, would be asked to make comparisons between alternate configurations of referral and intake.

Each interview would begin by seeking background information about the informant, and how he or she became a witness to the processes of referral and intake. Details of policy and procedure would be addressed by direct questioning and audio-recorded. The domains of these questions were:

- informant position and role within the agency's referral and intake philosophy and procedures;
- steps and tasks in the agency's referral and intake procedures;
- beliefs about the parent and child experience of the referral and intake procedures; and
- associated issues to do with continuance and discontinuance of contact.

In fact, the general form of the foundational interview was very similar to that of the case-oriented interview. The former was foundational in two ways. Firstly, the interviews with the directors and referral and intake workers preceded the case-oriented interviews. Secondly, these interviews provided the framework of policy and history whereby the actual practices of referral and intake work could be understood.

8.3.2   The case-oriented interview

The protocol for the semi-structured case-oriented interview for clinicians is presented in Appendix A9 and the protocol for the semi-structured case-oriented interview for parents is presented in Appendix A10. The case-oriented interview was designed to document, from informant recall, the actual steps of contact experienced by the parent, from the time of contemplation of seeking help to the time of the research interview. Special focus would be placed upon the referral telephone call. Details of the actual reasons for contact and the steps that occurred within, and subsequent to, the referral call would be recorded, along with the understanding of the significance of the events. A contact timeline could be used to facilitate memory of the process and to chronologically map the events.

Discussion of issues related to particular cases involved similar questions for both clinicians and parents. Informants would be asked what was important about the beginning contact that remains relevant, and whether anything changed that made those beginning processes become more or less important.

As in the foundational interviews, each interview would begin by seeking background information about the informant and how he or she became a witness to the processes of referral and intake in the particular case. Details of policy and procedure were to be recorded closely and by direct questioning. The domains of these questions were:

- informant position and role within the agency's referral and intake philosophy and procedures;

- timeline of the steps and tasks in the referral of the particular case;

- beliefs about the parent and child experience of the referral and intake procedures, both specific to the case and in general; and

- associated general issues to do with drop out and continuation of contact.

8.4   Data collection procedure

The foundational interviews were planned to occur first with the interviews with the directors preceding those with the referral and intake workers. Case-oriented interviews would then follow with the interview with the clinician preceding the interview with the parent. For each of the four data collection points, three sets of case-oriented interviews were planned, for each agency.

8.4.1   Preparation for data collection

In the first instance, the service director was to be approached to consider the agency's possible participation in the project. Once collaboration was agreed, the researcher would hold research-briefing meetings with the referral and intake and clinical staff. Letters of invitation to participate would be made available at these meetings, including a letter outlining the protocol for recruitment of parent informants by staff. These information letters are presented as Appendices A1, A2, and A3.

Data collection would be commenced at one child and adolescent mental health service before the other, but data collection at the two services could occur concurrently, after an initial delay. At each agency interviews were planned to be conducted in the following sequence:

1. foundational interview with the director;

2. foundational interview with the referral and intake coordinator;

3. case-oriented interview with the clinician for case at termination;

4. case-oriented interview with the parent for case at termination, with each interview pair repeated for three cases;

5. case-oriented interview with the clinician for case after assessment;

6. case-oriented interview with the parent for case after assessment, with each interview pair repeated for three cases;

7. case-oriented interview with the clinician for case after first interview;

8. case-oriented interview with the parent for case after first interview, with each interview pair repeated for three cases;

9. case-oriented interview with the clinician for case after referral call; and

10. case-oriented interview with the parent for case after referral call, with each interview pair repeated for three cases.

Twenty-six interviews, involving twelve cases, were planned to be conducted at each agency.

8.4.2   Recruitment of informants

Recruitment of parent informants would occur through the active collaboration of case clinicians. They could approach parents to participate in the research at the appropriate point in their contact, according to the relevant phase of contact. Recruiting through clinicians had the advantage of invitation by trusted professionals who could distance themselves from the research, and help the parent to do so as well. Clinicians could also monitor, buffer, and address any adverse research effects.

Recruitment of parent informants by clinicians was to occur in a pattern designated by the phases of contact. Once three sets of case termination interviews were completed, clinicians would be asked to recruit parents soon after the completion of clinical assessment. Similarly, clinicians would be asked to recruit parents for the third round of data collection at the time of the first interview. For the final round of interviews, just after first contact, coordinating referral and intake workers would be asked to recruit parents to the research during the referral telephone call.

Table 2

Summary table of phases of participant recruitment for retrospective study. Interviews for one

phase were not intended to begin until interviews for the previous phase were complete.

Recruitment phase, in order	Parents to be recruited	Number to be recruited
Termination	Terminating parents	3
Clinical assessment	Parents beginning therapeutic contact or finishing assessment	3
First interview	Parents having met with clinician for the first time, or soon after first contact	3
Referral	Parents at time of referral telephone call	3

8.4.3   Obtaining informed consent

Informants for the foundational interviews, clinic directors and referral and intake workers, would

be approached directly, and asked to consent to participating and for the audiotaping of the

interviews. Informed consent forms would be counter-signed by a colleague of the clinician. This

Consent Form is presented as Appendix A6.

Case clinicians would be asked to invite parents to participate in cases that had recently completed,

or were about to complete, being the final step of clinic contact. They would be requested to

discuss with parents the possibility of participation in the research project, providing at the same

time the Consent Form as the Research Information, presented as Appendix A4. The parent would

be informed of the freedom to withdraw at any stage without consequence. If the parent agreed, the

parent would formally consent in writing to be contacted by the researcher and to participate in the

research. This second parent Consent Form is presented as Appendix A6. Upon receipt of the

completed consent form, the researcher could then telephone the parent and arrange an appointment

to meet to discuss participation.

Once parental consent was gained, an appointment would also be made with the clinician, to gain his or her own written consent for full participation, and to conduct the actual interview, including permission to audio-record. This Consent Form is presented as Appendix A6.

8.4.4   Conduct of the interviews

To guide the conduct of both foundational and case-oriented interviews, protocol booklets were prepared, displaying in large print the questions to be asked. These questions are shown in Appendix A8 (parent), and Appendix A9 (staff). They could be modified in form and sequence to suit the individual informant, the researcher being guided by the expectations of the study, as listed in Section 7.6.1 of Chapter 7, and by the domains of enquiry articulated in Sections 8.3.1 and 8.3.2 above.

Case-oriented interviews would occur as close as possible to the time of passing of a data collection point, as set out in Section 8.4.1 above, and hopefully within a week of the passing of this point by the family. Interviews would be arranged to occur at a time and venue convenient and congenial to the informant.

All interviews would be audiotaped, given the written consent of the informants. Transcripts of the audio-taped interviews would be made and prepared for systematic qualitative data content analysis.

8.5   Qualitative data analysis procedure

As stated, the interviews were expected to illuminate the practices of the referral and intake process, its perceived meanings, and at least some of its perceived effects. The expectations

outlined in Section 7.6.1 would guide the analysis of the data as well as the conduct of the interviews.

To permit the embracing of the multi-level factors identified in the expectations, a grounded theory framework to the interview data was to be adopted. Grounded theory was formulated by Glaser and Strauss (1967) to enable the rigorous examination of textual data with a view to the construction of new understanding of the phenomenon being studied. The approach assumes an ontology derived from Heidegger (Collins & Selina, 1999) and an epistemology embedded in constructivism (Henwood & Pidgeon, 1995). Grounded theory is applicable to open enquiry where the outcomes of expectations cannot be formulated in any detail beforehand, and where the informants' experiences are elaborated within their own phenomenological and social contexts (Henwood & Pidgeon).

The grounded theory approach was considered appropriate here in view of the lack of existing descriptions of the referral and intake practices or existing formulations of the process. The approach is flexible and generative of new theoretical propositions. Such propositions can then suggest further research directions. In the present enquiry, some details of procedure or policy were expected to be able to be described directly, but other factors concerning the effects of processes were expected to emerge.

It may seem that the expectations provided in Sections 7.4.1 and Section 7.4.2 are at odds with the stated grounded theory approach. As was stated in Section 7.4.1, the expectations were articulated from the existing literature and from rational consideration of the overall field of the enquiry. These expectations allowed for the formulation of open-ended questions about participant experience. The actual responses were not predicted and were not predictable in their detail. Even where the answer to an expectation could be conceived as categorical, the aim was not to seek a test of the proposition, but rather to have the participant use the expectation to explore, in detail, how

they experienced an event or experience. The stated expectations provided the words to focus the participants on their exploration of their experiences.

The methodology would involve the coding of transcripts using low-level categories that facilitated the detection of patterns in the data. Data coding is iterative and involves revisiting the primary data as broader patterns are detected.

8.5.1   Initial coding of data

All interview data would be punctuated according to distinct themes, issues, or units of meaning emerging, in terms of the practices and procedures of referral and intake reported, separating these from remarks of the informants about either processes or the general functioning of the service. Transcripts were inspected and underlining identified details of referral and intake practices and their effects. Adjacent to such indications, comments were added to the transcript. These comments would then be used to produce a series of codes describing the themes identified. An example of one page of a coded transcript from a parent is presented as Appendix B1, a coded transcript page from a clinician is presented as Appendix B2, and a coded transcript page from a director is presented as Appendix B3.

8.5.2   Thematic content analysis

The coded data in respect of themes would be subjected to thematic content analysis. Themes would be reduced by display in matrices or tables, after the technique recommended by of Miles and Huberman (1994), by the counting of frequencies for each code for all interviews across informant type.

In accordance with the expectations of the study and the questions asked in the interviews, data would be analysed pertaining to themes in the following domains of content:

- referral and intake policies,
- referral and intake procedures,
- attitudes concerning referral and intake processes,
- issues concerning assessment and treatment,
- office issues,
- pre-referral status of parent,
- issues concerning waits,
- parent issues,
- parent attitudes about mental health professionals,
- reasons for discontinuance, and
- issues relating to the conduct of the research.

8.5.3   Interpretation of themes

Interpretation of the patterns of data would involve discerning links between the frequencies of response types, the types of informant, the phase of service contact, and correspondences with policies and procedures of referral and intake. Matrix display or the grouping of practices into more abstract categories, would then further reduce the data. Further interpretation would involve links with the assembled literature.

The findings would then be used to formulate the prospective study that was planned to follow this retrospective study, which would also use a grounded theory approach, permitting refinement of interpretation arising from the retrospective study stage and leading to development of new propositions in the area.

CHAPTER 9

RETROSPECTIVE ENQUIRY FINDINGS

To-day we have naming of parts. Yesterday
We had daily cleaning. And to-morrow morning,
We shall have what to do after firing. But to-day,
To-day we have naming of parts. Japonica
Glistens like coral in all of the neighbouring gardens,
And to-day we have naming of parts.
This is the lower sling swivel …..
"Naming of Parts" by Henry Reed (1942)

This chapter presents the findings of the retrospective study. The sample of informants is first

described in terms of recruitment and of composition. Secondly, the findings of the thematic

content analyses relating to the practices of referral and intake work, in the two agencies studied, as

described by informants are presented. Thirdly, the findings from the thematic content analyses of

the data relating to effects upon parents are then presented. Finally, findings related to process and

overall progress are presented.

The thematic content analyses of the interview data were conducted as described in Section 8.4.2 of

Chapter 8, using the matrix or table data reduction and display method proposed by Miles and

Huberman (1994). Findings of the thematic content analyses are displayed in two ways, namely,

by table or by exemplifying quotation. The source of quotation has been obscured to ensure

confidentiality of parents. The confidentiality of parents is further protected by the use of

pseudonyms for both parents and children.

The confidentiality of clinicians was also safeguarded, but the identity of service directors and

referral and intake workers cannot be hidden, even though no names have been used in this report,

as these are a matter of public record. These latter informants were, of course, aware of this factor before giving written consent to participation.

9.1 Sample of informants

Twenty-one individuals participated in the study. The data obtained included at least one interview with:

- the directors (both male) of the two child and adolescent mental health services involved,
- the senior referral and intake workers (one male, one female) of these agencies,
- 11 clinicians, who worked with the parent in each case, (3 male, 8 female), and
- 11 parents of clients (1 father, 10 mothers).

Two interviews were conducted with one director, and with one referral and intake worker, as this director and this referral and intake worker was the parent clinician for one case each. One parent clinician was interviewed about two separate cases. Clinicians working with the child were not interviewed.

Seven of the children referred for assistance in these eleven families were of primary school age (7 boys) and four of the children were of secondary school age (2 boys and 2 girls). The names of the children and parents are pseudonyms. Gender has not been changed, but implied cultural identification has been changed

9.1.1 Completed interviews

While it was planned to include 48 cases in the study, only eleven were recruited and only 26 of the planned 52 interviews took place. Both service directors had expected that full data collection

would be completed within a three to six month period. In the event, data collection was stopped after eighteen months. A sample page of transcript of interview is presented for a parent informant as Appendix B1, for a clinician informant as Appendix B2, and for a director informant as Appendix B3.

Recruitment required clinicians to invite parents to participate, but, despite avowed enthusiasm on the part of clinicians, this proved a difficult task for reasons that were difficult to clarify. Clinicians found the recruiting of parent informants more difficult when the recruiting had to occur earlier in the case contact process. No specific data were recorded on the willingness of clinicians to recruit, but on several occasions clinicians alerted the researcher about the possibility of a potential referral to the research, only to report later they had forgotten to ask the parent about participation and it had become too late. Rates of recruitment to the research were extremely slow, and efforts to encourage greater clinician action, through attendance at Team meetings, staff development forums, direct contact, and tearoom conversations, did not produce an increase in the rate.

Alternate strategies for recruitment were contemplated, including recruitment by receptionists or by the researcher in the waiting room. These strategies were felt to be directly confrontive and potentially coercive, and were disallowed by the Clinical Director on this account. Secondly, given that an approach was to be made at a certain stage of clinic contact for the clients, this information would have to have been conveyed by the clinician to the researcher or receptionist. Such information transfer could have compromised the confidentiality of the contact between clients and clinicians and such compromise was not acceptable to the clinicians.

With regard to the case-oriented interviews, Table B4-1 of Appendix B4 shows that interviews of parents and clinicians were completed for each data collection point targeted, with six interview pairs at the time of mutual termination and three interview pairs at the time of completion of the assessment. When, across both agencies, one interview pair was achieved following the initial

appointment, and one after the referral call, the data collection was drawn to a close. It was considered that while this was not an ideal situation, sufficient data across all data sources and points of collection had been obtained to plan the design of the prospective phase of the study.

Interviews with agency staff all took place in agency offices, and those with parents all took place in the family home, except for Alison, who was seen at the agency's office. Unfortunately, the acoustic recording attributes of some offices and some home spaces resulted in barely perceptible recording of several participant responses, especially when the participant was a quiet speaker or was distressed by the recall of events. Table B4-1 indicates that 17 transcripts were made from clear audio recording, with seven transcripts coming from recording of variable quality and one transcript having to be largely reconstructed from notes due to the poor quality of recording. One transcript was compiled from notes only, as the clinician declined to be audiotaped. However, for all interviews, comprehensive handwritten notes were made to support the accurate reporting of interview material, so that transcripts could be produced.

9.1.2   Parent informant sample

Demographic descriptors of the parent informants, along with some descriptors of their children, are presented in Table 3, on page 208 below. The descriptors listed correspond to some of the variables that Hershorn (1993) listed as contributing to the stability in life factor.

Table 3

Descriptors of the participants, their children and domestic stability

Parent child (age in years)	Contact phase	Marital status	Housing	Work status	School of child	Changes in last 2 years
Julie Ricky (5 yrs)	Post-termination	Separated	Rented	Full-time	Local Catholic	Kinder to school
Melanie Will (7yrs)	Post-termination	Separated	Rented	Part-time	Local primary	Maternal grandmother hospitalized
Kevin Thomas (14 yrs)	Post-termination	Separated	Rented	Part-time	Alternate high	Father lost job, 2 schools, 2 addresses
Leila Rae (14 yrs)	Post-termination	Separated	Rented	Supporting parent benefit	Local high	None
Pam Aaron (10 yrs)	Post-termination	Separated	Owned	Supporting parent benefit	Local primary	None
Vera Alex (9 yrs)	Post-termination	Married	Owned	Home-based parent	Local primary	None
Michelle Justin (13yrs)	Post-assessment	Separated	Owned	Home-based parent	Local high	None
Cheryl Rebecca (14 yrs)	Post-assessment	Married	Owned	Home-based parent	Private high	Primary to high school
Debbie Jim (6 yrs)	After first interview	De facto	Rented	Supporting parent benefit	Local primary	Parents separated, 2 addresses, de facto
Alison Matthew (8 yrs)	After first interview	Married	Owned	Part-time	Local high	None
Sharon Peter (6 yrs)	After referral call	Married	Owned	Home-based parent	Local primary	1 address, kinder to school

Table 3 shows that, overall, the informants were in relatively stable domestic circumstances.

Although changes of marital status, employment, address, and school did occur, as presented in

Table 3, only three of the parents, with their children, had more than one change in the past two

years. For one of these informants, there were five changes attendant to marital break-up and

changes of school while child concerns were addressed. Another informant had four changes, two

of which were of addresses following marital separation, which was followed later by finding a new partner. One informant had two changes, with a move of house at the time of the child starting school. Transitions to school from kindergarten or from primary to secondary school were changes experienced by three families. All children attended schools local to their home apart from Kevin's son, Thomas, who attended a special program for students with attendance and behavioural problems. Seven of the families had experienced marriage breakup, but in only two families had these occurred in the previous two years. Only three families had changed address in the past two years.

9.1.3   Staff informant sample

Fifteen staff interviews occurred with twelve staff. These included the directors and coordinating referral and intake workers from each centre. The eight clinicians interviewed included one team leader, three senior clinicians, and two junior clinicians. One senior clinician was interviewed with respect to two cases, and one director and one coordinating referral and intake worker were interviewed with respect to specific cases.

Within the clinicians' group were experienced and less experienced practitioners, with the responses of one of the experienced practitioners as comprehensive as the directors' and the coordinating referral and intake workers', due to his role as team leader. The differences between experienced and less experienced clinicians included time as a practitioner, but also experience with a range of referral and intake systems, especially those involving rosters. One junior clinician who commented insightfully upon the effects of referral and intake had worked in a mental health referral service for children and adults in rural Victoria.

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9.2   The practices and policies of referral and intake

The thematic analysis of the interview transcripts is presented in this section using tables. Separate findings are presented within two broad subsections:

- staff report of procedures, attitudes, and policies concerning referral and intake; and

- staff and parental attitudes about parents, attitudinal issues concerning parents prior to referral, and the concerns involved before making the referral.

The process of coding involved six steps. Firstly, four transcripts were read and a provisional list of codes generated. These codes are presented in Table B5-1 of Appendix B5. Then, secondly, these codes were then used across all the transcripts and frequencies were recorded for coordinating referral and intake workers and directors at each agency, senior clinicians, junior clinicians, parents, and, where appropriate for the team leader clinician and the intake clinician. Thirdly, the codes were then summarized under the original domains for the codes and are presented as Tables B6-1 to B6-13 of Appendix B6. Fourthly, these tables were then sorted alphabetically to produce Tables B7-1 to B7-3. The fifth step involved the production of Tables B8-1 to B8-7 of Appendix B8 by sorting the tasks into categories of activity and, where possible, listing the tasks in chronological order. Finally, Tables 4 to 9 were formed by summing frequencies for staff due to the low rates of response across all listed practices or activities.

For each of the Tables 4 to 9, the original, full version of the table is presented as an appendix (Appendix B8, Tables B8-1 to B8-6), but with such low response rates for any of the identified items and by the range of staff informants (2 referral and intake workers, 2 agency directors, 7 senior clinicians, 2 junior clinicians), the tables are more understandable with responses summed for staff and as presented as Tables 4 to 9. However, there were differences in responsiveness of referral and intake workers and directors to the foundational interviews and between experienced and less experienced clinicians.

The interview transcripts of the four different informant groups, namely, managers (2 directors, 2 coordinating referral and intake workers, and the single team leader clinician interviewed, 5 in total), seven experienced clinicians, two less experienced clinicians, and 11 parents, were examined to identify all statements relating to perceived practices and policies of referral and intake. There was widely varying knowledge and understanding of the purposes and functions of referral and intake from informant group to informant group. The managers were all very attuned to the practicalities and the philosophical concerns regarding referral and intake. Experienced clinicians had a sound knowledge of the purpose, philosophy, and practicalities of referral and intake. Less experienced clinicians had general knowledge, but had not paid too much attention to referral and intake as a clinical process, or to the clinical consequences of the procedures. The parents had least knowledge of the clinic referral and intake procedures, but did not seem to have needed to know and were unconcerned to have had no such knowledge.

The listing of observed items of referral and intake activity as procedure, attitude, or policy was supplemented by a secondary sorting, within the broad category of the items of activity into activity foci. These foci of activities were then brought together in Table 10 in Section 9.2.3, which demonstrates that referral and intake work has to be oriented toward receiving referrals, requires an administrative structure, involves certain transactional characteristics, begins with the recognition of a child problem, and then is enacted through a series of tasks, some of which have chronological order.

9.2.1   Staff reported practices of child and adolescent mental health referral and intake

Coding of the themes emerging from all of the interviews regarding issues of referral and intake practice produced a long list of the tasks involved, most of which could be arranged sequentially, as in Table 4. However, these practices were reported as embedded in a policy and procedural

framework at each of the agencies. The agencies' views, at each of the levels of practice, attitudes to formal procedure (Table 5), stated policy (Table 6), and general attitude (Table 7), varied on specific points, even though there was great commonality overall. The findings related to the clinics' functioning concerned referral and intake policy, procedures, and clinic attitude, administrative issues, the waiting period for first appointments, and the reasons for discontinuance.

9.2.1.1 Staff reported procedures of referral and intake

The interview transcripts of the 12 staff revealed sparsely reported knowledge of certain practices of referral and intake. Table 4, on page 215 below, which presents referral and intake procedures noted by staff, shows that 42 practices were reported and these were nested beneath four categories, namely task characteristics (12 practices), actual tasks of referral and intake (12 practices), chronological procedures (12 practices), and organizational issues (6 practices). Most of the recorded practices were noted by only one staff member (18 practices, see Table B8-1 in Appendix B8). Nine practices were noted by two staff and five practices were noted by three staff. The remaining twelve practices were noted by between four and seven of the 12 staff.

Table 4 has the four thematic categories of task characteristics, actual tasks of referral and intake, chronological procedures, and organizational issues. The staff distinguished between the administrative structure and the state of organizational readiness and the actual tasks in their chronological order. Presumably this difference reflects the difference between overall policy settings and the practices found to work by referral and intake workers and the clinicians.

Although it was the system managers who knew most of the actual procedures, Table 4 shows that the procedures most commented upon across all staff, concerned the interface between the referral and intake worker and the clinicians. The most recognized part of the procedure was the referral and intake sheet or form, which was delivered to the team meeting, which was the next most

recognized part of the procedure. Information gathering during the referral call was seen as

important and this included the application of the screening criteria and the gathering of other

demographic details. The next most commonly commented upon procedures were assessment of

urgency, referral to other agencies, and the opportunity for referring parents to re-contact the

referral and intake worker prior to the time of allocation of to the clinician. However these last

points were recorded by only four informants and mostly by managers.

Table 4

Referral and intake procedures reported by staff (N=12) (see Table B8-1 in Appendix B8)

PRACTICES	NUMBER OF RESPONSES
Task characteristics	18
Actual tasks of referral and intake	34
Chronological procedures	41
Organizational issues	10
TOTAL RESPONSES	**103**

From the transcripts, it is clear that the service managers regarded the referral and intake service as

being highly valuable and working well. The referral and intake worker role must be a specialist

one. Referral and intake is a first step in the provision of services and progression was wanted to

be smooth, clear, and promoting of continuity of service. Referral and intake could set expectations

of subsequent contacts with the service.

The sparseness of responses in the transcripts and in the full version of Table 4, presented as Table

B8-1 of Appendix B8, raises the general question of whether the interviews were able to draw

answers from informants that were detailed enough, especially since the managers and the referral

and intake workers often missed seemingly important practices. The listing of such sparsely

distributed responses would be providing too much detail if it were not that the complete list of

attitudes, policies, and procedures that is provided here, constitutes the fullest listing of such

aspects of the work ever made. The fact that there were clusters of response and these tended to do

with issues of transfer of information from referral and intake workers to clinicians suggests that

the system works in a way that is generally accepted and understood. Very few of these issues are about the referred child or the parent as a person who is suffering, such aspects will be addressed under the headings of parent attitude, parent before, and pre-referral status. But the system can run without concern for such matters and may explain the lack of knowledge of the clinicians or interest in the pre-referral state of the referrer and the referred.

9.2.1.2 Attitudes of staff concerning the referral and intake process

Table 5 on page 217 sets out the attitudes of staff concerning referral and intake. Thirty-one attitudes were recorded falling into four categories, namely, to access issues (4 attitudes), to purpose of referral and intake work (10 attitudes), to quality of relationship between caller and referral and intake worker (10 attitudes), and to organizational issues (7 attitudes). Most of these (13 attitudes) were located by one staff member, two staff members (11 attitudes), or three staff members (4 attitudes), as indicated in Table B8-2 of Appendix B8. The remaining three attitudes were voiced by between five and eight staff members. These foremost attitudes concerned the high priority of referral and intake within the service, the belief that referral and intake was the first step in gaining help, and the need for continuity of contact during the referral and intake period.

Although collected from a range of informants with few individual contributions, attitudes toward parent referrers during the referral call could be summarized as follows. Child and adolescent mental health services are for the most disturbed of children, but this goal can be achieved through prevention that starts with a flexible, available, and empathic referral and intake service that listens, spends time, allows the parent to tell his or her story, takes the concerns seriously, avoids blame, avoids stereotyping and labelling, is family focused and supportive and places emphasis on family strengths. Referral and intake should be parent sensitive and validating and respectful of the parent's decision-making role with his or her child. Adolescents who make contact on their own behalf certainly have rights of access.

Table 5

Attitudes of staff (N=12) concerning referral and intake process (see Table B8-2 in Appendix B8)

ATTITUDES	NUMBER OF RESPONSES
Access issues	8
Purpose of referral and intake work	29
Quality of relationship	17
Organizational issues	12
TOTAL RESPONSES	**66**

The overall attitudinal position of agencies toward the function of referral and intake could then be summarized as follows: the referral call is an opportunity for two-way exchange of information. The referral and intake worker needs to be a mature and experienced person who is trained and supervised, who is supported by the clinical teams and is able to receive feedback from the teams. The referral and intake service is neither an advice line nor an administrative function. It is a service that is inclusive, rather than isolating, and is not about case disposal. The service connects parents with other agencies and provides information about these other services. Internally, the referral and intake task involves the matching of family needs with service options. Optimal resourcing of the referral and intake service promotes overall service efficiency.

9.2.1.3 Referral and intake policy issues reported by staff

Table 6 on page 218 below, summarizes 38 policy issues that were raised by staff. Most of these (18 issues) were located by one staff member or two staff members (13 issues), as indicated in Table B8-3 of Appendix B8. The remaining 9 issues had endorsement by three to seven of the 12 staff members.

The policy issues were grouped into four categories, namely general policy (10 issues), readiness of agency to receive referral enquiry (9 issues), organizational issues, (10 issues), and procedural guidelines (9 issues). The general policy issues were locally decided and defined the referral and intake worker role, some of its tasks and functions, and the positioning of the function with respect to the community. The readiness issues were about the arrangements made so that a referral could be dealt with or referred on without too much recourse to third parties. The organizational issues concerned how the role was to be staffed and the place of the function within the agencies' communication networks. The procedural guidelines placed the broader policy issues into an action context. The policy issues of most importance were for a standard procedure with a dedicated referral and intake worker operating as first point of contact, who is able to discriminate the need for a crisis response or urgent appointment, and who is responsive to the professional referrers. These are operational parameters, rather than policy.

Table 6

Referral and intake policy noted by staff (N=12) (see Table B8-3 in Appendix B8)

POLICY ISSUES	NUMBER OF RESPONSES
Policy	12
Readiness of agency to receive referral enquiry	18
Organizational issues	25
Procedural guidelines	34
TOTAL RESPONSES	**89**

Comparing Table 5 with Table 6 shows that the distinction between service attitudes and formal policy was not important for service directors or coordinating referral and intake workers, who commented sparsely on issues of policy and with an emphasis on operational aspects. Similarly, the clinicians did not identify many issues of policy beyond the preference for a dedicated referral and intake system rather than one of rostered clinician responsibility. It is interesting that attitudes were not felt to be matters of policy and could be distinguished by clinicians and referral and intake

workers. This probably represents an attitudinal set that comes from professional training and experience and does not require any direction from management.

9.2.2   Staff and parental attitudes concerning parents prior to referral

The coding of the transcripts of the eleven parent informants used the same codes for service procedures, attitudes, and policies, which were used to code the staff informants' transcripts. Comparisons were then possible between staff views of parental understanding and the understanding of the parents themselves, of the procedures, attitudes, and policies. Four of the parents and three of the managers reported being listened to as important, but this was not noted by any clinicians. Three parents, one clinician, and one referral and intake worker noted a user-friendly attitude. Five other aspects of service attitude were noted by two parents, with lone parents noting six other aspects.

Unsurprisingly, then, parents claimed little knowledge of policy and procedures to do with referral and intake. Six separate aspects of policy were noted with only two of these having multiple informants. Two parents were re-referrals and, therefore, knew of the services somewhat. Four of the parents knew about professional referrals as each of these had been referred by other professionals. Procedurally, there was a similar pattern of parental knowledge with single responses on three procedures and two parent responses on five procedures. One of these was about improvements noted by the re-referred parents and the other was the usefulness of re-contacting the referral and intake worker by two parents who had done so. As will be noted in the case vignettes in Section 9.4, most parent informants had no knowledge of the referral and intake procedures and did not seem to think it was particularly necessary.

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9.2.2.1 Reported parental attitudes at referral

Eleven parents and 12 staff provided descriptions of parental attitudes at the time of referral as shown in Table 7 on page 221 below. Forty-nine descriptions of parental attitudes were discerned, falling into five categories, namely access (5 descriptions), affect in parent before referral (20 descriptions), affect in parent after referral (10 descriptions), focus of parent at referral (9 descriptions), and quality of relationship (5 descriptions), as indicated in Table B8-4 of Appendix B8.

Attitudes about access concerned the means of getting to the agency at a time that fitted with the family and included other barriers such as language and cultural practice barriers. Also, the search for help could be frustrated by a lack of knowledge or adequate direction, despite active help seeking or obvious needs. Being unsure of entitlement to use service was another barrier.

The affective state of the parent prior to referral was noted as a factor by both staff and parents. Within this category were a range of emotions characterized by frustration, fear, worry, ambivalence, lowered self-confidence, and determination. The affective state of the parent after referral was usually much more positively connoted with relief, comfort, hopefulness, and gratefulness being reported.

The focus of the parent at the time of referral was reported as often upon the child's needs. However, there was a range of other foci upon independence, emotional pain, a lack of alternate options, and sources of support. The quality of the relationship during the referral call was positively connoted and beneficial, however, one parent felt the need to exaggerate her concern.

For staff members, most of these were located by one staff member (18 descriptions), two staff members (10 descriptions), or three staff members (6 descriptions). Three of the descriptions were noted by four or five staff members, with twelve descriptions used by the parents not noted by staff,

at all. The remaining three descriptions of parental attitudes were voiced by between five and eight staff members. These foremost descriptions of parental attitudes concerned the high priority of referral and intake within the service, the belief that referral and intake was the first step in gaining help, and the need for continuity of contact during the referral and intake period.

Table 7

Attitudes about parents at time of referral noted by staff (N=12) and parents (N=11)   (see Table B8-4 in Appendix B8)

ATTITUDINAL ITEMS	STAFF	*PARENT*
Access	9	*7*
Affect in parent before referral	27	*39*
Affect in parent after referral	16	*34*
Focus of parent at referral	14	*24*
Quality of relationship	4	*9*
TOTAL RESPONSES	**70**	*113*

From the parents' point of view, 16 of the descriptions provided by the staff did not apply to parents. There was considerable agreement with respect to some descriptions. Nine of the parents reported being child-focused, eight parents being desperate, and seven being determined and committed. Six parents reported themselves as having decided to make the referral. Six parents reported being, after the referral, relieved, grateful, and as having found hope. Eleven of the descriptions of parental attitude were endorsed by one parent only, with two or three endorsing six of the descriptions and four or five parents endorsing seven of the descriptions of attitude.

Comparisons of the pattern of response between staff and parents in Table 7 shows very little correspondence, except for the description of the parent as determined (5 staff, 7 parents), the parent as having experienced a long search for help (3 staff, 4 parents), parents worried about the child (3 staff, 4 parents), and paternal support where four staff and four parents identified the father as a negative influence, although one parent noted the father as a positive support. Differences between the parents and the staff sometimes might have only been terminological. Four staff identified parents as at wit's end or at the end of their tether, a description not used by the parents,

whereas five mothers identified themselves as vulnerable, a term not used by staff. Two staff described parents as desperate, but eight parents did so.

The range of descriptions of parental attitudes was much less among staff than parents, with clinicians (not including directors or intake workers) providing 50 responses with respect to their parent clients. Only three clinicians (two senior, one junior) regularly described states that were also reported by the parents they had seen often for extended periods, but with fewer descriptions than provided by the parents. Issues charged with negative emotion, such as desperateness, feelings of failure as parent, and worries about the child, were markedly underreported by staff relative to parents. However, staff also underreported positive treatment orientation, such as commitment, determination, and child focus. Further, staff underreported positive attitudes in the parent, in general, such as happiness, gratefulness, relief, hope, and helpfulness of referral and intake worker. Knowledge of the parent at the time of referral might seem difficult for the clinician to acquire, but there was very little overlap of perception at all. Attitudes concerning the pre-referral status of parent and child, as reported by both staff and parents, are presented in Tables 8 and 9.

9.2.2.2 Pre-referral concerns about referral reported by staff and parents

Table 8 on page 223 below shows, again, the divergence of understanding of staff and parent informants. Three categories covering eight concerns about parents prior to referral were reported by parents and staff, as indicated in Table B8-5 of Appendix B8. Knowledge, or the lack thereof, was related to three concerns, with clinician unawareness of parental state being reported by a director, only. Clinicians were unaware of a lack of knowledge of services among parents, although two parents reported this directly. Two staff reported that parents would not know about referral and intake policy, a point also made by seven parents. Overall, low rates of response were evident for this group of codes, but there was no pattern of agreement.

Parental state before referral (4 concerns) was viewed differently by staff and parents, with two staff having noted that there would have been concerns about the parent's state of mind and capacity to parent prior to referral, but parents did not report such concerns. However, four parents did report the possibility of emotional pain, and only one clinician had become aware of this fact. For two parents, this pain was associated with a feeling of being on a referral "merry-go-round", an experience for parents not reported by staff.

Table 8

Pre-referral issues about referral reported by staff (N=12) and parents (N=11) (see Table B8-5 in Appendix B8)

CONCERNS	STAFF	*PARENT*
Knowledge	3	*9*
Parental state before referral	3	*6*
Focus	1	*1*
TOTAL RESPONSES	**7**	*16*

Only two informants raised the focus of parental concerns prior to referral. One parent identified that she left things to the last moment and, therefore, sought help when she was at her most vulnerable and, perhaps, in a state less able to benefit from help offered. By contrast, a senior clinician noted that parents were likely to be thoughtful in their approach to referral.

Two striking features emerge from Table 8. Firstly, only two clinicians reported the lack of knowledge of referral and intake processes that might be expected with parents, and was confirmed. Secondly, two clinicians assumed parental distress prior to referral, but awareness of parents' emotional pain before the referral was reported by only one clinician, but was experienced by at least four parents.

Table 9, on page 224 below, presents the concerns of the parents felt prior to referral that staff and parents identified. The lack of agreement between staff and parents concerning events and affect

prior to referral evident in Table 8 can discerned from Table 9, with the exception of concerns about the referring problem. Overall, 11 concerns were reported which fell into three categories, namely, child problem (5 concerns), parental position (3 concerns), and knowledge (2 concerns), as indicated in Table B8-6 of Appendix B8.

Table 9

Parental position at referral reported by staff (N=12) and parents (N=11) (see Table B8-6 in Appendix B8)

CONCERNS	STAFF	*PARENT*
Child problem	19	*25*
Descriptions of parent prior to referral	13	*2*
Knowledge	3	*1*
TOTAL RESPONSES	**37**	*29*

Agreement in reporting between parents and staff was high for four of the concerns listed within the category of child problem. Notably, five of the referred children had expressed a wish to die to their parent, but the clinicians did not report this situation. Possibly, this may have been because the clinicians did not want to disclose some types of clinical information to the researcher.

Otherwise, the differences of view between parents and staff remain strong in Table 9. Staff could identify four general descriptions of the parent before referral, only one of which was noted by parents. Two staff and one parent identified knowledge of services as a potential barrier to access. One staff noted that a parent and a child could not be identified as clients until contact was made.

9.2.3   Higher order analysis of parent and staff views of the referral and intake process

Higher order analysis of the code descriptors and category subheadings within Tables 4 to 9, generated a summary table (Table 10) of the important aspects of the referral and intake process at child and adolescent mental health agencies. Overall, using the code descriptors, there were identified 42 practices (Table 4), 31 attitudes of approach to referral and intake (Table 5), 38 policy

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issues concerning referral and intake (Table 6), 49 issues of attitude of referral and intake workers toward referrers (Table 6), 8 pre-referral concerns of the parents, and 11 descriptions of the position of the parent as referrer or client. Within each table there were category labels. Some of the code descriptors used applied in several tables and to several of the categories of practice, approach and attitude. The code descriptors for each of the tables were compared, as were the summary category labels within each table. Table 10 on page 226 below presents these category labels and demonstrates how these are linked within the several functions of referral and intake work.

Table 10 is quite a complex matrix showing how procedures, attitudes, stated policy, and referral concerns interact to produce views of the practices of referral and intake that can be described from staff and parental positions as orienting issues, administrative structural issues, transactional qualities, referral reason, and the tasks involved. Policy is important with respect to all these summary categories. In this table, the most appropriate place for the referral reason and the actual tasks involved was not clear. However, the policy and administrative settings of the agencies with respect to actual referrals would be in place prior to any particular referral and the capacity to greet parents, who may be in a variety of states of mind, would also be in place with a sound understanding of the receptive position to be occupied by the referral and intake worker. The table demonstrates the many levels of organization that a parent meets at the time of referral and the many levels of professional action expected to be enacted by the referral and intake worker during the time of the referral. Reducing the interview data in this way opens up questions for the prospective study regarding how these levels of organizational and professional action may affect the transaction of referral and of subsequent clinical contact.

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Table 10

Categories of items of activity found in Tables 3 to 8 with summary category provided

Table 4	Table 5	Table 6	Table 7	Table 8	T
Referral and intake **procedures** reported by *staff*	**Attitudes** of *staff* concerning referral and intake process	Referral and intake **policy** noted by *staff*	**Attitudes about parents** at time of referral noted by *staff and parents*	**Pre-referral issues** about referral reported by *staff and parents*	**Paren** at refe... reporte... *paren*
	Access issues	Readiness	Access *(and barriers)*	Knowledge *(lack of)*	Know... *of)*
Task characteristics	Purpose	Policy	Focus	Focus	
		Policy			
Organizational issues	Organizational issues	Organizational issues			
	Quality of referral relationship	Policy	Quality of referral relationship		
			Affect in parent before referral	Parental state before referral	Parent
			Affect in parent after referral		
		Policy			Child
Actual tasks		Policy			
Chronological procedures		Procedure			

9.2.4   Informant reports concerning the commencement of contact at a child and adolescent mental health agency

The data indicated that parents and clinicians arrived at the first appointment with very different perspectives upon contact. For parents it is a beginning, but it is also the end of a process of deciding to seek help and finding an appropriate service. This section presents transcript data on the experience of beginning.

For clinicians, the beginning occurred with the referral telephone call, although the first interview was their real beginning. Some clinicians recognized that as yet unreferred persons existed who might be considering referral, but the work cannot be considered to be started until the referral had been accepted. In fact, some clinicians did not understand the point of the question concerning what a parent, or child, was before they were referred. Some quotations illustrate views here.

> Really with the initial contact, whether that be from a worker or from a potential client to the agency ... they're individuals experiencing some sort of problems, some sort of distress usually and I mean sometimes it's a situation that the child's happy as Larry going around and everyone around them is in distress, but there's usually a level of a dis-ease. (Clinician of Melanie)

> The school might have sort of put them onto a number and came to parent teacher meetings and then it finally gets to the point where they say `look, this place is out there' and they get to the point further on in the process where they decide to make that time or else someone else makes it for them. So that maybe starts the grain of that idea of seeking psychological/psychiatric health for my child kind of starts to develop and how that process, what positive and negative influences they hear about or feel in that process before making the first phone call. (Clinician of Debbie)

The parents probably see them as clients before the kids do, maybe. Some of the kids don't see that at all. (Clinician of Debbie)

Referral and intake is that process that we have influence over and we have no influence over what occurs until the, either the referring agency or the parent is in dialogue with our referral and intake coordinator. (Team leader, clinician of Leila)

The formal definition of a parent once the child has been registered was clear, and indicative of the professional domain. But clinicians did think beyond the formal domain to issues of being a parent in attendance at a child and adolescent mental health service, according to Alison's clinician:

sometimes one sees them while they are a client and you meet them in a supermarket or somewhere, and you become very aware that they show you their weaknesses and not their strengths .... When I think of some of the things that I did as a 21-year-old who had no children, was unmarried, and had no concept of, you know, being a parent

The clinicians demonstrated concern for their domain of activity and thus had a general regard for referring parents as people in need of mental health assistance. The parents could be seen as people with needs, but parents did not really exist outside of definitions of mental health status, such as patient or client. Some referring parents, by contrast, expressed a determination premised in citizen's rights to service and in recognition of a child's needs. This conflict of perspective between clinician and parent might not always be perceived at the first appointment, but may affect the willingness of the parent to pursue referral.

9.2.5 Parent imposed barriers to service access

Citizen voice appeared in another form in the interviews. Two parents felt that their own commitment to the values of independence had hindered their capacity to access child and

adolescent mental health services. Both of these independent parents had had previous contact with the same service to which they applied for further help, although Melanie considered the first contact to have been unsatisfactory. In Melanie's case, she delayed seeking help until:

> when we are absolutely desperate. But I mean you're always hoping to be able to resolve it yourself ...

This delaying due to independence was identified by Alison as a life time trait:

> I have grown up pretty well on my own … to my own detriment, really, because if I'd asked for help a bit earlier, maybe it wouldn't have been so serious … I do tend to nut things out and make decisions.

The important point to be made about such delays, is that when such parents do seek help, they are likely to be clear in the information they present to the referral and intake worker, having given referral a lot of careful thought.

9.2.6   Reports of the referral and intake worker's role in setting expectations for contact

Both referral and intake workers were very keen to see their work as setting expectations in a clear and informative way about subsequent contact with the service. Clinicians had this view, too, as demonstrated by Leila's clinician, the team leader:

> It certainly is important in terms of setting the scene and clarifying patients' expectations. As a psychiatrist, I'm interested obviously in assisting parents, families and their children with emotional distress and concerns. As a team leader, I'm also interested in the effective allocation of resources. So, trying to match resources, which are not unlimited, to the most significant areas of demand.

Setting expectations facilitated subsequent contact, as demonstrated by Pam's clinician:

It is a very important stage in a person's involvement with the agency because it's the first point of contact … I think a great deal of time goes in to making that process as smooth as we can for the people who make referrals, and explaining the process and procedure to them, and making sure that they're fully informed about what happens next.

"Smooth" transition from referral to therapy was a goal identified by clinicians, referral and intake workers, and service directors at both services. One corollary of smoothness was the continuity of service provided by referral and intake workers with a primary and dedicated role in referral and intake work that then passed on to a case managing clinician with a primary relationship to the parent. Another corollary of smoothness was clarity of information about the service and its practices.

Yet, referral and intake workers cannot address all expectations, as some aspects of child and adolescent mental health work are not easily conveyed to parents, as Melanie's clinician observed:

Parents can sometimes get a nasty surprise at how active a role they have to take in the process, and it can be confronting for them.

9.2.7   Reports of the need for a dedicated role of referral and intake worker in child and adolescent mental health services

The issue of most unanimity among staff informants concerned the desirability of the child and adolescent mental health referral and intake role to be the primary responsibility of a designated professional. All but two of the clinicians interviewed had had experience of referral and intake systems using rostered staff, and some still had this experience when the designated referral and intake worker was on leave. The dislike of roster systems can be seen in the vehement comments of Alison's clinician:

It was everybody's responsibility to do intake, so there was this system of a roster, and I absolutely loathed that … you had no control over how many intakes would come in, in the time that you were on the roster … On other occasions, you'd finish with one and sort of half finish your paperwork, you'd discover that there were another two waiting in the line and you couldn't finish working on all of them during that day … I couldn't handle it, and so I was one of the people who pressed for a permanent full-time intake worker.

The chief advantages of a dedicated role were regularly listed as smoothness and continuity in contact, and the need for a specialist in knowing community networks. Talent for the work was also recognized as identified by Cheryl's clinician:

Roster systems is what I was used to. These are a good way [for young clinicians] to get experience, but they can be problematic as clients need continuity, and there is always someone who knows how to do intake better than others.

First hand experience of agencies with referral and intake services that received referrals for both adults and children and adolescents for one of the least experienced clinicians (of Debbie), and for one of the directors, demonstrated that such mixing of age groups was inappropriate, and likely to disadvantage families. The director commented:

I think it's a problem with people doing adult and child referral and intake team together ... the nature of the work is so different. I think it's quite different type of referral and intake, and the sort of patients, in that people [referral and intake workers] are isolated in the referral and intake system, so I think that's a problem. Cases where you don't have involvement with the teams, so that the referral and intake workers don't get that feedback from the team. Thus it means that the team can't be sure a case is appropriate for them ... There's got to be that specialist backup response to support them through difficulties, and if they don't have supervision, it seems that supervision is something that people think is very

important for getting doing clinical work. Yet I can't think of any service that has supervision for referral and intake roster staff.

9.3   Parental experience from before making the referral call to the time of the research interview

Key aspects of parental experience prior to the time of referral and until the time of the research interview are presented, to enable comparisons between families, in Tables 11 to Table 16. Table 11, on page 233 below, displays several aspects of pre-referral experience for each of the parents, including the time delay by the parent in seeking referral, professional or other referrer, the waiting period from referral to first appointment, support during this waiting period, and the reported experience of the waiting. Most commonly, the period spent contemplating options about the troubling child behaviour was reported to be about six months, although for four parents the period was much longer, and for two parents it was shorter. The case of Cheryl's daughter, Rebecca, for example, involved urgency upon discovery of the problem and this pre-referral period was only two weeks.

Table 11 shows the details of the pre-referral period and of the period of waiting between the referral call and the first appointment, as experienced by the parent informants. The delay in referring, that period of time from recognition of the need to act to actually calling, was long for some parents, but for eight of the parents was characterized by positive emotion, rather than frustration. The wait period, from the time of referral call to the first interview, was considerably reduced by one of the agencies with changes in clinic procedures, during the study period, as can be seen in the cases of Michelle, Cheryl, Debbie, and Alison. Only one of the parents experienced frustration due to an administrative problem.

Other important aspects of Table 11 concern other people supporting the referral. Parents acted to contact the referral and intake worker with others supporting them in all but one case, which was a re-referral. General practitioners facilitated referral in five cases, paediatricians in two cases, and schools in five cases.

Table 11

Details of periods before referral and wait for first clinic interview

Parent & child (age in years)	Point of research interview	Delay in referring	Referrer	Wait for first interview	Support during wait	Reported experience of wait
Julie Ricky (5)	Post-termination	2 years	Friend, GP,Paed	3 months (2weeks+)	Friend School	Excited, relief at end
Melanie Will (7)	Post-termination	18 months	MGM, GP		MGM friends*	Relief at end, but too long
Kevin Thomas (14)	Post-termination	6 months	ED SW, School	7 months (1month#)	School	Rising frustration
Leila Rae (14)	Post-termination	6 months	CHC SW, School	4 months	CHC SW, Fa, School	Supported continuity
Pam Aaron (10)	Post-termination	3 months	UniClinic Paed	4 months (6month^)	Clinic, friends	Passive acceptance
Vera Alex (9)	Post-termination	9 months	GP		GP, husband	Anxious, relief at end
Michelle Justin (13)	Post-assessment	6 months	School		School	Reluctant, dubious
Cheryl Rebecca (14)	Post-assessment	2 weeks	GP		GP	Anxious, relief at end
Debbie Jim (6)	First interview	9 months	School, MGM	2 days	School, MGM	Pleased so brief
Alison Matthew (8)	First interview	6 months	Mo		CAMHS SW	Relief at end
Sharon Peter (6)	Referral call	6 months	School, GP		School, GP husband	Pleased, relief at end

Abbreviations: MGM = maternal grandmother, Fa = father, GP = general practitioner, Paed = paediatrician, ED = education department, SW = social worker, CHC = community health centre, CAMHS = child & adolescent mental health service); + delay caused by out of area referral; seen within two weeks of service receipt of referral; # delay caused by loss of referral at time of industrial dispute; seen within 1 month once referral reactivated; ^ parent warned to wait two months longer than actually occurred; * support of friends was needed but mother did not like "unloading".

As indicated in Table 11, other agency professionals were involved in three cases, and a friend and a maternal grandmother in two others. These people were often also supporters during the period

of waiting for the first appointment, although friends and family, especially husbands, were supporters, as well.

At some point following the referral call, parents and children were assessed and provided with a clinical program according to their needs. Table 12, on page 235 below, shows the allocation of staff and programs after assessment, along with the type of problem identified and the experience of the service received. Table 12 indicates the number of clinicians for each case for each modality of intervention and the strength of support received from the agency.

Table 12 reveals that only three of the children were referred for behavioural and emotional problems without developmental problems. Developmental problems meant that the children were often in more than one of the clinical programs, such as occupational therapy, speech therapy, autism spectrum, educational, as well as psychosocial intervention. In this connection, it should be noted that three families had not yet completed assessment at the time of research interview, and the types of service likely to be offered were surmised from the parent reported referral and interview details. These parents had clear views of the service received at that point in time.

The quality of service received by families was universally regarded as high and involving strong support. Affirmations of the service were very positive, as indicated in Table 12. The strength of parental view about support was drawn from comments made in the interviews and as indicated by a summary quote in the final column of Table 12. Similar one-word summaries of parental opinion were applied in Table 13 and Table 14. These labels were drawn from the interviews and rated in terms of parental affect when reporting the situation during the interviews, and in comparison to other interviewees' perceived level of each of the relevant categories. Analysis of the interviews with respect to parental focus and position prior to referral, revealed factors to be operating within a referring parent's mind that oriented him or her in the task of seeking help. These factors are

shown for each case in Table 13. Mostly, these were personality-related factors manifested in the

context of referral, namely hope, pain, frustration, and determination.

Table 12

Reported details of period following contact

Parent & child (age in years)	Point of research interview	Clinicians involved	Number of programs used	Problem type	Support received from agency	Experience of service
Julie Ricky (5)	Post-termination	Parent cl, child cl	1	Behav, Emot	Strong	Excellent, Grateful
Melanie Will (7)	Post-termination	Parent cl, child cl	1	Behav, Emot	Strong	"Great"
Kevin Thomas	Post-termination	2Parent cl, 3+ child cl	3+	Dev'tal Behav.	Strong	"Cannot fault"
Leila Rae (14)	Post-termination	2Parent cl, 3+ child cl	3+	Dev'tal Behav.	Strong	"Always very good"
Pam Aaron (10)	Post-termination	2Parent cl, 3+ child cl	3+	Dev'tal Behav.	Strong	Professional
Vera Alex (9)	Post-termination	Parent cl, 2+ child cl	2+	Dev'tal Behav.	Strong	"I'm changed"
Michelle Justin (13)	Post-assessment	Parent cl, 2+ child cl	2+	Dev'tal Behav.	Strong	Professional
Cheryl Rebecca	Post-assessment	Parent cl, child cl	1	Behav, Emot	Strong	Professional
Debbie Jim (6)	First interview	Parent cl, child cl	1	Dev'tal Behav.	Strong	Quick, listened
Alison Matthew (8)	First interview	Parent cl, child cl	1	Behav, Emot *	Strong	"Feel at home"
Sharon Peter (6)	Referral call	IW only, so far	*3+	Dev'tal Behav.	Strong	Excellent

Abbreviations: cl = clinician, IW = referral and intake worker, Dev'tal = developmental problems, Behav = behavioural problems, Emot = emotional problems, *based on provisional indication of problems

Table 13, on page 236 below, shows that ratings for most of these variables were high to very high,

except for hope, which was bi-modal. All parents were seeking help in opposition to a person or an

idea. It is an important finding of this study that referring parents needed an external motivator to

carry through with referral.

Hope seemed to be a characteristic of the parent, but one that varied in level, which was open to

encouragement. Hope was experienced as an active, whole phenomenon that was high or low,

rather than as a relative state of hopefulness.

Pain was an active, internal state but felt in response to external factors, especially in empathy with the child's experience of his or her problems. All parents felt pain in the period before making the referral, but this varied between moderate to high to severe. Pain was probably linked to the level of frustration experienced at the time of referral for some of the parents, but one parent had not experienced much frustration. Frustration was a passive experience that varied in a way that was not directly linked to hope, pain, or determination.

Table 13

Key aspects of reported parental state before referral

Parent & child (age in years)	Point of research interview	Hope	Pain	Frust-ration	Deter-mined	Seeking help in opposition to (opponent)
Julie Ricky (5)	Post-termination	High, encouraged	Severe	High	Extreme	Father
Melanie Will (7)	Post-termination	Low, Encouraged	Severe	High	High	Father Friends (not to unload)
Kevin Thomas	Post-termination	High, encouraged	Severe	High	Extreme	Mother, child's problem
Leila Rae (14)	Post-termination	High, encouraged	Severe	Moderate	Moderate	Father
Pam Aaron (10)	Post-termination	High	Moderate	Low	Extreme	Father, child's problem
Vera Alex (9)	Post-termination	Low, Encouraged	Severe	High	High	Child, child's problem
Michelle Justin (13)	Post-assessment	High, encouraged	Moderate	Moderate	Moderate	Child's problem
Cheryl Rebecca	Post-assessment	Low, Encouraged	Severe	Moderate	High	Child's problem
Debbie Jim (6)	First interview	High, encouraged	High	High	High	Father
Alison Matthew (8)	First interview	Low, Encouraged	Severe	High	High	Father
Sharon Peter (6)	Referral call	High, encouraged	High	Moderate	Extreme	Child's problem

Nearly all parents commented upon their goal orientation, which was shown by being determined. Being determined was an actively lived state of some intensity and was fuelled by the presence of an opponent. An opponent was usually somebody external and, usually, who the parent wished to prove wrong or over whom to express some superiority. This was often an estranged spouse or

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other family member. One parent's opponent was her tendency to "unload" upon her supportive friends. She wanted to find a professional whose job it was to listen to such distress. This mother, also, had an opponent former husband. The child's problems or behaviour could also be the object against which a parent could set his or her will. Overall, the sample demonstrated all of these factors prior to referral. These characteristics are presented using parent and clinician informant transcript excerpts in Section 9.4.

These same factors were present for parents when the assessment and therapy phases were encountered, as shown in Table 7. But some of the difficulties were reported to have been alleviated by the service received. The pain felt before the referral was continued to be felt, but more in the form of a fear that the child would not benefit from the assistance offered. As will be seen, the pain experienced before the referral, was rarely addressed by clinicians (see Section 9.4).

Additional factors encouraged and satisfied, existed alongside the other factors, but were not necessarily evident to the clinicians. Encouraged was a state not distinguished from hope at the time of referral, but was well established at the time of the research interview as a separate experience, apart from for Sharon who was interviewed soon after referral. Ratings for this factor were high to extreme indicating a very positive experience of contact with clinicians. The hope factor had changed following referral with no low ratings and some moderate ratings. Two of the original high ratings had become moderate (Julie and Leila) which seemed more in line with their personality, overall.

The satisfied factor was uniformly high for this group and would not be reported except that such uniformity and appreciation would be very unlikely in unselected clinical samples. It is clear that this sample had become committed and enthusiastic about the service they had received from their child and adolescent mental health agencies.

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At the time of the first research interview, as presented in Table 14 below, parents were at various

phases of their overall contact with the agency, but no matter when this interview occurred,

determined was moderate to high, fear of not gaining and frustration were moderate to low. The

opponent factor was either no longer relevant (for four parents) or was less relevant (for five

parents). For two parents this factor was of ongoing concern, where the case was still in the early

phases of contact.

Table 14

Key aspects of parental state at time of first research interview

Parent & child (age in years)	Point of research interview	Hope	Fear not gain	Frust-ration	Deter-mined	Encou-raged	Satis-fied	Seeking help in opposition to (opponent)
Julie Ricky (5)	Post-termination	Moderate	Low	Low	High	Extreme	Very	Father, less relevant
Melanie Will (7)	Post-termination	Moderate	Low	Low	High	High	Very	Father, less relevant, Friends, not relevant
Kevin Thomas (14)	Post-termination	High	Low	Low	High	High	Very	Mother, not relevant, Child problems, less relevant
Leila Rae (14)	Post-termination	Moderate	Low	Low	Moderate	High	Very	Father, not relevant
Pam Aaron (10)	Post-termination	High	Low	Low	High	High	Very	Child problems, not
Vera Alex (9)	Post-termination	High	Low	Low	High	Extreme	Very	Child problems, not
Michelle Justin (13)	Post-assessment	High	Moderate	Moderate	Moderate	High	Very	Child problems,
Cheryl Rebecca	Post-assessment	High	Low	Low	High	High	Very	Child problems, less
Debbie Jim (6)	First interview	High	Moderate	Low	Moderate	High	Very	Father, less relevant
Alison Matthew (8)	First interview	High	Moderate	Low	High	High	Very	Father, less relevant
Sharon Peter (6)	Referral call	High	Moderate	Moderate	High	High	Very	Child problems,

These data do not confirm that the referral and intake process reduced the family troubles, although

for seven of the eight post-assessment and post-termination cases, during the early phases of

contact (up until completion of assessment), the opponent had become less relevant and the other indicators were similar to the cases at the end of contact. It can be concluded that once parents became satisfied with the service offered, perhaps with a lowered feeling of threat from the opponent, there were large positive shifts in parental affect. Changes in family adjustment may have been related to such changes in the parent.

The qualities of the parental state of mind evident at the research interview were relevant to how the initial referral call was received. Table 15, on page 240 below, demonstrates how the referral call was viewed at the time and in its subsequent effect upon the course of assistance. Note that the contact was perceived with satisfaction and importance by nearly all parents, and that the referral call involved a positive exchange between parent and referral and intake worker. Table 15 involves a lot of similar responses from the participants, irrespective of the time of the research interview. Table 15 shows that the importance of the referral telephone contact, as perceived for the time, and as perceived at the time of the interview, did vary from participant to participant.

Table 15 shows that the referral contact when reviewed at the final research interview was regarded in two general ways, as formative of the subsequent work, or simply as a necessary procedure. Given the success of the treatments and the quality of professional assistance received from the treating professionals, it might have been that the importance of the first contact may have faded over time for more of these parent informants. However, it is not clear if it was the quality of the referral and intake call that was of great importance, or that the call had simply occurred and punctuated the family's experience of the problem and its resolution. In Kevin's case, the use of the word "crucial" in spite of the major delay suffered due to an administrative failure, suggested that referral was experienced as a valuable punctuation point rather than as a facilitative transaction.

Table 15

Key aspects of parental experience of referral as reviewed at time of research interview

Parent & child (age in years)	Point of research interview	Satisfied	Listened to	Informed	Importance, then	Importance, now
Julie Ricky (5)	Post-termination	Very	Yes	Yes	Great	Great
Melanie Will (7)	Post-termination	Very	Yes	Yes	Great	One step to recovery
Kevin Thomas (14)	Post-termination	Once started	No, then, Yes	Yes	Eventually, great	Crucial
Leila Rae (14)	Post-termination	Very	Yes	Yes	High	One step to recovery
Pam Aaron (10)	Post-termination	Very	Yes	Yes	Moderate	One step to recovery
Vera Alex (9)	Post-termination	Very	Yes	Yes	High	Great
Michelle Justin (13)	Post-assessment	Very	Yes	Yes	Great	Great
Cheryl Rebecca (14)	Post-assessment	Very	Yes	Yes	Great	Great
Debbie Jim (6)	First interview	Very	Yes	Yes	Great	Great
Alison Matthew (8)	First interview	Very	Yes	Yes	High	Great
Sharon Peter (6)	Referral call	Very	Yes	Yes	Great	Great

Complementary to the parental view of the importance of the referral call, were the views of the

clinicians. These are presented in Table 16 on page 241 below. Often, the clinician was not clear

about the circumstances of the referral call, and did not know of its importance to the parent when

it occurred, or at the time of research interview.

Overall, parents were seen by clinicians to have been positive about the reception received at the

time of referral. However, the clinicians did not provide much firm evidence that the referral call

had facilitated the subsequent work. For some parents, an engendered mood of positivity was

carried forward into subsequent programs of assistance, but for others the first contact was a first

step, only. Clinicians, given that they did not conceptualize a parent or a child prior to the time of

presentation, could not be expected to discriminate between the referral call as a first step or as a

facilitative transaction.

In summary, parental attributes of hopefulness and determination, opposition to another or the

problem, and encouragement and satisfaction received at referral were evident at research

interviews and corresponded with the willingness to participate in the research. The pain of before

did not come to the attention of clinicians, as parents had not reported this phenomenon to the

clinicians, even though at research interview this pain was often abundantly evident (see Section

9.4, below). General affirmations of the importance of referral and intake were readily made by

clinicians, but were not given great importance in their account of cases.

Table 16

Key aspects of clinician view of parental experience of referral

Parent & child (age in years)	Point of research interview	Hope	Encouraged	Satisfied	Listened to	Informed	Importance then	Importance now
Julie Ricky (5)	Post-termination	Low	Yes	Yes	Yes	Yes	Yes	Yes
Melanie Will (7)	Post-termination	Low	Yes	No (wait)	Yes	Yes	Yes	One step to recovery
Kevin Thomas (14)	Post-termination	High	No	No	Yes	Yes	Yes	Yes
Leila Rae (14)	Post-termination	Low	Yes	Yes	Yes	Yes	Yes	One step to recovery
Pam Aaron (10)	Post-termination	High	Yes	Yes	Yes	Yes	Yes	One step to recovery
Vera Alex (9)	Post-termination	High	Yes	Yes	Yes	Yes	Yes	Yes
Michelle Justin (13)	Post-assessment	High	Yes	Yes	Yes	Yes	Yes	Yes
Cheryl Rebecca (14)	Post-assessment	High	Yes	Yes	Yes	Yes	Yes	Yes
Debbie Jim (6)	First interview	High	Yes	Yes	Yes	Yes	Yes	Yes
Alison Matthew (8)	First interview	High	Yes	Yes	Yes	Yes	Yes	Yes
Sharon Peter (6)	Referral call	High	Yes	Yes	Yes	Yes	Yes	Yes

The distinction between a general valuing of referral and intake work and other work of the agency

and a disregard of such general propositions in specific case work can be seen in views of clinicians

concerning discontinuance. Continuing parents were usually not attuned to this phenomenon or its possibility.

9.3.1   Causes of discontinuance

Discontinuance has been seen in the psychotherapy literature as a measure of therapy effectiveness, but others (Hershorn, 1993; Pekarik, 1986) had seen discontinuance as a choice of parents or an effect of changing family life. As can be seen in Table 17, below, staff knew about such causes.

Table 17 presents parental and staff views of reasons for discontinuance of contact with a child and adolescent mental health agency. For the parents, the reasons why were hard to find as for them discontinuance was not an option they had taken or one for which that they could have much sympathy. No discontinuing parents were interviewed.

Table 17

Reported reasons for discontinuance by staff (N=12) and parents (N=11) (see Table B8-7 in Appendix B8)

REASONS FOR DISCONTINUANCE	STAFF	*PARENT*
Access to service	8	*3*
Motivation of parent	5	*0*
Alternate referral of family	5	*0*
Life changes	6	*0*
Positive referral and contact for child and family	9	*0*
Negative referral and contact for child and family	34	*4*
TOTAL RESPONSES	**66**	*7*

Staff and parents could identify reasons for discontinuing as shown in Table 17, with waiting being a major factor for both groups. Most of the reasons concern the fit between a service and the referring family. Coercion was deemed a likely cause of discontinuance. Alternate sources of help

and life changes were also given as common reasons for discontinuance. Discontinuance was observed by clinicians to be a sign of positive referral experience as well as negative factors.

The full version of Table 17 given in Appendix B8-7 of Appendix B8, shows 66 reasons for discontinuance given by staff falling into six categories, namely access (especially waiting), motivation of parent, alternate referral, life changes, positive referral and contact, and negative referral and contact. However, 18 of these reasons were listed by one staff member, with eight staff members, endorsing two or three reasons, and six staff members endorsing four to six reasons. The most common reasons for discontinuance given by clinicians were coerced referral (6 reasons) and access problem, usually transport (5 reasons).

Although parents provided little data concerning discontinuance, from the seven responses provided the issues of importance for parents might have been indicated. It was noted that access issues, the referral and intake procedures, the request for a school report, and the waiting period could lead to discontinuance. All of these parental reasons identified discontinuance as a negative option.

9.3.2   Parental attitudes toward referral and intake workers, treatment, and mental health professionals

While agency practices were a potential reason for discontinuing noted by parents, this was not the experience of these parents in their recall of their first contact with their agency. Even the parent who was obstructed at this phase of contact reported the contact as crucial. Inspection of the interview transcripts, and of Tables 13 (page 235), 15 (page 240), and 17 (page 242), shows that this group of parents was almost uniformly affirming of the work and the workers.

With respect to issues concerning assessment and treatment, the parents offered the same general positive opinions. Some commented that their expectations had been accurately formed by their

referral and intake experience. This is unsurprising, given that many of the parents interviewed had terminated mutually after several years of what they regarded as high quality service. Also, the assessment process had revealed, in seven out of eleven cases, that the child had specific developmental problems, previously undetected, and which required specialist intervention that was provided.

Unsatisfactory service was only mentioned in relation to previous contacts of the parent with the agency. These findings reflect a clear bias in the sample of informants toward gratitude and willingness to participate in research. This was usually the reason given for agreeing to participate, that they hoped they could help other parents through the research process. The thought of somehow helping at the point of first contact was especially pertinent to all, even the most pragmatic of informants. One mother had commented about referral as no more than a necessary step, but also spent some time in the interview describing her efforts to get an anxious friend to make contact to refer her own son. Therefore, the findings cannot be considered to be easily applicable to another sample of service users. Rather this data provides a set of pointers for any further research.

For four parents, a key indicator of the value of the work was that a child liked the treatment. Most parents were highly impressed with the quality of the service provided. Some parents felt that they needed a little more service than was received, but were grateful for their assistance, in any case.

Parents seemed not to have noticed problems in the clinics, apart from the smallness of the waiting room. Criticisms about administrative issues were identified by some staff at one of the clinics, where telephone access was sometimes difficult and the arrival of clients was not always indicated to clinicians by reception staff. Availability of the referral and intake worker at the time of a referral was not felt to be a concern by parents, although clinicians saw this a potential source of dissatisfaction and discontinuance.

The length of the waiting period, between referral call and first appointment, was cause for general concern for clinicians, but mostly the parents were pleased by the wait being short, often much shorter than expected, and often shorter than indicated at the time of referral. For three parents, the wait was frustrating, given the level of trouble at home but the wait did not deter the seeking of help.

9.4   Case vignettes of the parents, their children, and contact with the agencies

The third aim of this retrospective study was to understand the effects of the referral and intake practices upon subsequent contact with the agency. This aim can be explored using case vignettes to highlight aspects of the contact and the perceived flow of beginning effects, over time.

It was noted in Section 9.2.4 that, in general, clinicians appreciated the state of mind of the parent at the time of referral. Directors, the team leader, and most clinicians had imagined parental concerns with making a referral of a child. The parents described their state of mind in similar terms, but as more anxious and much more specifically than the clinicians or referral and intake workers thought. One parent admitted to exaggerating her state in order to secure an earlier appointment than she thought she would be able to get (in fact, the appointment was provided promptly within the ordinary waiting periods that occurred at this clinic at that time).

However, only one clinician appreciated the painfulness of the pre-referral period for parents, especially those who had to seek an appropriate service with much effort, and this was because the research process created the circumstances under which this pain was revealed. This case, which demonstrated the commitment needed to get help for a child when the appropriate service cannot be located, is presented in Section 9.4.2.

In this section, examples of some of the parent factors identified in Section 9.3 and displayed in Tables 14, 15, 16, and 17, such as "hope", "pain", "determined", and "the opponent", are presented using transcript excerpt. The case of Sharon exemplified "hope". The case of Julie showed the "pain of before". The cases of Pam and of Cheryl revealed "determined" to be both a personality attribute and an issue of citizen's rights. The case of Debbie demonstrated "the opponent". Many of these factors can be seen in other cases and from the perspectives of the respective clinicians, which are also demonstrated with transcript excerpts.

To briefly summarize the quality of the research interviews, the parents reported their experience of the referral call with four different sorts of emotions. Firstly, there was desperation for help for their child, characterized by a long list of negative descriptions of anxieties. Secondly, there was a sense of determination and committedness to gaining help. Thirdly, there was relief and gratitude toward the agency. Finally, there was hopefulness about life, in general. Largely, clinicians knew of these states. But, clinicians did not have a ready description of the parent or child before contact was made. There was a disjuncture of expectations at the point of referral with the parent having completed the major challenge of making a call for help and the referral and intake worker and clinicians regarding the work as having just commenced.

9.4.1   Hope: The cases of Sharon and Melanie

Nearly all the parent informants recounted their hopefulness about the referral. But it was not always clear if the hopefulness was something brought to the referral call, or something that was engendered by the referral call, along with relief and clarity. Sharon reported:

> I was so pleased that I received the [appointment] letter well within the month. And I just
> sort of jumped on the phone straight away, and said … thank you' … so I was just over the
> moon …. The sooner we get on to this, the sooner we're going to get an end result ….
> vitally important … without this first contact I'd be pushing, as I said, and I don't like

pushing ... I want to get it fixed now. Even if there's something that's not fixable, I want that final answer to say 'Sharon, we've done everything humanly possible' …

Sharon's energy and focus was heightened by the handling of the referral from the paediatrician to the service. By contrast, Melanie had known of the service and was reluctant to make contact, even though her general medical practitioner had made a strong recommendation to her:

> It was good, you know, to put my mind at rest. It gave me a bit of hope that, you know, we might be able to solve something, get to the bottom of it ... [the referral and intake worker] was very helpful ...

9.4.2 The pain of before: The cases of Julie, Kevin, and Sharon

Julie reported herself to be a deserted Asian bride with a 4-year-old son who was difficult to manage. Julie had been looking for help for nearly two years and her child carers had suggested that Ricky would "grow out of it". Julie had been a teacher in her country of origin and had detected trouble early, but had trusted the judgement of others. However, the troubles worsened and she was unable to find a service suitable for her son's needs. She described the emotional pain associated with the lengthy problems she experienced in finding her way to child and adolescent mental health referral and intake.

When Ricky was three and a half years, Julie had managed to get the name of a local non-government family support agency who had suggested she self-refer to a child and adolescent mental health service, but she could not locate the service through the information service of the large regional general hospital. Nine months later, she tried the latter again and was referred back and forth between the two large general hospitals, each of which had mental health services for children, but both of which claimed that the other was regionally responsible.

Defeated, Julie discussed her situation with a work friend who was also a single mother, but with teenage children. The friend suggested that Julie consult her general medical practitioner. From there, a referral was made to a paediatrician, who wrote a strong letter to a child and adolescent mental health service urging priority for the child to be seen at that child and adolescent mental health service. This letter was later sent on to another such service and, after three months from the letter being written, the referral and intake worker at the second service contacted Julie, and confirmed the details of referral, and indicated that an appointment would be made soon with a clinician who would telephone. Then started nine months of very useful and productive work.

Julie commented on this work:

> I'm very pleased, there's really big improvement. Probably … just by myself alone, if I did not happen to know the agency or if, at the same time, if I did not persevere, probably I would be still having the same problem.

Julie's clinician reflected:

> Once they [mother and child] actually got into the service, or into contact, everything, the contact, the management, whatever, became a bit smoother ... we were able to offer something that was fairly clear and consistent for her. But I think also she was extremely conscientious about - now I've talked about her relief as being one of the major things -she was also I think very grateful for anything that was offered. So the fact that she'd hunted around a lot, and finally got to a place where she felt that she - her difficulties - were going to be addressed … that meant that her commitment to the process was in fact very high throughout.

The surprising part of this case was an effect of this research project. When the clinician requested the mother to participate in the study, termination issues were being discussed, and asked the mother about any left over issues with service contact. The clinician had expected to hear about

issues since the time of referral. Instead, there was revealed the terrible tale of trying to get help over nearly two years, the barriers to access experienced, and the frustration and fear experienced by the mother. At the research interview two days later, the mother commented:

> when he was in kinder, looks like the problem wasn't going yet. So what I did - I tried to ring up a few agencies around the area, but they told me they couldn't help me. So when I rang up [there], they told me to ring up [named] Hospital … then when I rang up [that] Hospital, they said ring up - what do you call this family [support agency] and … but then when I rang up … they told me to ring up [Hospital] again. So I told them 'You are throwing me from one agency to another', until I finally got fed up.

The important issues from this case concern the high quality of referral and intake work, and of subsequent service, and the seeming shield that such professional success placed between the pain around referral and the service itself. This pain was evident in other cases. For instance, the one father who was interviewed (Kevin) said:

> You see, what people need is some sort of catharsis. That's what helped me and it could happen, I don't see why not. But I got into this Gestalt group, and it helped me enormously. I finally got round to discussing my situation with my son with the group, and I was able to express - it's hard to say what happened really - but, it was the abreaction, was ... well … catharsis, that's the best word. And that's what parents need when they're ringing up about their child. It's more than information; it's more than reassurance. They need something to clear it all away.

The pain that can be held or contained by the parent over much of the entire period of extended contact with the mental health service was evident in the case of the parent interviewed two days after her referral call. The referral and intake worker emphasized that she had much difficulty in finding a parent in a state where even asking to participate in the research was a possible option.

Therefore, the one parent who did volunteer must be considered both remarkably accommodating and thoughtful. But, Sharon, mother of Peter, 6 years, was very emotional during the call:

> I've only spoken to [the referral and intake worker] over the phone, and I've spoken to her about three or four times, and she's just been lovely every time. And I'm one of these people who pours my heart out, and she has sat there and she's listened. She's just been fabulous ... Seemed to understand almost immediately, but maybe because I was … I had my words picked out very well that day or something, or I described the situation very well, very quickly, you know.

This mother went on to describe her worries about her son, who had had multiple mild developmental problems that had led him to be distressed. Further to this were her fears of having to talk about her own lonely childhood, and how she had feared having to reveal her teenage unhappiness and her contact with a psychiatrist. All this bubbled away beneath the surface during the referral telephone call, although little was actually revealed. Clearly, her determination to help her son propelled her to contact a place that was potentially very threatening for her. The referral and intake worker commented:

> She was very enthusiastic and grateful for the opportunity to contact the [child and adolescent mental health agency] and to proceed with the referral. We had some information from the neurologist, and then she provided other information and confirmed that, yes, she would like to go ahead and get some more assistance from this department ... We don't hear the whole story and we don't probably request the sort of the depth of painful issues that might be addressed by a clinician.

However, the fact that the referral and intake worker was limited in the depth that could be revealed was balanced by the immediacy of the distress when referring a child. The pain of before can be available to the referral and intake worker, but may not be present in clinical contact. As the director of this service commented:

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Sometimes people are quite distressed and the service doesn't deal with that. It's the referral and intake workers that field that stuff and the clinicians are blissfully unaware. Why a screen should be drawn across such pain was investigated in the prospective study of this research.

9.4.3 Determination: The cases of Leila, Pam, and Cheryl

Determination and commitment were evident in the reports of all the parent informants. Although not so aware of the depth of the emotional pain pre-referral, their clinicians knew how the referral could be experienced as threatening, and knew of the energy required to carry through the referral and intake processes. For example, the team leader, clinician of Leila, commented:

I'd expect [referral and intake] would be pretty daunting, that it's fairly clear acknowledgement of significant difficulties in the management of their child or children. And probably having no knowledge of the culture or working practices of a child psychiatric agency, and would probably have only the vaguest idea of what may be occurring after that, after the referral and intake. They may well be also daunted by the amount of information that we require from them at first contact. And whilst from my perspective, we see this as facilitating the decision in terms of the appropriateness of our agency being involved, I dare say some parents would experience that as being a series of hurdles that have been put up, that they need to jump over.

This comment reflected more of the position of the team leader, than of the parent in this case, as this parent's determination and commitment was in fact well supported through the referral phase by the mother's counsellor, who referred the family. The team leader could see how parents might experience the processes, but provided little detail of the actual experience. This parent had been very worried by the recurrent battles with her daughter, as the daughter was coping with feeling like a failure in the early years of primary school. Such emotion belongs to the category of the pain

of before, but the team leader did not describe knowledge of this pain, although he knew well of the mother's gratitude.

Informants did not detail what constitutes determination, but it was frequently asserted. Clinicians could appreciate the force of parental determination, as with the following report by Pam's clinician:

> I think it had something to do with the personality of the parents, particularly the mother, who was very determined to get the best care for her child … She's really had to be proactive ...

Proactivity was a feature of the referral behaviour of many of the parents and highlights another way of understanding the determination. The determination to secure referral was fuelled by the child's needs and the parent's belief that an appropriate service existed and that they had rights to use it. One parent, Cheryl, was very keen for help, very worried about her adolescent daughter's mood, but was concerned about social entitlement:

> I wasn't sure whether it was for people like us, on our income, or whether it was for people who couldn't afford private service.

From a comfortable, upper middle class family, Cheryl was worried that she was not entitled to receive free, government funded services, and this made her feel very unsure of the process until after the first interview. The referral call had assured her of her rights, and of the appropriateness of the service for her daughter, but the sense of right to access was not secured until after her daughter had settled into treatment with her clinician.

Pam and Cheryl were very different people with very different means and lifestyles, but shared a determination to assist their child that was premised upon citizen rights to service and the citizen's right to be heard by a public agency. This same motivation could be seen in the determination of Julie, Kevin, Melanie, Vera, and Sharon. Neither was this citizen's rights' determination a form of

manipulation to secure inequitable access to resources. Service was needed, the child's needs deserved attention, and the parent was set on accessing quality service. Such determination would seem to be an asset when referring a child for mental health assistance.

9.4.4   The opponent: The cases of Debbie, Melanie, and Alison

While pain was present in all cases, and hope was engendered or encouraged by the referral call, many cases had a negative force driving the contact. This force is here called "the opponent" because it was against the perception of the opponent's wishes that the push to refer was directed. Usually, a supporter was also needed to combat this force. This was described by Debbie:

> [Jim] goes to dad's every weekend and I usually find on the Sunday that he comes home … I mean, his dad reckons that he's perfect around there, and goes to bed and all that sort of thing by himself, and as soon as he walks in that door … he'll just start and just won't do anything I say, won't do anything until he goes to bed. So it's full on. … Mum was very concerned. Actually it was her, she sort of pushed me to finally seek some help ... As for his dad, well he's pretty skeptical about this, full stop. As far as he's concerned, there's nothing wrong with Jim and it's, you know, I'd say he thinks it's me.

An estranged spouse was almost always the opponent, and the parent informants could see aspects of this opponent in their child. But some informants felt that they could over-use their supporters. For example, Melanie stated:

> Sometimes he has expressions that are very much his father and it's like a bit scary ... I said to him actually the other day, 'Well that was your father, that's your father all over, there' ... Like I used to think, "Why can't his father cop some of this bloody behaviour? Because it's his fault" … when I did talk to my friends too, especially my friend who was … divorced and all that, with her own child and that, I always used to feel guilty. Like I always used to always feel like I'm unloading my problems on her, and she's got enough to deal with as

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well. That's why I thought, you know, like I really need to speak to somebody where this is their job as well …

Sometimes the opponent was still part of the household and this created domestic tension and required careful timing of any discussions of the referral, as for Alison:

I did discuss it with his dad that night. To the effect that Matthew was struggling with something, and we're going to have to deal with it. He [manic-depressive father] doesn't seem to understand the connection at all. And his response, of course, was that it was only me trying to make him and the boys insane.

In a somewhat more abstract way, the opponent was a goal in the mind of the parent and involved the child's problem, the problem's effect upon the parent, or the child's future. Vera needed help for Alex (9 years), for his sake and for the sake of her sanity. Sharon had hopes for her son's treatment and his future. Michelle wanted to fashion a rewarding present and satisfying future for her son, Justin (13 years). Pam wanted help for Aaron (10 years), no matter what. All of these goals provided something against which to push. Determination was a characteristic of many of the parents in seeking help.

9.5   Effects upon the informants of the research procedure

As part of the interviews, informants were asked about their experience of participation in the research program. None of the informants felt under pressure to disclose information beyond what they were prepared to offer. All informants were positive about having participated and looked forward to research leading to improved clinical services, in general.

Parents were pleased to think that they could help other parents, especially at the time of referral. The thought of a parent not getting needed help brought tears to the eyes of two parents, when the

research interview was discussed. Parents also felt that research participation was a way of giving something back for what they had gained. A most heartfelt expression of this came from Alison:

> Yes, no absolutely, because I actually offered up a stillborn baby for pathology for the same reason and, … When was it? When I was having Matthew in Western Australia and my obstetrician, because I knew how the other baby had died, and he was able to say `Look in the last few years, the research has shown that you can be a carrier of B- strep, etc, etc, and you can' … like they now give you an antibody course around about 20 weeks or so. And he said `Well that is the one reason why', and it was identified. Maybe my experience was something that helped that.

The managers of the service, including the referral and intake workers, were all keen to have the referral and intake process documented. Clinician informants were supportive of the idea of research per se, rather than being interested in the particular research program. One clinician observed the variable levels of commitment to the research project in her colleagues:

> you probably get the ones that have had a nice service ... Because [colleagues] aren't really willing to give you ones that they think will interview really badly.

Familiarity with the processes of research and its value was probably also a motivating factor for participation. The discipline of psychology, trained in research, provided five of the eleven cases. The remaining six cases came from different professions, but all, apart from one referral and intake worker, had been involved in large mental health research projects.

9.6   Review of the aims and expectations of retrospective study

The aims of this retrospective enquiry as set down in Section 7.4.1, were to document:

1. the processes of referral and intake;

2. the effects of the processes of referral and intake on parents; and

3. the effects of the processes of referral and intake on the overall progress of cases.

Each of these aims has been addressed. Sections 9.2.1 and 9.2.2, through Tables 4 (page 215) to 9 (page 224), set down the procedures, attitudes, and policies associated with child and adolescent mental health referral and intake work. The categories of activity identified in each of these tables were brought together in a higher order analysis in Table 10 (page 226) in Section 9.2.3 and showed that referral and intake work has a complex structure involving orienting issues, administrative structure, transactional qualities, the referral reason, and specific tasks.

Section 9.3 with Tables 11 (page 233) to 17 (page 242) described the effects of the work upon parents and, thereby addressed the second aim. These tables showed that referral and intake was viewed with importance by the referring parents and for some brought almost instant relief. Six factors were identified as significant: hope, pain, determination, frustration, the opponent, encouragement, and satisfaction, with the pain factor becoming a fear of not benefiting, as therapy unfolded. These factors were demonstrated within the case vignettes prepared in Section 9.4.

These same sets of data (Sections 9.3 and 9.4) also demonstrated case progress, which was the third aim of the retrospective study. The cases were all successful to the point at which the research interview was conducted. However, parental opinion was divided over whether the referral call was just one step toward recovery or a great influence on subsequent events. For this sample of parents, the beginning was important, but the content of subsequent therapeutic input was also very important.

As the stories of referral and intake concerned positive experiences in all but one case, it is not possible to say how negative experiences affected subsequent events (Expectation R1). In the one negative case where the referral information was lost due to an industrial issue, the enforced wait seems to have made the father more determined. All of the remaining cases were positive instances

of referral and intake, although some regarded the making of the referral call as little more than a necessary procedural step. Others placed great emphasis upon the value of the first call. Those who had been in contact with the service for longer were just as likely to see the first contact as important as were those who had briefer contact. Therefore, these expectations have qualified positive support.

Ambivalence to referring was reported (Expectation R2.1), but this was against a background of great enthusiasm for the services and the need to get help for the child (Expectation R2.3). Most parents reported strong positive effects of the assistance provided to their families. Most parents reported great relief at referral and increased wellbeing over the period of contact with the agency, however, health status at the time of referral was not really described, except in terms of the pain factor (Expectation R2.2).

The expectation concerning consumer status was not specifically explored, but parents did not raise this issue (Expectation R2.4). The parents were comfortable with being in need of help and had no real desire to communicate with other families, except for Pam who chatted to other parents while Aaron was in a group program and Vera, who sought out other parents with difficult children at her child's school to gain support. Sharing the worry was a need for some parents, but the lack of interaction at the clinic was not a negative. This may have been a sign that the parents preferred anonymity when in attendance at the agency.

Broadly, the expectations concerning directors and clinicians were confirmed. Directors gave clear accounts of policy (Expectation R3.1), as did clinicians (Expectation R3.2), although the detail provided by clinicians was more limited. Clinicians regarded the case as beginning from the time of first contact (Expectation R3.4) and had little idea of the status of a parent or child prior to the referral call. Many of the clinicians did not have a clear idea of how a case began for the family with whom they consulted and (Expectation R3.3), therefore, were not sure how the beginnings

affected the status of the case at the time of the research interview (Expectation R3.5). Basically, clinicians regarded the parent in terms of the referred child and had great difficulty thinking of them in any other way (Expectation R3.6). Overall, there was a greater degree of concordance between parental and staff views than was expected.

Unsurprisingly, the referral and intake workers had a detailed and systematic view of the procedures (Expectation R4.1). One referral and intake worker felt able to predict case progression beyond assessment (Expectation R4.3). The mystery analogy of Brown (1993) intrigued both referral and intake workers, but was not readily identified as analogous to their manner of conducting referral calls (Expectation R4.4). Decision-making strategies were not clearly articulated, but both referral and intake workers believed that their decisions were usually appropriate (Expectation R4.5). One of the referral and intake workers believed training in telephone counseling to have been important in gaining the position and in undertaking the work (Expectation R4.6). The other referral and intake worker, who had a mental health nursing background, mentioned triage as a skill base. Both referral and intake workers believed that their work had less status than clinical work, even though both stated that their agency had given the work high priority and that clinicians valued their contribution to the conduct of cases (Expectation R4.7).

The phases of contact were identified by the parent and staff informants as clear, distinct, and important to the understanding of case progression (Expectation R5.1). The expectations concerning discontinuers were not explored directly, as there were no discontinuers interviewed. This had proved impossible because of the ethical issues in recruiting people not cooperating with the services studied, but is a weakness of the study. A long list of reasons for discontinuance was generated (Table 17), with parents offering few reasons and staff offering many.

The final expectation concerned the emergence of unexpected factors. (Expectation R6). The pain of before and the opponent were issues not indicated in the literature. Another unexpected effect was the over representation of developmentally compromised children (hearing, coordination, speech) in the sample. It may have been easier for a parent to volunteer for participation in the research when parenting was not so intimately connected to the child's problems.

The degree of determination among the parents interviewed suggested that many of these parents were likely to belong to group of applicants labelled as committed in Chapter 5. An expectation concerning state of applicancy was not formulated for the retrospective study, although an expectation was formulated for the prospective study, as access to reports of parental commitment at the time of referral were not envisaged as being reliable after the event, but it would appear that the proposal in Section 5.3 has support. Certainly at the time of the research interview these parents were totally committed to their agency and the work that had occurred. Some of the parents, at referral, had needed supportive response from the referral and intake workers, but it is not known how much this influenced the decision to pursue referral. It is probable that Julie, Vera, Michelle, Cheryl, and Sharon were contained by the referral and intake workers during the initial referral call, although it is unclear whether they were containable or committed applicants, as described in Section 5.3, at the outset. This is a sampling issue, which is likely to be active in the prospective study. That is, only committed applicants might be willing to commit to an ongoing research project.

Complementary to the finding about the commitment of the parents was the finding that instability in life was not a factor for this sample of parents. This does not directly confirm Hershorn's (1993) view about discontinuers and instability, but does demonstrate a connection between commitment and stability and life.

9.7   Implications for the prospective study

This retrospective study demonstrated that the referral and intake process is indeed complex and has potentially great influence on the course of clinical contact at a child and adolescent mental health service. Prospective study of the effects of referral and intake on clinical contact was warranted, even though the breadth of the findings would be limited by restrictions upon the recruitment of parent informants.

The findings of the retrospective study have implications for the prospective study on several levels. The implications concern informant recruitment, the phase of contact, family wellbeing, stability in life, and access to services, the pre-referral issues for the parent of pain, hope, frustration, and determination, the presence of developmental problems in the child, the presence of an opponent to the parent's decision-making, clinic administrative issues, the description of the tasks of referral and intake work, and the influence of the positive effects of sound referral and intake practice over time.

There are strong indications that the capacity to recruit informants who might be categorized as crisis-reactive or containable might be severely limited in the prospective study. The parent informants were keen to give something back to the service in gratitude for the service received in the retrospective study. It was also far more difficult to recruit informants in the early phases of their contact with the service. Even if only committed parents can be recruited, it would still be possible to map the issues pertinent to referral and intake as they arise over the course of subsequent contact.

The phases of contact may be able to be mapped more closely and prospectively and with reference to other factors linked, in the literature, with help seeking, such as parental state of mind, child behaviour problems, family cohesiveness, and stability in life. The lack of administrative issues

that acted as barriers in the retrospective study was unexpected given the long list of clinic issues that were documented to affect progress within the literature. A measure of barriers to treatment participation would be a necessary safeguard to the failure to detect such issues in the retrospective study. The hidden factors of pain, hope, frustration and determination that emerged from the retrospective study will need to be explored in the prospective study. Questions will need to be asked about a child's developmental status and the presence for the parent of an opponent.

The prospective study could add to the description of the tasks and functions of the referral and intake worker role within child and adolescent mental health services. More in-depth interviews of the referral and intake workers would be needed to allow for the processes of enquiry and decision-making of referral and intake workers to be described in more detail. Further, the following of a parent cohort over time might capture the effects of sound referral and intake practice as they arise in reports of later clinical transactions.

CHAPTER 10

PROSPECTIVE ENQUIRY METHOD

There are many events in the womb of time which will be delivered.
Shakespeare. *Othello, I:3.* (Alexander, 1951, p. 528)

The third enquiry of this thesis was envisaged to follow the course of child and adolescent mental health services cases from the time of first contact to one year after the first contact. This was to be done in a second empirical study through parents' perceptions reported in interview at each phase of contact with child and adolescent mental health services, and with these perceptions supplemented by relevant parametric measures. The conduct of the retrospective study had revealed that the likelihood of achieving recruitment of a large of sample of participants was low, so emphasis moved from the preferred quantitative study to a qualitative, multiple case study involving interview data and the standard measures.

This chapter sets out the method for the prospective enquiry, which was planned subsequent to the completion of the retrospective enquiry. Firstly, the background to the prospective enquiry is described in terms of implications of the findings of the retrospective enquiry. This leads into an outline of the aims of the prospective enquiry. This is followed by a description of the desired sample and informant recruitment. Thirdly, the multi-method design, with its several measures, is set out. Fourthly, the procedure for the enquiry is presented, followed by the procedures for data collection. Finally, the qualitative data analysis that was planned is described.

10.1   Background to the prospective enquiry

The design of the retrospective enquiry was based upon the finding of Armbruster and Fallon (1994), Sirles (1990), and Tuckman and Lavell (1958), that different concerns were manifested at different phases of clinical contact, discussed in Section 5.1.1 above. These phase points had, as anticipated, also provided different perspectives on the clinical process in the retrospective study. It was decided to use these phase points to structure the prospective study also, but with two major modifications.

It had been found, both in the literature and in the retrospective study, that the phases of contact could be of widely varying length. In the latter, the period between referral call and first interview varied from a few days to more than half a year. The period between first interview and completion of assessment could also vary from weeks to months. The period of contact for treatment could be months or years. To adjust for such variations, the third data point was set at three months after the first interview, to be sure that assessment had been completed. This decision brought the risk of families having already left the service by this time, but it was intended to ensure that the families would have had feedback on the intended direction of any intervention, if any was planned. The possibility of a very brief wait meant that some of the proposed measures might have been used twice in the same fortnight and this would be likely to invalidate any results with a learning effect. It was decided that a full set of parametric measures could not be collected at the second data point. The schedule for data collection is presented, below, in Section 10.4.

Secondly, rather than at termination, the fourth data point was set at twelve months after first interview. Mutual termination had been found to be a rare event during the period of recruitment of informants in the retrospective study, and it was hoped to be able to keep in touch with any informants who finished treatment for a reasonable period of time. It could be anticipated that at 12

months after the first interview, some families would have completed contact, while others were expected to be in ongoing treatment.

10.1.1 Aims of the prospective enquiry

The aims of the prospective enquiry were to:

1. document in more detail the tasks and practices of referral and intake identified in the retrospective study

2. document the effects of referral and intake practices on the unfolding experience of parents,

3. document the effects of the processes of referral and intake on the progress of cases,

4. investigate the measures of parental wellbeing, child behaviour, family cohesion, parental hopefulness, stability in life, and access barriers within the context of case studies, and to

5. write case studies of the experience of change over the course of a year following referral of a child to a child and adolescent mental health service.

A multiple case study approach would be used at different data collection points, with qualitative interview data augmented with parametric measures of child behaviour, parental wellbeing, family cohesion, barriers to treatment participation, and stability in life.

10.2   Sample of informants

One child and adolescent mental health service in Melbourne, Victoria, Australia, different to those previously involved in the research, would be approached and requested to provide access to potential informants. Eventually, six parents, the referral and intake workers and the directors of the service were to be invited to participate.

Parent informants were to be recruited by the referral and intake worker at point of first contact. Interviews were planned to occur for each parent informant soon after referral, soon after the first interview, three months after first interview, and twelve months after the first interview. This would result in the conduct of a total of 24 interviews with the six parents, plus four interviews with the directors and the three referral and intake workers.

To avoid the problems of recruitment encountered in the first phase, it was decided to use the referral and intake workers to recruit in the second phase. These workers had successfully recruited research participants for other research in the past and did not expect it would be difficult for this project. It was on the basis of their confidence in doing the recruiting that the design of the second phase was agreed. In the event, they found it almost impossible to ask referrers to participate into research upon their own practices. Re-design was necessary and it was decided by agency management to ask the receptionist to ask new registrants to participate. This occurred, but at a slow rate. In the data collection period of six weeks, 62 new cases were registered, and 15 parents agreed to participate. Of these parents from 10 families agreed to be contacted to participate, with only seven parents signing participation consent. At the first data collection, one set of questionnaires was completed in parts by each parent, rather than the referring parent. This family was withdrawn from subsequent data collection.

10.3   Design of foundational interview data collection with staff

Interviews were planned with the three referral and intake workers and the director of service with the same general questions as used in the retrospective study. However, the questions of the referral and intake workers were planned to search more closely their actual practices, to explore how past occupational preparation continued to influence their practice, to explore relationships between the referral and intake worker and colleagues within the agency would be explored, and to

consider options for innovative referral and intake procedures that had been located in the literature and presented in Section 4.2 of Chapter 4.

10.4   Design of data collection protocol design with parents

Observations would be made at four points in time using brief qualitative interviews and parametric measures. These data would be analysed using the appropriate scoring methods for each measure and rendered within case studies to examine the effects of the referral and intake process up to 12 months after first interview.

There were some concerns about the use of some of the instruments as repeated measures, especially if completed within short periods after a previous administration. For this reason, only the stability in life demographic questionnaire (see Section 10.4.2.1 below) was to be used at the second data collection point, that is after the first interview. This was envisaged to be within as short a period as one week from the time of referral. Although, in some cases, it could be as long as three months or more, depending on waiting periods which fluctuated widely across the year.

10.4.1 Interview protocol design

At each data collection point, the informants would be asked the simple questions, as shown in Appendix C6:

- What is left now of the original concerns that took you to child and adolescent mental health services?

- What has been the influence of these early procedures on your current family circumstances?

Elaboration of answers to these questions by the parent could lead to consideration of the pain of before, the opponent, and parental determination, as indicated in the retrospective study, but these

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details would not be pressed and other details would not be requested. Probing questions of clarification would be asked only where essential to the point at issue.

In addition, at the third and the final collection, parents would be encouraged to review their contact over the whole period, while still answering the basic question. The hope, pain, frustration, determination, and the opponent would be explored, also. Other factors identified in the retrospective study, such as developmental problems, would be addressed through demographic details.

10.4.2 Parametric measures

As summarized in Section 7.2 of Chapter 7, the literature review had identified the following factors as important to the referral and intake process:

- stability in life,

- child behaviour and problems,

- parental wellbeing,

- family cohesion, and

- barriers to participation.

The retrospective study had further identified the factor of parental hope. All of these factors could be documented by questionnaire.

10.4.2.1   Stability in life

Hershorn's (1993) stability in life factor was not formalized as a measure, nor did he indicate how many changes in a two-year period represented instability in life, although he did compare families with many changes with families with less than three changes. Therefore, a demographic data

form, called the Background Information questionnaire (Appendices C11 and 12), was devised for the present study, that asked questions of changes over the previous two years in home address, schools attended, parental employment, and parental relationship status. The aim in the first instance was to count the number of changes and, depending on the size of the sample, compare the high scores with a similar number of low scores. The operationalization of the indicator was envisaged as a potential outcome of this research. The factors embraced here were similar to the life events that Kazdin et al. (1997) believed gave context to the interpretation of their measure of the Barriers to Treatment Participation (see Section 10.3.2.5, below).

10.4.2.2   Prediction of continuation

To complement this information about stability of life, Ewalt et al.'s (1972) telephone referral and intake screening tool was to be used. This tool enables prediction of likelihood of a family to continue with a child's referral to completion of the assessment phase, by asking five questions, as follows:

1. Child's age less than **or** greater than 12 years

2. Mother's education level less than **or** greater than year 12

3. Worry about child **or** worry about other authority

4. Child not stubborn **or** stubborn

5. Referrer wanting help for self with child **or** don't know/just for child

The questions are scored with a favourable answer to the first part of the question gaining one point. Ewalt et al. reported that five points meant that a child had a 72.5 per cent chance of continuing contact and four points had a likelihood of continuing of 69.5 per cent. Lower scores were below 50 per cent. The predictive power for continuance with adolescents was much lower, although for scores of less than three, there was a 70 per cent chance of discontinuing.

Data relating the first three of Ewalt et al.'s (1972) questions were available from the Background Information questionnaire. The fifth question's answer could be inferred from this same questionnaire and from interview transcript. The question on stubbornness was found in reverse on the Strengths and Difficulties Questionnaire (Goodman, 1997) as Question 7 "Generally obedient, usually does what adults request". The answer "Not true" would be considered to be analogous to stubbornness.

10.4.2.3   Perceived child behaviour and problems

Child behaviour was found to be the major reason, among a range of other reasons, for referral to a child and adolescent mental health service by Gath (1968, 1972), Garralda and Bailey (1987, 1988), and Jensen et al. (1990), as discussed in Section 4.2.2 of Chapter 4. A measure of child behaviour was needed, therefore, to assess the relevance of disturbed behaviour to the processes of referral and intake at a child and adolescent mental health service.

The Strengths and Difficulties Questionnaire (Goodman, 1997) is a recently developed, 25 item questionnaire for parents to report child behaviour, both problem behaviour and prosocial behaviour. The Strengths and Difficulties Questionnaire is comprised of five subscales of five questions each, with each item scored as 0, 1, or 2 (Goodman, 1997). The Total Difficulties Score is calculated from the hyperactivity, emotional symptoms, conduct problems, and peer problems subscales. The TDS does not include the score for the prosocial subscale. The abnormal range on the Strengths and Difficulties Questionnaire TDS is a score of 7 or more (Goodman).

The Strengths and Difficulties Questionnaire has been shown to be as effective a measure of childhood strengths and weaknesses when compared to the Rutter (Rutter, 1967, cited in Goodman) and Achenbach measures (Achenbach, 1991, cited in Goodman). Goodman and Scott (1999) compared the Strengths and Difficulties Questionnaire to the Achenbach CBCL with both equally

able to discriminate psychiatric cases from dental cases, comparable in detecting internalizing and externalizing problems, but the Strengths and Difficulties Questionnaire was significantly better at detecting hyperactivity and inattention than the CBCL. The brevity of the Strengths and Difficulties Questionnaire was more popular with the mother informants.

Goodman (2001) investigated the statistical properties of the Strengths and Difficulties Questionnaire with respect to internal consistency and validity. To test for internal consistency, the measured mean for Cronbach's Alpha, across the five subtests, was found to be 0.73, with a range from 0.57 (Peer problems subscale) to 0.82 (Total Difficulties Score). To test for validity, comparison was made with psychiatric disorder as defined by the *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition (DSM IV; American Psychiatric Association, 1994), by comparing the Strengths and Difficulties Questionnaire scales with corresponding DSM IV diagnoses for the 10 per cent most acute in the population. Goodman found the Total Difficulties score to be associated with DSM-IV diagnosis for 46.3 per cent of those at high risk.

Goodman has published on the Strengths and Difficulties Questionnaire seven times as primary author (1997; 1999; 2001; Goodman, Ford, Simmons, Gatward, & Meltzer, 2000; Goodman, Meltzer, & Bailey, 1998; Goodman, Renfrew, & Mullick, 2000; and Goodman & Scott, 1999) and with collaborations in studies with non-English speaking samples (Klasen, Woerner, Wolke, Meyer, Overmeyer, Kaschnitz, Rothenberger, & Goodman, 2000; van Widenfelt, Goedhart, Treffers, & Goodman, 2003). The instrument has been accepted as a mental health monitoring by the national Governments of both the United Kingdom and Australia (British National Children's Services framework, Department of Health (UK), 2003; Wolpert & Garralda, 2003; National outcomes and casemix collection, Australian Department of Health and Ageing, 2002) and translated into 51 languages (Youthinmind, 2004).

10.4.2.4   Parental state of mind

Parental wellbeing would be measured in two ways. Studies reported by Graham (1985) used the widely recognized measure of wellbeing, the General Health Questionnaire (Goldberg, 1978; Goldberg & Huxley, 1980; Goldberg & Williams, 1988), to demonstrate that parents tend to refer a child to child and adolescent mental health services when the parent is physically ill. Garralda and Bailey (1987) demonstrated this effect and included mental ill health, as well. As well, over two decades (from Griest, Wells, & Forehand (1979) to Chi & Hinshaw (2001)), many studies have connected maternal depression with referral of children for behavioural problems. The General Health Questionnaire was to be used to measure the general state of wellbeing of the referring parent in the current study.

The General Health Questionnaire has been produced in several versions since it was first developed, such as GHQ-60, GHQ-30, GHQ-28, and GHQ-12 (Goldberg & Williams, 1988). The GHQ-30 had the same items as the GHQ-60, except that the physical illness items were removed. The GHQ-28 was developed from the GHQ-60 and the GHQ-30 based explicitly on the four factor structure found for the earlier versions of the test and differentiates psychological health from psychological ill health (Goldberg & Williams; Vieweg & Hedlund, 1983).

The General Health Questionnaire-28 (Goldberg & Williams, 1988) is a 28-item self-report instrument that covers general physical and mental health as perceived over the recent past and in comparison to the usual state. There are four subscales, namely, depression, anxiety, social dysfunction and somatic symptoms. The General Health Questionnaire is focused upon the capacity for normal functioning and, therefore, differentiates the appearance of disturbing phenomena, but cannot be used for purposes of psychiatric diagnosis. Vieweg and Hedlund (1983) reported a correlation on the GHQ–28 of between .67 to .76 for two groups of diagnosed general medical patients and their psychological state determined by interview.

Each GHQ-28 answer can be scored using a Likert scale (0,1,2,3) or by the "GHQ method" (Goldberg & Williams, 1988, p. 63; 0,0,1,1). The description of patients that can be gained using the GHQ–28 subscale and total scores depends on the purpose of the enquiry in which the GHQ-28 is used. Scores can be used descriptively to indicate relative states of psychological wellbeing, or, in larger samples where severity and specificity of diagnosis can be ascertained, "cases" can be differentiated from "normals" (Goldberg & Williams, p. 8) using a threshold or cut-off score. For most studies using the GHQ-28, a threshold of 4/5 has been used, although sometimes 5/6 and 11/12 have been used (Goldberg & Williams, p. 64). The validity of the GHQ-28 has been reported in 12 studies with the sensitivity ranging from 100 per cent down to 44 percent and the specificity ranging from 93 per cent down to 74 per cent (Goldberg & Williams, p. 50).

The General Health Questionnaire would be complemented by a measure of hopefulness, given the importance of this variable in the referral of a child, as found in the retrospective enquiry documented in Section 16.4.2. Seligman's (1992) optimism measure was chosen. In choosing a positive measure of state it was intended to engage with the respondents' positive attitudes in the filling out of this and all other questionnaires. However, it should be noted that, theoretically, low optimism scores would be expected to be connected with a negative or depressed state of mental health.

Seligman's (1992) measure of optimism was developed with his interest in *Learned Helplessness* (1978) and the Attributional Style Questionnaire (Peterson et al., 1982), which measured the tendency to attribute unexpected events to internal or external forces, to stable or unstable circumstances, and to global or specific factors. Later, these three polar attributional characteristics have been re-labelled, respectively, as personalization, permanence, and pervasiveness (Seligman, 1992). When Seligman's attention moved from pessimism to optimism, he published *Learned Optimism* (1992) along with the version Attributional Style Questionnaire which appeared in that

publication under the title: "Test your own optimism". The Attributional Style Questionnaire (Peterson et al.) is a 48 item self-report inventory. The scale was designed for repeated use for self-monitoring but it is not clear how close in time two presentations of the questionnaire can be. Some of the terminology has had to be adapted in this research to suit Australian expression (for example, "stocks" have been renamed "shares").

Reivich (1995) reported the individual subscales of personalization, permanence, and pervasiveness as having unsatisfactory reliability ranging from .39 to .64. However, on the composite scores of positive answers (CoPos), negative answers (CoNeg), and their sum, that is negative subtracted from positive (CPCN), reliabilities were reported between .69 and .73. Smith and Hall (1999) reported reliabilities on the composite scores of .64 (CoPos), .61 (CoNeg), and .76 (CPCN).

10.4.2.5   Perceived family environment

Armbruster and Fallon (1994), in their extensive survey of the literature, found only one measure to discriminate discontinuers from those who continued with a referral at a child and adolescent mental health clinic. This was the Cohesion subscale of the Family Environment Scale (FES, Moos and Moos, 1994). The FES is a 90 item self-report questionnaire completed by a parent, which can be used to measure changes in families during and after treatment (Koegal, Koegal, & Schreibman, 1991, cited in Moos & Moos).

The FES can be analysed in two ways, namely subscale analysis and family typology, both of which begin with the conversion of raw scores into subscale scores (Moos & Moos, 1994). The FES is comprised of ten subscales: Cohesion, Expressiveness, Conflict, Independence, Achievement Orientation, Intellectual Cultural Orientation, Active Recreational Orientation, Moral/Religious Emphasis, and Organization and Control. Negative family environment has been

identified with one or more significant scores on the first five of these subscales (Moos & Moos). FES subscale scores would be used to demonstrate change over time in the current study.

The FES can describe seven family typologies: independence oriented, achievement oriented, intellectual-cultural oriented, moral-religious oriented, support oriented, conflict oriented, and disorganized (Moos & Moos, 1994). The typologies are based on the dimensions of personal growth, relationships, and system maintenance within the family. FES family typology was to be used to augment each of the case studies in the current study.

Moos and Moos (1994) reported data that demonstrated the reliability of the FES. Cronbach's Alpha, used as a measure of internal consistency, calculated for each subscale, showed variation between 0.78 for Cohesion and to 0.61 for Independence. The strongest finding was for the variable of most interest in the present study, the Cohesion subscale. Further, test-retest reliability of the FES, as set out in the FES manual (Moos & Moos), over two months, was in the range of 0.68 for Independence and 0.86 for Cohesion. Reliability was stable over one year and could be used to study changes in a family over that time.

Moos and Moos (1994) provided two sorts of validity data in their manual. Firstly they reported a study (Dickerson & Coyne, 1987, cited in Moos & Moos) which compared the FES with two other common family instruments: the Family Assessment Device (FAD) and the Family Adaptability and Cohesion Scales (FACES II and III), and found correlations between the FES Cohesion and control subscales of approximately 0.60. Secondly, construct validity was tested by comparing sets of related indices or subscales. The family arguments index correlated with the Conflict subscale at .49. Religious involvement was correlated at .62 with the Moral Religious subscale.

10.4.2.6   Perceived barriers to mental health service participation

The measures of stability in life, parental state of mind, child behaviour and family environment would be complemented by a measure of perceived accessibility of the child and adolescent mental health service. The Barriers to Participation Scale (BTPS), developed by Kazdin and colleagues (Kazdin, Holland, & Crowley, 1997; Kazdin, Holland, Crowley, & Breton, 1997), the main section of which is a 44 item self-report inventory, documents the sorts of obstacles experienced by parents as they sought to refer a child for child and adolescent mental health assistance and completed after exiting the service. The four subscales of the BTPS concern stressors and obstacles that compete with treatment, treatment demands and issues, perceived relevance of treatment, and relationship with the therapist.

The BTPS is complemented by an additional Life Events Scale (LES) that maps events on a 7-item scale, such as bereavement, trauma, abuse, and other life changes, that make parents reluctant to refer their child, even if a child's behaviour would seem to the parent to warrant referral. The BTPS, without the LES, can be adapted, by changing the tense of the verb, to assess the presence of barriers throughout the course of treatment, although no studies have actually used the BTPS in this way. The LES, with its inclusion of questions concerning child abuse, could only be used after the contact has ceased as these questions may prompt discontinuance of a referral by a defensive parent and, thereby, rendering both research and treatment impossible and, perhaps, endangering the child. The LES score provides context against which to assess the Total Barriers score on the BTPS.

Kazdin, Holland, Crowley, and Breton (1997) demonstrated that it was reliable and valid measure of treatment barriers. Internal consistency, as measured by the coefficient alpha and by the Spearman-Brown coefficient was found to be .86. Validity was established by comparing high BTPS scores with low BTPS scores using the criteria of number of weeks in treatment, number of cancelled appointments and number of appointments missed without notice. Groups with high and

low levels of barriers to treatment were discriminated by the BTPS scores (Hotelling's T^2 (3, 56) =10.42) with a mean of 66.0 and a standard deviation of 13.8 within the potential range of 0 to 220.

10.4.3 Planned data collection procedure

The same process was used for preparing for the collection of data as was used in the retrospective study. The Royal Children's Hospital Mental Health Service agreed to participate. After negotiations and relevant approvals, referral and intake workers using a consenting procedure identical to that of the retrospective study would recruit parent informants. Interviews would be conducted, again with foundational interviews preceding the case-oriented ones.

Table 18 shows the four planned data collection points and the data to be collected at each point.

Table 18

Program of planned data collection points and data to be collected

Soon after telephone contact (referral)	Soon after first interview (intake)	Three months post telephone contact	Twelve months post telephone contact
Full demographics	Basic demographics	Basic demographics	Basic demographics
Situational data	Situational data	Situational data	Situational data
Barriers to Participation		Barriers to Participation	Barriers to Participation
			Life Events Scale
Consumer relations and development	Consumer relations and development	Consumer relations and development	Consumer relations and development
Optimism (Attributional Style Questionnaire)	Optimism (Attributional Style Questionnaire)	Optimism (Attributional Style Questionnaire)	Optimism (Attributional Style Questionnaire)
General Health Questionnaire		General Health Questionnaire	General Health Questionnaire
Family Environment Scale		Family Environment Scale	Family Environment Scale
Strengths & Difficulties Questionnaire		Strengths & Difficulties Questionnaire	Strengths & Difficulties Questionnaire
Qualitative questions	Qualitative questions	Qualitative questions	Qualitative questions

10.4.3.1　Preparation for data collection and relevant instruments

After gaining ethics approval for the conduct of the enquiry from both Victoria University and the Royal Children's Hospital (RCH), the referral and intake workers of the RCH Mental Health Service were to be asked to recruit research participants at the point of referral using the protocol presented as Appendix C8; later this was revised for recruitment by the receptionist as presented as Appendix C9. Clinical staff would be briefed on the study and asked to be aware of the potential for impact on their case work and to notify the researcher if there were any troubles. A letter of invitation to participate in the research that was similar to that used in the retrospective study was prepared and is presented as Appendix C1. The double consenting procedure used with parents in the retrospective study, described in Section 8.3.3 of Chapter 8, was again to be used with potential participants being asked to give signed consent for the release of contact details to the researcher. This form is presented as Appendix C2. The signed form was then to be passed on to the researcher, who would telephone the parent and arrange an appointment to secure formal informed consent to participate, and to begin the process of data collection. At this interview, further information about the research was to be given and is presented as Appendix C3. Signed consent to participate was to be gained by the form presented as Appendix C4. Signed consent to audio record the interview was to be gained with the form presented as Appendix C5.

10.4.3.2　Data collection

At each point of data collection, a package of questionnaire forms was to be hand-delivered to the home of the parent participant, and a time arranged to collect the completed forms. At the second meeting, any questions related to the forms would be addressed, and the brief semi-structured qualitative interview would be completed, with audiorecording. Participants with language or reading difficulties would have each question read out, with the researcher completing the forms.

To guide the conduct of the interviews, a protocol booklet was prepared displaying in large print the questions to be asked. These questions are included in Appendix C6 (parents), and Appendix C7 (staff).

Research interviews would occur as close as possible to the time of passing of a data collection point, hopefully within a week of the passing of this point by the family. Interviews would occur at mutual termination, upon completion of assessment, after first interview, and after first contact. Interviews would be arranged to occur at a time and venue convenient and complaisant with the informant.

All interviews would be audiotaped, with the written consent of the informants. Transcripts of the audiotaped interviews would be made and prepared for systematic qualitative data content analysis.

10.5   Qualitative data analysis procedure

Primarily, analysis was to be qualitative with the measures used to support the ongoing effects of initiating conditions upon subsequent agency contact for the recruited families. If a large enough sample could be procured, descriptive statistics would be employed to indicate progress over time. Review of the tasks of referral and intake developed in the retrospective study would occur through analysis of the interview data.

10.5.1 Interview data analysis

The procedure used to analyse the qualitative interview data for this prospective study would have the same basic form as used for the retrospective study, as outlined in Section 8.4 of Chapter 8. However, here, the two sets of interviews, with parents and with referral and intake workers, have

different purposes, so it was anticipated that the analysis codes would probably be different, or at least expanded or be more focused.

The referral and intake worker interviews, relating to the work of referral and intake, were to be first coded using the codes established in the retrospective study and augmented with new codes, as appropriate. It was expected that there would be new codes under domains relating to occupational preparation, relationships within the organization, and innovative referral and intake procedures.

The transcripts of the brief interviews with the parents were to be coded as previously. Once more, within a grounded theory framework, the material itself would guide punctuation and coding of the material.

10.5.2 Parametric data analysis

The intent was to procure a sample large enough to permit the use of descriptive statistics that could be generalized to a child and adolescent mental health service parent population, for all variables of interest. If such a sample could not be gathered, the parametric scale scores were to be considered in respect of particular families, which data could be integrated with interview material to produce illustrative case studies or case vignettes.

CHAPTER 11

PROSPECTIVE ENQUIRY FINDINGS

The web of our life is of a mingled yarn, good and ill together.
Shakespeare *All's well that ends well, IV:3.* (Alexander, 1951, p.191)

This chapter presents the findings of the prospective study. The modified procedure, the samples of staff and parent informants, and the findings of the interviews are presented. The results of the parametric measures over time are presented in a series of tables and then used to augment the presentation of the family case studies. Important findings relate to those factors identified in the retrospective study as pain, hope, determination, and the opponent. The stability in life factor of Hershorn (1993) is evaluated. The place of the referral call in the life of families is presented, as is the value of the treatment received. The categories of applicant, proposed in Section 5.3 of Chapter 5, are appraised. Finally, the aims and expectations of the prospective study are reviewed.

Originally, the prospective study was intended to be the central concern of the project with a quantitative design and a sample of forty or more participants. It became apparent, however, that recruiting sufficient participants to the study to enable quantitative data analysis of the scores from parametric measures was not possible. Therefore, a qualitative, multiple case study design was implemented. The prospective enquiry was not as clarifying as expected when this project was originally designed.

11.1   Modified procedure

Originally, it was planned for referral and intake workers to request participation of parents in the research project once all referral information had been collected, and the necessary information about the service had been given to the caller. The referral and intake workers were very enthusiastic about the research and expressed certainty that they could recruit participants. However, the referral and intake workers discovered that it was inappropriate and extremely difficult for distressed and overwhelmed parents. This incapacity to recruit participants is discussed as a finding in Section 11.2.1.

The original plan for recruitment was abandoned after four months, and it was agreed within the service that the agency's receptionist would recruit participants at the time of the first appointment. All parents of new clients were asked if they would like to participate and given the letter of invitation to participate in the research, presented as Appendix C1. If the parents indicated interest, they were asked to provide signed consent to release contact information to the researcher (Appendix C2), as had been the process in the retrospective study. The researcher then made contact with the parent and visited the parent in their home to obtain written informed consent and to begin the data collection.

One other change in the design was necessitated by the inability to recruit participants at the time of referral. Recruitment at the time of first interview meant that subsequent contacts could be planned straight away and spaced, such that the likelihood of learning the content of the several questionnaires was reduced and, therefore, all measures could be applied at each of the three administrations, namely after first interview, three months after first interview, and twelve months after first interview. Otherwise, data collection occurred as planned.

11.2 Sample of informants

Informants for the prospective study were the child and adolescent mental health agency director, three referral and intake workers, and six female parents.

11.2.1 Parent informants

Fifteen parents agreed to have their contact details released to the researcher by the receptionist. Two of these people had insufficient English language skill to discuss participation over the telephone. Many of the parents were surprised by the amount of time and the extended period to which they had to be prepared to commit. One parent agreed on behalf of her husband and they subsequently withdrew at the time of consent. One couple completed the first data set, but it was found, at the time of collection, that both parents had filled out the forms, thereby invalidating the parental state of mind data. This family was thanked and was withdrawn from the study. Of the seven families who had made the commitment to participate, only this family did not provide data at each of the points of collection. One parent was illiterate and had to have the several questionnaires read to her, while the researcher completed the forms. All were fluent speakers of English. All parents, but one, were from Anglo-Celtic backgrounds, although their partners or former partners, for at least three families, were of European backgrounds.

Six mothers, varying in ages from mid-twenties to early fifties, with referred children varying in age from three years to 13 years, the youngest being a girl, and, for one family the primary school aged daughter was the identified child, but all three children were of concern. Three intact families owned their own home in middle-class suburbs. Three families were in poorer suburbs with two in rented accommodation, one of whom was a lone parent family, and one other lone parent family

shared accommodation with the maternal grandparents in the home in which the parent had grown up.

The difficulties in recruiting informants represent the first finding of this study. The difficulties were not with the parent informants, as they seemed able to volunteer when requested to do so by the agency's receptionist. Rather, the referral and intake workers had found it almost impossible to even ask a referring parent to participate. Two factors were identified. Firstly, after the emotion and struggle involved in making a referral, it was felt not appropriate to ask the referrers to participate in the extra task of a research project; this factor concerned the parent's state. Secondly, the referral and intake workers, having achieved the information necessary for the making of a referral, found it very difficult to then ask the parent to participate in a research project whose central focus was the conversation just completed; this factor concerned the referral and intake worker's role and status.

11.2.2 Child and adolescent mental health staff informants

The agency's referral and intake team was comprised of the coordinating referral and intake worker, and two full-time referral and intake worker positions. One of the referral and intake worker positions was filled on a permanent part-time basis by one of the people interviewed. The remaining part-time position had been filled by a variety of persons with a variety of clinical backgrounds, including nurses from the Hospital's employment bank.

11.3   Findings from foundational interviews on referral and intake process

The foundational interviews were modelled on those undertaken in the retrospective study, as described in Section 8.4.1 of Chapter 8. As understanding of the role of the referral and intake work at this agency expanded, greater emphasis was placed on the additional areas of the interview

protocol concerned with understanding the work style of the referral and intake workers, their occupational backgrounds, and their thoughts about potential innovations for their service that referral and intake services in other part of the world had tried.

11.3.1 Findings in respect of the referral and intake workers

The coordinating referral and intake worker was a female social worker. The full-time referral and intake worker was a female mental health nurse. The part-time referral and intake worker was a female occupational therapist. All had more than fifteen years of experience in mental health services, at least six years of which was in child and adolescent mental health services. The team seemed comfortable with each other and reported that they were still learning from each other, despite working together for over three years.

Listening was the most important part of the work with both referrers and colleagues. Listening had a special purpose in referral and intake work and some who attempted the work did not know what to listen for or how to contain unnecessary talking from a distressed referrer. The mental health nurse cited a number of clinicians who took on referral and intake work in a temporary capacity with a view to taking the role into the future, and how they spent much more time on the telephone than was necessary and became confused by the detail collected. Contained listening, which allowed for efficient collection of the relevant details, was considered to be a sign of how well suited a person was to the task of referral and intake work. The aim was not to allow endless descriptions of distress, or recriminations, or confusions, but to allow these as evidence of a service that was compassionate and open to really listening to parental concerns in a non-judgemental way.

All three referral and intake workers liked the 9 to 5 office hours and the freedom of leaving work without incomplete tasks or emotional burdens of worrying clients. They had all experienced these burdens in other employment and were pleased to be free of them, although each recognized that

some situations did leave them with things to ponder overnight, but these were not of the same order of burden as carried when they had ongoing clinical responsibilities. There were other burdens with the current position, for instance, the occupational therapist found sitting in the one chair all day rather stultifying and used her lunchtime each day to get out into the open air for some mind clearing time. Also, boredom occurred during the rare slow day.

Although each referral and intake worker declined to describe aspects of their work as boring, they did agree that the work could have a sameness about it that would ultimately limit the amount of time they would spend in the job. Not all of the clinical skills of each referral and intake worker could be used within the role. However, the hours and the time-limited nature of clinical contacts were an ample trade-off, and each was satisfied in her work and satisfied with what could be offered to callers.

Relative isolation was another theme of the three referral and intake worker interviews. The coordinating referral and intake worker enjoyed the privacy of having her own office. However, all three felt that connections with clinicians within the building were limited by the coincidence of breaks, and often confined to discussing doubts about the appropriateness of referrals. Each of the referral and intake workers listed the grumbles of clinical staff among their least liked aspects of the work. The coordinating referral and intake worker felt that the service would be better placed if all clinicians were on the one campus, rather than at distant suburban or hospital locations. She felt that concerns about referrals were more directly dealt with when the meeting occurred face-to-face rather than on the telephone.

The referral and intake workers differed in qualifications, which provided an opportunity to explore how prior training and other experience prepared a person for referral and intake work. There was a clear difference between the mental health nurse and her two colleagues in approach to the central purpose of referral and intake. The mental health nurse felt it was necessary to collect sufficient

data in order to make the decision to accept the referral or not, as the priority of the work. She felt that mental health nurses were trained well for listening and were very skilful at this task. The social work and the occupational therapy trained referral and intake workers placed more emphasis on providing direction for the referring parent. In the course of finding out what was needed, the decision concerning acceptance eventuated.

This difference between inclusiveness and regulation of the boundary was felt to come from the training and experience of each of the referral and intake workers. Each could appreciate differences in style between each other, but felt such differences allowed for the emergence of a balance between the potentially competing tendencies of such stylistic differences. These differences were felt as a balance within each of the referral and intake workers.

With respect to innovations, there was a range of opinions. All thought changes to procedures would help and, perhaps, relieve the sameness of the work, but all recognized resources were limited. The referral and intake coordinator was diversifying by working within the group program of the agency without having to take on a specific caseload. The occupational therapist was interested in doing more in providing information to referring parents and in preparing parents for the services that might be offered. The mental health nurse felt that the several innovations tried elsewhere were interesting, but really inappropriate. Her wish was to be used for crisis and urgent face-to-face assessments.

On the basis of these interviews, and especially with respect to occupational backgrounds, it was decided to re-inspect the data collected from the referral and intake worker interviews of both the retrospective and prospective enquiries in a separate enquiry that is presented in Chapter 12.

11.3.2 Findings in respect of the service director

The director of the agency was pleased with the contribution the referral and intake workers made to the agency and to the whole of the State of Victoria. He was pleased to be able to participate in the research into the service, as he felt it could demonstrate its value. The interview was brief, because he did not perceive a need for direct management of this service:

> Well, it works well, as far as I can tell. [The coordinating referral and intake worker] is a good manager and I don't get too many complaints from staff or the community. There are always issues about whether cases are appropriate, but these seem to be worked out between the team leader and the referral and intake coordinator. I don't have to be very involved.

The director was clear that referral and intake was a clinical activity:

> I think our aim is to listen well to the referrers; it is a clinical service requiring listening to difficult stories.

It was clear that listening was not only constitutive of a clinical service, but was also linked with service efficiency. Resources required careful management. The director commented in passing how an audit showed that the longest cases were ten per cent of the total referrals, but consumed almost one third of resources. It seemed that the referral and intake service saved resources by careful listening, such that the whole agency was able to respond efficiently, and did not use resources with cases for which those resources were inappropriate. In turn, according to the director, referred families arrived at the agency with appropriate expectations: "referring parents need to know what is happening, and need to know they have a place in the service".

11.4   Findings concerning parents' perceived experience of referral and intake and case progress

The progression from referral and intake to the agency and toward completion of contact for six families was recorded through the use of certain parametric instruments and brief interviews, the

data from which is presented in this section. These measures were employed to evaluate later effects of practices of referral and intake upon the course of agency contact. The data from the parametric measures is presented in tabular form that demonstrates the changes over time and the differences between the families. Occasionally, to aid comparisons, results from other measures are presented alongside the particular measure that is the focus of the table.

As for the retrospective study, pseudonyms are used to protect the confidentiality of the families. Further, other details of ethnicity, occupation, and residency have been changed.

11.4.1 Stability in life and quality of service

Data was collected about the stability in life factor and about service quality using two survey forms devised for this study. Data was often categorical, for example, educational achievement level and past contact with a mental health agency, and did not require subsequent updating, but some of these details may have changed, like address or marital status, so, in subsequent data collections, only changes of status were requested. Table 19 on page 290 below shows the stability in life factors for each case, as inferred from Hershorn (1993; Hershorn & Rivas, 1993). As can be seen, some data were not entered for the second and third data collections in Table 19.

The questions regarding service quality were repeated for each data collection but did not produce results that could be easily displayed in a table. Basically, for each data collection, each informant recorded strong and positive ratings of the conduct of interactions by receptionist, referral and intake workers, and other staff. Similarly the contribution of those who suggested referral was consistently appraised as positive. Similarly, the support, or opposition, of a family member or other professional regarding the referral was consistently rated. The variables that were addressed in each question did not discriminate in this sample. Hershorn listed issues of drug abuse, legal issues and concern for a person other then the child with the problem, as indicative of instability.

These issues were surveyed, but did not apply in any of the cases, although one estranged father

had had drug issues. These issues are not shown in Table 19.

Table 19

Stability in life indicators for each case at each data collection point

Parent and child	Data collection point	MARITAL STATUS	EDUCATIONAL ACHIEVEMENT (year level or Higher Education. HE)	RESIDENCE CHANGES IN PAST 2 YEARS	KNOWLEDGE OF LOCAL AGENCIES	ACCESSIBILITY OF SERVICE	COSTS WHEN ACCESSING SERVICES	PERIOD OF TIME SPENT SEEKING REFERRAL (months)	PERIOD OF TIME SPENT WWAITING FOR INTERVIEW (months)	PAST CHILD MENTAL HEALTH INVOLVEMENT	PAST ADULT MENTAL HEALTH INVOLVEMENT	REFERRAL AGENT	FOCUS OF CONCERN NOW	NEURODEVELOPMENTAL PROBLEMS
ANNE	1	M	HE	0	N	E	T	4	4	N	Y	g	ch	N
Ben	2	M		0			N		4				ch	N
12 years	3	M		0			N		4				ch	N
CAROL	1	M	HE	1	N	E	N	9	10	N	Y	g,n	0	N
Lucy	2	M		1			N		9				0	N
3 years	3	M		1			N		8				0	N
MARY	1	L	7	0	N	D	T	6	7	Y	N	p	ch	N
Jason	2	L		0			T		3				ch	N
14 years	3	L		0			T		8				ch	N
PATRICIA	1	D	11	0	N	O	T	4	4	Y	N	v	ch	N
Amy	2	D		0			N		8				ch	A
8 years	3	D		0			N						ch	AY
ROSALIE	1	S	11	3	Y	E	N	9	4	N	N	m	ch	N
David	2	S		3			N		9				ch	N
9 years	3	S		3			N		4				ch	N
SARAH	1	S	11	1	N	E	N	6	5	N	N	g	ch	N
Michael,	2	D		1			N		10				ch	N
11 years	3	D		2			N		7				ch	N

Abbreviations: Marital status: M = married, D = de facto, S = separated, L = lone parent; Knowledge of local services: N = no, Y = yes; Costs: T = costs associated with transport; Accessibility: E = easy access, O = ordinary difficulty, D = difficult access; Referral agents: g = general practitioner, m = maternal grandmother, n = nurse, p = paediatrician, v = voluntary agency; Focus of concern: ch = child focus, 0 = no concerns; Neurodevelopmental problems: N = none, A = assessed

Table 19 presents the data on the stability of life indicators, as inferred from Hershorn (1993; Hershorn & Rivas, 1993). Letters in the table refer to qualitative codings as given in the abbreviations below the table. Numbers indicate time in months.

Apart from Sarah who separated and re-partnered and moved house twice, there were few changes in the domestic arrangements of these six families. Carol lowered her estimation of the first contact over time and, as there was no real cause for concern with her daughter, there was no longer any focus upon her with respect to mental health issues.

While Sarah only hinted at some attempts at couple counseling prior to her separation, all other families had past contacts with mental health services, including counseling services and family preservation services. Carol and Anne had had only adult mental health involvement. Mary and Patricia had had only child mental health involvement. Rosalie had had both adult and child mental health involvement. No negative comment was made about these previous encounters with helping professionals, with Anne and Rosalie speaking positively of their past contacts. Past contact would seem to have led to confidence in further contact for these parents. The level of past contact with mental health services is a further indicator of the select and distinct character of this group of referring parents who volunteered as participants in this research.   Clearly, no generalizations can be made from this sample to the population of referring parents, but the sample has provided many indicators of issues important when referring a child to such services.

Only one of the identified children (Patricia's daughter, Amy) in the sample had developmental, or inferred neurological, deficits. Mary's son Jason had been assessed for stimulant medication to treat his activity levels and problems in sleeping, but the paediatrician had suggested the referral for mental health treatment.

11.4.2 Prediction of continuation from referral to completion of assessment

The data concerning Ewalt et al.'s (1972) simple test of likelihood to attend six clinical sessions are presented in Table 20, below. Section 5.3.2.1.2 of Chapter 5, described how, using five questions concerning the age of the child, maternal educational achievement, the source of the worry, the stubbornness of the child, and the focus of the help requested, Ewalt et al. could predict subsequent attendance. The five questions and scores are presented in the columns of the table adjacent to the name of the parent, and for each data collection point.

Table 20
Ewalt et al.'s (1972) measure of likelihood to proceed with referral, including prediction of outcome

Parent and child	1 (age less than 12 yrs)	score	2 (mother's education less than year 12)	score	3 (worry about child or worry about other authority)	score	4 (child stubborn)	score	5 (wanting help for self with child or other)	score	TOTAL	PREDICTED OUTCOME
Anne Ben, 12 years	N	0	Y	1	CH	1	NS	1	S+CH	1	4	Proceed
Carol Lucy, 3 years	Y	1	Y	1	CH	1	NS	1	D/K	0	4	Proceed
Mary Jason, 14 years	N	0	N	0	CH	1	ST	0	S+CH	1	2	Not proceed
Patricia Amy, 8 years	Y	1	N	0	CH	1	NS	1	S+CH	1	4	Proceed
Rosalie David, 9 years	Y	1	N	0	CH	1	NS	1	S+CH	1	4	Proceed
Sarah Michael, 11 years	Y	1	Y	1	CH	1	NS	1	S+CH	1	5	Proceed

Abbreviations: *sc* = score, N = no, Y = yes, CH = worry about child, NS = not stubborn, ST = stubborn, S+CH = concern of self with child, D/K = don't know where concern lies

All cases in this sample proceeded to the end of assessment, which was predicted by this screen for all but one case. One case was accepted for assessment that was found to not need assistance (Carol). Two children of twelve years of age were included, with the twelve-year-old proceeding. The fourteen-year-old was not predicted to proceed, but actually did.

11.4.3 Perceived child behaviour and problems

The Strengths and Difficulties Questionnaire (Goodman, 1987) measured parents' perception of their child's behaviour at each of the three data collection points. These data are presented in Table 21 with the parents and their child presented in the first column and SDQ subscale scores presented in successive columns, along with the Total Difficulties score. Note that the Total Difficulties score is calculated by the addition of the first four subscales and does not include the Prosocial scale scores, which are to be interpreted as moderating the overall difficulties experienced by the child. Clinical and subclinical scores on the Total Difficulties score of the Strengths and Difficulties Questionnaire are indicated in Table 21 on page 293 below.

Table 21 shows that this was a sample of clinically abnormal children, as measured by the Strengths and Difficulties Questionnaire, and that those children who were in the clinical or subclinical ranges on a subscale score tended to stay in that range, as perceived by their parent. The Strengths and Difficulties Questionnaire showed that, at referral, five of the six children showed Total Difficulties' scores in the abnormal range, which warranted referral. The sixth child, Sarah's son Michael, had a high normal overall score, but had an abnormal range score for the emotional problems sub-scale. The Strengths and Difficulties Questionnaire was an accurate predictor of the perceived need for intervention.

Table 21

Strengths and difficulties subscale scores for each case at each data collection point

Parent and child	Data collection point	1= Emotional symptoms score	2= Conduct problems score	3= Hyperactivity score	4= Peer problems score	5= Prosocial behaviour score	Total Difficulties score (= 1+2+3+4)
ANNE	1	8#	7#	5	6#	6	26#
Ben	2	6#	8#	0	6#	4#	20#
12 years	3	6#	6#	0	6#	8	18#
CAROL	1	2	5#	4	7#	6	18#
Lucy	2	2	1	5	2	6	10
3 years	3	1	1	2	1	10	5
MARY	1	5#	8#	7#	4#	5*	24#
Jason	2	7#	8#	6*	4#	3#	25#
14 years	3	4*	8#	10#	3*	5*	25#
PATRICIA	1	6#	8#	10#	7#	2#	31#
Amy	2	6#	9#	9#	8#	3#	32#
8 years	3	4*	6#	10#	9#	0#	29#
ROSALIE	1	7#	3*	6*	5#	6	21#
David	2	7#	1	6*	4#	9	18#
9 years	3	6#	2	7#	3*	6	18#
SARAH	1	7#	1	4	0	10	12
Michael,	2	4*	1	4	2	10	11
11 years	3	4*	2	4	0	10	10

Clinical rating: * borderline, # abnormal

Carol's daughter Lucy moved back into the normal range by the second data collection, with conduct problems and peer problems resolving without intervention, although her Prosocial score was in the clinical range at the third data collection point. Michael's emotional symptoms score was borderline at the subsequent data collections. The other four children remained in overall abnormal range throughout the research period, although for some the Total Difficulties score did decrease.

The overall lack of movement with respect to adjustment measured by the Strengths and Difficulties Questionnaire Total Difficulties score parallels the finding, that at follow-up, Patricia's family, whose child was measured to have been the most disturbed of all the children, was still in therapy contact and some other parents (Anne, Mary, and Sarah) were considering renewed contact

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for their family. Rosalie was arranging another program for her son and was again concerned for her daughter who had previously been for help.

11.4.4 Parental state of mind

Parental state of mind involved two measures, both of which assessed psychological wellbeing: the Attributional Style Questionnaire (Peterson et al., 1984) and the General Health Questionnaire (GHQ-28, Goldberg & Hillier, 1979). The Attributional Style Questionnaire was intended as a positive measure of parental state of mind, with variations in optimism over time expected to correspond with family changes and scores are shown in Table 22, on page 295 below.

Table 22 provides the subscale scores for each parent at each data collection point, along with a corresponding rating for each subscale score of relative states of optimism, pessimism, hopefulness, or self esteem, as indicated by Seligman (1992). The table reveals that overall ratings on the Attributional Style Questionnaire for each subscale score remained fairly constant across time with parents overall in the average to very pessimistic range. Only Mary was in the high self-esteem range. The measure of hopefulness was even, and in the moderate to high range for Anne, Carol, Rosalie, and Sarah, but hopefulness varied across the data collection points for Mary and markedly declined for Patricia. Although committed to therapeutic change for their child, these parents were not measured to be optimistic people.

In complement to the Attributional Style Questionnaire, the General Health Questionnaire measured parents' perceived state of wellbeing. Poor parental wellbeing was associated with increased likelihood of referral of a child with behaviour problems (Graham, 1985).

Table 22

Attributional Style Questionnaire subscale scores for each case at each data collection point

Parent and child	Data collection point	PmB (permanence, bad)	INTERPRETED RATING OF OPTIMISM/PESSIMISM	PmG (permanence, good)	INTERPRETED RATING OF OPTIMISM/PESSIMISM	PvB (pervasiveness, bad,)	INTERPRETED RATING OF OPTIMISM/PESSIMISM	PvG (pervasiveness, good,)	INTERPRETED RATING OF OPTIMISM/PESSIMISM	HoB (hope = PmB + PvB,	INTERPRETED RATING OF HOPEFULNESS	Ps B (personalization, bad)	INTERPRETED RATING OF SELF ESTEEM	PsG (personalization, good)	INTERPRETED RATING OF OPTIMISM/PESSIMISM	B sc (Total bad)	G sc (Total good)	G-B (Total good – Total bad)	INTERPRETED RATING OF OPTIMISM/PESSIMISM
ANNE	1	4	AV	4	AV	2	MO	3	MP	6	MH	5	MLS	2	VP	11	12	1	MP
Ben	2	5	MP	7	VO	2	MO	4	AV	7	AV	5	MLS	3	MP	12	14	2	MP
12 years	3	6	MP	6	MO	2	MO	5	AV	8	AV	6	MLS	2	VP	14	13	-1	VP
CAROL	1	1	VO	4	AV	0	VO	2	VP	1	EH	4	AV	2	VP	5	8	3	AV
Lucy	2	1	VO	4	AV	0	VO	2	VP	1	EH	5	MLS	2	VP	6	8	2	MP
3 years	3	3	MO	4	AV	2	MO	2	VP	5	MH	4	AV	5	AV	9	11	2	MP
MARY	1	6	MP	5	AV	3	MO	5	AV	9	ML	2	MS	5	AV	11	15	4	AV
Jason	2	4	AV	4	AV	1	VO	5	AV	5	MH	0	VHS	2	VP	5	11	6	MO
14 years	3	5	MP	3	MP	2	MO	6	MO	7	AV	0	VHS	2	VP	7	11	4	AV
PATRICIA	1	5	MP	1	VP	2	MO	2	VP	7	AV	7	VLS	4	AV	14	7	-7	VP
Amy	2	4	AV	1	VP	1	VO	1	VP	5	MH	6	MLS	2	VP	11	4	-7	VP
8 years	3	5	MP	2	VP	7	MP	2	VP	12	SL	6	MLS	1	VP	11	5	-13	VP
ROSALIE	1	4	AV	6	MO	2	MO	6	MO	6	MH	3	MS	0	VP	9	12	3	AV
David	2	5	MP	5	AV	1	VO	5	AV	6	MH	6	MLS	1	VP	12	11	-1	VP
9 years	3	4	AV	4	AV	1	VO	6	MO	5	MH	4	AV	2	VP	9	12	3	AV
SARAH	1	3	MO	7	VO	4	AV	6	MO	7	AV	4	AV	3	MP	11	16	5	AV
Michael	2	3	MO	5	AV	5	MP	3	MP	8	AV	4	AV	1	VP	12	9	-3	VP
11 years	3	3	MO	4	AV	7	VP	5	AV	7	AV	6	MLS	3	MP	13	12	-1	VP

Abbreviations: VO = very optimistic, MO = moderately optimistic, AV = average, MP = moderately pessimistic, VP = very pessimistic, EH extremely hopeful, MH = moderately hopeful, ML = moderately hopeless, SL = severely hopeless, VHS = very high self-esteem, VLS = very low self-esteem, MLS = moderately low self-esteem.

Table 23 on page 296 below displays the General Health Questionnaire subscale scores and total

score, with ratings of optimism (ASQ; Seligman, 1992) and childhood difficulties (SDQ;

Goodman, 1997). The Likert scale method (0,1 2, 3) for scoring the GHQ-28 (Goldberg &

Williams, 1988) was used to give these estimates of relative state of psychological health with a

threshold score of .80.

Scores on the subscales for each of the informants, at each timepoint were often moderate, but four

of the mothers had scores above the threshold at the third data collection point. The General Health

Questionnaire self-rating of the health of Carol was stable and well with Rosalie being close to the threshold. Mary was just below the threshold for the first two measures and unwell at the third collection. Sarah was unwell initially, but this moderated, and then returned at the third data collection. Anne's health rating always had an anxiety component, but depression, and social dysfunction had impaired her health and was matched by a change from moderate pessimism to being very pessimistic. Patricia was very pessimistic from the outset, though at first and second data collection her health was sound, but had deteriorated at follow-up. It is possible that the low initial measure reflected some relief from having begun the mental health work with her family.

Table 23

General Health Questionnaire subscale scores for each case at each data collection point, with Total Difficulties rating, from Table 21, and Attributional Style Questionnaire rating, from Table 22, included for comparison

Parent and child	Data collection point	A: depression	B: anxiety	C: social dysfunction	D: somatic symptoms	Total	GHQ overall rating (case =.80)	ASQ overall rating	SDQ TD score
ANNE	1	*1*	*+9*	*1*	*2*	**13**	.46	MP	26#
Ben	2	*1*	*+9*	*+6*	*0*	**16**	.57	MP	20#
12 years	3	*+6*	*+15*	*+10*	*0*	**31**	+1.11	VP	18#
CAROL	1	*5*	*2*	*+7*	*0*	**14**	.50	AV	18#
Lucy	2	*2*	*2*	*4*	*0*	**8**	.29	MP	10
3 years	3	*0*	*2*	*0*	*+7*	**9**	.32	MP	5
MARY	1	*3*	*+7*	*+7*	*5*	**22**	.79	AV	24#
Jason	2	*4*	*+7*	*+7*	*4*	**22**	.79	MO	25#
14 years	3	*5*	*+8*	*+11*	*+7*	**31**	+1.11	AV	25#
PATRICIA	1	*+6*	*+6*	*+7*	*0*	**21**	.75	VP	31#
Amy	2	*+6*	*5*	*+7*	*0*	**18**	.64	VP	32#
8 years	3	*+15*	*+13*	*+10*	*+6*	**44**	+1.57	VP	29#
ROSALIE	1	*4*	*+6*	*+6*	*0*	**16**	.57	AV	21#
David	2	*4*	*+6*	*+6*	*1*	**19**	.68	VP	18#
9 years	3	*3*	*+6*	*+7*	*5*	**21**	.75	AV	18#
SARAH	1	*0*	*+8*	*+7*	*+15*	**30**	+1.07	AV	12
Michael	2	*+7*	*4*	*+7*	*2*	**20**	.71	VP	11
11 years	3	*+18*	*+10*	*+8*	*+6*	**42**	+1.50	VP	10

Abbreviations: + = case on GHQ; AV = average, MP = moderately pessimistic, VP = very pessimistic, on ASQ; * = borderline on SDQ, # = abnormal, on SDQ

The three parents (Anne, Mary, Sarah) actively considering re-referral had appreciable negative

changes in general health and mood between the second and third data point. Rosalie was

considering a further option for her son, but this was an enhancement program rather than one for

recovery. She did not show much change in her health status. Carol was well and her child did not

need help. Patricia was unwell and her child and family continued to need help. It would seem that

GHQ-measured health status deterioration was linked with a tendency to refer a child for this small

sample.

When General Health Questionnaire and Strengths and Difficulties Questionnaire Total Difficulties

scores are compared, it can be seen that the impetus to refer, if the cause of referral was child

behaviour, was present for four of these parents. Patricia had remained with her family in therapy

so did not need to re-refer. The difficulties experienced by the children of Anne, Mary, and Rosalie

were measured as clinically abnormal. But the re-referral thought only occurred to the two parents

whose own health had deteriorated. By contrast, Rosalie, whose health was not far below the

threshold, had a son with consistent clinical ratings on the SDQ, did not re-refer. Sarah's child,

Michael, whose difficulties were always at the edge of the normal range, was to be re-referred in

the presence of the growing anxiety and depression of his mother.

These data suggest that parental state and the likelihood of referral are linked, as was suggested in

the literature (Garralda & Bailey, 1986a, 1988; Graham, 1985). Of course, this is a special sample

of research friendly parents who had experienced quality, if foreshortened, therapy at a previous

contact with a trusted agency.

11.4.5 Perceived family environment

The Family Environment Scale (Moos & Moos, 1994) was included as an overall measure of

family adjustment, but more specifically because Armbruster and Fallon (1994) reported that the

Cohesion subscale was a sound predictor of treatment continuance. The raw scores obtained from the parents were converted to standard scores using the table in Appendix A of the Moos and Moos manual.

Table 24, below, displays the parents names alongside the data collection points and with columns for the ten subscales of the Family Environment Scale and a rating of family typology interpreted following Moos and Moos (1994). The Total Difficulties score of the Strengths and Difficulties Questionnaire for the children are from Table 21.

Table 24

Family Environment Scale subscale scores for each case at each data collection point, family typology and Total Difficulties Scores from the Strengths and Difficulties Questionnaire from Table 21

Parent and child	Data collection point	Cohesion	Expressiveness	Conflict	Independence	Achievement Orientation	Intellectual-Cultural Orientation	Active-Recreational orientation	Moral-Religious emphasis	Organization	Control	Family typology	SDQ Total Difficulties score
ANNE	1	11	40	75	21	53	58	53	46	32	49	Conflict Oriented	26#
Ben	2	11	34	75	37	47	47	43	51	32	59	Conflict Oriented	20#
12 years	3	65	53	60	53	59	63	64	56	48	54	Intellectual-Cultural Orientation	18#
CAROL	1	59	71	44	53	41	63	43	56	26	43	Intellectual-Cultural Orientation	18#
Lucy	2	65	59	39	53	41	63	43	56	26	38	Intellectual-Cultural Orientation	10
3 years	3	65	71	33	69	47	63	59	61	42	43	Independence Oriented	5
MARY	1	25	40	75	45	41	36	59	46	48	49	Conflict Oriented	24#
Jason	2	31	40	75	37	35	36	38	36	37	38	Conflict Oriented	25#
14 years	3	41	34	65	53	41	25	28	41	48	54	Conflict Oriented	25#
PATRICIA	1	45	40	54	61	59	41	43	36	42	76	Independence Oriented	31#
Amy	2	45	40	70	61	53	52	43	36	69	54	Independence Oriented	32#
8 years	3	11	34	65	61	53	41	43	32	32	54	Independence Oriented	29#
ROSALIE	1	59	22	49	45	53	52	48	51	58	70	None applicable	21#
David	2	31	22	54	37	59	41	43	36	53	70	None applicable	18#
9 years	3	25	28	49	45	59	41	48	41	53	70	None applicable	18#
SARAH	1	65	40	65	21	41	52	59	61	63	70	Str Moral Religious	12
Michael	2	31	28	65	45	47	52	53	56	58	65	Conflict Oriented	11
11 years	3	31	34	65	45	47	41	59	41	58	49	Conflict Oriented	10

Abbreviations: * = borderline on SDQ, # = abnormal, on SDQ

As can be see in Table 24, family typology remained fairly constant over data collection points. Some changes are evident. The change in Anne's family from conflict oriented to intellectual cultural orientation, at the third data collection point, was associated with a drop in perceived conflict and great increase in family cohesion. The change in Carol's family from intellectual cultural orientation to independent orientation, at the third data collection point, was associated with a perceived increase in independence, achievement orientation, and control. The change in Sarah's family from structured moral-religious type to conflict oriented, at the second and third data collection point, was associated with a perceived decrease in cohesion and expressiveness and an increase in independence. Rosalie's family did not fit with any of Moos and Moos' family typologies.

Specifically, with respect to the cohesion subscale on the Family Environment Scale, the family with highest measured cohesion was the family that did not need therapy. This scale was reported by Armbruster and Fallon (1994) as the only family measure to be reliably associated with attrition. Cohesion increased over time for Mary's and Anne's family, but both felt more therapy was necessary. Patricia's, Rosalie's, and Sarah's family cohesion decreased over time, but all felt the need for further input. This measure was not predictive for this small sample of committed families.

Given that there were great differences between families on the subscales, comparisons with the measured adjustment of the child using the Total Difficulties score of the Strengths and Difficulties Questionnaire were not clear.

11.4.6 Service access

The Barriers to Treatment Participation Scale (Kazdin et al., 1997) was included to measure the difficulties in gaining access to service and includes questions designed to measure external impacts and psychological factors that lead to reluctance in attending for mental health treatment. Table 25 shows the measures over time for the six families and includes the measure of critical life events. The Life Events scale involved Yes or No answers to 14 questions and provided context against which to view the other scores, but was not expected, nor had it been demonstrated, that a relationship existed between subscale scores and the Life Events measure.

Table 25, on page 301, below shows that families had Total Barriers scores that were mostly within one standard deviation of the mean calculated for Kazdin et al.'s (1997) sample. Three scores were more than one standard deviation lower than the Kazdin et al. mean. The family with the least adjustment, Patricia's, as indicated by the SDQ and GHQ scores, and the overall greatest psychosocial disadvantage, showed the highest Total Barriers score, with scores consistently beyond two standard deviations. Five of the six families did not experience high barriers to their treatment participation and the experience of high barriers did not prevent one family from pursuing help.

Stefl and Prosperi (1985) had found that perception of barriers increased during the first stages of treatment. Table 25 shows that four of the families had the pattern of highest barriers at the second data collection point, which was not long after treatment had begun. For Carol's family, going to the service was a great barrier to be overcome and they only attended two times. Contact was finished before the second data collection. Mary's family did not change greatly in level of perceived barriers over time, with the second data collection as the lowest and the third data collection the highest, at the time that re-referral was being actively considered.

Table 25

Barriers to Participation Scale subscale scores for each case at each data collection point, Total Barriers score, and Life Events Scale scores at final data collection point

Parent and child	Data collection point	Stressors and Obstacles that compete with treatment	Treatment demands and issues	Perceived Relevance of treatment	Relationship with the therapist	Total Barriers score	Rating (Kazdin et al., 1997, reported mean score of 66.0 with a standard deviation (SD) of 13.8 for the total score range of 0 to 220)	Life Events (total YES)
ANNE	1	24	10	8	5	47	> 1 SD below mean	
Ben	2	37	12	10	6	65	Within 1 SD of mean	
12 years	3	28	18	10	5	53	Within 1 SD of mean	2
CAROL	1	31	13	19	5	68	Within 1 SD of mean	
Lucy	2	26	10	12	5	53	Within 1 SD of mean	
3 years	3	24	10	12	5	51	> 1 SD below mean	1
MARY	1	28	12	8	8	56	Within 1 SD of mean	
Jason	2	25	12	19	7	55	Within 1 SD of mean	
14 years	3	26	12	16	9	63	Within 1 SD of mean	5
PATRICIA	1	42	18	13	13	86	> 1 SD above mean	
Amy	2	51	22	16	13	102	> 2 SDs above mean	
8 years	3	41	23	20	9	93	> 2 SDs above mean	2
ROSALIE	1	25	10	10	5	50	> 1 SD below mean	
David	2	31	16	15	12	74	Within 1 SD of mean	
9 years	3	23	18	12	5	51	> 1 SD below mean	6
SARAH	1	28	20	10	5	63	Within 1 SD of mean	
Michael	2	34	15	13	6	68	Within 1 SD of mean	
11 years	3	26	11	12	5	54	Within 1 SD of mean	3

The families had experienced few adverse life events before or during treatment and, therefore, would not be considered to have been a great effect on the overall level of barriers to treatment perceived by the parent informants. In some cases, adverse events promoted attendance. For instance, Rosalie's children's experience of what she perceived to be "mental abuse" had motivated her to try to help her children more. Illness in Patricia's family has also motivated attendance. Kazdin et al. (1997) had suggested that these adverse events did not have predictive value with respect to particular cases and this seems to have been found with these six cases. In any case, this sample of committed parents experienced mostly moderate levels of barriers to participation.

11.5 Case studies

To augment the picture of factors generated by the parametric measures at the three data collection points, the interview material provided a focus on the influence of referral upon the family over the research period. Principally, however, the case study vignettes presented below can be read as accounts of contact over a period of about one year. Comparisons between the case studies are made, where useful with the factors arising from the retrospective study, namely hopefulness, pain, determination, and the opponent. The case studies begin with a general commentary on the family and the referring parent. Not all parents supplied the same amount or depth of general information.

The sample of informants was diverse in demographic characteristics; yet, there were commonalities in their experiences of the referral and intake processes and subsequent treatment at the agency. The parent age range was from 26 years to 51 years and the income level disparities were great. Half of the sample were in their own home and half were in rental accommodation. Four of the six women were in stable partnerships, but only two were married. The children varied in age from three years to fourteen years. In writing these case vignettes every attempt has been made to conceal the identity of all family members with respect to nationality, residence, and names. The details included are those pertinent to the issues of seeking mental health assistance.

11.5.1 Anne, mother of Ben, aged 12 years

Anne's family life was dominated by a building project during the course of research contact, but this was an upstairs extension, that only involved dislocation of the usual downstairs furniture arrangements. House proud and hard working, Anne had to apologize, always, for the state of her home. She had a part-time physical health consultancy, as well as being domestic executive and transporter of the two boys to their extra-curricular activities. Her husband was a highly paid

technical professional, in an occupation that involved periods of international travel. Anne, a vibrant, healthy, woman, was seemingly well organized.

Anne had been concerned for Ben's mood for a while and was referred to the agency by the family's general practitioner. She felt this was the right thing to do and was unperturbed by the prospect of discussing family life in order to assist her son. The couple had sought counseling sometime earlier and had felt the value of mental health assistance. Similarly, research was something they believed in and wanted to assist.

At the final meeting, Anne was not so relaxed or organized, although the house had returned to order. Her husband was also present and seemed rather flat. He had lost his position and was finding the several adjustments involved very difficult, and Anne reported these adjustments as wearing on everybody in the family.

Anne was clear that the original conversation with the referral and intake worker had been pleasant, but only a step in the process of achieving clinical assistance. Poor interpersonal relating by a referral and intake worker would have disappointed Anne, but would not have deterred her from her aim. In fact she became quite weary with the repeating of a question that was inconsequential to her, although she could see, in principle, that making a good start was important, and it was a principle she applied in running her own business. Because she encountered no problems, there was no issue for her. She was pleased by the efficiency of the process. Soon after the family had started with the clinician, the referral call had become no longer relevant, except as a marker of their beginning.

On the specific measures used, Anne remained reasonably consistent across time. Stability in life (Table 20) was affected by her husband's loss of employment, but all other things were constant.

Ben's behaviour remained in the clinical range on the Strengths and Difficulties Questionnaire (Table 21), but there was some improvement across time. Anne rated Ben's behaviour in the clinical range for emotional problems, conduct problems, and peer problems, but not for hyperactivity. The prosocial score was in the normal range at first data collection, had become abnormal at the second data collection, but had returned to the normal range at the final data collection. Ben, who was listless again at this final contact, had been referred once more and their first appointment was imminent.

Anne's responses to the optimism measure (Table 22) demonstrated that she had become very pessimistic given her husband's job loss and the added pressure on her as income earner, but her hopefulness remained in the average range. There had been a consistent raised level of anxiety measured by the General Health Questionnaire (Table 23), but this had become depressive and somatized with the added family stressors.

The Family Environment Scale family typology (Table 24) changed from conflict-oriented to intellectual cultural orientation at the third data collection point. Conflict had dropped, and cohesion and expressiveness had risen, but the boy's adjustment and the whole family's adjustment was reported to have deteriorated.

Scores on the Barriers to Treatment Participation Scale (Table 25) showed the pattern of barriers increasing during the early phases of treatment but receded back to pre-assessment level at follow-up. Barriers were never really a problem for this family.

Anne had a very straightforward view of the tasks of life, and that was to confront them and work hard. This did not change over the contact period, but the challenges had become more demanding upon her.

11.5.2 Carol, mother of Lucy, aged three years

Carol was never really ready for the researcher's visits, which were dominated by the play of the two girls and the two small dogs, and the beleaguered efforts of the mother to tidy a small patch of the home for conversation and note-taking. The home had been renovated prior to the arrival of the first baby and showed signs of some small jobs still needing to be completed, nearly three years later. At the last visit, she admitted resenting the researcher's visits and the filling out of the forms, even though she valued research and believed that it could contribute to the service received by other families. Carol's resentment was also directed toward her husband, Gary, who had initially agreed to participate in the research, and had insisted on the referral to the agency.

The contact with the agency had been for only two sessions and had ended with the agreement that nothing needed to be done. This had always been the mother's position. It was the father who had been worried by a maternal health nurse's and paediatrician's suggestion of referral to the mental health service and wanted to be sure that everything was going well for Lucy.

Carol had had another reason for not wanting to refer. She had been post-natally depressed after the birth of the second child, Lucy's sister, now twenty-two months, and had found this experience quite terrible. She had had great support from her husband and from her mother, and recovered after a period of hospitalization. Revisiting this nightmare of mental health service involvement was not wanted. Gary, on the other hand, had been worried by any hidden sequelae for their daughters. In fact, Carol had found the clinicians so respectful, interested, and willing to listen, that she was unconcerned by any future need for referral. She would be very willing to contact again, if necessary.

Carol was very proud and determined, but remained concerned that others had not trusted her judgement as a mother. After expressing her resentment of the research visits, her good will

returned and she expressed hope for the completion of the research. Family life had been formally stable for the past three years, but the advent of babies had been tumultuous, and family life remained demanding.

Carol had been most reluctant to make referral contact and did so only after the strongest advocacy of her husband and the support of her mother who felt that, in the end, there was probably nothing to lose. She had still found making the call very difficult, but was pleased by the polite and courteous manner of the person with whom she spoke. She had been pleased that the place seemed well organized and oriented to listening. She did not feel judged. Nevertheless, in her mind, the referral call was little more than a necessary step in getting to meet with the clinicians. She agreed that she was in danger of being deterred from proceeding with the referral, but had not been, which was a relief.

The stability of life indicators showed that Carol's domestic life was stable, with no real changes over the contact period. According to Carol's perception, Lucy's adjustment on the Strengths and Difficulties Questionnaire (Table 21) showed improvement over time, especially her prosocial score. Carol's optimism (Table 22) declined from average to moderately pessimistic over time, but her hopefulness remained high and her psychological state (Table 23) remained well. Similarly, the Family Environment Scale (Table 24) scores did not vary much at all. The Barriers to Treatment Participation Scale (Table 25) showed a slight drop over time, which probably reflected the positive view of the contact that the family had had with the agency. Overall, the scales and the comments of Carol indicated that her family were getting on with their lives and the causes of concern about Lucy had receded.

11.5.3 Mary, mother of Jason, aged 14 years

Mary and her family lived in a small rented house, with many family photos on the walls. She had been single for a very long time and her elder two children were in employment, but still at home. She reported her younger boy to be struggling at year nine in secondary school. He was having behavioural problems, as well, but his major problem was in getting to sleep.

Mary was illiterate, but was unconcerned about this and was pleased to be involved with an extra person "to talk to". There was clearly much conflict in her home, but she was proud of her children and seemed to be able to tune out from potential sources of distress.

Mary's measured barriers to participation (Table 25) at the agency were fairly even across the data collection timepoints and at the high end of the lowest quarter of potential results. Mary had reported in interview some reluctance to refer because of concerns about discussing herself and her parenting, but had not been deterred, once she realized referral was necessary.

Mary considered the first contact with the agency to be a necessary step. She had been concerned and feared judgement, but found it all rather matter-of-fact and pleasant. She liked receiving an appointment with a named clinician. These details were put behind her soon after she started with the clinician. She could imagine parents being reluctant to call, and being put off by the potential for rudeness or the lack of care. She had suggested to others that they use the service, but these parents were reluctant to take the first step, even through it was clear they needed help.

Mary's life changed little over the period of the research. Her son's problem with sleeping had improved, but at the final research interview was again becoming troublesome (Table 21), so that a further referral was planned. The other parametric measures showed this same lack of change over the period of contact apart from a slight tendency for further difficulties at final contact. Mary's living circumstances were stable (Table 20), as was her mild optimism (Table 22). Her hopefulness

had improved, initially, but then declined. Her responses on the General Health Questionnaire (Table 23) indicated a small lowering of wellbeing at the third contact.

The Family Environment Scale scores (Table 24) for Mary's family remained consistently within the conflict-oriented family typology. While cohesion improved and conflict declined somewhat, the major change was a marked drop in the active-recreational orientation of the family between the first two data collection points. This background of conflict was paralleled by Mary's perceptions of Jason on the Strengths and Difficulties Questionnaire subscale scores (Table 21). Across the three data collection points for all subscale scores and the Total Difficulties score, there were five measures in the borderline range and, the 13 others in the abnormal range. Unsurprisingly, therefore, Mary's perceptions placed Jason's Total Difficulties score in the abnormal range at each data collection. Three of the borderline scores recorded by Mary, were at the third data collection point, which indicated some alleviation of the difficulties in some areas, but re-referral was on the agenda.

11.5.4 Patricia, mother of Amy, aged 8 years

Patricia was a large young woman with a partner and three children, the eldest of whom was at school, and the youngest being a toddler who preferred to be like a baby in arms. At the first contact her partner seemed not to like the researcher's presence, but over the course of the visits seemed happier. In fact the whole family seemed much more hopeful and happier, although the physical surroundings had not improved in this small, rented home with well-worn furniture.

Patricia provided the information in a diligent, almost studious way and, despite her partner's reluctance, seemed to enjoy the opportunity to have a visitor interested in her attempts to help her family. At the last meeting, the family were still attending and although much had been achieved there was much more to do. She was standing taller and was much more willing to sustain eye

contact. She was proud of her efforts in helping her family, and help had been received despite two changes of clinician. When asked what it was that had helped most, the clinicians or her determination or something else, she smiled with self-satisfaction and said "my determination".

Patricia had been very nervous about making contact with yet another service, after having not gained greatly from the in-home support provided by a major welfare agency. She felt she might be blamed, but felt that action was needed. The welfare agency had referred the family ahead of her telephone call and had been with her when she called. This support had made the process much more possible, and she found that she could answer all the questions asked. She was grateful to be informed about what was to happen next. The contact gave her courage to pursue the help she was determined to get. Patricia had been hopeful of getting past the family problems before the call. After the call, she felt that things might happen that could help. Her hopefulness had been kindled by the referral call transaction.

Subsequently, a successful beginning was made with the service. The effects of the circumstances of referral had been for her more than a necessary administrative step, but in time this was only a small part in the bigger project of family recovery. Patricia was pleased to have been greeted respectfully and professionally.

Patricia's family were in stable, if uncomfortable, living circumstances (Table 20). The overall picture using the measures was in contrast to the interview report of Patricia, which had been forward looking, with anticipation of continued improvements. The measures suggested some slight deterioration in Patricia's optimism (Table 22) and her general psychological health (Table 23). Her hopefulness had declined, markedly. Although, the Family Environment Scale (Table 24) located the family as independence-oriented at each data collection, there was less control and cohesion at the final data collection.

Patricia's reports on the Strengths and Difficulties Questionnaire Total Difficulties score (Table 21) placed Amy's behaviour in the clinical range with only one score in the borderline range for all measures. Things had evidently continued to be very difficult for this girl and her family.

With respect to the barriers experienced in receiving treatment, Patricia's scores demonstrated the pattern of most obstacles as the treatment had begun, rather than before or at follow-up (Table 25). Adverse life events, for example illness in a relative, had increased Patricia's determination to see things through.

The difference between the measured decline in general wellbeing and the interview data, which supported a view of general improvement, warrants comment. At the third interview, Patricia seemed much more alert, as if she had woken up from a chronic state of malaise. The clarity of mind achieved with the therapeutic contact was valued and fuelled her determination. With this alertness, had come more variation in her emotional state and a more accurate appraisal of her very difficult situation. Her measured decline in hopefulness and general psychological health reflected her increased accuracy of perception.

11.5.5 Rosalie, mother of David, aged, 9 years

Rosalie had had a difficult life, particularly in relation to her children's father. Although divorce had occurred five years previously, life was still uncomfortable with the father's inconsistent relationship with the children. She and her children were back in her own childhood home, and her relationships with her parents were often tense.

The younger child, Amelia was seven, and was finishing therapeutic work at the agency, when the troubles with her nine year old brother, David, became apparent. Despite others, especially the grandparents and the father, believing the boy to be trouble-free, Rosalie was convinced that David

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needed the sort of help that Amelia had received. Consequently, a new referral was arranged, which involved the referral and intake worker taking the unusual step of contacting the mother.

The quality of service received had meant that Rosalie was very pleased to give something back through participation in the research, but was rarely ready with completed data sets at collection. She commented at the finish about how large the commitment had been.

Rosalie's beginning with David was thus through the ending with Amelia. Amelia's clinician asked the referral and intake worker to contact Rosalie to get the referral information. This much impressed Rosalie and she felt privileged to have been treated in such a thoughtful way by the service. In fact, she wondered if she might not have cheated, in a way. Rosalie recalled the contact as efficient, helpful, and positive. For Rosalie, the importance of this event faded quickly into her many memories of the positive things offered by the service to her children, especially when the work started with a very capable clinician who was able to verify much of Rosalie's opinion and bring out other aspects as well. The specific clinician, for each of her children, was the most important part of the contact.

Rosalie was asked if she might have been deterred from referring her son. She felt that only one thing would have stopped her carrying through with the referral and that was the insistence that she attend the local clinic of the agency. She had heard stories about the service provided at that clinic that she would simply have refused to go there.

On the survey measures, Rosalie had a very positive view of reception and the referral and intake processes. Her family's life circumstances had been stabilized by the move to her parents' home (Table 20). Rosalie's son's reported behavioural difficulties had remained relatively stable, as well, with scores on the SDQ Total Difficulties (Table 21) always in the clinical range, as were his scores on the emotional problems subscale. Borderline or clinical range ratings were recorded for the

conduct and hyperactivity subscales. Rosalie reported in interview that her parents did not feel that there was much wrong with David, and this may have been reflected in his prosocial subscale scores, which were always within the normal range.

The therapeutic contact began well and continued with great improvement for the three months that the rotating registrar was able to see David. At the time, termination was felt by all to be somewhat premature, however, it was necessary and transfer to another clinician was not requested. Consequently, at the time of the final data collection, Rosalie was considering further contact with the agency.

Rosalie's state of mind was stable across the three data collection timepoints. She was moderately hopeful (Table 22) across the time, but had much lowered self-esteem at the second data collection and had become very pessimistic, but both of these had returned to average by the third contact. Her self-reported psychological health was stable across the period (Table 23), although there were mild somatic symptoms at the last contact not previously present.

A family typology was not identifiable from Rosalie's responses to the Family Environment Scale (Table 24), but the family did feature a consistently high score on the control subscale. Extrapolating from the interview data, this may have been an effect of the bind she experienced in living with her parents. She did not want her children upsetting their grandparents and was vigilant about this, but, at the same time, did not enjoy the regulated times of domestic life laid out by her parents. She wanted life to be "more spontaneous", which she recorded on her Life Events Questionnaire.

The barriers to treatment for Rosalie and David were not experienced to be much different from other of the informants as measured by the Barriers to Treatment Participation Scale (Table 25).

However, the reported barriers at the second data collection had increased quite markedly before returning to initial level.

11.5.6 Sarah, mother of Michael, aged, 11 years

The period of contact with Sarah involved two moves of address with her family of partner and four children. As contact commenced with the agency for the eldest child, 11 year old, Michael, the family moved into temporary accommodation while their house was pulled down and replaced with a larger home. Michael had developed school problems, having been popular and achieving.

The referral to the agency had been "messed up" according to Sarah. The family waited and watched as Michael's mood slowly declined. Eventually a telephone call came offering an appointment with the autism team and Sarah was both shocked and angry. She knew a little about autism as her youngest child had been slow to talk and had been referred as a three year old to a paediatrician for assessment. Sarah knew Michael was not autistic. Assertion changed the appointment and soon a psychologist saw Michael.

Sarah worked part-time as a specialist nurse. Her children all had several outside of school activities, and she had to supervise the building project, as her partner was "not good at any of that sort of thing". Sarah was always in a rush, but was always on time with research appointments and keen to contribute. She seemed keen to just talk to someone amid the chaos of her day. She was thorough and careful in completing the questionnaire forms. She was pleased with the assistance actually provided to Michael and he had improved quite quickly and had become much happier. However, the therapy ended when the psychologist left the service. At the time of the final contact, Michael's mood had again become a concern and Sarah was thinking of referring once again.

Sarah's family had stability of purpose in life (Table 20), even if the pace was hectic and there had been two changes of address. Schools, employment, and friendship groups had remained intact.

Sarah had reason to complain about the referral and intake process. However, she felt the referral call she made initially was pleasant and welcoming, and it had relieved her of concerns as to whether this was the appropriate service. The fact that her son had ended up on the wrong list for assessment irked her and, subsequently, she had run through the content of the referral call in her mind to see how Michael's name was placed on the autism list. She claimed to be able to recall much of the conversation and seemed to think it was appropriately informative and relieving of concerns.

Sarah felt that the misplacement of Michael's name had had at least two negative effects upon the family. The first was that he might have been seen earlier and difficulties may not have escalated as they did. The fact that he was able to get in very quickly once the problem had been recognized convinced her that the wait had been much longer than it should have been. Secondly, as the therapy terminated with the departure of the staff member, she felt that if he had been seen earlier, then he would not have been terminated prematurely. She could not be sure, but felt that if Michael had been given sufficient time another referral may not have been necessary, and the troubles experienced more recently may not have occurred.

These concerns of Sarah would seem to be legitimate and clearly stem from a clear problem with the procedures of the service after the referral call was completed. However, the effect of other aspects of the referral upon the case would appear to be not very great or longstanding. The referral call was remembered as positive and efficient, and without any negative factors during the time of the call. There was a considerable gap in time between the referral call and the first appointment. The time was brief between the discovery of the mistake and the provision of the appointment, so that issues about the mistake made with the referral were in part treated by the

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quick appointment. The subsequent therapy was effective and Sarah credited positive effects to this contact.

The move to the temporary rental property coincided with a change in family type as indicated by the Family Environment Scale (Table 24). Mostly scores fluctuated slightly on all the subscales of this measure, except for the family cohesion score which dropped markedly at this time, and did not recover. This moved the family from a Structured Moral Emphasis type to a Conflict-Oriented type.

Sarah's scores on the parental state of mind measures were reflective of the demands of the change of address. At the second data collection she had become very pessimistic, even though her hopefulness remained average (Table 22). Her psychological health progressively declined with depression and anxiety increasing, even though somatic symptoms declined (Table 23).

The effects of the moves were not really apparent upon Michael whose SDQ Total Difficulties score (Table 21) remaining in the normal range, as were the other subscale scores apart from emotional problems. Michael had had an emotional problems subscale score in the clinical range, which improved to the borderline range at subsequent data collection timepoints. The decision to re-refer Michael may have been warranted by his distress, but would seem linked to his mother's declined state of wellbeing.

11.6   Pain, hope, determination, stability in life, the opponent, and research participation in the case studies

Each of these families had stability in life. All informants were pleased to contribute to the research and pleased to have the research visitor, except for Rosalie and Carol, both of whom were not well prepared at the time of the visit to collect the data. But the differences between these two women were marked. Carol did not really want to participate, her children were not disturbed and

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her family was in stable economic and domestic circumstances. By contrast, Rosalie found her presence in her parents' home to be a constant, if economically necessary, challenge.

All informants were determined women, although neither Rosalie nor Carol had the routinized lives that the others had. Patricia's lack of financial and emotional resources had not impeded her ability to get things done. All women valued the service offered by the child and adolescent mental health service, although, only Carol had no cause to visit the service at any time in the future. Patricia's family had remained in contact with the service. All other mothers were in various stages of re-contacting the service with the same sort of concerns that had prompted the original referral. Three of these cases had finished prematurely due to staff changes. Mary's family had had two changes of clinician and had finished at a time when her son seemed to have stopped getting into trouble.

Only Rosalie had an opponent like those described in the retrospective study. Arguably, Carol was opposed by her husband, and felt great opposition to the maternal health nurse, but followed through with the referral that would not have happened if she had had the same sort of oppositional drive that the parents in the retrospective study had had. However, each of the women did set themselves against the perceived problem. There was something wrong with a child and they were going to get it fixed. Along with this, Mary, Anne, and Sarah seemed to have a sense of social standards guiding their determination, which provided an external measure of acceptable and appropriate behaviour and emotional experience in their children.

The pain of before that was quite prominent in a number of cases in the retrospective study was not prominent in this sample. Rosalie provided plenty of hints that she had buried pains, but these had been mostly concerning her former husband, his family, and her parents. Anne had accepted the challenge of needing to do something and had not, then, given herself worries over what to do and, therefore, had found the finding of an appropriate service not particularly difficult. Sarah was somewhat like this, although there had been doubt about the appropriateness of the service, and

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great annoyance over the extended wait for service due to the wrong waiting list for her son. This was painful, but had not been accompanied by the suffering and self-doubt in the parents of the retrospective study, beyond concern for the steadily declining mental state of her son. Carol's pain of before was not connected with her child and had not prevented referral.

Both Mary and Patricia may have had this experience, but it was not clear. Mary's taciturn manner was not easily penetrated to discover how she felt about needing to refer and about any personal doubts of herself. There had been a long history of trouble with her boys and it was, as if, one challenge faded into the next. Mary did not feel the need to disclose what happened to the father of the children. There were no men in the many photographs on the walls and she reported not having had a partner for a very long time and seemed intent on remaining independent of male company.

Patricia surely had great troubles at the time of referral. The details of these troubles were not disclosed. Like all other mothers, Patricia found it impossible to take part in the research without providing context for the referral. The sense of growth and maturity in Patricia over time, and her determination to continue what she called "difficult work", indicated a breadth and depth of problems. It was, as if, Patricia did not want to recall her past pain and that there might be danger in revealing it. This was as close to the phenomenon that had been so clear in the retrospective study with those parents who had mutually terminated. This case gives support to the idea that during the contact the extent of the prior pain cannot be acknowledged with clinicians for fear of upsetting the progress enjoyed over the course of contact. It is only after termination that the severity of the pain can be acknowledged or be fully recognized, but only if somebody can help the parents do the task of such recognition. This would explain why clinicians have never really identified this clinical phenomenon.

The question of hope and where it arose for these parents, whether before referral or within the process of referral and intake was not always clear, as was the case in the retrospective study.

Anne, Sarah, and Rosalie were confident about seeking help before the referral. Rosalie had direct experience of the helpfulness of the service. Both Anne and Sarah took a positive view on life. Mary knew she had to seek help, but probably was not very hopeful. Hopefulness about referral was not really an issue for her. Carol was not hopeful, but was more than pleasantly surprised by the service received from the clinicians. Patricia was probably hopeful as the suggestion for referral had come from an in-home family support program of a major welfare agency, and the help that had been received had been sufficiently encouraging to support mental health referral. Hopefulness grew for Patricia with ongoing contact with the service.

The measure of hope within the Attributional Style Questionnaire did not reveal much change over time, except for Patricia, although the optimism measure did fluctuate. Interestingly, hope was generally on the high side and optimism was generally on the low side. The hope measure would seem to have corresponded to the hopefulness detected at interview with the informants.

11.7   The place of the referral call in the life of the families

All of the referring parents considered the referral call a necessary administrative step. All of the parents found the referral and intake workers to be careful and respectful listeners and efficient in their work. All parents were well informed about the next steps in the contact and these expectations were subsequently confirmed. The only parent who felt that there were long-term negative sequelae of the referral process was Sarah, whose son had been placed on the wrong waiting list.

The referral call was clarifying of the need to seek help for all parents. Uncertainty about referring was an issue for all but Anne, and the referral and intake worker was able to clarify that there was good sense in pursuing clinical contact. The referral call increased confidence in the service for all parents, but was particularly significant, in this regard, for Mary, Patricia, and Carol. All three

were concerned that negative judgements of them would come from referring and all were relieved to not have been treated in this way. For Mary, her fears of blame were cleared away. For Patricia, her hopefulness was encouraged. For Carol, her fears of stigma were relieved and she was able to meet the clinicians in a positive frame of mind.

However, the effect of the referral call was reported retrospectively. Just as for the proposed rise in hopefulness that might occur after completing the referral call was not measured, other immediate consequences of the referral call were not open to documentation in this prospective study.

In summary, the referral call was an important step with special extra qualities for each family that were specific to the concerns of that family. The referral call opened the agency to the families and set up appropriate expectations of what was to follow. The relevance of the referral call faded quickly once the clinical work had begun. Further referral contact with the agency was not feared and was soon to be acted upon by several of the families.

11.8   Applicant type of participating parents

Given that all these parents, at the time of the research, presented as determined to gain assistance and open to new experience in the context of the mental health service, including participation in research, these people could all be placed in the committed category of service applicants, as described in Section 5.3. However, they may not have always been so committed. Firstly, Carol did not believe her child had a problem and did not want to refer her child, even though her husband did. Nevertheless, she was able to pursue the referral because of the reception from the referral and intake worker. Carol's was the clearest example of a case in which a skilful referral and intake worker led to an ambivalent parent becoming contained and open to further contact.

Patricia and Mary also reported being ambivalent referrers. Again skilful referral and intake work assisted the parents to become committed to the pursuing of the referral and the seeking of help. Similarly, Sarah and Rosalie indicated that they had had any doubts cleared away by the skilful work of the referral and intake worker. Probably only Anne was undeterrable, yet, she, too, experienced the referral and intake worker as pleasant, efficient, and informative.

The categories of committed and containable applicants would seem to have validity with this small sample of parents and the difference between these types of applicants revealed the skills of the referral and intake workers. Of importance were pleasantness, efficiency, informativeness, respectfulness, and the willingness to listen. These parents all reported the value of expectations of the next procedural steps being set with accuracy by the referral and intake worker.

While this can hardly be considered a proof of the validity of the categories, their basis in the literature and the discriminative value with these few cases, suggests that referral and intake workers may find the distinction one that could support the effectiveness of their work and allow a better understanding of the special skills needed to work with applicants who might be containable.

11.9   Review of the expectations

The expectations for the prospective study, outlined in Section 7.6.2 of Chapter 7, are reviewed under sections relating to the six broad domains of expectations, of the overall process, the parents, the clinicians and the directors, the referral and intake workers, the phases of contact, and to emergent findings.

11.9.1 The overall effect of the referral and intake process

The effect of the beginning processes did decline over time (Expectation P1.1). The effect was not one of simple degrading; rather how the process was viewed produced a qualitative difference

between informants. Those who regarded the referral call as a necessary administrative step did not see any effect coming from the call, beyond this fact. Those who were reluctant or wary of stigma regarded the referral call with great importance, even if the importance did degrade for some while for Patricia, the step remained a high point.

All parents described an effect of the referral call upon subsequent contact (Expectation P1.2), although for some it was only of administrative importance. The parents reported effective and pleasant beginning transactions and encountered little to put them off, despite one parent's child's placement on the wrong waiting list. As parents arrived with a very committed and determined attitude, a link between positive attitude to a service and a subsequent positive attitude toward treatment cannot be claimed or disconfirmed. The connection between negative beginnings and subsequent negative treatment interactions could not be explored.

11.9.2 Parents

Parental ambivalence (Expectation P2.1) about referral was expressed by all parents, but with varying degrees of complication. Rosalie was basically positive, even though she did not like the fact that her son needed such help. Sarah and Anne were keen for help, even if they did not really want to go with the process. Mary and Patricia were basically daunted and concerned about being stigmatised. Carol was against referral as she saw it as unnecessary and was also worried about revisiting her previous post-partum depression. Negative attitude did not deter any of these parents (who were so keen for service that they were willing to participate in the research).

Due to the lack of a first data collection, the expectation concerning parental health and referral of a child (Expectation P2.2) was not explored. However, the three parents who were considering re-referral at the final contact (Anne, Mary, Sarah) did have impaired health at this time, even though

their son's level of difficulties were not greatly changed, from time of the first data collection. It would seem that maternal health was a factor in precipitating re-referral.

Decreased levels of difficulties in the children, as reported by the parent, (Expectation P2.3) were not evident for five of the six children. This may have been an effect of curtailed therapy in four cases.

Barriers to treatment participation (Expectation P2.4) did show the expected trend of increase then decrease, in the measured levels of barriers in four of the cases. This sample had few current adverse life events, and those that did occur did not deter attendance, and in two cases provided motivation to continue. Instability in life (Expectation P2.5) was not evident among this sample of families and neither was discontinuance able to be explored.

The Family Environment Scale did not show great change in these families on any scales. Mostly, families remained within the original family typology. The subscale measure of cohesion (Expectation P2.6) did show movement for the families of Anne, Patricia, Rosalie, and Sarah. Anne's family cohesion improved after the father had lost his job, whereas the other families experienced decline in cohesion for case-specific reasons. The connection between lowered cohesion and referral cannot be sustained on the basis of this data.

Parents showed allegiance to the agency through its specific employees, but showed no allegiance to other families or to consumer objectives (Expectation P2.7). The simplest description of all the parents, as a collective, would be that all perceived that their child and themselves needed help. This is a position more akin to that of a patient.

11.9.3 The director

The clarity and depth of discussion about referral and intake policy and procedures encountered in the retrospective study was not evident in the prospective study (Expectation P3). The referral and intake team was larger than at either of the previous services and a manager, the coordinating referral and intake worker, had been appointed to oversee this work. The director viewed the coordinating referral and intake worker to be effective and, therefore, the director's intervention was rarely required. However, he did emphasize two important principles. Firstly, he required that referring parents needed the referral and intake worker to listen very carefully to them. Secondly, he considered that referring parents needed to be helped to feel that they had a place within the agency.

11.9.4 Referral and intake workers

The referral and intake workers did give a clear account of their work (Expectation P4) and the practices they described reflected those documented in the retrospective study. In fact the detail collected indicated that further analysis of the interview data and follow-up of certain aspects was warranted. The rationale and findings of this further exploration are presented in Chapter 12. All the other referral and intake worker expectations were confirmed and are reviewed, in depth, in Chapter 12.

11.9.5 Phases of contact and discontinuance

Parents did not report on the phases of contact in any great detail (Expectation P5.1). However, the timing of data collection points was such that the separate sorts of relationships that families have with agencies as contact continues were certainly recognizable. Families noted the differences between referral, the first interview, the assessment, and the planning for, and implementing of,

therapy. These phases were experienced by them as different and the differences were due to the change in task.

Discontinuance was not directly explored in this study (Expectation P5.2 and Expectation P5.4).

The finding from the literature enquiry of the present research that applicants can be characterized as committed (Expectation P5.2) was supported. However, because data could not be collected before the first assessment interview as planned, it is not clear if any of the applicants were of the containable category at the point of referral and intake. Nothing can be said about the crisis-reactive category, as none of this type of parent applicant was interviewed.

The parent informants were committed clients of the agency when they agreed to participate in this research. However, it is likely that Carol, Mary, and Patricia were originally of the containable category, and became committed through the initial referral and intake processes. Carol's case is probably rather extraordinary in that it was the husband who insisted on attending for appointments and volunteering Carol for the research. In her mind there was no problem, but her commitment to her husband and her child, eventually took them all to the first interview. After the second contact no further contact was needed. The containment of Carol came from mostly outside the referral process and largely within herself, although the sympathetic hearing at referral probably helped in a small way. Both Mary and Patricia were fearful of being stigmatised or mistreated prior to their referral call. By the time they had their first interview they had become committed clients. Both valued the referral call.

11.9.6 Emergent findings

The importance of the emergent findings of the retrospective study concerning hope, the pain of before, determination, and the opponent were confirmed by the prospective study, although the pain

of before may be an active issue in only some cases, or may only be identifiable in retrospect. The retrospective study finding that parents with children with developmental problems were more likely to participate in the research was not confirmed, but variations in the method of recruitment and the clinical populations preclude any definite statements about such a proposition.

The emergent finding from this second enquiry was that further review of the referral and intake worker interview material was warranted and is reported in Chapter 12.

11.10   Summary

Referral and intake processes were found in this prospective enquiry to be of varying degrees of importance for the families, varying from administrative, in some cases, to formational, for other cases. Parents observed the processes of referral and intake to be carried out professionally and compassionately. Parents in this study and the retrospective study recognized the phases of contact. Very little can be said about whether the transfer, from the referral and intake phases of contact to the assessment and treatment phases, was facilitative of subsequent contact. The practices of referral and intake workers were brought into light by each of the three studies and the set of conclusions has warranted closer attention.

The parametric measures did not lead to conclusive findings as the sample was small and non-representative. However, certain trends in the literature were probably present for the surveyed samples. Stability in life seemed to have made attendance more likely, but no evidence was collected that could link non-attendance to instability in life. Trends in the parametric data were similar to other literature trends: that disturbed children get referred, that referral may be made when the parent is unwell, and that barriers to treatment participation increase in the early stages of contact and then decline. By contrast, a connection between cohesion measured on the Family Environment Scale and treatment continuance was not evident.

Several issues were not addressed in the prospective study because of problems of recruitment at the beginning stages of contact and of the size of the sample. For instance, no expectations concerning discontinuance could be pursued. Also, the list of tasks established in the retrospective study was not addressed. This will be pursued in the further enquiry of referral and intake worker interviews presented in Chapter 12.

CHAPTER 12

FURTHER ENQUIRY CONCERNING THE REFERRAL AND INTAKE WORKER ROLE

Asking applicants at intake about their expectations regarding the problems
and difficulties of using the agency's services and clarifying these
expectations with them may prove useful for achieving an initially better
motivated caseload. (Krause, 1966, p. 519)

It would be interesting to objectively determine those variables which lead
referral and intake workers to assess whether a client is motivated, and then
to see how these variables relate to defection (Gaines, 1978, p. 60).

Buried in the literature are odd comments that illuminate aspects of the child and adolescent

referral and intake worker role. Similarly, buried in the text of the interviews from the empirical

studies used to map the practices of the work, and the effects that such practices have on

subsequent clinical contact for the family, were comments that illuminate the general functioning of

the referral and intake workers in their role. As concluded in Chapter 6, no study in this area has

resulted in the construction of a comprehensive map of referral and intake work in child and

adolescent mental health services. It was also concluded that such a gap conditions the dearth of

understanding of the potential significance of the referral and intake worker role in service

processes and outcomes.

The data analyzed thus far concerned specific cases and their progress as described by parents in

both studies, and by clinicians in the retrospective study only. In both studies, referral and intake

workers had provided comments about their general functioning. It therefore seemed useful, as a

fourth project within this research, to re-visit the interviews conducted in both retrospective and

prospective enquiries, especially those with the referral and intake workers, and to draw together

the information embedded there. It also seemed that it would be useful to conduct follow-up interviews with the particular referral and intake workers of the retrospective study to confirm the integrated information. Consequently, the data from the planned empirical studies were supplemented by additional data collection.

After crystallizing the specific aims of this additional enquiry, this chapter describes the method employed to assemble the data relevant to the proposed attempt to map the referral and intake worker role. It outlines the method by which the analysis of those data was conducted. The findings of this analysis are then presented. It was possible to identify the role of the referral and intake worker in making the organization ready to receive referral calls, in receiving referral information, in providing information and deciding upon further actions, and in processing the information after the referral call is complete. This further enquiry thus affords a fuller account of the mechanisms of referral and intake work.

12.1   Aims of the further enquiry of the referral and intake role

This further enquiry into the referral and intake worker role aimed to

1. examine the data collected on the general functioning of referral and intake workers not analysed from the retrospective and prospective studies,

2. integrate collected data with the findings of the literature review upon the general functioning of referral and intake workers,

3. consider if these integrated findings on the general functioning have a pattern or structure,

4. empirically explore aspects of the general functioning and any inferred structure with the referral and intake workers of the retrospective study, and

5. analyse and interpret the relevance of any inferred structure to the experience of referral and intake workers as already reported.

12.2   Method

Flowing from the aims, four steps were involved in conducting this further, integrative enquiry. The informants for this further enquiry included all previous informants, but with the addition of follow-up interviews with the referral and intake workers of the retrospective enquiry. Firstly, the existing findings of the literature review and the previous two studies were drawn together to help construct an interview protocol. Secondly, the interviews were conducted with the coordinating referral and intake worker from each of the two agencies where the retrospective enquiry had been conducted. Thirdly, unanalyzed comments upon the general functioning and role of referral and intake workers from the parents, directors, clinicians and referral and intake workers of the initial empirical studies were now analyzed, along with the data from the follow-up interviews. Fourthly, the list of practices, attitudes and approaches of referral and intake workers summarized in Tables 4 to 7 of Chapter 9, were reviewed, added to from the findings of the prospective and further enquiries, and then, by reason of similarity, reduced to a comprehensive list of separate items of activity. Following this, an integrated synthesis of all the data allowed for an interpretation of the clinical thinking of referral and intake workers and the location of the referral call within the life of the agency.

12.2.1 Design and conduct of the interview protocol

A new interview protocol was developed for this enquiry. The protocol was partly designed on the basis of the literature presented in Chapter 6 concerning the referral and intake worker role, and partly on the basis of unanalyzed data from the empirical studies concerning the general functioning of the referral and intake worker. Two metaphors found in the literature were put to the referral and intake workers as potential summary statements of their work. One metaphor was

Brown's (1993) analogy to crime mystery fiction. The second metaphor concerned a thinking strategy, which used analogues of menus for action within the process of receiving a referral.

In the course of the prospective study, after the decision to not recruit at the time of the referral telephone call, the agency's referral and intake staff remained keen to contribute to the study and wanted to be interviewed about their work. The answers received were general, as they could not be attached to particular cases that were being followed in the prospective study. Previous interviews had also involved more general observations. The prospective study referral and intake workers were able to comment on notions that had been located in the literature. It became apparent that the specific case focus of the empirical studies had narrowed appreciation of the broader referral and intake role. It was decided to describe all findings to the two retrospective study referral and intake workers, and to gain their perceptions upon the view of their role emerging from the research.

The interview protocol designed on these bases is presented as Appendix E3 and focused upon the following domains:

- skill bases and occupational backgrounds,

- innovations, described in the international literature, employed by referral and intake workers in other child and adolescent mental health services,

- referral and intake tasks and the steps in the process,

- menus for decision-making and clinical thinking,

- the organizational place of the referral call, and

- the typology of referrer applicancy.

The follow-up interview was then conducted with the retrospective enquiry referral and intake workers. An invitation to participate letter was provided to them, as presented in Appendix E1. Signed consent was received through the form presented as Appendix E2. Audio recording of these

follow-up interviews did not occur, but notes were taken and later written up in transcript form, as shown through one page presented as Appendix E4.

12.2.2 Analysis and synthesis of the data

Using the domains of the protocol for the follow-up interviews, described above, all interview protocols including those of the retrospective and prospective studies, were reviewed. Of most interest were the interview data provided by the referral and intake workers of the prospective study and the follow-up interviews of the referral and intake workers of the retrospective study. A total of fifty sets of interview notes or transcripts were inspected to gather data for this enquiry. Then these data were analyzed for themes. The data coding domains developed in the retrospective study and refined in the prospective study were expanded to include codes concerning occupational background, day-to-day functioning, and organizational communication. Eliminating similar code descriptors produced the comprehensive list of activities.

Over time, the research process moved from analysis of transcripts to synthesis of the various categories of experience into an integrated model of the tasks, practices, organizational place, and occupational origins and skills of referral and intake work. The design of the follow-up interview protocol provided the impetus from data analysis toward what became an interpretative process.

12.3   Integrated findings concerning the referral and intake role

Analysis of the overall data located opinions of referral and intake workers concerning seven different aspects of referral and intake work. These were:

- the skill bases of referral and intake work, including triage as referral and intake work analogue, occupational backgrounds, and role autonomy,
- referral and intake role innovations,

- the tasks of referral and intake work, the flow of the process and its punctuation by referral and intake worker action,

- the structure of referral and intake action,

- the place of the call in the life of the organization and the families,

- the overall place of referral and intake within the organization, and

- applicancy and prediction of discontinuance.

12.3.1 Skills, training, and teamwork: The work life of referral and intake workers

On the basis of all interviews with referral and intake workers it was clear that the referral and intake workers regarded themselves as multi-skilled, clinical professionals with well-developed listening skills. This was the domain that accounted for most of the unanalyzed interview data of the prospective study. Differences between the skill bases of the several referral and intake workers interviewed were apparent, and seemed connected with the occupational background of the workers and the limitations of role designated by the agency. These issues were connected with the degree of professional autonomy able to be exercised within the referral and intake role.

Overall, the work is demanding intellectually, which the referral and intake workers appreciated and enjoyed. It was found that part of the challenge is to listen, part of the challenge is to supportively limit, and part of the challenge is to work out, sufficiently well, what has been going on, in order to provide support and a decision on the suitability of the referral. Questions need to be framed carefully to achieve these objectives.

12.3.1.1   Basic skills

Listening and communicating skills, according to the referral and intake workers, are the first necessity of the job, but knowing how to limit the need for talking that referring parents have, is

almost as necessary. The skills are basically those of the telephone counsellor with specialist knowledge of child and adolescent mental health services, and specific knowledge of community and referral networks, as was specifically stated by the coordinating referral and intake worker from the retrospective enquiry who had done telephone-counseling training.

Limiting of the referral transaction was reported as mostly achieved by observing the limits of the role and, especially, by not moving into a therapeutic mode. The referral and intake form was seen as providing the referral and intake worker with direction in seeking information, and confirming the depth and breadth of the answers sought. The referral and intake workers believed that, usually, it is not possible to solve problems over the telephone.

12.3.1.2   Descriptive metaphors of referral and intake work

In the interview, as outlined above, two metaphors to describe their work were put to the referral and intake workers. The first was Brown's (1993) analogy with crime mystery fiction, where the reader and the antagonists are continuously in a position of having an incomplete picture, but knowing that clarity will emerge through the ongoing narrative of the transactions. This was mentioned and was interesting to the referral and intake workers interviewed in all three studies, but they considered themselves to be collectors of information rather than as solvers of a mystery.

The second metaphor was a thinking strategy analogous to computer drop-down menus for action, which gained the immediate interest of one referral and intake worker during the prospective enquiry interviews as the idea was being formed, and firm confirmation at the follow-up interviews. The referral call proceeds until a point of issue, which triggers a change in direction. Experienced referral and intake workers inspect an internalized list of options, select an option, and then proceed to a new set of enquiries based on the selected item. The referral and intake workers were attracted to this metaphor as it described well how their work was punctuated, and how their work involves

thinking and choices. However, the referral and intake workers also wanted to hear the parent's story and the story of the problem. They do not know ahead of time which menus for action will be used, but they know which ones to use when the transaction arrives at a point for decision.

12.3.1.3   Autonomy and collaboration

The referral and intake workers interviewed for the retrospective study liked their professional independence. Both had been lone workers for a long period of time, although recently before the retrospective study, one of the agencies had expanded the referral and intake role by creating a further half-time position. Both described a sense of belonging to the clinical teams with whom they met each week. Both described having the respect of their clinical colleagues and received little negative feedback.

The interviews of the three referral and intake worker informants in the prospective study agency revealed shared themes. There was enjoyment of the autonomy of the work and the capacity to carry something through from beginning to end, and pleasure in the gratefulness of the referrer. There was an orderly daily routine of starting and finishing and not having to take work home, mentally. After nearly two years together as a stable team, they were still enjoying being able to learn from each other by sitting near to their colleagues during slower periods and listening to how the other works. But the sense of connectedness with the clinical teams was not like the other two agencies.

The coordinating referral and intake worker described how difficult it was to communicate with the clinicians who were not on the same campus, and the lack of incidental contact to nurture work relationships with them. There were few instances of positive feedback received by this referral and intake team, and frequent incidents of negative feedback. Referral and intake work was only

felt to be visible to clinicians when the clinicians wished to question a referral and intake workers judgement.

By the time of the follow-up with the first referral and intake workers interviewed, both agencies had now expanded their referral and intake teams by a further half-time position. The coordinating referral and intake worker, who had had half-time assistance, now had two half-time referral and intake colleagues, which she said worked well. Originally, she had not reported receiving negative comments about the referral and intake work, but now it was more common. Further, positive comments were not as frequent as previously. Clinicians would sometimes initially doubt the appropriateness of crisis appointments, but would agree with the judgement after the consultation. The size of the team seemed to increase distance between the work of referral and intake and the other clinicians. The other coordinating referral and intake worker, who had been a lone referral and intake worker, had had assistance for two years, but his esteem in the agency and that of the referral and intake work remained, as it had been, with the two clinical teams. In one of the agencies each of the two referral and intake workers had part-time clinical loads on a team, which lessened distance between the referral and intake and clinical functions.

12.3.1.4   Occupational background

The referral and intake worker role was reported consistently to have the advantages of professional autonomy, collegiate teamwork, and regular hours. However, the paths to taking up a referral and intake work position involved choices that were very different according to occupational background. These differences were predicted in the literature survey in Chapter 2, which located the histories of mental health nursing and of social work as having shaped the role characteristics of referral and intake work in specific ways. A division was evident between those referral and intake workers who were trained mental health nurses, and those referral and intake workers who had

university education. This was most apparent in the use of the term triage to describe referral and intake work.

The mental health nurses readily identified their work as triage. The coordinating referral and intake worker at the prospective study agency, a social worker, distinguished the role markedly from triage, even though friends would use the term as means to understanding what she did. The teacher trained coordinating referral and intake worker and the occupational therapist agreed that the term triage could be used, but felt that referral and intake work was really something different. This confirms the proposition generated within the literature review, in Chapter 2, that referral and intake work has little in common with triage, but for nurses, where triage is a part of training, the term was likely to be used (Kevin, 2002). Triage sounds like a professional role, whereas referral and intake worker does not have the same clarity of status.

The occupational therapist referral and intake worker agreed that social workers and mental health nurses were often in the referral and intake worker positions in child and adolescent mental health services, although there was nothing inherent in the positions that required specialized experience with child mental health. For the occupational therapist, the work was about involvement without overnight responsibility. The coordinating referral and intake worker reported being attracted to the work because of the capacity to be close, but also distant from hard cases. The mental health nurse colleague reported wanting more autonomy, but had wanted clinical work that did not involve overnight concern or rosters.

The coordinating referral and intake worker at the agency which had designated the referral and intake role as administrative, was different to the other referral and intake workers interviewed, as she did not have a clinical background or a clinical caseload. She had training as a secondary-school economics teacher and telephone counsellor. The previous encumbent, a skilled administrator, had shaped this position, with clear limits on clinical involvement, and emphasis

upon supportive listening. The director and team leader emphasized that the role was to take referrals, as intake was a process owned by the clinical teams. These limits defined the place of referral and intake work in clearer and more professional terms than was evident at the other agencies.

At follow-up, the coordinating referral and intake worker spoke of several years of trying to select and train other referral and intake workers, and had come to the conclusion that those best suited to the role were university graduates, but not clinicians. Recently, the agency had agreed to include a bachelor's degree as a basic qualification within the job description. University training, according to the coordinating referral and intake worker, ensured greater mental flexibility and a willingness to use initiative. People from secretarial backgrounds who had occupied the part-time positions in the past required too much direct supervision.

Clinicians were rarely suitable for referral and intake work, as they would try to solve the problem and would spend a lot of time listening. A child psychotherapist at this retrospective study agency was not very efficient as a referral and intake worker and found the experience unsatisfying. The prospective study agency referral and intake workers reported similar troubles when clinicians relieved in referral and intake work positions.

In the experience of the coordinating referral and intake worker with teacher training, recent fourth year psychology graduates were often best adapted to the work because they had training in listening skills and data entry and analysis, with sound keyboard skills. She reported that young psychology graduates saw referral and intake work as a potential pathway to employment in a clinical position and were highly motivated to do well. One of the clinicians at the other retrospective study agency had, indeed, taken this path into her position, by working in referral and intake work in a rural setting.

The skills of the psychology graduates point to other changes that are likely to become manifest in referral and intake work. Changes in technology might change the training requirements for referral and intake workers. For instance, the referral and intake workers at the other agencies did not direct key referral data, preferring to take notes and enter information into the database at the end of the referral call. Data entry was usually regarded as a minor part of the task.

Finally, it should be noted that dedicated referral and intake worker positions are a fairly recent innovation within child and adolescent mental health services, in Victoria, Australia. Two of the coordinating referral and intake workers interviewed actually established the role, and one of them had expanded it from that established by the previous occupant. Although referral and intake work has existed from the beginning of the child guidance movement, the attributes and skill base of the dedicated referral and intake worker may yet still be emerging, balancing listening skills, mental flexibility, and knowledge of community resources.

The interviews pointed to two other important and linked qualities, namely acceptance of the constraints of the role and enjoyment of the work within its day-to-day functioning. The constraints were reported as flowing from its beginning in clinical contact, with little prospect of knowing what happens for the family beyond the period of waiting for an appointment. The period of contact could be as brief as a few minutes, but also could involve several contacts over time and an initial phone call of over half an hour. With these constraints, however, were regular office hours, few overnight concerns, autonomy to act, close contact with vulnerable but courageous people, few long-term case commitments, and collegial support. There are other negatives to the role such as physical confinement, but the longevity of all three coordinating referral and intake workers suggests that referral and intake work can be experienced as a very interesting and satisfying occupation.

12.3.2 Practice innovations to improve the referral and intake process

In the interviews with referral and intake workers, comments were also offered about innovations to improve the work. Often this would lead into the discussion of referral and intake process innovations raised by the international literature. Group orientation meetings, attendance reminders personal, mail, or video information services, and the filling out of questionnaires by mail or in person prior to initial attendance were all discussed. However, these were not considered to be viable given the need to be at the desk ready to receive referral telephone calls.

Pre-appointment group meetings were considered worthwhile, but hard to arrange given the current work and resources. Orientation videos were considered worthwhile, too, but were felt to be the responsibility of specialized health promotion professionals, who had become part of the professional profile of child and adolescent mental health services over the period of this research. Client advocacy was already part of the work when referrals were passed from the referral and intake team to the clinical teams, but consumer advocacy was thought to be appropriate for the consumer advocates. Improved technology had helped the work of the current referral and intake workers, but not all were keyboard competent, and they were not inclined to become touch typists, as they considered data entry to be a minor aspect of their role.

The mental health nurse referral and intake worker at the prospective study agency advocated that referral and intake workers could have a role in providing face-to face interviews with crisis and urgent cases, at least as a screening process. This has been a practice in other places, internationally, but not in metropolitan Victoria in recent times. She did not consider that this change was likely to occur in the near future.

The coordinating referral and intake worker who operated within administrative limits was the most open to innovation and held orientation meetings for referring professionals, but, although

interested in extending these to potential clients, was aware of the resource implications. The coordinating referral and intake worker who had other clinical as well as referral and intake responsibilities was less interested in innovations than any of the other referral and intake workers. Overall, attitudes toward innovations were not particularly positive, even if there was interest to move away from the static physical positioning of referral and intake work. Knowledge of the actual tasks of referral and intake work seemed to limit the desire for innovation.

12.3.3 Referral and intake action

Overall, among the many attitudes, approaches, tasks and options that are enacted during a referral call, analysis of the referral and intake workers' comments, along with those of parents, directors, and clinicians, identified categories of action or features of action, which, when reduced by reasons of similarity, produced a list with a total of 89 different items. This list is presented as separate, chronologically different, tables in Appendix E5.

In turn, this list of tasks, practices, and other aspects of referral and intake work, developed by iteration over the course of the three empirical enquiries, led through analysis and synthesis to the construction of a model of referral and intake worker clinical thinking. This cannot be considered a complete model of thinking, as each agency has its own special requirements, and there are particular activities associated with special interest groups like indigenous or non-English speaking families, or specialist teams focusing on particular developmental problems.

The list of referral and intake practices pertain to different phases of referral action. The role functions or practices of referral and intake within each phase are listed in tables in Appendix E5. In the following sections, summaries are provided of phases of action within the worklife of referral and intake workers, especially with regard to the chronology of events surrounding the receiving and processing of telephone referrals from parents. Of course, referrals are received from

community agents and professionals, but the process with such referrals still require parental confirmation and it is the parent referral information that structures the largest and central part of the work of referral and intake.

12.3.3.1 Pre-call readiness

Pre-call readiness is an active state whereby the child and adolescent mental health service is organized to receive referral enquiries at any time during the working hours of the agency. Aspects of pre-call readiness listed in Table E5-1 of Appendix E5 include policy (high priority of the service), attitudes (beginning trust), role description (dedicated referral and intake worker), and network tasks (community resources guide). Aspects of pre-referral readiness in this table are nested in terms of importance, as expressed by the referral and intake workers. It was important to have somebody ready to receive a referral call. The consequences of having somebody in such a position included specialization and the establishment of community network liaison. The nesting of less important issues within broader policy guidelines may represent an implicit policy hierarchy, where accessibility and continuity of contact for referrers is foremost and community connections provide support for the primary purpose. This would fit with how each of the directors of the three agencies described their referral and intake service.

12.3.3.2 The clinical stance of the referral and intake worker during the telephone call

Referral and intake workers described bringing a certain approach to each referral call, which was a communicative stance occupied throughout the call. The approach involved the recognition of the importance of the first contact in the person's life and in the processes of assessment and treatment, and involves the task of interviewing. The during call approach items presented in Table E5-2 of Appendix E5 concern issues of complexity and value that require the referral and intake worker to have a deep thoughtfulness about personal values and the practicality of such values in difficult

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emotional circumstances. The approach items include, first, values and knowledge that guide the professional action listed in the during call tasks in Table E5-3 of Appendix E5. For instance, the stance of the referral and intake worker is empathic, involving listening and communicating that the referring parent has been heard.

Table E5-3 of Appendix E5 consists of a chronological listing of procedural steps performed in the course of a referral. Not all the tasks have specified ordinal places, although the placement on the list does indicate the approximate chronological position of the task. The order of these tasks, during the course of the work, is probably dictated by the referral and intake form, but the list as a whole, demonstrates the complexity of the overall task. Remarkably, in the course of a referral call of varying length, 10 minutes to half an hour, 25 specific practices are enacted in order, punctuated with seven other necessary practices.

When the referral call has concluded, the referral and intake worker has a number of things to do that are guided by attitudinal factors and options for further action within the agency, as the case is handed on to a clinical team or referred elsewhere. The attitudinal approach factors concern matters of policy, such as 'smooth progression' and 'team leader supervision'. The tasks, displayed in Table E5-4 of Appendix E5, are several, varied, and some of which have a definite order. Table E5-4 displays specific practices involving the mail out of information, decision making on disposition and urgency, and attendance for presentation to, and feedback from, the clinical teams. There are also general sets of tasks that are dependent upon the outcome of the referral call, such as appointment urgency and consultation with the team leader.

Referral and intake workers did not mention the task of monitoring rates of referral and the checking of referral and intake forms for accuracy of information. The closest to describing the task of checking was brief reference, by one coordinating referral and intake worker during the follow-up interview, to finishing off the referral and intake form, printing it out, and sending it off

after completing the call. Checking would seem to be one of potentially many more tasks that referral and intake workers perform, but during the interviews was considered too mundane or obvious to report.

The final items involving referral and intake work, as indicated in Table E5-4, are about the subsequent contact by the clinician of the parent. The case can be registered if the family attends the first interview, but other plans need to be in place if the appointment is not attended. The allocated clinician is in charge of this process, but, until registration, the referral and intake worker retains a watching brief over unregistered referrals.

It is apparent that many of the tasks of referral and intake are arranged chronologically in the mind of referral and intake workers, even if specific activities have qualitatively different functions. Also, the referral and intake workers would represent some of the functions in parallel. This would probably create difficulties in the training of referral and intake workers as the chronology would not be clear and the juxtaposition of tasks, attitudes, and options would be very confusing at first. Yet training does occur and discussions between referral and intake workers do lead to sequences of sensible action that incorporate parallel activities.

12.3.4 Building of a model of referral and intake clinical thinking

The data received by referral and intake workers is complex and disorganized. Each referral call was felt to be unique and required access of many different sources and sorts of information. Yet, the referral and intake workers described a rather steady process of conducting referral interviews, with a reliable outcome. This suggests an internalized model for processing the incoming information. The interview descriptions were brought together and synthesized to build such a model of referral and intake clinical thinking and is presented in Table 26, on page 344 below.

Table 26

Representation of seven phases of referral and intake contact and menus for action accessed during each phase

			CONTACT PHASE				
	GREET	**SCREEN**	**ASSESS URGENCY**	**OTHER AGENCY INVOLVEMENTS**	**PROBLEM DESCRIPTION**	**INFORMATION PROVISION**	**CHECKING**
CONTENT OF DISCUSSION	*What's going on *Who suggested *Why child and adolescent mental health	*Age *Address *Contact means *Phone *Gender *Ethnicity *Family members *School *Work	*Why call now *How long problem *How long acute *What tried *Others contacted	*Been elsewhere *Know of local agency *Tried local agency *What happened *Other agencies *Other supports	*Legal issues around problems *Symptoms *Duration of symptoms *Trigger events *Effects upon others *Family *School *Agencies	*Location of service *Transport access *Information to be sent *Forms to be returned *Appointment arranging *Clinical process steps *Waiting period *Other referral options *Re-contacting if need arises	*Caller's mood *Caller's understanding *Reason for referral *Disposition decision *Information received *Further contact *Appointment *Access *Supports *Action plan
PROTOCOLS ACCESSED	*Referral and intake form	*Indigenous *Disadvantaged group *Second language difficulties	*Crisis	*Agency directory *Specific agency referrals	*Legal issues *Diagnostic signs	*Mail out information *Other agency information *Waiting list or period	*Referral auditing *Clinician availability
ACTION OPTIONS	*Referral and intake form begun	*Continue intake *Refer to other agency	*Crisis roster *Refer to Emergency department	*Accept referral *Refer to other agency	*Complete referral and intake form	*Prepare mail out	*Process successive steps *Refer to Team or Clinician
NEXT STEP	Screen or Urgency	Urgency or Other agency	Problem description or Other agency	Problem description or Information provision	Information provision or return to Urgency	Checking	Proceed to end call and begin data entry

Referral and intake workers operate at several concurrent levels as they negotiate the steps involved in referral and intake. There are definite steps and there are alternate action points in a referral call. These can be summarized as greeting, screening, assessing urgency, considering contacts with other agencies, collecting specific data, providing information about the agency, and then checking details. The concurrent levels involve agency readiness, attitudes and values of approach to the referral and intake task, and alternate paths of enquiry on specific issues applicable to small numbers of cases, such as language status, legal issues, or crises.

Therefore, the items relevant to referral and intake work involve a foreground sequence that is largely driven from the referral form. In the background is a range of readiness and attitudinal attributes, which colour the transaction and support meaningful enquiry. Thirdly, there are issues that arise that are orthogonal to the sequence of steps.

Referral and intake workers described a tension experienced between the need to let a parent describe the issues in their own words and at their own pace, and the need to complete the intake form through an orderly unfolding of steps that also led to closure of the referral call. This characteristic of steps, flow, and orthogonal subordinate tasks, was tentatively conceptualized by the researcher as a series of menus for action and was suggested to the referral and intake workers in the follow-up interview. Each of the referral and intake workers instantly agreed to this suggestion. This generated a new model of the flow of the referral and intake process that is presented in Table 26.

Table 26 presents the seven steps involved in referral call contact as occurring as chronological phases across the table. However, progression across the rows in the course of a referral call need not be direct, as particular pieces of information can lead to jumping forward or going backward or pursuing

tangents. Each phase has particular issues, which can call forth specific protocols for information seeking, for potential action, and for a range of subsequent steps. The information seeking protocols are presented at the second level (third row) of Table 26. The protocols for actions are presented at the third level (fourth row) of Table 26. The fourth level (fifth row) of Table 25 shows options for progression to the next step in the referral call process.

Table 26 is a proposed model of how the 89 items of referral and intake worker practice identified in the empirical studies fit together over time and at different levels. However, many items are not included in this table. The organizational readiness and attitudinal approach variables cannot be displayed in a chronological timeframe, as these are omnipresent. Similarly, some of the post-referral call items are not displayed as these involve ongoing tasks or involve specific chronological tasks that were listed in Table E5-3 of Appendix E5. Also, discussing and debriefing after a referral call as a form of professional development, shared learning, and collegiate monitoring are important tasks not represented on Table 26.

12.3.5 The organizational place of the referral call: A fresh interpretation

Throughout the interviews with both referral and intake workers and with parents, the referral call seemed to have special significance. Although the call was a transaction between two people, it was as if the call was a separate social space and signified a point of punctuation in the flow of life. Asked to remember the call, some parents would display a satisfied and happy smile, and recall details of the transaction that were about interpersonal issues. When referral and intake workers were asked to give instances of certain issues, they would usually begin with a statement like "there was one call from …". This quality of a unique transaction, detached from family life and from subsequent clinic

contact, was a challenge to represent, but is presented in Figure 3, below.

Community relationships and knowledge of child & adolescent mental health agency

PARENT

Referral pathway directs parents to child & adolescent mental health agency

Maintain liaison with agencies

Referral and intake worker available to receive call

Maintain agency directory

Contact with Crisis Response team or Emergency Department

call

Contact with Teams and clinicians

Contact with agencies, GPs, Schools, etc.

Figure 3: The place of the referral call in the life of the parent, the community, and the referral and intake worker

A diagram was presented that had been constructed on the basis of Freestone's (1994) report of the Royal Children's Hospital Telephone Information Service, as Figure 2 in Chapter 6 on page 162 above. This diagram was used to develop Figure 3 above, which provides an ecomap of the place of the referral call in the work of the referral and intake worker, but also, in the life of the family, the child and adolescent mental health service, and the community and referral networks in which the transaction is embedded.

The referral call is placed near to the centre of the ecomap, but more than halfway down, as the vertical dimension of the ecomap indicates the passage of time. Chronologically, the call exists after a whole range of community and referral networks have been established, partly by the direct action of referral and intake workers and partly by the pattern of formal and informal contacts that exist in the community. This network provides an impetus for worried parents toward referral of their troubled child to a local child and adolescent mental heath agency.

In Figure 3, the referral call then acts to coordinate a range of potential responses from the agency and contact is established between clinicians, the family, and the supporting referrers. The referral and intake worker withdraws and the clinical work begins. The call remains significant to the parent and the referrers, and to the referral and intake workers, perhaps. Nevertheless, the call is barely noticed by the clinicians, who begin their work by looking forward from the time of the first interview, and review the past as if the parent had directly approached the clinician. Thereby, the content of the referral call becomes lost to the clinical process.

12.3.6 Overall place of referral and intake work within the organization

The ecomap that is Figure 3 confirms the paradoxical visibility of referral and intake work. To the outside, the referral and intake worker is a clearly identified agent of the child and adolescent mental health service, highly visible and expected to receive all kinds of commentaries upon the work of the agency. Within the agency, however, the work cannot be recognized consistently by the clinicians. When there is a problem, interaction between clinician and referral and intake worker can occur, otherwise they exist in different task spaces. This was represented in Figure 1 of Chapter 5 on page 136, which by emphasizing the process phases of contact obscures the importance of referral and intake.

The ecomap has a major flaw in that it suggests constancy in the connections drawn. In fact, the only constant in the ecomap are the referral and intake workers. The community is not homogenous or stable in its connections. Referrers change, and their view of the agency changes, with each referral and its degree of success or harmoniousness of interaction. Referral and intake workers do work hard to make links, but the links need ongoing maintenance. In turn, each referral from an external source can involve a degree of uncertainty and will incur the need for information renewal. Even the fact that initial contact is with a referral and intake worker, while subsequent contact is with a clinician, can create discrepancies of perception of what the agency can deliver.

The lack of clarity of role and status of referral and intake work and agency functioning among outsiders can also be found within child and adolescent mental health agencies themselves. This research has demonstrated that there may be little knowledge of referral and intake work among clinicians, and that communication opportunities between referral and intake workers and clinicians

can be constrained by location, and by the desk-based tasks of referral and intake workers. The communication between the two groups was often channeled by the referral and intake form, which provides a focus for questioning referral and intake worker judgement and the accuracy of details, but little opportunity for general appreciation or acknowledgement. General support for the referral and intake function was felt to be agency-wide and team leaders were felt to support the work as a high priority of the agency, but clinicians did not seem to fully appreciate the existence of cases before they receive the referral and intake form.

In the present findings, the agency's front-of-house and community liaison functions were considered to be actively promoted by referral and intake workers, and could involve receiving feedback about the clinical activities of clinicians that affect perception of the agency. These could require defensive action from the referral and intake worker, without proper knowledge of the source of the complaint. The referral and intake service, as a specialist part of the agency's work, sections off the clinicians from a range of input, thereby protecting the clinical relationships, but at the cost of obscuring the importance of the beginning transactions.

At follow-up, the referral and intake workers were interested to see their many tasks beginning to be listed and to have their work conceptualized as more than just filling out the referral and intake form. The list was seen as valuable in itself, and for the training of new referral and intake workers.

12.3.7 Applicancy and referral and intake workers' evaluation of prediction of continuance

Both referral and intake workers, at the follow-up interviews, appreciated the categories of applicancy and the capacity to predict continuance to the first appointment was acknowledged by one referral and

intake worker. The three categories of applicancy, crisis-reactive, containable, and committed, were readily recognized and both referral and intake workers supplied examples of each.

One referral and intake worker at follow-up extended the taxonomy to classification of professional referrers, as well. This worker recounted a recent case involving the actions of a worried primary school principal and a community police officer. It would seem that events had occurred at a local school which had not been handled with due urgency and referral to the child and adolescent mental health service was a means for recovering lost time. The agitation and urgency of these professionals was responded to and contained. This example revealed the method employed by this referral and intake worker to move the presentation of crisis toward contained responding. This involved making plain what the agency could do and what would be required of the referrer. In the end, the referral was not appropriate, but valuable and efficient work had occurred in containing the anxieties of the school principal and the community police officer.

The above example demonstrates the ease with which all of the referral and intake workers were able to adapt to the proposed new terminology and, how closely the terms captured ordinary day-to-day experience.

Over the course of the referral and intake worker interviews, all but one of the referral and intake workers felt that they gained a sense of the likelihood of subsequent first appointment attendance. However, they could not locate specific characteristics of attending or discontinuing families, but felt that parental concern for or fear about their child's future was a significant issue in believing that future attendance was likely. Associated with this was a sense of rapport and a depth of expressed feeling that not only concerned parental fears for their child, but also allowed the parent to experience

the agency as willing to listen and to support the exploration of feelings and attitudes felt to be potentially dangerous.

12.4   Review of aims and expectations

As articulated in Section 12.1 above, five aims were set for this further enquiry into the referral and intake worker role, based on the literature review, data previously collected, and a follow-up interviews with the retrospective studies' referral and intake workers. The aims were met as discussed below.

Eight expectations were established in Section 7.4.1 of Chapter 7 concerning the activities of referral and intake workers, for the retrospective and prospective empirical studies. Six of the eight expectations were further addressed in the further enquiry reported in the present chapter. These expectations were confirmed and are reviewed here.

The first aim, that data collected on the general functioning of referral and intake workers not analysed from the retrospective and prospective studies be examined, and the second aim, that this data be integrated with the findings of the literature review upon the general functioning of referral and intake workers, provided a deeper and broader view of the work. Indeed, when considering if these integrated findings on the general functioning had a pattern or structure, the third aim, a preliminary model of referral and intake clinical thinking began to emerge. This model, along with other aspects of referral and intake work, were explored empirically with the referral and intake workers of the retrospective study, as guided by the fourth aim of this further enquiry. Finally, in accordance with the fifth aim, the analysis of the previously unanalyzed data, in combination with the literature findings

and the new interview data, did allow for the emergence of an inferred structure of referral and intake work, as displayed in the model presented in Table 26, and this was found to be relevant to the experience of referral and intake workers.

The general expectation that referral and intake workers could give a full and clear account of their work and were able to describe the many practices (Expectation R4) was confirmed. A clear overview of the policy and procedures and an understanding of the historical roots of the current referral and intake system were provided (Expectation R4.1). Referral and intake workers seek a clear basis for accepting or referring elsewhere all cases (Expectation R4.2). Referral and intake work was conducted using discernible decision-making strategies (Expectation R4.5).

Referral and intake work does share a skill base with commonalities to receptionists, telephone counselors, and health advice line consultants, but not triage (Expectation R4.6). Referral and intake workers did vary in their practice in ways linked to their original professional training (Expectation R4.8). However, not all referral and intake workers had a sense, at the time of referral, of the likelihood of cases to progress beyond assessment (Expectation R4.3). None of the referral and intake workers described their experience of referral and intake work in a manner consistent with Brown's (1993) mystery analogy (Expectation R4.4), even though listening to the parent referrer's story was important and involved much uncertainty.

Clinicians did not seem to perceive referral and intake work to have the same status as other clinical work, even though team leaders and directors did (Expectation R4.7). This would seem to be a criticism of clinicians, but clinicians seemed not to have been well placed to observe the work of referral and intake and its effects upon their work, except when details upon referral and intake forms

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required questioning. The confirmation of this expectation would seem to be a natural corollary of the structure of referral and clinical work within child and adolescent mental health agencies and not a specific intention of the clinicians.

12.5   Of naming and the name of the role

This chapter was directed toward two of the overall research aims, being the documentation of the tasks, functions, and procedures of the referral and intake worker, and the establishment of the place of referral and intake processes within the work of the clinics. This work has been directed largely at giving names to the tasks and mechanisms whereby referral and intake work is performed. Additionally, the analyses performed in this further enquiry have generated a model of clinical thinking for referral and intake work in child and adolescent mental health services.

This further enquiry into referral and intake worker practices has suggested a means by which referral and intake effects have not been noticed to influence subsequent clinical contact. The protective separation of clinicians from referrers by means of referral and intake workers has clinicians believing that the work begins with the first interview. Thereby, important information collected by referral and intake workers in the course of referral calls, such as the pain of before, likelihood to pursue referral, and the impetus toward help-seeking is obscured or lost in the transfer of case information. That is, a structural organizational feature creates a systemic blindness among clinicians and reduces the meaningfulness of the referral call to a mechanism of information transfer.

Eventually, this enquiry has demonstrated that referral and intake work is important, ongoing activity that occurs outside of the therapeutic work of a child and adolescent mental health service. Referral

and intake can shape therapy, but clinicians are unlikely to be aware of the shaping as for clinicians, the work begins with the first face-to-face contact and registration of the case. Intake happens at registration. It would seem more descriptive of the role to have a new name, such as referral consultant.

CHAPTER 13

DISCUSSION OF THE FINDINGS

> It was the best of times, it was the worst of times, it was the age of wisdom,
> it was the age of foolishness, it was the epoch of belief, it was the epoch of
> incredulity, it was the season of Light, it was the season of Darkness,
> it was the spring of hope, it was the winter of despair,
> we had everything before us, we had nothing before us
> Charles Dickens (1847). *A tale of two cities*.

Beginnings matter. It was all too obvious from the outset. The evidence is on the backs of trucks, in the popular media, implicit to many of the chapter heading quotations in this thesis, and in Chaos Theory (Gleick, 1987). Beginnings shape future events, past beginnings have shaped current beginnings, and beginnings have preludes.

This thesis was inspired by the entreaties of Socrates (Jowett & de Botton, 1871/1999) and Simmel (Wolff, 1950) to examine the banalities of life in order that the way routines have been shaped and how routines shape life can be evaluated. With respect to referral and intake to child and adolescent mental health, the practices of referral and intake were given names and categories under domains of action, knowledge, or attitude. The history of professions was found to have shaped contemporary practice. The experience of parents was brought to the fore, especially for the period prior to referral.

It is customary in the discussion section of a psychological report to connect the current findings with

past literature. In this chapter, however, few such connections will be made. Although a vast literature was accessed to bring the practice of referral and intake from the shadows, very few reports were found that documented the practices in any thoroughgoing way (Freestone, 1994). There were several reports concerning the need for policy articulation and documentation (Rooney & Miller, 1955; Anderson & Dean, 1956; Gordon, 1965; Levinson, 1969), but these were either lacking in detail or critical of the lack of documentation. In terms of documentation, this thesis is the beginning.

The questions that guided this research have been addressed by the four enquiries conducted. The literature survey responded to the first research question, and revealed how referral and intake practices of child and adolescent mental health agencies have been shaped over time, particularly within the professions and within child guidance clinics. The retrospective study addressed the second research question by providing a long list of practices that are undertaken within the course of referral and intake work. The list was refined by the prospective enquiry, and by the further referral and intake worker enquiry presented in Chapter 12. The practices and their effects upon subsequent contact, the subject of the third research question, were to be studied in the prospective study, but due to issues of recruitment, the question was not adequately addressed. However, the prospective and the referral and intake worker enquiries provided more information about the practices of referral and intake and their transactional form and organizational position. It is proposed that the structural separation of referral and intake work and clinical work results in overvaluing of later clinical work, and under-recognition of the effects of referral and intake transactions on subsequent clinical contacts.

From the first chapter onward, the tension between modes of enquiry for documenting of mechanisms and understanding of meaningfulness has been noted, although for participants in a referral call, these two enquiry purposes seemed to have worked in complement. For the referral and intake worker the

intake form helps to structure the collection of necessary data and contain the transaction to the task of receiving and providing information. For the parent, the structure of the referral call enables a sense of efficiency and a sense of support. Difficult and distressing information is discussed, but usually in a way that builds trust and rapport and encourages attendance for clinical consultation. The separation of meaning and mechanism was found to occur when the case is transferred to the clinician, who receives the referral facts on an intake form.

The availability of data concerning the meaningfulness of the transaction, in complement to the rich data concerning the mechanism of practices of referral and intake, allowed for the emergence of findings and for theory building. Case study method was advocated by Yin (1989) to facilitate theory building and was most useful in this research. A representation of the clinical thinking involved in referral and intake was brought forth. The place of the referral call in the life of the clinic was mapped. Thirdly, a better understanding of the parent as a person who refers their child was achieved.

This chapter discusses aspects of these findings firstly in terms of the strengths and limitations of the research. It goes on to examine the findings in terms of the research questions and of the expectations of the empirical studies. This includes attention to the findings of the literature enquiry where useful, attention to specific findings concerning the process, its practices, its time frames, and its personnel, and attention to parental state and role in the process. The findings concerning the representations of the parent, referral and intake clinical thinking, and the place of the referral call in the life of the clinic are then discussed. Finally, the methodological issues that arose and their implications for the research, in total, are discussed as foundational to further focused research of this area of clinical practice.

13.1   Strengths and limitations of the present research

This study was a thoroughgoing examination of referral and intake to child and adolescent mental health services. The practices were listed and analysed from a wide range of perspectives, involving literature and empirical enquiries that had different timeframes and many different positions of informant. The essential task of seeing the unseen was investigated philosophically, methodologically, and practically. Parts were named and the naming was refined. Triangulation of findings occurred at the level of literature, methodology, data collection, data analysis, and informant follow-up. Informants, once recruited, provided full sets of data. Fifty interviews were conducted, documented, coded, and analyzed, which led to a model of the clinical thinking behind referral and intake work, and an ecomap of the place of the referral call within the life of a clinic, being derived synthetically.

13.1.1 Overall design of the research

The foremost strength of this research, then, was its multi-dimensional exploration of the phenomena of referral and intake to child and adolescent mental health services. Many facets of the referral and intake phenomena were explored, in considerable depth. Because of their ordinariness or banality, and the fact that they had always been taken for granted, and because so little had been directly studied in this area previously, it was decided to not let any practice or strategy of exploration go without close examination. Placing referral and intake in a range of historical contexts facilitated a more informed critique of the areas of past empirical research conducted that could be seen as relevant. This in turn permitted the articulation of basic research questions, the planning of the retrospective and prospective empirical enquiries, and the addition of a further enquiry concerning the role of referral and intake workers.

It was argued in Chapter 1, again because of the dearth of research in this field, that the research design needed to include the possibility of the emergence of unpredicted findings. The qualitative approach was certainly effective in this regard. Integration of diverse bodies of literature produced some new and helpful conceptualizations, especially concerning applicancy and parental status in child and adolescent mental health services. Similarly, the empirical enquiries elicited emergent findings at several levels. The emergent findings were among the more important outcomes of this research. For example, the phenomena of the pain of before and of the opponent were emergent findings of the retrospective enquiry. The further enquiry into referral and intake worker practice was an emergent finding of the prospective enquiry, with a model of clinical thinking used by referral and intake workers emerging from this further enquiry. Recruitment was a problem in the retrospective and prospective enquiries, and the problem represents in itself an emergent finding of the research as a whole.

It had been hoped that the prospective enquiry would provide evidence of the effect of referral and intake practices on subsequent clinical work in child and adolescent mental health services. However, following the completion of the retrospective study, it was clear that recruitment of sufficient informants in the prospective study to enable quantitative data analysis was unlikely. As implementation of the prospective study progressed, the impossibility of a quantitative approach was confirmed. Access to informants who varied in their enthusiasm to continue with referral was highly restricted, which limited both the generality and the generalizability of these research findings. On the other hand, a qualitative exploration of the factors associated with referral and intake was well-suited to the small numbers of informants who volunteered to participate, all of whom were keen to pursue clinical consultation.

13.1.2 Recruitment of informants and resulting samples

Recruitment of informants was difficult in both of the planned empirical enquiries. Clinicians found it difficult to invite participation of parents, but once participation was secured, both staff and parents provided full accounts. Agency directors and referral and intake workers were very supportive of the thesis as a whole.

13.1.2.1   Parent informants

Recruiting parent informants to this study was extremely difficult at several levels. Indeed, as discussed in Section 11.2.1 of Chapter 11, the problems of recruitment themselves were considered a major finding of the prospective study, which helps to explain the dearth of literature on referral and intake practice in mental health services. These problems limited empirical enquiry to very grateful parents who wanted to give something back to the agencies, which had provided service. These parents had all become committed to the process of receiving help by the time of the research interviews.

The parent informants, in both empirical studies, were sources of important data, thoughtfully provided, that illuminated much of the process of referral and intake. This depth is a clear strength of the research.

However, the non-participation of parent informants who were less enthusiastic limited the study to consideration of committed applicants only.

13.1.2.2   Child and adolescent mental health staff informants

Similarly, the twelve staff who provided interview material for the retrospective enquiry, and the four staff who provided interview material for the prospective study, were enthusiastic about the project. The clinicians who participated embraced the aims of the research and provided detailed accounts of the practices, the procedures, and their effects upon other work, as well as recruiting parents to the retrospective study. The directors provided overviews of the development and implementation of policy, and vivid understanding of the drama of referring a child to such an agency.

Given the size of the informant samples in each study, a qualitative approach to both empirical enquiries was the only option possible. The strength here was that the in-depth data collected were comprehensive.

13.1.3 Qualitative case-based design

The retrospective study was designed as a qualitative mapping of the processes and practices of referral and intake, and its findings were envisaged as setting the scene for design of the prospective study. Once the prospective study was redesigned as being also based upon multiple case studies, the generalizability of its findings was limited. However, the method of both enquiries did deliver a richness of data. The ordinariness of the practices of referral and intake meant that each individual informant overlooked most steps and practices documented in this study, but the combined and independent reports of clinicians, referral and intake workers, directors, and parents produced the extensive lists presented in Tables 4 to 9 in Chapter 9 that were reworked and summarized as a model of referral and intake worker thinking in Table 26.

A particular strength of the two-phase case study design, with the further referral and intake worker interviews and analysis, was that it permitted review of the initial list of tasks in subsequent phases of the research, leading eventually to the development of a model of clinical thinking by referral and intake workers, and to the mapping of the place of the referral call within the life of the clinic.

13.1.4 Parametric data collection instruments

It seemed that continuance by parent referrers through the early interviews at a child and adolescent mental health service was indeed influenced by the factors that were attempted to be measured, namely, child adjustment, parental state of mind, family environment, and obstacles to service access. However, the specific scale measures employed in the prospective study, while all indicated within the literature and supported by the findings of the retrospective study, varied in their applicability and usefulness within the prospective study.

The measures of child adjustment (Strengths and Difficulties Questionnaire, Goodman, 1997), the Barriers to Treatment Participation Scale (Kazdin et al., 1977), and the General Health Questionnaire (GHQ-28, Goldberg & Hillier, 1979; Vieweg & Hedlund, 1983) did provide useful data concerning the families studied and were responsive to changes of phase of contact and to the reported life circumstances of the families. However, the Optimism Scale, based on Peterson et al.'s (1984) Attributional Style Questionnaire, contained several questions that were not relevant to lone parents who did not invest on the stock market. While the results did reflect changes in parental state of mind, the scoring of the Optimism Scale produced a somewhat general description of state of mind that was difficult to interpret. The Family Environment Scale (Moos & Moos, 1994) produced complex

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descriptions of family life, but these were not easily interpreted in terms of the families studied.

The demographic data form used in the prospective study (Background Information, Appendices C10 & C11), although yet not validated, did allow for estimation of the state of family stability of life, confirming that the committed parent sample were highly stable in Hershorn's (1993) terms and sufficiently organized to attend clinical appointments.

Similarly, the questionnaire that sought consumer feedback on the quality of service received at the agency in the prospective study did not produce data that differentiated factors concerning service quality. Again, this was a function of a stable, committed sample rather than the instrument. The parent informants were uniformly very positive about the service received, and the only instances of poor service mentioned concerned the misplaced referrals of Kevin's Thomas in the retrospective study and Sarah's Michael in the prospective study. In both these cases, the parents expressed appreciation of the work of the referral and intake worker.

Testing of Ewalt et al.'s (1972) screening protocol for continuance with a referral was reported in Section 11.4.2. The screening protocol could be used in two ways: firstly, to indicate if applicant families are likely to progress to the end of the assessment phase and thereby to predict resource demands upon the clinical service. Secondly, where progress is not predicted, to warn the referral and intake worker of the need to do some preparation of the referrer for the demands that the service may place on a family and thereby potentially avert discontinuance.

Service quality and stability of life were intended to be evaluated in this study using the Background Information questionnaire (Appendices C10 & C11) and by the Feedback questionnaire on CAMHS

service access and staffing (Appendices C14 to C17). The stable lifestyles and uniformly positive attitudes toward the agencies' staff by the parents in both samples meant that the utility of the questionnaires was not tested. Instability and poor service may affect the uptake of child and adolescent mental health services but examples of each, and their interactive effects, were not encountered. These questionnaires could provide the basis for future research.

13.1.5 Overview of strengths and limitations of the research

The strengths of this study include the quality, richness, broadness, and depth of the data collected. Triangulation of findings occurred at several levels and by separate studies with different designs. Strong internal validity was demonstrated. However, external validity was low, due to the small size of the samples recruited for each study resulting in homogeneous samples, unrepresentative of the heterogeneous population of parent applicants for service. Also, there were several types of parent informants who could not be recruited to the study. Despite very limited generalizability of findings, nevertheless, the data do provide a sound basis for hypothesis generation and theory building.

Within these constraints, especially that of the recruitment of reluctant referrers, most of the issues raised in the broad literature survey could be pursued, but the direct study of the causes of referral reluctance and discontinuance was not possible. The design accommodated the possibility of emergent findings and several of these occurred that have not been reported elsewhere.

13.2   Addressing the research questions and the expectations of each study

The research questions and expectations are reviewed in this section. Specifically, the historical

precedents for the practices have been established. The actual practices have been named and listed. But the effects of the practices on cases were not documented directly. Most of the expectations, drawn as they were from the literature, were met.

13.2.1 Shaping the practices of referral and intake to child and adolescent mental health services

Substantive findings were generated from researching the literature deemed relevant to the history and contemporary practices of referral and intake to mental health services. However, as the literature review involved critical analysis, many of the findings from this part of the research are not directly tied to any particular past contribution. Further, the dearth of specific past literature does not accommodate to presenting the current findings in terms of past contributions.

Firstly, the inappropriateness of the concept of triage in referral and intake to child and adolescent mental health services is important, especially as there has been a demonstrated tendency for some professional groups to promote referral and intake as triage in mental health services. This finding has implications for the training of mental health staff generally. Secondly, the importance of the gate and the function of entry were exhaustively mapped historically and organizationally (Freestone, 1994; Levinson & Astrachan, 1976). The emergence of the professional categories of psychiatry (Foucault 1961/1971; Shorter, 1997), mental health nursing (Carpenter, 1980; Martyr, 1999; Walk, 1961), social work (Furlong & Smith, 1995; Ife, 1997; Wood, 1996), and child guidance (Horn, 1989; Richardson, 1989, Wardle, 1991b) were shown to have contextualized the development of the practices and precepts of referral and intake work. These historical accounts may be useful for practitioners within each discipline, and within child and adolescent mental health services in general. The history of the ambiguous and tenuous place of parents within child and adolescent mental health services was also

documented (Feldman, 1937; Horn, 1989; Tsiantis et al., 2000).

Thirdly, the published clinic-based research on psychotherapy and clinical administrative practices, although vast, was found to be largely tangential to the defining of the practices of referral and intake. However, phases of clinical contact and discontinuance were delineated, and classes of applicants for service were able to be discriminated as part of the contribution of the present research (Tuckman & Lavell, 1959; Sirles, 1990).

Finally, appropriate parametric measures of families, parents, children, and access issues were identified in the field of research, assisting in the design of the present studies.

13.2.2 Describing the practices of referral and intake

At follow-up, all participating referral and intake workers agreed that the three classes of mental health applicants, committed, containable, and crisis-reactive, were identifiable and could be discriminated among their recent referrals. The relaxed confidence in making such discrimination would seem linked to other factors, especially the capacity to predict the likelihood of referral and intake workers to be able to predict continuation through assessment, at the point of referral, as reported by Sirles (1990). In this study, four of the five referral and intake workers felt that they would have a feeling about the parent's likelihood to pursue referral. However, they were not clear as to what comprised their perception of this likelihood. Certainly, they could locate reasons why pursuance of referral was not likely, and this information provided an alternate description of crisis-reactive families. On the positive side, the referral and intake workers could discern determination in the parent's commitment to the request for service, and a focus upon the child's needs. Also, the expressed pain about a child's

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discomfort or behavioural difficulties was perceived as another indicator of pursuing referral.

A factor that was very evident in the retrospective study was not clearly seen in the prospective study, although it may have appeared there as a fear for the child's future. This was the factor called the pain of before. The parents interviewed for the retrospective study, who had completed contact, were able to describe in graphic detail the pain of the search for an agency to help with their child's problems. Looking back over their successful contact with their agency, the removal of this pain, almost from the time of beginning, had been a great relief but also a driver for other improvements. Referral and intake workers may get some sense of it, but even clinicians who had been very successful, and very detailed in their work, did not know about the power of this pain. The fact that the researcher began with the informants during the period of their actual clinical contact may explain why this factor was not manifested in this enquiry.

This research has suggested two further factors predictive of completion of assessment that may operate in the referral and intake phase. In the retrospective enquiry, seven of the eleven parent informants had participated, in the past, in helpful interactions with adult or child mental health services, broadly defined to include counseling and family preservation services. Two of the other parents had experienced ongoing support from health or educational professionals, as had some of those who had had past contact with mental health professionals. The remaining two parents came to the agency in very different circumstances, but with solid support from their general medical practitioner. In the prospective enquiry, five of the six, or perhaps all, parent informants had previously received help from adult or child mental health services, broadly defined. It would seem that, in these samples of parents, past helpful contact may increase the likelihood of subsequent referral. The literature has been divided on this point, with previous contact with adult mental health

services sometimes seeming to have lessened the likelihood of seeking help (Brown, 1993), although for children some studies reported a positive influence (Garralda & Bailey, 1986a, 1988).

The second potentially predictive factor not noted in previous literature was the presence of an opponent in the mind of the parent, a force against which the parent set his or her motivation to persist with referral. In Section 3.4.6, in Chapter 3, an heuristic was proposed by which to research the status of the parent who makes a referral. Rather than seeing the parents as simply seeking help, it was proposed that the parent was as strongly for referral as against it and pursuing the referral required a greater impetus toward referral than existed away from seeking help. The benefits of this heuristic were evident in the interviews and, potentially, may have been the reason that the pain of before was uncovered, as such pain had been precluded from subsequent clinical conversations. This heuristic, which regarded referral as some sort of competition of painful options, also helped to locate what was called, in shorthand, the opponent. Most often the opponent was experienced as an estranged father of the child for whom there was concern, but was sometimes the child's difficult behaviour or developmental problem, or the child himself or herself. Another potential opponent was internal, for example a desire to stop damaging supporters by dwelling on problems, and to talk to an independent professional.

It would seem that referral and intake workers are well placed to assess the presence and motivating strength of such an opponent. For a subgroup of those parents who did not participate in this research, the opponent might not be a motivator toward attendance. As evidence of this, clinician informants gave the foremost reason for discontinuance as coerced referral (see Table 17 in Chapter 9 on page 242), usually from a Government welfare service, a doctor, or a school. Referral and intake workers may already compute information about the presence of an opponent when gathering information for

the referral and intake form as the referral call proceeds and, perhaps, link this with the likelihood of subsequent attendance.

The protocol for screening referral calls developed by Ewalt et al. (1972) was applied to the parent informants in the prospective study. Continuance was accurately predicted in the five cases with children less than twelve years, although one of these only required two sessions of attendance. The accuracy of the Ewalt et al. protocol for adolescents was not felt to be better than chance, but for the one case of a child older than twelve years continuance was predicted and did occur.

Applicancy type, past contact, the opponent, and the Ewalt et al. (1972) screen, are indicators to the referral and intake workers of subsequent referrer behaviour. These indicators are suggestive that referral and intake workers do apply computer drop-down menus when appraising the clinical data collected during the referral call, as suggested in Table 26 of Chapter 12 on page 344. As such, these indicators might model how a meaningful transaction is reduced, on the referral and intake form and in the mind of the referral and intake worker, into a mechanistic prediction.

The model of referral and intake worker clinical thinking presented in Table 26 embraces all the listed tasks of referral and intake work, configured in a dynamic and chronological display. The model was constructed from the collected data, but also from a close reading of decision-making literature mentioned in Section 6.2 of Chapter 6. Very experienced referral and intake workers supported the validity of the model at the follow-up interviews.

13.2.3 The effect of the referral and intake practices on cases

The third research question asked how the beginning processes of contact with child and adolescent mental health agency affects subsequent therapeutic contact and its outcomes. The retrospective enquiry provided some signposts as to how beginning processes might lead into subsequent clinical processes, especially through different phases of contact. However, these findings were not detailed enough to indicate clear links between referral and intake practices and clinical outcomes, and, as discussed in Section 13.1.2.1 above, would need to be complemented by data concerning less committed parents.

The prospective enquiry was originally conceived as providing the links between beginning practices and later effects upon clinical progress. However, as recruitment transpired to be not possible at the time of referral and only a small sample agreed to be involved in this part of the research, a qualitative design emerged, with augmentation using repeated measures of standard psychological instruments. As the parent referrers were encountered at the first research interview, which occurred after the family's contact with the agency, the impact of referral and intake worker practices could not be directly assessed. Further, these referrers were all committed to clinical contact with the agency, so it may be that the referral and intake worker practices were not particularly critical to establishing ongoing contact.

It can be concluded that for committed referrers the referral call is important, but the actual behaviour of the referral and intake workers in receiving the call, is probably not crucial with respect to subsequent contact and outcome. All parent informants spoke of referral and intake interactions as facilitative and some expressed strong appreciation of the referral and intake worker's approach and

efficiency. Clinically, the interaction of reluctant parent applicants with referral and intake work practices would be a most important area to pursue, but this was not possible to study with the sample available.

13.2.4 Findings in terms of the expectations of the study

The findings are usefully reviewed in the light of the six general expectations for the empirical enquiries were set in Section 7.6 of Chapter 7.

Referral and intake processes were expected to affect the overall progression of child and adolescent mental health services cases (Expectations R1 and P1) and this was shown in both studies. More detail was revealed in the prospective study, where the effect was shown to decline over time, as expected. The value of the referral call was for some largely administrative, and therefore, of little continuing value. For reluctant callers, the referral call and the referral and intake workers behaviour were very important in encouraging referral and reducing stigma.

A second set of expectations concerned more specific parental perspectives upon the practices and effects of referral and intake (Expectations R2 and P2). The parents in the retrospective sample reporting positive beginnings that continued over the course of contact. Prospective study parents were ambivalent but not deterred at referral. Neither sample reported a consumerist orientation as against the research expectations of Luntz (1998), Spink (1998a), or Wadsworth and Epstein (1998), with the prospective study parents reporting allegiance to their clinician, but not to other parents. Expectations concerning parental health at referral were not determined originally, although maternal health was implicated in re-referral decision. Treatment barriers did rise, as predicted during the early

stages of clinical contact (Leaf et al., 1987; Stefl & Prosperi, 1985).

Staff of the child and adolescent mental health services were expected to give a different view of the referral and intake process from that of the parents (Expectations R3 and P3). The views of directors and clinicians upon the processes of referral and intake reported in the retrospective study were clear and full. However, there was more agreement on steps and practices between staff and parents than expected, except that the parents did not observe the internal processes, which was of no concern to them. The director of one agency identified two aspects of referral and intake practice as critical, namely a willingness to listen, and conveying that a place was available for the family within the agency's programs.

It was expected that referral and intake workers would give a full and clear account of their work and be able to describe the many practices (Expectations R4 and P4) and this was found in both studies. However, as no one informant located even half of the steps and factors in the process of referral and intake identified overall, it was decided to review all the referral and intake worker interviews to determine if there was a deeper form to the work. This further enquiry, reported in Chapter 12, resulted in a model of clinical thinking for referral and intake workers. The follow-up interviews and further analysis within Chapter 12 showed that there were training background differences in approach to the task of referral and intake work, and that those with nursing background identified the work as similar to triage work, although those with other paramedical backgrounds did not make such a connection. It would seem that nurses retain their links to their profession through the use of the term triage, even if the practice is different. All referral and intake workers felt their work was less valued than the work of the clinicians.

Phase of contact effects (Tuckman & Lavell, 1959; Sirles, 1990) were expected to be discernible through the manner of the parent at first contact and at subsequent continuance or discontinuance (Expectations R5 and P5). Effects on continuance were very clear in both the retrospective and prospective studies. Discontinuance was not documented directly in either study, as no family discontinued. The clinicians in the retrospective study found many reasons for client discontinuance. In the prospective study, an expectation was formulated that committed applicants would participate in the study. This was demonstrated, although some of the parents were possibly initially only containable, but became committed through the course of the referral telephone call.

It was also expected that, as the study was exploratory, novel and unpredictable factors would emerge (Expectations R6 and P6). This expectation was indeed borne out. The literature review demonstrated differences between applicants who were committed, containable, or crisis-reactive, which classification helped in the analysis of the empirical findings. The retrospective study identified two important, hitherto unreported, factors as contingent on referral. The first of these was the "pain of before" that parents experience as they search for an appropriate service to help their child. The second of these was the motivating effect of the presence of an "opponent" in the mind of the parent applicant. Hope and determination were also identified as important motivating factors for referral, although these have been reported elsewhere. In the prospective study, the Ewalt et al. (1972) screen of applicants likely to proceed through the assessment phase of contact was found to be unexpectedly valuable. The generation of the further study of referral and intake worker practices reported in Chapter 12 was an emergent finding of the prospective study as well. The refined lists of referral and intake worker tasks and the model of referral and intake worker clinical thinking were unexpected outcomes, although Chapter 6 had pointed to the need for gaining such information. Similarly, the ecomap of the place of the referral call in the lives of parents, referral and intake workers, the agency

and the wider networks was an unanticipated result of the research.

13.3 Interpretations of key findings

The significance of certain key findings is interpreted in the following section. These concern the mechanisms and meaningfulness of the transactions of referral and intake. There were findings that were synthetically derived involving representations of the parent as person referring their child, the model of clinical thinking in referral and intake work, and the ecomap of the place of the referral call within the life of the clinic.

13.3.1 Phases of contact

This research confirms the importance of the phases of contact and how these differentially affect continuance of child and adolescent mental health service. Such a finding was first articulated by Tuckman and Lavell (1959) with respect to contact discontinuance and confirmed by Sirles (1990). Parents and clinicians know these phases to be experientially different.

13.3.2 Parental state at referral and the applicancy typology

The two samples of parent informants felt that beginning was an important, if not crucial, part of their contact. The parent informant samples were different, but mostly included determined and hopeful persons, who wanted help for their child, and who had something to prove to an estranged partner or themselves.

The finding of the retrospective study of the pain experienced by parents during the period of contemplation of referral and seeking an appropriate agency, called the "pain of before", was not clearly evident in the prospective study. This may be a phenomenon only recognizable by parents at the end of relatively successful treatment. It was an important factor for several parents and may be active but unacknowledged during the beginning phases of clinical contact.

This pain about a child was felt personally and may provide a bridge between the parental perception of a child's need for help and the higher rate of referral that occurs when a parent is unwell, reported richly in the literature (Chi & Hinshaw, 2002; Garralda & Bailey, 1988; Graham, 1985; Griest et al., 1979; Jensen et al., 1990; Richters, 1992). That is, for referral to occur, there needs to be disturbed child behaviour, parental unwellness, and a feeling of parental need, which may be desperate or involve a sense of failure or guilt. However, general unwellness was not clearly evident in either sample of parents, except at follow-up during the prospective study, those parents considering further referral had become less well during their period of contemplation of further referral. This pain might provide a specific sense of poor well being in the parent that produces determination to refer.

Although not immediately committed, the recruited parents became committed to the work soon after clinical contact was begun, if not before. The typology of applicancy proposed in Chapter 5, involving committed, containable, and crisis-reactive categories, could not be tested with this sample, but referral and intake workers confirmed the utility of the categories. This typology could be very significant in the way referral and intake workers conduct referral calls.

More generally, the idea that parents have both reasons for referring and reasons against referring, despite making referral calls, has been supported by this research, as even the most positive of the

parent informants admitted to not wanting to expose themselves being asked certain questions, or to face certain of their parental responsibilities.

13.3.3 Stability in life

One half of Hershorn's (1993) proposition concerning stability in life was supported by this research, namely that stable domestic circumstances are associated with attendance for mental health treatment. However, the more important part of the proposition, that instability and non-attendance are associated was not tested. There was difficulty encountered in turning the several indicators of instability into a specific measure of domestic instability over the previous two years and further research is needed.

Even so, Hershorn's (1993) contribution has separated three factors previously subsumed as one, namely the stating of needs, the seeking of help, and the living of a lifestyle conducive to receiving help. The parents in these samples were able to recognize needs, ask for help, and provide the lifestyle support necessary for their child to receive treatment. These separate issues may be discernible at referral and provide hints for the referral and intake worker as to how best to facilitate further agency contact.

13.3.4 List of practices

The list of 89 practices that have been named and, where applicable, arranged chronologically, is an important step in developing understanding of the skills and effects of referral and intake work. This has not been documented previously.

This list of practices stands as a set of named parts rather than as functional strategies. Most of the studies cited in the literature, especially in Chapters 4 and 5, concerned strategies to avoid missed appointments and the wastage of resources and of opportunities for change. These documented innovations may be useful to implement, but can now be implemented in a way that recognizes the place of any particular practice within the overall context of beginning contact. In turn, unintended consequences of innovation can be recognized and evaluated.

As different types of applicants have been described, different practices may be appropriate to be implemented with the different types of applicant. In turn, the effects of such practices on applicants of different types can be evaluated.

13.3.5 Effects of practices

However, the effects of the many practices upon subsequent case management and clinical interventions were not clear, although three different types of initial connection were discerned. In some cases, the referral was no more than a first, and administrative, step. For other cases, the referral call was highly facilitative of all that subsequently happened. In other cases, the quality of clinical service was found to be flawed, but in some way that was not related to the processes of beginning, for example as a function of staff changes.

13.4 Representations related to the transaction of referral and intake to child and adolescent mental health services

Chapter 1 traced the emergence of three ways of conducting enquiry in the history of Western thought.

Although these three ways were different in their purpose and in the visual metaphor that has exemplified the associated practices of enquiry, one idea joined them. All were about finding representations of phenomena. The present research has revealed a representation of the parent, a model of clinical thinking for referral and intake workers, and a model of the place of the referral call within the life of the clinic and perspectives upon this from the point of view of parents, clinicians, and the referral and intake workers themselves. These models emerged from the data implying both the mechanism and meaningfulness of referral and intake work.

13.4.1 Committed parents and their experience of referral and intake

The most far-reaching results of this research concern the parent. The findings of the retrospective study concerning parental state have implications for the conduct of the referral call interview, but also for the conduct of the beginnings of therapy. The literature review findings concerning classes of applicancy (Section 5.3, above) reflect directly upon how the referral call interview is conducted.

For the clinicians interviewed in the retrospective study, the parent existed only after the referral was accepted or after the case was registered. Then the parent was either a client or a parent of a client. Yet, as discussed in Sections 3.4 of Chapter 3, there are many relationships between a parent and the clinicians. One parent called clinicians "particular communicators" (see Section 9.3.2), identifying how well clinicians work on clinical specifics, but do not take a more general position.

Parents were able to give a broader and fuller account of what happens at a child and adolescent mental health agency than the clinicians, but mostly the parent informants observed the benefits of being patient and fitting in with treatment regimes. Glimpses of other aspects of being a parent were

provided when discussing attitudes prior to and during the referral call, particularly in cases which revealed the pain of before, and with respect to outcomes when contact was terminated due to staff changes. Parents felt themselves to be capable advocates for their children and did not regard themselves as consumers of mental health service.

13.4.2 The model of clinical thinking in referral and intake work

The model of clinical thinking, presented as Table 26 in Chapter 12, cannot be interpreted as a complete guide to the practices of referral and intake. It implies the presence of unknown alternate menus of action or information that are accessed by referral and intake workers in other agencies. Further, the movement between phases of referral transaction does not have to be linear, or involve only jumps from phase to phase listed in the final row of Table 26. However, the model does represent the fluidity needed to conduct this focused, yet uncertain activity. The model is open to exploration and testing.

13.4.3 The place of the referral call in the life of the clinic

The ecomap of the clinic presented as Figure 3 in Chapter 12 was derived from the accounts of the informants, and was based on the ecomap constructed from Freestone's (1994) report of the new Telephone Information Service for the integrated Royal Children's Hospital and Travancore mental health services. The system, thus represented, is exquisitely attuned to be responsive to the approaching parent. The gate to services is almost held open to would-be service users. The call, as transferred to an intake information form, coordinates parts of the organization around the referring family and activates clinical processes, albeit that the period of waiting for the first assessment

appointment can be extended. The call, in this important sense, wakes up the system.

Although this is a very positive view of the attunement of the service to its applicants, the ecomap does not describe the visibility of the service within the community. The gate may be held open, but community members may not know where the gate is, or if one even exists. It is very likely that knowledge of how to apply is not evenly spread among those in need of service, as was discussed with respect to epidemiology and clinic utilization in Section 4.1.1 of Chapter 4. The ecomap does not adequately describe what happens after the applicant enters the agency, either.

However, the system so quickly mobilized, quickly reverts to its self-contained parts once the plan for attending to the family has been laid out. The referral is transferred to the clinician and waits for an available appointment. Then the process re-starts for the service, with a new person meeting clients for the first time. What has gone before is all but obliterated and new opportunities are explored. The pain of getting to the service is put aside for the hope of achieving change for a child and for the family. Important issues at the time of referral, if not recorded on the intake form, will not be accessible. The client might well be committed to help and any hiatus in contact may not be deterring. On the other hand, the client may have been given special handling to ensure first appointment attendance and this is unlikely to be known, as the referral and intake worker may not have been able to communicate what the special handling involved. This research would suggest that the referring parent probably was of a particular type of applicancy and that certain indicators of ambivalence would have been detected, but the referral and intake worker would not have been able to identify these subtle signs. Hopefully, these nuances might become clearer in subsequent research.

As a map of system readiness, Figure 3 hides the propensity of the agency to value the parent who fits

comfortably with the clinical process. Persons will become clients and clinicians will see clients.

Persons who cannot become clients will not enter and persons, who acquiesce to becoming clients, will

eventually be confronted with a treatment choice. But, clinicians will never learn of patients'

discomfort with their assigned role. The structure of clinic activities precludes clinicians from

appreciation of clients as persons making broad life choices in seeking to attend for their sessions.

13.5   A case study of the methodological issues: Lessons from this study

At every level of this research, there were findings of methodological importance. Chapter 1 provided

a detailed and extensive examination of the evolution of mixed methods research design when the

phenomenon of enquiry is obscured by its ordinariness and observational technique is confused by the

purpose of observation, especially with respect to discrimination of mechanism and of meaning. At

another level, the research indicated that discrimination of the observational parameters of frame,

stance, source, purpose, and means provides a guide that, if further developed, could aid the choice of

appropriate techniques of observation in psychosocial research.

The tripartite design of the research built in triangulation of findings from the outset, and generated the

identification of the further enquiry concerning the detail of referral and intake work. Reviewing the

extensive, but fragmented literature evidenced the need to examine historical roots for psychosocial

practices and to trust the wisdom of those who publish to document the obscure. For instance, the

literature concerning phases of discontinuance, which was sparse and disorderly (Tuckman & Lavell,

1959; Cohen & Richardson, 1970; Sirles, 1990; Armbruster & Fallon, 1994), eventually provided the

structure for the design of the subsequent empirical studies.

Both empirical studies were structured on the basis of the phases of clinical contact and the noted phases of discontinuance. In the retrospective study, these points of contact did provide a context for reporting of the effects of qualitative changes in the relationship between the agencies and the families. The phases were also notable within this research for another reason. The earlier the phase of agency contact for a family, the more difficult it was to recruit parents to the research, due to general issues of confidentiality and the primacy and privacy of the clinical relationship. A further phase related factor was the limited capacity of parents to reflect upon the effects of referral and intake processes when important clinical processes were in train.

The prospective enquiry drew on the literature review to locate measures of important aspects of family life when a child has been referred for mental health assistance. In the end, the parametric measures were of variable value, as the recruited informants were committed to the purposes of treatment and were in stable domestic circumstances. However, trends evident in the literature were found for these small samples. The tendency for parents to refer troubled children when they themselves were distressed was found. Barriers to participation were found to rise with the movement from the beginning phases of contact to early treatment when the difficulties in gaining access became clear (Stefl & Prosperi, 1985). Future research can reliably use the General Health Questionnaire (Goldberg & Hillier, 1979), the Strengths and Difficulties Questionnaire (Goodman, 1997) and the Barriers to Treatment Participation (Kazdin et al., 1997) scale to map the effects of contact with child and adolescent mental health services, over time. Stability in life was evident in all families who participated in this research, but this measure requires further development than was possible with this sample and with the way in which it was operationalized. The Family Environment Scale (Moos & Moos, 1994) did not provide very useful results, neither did the Attributional Style Questionnaire scale (Peterson et al., 1982; Seligman; 1992).

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The questionnaire designed to enable evaluation of quality of service was deemed to be better than adequate and usually professional by the parent informants. In any event, for this sample, the work of receptionists, referral and intake workers, and other staff did not impede the work for which the parents had come to the service. A better test of the quality of such support services is performance when the clients are open to distraction from the purpose of attendance by administrative inefficiencies or inadequacies.

While the prospective enquiry with the parent informants did not add greatly to the knowledge about the effects of referral and intake upon subsequent clinical contact because of the recruitment issues, the referral and intake workers interviewed in this stage of the overall study provided the impetus for the post-hoc study of these interviews. In fact, Chapter 6 generated such an impetus with its presentation of disparate knowledge bases for referral and intake work in child and adolescent mental health services. Enquiry about these knowledge bases helped reveal the menu-driven, step-wise protocols for the referral interview. While the method of thematic analysis of qualitative interviews was employed across all interviews, the sequential nature of the interviews allowed for probing of particular aspects of the practices of referral and intake. More importantly, the interviews and their thematic analysis revealed the structure of the interviews that was best understood through schematic representation, rather than word descriptions.

This research also constituted a case study in a mixed-methods approach (Creswell, 2003; Takashori & Teddlie, 2002). At the broadest level, it has demonstrated the intellectual roots of a mixed-methods approach and its continued use in scientific enquiry. At the level of design, the research demonstrated how complex issues could be triangulated using thoughtful design. At the specific level, different

kinds of data were mixed to evaluate change over time in the same way that is used in the writing of clinical psychology assessment reports. Arguably, all that the current focus upon mixed-methods approaches has really done has been to reveal the many sources of questions that enquirers use to generate propositions. In the Popperian scheme of scientific enquiry (Popper, 1965) there has been a problem as to where the hypothesis comes from. Mixed-methods approaches would suggest that close observation of a phenomenon and the capacity of humans to synthesize knowledge from various sources may lead to formal hypothesis testing, but can also lead to the generation of understanding about factors operating in particular contexts.

13.6   Conclusion: The drama of the referral call

Through a complex, iterative research design, the drama of the referral call has been revealed. The parent spends time to weighing up child and family needs and searching for options for action in respect of perceived child problems. Eventually the agency is found and contact is made with a referral and intake worker, who seems well prepared to answer basic and tentative questions about child behaviour and the need for help. With some difficulty and personal pain, the parent conveys the concerns and is listened to, thoughtfully. Meanwhile the referral and intake worker is steadily acquiring a host of demographic details and problem descriptions. Alternate options for assistance are considered along with notes taken of past involvements. The processes of subsequent contact are described and any further concerns, especially reluctance are discussed. The call is terminated as supportively as possible and the processing of the referral begins. Further contacts may occur with the referral and intake worker during the waiting period. The case will go to the clinical team leader and allocation will occur. The parent will receive a bundle of information in the post, which may include the date of the first appointment and the name of the clinician involved. At the first interview, the

client will be registered. The process of getting started will have been completed, but the clinician will see the family as starting, just then.

Every part of this complex drama has implications for practice and for further research concerning the referral and intake process to child and adolescent mental health services.

CHAPTER 14

IMPLICATIONS OF THIS RESEARCH FOR

PRACTICE AND FUTURE RESEARCH

On the turning away
From the pale and downtrodden
And the words they say
Which we don't understand
'Don't accept that what's happening
is just a case of others suffering
or you'll find that you're joining in
the turning away'
Gilmour & Moore, 1986.
From Pink Floyd. (1987). *A momentary lapse of reason*. USA: CBS.

The findings of the study concerning applicancy status, practices of referral and intake, referral and intake worker role and thinking, parental status, continuance in referral, and research methodology all have implications for future practice and research. Of most importance has been the demonstration of the ways referral and intake workers perform their tasks that serve the mechanistic functions necessary for efficient beginnings of contact with a child and adolescent mental health service, while making the referral transaction meaningful for the referring parents and themselves.

14.1   Implications for referral and intake practice in child and adolescent mental health services

This research has revealed that referral and intake workers conduct the referral calls in ways that can be very meaningful for referring parents, yet can effectively serve the administrative purposes of the agency. This would appear to be encouraging for parents who, like those who reported their experience in the empirical enquiries are committed from an early stage. However, not all parents are likely to experience a referral call in this way because of issues that concern themselves and their living circumstances, which are outside the influence of the agency.

14.1.1 Development of referral and intake practice guides

The list of tasks and their nesting within the steps of the procedure reported in Chapter 12 provides the first documented basis for description of the practices of referral and intake. The model of clinical thinking in referral and intake work, presented as Table 26 can assist referral and intake workers to audit and monitor their activities, including during or after a referral call. It would also be very useful in the training of new referral and intake workers and in explaining the referral and intake process to new administrative and clinical staff. Local refinements can easily reflect differences in specific procedure.

It is recommended that agencies use the model to develop ways of monitoring referral casework and to conduct research into the effects of referral and intake upon subsequent clinical contact. Of importance would be monitoring those who continue and those who do not continue with the referral to the end of the assessment period using Ewalt et al.'s (1972) referral screen and the social and economic circumstances of referrers, especially domestic stability. The literature suggested a link between

perceptions of referral and early discontinuance. Practices need to be developed that attend to this issue, which is discussed further in Sections 14.2.2 and 14.2.3 below.

Such monitoring and research would need to be responsive to the category of applicancy of the parent. Specific protocols would seem necessary to assist the beginning with containable and crisis-reactive applicants and would require development. Such development might locate other categories or sub-categories of applicants. Research reported in the literature, for example Hershorn (1993), has recommended the implementation of immediate appointments for those families thought to be crisis-reactive de-mystifying the agency and its processes, and setting up an expectation that the family could take up services at some stage in the future.

14.1.2 Consideration of the meaning of the referral and intake process

Referral and intake calls are meaningful to the parent in several ways. The call marks the end of a process of deliberation and searching and this needs to be recognized. The call can have a confessional quality, as some parents want acceptance as such, as they speak of their involvement in their child's difficulties. Conversely, a referral call can be a disowning of responsibility by the parent, a shifting of blame to others or circumstances, possibly to the child. In either event, the call demands of the referral and intake worker a willingness to listen, to recognize the parent as applicant, and to recognize the parent's difficulties as parent.

The meaningfulness of the transaction for the parents interviewed in these studies was threefold. Firstly, the transaction concerned hopes for the child and for the future of the family. Secondly, in the same act of acquiring referral information, the referral and intake worker interacted supportively with

the parent. Thirdly, when the referral and intake worker provided information about agency processes, the parent was prepared for further contact, which information was greatly valued by the referring parent.

The oblation of meaningfulness by the enacting of efficiency mechanisms within bureaucracies that was identified in Section 1.3 of Chapter 1 did not occur in the course of the referral calls reported in this research. In the first instance, the parent felt the referral step was very important. The referral and intake worker, faced with the parent's concerns and distress, could not have received the referral information without regarding the call as significant. In fact, the referral and intake workers interviewed in these studies enjoyed the referral contact as an intellectual challenge and as an important clinical encounter requiring specialist skill. Both referral call participants emphasized the meaningfulness of the transaction and observed that bureaucratic procedures followed after the contact.

However, at the point of transfer from referral and intake worker to clinical team and clinician, all agencies had constructed barriers to protect the immediate professional responsibilities of the referral and intake workers and the work routines of the clinicians. The effect of these barriers was to obscure from the clinicians' view the importance for the parent of the referral call and the steps taken by the parent prior to referral. While such a barrier ensures that the clinician begins contact with the family with a fresh view of the presenting problems, issues that motivate referral are also obscured. The retrospective study demonstrated that in the referral information received were indicators of motivations for attendance like the pain of before, levels of hopefulness and determination, and the presence of an opponent, but that clinicians did not necessarily know these factors. The barriers between referral and intake workers and clinicians would seem to conceal the issues of beginning and, presumably, create the conditions whereby clinicians cannot recognize the full clinical value of referral

and intake work. Importantly, the concealed information may be valuable in making the intervention more cost-effective.

Procedures need to be developed whereby the underlying motivations to attend are reported to clinicians, especially the pain of before, as this may continue to affect the wellbeing of the parent, even if other clinical improvements are instigated. Communication about such issues between referral and intake worker and clinician might be expected to have clinical value, but would also increase the appreciation by clinicians of the referral and intake worker tasks.

One effect of the barrier between the referral phase of contact and the assessment phase is to help the parent move from the social role of applicant or referrer to that of client. While advantageous in some ways to the clinicians and to the agency, this screening of the referral and intake work from the view of the clinician also conceals the parent as child advocate and the parent as citizen from the purview of the clinician.

14.1.3 Referral and intake as facilitative of continuance

The literature review pointed to referral and intake workers capacity to predict continuance through the phase of assessment (Gaines, 1978; Sirles, 1990). Four of the five referral and intake workers interviewed in this study believed they could do this. Ewalt et al.'s (1972) protocol for predicting continuance was found to apply well to the small sample of families followed during the prospective enquiry. At the very least, this simple procedure involving five questions might be used to alert the referral and intake worker to the possibility that a case may discontinue and trigger the protocol for action relevant to parents displaying ambivalence or uncertainty. Krause (1966) felt that the most

effective referral and intake worker in his study made it clear what the service required of clients, as a means of pre-empting potential reasons for discontinuance. This fits well with Hershorn's (1993) observation that instabilities in life affect attendance. Predicting these ahead of time could help to settle the reluctant referrer during the early stages of contact.

Three protocols for action could be incorporated into the overall structure of the model presented as Table 26 to enhance the probability of continuance through to assessment. One protocol would be based on Ewalt et al.'s (1972) five-question screen of likelihood to proceed through assessment. One protocol would explore potential sources of instability in life which may make continuance difficult, following Hershorn (1993). A third protocol would outline the expectations of the agency concerning client attendance (Krause, 1966). These sets of response to an ambivalent applicant parent would make the parent aware of the challenges and place the parent in the position of being a rational decision-maker about options for their family. Although this strategy may not secure referral to the agency at the time of the first referral call, the parent who chose not to pursue referral would be clearer about the services offered, and would feel respected in his or her decision-making. The next opportunity for seeking referral to child and adolescent mental health services would seem likely to be less stressful for the parent.

14.1.4 The parent as citizen

Child and adolescent mental health services need to recognize that parental contact sets up, in parallel and in complement, several sorts of relationship, as articulated in Chapter 3. The relationship most obscured by clinical work is the citizen-public servant relationship. All mental health professionals need to understand the citizen's rights to speak and to be heard, and to understand how such rights can

be eroded within health management regimes. Change in attitudes regarding the citizen-public servant relationship requires a great deal of effort on behalf of the public servants. This is to be distinguished from a consumer-provider relationship, which is discussed in Section 14.1.5 below.

The idea of parent as citizen did not emerge as critical in the empirical studies of this research. When clinicians, directors, and referral and intake workers were confronted with this idea, it was clear that they had not thought about it. For parents, however, the frantic search for services that some parents underwent indicated determination to access service, as well as the belief that they had rights as citizens to access particular forms of service. The conceptions of applicancy and patienthood held by staff could not entertain notions of the parent prior to contact and therefore precluded notions of citizenship. This conclusion deserves closer examination.

Other relationship qualities between parents and clinicians require conceptual review. The relationship of health agent to parental custodian as one of recommendation and support would require effort to be established as a common principle of practice. The relationship of coordinated effort in a common direction for the child needs to be observed in order to reduce access barriers, especially with respect to transport, and sources of dispute. The relationship of health professional to child needs to be established in a collaborative space, rather then a conflicted or competitive one. The relationship of advisor to a parent with respect to a range of health and behavioural issues needs to be thought about, as advising and therapy do not necessarily fit well together. Such issues can be more tangled when the role of mental health professional involves inviting the parent to be more mindful of the child's needs, or when the parent's needs for therapy are such that the needs of the child might have reduced priority as the urgent work with the parent, as adult psychotherapy patient, ensues.

For clinicians, and probably other staff as well, a confusion of these roles probably arises as a corollary of the fact that clients attend at times and places of the clinicians' choosing. A service is needed and the service has to be attended in order for families to receive the benefits. The authority over the expertise to carry out assessments and treatments would seem easily applied beyond its specific limits and, among other effects, lead to clinicians blaming themselves for discontinuance (Feldman, 1937; Pekarik, 1983b). Clinicians need to assess the multiplicity of relationships in which they are engaged. A belief in the potency of technique would seem likely to be easily misplaced.

Any one of these relationships between parent and clinician can be negotiated well. The problem is that, in many cases, all types of relationship have to be simultaneously addressed, as discussed in Chapter 3. Adjustment in all these matters has to be on made by agency staff, from receptionist to service director, but particularly by the clinicians.

14.1.5 The place of consumer consultancy and advocacy

The relationship between parent and clinician in child and adolescent mental health services may not be most appropriately characterized as between consumer and provider as has been promoted for adult mental health services. The consumer-provider model arose because of human rights abuses in the context of institutions designed to manage chronic disabling conditions. As identified in Chapter 8, child and adolescent mental health services do not usually involve chronic conditions that are treated from within closed institutions. The need for general advocacy on behalf of consumers has arisen in adult mental health contexts, where citizens are not accorded appropriate status and voice. In the child and adolescent area, individual parents primarily want to be satisfactory advocates for their own positions, in most circumstances.

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Findings of the study do, however, point to value in discussions with other parents who have similar concerns. This was recorded by parents during the retrospective study in the two particular contexts of informal discussions at a school between parents with a child with difficulties, and informal discussions between parents as they attended while transporting their child to a group program. The importance of these discussions was premised in a choice made to discuss personal issues that arose from particular circumstances. Secondly, the discussions were not compelled or regulated. Thirdly, the discussions involved the sharing of worries about their children but also the sharing of the experience of being a parent with a child with difficulties. Effectively, these discussions occurred outside of professional consultation.

Just because consumerism does not fit as a model with the activities of child and adolescent mental health services, does not mean that such agencies should not consult with their clients to improve service quality. But such consultation has three different sorts of problems identified in this thesis. Firstly, leaving satisfied does not equate with effective or complete treatment. Rather people can leave largely satisfied when other events require greater priority. Secondly, those who leave prematurely are not likely to be able to be contacted to gain an opinion about service adequacy. Thirdly, this research uncovered families who left when satisfied, but for whom the changes were not maintained and intended to seek further help. The only reliable client behaviour is biased toward maintenance of the current practices, yet those in need but who do not access may provide the most useful information. It is a paradox not readily resolved.

Anecdotally, there has long been a view in welfare agencies that the children with greatest need cannot gain access (Cowling, 1999, 2004). It would seem that child and adolescent mental health services

have developed approaches to assistance that can be beneficial to those who attend for long enough. In turn, conditions of entry have been developed that ensure sufficient levels of clinical effectiveness for willing clients. It would seem that there is a need for advocacy for groups excluded, but consumer research cannot be expected to locate such families in need of assistance or to describe their needs. Consultation with welfare agencies and research of their service users would be more appropriate.

It would seem that a wider and more complex view of a parent of a child with mental health needs is required to be developed by child and adolescent mental health agencies. Clinicians need to examine their narrow expectations of a parent of a client and to recognize that attendance for therapy is just part of the day-today functioning of families in turmoil and that although therapy can address such turmoil over a period of contact, such turmoil can prevent families from taking advantage of what is offered. Clinicians need not judge their work, themselves, or their clients when discontinuance occurs, even while there remains a responsibility to review what might have been done differently to have maintained the contact.

14.1.6 The name of the role

Another important implication of the present research is the differentiation of the referral process from the client registration process. The global label "referral and intake worker" did not fit that well with what the child and adolescent mental health services referral and intake workers actually did. More accurately, these workers would be described as referral consultants, as the intake registration function for child and adolescent mental health service occurring within the first interview with the appointed clinician or case manager. It would be appropriate for services to change the name of the role, as currently the name intake worker may mislead applicants for service into believing that they have

become clients upon conclusion of the telephone conversation with the worker, although no parent informants reported being misled in this way. Similarly, the name can confuse clinicians as the referral and intake workers' major source of communication with clinicians was about the appropriateness of accepted referrals. This suggests that clinicians regard intake to be a completed task, psychologically, prior to the first appointment, even though registration, actual intake, happens at the first appointment. A name change would draw a line at the actual point of distinction, that is, between applicancy and registration.

14.2   Implications for future research

Many potential opportunities for further research emerge. All child and adolescent mental health services with a referral and intake function can learn from this research to develop projects concerning referral and intake practices and their practices of beginning treatment, especially with respect to the motivations for treatment such as undisclosed pain or an opponent. Further, the implications for psychotherapy research are radical. The validity and generality of psychotherapy research, and indeed other research on health interventions, which has not in the past adequately documented issues of beginning has been opened to scrutiny. Future psychotherapy research will need to be rigorous about reporting beginnings.

14.2.1 Documentation of referral and intake practices

The list of tasks and the model of clinical thinking are immediately available for services with an intake function to audit, monitor, and evaluate their practices. Research could be aimed at verifying the presence of practices within the ordinary referral and intake practices of an agency, and may add to

the practices identified or modify the structure proposed. In turn, with such documentation, the possibility of discerning the longer-term effects of the practices through case study investigation would become possible. Importantly, agencies may be able to better understand the interaction between agency practices and the applicancy status of the referring parent.

The categories of applicancy may be more widely applicable to other services that have a referral and intake function, or, indeed, to entities that have a customer relations role. Of course, the same categories of applicancy may not be relevant, but further study of applicants and applicancy may generate further differentiation and categorization.

14.2.2 Referral and intake and discontinuance

This research has demonstrated the utility of the phases of clinical contact for mapping the relationships between agency and family. Tuckman and Lavell (1959) and Sirles (1990), among others, have linked phase of contact with patterns of client discontinuance. All research into discontinuance needs to pay attention to such influences. It would also seem important to link such research to type of applicancy and to Hershorn's (1993) concept of stability in life.

Recognition of such factors as past attendance, the opponent, ambivalence, hope, or determination might lead to careful observation and research and might increase the efficiency of the beginning contacts. These may be the sorts of factors that affect the capacity of referral and intake workers to assist crisis-reactive applicants to move into the containable category. If discontinuance is a choice made amid competing priorities (Hershorn, 1993; Pekarik, 1983), then sorting some of these priorities at first contact may obviate some of the difficulties of attendance. The proposed protocols for action

regarding continuance, as described in Section 14.1.3 could be researched for rates of progression to completion of assessment and related to categories of applicancy.

Along these same lines, innovation with referral and intake procedure may help to separate the issue of access from the confrontation of emotional problems with a stranger. For instance, Deane's (1991) innovation at a New Zealand child mental health centre involved parents coming to the centre to complete forms, and thereby separated the issues of traveling to an agency for the first time from those of confronting emotional problems during the first appointment.

At this fine-grained level, the detailing of the practices of referral and referral and intake work opens up further lines for reflection and research. The move to a consistent view of the referring parent as both for and against referral might also help. Such disharmony in the applicant parent would then be thought of as common and understandable, rather than as a sign of potentially pathological ambivalence.

14.2.3 Implications for theories of psychotherapeutic change

Theories of change in psychotherapy have a usual focus on particular techniques and theoretical formulations. The observation of the importance of beginning has few immediate implications for the conduct of particular models of therapy. However, some clinicians as reviewed in Section 3.3.2 of Chapter 3 did take beginning conditions seriously. Also, Prochaska and DiClemente (1984) did provide a model of readiness of therapy clients for change that may be relevant here. This thesis points to qualities of the applicant as relevant, as do Prochaska and DiClemente in describing the pre-contemplation and contemplation phases of therapeutic change, and qualities of the circumstances,

especially domestic stability. Further, a place has been opened up for exploration of placebo effects as linked to the quality of beginning (Frank et al., 1959; Fish, 1972, cited in Pentony, 1980; Shapiro & Shapiro, 1997).

The present findings suggest that a network of influences orients a parent toward seeking help and making the referral call. The network provides momentum toward help-seeking and beginning therapy. This momentum may be used to take the family past any initial disincentives to continuance or to change. The role of the therapist is to marshal the momentum, assess needs and appropriate strategies for change, and help continue the movement toward family adjustment. Therapeutic technique becomes more relevant over time, but is not the only impetus toward problem solution. This conception places the client back in the central role of actively making changes. However, this conception would probably make research of specific techniques more difficult.

14.2.4 Implications for research methodology in this area

This thesis has provided a demonstration concerning the conduct of research when the phenomenon has not been observed in any great depth and has usually been obscured by its obviousness and commonplaceness. It has shown how it is possible to name factors not previously identified, which are now available to systematic examination. The lists of tasks involved in referral and intake work, the model of clinical thinking, the categories of applicancy, and the states of mind of the referring parent can all be explored further. This research has given names to ephemera and thus transformed ephemera into phenomena.

14.2.5 Implications for research procedures

Whatever aspects of research and intake subsequent research projects might explore, and however large projects are, recruitment of parent informants will present practical and ethical problems. The recruiting of parents to referral and intake research was found to be very difficult in this project. The agency at which was conducted the prospective study did not envisage such problems, but the referral and intake workers found it impossible to ask referring parents to participate.

It would seem possible that a referral consultant could inform all parent referrers that the agency had ongoing research projects, some of which concerned referral and referral and intake work, and that participation in such projects was an ordinary, but non-compulsory, part of attending the agency. A further question could then be asked about the parent receiving information on the current projects among the general information posted to families. The package could then contain the research information plain language statement and a consent form to be signed and returned to participate provided the referrer was English-literate.

The recruiting of parents to such research might be the research project, itself, as it would be predicted that those who took up such an invitation were likely to be committed applicants for service. Other categories of applicants may not be researchable in this way, although referral and intake workers may be able to ask questions as to why participation in ongoing research does not suit particular applicants.

Researching the practices of referral and intake workers would provide a broader and deeper view of the process and how categories of parent applicants are discriminated following some of the questions used in the present research. Recruitment of staff with a clear interest was almost automatic in this research, which was helpful, but having only the views of interested parents was a constraint.

14.2.6 Implications for psychotherapy research

The findings of this research were not able to be definitive with respect to the beginnings of clinical contact and the effect upon subsequent therapy. However, although this research was concerned specifically about the processes of referral and intake to child and adolescent mental health services, there are wider implications that have emerged for the conduct of psychotherapy research. These implications concern the reporting of beginning conditions, exploration of the effects of beginning conditions, and focus upon the placebo effect of the beginning conditions. The distinction between meaningfulness and mechanism explored with respect to referral and intake practices also applies to the understanding the process of therapy and to debates between psychotherapy schools.

The findings of this research clearly imply that much past psychotherapy research, especially university clinic studies, were conducted with client participants who were probably committed to the securing of help. At the very least, future studies need to report closely the process of recruitment, preferably, attempting to categorize the applicancy category (committed, containable, crisis-reactive) of all participants. Even better, psychotherapy studies could analyse the findings in terms of the initiating conditions, as well as with respect to the technical matters under primary examination.

There is great scope for making the initiating conditions the primary focus of psychotherapy research. There are definite problems of recruitment of participants to such projects and for the direct observation of such phenomena. If beginning can be made therapeutically enhancing, there would be great savings of time, resources and emotional pain to be made.

This research would seem to provide a new way of investigating the phenomenon of the placebo effect. It may be that placebo is the beginning effect, or that the placebo effect may be disentangled from initiating factors. In this way, this research has implications for clinical interventions far wider than psychotherapy.

The tension between enquiry of meaningfulness and enquiry of mechanism evident in this research has been pervasive in the history of Western enquiry as was detailed in Chapter 1. Mechanism and meaningfulness sit comfortably together in the practices of referral and intake work, but a divide emerges soon after in the transfer from referral and intake worker to clinical team and clinician. Thereafter the contact is mediated by model of therapy preferred by the therapist. These models of therapy can be premised predominantly on meaningfulness or upon mechanism and the capacity to conduct reasonable cross-model discussions is limited by the different purposes of the therapeutic endeavour. The debate between practitioners of interpersonal therapies and cognitive-behavioural therapies is primarily a debate between different purposes of enquiry, rather than primarily between measures of outcome.

14.3   Conclusion

Behind the transaction of the referral telephone call is a vast set of historical factors that have shaped the practices of referral and intake. Most of the influences upon it have been obscured by the banality or ordinariness of making a telephone call in order to seek assistance. In this research, multiple methods of enquiry have been employed to throw light on the object of study previously so effectively obscured. The research has been deep and wide.

Practices of referral and intake have been identified and found to be a nested within a strategy employed by the referral and intake workers interviewed. These practices have arisen contextually for the referral and intake workers, but that context includes a long history that has shaped the role and the backgrounds of likely applicants for the role. Those who call to make a referral of their child have been classified into three groups based on commitment and vulnerability to changes of plans due to unforeseen circumstances. The important issues of how the content and conduct of the referral exchange can influence subsequent contacts were not canvassed directly for those groups of parents identified as containable or crisis-reactive, but this was because these types of service applicants could not be recruited to the research and may be beyond the reach of empirical research due to ethical issues. Those parents who participated in this research were committed to a process of helping their children and, therefore, the effect of the intake process upon them was largely of an administrative form, even if the referral call did lead harmoniously to subsequent therapeutic work.

New options for understanding the role and function of referral and intake within child and adolescent mental health services, and other health and commercial entities, have been opened up by the documentation of the actual practices. The place of the parent within child and adolescent mental health services has been opened up for examination within all treatment plans.

There is much emotional pain, intellectual endeavour, and accumulated wisdom in bureaucratic processes. Referral and intake in child and adolescent mental health services is complex and important clinical work.

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PRACTICES AND PERCEPTIONS:
REFERRAL AND INTAKE TO CHILD AND ADOLESCENT
MENTAL HEALTH SERVICES

A thesis prepared for the degree of Doctor of Philosophy

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Volume II: REFERENCES AND APPENDICES

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APPENDICES A (RETROSPECTIVE ENQUIRY)

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The same set of forms and information letters were used for each of the agencies, with name

substituted as appropriate and the relevant research liaison officer given for each agency with a contact

telephone. The forms and letters were printed onto agency letterhead, as requested.

Victoria University, Department of Psychology
LETTER OF INFORMATION FOR STAFF AND INVITATION TO PARTICIPATE IN RESEARCH PROJECT:
Referral and Intake to Child and Adolescent Mental Health Services

Researcher :   Jo Grimwade   *Supervisor :*   Dr Suzie Dean

Dear Staff member,
re : Referral & Intake research
Thankyou for assisting with this research. I hope you have been in attendance at a forum where this research has been discussed, and that you know the broad means by which the research is to be conducted, the issues under question, and the confidentiality procedures associated. The purpose of this letter is to inform you about how you could facilitate the recruitment of participants to the research.

Please be clear that the research is not intended to interfere with the ordinary work of your Department. Nor do I want to intrude upon the lives of parents, or the client family-practitioner relationships established as programs of assistance are pursued. This needs to be conveyed to all participants.

The research has two stages; a series of semi-structured interviews with parents and staff about what actually happens and what is important about intake and referral; and a second, quantitative stage using a structured questionnaire that follows a cohort of client families from first contact to twelve months after first interview. You have been asked to participate in the first stage.

Because so much happens during Intake, and it is a tense time for client families, I would like to know from those who have been through the system what effects intake has. The vantage point of parent and staff member at the end of a program of assistance will highlight different issues to those noticed just after assessment, or after the first interview, or after the first contact. Some of these issues will involve memory of facts, others will involve perception. By asking people removed from the immediacy of Referral first, I will not need to ask as many questions of detail of those who are in that position. Secondly, by asking Staff members prior to parents about Referral and Intake with respect to specific cases, the parent will not need to be relied upon for details obtainable from files, while allowing the parent's perception of events to come forward.

Staff will recruit parent participants. If you, a staff member, do not want to participate in the research, then you will not need to do any of the following; there are no repercussions of not participating. However, your participation would be much valued. Hopefully, you will not be needed for further interviews, but it is possible that several of your client families might be at pertinent stages of progression and so it may be appropriate to ask you to be interviewed several times, but about the specifics of separate cases.

Recruiting of parent participants will occur in the context of the ongoing relationship between clinician and parent. Two protocols have been prepared in conjunction with your Head of Department that need to be followed when discussing the research with a parent. It is important to get across the ideas that participation is voluntary, that participation is independent of service provision, that the research is not intended to be intrusive, and that the research may have implications for the way Intake and Referral procedures could be carried out in the future. The first protocol will apply to most instances; the second protocol applies only when potential participants are not yet registered clients of your service.

When the research has advanced to the stage when certain types of client family are needed to be interviewed, a letter will be sent to clinicians requesting them to recruit participants. This call for participants will go out in advance such that staff will have time to make the request to parents in the most appropriate way.

The protocols for recruitment are given in the table below. Please note that referring parents require more sensitive handling as they do not become clients of the Department until they attend for their first interview. If you are the person receiving the first contact from the parent, receive all relevant referral information first, then discuss the research as an extra thing that the parent may wish to participate in. Be clear that participation in the research is **not** a condition of receiving service; parents may be confused as they refer their child and may misinterpret your invitation to participate in the research. Answer questions as appropriate, and say you will send out the letter of support for the research from the Department Head and the Information Pamphlet. Ask them to read the pamphlet carefully and invite them to call back if they have concerns or to direct enquiries to the researcher. Ask them to send back the Consent Form for release of information as soon as possible as the interview needs to occur before their first interview. Once the information has been received by your Department and I am informed of its arrival, I will want to talk with you almost immediately.

step	**UNREGISTERED** PARENTS	**REGISTERED** PARENTS
1	take referral information	receive request for parent participants in process of : (i) completing a program of assistance (ii) completing assessment (iii) completing first interview
2	discuss with (potential) parents	the possibility of participation
3	provide Head of Department support to parent, encourage careful release information form	letter and Information Letter scrutiny, and return of consent to Department
4	Department informs researcher of information form and passes on	receipt of consent to release details
5	Researcher contacts staff member interview (and, then, to conduct	to make time to consent to interview)
6	Researcher contacts parent to interview (and, then, to conduct	make time for consent to interview)

Thankyou once again,

Yours Sincerely,

Jo Grimwade
Researcher

Dated : __/__/____

APPENDIX A2   LETTER OF SUPPORT FROM DIRECTOR, DEPARTMENT OF CHILD
& FAMILY PSYCHIATRY

Dear Family,

I write to you to make a special request. You know about the services of the (your agency); maybe you have been a client family for a long time; maybe you are only considering making use of our services. Our Department is committed to providing quality services and I hope you see evidence of this.

One way to ensure quality is to have ongoing research and evaluation of our services. I write to you about one of our current projects being undertaken by Victoria University Lecturer in Psychology, Mr. Jo Grimwade.

Jo Grimwade is an experienced clinical psychologist of over twelve years experience in child and family mental health services. He is interested in studying how mental health agency staff assist client families during the early stages of their contact with the Department. He would like to interview parents and staff about the referral and intake stage of mental health service provision. I hope you will be able to assist in this important research project.

The project is important to us because it will allow us to review our current procedures and, possibly, improve how we greet families to our service. We imagine future parents will benefit from this research.

Mr Grimwade informs me that he would like to interview you for no more than an hour, at a time and place convenient for you. We would like to assist his research, but our client families and their privacy are more important than research projects. Let me be clear; you are not obliged in any way to participate in this research. Further, you can withdraw at any stage. There are no advantages in your participation other than your contribution to the research.

I encourage you to read the project description (attached here) and consider carefully your wish to participate. If you do wish to participate, please sign the Consent to Release Information form, below, and return to this Department. Mr Grimwade will contact you soon after we release the information to you.

Thankyou for considering this request and I trust your time at the Department is productive for your family.

<div align="center">Yours Sincerely,</div>

<div align="center">Director (of agency)</div>

Dated : __/__/____

<u>**APPENDIX A3**</u>   **INITIAL INFORMATION LETTER TO POTENTIAL PARENTS**
          ASKING FOR PERMISSION TO CONTACT

Dear Family,

Thankyou for considering participation in this research. Please read the information below and fell free to seek clarification from the Department or myself (on **03 9365 2336**). The information is the same as you would read when you come to consenting to participate. But the purpose here is to provide you with information enough to allow the release of information by the child mental health Department you have contacted to me. They will release only a name and a contact telephone number.

Thankyou for agreeing to read about this project.

The aim of the project is to study *what actually happens when a family seeks help from a child mental health Department.* The research is particularly concerned with the events that happen between client families and Department from the time of first contact to the time of the beginning of a program of assistance. This includes contact with reception staff by telephone, letter, or face to face. A lot happens during this time that might be important in a family getting the most appropriate help.

You have been approached to participate because a member or members of your family recently completed one of the following stages of child mental health contact:
    1. completed a program of assistance
    2. completed assessments for a program of assistance
    3. had your first interview at (your agency)

The Departmental Director has agreed to this project being undertaken and has given me permission to approach parents of clients of the service. Moreover, the staff you have spoken to have agreed for me to contact you and you will have had a discussion, perhaps only briefly, about the possibility of participation in the research. If you agreed to be contacted by me, a letter would have been sent to you by the Department describing the research. The letter is similar to this statement of aims and methods.

Participation in this research will not help you in gaining assistance, but the results are likely to help others in the future. Participation in the research will involve some time on your part, but the research is not intended to intrude on what is a very private arrangement that you and your family have with the Department. I do not want to spend more than one hour with you. I do not need to know the details of your personal concerns, but I would like to ask about your contacts with the Department (sort of contact, length of contact, and satisfaction with the contact).

These questions will be asked of staff, as well. In fact, before I speak with you, I will have spoken with the staff member with whom you have had most contact. The aim here is to get a staff perspective on what is important about first contacts.

By asking staff first, who will have records available to them, I will not have to concern parents with concrete details of times and dates. Your time will be saved in this way, and you will be in the position to clarify any issues of uncertainty. Actual events are important, but how they have been

experienced by parents and staff are more important.

It is important to note that the researcher cannot actually advise parents or improve the procedures during the research project, itself. If such issues should arise, parents will be encouraged to discuss these issues with staff.

Information will be collected by written notes from the interview and, hopefully, audio-recording. A summary of the interview will be sent to you for verification or correction. Only two people will have access to the data : myself as researcher and my supervisor, Dr Suzanne Dean. Summary reports of information gathering at each of the agencies will be provided which will be available to all who have contact with the Department concerned. This summary will not contain any interview material and will not refer to individual clients in any way.

Participation is voluntary : parents and staff members will only be involved with their signed consent. You are free to withdraw from the research at any time and without any consequences for yourself or the service you are receiving from the Department.

The next step after consent is to be interviewed. Following this, a transcript of the research will be sent to you. You should read through the transcript and correct any points, and then return the information to the researcher; this would be the end of your involvement. (If you cannot participate, and someone else in the family would like to, then I would appreciate the chance to invite them to participate. Please pass on this information.)

Participants (or potential participants) can contact (research liaison officer), Human Ethics Committee, (administering hospital) on **03 9--- ---** to discuss any matters related to the ethics and conduct of this research project. Should you have any other questions about this research, you are welcome to contact myself or Suzie Dean on **03 9365 2336**. If you would like feedback, please fill out the Request for Feedback form which will be available from me at the end of your interview. Such feedback will be general. Feedback will be made available prior to the commencement of the second stage of the project.

Thankyou for giving this project your careful consideration,
Yours Sincerely,

Jo Grimwade
Researcher

Dated : __/__/____

APPENDIX A4 **PARENT CONSENT TO RELEASE INFORMATION**

Victoria University
Department of Psychology

CONSENT TO RELEASE INFORMATION TO THE RESEARCHER

Title of Research Project :   Practices and Perceptions : Referral and Intake to Child and Adolescent
                                Mental Health Services

Name of Researcher :   Jo Grimwade

Consent of Participant :
I, _____ ,
of_____ ,
certify that I have the legal ability to give valid consent and that I voluntarily give my consent to
having the following information released to the researcher, Mr Jo Grimwade:

Name :_____Contact Telephone Number:_____

The purpose of this Release of Information has been fully explained to me and I have read the attached
explanatory statement of aims (Invitation to participate in research).

I have been informed that the confidentiality of the information I provide will be safeguarded.

Signed:**..**   **}**

Witness other than the experimenter: **Date: ....**

...}

Victoria University, Department of Psychology
INVITATION TO PARENTS TO PARTICIPATE IN RESEARCH PROJECT:
      Referral and Intake to Child and Adolescent Mental Health Services

Researcher :   Jo Grimwade   *Supervisor :*   Dr Suzie Dean

Thankyou for agreeing to read about this project. This statement is an invitation to you to participate in the project.

The aim of the project is to study *what actually happens when a family seeks help from a child mental health Department.* The research is particularly concerned with the events that happen between client family and Department from the time of first contact to the time of the beginning of a program of assistance. This includes contact with reception staff by telephone, letter, or face-to-face. A lot happens during this time that might be important in a family getting the most appropriate help.

You have been approached to participate because a member or members of your family recently completed one of the following stages of child mental health contact:
      1. completed a program of assistance
      2. completed assessments for a program of assistance
      3. had your first interview at (your agency)
      4. contacted the Department.

The Director, (your agency)has agreed to this project being undertaken and has given me permission to approach parents of clients of the service. Moreover, the staff you have spoken to have agreed for me to contact you and you will have had a discussion, perhaps only briefly, about the possibility of participation in the research. If you agreed to be contacted by me, a letter would have been sent to you by the Department describing the research. The letter is similar to this statement of aims and methods.

Participation in this research will not help you in gaining assistance, but the results are likely to help others in the future. Participation in the research will involve some time on your part, but the research is not intended to intrude on what is a very private arrangement that you and your family have with the Department. I do not want to spend more than one hour with you. I do not need to know the details of your personal concerns, but I would like to ask about your contacts with the Department (sort of contact, length of contact, and satisfaction with the contact).

These questions will be asked of Department staff, as well. In fact, before I speak with you, I will have spoken with the staff member with whom you have had most contact. The aim here is to get a staff perspective on what is important about first contacts. By asking staff first, who will have records available to them, I will not have to concern parents with concrete details of times and dates. Your time will be saved in this way, and you will be in the position to clarify any issues of uncertainty. Actual events are important, but how they have been experienced by parents and staff are more important.

It is important to note that the researcher cannot actually advise parents or improve the procedures during the research project, itself. If such issues should arise, parents will be encouraged to discuss these issues with staff.

Information will be collected by written notes from the interview and, hopefully, audio-recording. A summary of the interview will be sent to you for verification or correction. Only two people will have access to the data : myself as researcher and my supervisor, Dr Suzanne Dean. Summary reports of information gathering at each of the agencies will be provided which will be available to all who have contact with the Department concerned. This summary will not contain any interview material and will not refer to individual clients in any way.

Participation is voluntary : parents and staff members will only be involved with their signed consent. You are free to withdraw from the research at any time and without any consequences for yourself or the service you are receiving from the Department.

The next step after consent is to be interviewed. Following this, a transcript of the research will be sent to you. You should read through the transcript and correct any points, and then return the information to the researcher; this would be the end of your involvement.

(If you cannot participate, and someone else in the family would like to, then I would appreciate the chance to invite them to participate. Please pass on this information.)

Participants (or potential participants) can contact (research liaison officer), Human Ethics Committee, (administering hospital) on **03 9--- ---** to discuss any matters related to the ethics and conduct of this research project. Should you have any other questions about this research, you are welcome to contact myself or Suzie Dean on **03 9365 2336**. If you would like feedback, please fill out the Request for Feedback form which will be available from me at the end of your interview. Such feedback will be general. Feedback will be made available prior to the commencement of the second stage of the project.

Thankyou for giving this project your careful consideration,
<div align="center">Yours Sincerely,</div>

<div align="center">Jo Grimwade
Researcher</div>

Dated : __/__/___

Victoria University, Department of Psychology
CONSENT TO PARTICIPATE IN A RESEARCH PROJECT

Title of Research Project : Practices and Perceptions : Referral and Intake to Child and Adolescent Mental Health Services

Name of Researcher : Jo Grimwade

Consent of Participant :
I, _____ ,
of_____ ,
certify that I have the legal ability to give valid consent and that I am voluntarily giving my consent to participate in the study entitled:
Practices and Perceptions : Referral and Intake to Child and Adolescent Mental Health services being conducted at Victoria University by Jo Grimwade.

The purpose of the above project has been fully explained to me and I read and signed the attached explanatory statement of aims (Invitation to participate in research). I have also read the statement about feedback and understand that this is a statement about the feedback process rather than the content.

I certify that the objectives of the study, together with any risks to me associated with the procedures listed hereunder to be carried out in the study, have been fully explained to me by the researcher, Jo Grimwade;

and that I freely consent to participation in the interview procedures.

Procedures: a semi-structured interview of approximately one hour that identifies the various steps and stages that I encountered during the beginning of my time as a referring parents of client to the child mental health Department I attended.

I certify that I have had the opportunity to have any questions answered and that I understand that I can withdraw from this experiment at any time and that this withdrawal will not jeopardise me in any way.

I have been informed that the confidentiality of the information I provide will be safeguarded.

Signed:**..** **}**

Witness other than the researcher: **Date: ....**
..}

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Victoria University, Department of Psychology
CONSENT TO AUDIO RECORD RESEARCH INTERVIEW

Title of Research Project :   Practices and Perceptions : Referral and Intake to Child and Adolescent Mental Health Services

Researcher :

I, Jo Grimwade, certify that I have fully explained the aims, risks, and procedures associated with the audio recording of the research interview with the participant named herein, and have handed to the participant a copy of this Consent. The recordings will be transcribed and presented to the participant for verification before data analysis commences.

In my opinion the participant appears to understand and wishes to participate.

I have undertaken to the participant that the confidentiality and anonymity of the participant and his or her records will be preserved at all times.

Signed : .... Date : ..../..../....

Consent of Participant :

The purpose of the above project has been fully explained to me and I read and signed the attached explanatory statement of aims (Invitation to participate in research). I have also been explained the purpose of the audio recording and that I will have the opportunity to read and verify the transcripts of the interview. I understand the aims and procedures of the study and any risks to myself which are involved and I hereby give consent to audio recording of my interview on the condition that I can withdraw my consent at any time.

Signed : .... Date : ..../..../....

APPENDIX A8   FOUNDATIONAL SEMI-STRUCTURED INTERVIEW SCHEDULE FOR DIRECTORS AND REFERRAL AND INTAKE WORKERS

1. Background
1.1 What is your position in the agency?
1.2 How long have you been there?
1.3 Have there been other referral and intake systems in the time of your employment?
1.4 What is the history of Referral and Intake at your agency?
1.5 What is your role in the current Referral and Intake process?
1.6 What is your agency's general philosophy about Referral and Intake?
1.7 Who has responsibility for management, co-ordination, and delivery of these services?
1.8 Is there a standard procedure for Referral and Intake?
1.9 Is there a special kit for Referral and Intake?
1.10 Are you aware of any particular literature on the Referral and Intake process?

2. Intake Procedure
2.1 What is the first question you ask a referrer?
2.2 What are the steps in the referral and Intake process?
2.3 Could you give time lengths for each of the steps?
2.4 Are there particular strategies or techniques you employ when receiving a referral?
2.5 What things make for an irregular referral?
2.6 Would the parent regard Referral and Intake differently to you? In what ways?
2.7 Not all referrals lead to client families, what happens that people do not come for a first face-to-face contact?

3. Opinions about Intake
3.1 Why do you think dropping out occurs?
3.2 Are agency procedures implicated?
3.3 Why do client families continue?
3.4 Among all the services provided by your agency, what priority or importance is given to Referral and Intake?
3.5 Have you had the opportunity to work under a different Referral and Intake system?
3.6 Where was this?
3.7 What are the differences?
3.8 How significant do you consider these?
3.9 In the mind of the parent, when does Intake begin?
3.10 A parent of client is somebody who has agreed to attend your agency, how would you describe such a person before they become a parent of a client?
3.11 What else would you like to tell me about Referral and Intake?

4. This Research Process
4.1 What were the effects on parents of the research?
4.2 What were the effects on staff of the research?
4.3 Is there something more that I should know about the conduct of this research?

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APPENDIX A9   CASE-ORIENTED SEMI-STRUCTURED INTERVIEW SCHEDULE FOR CLINICIANS

1. Background

1.1 What is your position in the agency?
1.2 How long have you been there?
1.3 What is your role in the Referral and Intake process?
1.4 What is your agency's general philosophy about Referral and Intake?
1.5 Who has responsibility for management, co-ordination and delivery of these services?
1.6 Is there a standard procedure for Referral and Intake?
1.7 Is there a special kit for Referral and Intake?

2. Intake Procedure

2.1 What is the first question you ask a referrer?
2.2 What are the steps in the referral and Intake process?
2.3 Could you give time lengths for each of the steps?
2.4 Are there particular strategies or techniques you employ when receiving a referral?
2.5 What things make for an irregular referral?
    2.6 Would the parent regard Referral and Intake differently to you? In what ways?

    2.7 Not all referrals lead to client families, what happens that people do not come for a first

    face-to-face contact?

3. Opinions about Intake

3.1 Why do you think dropping out occurs?
3.2 Are agency procedures implicated?
3.3 Why do client families continue?
3.4 Among all the services provided by your agency, what priority or importance is given to Referral and Intake?
3.5 Have you had the opportunity to work under a different Referral and Intake system?
3.6 Where was this?
3.7 What are the differences?
3.8 How significant do you consider these?
3.9 In the mind of the parent, when does Intake begin?
3.10 A parent of client is somebody who has agreed to attend your agency, how would you describe such a person before they become a parent of a client?
3.11 What else would you like to tell me about Referral and Intake?

4. This Research Process

4.1 What were the effects on parents of the research?
4.2 What were the effects on staff of the research?
4.3 Is there something more that I should know about the conduct of this research?

APPENDIX A10   CASE-ORIENTED SEMI-STRUCTURED INTERVIEW SCHEDULE FOR PARENTS

1.Steps in making contact
1.1 Why did you decide to contact the agency?
1.2 Who made the suggestion?
1.3 How long was it before you knew you needed help and when you actually contacted?
1.4 What was it like making the first contact?
1.5 How did you feel about the greeting you received and the way you were treated, in general?
1.6 Was it helpful, or what?
1.7 Did past experiences influence the way you felt at the time of referral?
1.8 Do you have an idea about the Referral and Intake policy, procedure or philosophy at the agency?
1.9 How long did it take to get your concerns understood and the information collected?
1.10 Was it uncomfortable to reveal private information?
1.11 So what happened next?
1.12 Can you describe the several steps before the first contact?
1.13 Was there anybody you discussed the referral with during this time?
1.14 Why did you do this, what need was involved?
1.15 What did they say about this?
1.16 What part did your child (other family members, partner) play in the decision-making?

2. Significance of Intake Procedures
2.1 How important was the first contact to you, in the longer run?
2.2 What suggestions for change would you make to the Intake system?
2.3 Did past experiences influence the way you felt at the time of intake?
2.4 What is your attitude toward the events that followed after the first interview?
2.5 Which of those events after the first interview were significant?
2.6 What is your attitude toward Mental Health professionals?
2.7 Has your attitude changed?
2.8 How would you sum up the attitude of the agency to Referral and Intake?
2.9 What else would you like to tell me about Referral and Intake?

3. This Research Process
3.1 What was it like for you and your family to participate in this research?
3.2 What was it like for staff to participate in this research?
3.3 Is there something more that I should know about the conduct of this research?

APPENDICES B   (RETROSPECTIVE ENQUIRY FINDINGS)

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attitudes of parents toward mental health professionals, with frequencies reported for intake workers at each agency (IY & IZ), directors at each agency (DY & DZ), team leader clinician (TL), intake clinician (IC), senior clinicians (SCL), junior clinicians (JCL), and parents.

APPENDIX B7   PROVISIONAL CODING OF TRANSCRIPTS OF INTERVIEWS

(RETROSPECTIVE STUDY)

APPENDIX B8   FINAL CODING OF RETROSPECTIVE STUDY RESPONSES UNDER
SUMMARY HEADINGS

Table B8-1   Referral and intake procedures noted by staff with frequencies reported for
intake workers at each agency (IY & IZ), directors at each agency (DY & DZ), team leader
clinician (TL), intake clinician (IC), senior clinicians (SCL), junior clinicians (JCL), and
parents (corresponds to Table 3 of Chapter 9, page 220).

Table B8-2   Attitudes of staff toward referral and intake process under summary headings
with frequencies reported for intake workers at each agency (IY & IZ), directors at each
agency (DY & DZ), team leader clinician (TL), intake clinician (IC), senior clinicians
(SCL), junior clinicians (JCL), and parents (corresponds to Table 4 of Chapter 9, page 223).

Table B8-3   Referral and intake policy under summary headings with frequencies reported
for intake workers at each agency (IY & IZ), directors at each agency (DY & DZ), team
leader clinician (TL), intake clinician (IC), senior clinicians (SCL), and junior clinicians
(JCL) (corresponds to Table 5 of Chapter 9, page 225).

Table B8-4   Attitudes about parents at time of referral under summary headings with
frequencies reported for intake workers at each agency (IY & IZ), directors at each agency
(DY & DZ), team leader clinician (TL), intake clinician (IC), senior clinicians (SCL),
junior clinicians (JCL), and parents (corresponds to Table 6 of Chapter 9, page 227).

Table B8-5   Attitudes about parents prior to referral under summary headings with
frequencies reported for intake workers at each agency (IY & IZ), directors at each agency
(DY & DZ), team leader clinician (TL), intake clinician (IC), senior clinicians (SCL),
junior clinicians (JCL), and parents (corresponds to Table 7 of Chapter 9, page 227).

Table B8-6   Concerns prior to referral under summary headings with frequencies reported for
intake workers at each agency (IY & IZ), directors at each agency (DY & DZ), team leader
clinician (TL), intake clinician (IC), senior clinicians (SCL), junior clinicians (JCL), and
parents (corresponds to Table 8 of Chapter 9, page 232).

Table B8-7   Reported reasons for discontinuance under summary headings with frequencies
reported for intake workers at each agency (IY & IZ), directors at each agency (DY & DZ),
team leader clinician (TL), intake clinician (IC), senior clinicians (SCL), junior clinicians
(JCL), and parents.

APPENDIX B1   SAMPLE PAGE OF PARENT INFORMANT TRANSCRIPT

Interviewer	**Informant** (Julie, mother of Ricky, 6 years)	CODES	*Comments*
So why did you decide to contact the agency and who made the suggestion?	Actually, I <u>didn't know about the [CAMHS],</u> I mean the child and adolescent mental health. When my son, because being <u>a single mum, I want to make sure that I raise my child properly</u>. Now when he was in <u>kinder, I noticed a little bit of problem</u>, or even before that when he was still going in the creche - that was about when he was <u>two years old - I noticed that he got problem</u>. Now I don't like just to let it go, so when he was in kinder, looks like the problem wasn't going yet. So what I did I tried to ring up a few agencies around the area, like the se, but they told me they couldn't help me. So when I rang up [CAMHS], they told me to ring up S Hospital, but then when I rang up S Hospital they said ring up - what do you call this - the one in [local suburb], the family and, but then when I rang up the one in [local suburb] they told me to ring up S again. So I told them <u>'you are throwing me from one agency to another'</u> until I finally got fed up. But then the problem was still there but my son, but because being a single mum I have to <u>share my problem to a close friend</u>. So one day, actually during breaktime I happened to mention to my friend - another single mum - but she happened to have a three grown up children so I said to her 'I'm having problem with Ricky, I don't know what to do, I don't want him to grow up like this, like that'. So first she said to me 'don't you think your son has ADD?', attention deficit disorder. I said 'I don't know'. She said 'why don't you bring him to see our doctor, where our <u>family doctor</u> and ask if she could assess Ricky'. So what I did I made an appointment, I rang up our doctor from Springvale. Then she said, physically he is all right, she doesn't see anything wrong with him. She then said 'but if you worry, before you go to any institute or like child psychologist, you better having a complete physical assessment'. No so she referred me to a paediatrician. So I went to <u>a paediatrician</u> and then the paediatrician did a few tests and he said that he doesn't have that ADD, but then he especially said - the paediatrician said 'all right, if you still have worry I will <u>refer you to SE Hospital to a child psychologist</u> there'. So but then he said 'you have to wait for at least six weeks or more'	NOKNLSER PROBDESC REFMGR- FFRND GP Paed CAMHS	*No knowledge of services* *Dedicated single mother* *Problem in kinder* *2 years ~ problem* *Referred around* *Shared with a friend* *Friend's doctor* *Paediatrician* **Referred to CAMHS**

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Interviewer	Informant ([C], clinician with Vera and Alex)	CODES	Comments
What is your position at the agency and how long have you been here and involved in the intake process?	My position is Family Therapist. I've been at the agency five years. Within a Child and Family Therapist position for four of those years and for a year I've been in a Family Therapist position and there's a major distinction in the work. But I do more family therapy now and take more, more of a role in co-ordinating family therapy in our team. My role in referral and intake. Well I'm not directly involved in it. I mean we have our intake team that do all the intake process so any first contact is through there. Although you occasionally get somebody that knows of you, you know, referred to you, like recently somebody rang me wanting to make a referral and you have to then put them on to intake or whatever is necessary. So I don't have a direct role in there. I try and get the intake people to do that.	FT 5yr RCVR	*Family therapist* *5 years* *Receives referrals*
We're going to be ranging across things, it's not necessary to do all these things, but I just want to know what part you play. But so you're happy, basically you're happy to leave it to them. Does it work well?	Well yes, well I should clarify - yes it works well. I mean with that of course comes that we have a team meeting every week at which all new referrals are discussed. So when I say they take the contact, anything that's referred is discussed with the team leader and with the team. So all clinical staff can have an input into what should happen. So I suppose I'm adding to what I just said but it's not like intake staff totally decides what happens. They bring it to the team and the intake staff will generally decide whether something needs to be referred on elsewhere or whether they come to our team. Sometimes some different decisions are made at our team but that's not, it's more likely the decision with our team are, you know, if they're on our waiting list - do we need to respond very soon or should there be other agencies involved or do we need to set up a secondary consult beforehand. So it's more those clinical issues about management speed of response involved with other agencies. But intake really does a, generally does all of the things about whether somebody should come here or go somewhere else, unless they're uncertain.	SATwR&I R&IPOL	*Intake works well* *Team and team leader*
So what is your agency's general philosophy then about referral and intake?	It's interesting I haven't seen anything written anywhere. What do you mean a practical, sort of working philosophy or do you mean more like what it means to people?	NO WRTN POL	*No written philosophy*

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Interviewer	Informant	CODES	Comments
So in general terms, what's the first thing that you'll ask the referrer?	Ask the referrer? That's interesting. I guess the very <u>first question is to ask who the caller is and find out something a bit about</u> so that we know where that person's coming from. We want to get accurate information about the referrer their <u>address and contact number</u> because we need to send to feedback to the referrer about steps at all levels from intake right through to assessment with the case manager. So making sure that that's been documented. Then to the next question is concerned with the demographic details of the person <u>who's being referred</u> so that we know that they're appropriate <u>in terms of age and the area and their concerns. ...?</u>	CRIT DEMOG PROBDESC	*Who caller is* *Demographics* *Who* *Why*
Yes.	... Well I suppose ours is a bit different because our referral, <u>intake, is done by a team</u> so that they can actually do a face-to-face interview. And I think that depending on whether it's the parent first contact or whether it's coming from another source. If it's coming from another source that's not the referrer, the parent is asked for the information. So we take all the details, find out the contact and establish how to proceed and therefore, generally, it has been asking the <u>referrer to get the family to contact us</u> and establish that they're happy to referral to the service because we've had a number of cases where someone makes a referral but the family don't know about that, you know or they're not happy about that so we cannot proceed. And we would ask, if someone's making a referral with the family with them in their office, we may speak to them on the phone but we still ask the family to come in to us and they may have to speak to them and from different services. So that's why we actually vary. With some it's simple. With others it can be quite difficult to even feedback to the referrer to say that the family hasn't contacted or we write a letter to them to say there's been a referral made by whomever. What would then happen in terms of the first interview would vary depending on how the child was. If it was a <u>crisis case</u>, then the intake worker would find out something about that and the intake worker would allocate it to the crisis once we get consent of the referrer, the parent, and if it was an urgent case there is a process, it would be <u>allocated within two to three days</u>. Otherwise it would be <u>discussed by the intake worker with the team leader and discussed at the team meeting</u> and at that discussion we'd decide whether they need to be seen urgently as an <u>urgent outpatient which is generally about three weeks</u> from the initial referral, or it would go on the waiting list. And that's actually a difference too. In terms of <u>monitoring the waiting list, that's done by the intake worker in consultation with the team leader</u>. So they can go to the waiting list and if needed <u>prioritize</u> the waiting list	TMINT PCONF CRI ALLOC CRI TLO/S TM URG WTLST TLO/S	*Intake by clinical team* *Family to contact on referrer instigation* *Crisis* *Allocate crisis, 2-3 days* *Referral discussed by IC & TL, present to team* *Urgent allocation* *3 weeks* *Wait list monitored by IC & TL Can prioritize*

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Table B4-1

Interviews completed, with data quality, for the retrospective enquiry

DATA COLLECTION POINT		CAMHS AGENCY X	DATA QUALITY	CAMHS AGENCY Y	DATA QUALITY
Foundational interviews	Director on referral and intake, history, philosophy, policy, and procedure		Variable transcript	Director on referral and intake, history, philosophy, policy, and procedure	Notes. Recording often inaudible
	Coordinating referral and intake worker on training, experience, and procedures		Clear transcript	Coordinating referral and intake worker on training, experience, and procedures	Notes. Recording variably audible
Mutual termination, case completed		Clinician of Leila	Clear	Clinician of Julie	Clear
		Leila, mother of Rae, 14 years	Clear	Julie, mother of Ricky, 6 years	Clear
Mutual termination, case completed		Clinician of Pam	Clear	Clinician of Melanie	Variable
		Pam, mother of Aaron, 10 years	Clear	Melanie, mother of Will, 8 years	Clear
Mutual termination, case completed		Clinician of Vera	Clear	Clinician of Kevin	Variable
		Vera, mother of Alex, 9 years	Clear	Kevin, father of Thomas, 13 years	Clear
Completed assessment				Clinician of Michelle	Clear
				Michelle, mother of Justin, 12 years	Variable
Completed assessment				Clinician of Cheryl	Notes only
				Cheryl, mother of Rebecca, 14 years	Variable
Completed 1st interview				Clinician of Alison	Clear
				Alison, mother of Matthew, 8 years	Variable
Completed 1st interview				Clinician of Debbie	Clear
				Debbie, mother of Jim, 7 years	Clear
Completed 1st contact, referral call		Clinician of Sharon	Clear		
		Sharon, mother of Peter, 6 years	Clear		

APPENDIX B5   **PROVISIONAL CODING SHEET FOR TRANSCRIPTS OF INTERVIEWS (RETROSPECTIVE STUDY)**

Table B5-1
Original coding sheet for parent, clinician, and director transcripts for retrospective study

CODES	MEANING	IW	DIR	TL	SCL	JCL	CATEGORY
X YRS	Length of employment at service						*EXPERIENCE*
P	Parent						
MO	Mother						
FA	Father						
C	Client						
PT	Patient						
CLIN or CL	Clinician						
IW	Intake Worker						
IC	Intake Coordinator						
DIR	Director						
TL	Team leader, consultant psychiatrist						
PSY	Psychologist						
SW	Social Worker						
REG	Psychiatric Registrar						
GP	General Practitioner						
Paed	Paediatrician						
MEDSPEC	Medical specialist						
CHPSYCH	Child Psychiatrist						
MHN	Mental Health Nurse						
OT	Occupational Therapist						
FFRND	Female friend						
MGM	Maternal Grandmother						
MSIS	Maternal sister						
SCHL	School						

CODES	MEANING	IW	DIR	TL	SCL	JCL	CATEGORY
LOCAG	Local agency						
RCH	Royal Children's Hospital						
CAMHS	Child and adolescent mental health service						
FSTSTP	First step						*SERVICE ATTITUDE*
HIPRI	High Priority						
INFLATR	Influence later						
PRVNT	Prevention						
SMTH	Smooth progression						
MH--	Most disturbed persons						
CONTY	Continuity of contact and support						
OPTRES	Optimal resourcing						
RESMTCH	Match of resources to needs						
SPECROL	Specialist role						
CLMIX							
NOTADVL	Not Advice Line						
NOTADMIN	Not administrative function						
WRKSWLL	Evaluation of R&I						
LSTND	Listening						
SPNDTIM	Spend time						
STORY	Tell story						
SERI	Take seriously						
PVLID	Parent validated						
PSENS	Parent sensitive						
PDEC	Parent as decision maker						
SKSTR	Seek strengths						
EMPSTNC	Empathic stance						
AVDBLM	Avoid blame						
AVDSTYP	Avoid stereotyping						
FAMFCS	Family focus						
FAMSUP	Family support						
FAMSTR	Family strengths						
NLBL	Not labelling						

CODES	MEANING	IW	DIR	TL	SCL	JCL	CATEGORY
CLAR	Provided clarity						
SETEXPS	Set expectations of assessment & treatment						
FLEX	Flexible						
AVAIL	Available						
IWMAT	Intake worker mature person						
IWEXP	Intake worker experienced person						
IWSUP	Intake worker supported by teams						
IWFB	Intake worker feedback from teams						
TRND	Intake worker trained						
S/V	Supervision						
NOTDISP	Not case disposal system						
TRI++	Much enhanced triage						
INC/ISO	Inclusive not isolating						
ADOLR	Adolescents have rights at referral						
O/RES	Other resources in network						
LINK	Connect services with persons						
2WAY	Intake as exchange						
FSTPCON	First point of contact						*R&I POLICY*
SMTH	Smooth progression						
CONTY	Continuity of contact and support						
DEDI	Dedicated intake worker						
ROS	Rostered intake system						
CRIROS	Crisis response roster						
CONFID	Confidential process						
CLEARPRO	Clarity of procedure						
STANPRO	Standard procedure						
PROFREF	Professional referral						
PCONF	Parent to confirm professional referral						
PREF	Parent referral						
AREA	Screen for address						
AGE	Screen for age						
CRI	Crisis appointment						

CODES	MEANING	IW	DIR	TL	SCL	JCL	CATEGORY
URG	Urgent appointment						
ORD	Ordinary appointment						
ORDPRI	Ordinary appointment prioritized						
ACCSERV	Access to service						
ACCSPK	Access to speaking						
ETHSHS	Ethno-sensitive						
MGPSNS	Minority group sensitive						
NOIDEA	No knowledge of policy						
NOTCLR	Not clear about the policy or how it works						
COMRES	Community resources guide						
REFMGR-	Referral merry-go-round						
LIAISE	Intake worker liaises with network						
TRKG	Tracking of linked callers						
TLAVAIL	Team leader available						
TLALLOC	Team leader monitors & allocates cases						
IWTRES	Intake worker team response						
CENTIS-	Centralized intake services						
CMBINT-	Combined adult and child intake						
RLVR	Intake worker reliever for leave						
EVOL	Intake system evolved						
TERTREF	Tertiary referral agency						
MULTAG	Multiple agency involvement in complex						
LEGISS-	No legal issues cases						
IFORM	Intake form or sheet						*R&I PROCEDURE*
TCFORM	Telephone contact form or sheet						
ASSSEV	Assess severity						
ASSBNFT	Assess likelihood of benefit for family						
ASSURG	Assess urgency						
ASSAPP	Assess appropriateness for service						
CRIT	Criteria						
DEMOG	Demographic data						
INFOGATH	Information gathering						

CODES	MEANING	IW	DIR	TL	SCL	JCL	CATEGORY
INFOGIV	Information provision about service						
PROBDESC	Problem description						
REFON	Referred on						
MAILOUT	Send letters with relevant information						
ALLOC	Allocate case to clinician						
TM	Team meeting						
IMPPRO	Procedures improved						
TLO/S	Team leader supervises R&I work						
ACPTREF	Referral acceptance						
PERSREF	Referral by personal contacts						
RE-CON	Caller can re-contact prior to appointment						
CLINPH	Clinician phones to make appointment						
SECCONS	Secondary consultation						
TERCONS	Tertiary consultation						
NONATPRO	Non-attendance procedure						
STANASS	Standard assessment						*ASSESSMENT & TREATMENT*
SETEXPECS	Set expectations						
MUTTERM	Mutual termination						
CHLKD	Child liked						
GOOD	Quality help						
UNSAT	Unsatisfactory service						
NOTENGH	Not enough service						
DEVTPROB	Developmental problem diagnosed						
MORNDD	More needed						*ATTITUDE ABOUT MH PROFS*
POS	Positive						
MSTGD	Most are good						
VAR	Varies						
WRNARR	Not warned of client arrival						*OFFICE ISSUES*

CODES	MEANING	IW	DIR	TL	SCL	JCL	CATEGORY
PHACC	Phone access to service problematic						
RCPTATT	Receptionist's attitude disliked						
IWUNAV	Intake worker unavailable, message taken						
AH	After hours service access						
ANSMAC	Answer machine as barrier						
MIN	Minimal wait						*WAITS*
LONG	Long wait						
BRF	Brief wait						
WTLST	Waiting list						
LTE	Less than expected						
WT O/F	Other factors in wait period						
WTINDIC	Indication of length of wait						
WTLTR	Letter sent about wait						
CMTMT	Commitment						*PARENT ATTITUDE*
DET	Determined						
CHFCS	Child focus						
CONSCI	Conscientious						
POL	Polite						
HAP	Happy						
GRTFL	Grateful						
HLPFL	Helpful						
USEFL	Useful						
WEND	At wit's end, end of tether						
UPS	Upset						
RLVD	Relieved						
HOPE	Found hope						
SKG	Seeking help						
INDEP	Independent						
SRCH	Long search for help						
FAIL	Felt failure as a parent						
AMBIV	Ambivalence						

CODES	MEANING	IW	DIR	TL	SCL	JCL	CATEGORY
ASKLATE	Seek help at last						
DAUNT	Daunted in calling						
DESP	Desperate						
DANG	Dangerous						
TENS	Tense						
ANX	Anxiety provoked						
WORR	Worried about child						
SCRDCH	Scared for child						
?ENT	Unsure if entitled to use service						
MOVULN	Mother vulnerable						
FAUNSUP	Father unsupportive						
FRBLM	Fear Blame						
FRLOR	Fear loss of respect						
FRCONQS	Fear consequences (of not getting help)						
FRJDG	Fear judgement of others						
EXAGPROB	Exaggerate problem to ensure response						
PDEC	Parental decision						
NOOPTN	No other option but to seek help						
NOCOMPL	No complaints						
COMPL	Complaints						
SERVFIT	Service fit						
PERSFIT	Personality fit with clinicians						
ATHOME	Feeling at home with the service						
CHKG	Checking						
NDYFAM	Needy family						
PAIN	Hidden emotional pain concerning pre-referral circumstances and events						*PARENT BEFORE*
REFMGR	Referral merry-go-round						
NOKNLSER	No knowledge of services available						
NOKNLRI	No knowledge of referral & intake policy						
CLUNAW	Clinician unaware						

CODES	MEANING	IW	DIR	TL	SCL	JCL	CATEGORY
POTC	Potential client						*Pre-referral STATUS*
SKG	Seeking help						
CHTRB	Child troubles						
CHPROB	Child with problems						
CHDIE	Child wanting to die						
FAMTRB	Family troubles						
PWRND	Parent warned about child need						
TOC	Recognized from time of contact						
KNOS	Knowledge of service						
VARP	Variety of parental positions						
IPRO	Intake procedure unsatisfactory						*DROP OUTS*
HLPUSAT	Help unsatisfactory						
CONTY-	Lack of continuity						
UPSET	Parent upset with service						
SCHLRPT	Request for school report antagonizes						
SERVFIT-	Fit with service unsatisfactory						
PERSFIT-	Fit with clinicians unsatisfactory						
COERC	Coerced referral						
ND/VAL+/-	Recognize need, question value of effort						
AMBIV	Ambivalence						
REFON	Referred on						
PRIV	Private services accessed						
ACCPROB	Access problem, usually transport						
WAITPROB	Problem with waiting						
WAITRSLV	Waiting resolved issue						
SMLPROB	Small problem not worth effort						
ASSUSFL	Assessment was useful						
LIFCHG	Life change						
BETTER	Improved						
DECON	Decide not proceed with referral						

CODES	MEANING	IW	DIR	TL	SCL	JCL	CATEGORY
IEXPECS-JNRSTF	Intake expectations not met Junior staff						
HLPOTHS	Help others						*RESEARCH*

APPENDIX B6   PROVISIONAL CODING OF TRANSCRIPTS OF INTERVIEWS (RETROSPECTIVE STUDY)

Table B6-1

Summary table of coding of transcripts for retrospective study for aspects of referral and intake policy, with frequencies reported for intake workers at each agency (IY & IZ), directors at each agency (DY & DZ), team leader clinician (TL), intake clinician (IC), senior clinicians (SCL), junior clinicians (JCL), and parents.

CODES	MEANING	IY	IZ	DY	DZ	TL	IC	SCL	JCL	PARENT	CATEGORY
ANTIPLCE	Anticipated place in program							J			*R&I POLICY*
CENT	Intake centralized in CAMHS							PV			*R&I POLICY*
CENTIS-	Centralized intake services				-				D-		*R&I POLICY*
CLEARPRO	Clarity of procedure							J	Me	J	*R&I POLICY*
CLNM	Clinician's name provided							P			*R&I POLICY*
CMBINT+/-	Combined adult and child intake				-				D-		*R&I POLICY*
COMRES	Community resources guide				1				Me		*R&I POLICY*
CONFID	Confidential process				1						*R&I POLICY*
CONTYPOL	Continuity of contact and support									K-	*R&I POLICY*
CRI	Crisis appointment	1	1		1			PVJ			*R&I POLICY*
CRIROS	Crisis response roster								MeD		*R&I POLICY*
DEDI	Dedicated intake worker		1	1			1	PJA	Me		*R&I POLICY*
ETHSNS	Ethno-sensitive				1		1				*R&I POLICY*
EVOL	Intake system evolved		1		1						*R&I POLICY*
FSTPCON	First point of contact	1		1	1		1	VJ		D	*R&I POLICY*
IPOLSTAB	Intake policy stable		1								*R&I POLICY*
IWLEAVE	Does IW role when IW on leave							J			*R&I POLICY*
IWLIMITS	IW role has specific limits		1								*R&I POLICY*
IWTRES	Intake worker team response				1						*R&I POLICY*

CODES	MEANING	IY	IZ	DY	DZ	TL	IC	SCL	JCL	PARENT	CATEGORY
LEGISS +/-	Legal issues cases					-					*R&I POLICY*
LIAISE	Intake worker liaises with network				1						*R&I POLICY*
LOCAGSUP	Local agency support					W				W	*R&I POLICY*
LOTE	Language other than English		1			W					*R&I POLICY*
MULTAG	Multiple agency involvement in complex					W		V			*R&I POLICY*
NAME	Name of clinician to be given		1		1						*R&I POLICY*
NOTROS	Not roster system		1			1		A			*R&I POLICY*
NOWRPY	No written policy							V			*R&I POLICY*
ORD	Ordinary appointment				1						*R&I POLICY*
ORDPRI	Ordinary appointment prioritized				1						*R&I POLICY*
PCONF	Parent to confirm professional referral	1			1		S	VJ			*R&I POLICY*
PREF	Parent referral		1			1					*R&I POLICY*
PROFREF	Professional referral	S				W		PVJ		WPVS	*R&I POLICY*
REFMGR-	Referral merry-go-round									J	*R&I POLICY*
RLVR	Intake worker reliever for leave							J			*R&I POLICY*
ROS +/-	Rostered intake system							V-J-C-A-			*R&I POLICY*
ROS-STF +/-	Rostered staff			-				V-			*R&I POLICY*
RR	Re-referral								Me	MeA	*R&I POLICY*
STANPRO	Standard procedure			1	1			PVJ CA			*R&I POLICY*
TERTREF	Tertiary referral agency					1					*R&I POLICY*
TLALLOC	Team leader monitors & allocates cases					1		A			*R&I POLICY*
TLAVAIL	Team leader available				1						*R&I POLICY*
TRKG	Tracking of linked callers				1						*R&I POLICY*
URG	Urgent appointment	1	1		1	1		J			*R&I POLICY*

Table B6-2

Summary table of coding of transcripts for retrospective study for aspects of referral and intake procedure, with frequencies reported for intake workers at each agency (IY & IZ), directors at each agency (DY & DZ), team leader clinician (TL), intake clinician (IC), senior clinicians (SCL), junior clinicians (JCL), and parents.

CODES	MEANING	IY	IZ	DY	DZ	TL	IC	SCL	JCL	PARENT	CATEGORY
ACPTREF	Referral acceptance						1				*R&I PROCEDURE*
ALLOC	Allocate case to clinician										*R&I PROCEDURE*
ASSAPP	Assess appropriateness for service							J	Me		*R&I PROCEDURE*
ASSBNFT	Assess likelihood of benefit for family						1				*R&I PROCEDURE*
ASSSEV	Assess severity							JA			*R&I PROCEDURE*
ASSURG	Assess urgency				1		1	J	Me		*R&I PROCEDURE*
CLOAD+/-	Clinical load	+	-	+							*R&I PROCEDURE*
CLPH	Clinician phones to make appointment	1		1			1	P	Me		*R&I PROCEDURE*
CLTKS	Clinician takes case							P			*R&I PROCEDURE*
CONFLET	Confirmation letter						S				*R&I PROCEDURE*
CRIRARE	Crises are rare							J			*R&I PROCEDURE*
CRIT	Criteria	1	1		1			PVJ	Me		*R&I PROCEDURE*
DEMOG	Demographic data	1	1		1		1	J			*R&I PROCEDURE*
FBTM	Feedback from team to IW		+		-						*R&I PROCEDURE*
FSTIV	First appointment							J		JC	*R&I PROCEDURE*
HAND	Handwritten notes by IW		1								*R&I PROCEDURE*
HO	Handover to allocated clinician		1								*R&I PROCEDURE*
HURD	Hurdles and barriers to access						1				*R&I PROCEDURE*
IFORM	Intake form or sheet	1	1				1	JPA	Me		*R&I PROCEDURE*
IMPPRO	Procedures improved									MeA	*R&I PROCEDURE*
INFOGATH	Information gathering	1	1	1	1	1	1				*R&I PROCEDURE*
INFOGIV	Information provision about service	1				W	S				*R&I PROCEDURE*

CODES	MEANING	I Y	I Z	D Y	D Z	TL	IC	SCL	JCL	PARENT	CATEGORY
IWCON	Intake worker contacted	1				W		J		A	*R&I PROCEDURE*
JOBSTYLE	Style of undertaking the work		1								*R&I PROCEDURE*
LETRFR	Letter to referrer prior to appointment							P			*R&I PROCEDURE*
MAILOUT	Send letters with relevant information	1	1			1		V	Me	W	*R&I PROCEDURE*
MAILALLOC	Letter sent to confirm allocated clinician							V		PS	*R&I PROCEDURE*
NONATPRO	Non-attendance procedure					1		P			*R&I PROCEDURE*
PERSREF	Referral by personal contacts				1		1				*R&I PROCEDURE*
PREDICT	IW able to predict if complete assessment		1								*R&I PROCEDURE*
PROBDESC	Problem description				1			J	Me		*R&I PROCEDURE*
RE-CON	Caller can re-contact prior to appointment	1	1			1	S			VS	*R&I PROCEDURE*
REFON	Referred on		1		1	1		P			*R&I PROCEDURE*
REGIST	Registration of cases							JC			*R&I PROCEDURE*
RFRCONT	Referrer contacted				1						*R&I PROCEDURE*
RFRCLAR	Referral purpose clarified				1						*R&I PROCEDURE*
SECCONS	Secondary consultation				1	1					*R&I PROCEDURE*
T*	Telephone referral time length		15-20			20-30					*R&I PROCEDURE*
TCFORM	Telephone contact form or sheet		1		1			P		C	*R&I PROCEDURE*
TERCONS	Tertiary consultation				1						*R&I PROCEDURE*
TLL	Team Leader liaison							PV			*R&I PROCEDURE*
TLO/S	Team leader supervises R&I work							V			*R&I PROCEDURE*
TM	Team meeting	1		1	1	1		PV			*R&I PROCEDURE*
TMRESP	Team response				1						*R&I PROCEDURE*
TPIV	Telephone interview							V			*R&I PROCEDURE*
UNDERS	Understanding									VS	*R&I PROCEDURE*
VOLALLOC	Voluntary allocation of cases							P			*R&I PROCEDURE*

Table B6-3

Summary table of coding of transcripts for retrospective study for aspects of service attitude toward referral and intake, with frequencies reported for intake workers at each agency (IY & IZ), directors at each agency (DY & DZ), team leader clinician (TL), intake clinician (IC), senior clinicians (SCL), junior clinicians (JCL), and parents.

CODES	MEANING	IY	IZ	DY	DZ	TL	IC	SCL	JCL	PARENT	CATEGORY
ADOLR	Adolescents have rights at referral				1			V			*SERVICE ATTITUDE*
AVAIL	Available			1						A	*SERVICE ATTITUDE*
AVDBLM	Avoid blame				1						*SERVICE ATTITUDE*
AVDSTYP	Avoid stereotyping				1						*SERVICE ATTITUDE*
BEGTRUST	Begins trust		1					J			*SERVICE ATTITUDE*
BURDEN	New case as burden								Me		*SERVICE ATTITUDE*
CLAR	Provided clarity	1	1					P		CD	*SERVICE ATTITUDE*
CONTY	Continuity of contact and support		+	+			+	+PJ A			*SERVICE ATTITUDE*
CRUX	Crucial to process									VK	*SERVICE ATTITUDE*
EMPSTNC	Empathic stance	1			1			J			*SERVICE ATTITUDE*
EX-PT	Former patient							A	Me	MeA	*SERVICE ATTITUDE*
FAMFCS	Family focus				1				Me		*SERVICE ATTITUDE*
FAMSTR	Family strengths				1						*SERVICE ATTITUDE*
FAMSUP	Family support				1						*SERVICE ATTITUDE*
FRNDLY	Friendly									P	*SERVICE ATTITUDE*
FLEXI	Flexible		1							MiA	*SERVICE ATTITUDE*
FSTSTP	First step	1	1	1				PC			*SERVICE ATTITUDE*
HIPRI	High Priority	1	1		1	1		PVJ A		S	*SERVICE ATTITUDE*
INC/ISO	Inclusive not isolating		1		1						*SERVICE ATTITUDE*
INFLATR	Influence later				1						*SERVICE ATTITUDE*
IWEXP	Intake worker experienced person			1	1						*SERVICE ATTITUDE*

CODES	MEANING	IY	IZ	DY	DZ	TL	IC	SCL	JCL	PARENT	CATEGORY
IWFB +/-	Intake worker feedback from teams				-						SERVICE ATTITUDE
IWMAT	Intake worker mature person		1		1						SERVICE ATTITUDE
IWSUP	Intake worker supported by teams				1						SERVICE ATTITUDE
LINK	Connect services with persons				1			A			SERVICE ATTITUDE
LSTND	Listened to and heard	1	1		1					PSCA	SERVICE ATTITUDE
MAXCSS	Maximum cases to be seen								Me		SERVICE ATTITUDE
MH--	Most disturbed persons	1						A			SERVICE ATTITUDE
NLBL	Not labelling				1						SERVICE ATTITUDE
NOTADMIN	Not administrative function				1			A		K	SERVICE ATTITUDE
NOTADVL	Not Advice Line							J			SERVICE ATTITUDE
NOTDISP	Not case disposal system				1						SERVICE ATTITUDE
OPTRES	Optimal resourcing		1			1			D		SERVICE ATTITUDE
O/RES	Other resources in network				1						SERVICE ATTITUDE
PCONS	Parent consulted				1						SERVICE ATTITUDE
PDECM	Parent as decision maker			1	1			J			SERVICE ATTITUDE
PRVNT	Prevention		1					A			SERVICE ATTITUDE
PSENS	Parent sensitive							PJ		PS	SERVICE ATTITUDE
PT	Patient rather than client				1						SERVICE ATTITUDE
PVLID	Parent validated				1						SERVICE ATTITUDE
READY	Service ready and available for referral			1							SERVICE ATTITUDE
2WAY	Intake as exchange			1							SERVICE ATTITUDE
RESMTCH	Match of resources to needs					1					SERVICE ATTITUDE
SERI	Take seriously				1	W				W	SERVICE ATTITUDE
SETEXPS	Set expectations of assess& treatment	1		1	1	1		PJ		W	SERVICE ATTITUDE
SMTH	Smooth progression				1			PJA			SERVICE ATTITUDE
SPECROL	IW as specialist role			1	1						SERVICE ATTITUDE
SPNDTIM	Spend time		1		1						SERVICE ATTITUDE
STORY	Tell story				1						SERVICE ATTITUDE
STR	Strengths				1						SERVICE ATTITUDE
S/V	Supervision				1						SERVICE ATTITUDE
TRI+/-	Enhanced triage		-		+			J			SERVICE ATTITUDE

CODES	MEANING	IY	IZ	DY	DZ	TL	IC	SCL	JCL	PARENT	CATEGORY
TRND	Intake worker trained				1				D		*SERVICE ATTITUDE*
UF	User friendly	1						J		PVS	*SERVICE ATTITUDE*

Table B7-1

Alphabetical listing of codes for transcripts for retrospective study for aspects of referral and intake work, with frequencies reported for intake workers at each agency (IY & IZ), directors at each agency (DY & DZ), team leader clinician (TL), intake clinician (IC), senior clinicians (SCL), junior clinicians (JCL), and parents.

CODES	MEANING	IY	IZ	DY	DZ	TL	IC	SCL	JCL	PARENT	CATEGORY
X YRS	Length of employment at service	3	3	22	5	15	3	5,20, 20,20	3,1		*EXPERIENCE*
A&E	Accident & Emergency or Casualty Dept		m								*EXPERIENCE*
CAMHS	Child and adolescent mental health service										*EXPERIENCE*
C	Client										*EXPERIENCE*
CH	Child										*EXPERIENCE*
CLIN or CL	Clinician										*EXPERIENCE*
CHPSYCH	Child Psychiatrist			1		K	W				*EXPERIENCE*
DIR	Director			1	1						*EXPERIENCE*
FA	Father									K	*EXPERIENCE*
FFRND	Female friend									PJVMeCMiA	*EXPERIENCE*
FT	Family Therapist						V				*EXPERIENCE*
GP	General Practitioner									JMeVSMi	*EXPERIENCE*
IC	Intake Coordinator	1	1				S				*EXPERIENCE*
IW	Intake Worker	1	1								*EXPERIENCE*
LOCAG	Local agency					W		A		A	*EXPERIENCE*
MEDSPEC	Medical specialist										*EXPERIENCE*
MFRND	Male friend									K	*EXPERIENCE*
MGM	Maternal Grandmother									MeD	*EXPERIENCE*
MHN	Mental Health Nurse		1								*EXPERIENCE*
MIL	Mother in law									V-	*EXPERIENCE*
MO	Mother									WPVSJMeCMiA	*EXPERIENCE*

CODES	MEANING	IY	IZ	DY	DZ	TL	IC	SCL	JCL	PARENT	CATEGORY
MSIS	Maternal sister									Me	*EXPERIENCE*
OPP	Opponent									JMeKDAVS	*EXPERIENCE*
OT	Occupational Therapist										*EXPERIENCE*
P	Parent										*EXPERIENCE*
Paed	Paediatrician							VS		WPVJS	*EXPERIENCE*
PRIV	Private consultant							MiC			*EXPERIENCE*
PSY	Psychologist							JCMi	MeD		*EXPERIENCE*
PT	Patient rather than client				1						*EXPERIENCE*
PTX	Psychotherapist							P			*EXPERIENCE*
RCH	Royal Children's Hospital									WMiCD	*EXPERIENCE*
REGR	Psychiatric Registrar									WmeK	*EXPERIENCE*
SCHL	School									WPVJKMiA	*EXPERIENCE*
STDNT	Student								Me	JMe	*EXPERIENCE*
SW	Social Worker							A			*EXPERIENCE*
TL	Team leader, consultant psychiatrist					W					*EXPERIENCE*

Table B7-2

Alphabetical listing of codes for transcripts for retrospective study for aspects of referral and intake policy, with frequencies reported for intake workers at each agency (IY & IZ), directors at each agency (DY & DZ), team leader clinician (TL), intake clinician (IC), senior clinicians (SCL), junior clinicians (JCL), and parents.

CODES	MEANING	IY	IZ	DY	DZ	TL	IC	SCL	JCL	PARENT	CATEGORY
ANTIPLCE	Anticipated place in program							J			*R&I POLICY*
CENT	Intake centralized in CAMHS							PV			*R&I POLICY*
CENTIS-	Centralized intake services				-				D-		*R&I POLICY*
CLEARPRO	Clarity of procedure							J	Me	J	*R&I POLICY*
CLNM	Clinician's name provided							P			*R&I POLICY*
CMBINT+/-	Combined adult and child intake				-				D-		*R&I POLICY*
COMRES	Community resources guide				1				Me		*R&I POLICY*
CONFID	Confidential process				1						*R&I POLICY*
CONTYPOL	Continuity of contact and support									K-	*R&I POLICY*
CRI	Crisis appointment	1	1		1			PVJ			*R&I POLICY*
CRIROS	Crisis response roster								MeD		*R&I POLICY*
DEDI	Dedicated intake worker		1	1			1	PJA	Me		*R&I POLICY*
ETHSNS	Ethno-sensitive					1	1				*R&I POLICY*
EVOL	Intake system evolved		1		1						*R&I POLICY*
FSTPCON	First point of contact	1		1	1		1	VJ		D	*R&I POLICY*
IPOLSTAB	Intake policy stable		1								*R&I POLICY*
IWLEAVE	Does IW role when IW on leave							J			*R&I POLICY*
IWLIMITS	IW role has specific limits		1								*R&I POLICY*
IWTRES	Intake worker team response				1						*R&I POLICY*
LEGISS +/-	Legal issues cases						-				*R&I POLICY*
LIAISE	Intake worker liaises with network				1						*R&I POLICY*
LOCAGSUP	Local agency support					W				W	*R&I POLICY*

CODES	MEANING	IY	IZ	DY	DZ	TL	IC	SCL	JCL	PARENT	CATEGORY
LOTE	Language other than English		1			W					*R&I POLICY*
MULTAG	Multiple agency involvement in complex					W		V			*R&I POLICY*
NAME	Name of clinician to be given		1		1						*R&I POLICY*
NOTROS	Not roster system		1			1		A			*R&I POLICY*
NOWRPY	No written policy							V			*R&I POLICY*
ORD	Ordinary appointment				1						*R&I POLICY*
ORDPRI	Ordinary appointment prioritized				1						*R&I POLICY*
PCONF	Parent to confirm professional referral	1			1		S	VJ			*R&I POLICY*
PREF	Parent referral		1			1					*R&I POLICY*
PROFREF	Professional referral	S				W		PVJ		WPVS	*R&I POLICY*
REFMGR-	Referral merry-go-round									J	*R&I POLICY*
RLVR	Intake worker reliever for leave							J			*R&I POLICY*
ROS +/-	Rostered intake system							V-J-C-A-			*R&I POLICY*
ROS-STF +/-	Rostered staff			-				V-			*R&I POLICY*
RR	Re-referral								Me	MeA	*R&I POLICY*
STANPRO	Standard procedure			1	1			PVJCA			*R&I POLICY*
TERTREF	Tertiary referral agency					1					*R&I POLICY*
TLALLOC	Team leader monitors & allocates cases					1		A			*R&I POLICY*
TLAVAIL	Team leader available				1						*R&I POLICY*
TRKG	Tracking of linked callers				1						*R&I POLICY*
URG	Urgent appointment	1	1		1	1		J			*R&I POLICY*

Table B7-3

Alphabetical listing of codes for transcripts for retrospective study for aspects of referral and intake procedure, with frequencies reported for intake workers at each agency (IY & IZ), directors at each agency (DY & DZ), team leader clinician (TL), intake clinician (IC), senior clinicians (SCL), junior clinicians (JCL), and parents.

CODES	MEANING	IY	IZ	DY	DZ	TL	IC	SCL	JCL	PARENT	CATEGORY
ACPTREF	Referral acceptance						1				*R&I PROCEDURE*
ALLOC	Allocate case to clinician										*R&I PROCEDURE*
ASSAPP	Assess appropriateness for service							J	Me		*R&I PROCEDURE*
ASSBNFT	Assess likelihood of benefit for family						1				*R&I PROCEDURE*
ASSSEV	Assess severity							JA			*R&I PROCEDURE*
ASSURG	Assess urgency					1	1	J	Me		*R&I PROCEDURE*
CLOAD+/-	Clinical load	+	-	+							*R&I PROCEDURE*
CLPH	Clinician phones to make appointment	1		1			1	P	Me		*R&I PROCEDURE*
CLTKS	Clinician takes case							P			*R&I PROCEDURE*
CONFLET	Confirmation letter						S				*R&I PROCEDURE*
CRIRARE	Crises are rare							J			*R&I PROCEDURE*
CRIT	Criteria	1	1		1			PVJ	Me		*R&I PROCEDURE*
DEMOG	Demographic data	1	1		1	1		J			*R&I PROCEDURE*
FBTM	Feedback from team to IW		+		-						*R&I PROCEDURE*
FSTIV	First appointment							J		JC	*R&I PROCEDURE*
HAND	Handwritten notes by IW		1								*R&I PROCEDURE*
HO	Handover to allocated clinician		1								*R&I PROCEDURE*
HURD	Hurdles and barriers to access						1				*R&I PROCEDURE*
IFORM	Intake form or sheet	1	1				1	JPA	Me		*R&I PROCEDURE*
IMPPRO	Procedures improved									MeA	*R&I PROCEDURE*
INFOGATH	Information gathering	1	1	1	1	1	1				*R&I PROCEDURE*
INFOGIV	Information provision about service	1				W	S				*R&I PROCEDURE*

CODES	MEANING	IY	IZ	DY	DZ	TL	IC	SCL	JCL	PARENT	CATEGORY
IWCON	Intake worker contacted	1				W		J		A	*R&I PROCEDURE*
JOBSTYLE	Style of undertaking the work		1								*R&I PROCEDURE*
LETRFR	Letter to referrer prior to appointment							P			*R&I PROCEDURE*
MAILOUT	Send letters with relevant information	1	1			1		V	Me	W	*R&I PROCEDURE*
MAILALLOC	Letter sent to confirm allocated clinician							V		PS	*R&I PROCEDURE*
NONATPRO	Non-attendance procedure					1		P			*R&I PROCEDURE*
PERSREF	Referral by personal contacts				1		1				*R&I PROCEDURE*
PREDICT	IW able to predict if complete assessment		1								*R&I PROCEDURE*
PROBDESC	Problem description				1			J	Me		*R&I PROCEDURE*
RE-CON	Caller can re-contact prior to appointment	1	1			1	S			VS	*R&I PROCEDURE*
REFON	Referred on		1		1	1		P			*R&I PROCEDURE*
REGIST	Registration of cases							JC			*R&I PROCEDURE*
RFRCONT	Referrer contacted				1						*R&I PROCEDURE*
RFRCLAR	Referral purpose clarified				1						*R&I PROCEDURE*
SECCONS	Secondary consultation				1	1					*R&I PROCEDURE*
T*	Telephone referral time length		15-20			20-30					*R&I PROCEDURE*
TCFORM	Telephone contact form or sheet		1		1			P		C	*R&I PROCEDURE*
TERCONS	Tertiary consultation				1						*R&I PROCEDURE*
TLL	Team Leader liaison							PV			*R&I PROCEDURE*
TLO/S	Team leader supervises R&I work							V			*R&I PROCEDURE*
TM	Team meeting	1		1	1	1		PV			*R&I PROCEDURE*
TMRESP	Team response				1						*R&I PROCEDURE*
TPIV	Telephone interview							V			*R&I PROCEDURE*
UNDERS	Understanding									VS	*R&I PROCEDURE*
VOLALLOC	Voluntary allocation of cases							P			*R&I PROCEDURE*

Table B7-4

Alphabetical listing of codes for transcripts for retrospective study of attitudes toward the referral and intake service, with frequencies reported for intake workers at each agency (IY & IZ), directors at each agency (DY & DZ), team leader clinician (TL), intake clinician (IC), senior clinicians (SCL), junior clinicians (JCL), and parents.

CODES	MEANING	IY	IZ	DY	DZ	TL	IC	SCL	JCL	PARENT	CATEGORY
ADOLR	Adolescents have rights at referral				1			V			*SERVICE ATTITUDE*
AVAIL	Available		1							A	*SERVICE ATTITUDE*
AVDBLM	Avoid blame				1						*SERVICE ATTITUDE*
AVDSTYP	Avoid stereotyping				1						*SERVICE ATTITUDE*
BEGTRUST	Begins trust		1					J			*SERVICE ATTITUDE*
BURDEN	New case as burden								Me		*SERVICE ATTITUDE*
CLAR	Provided clarity	1	1					P		CD	*SERVICE ATTITUDE*
CONTY	Continuity of contact and support		+	+			+	+PJA			*SERVICE ATTITUDE*
CRUX	Crucial to process									VK	*SERVICE ATTITUDE*
EMPSTNC	Empathic stance	1			1			J			*SERVICE ATTITUDE*
EX-PT	Former patient							A	Me	MeA	*SERVICE ATTITUDE*
FAMFCS	Family focus				1				Me		*SERVICE ATTITUDE*
FAMSTR	Family strengths				1						*SERVICE ATTITUDE*
FAMSUP	Family support				1						*SERVICE ATTITUDE*
FRNDLY	Friendly									P	*SERVICE ATTITUDE*
FLEXI	Flexible		1							MiA	*SERVICE ATTITUDE*
FSTSTP	First step	1	1	1				PC			*SERVICE ATTITUDE*
HIPRI	High Priority	1	1		1	1		PVJA		S	*SERVICE ATTITUDE*
INC/ISO	Inclusive not isolating		1		1						*SERVICE ATTITUDE*
INFLATR	Influence later				1						*SERVICE ATTITUDE*
IWEXP	Intake worker experienced person			1	1						*SERVICE ATTITUDE*
IWFB +/-	Intake worker feedback from teams				-						*SERVICE ATTITUDE*
IWMAT	Intake worker mature person			1	1						*SERVICE ATTITUDE*
IWSUP	Intake worker supported by teams				1						*SERVICE ATTITUDE*

CODES	MEANING	I Y Y	I Z	D Y	D Z	TL	I C C	SCL	JCL	PARENT	CATEGORY
LINK	Connect services with persons				1			A			*SERVICE ATTITUDE*
LSTND	Listened to and heard	1	1		1					PSCA	*SERVICE ATTITUDE*
MAXCSS	Maximum cases to be seen								Me		*SERVICE ATTITUDE*
MH--	Most disturbed persons	1						A			*SERVICE ATTITUDE*
NLBL	Not labelling				1						*SERVICE ATTITUDE*
NOTADMIN	Not administrative function				1			A		K	*SERVICE ATTITUDE*
NOTADVL	Not Advice Line							J			*SERVICE ATTITUDE*
NOTDISP	Not case disposal system				1						*SERVICE ATTITUDE*
OPTRES	Optimal resourcing		1			1			D		*SERVICE ATTITUDE*
O/RES	Other resources in network				1						*SERVICE ATTITUDE*
PCONS	Parent consulted				1						*SERVICE ATTITUDE*
PDECM	Parent as decision maker			1	1			J			*SERVICE ATTITUDE*
PRVNT	Prevention		1					A			*SERVICE ATTITUDE*
PSENS	Parent sensitive							PJ		PS	*SERVICE ATTITUDE*
PT	Patient rather than client				1						*SERVICE ATTITUDE*
PVLID	Parent validated				1						*SERVICE ATTITUDE*
READY	Service ready and available for referral			1							*SERVICE ATTITUDE*
2WAY	Intake as exchange			1							*SERVICE ATTITUDE*
RESMTCH	Match of resources to needs					1					*SERVICE ATTITUDE*
SERI	Take seriously				1	W				W	*SERVICE ATTITUDE*
SETEXPS	Set expectations of assess& treatment	1		1	1	1		PJ		W	*SERVICE ATTITUDE*
SMTH	Smooth progression				1			PJA			*SERVICE ATTITUDE*
SPECROL	IW as specialist role			1	1						*SERVICE ATTITUDE*
SPNDTIM	Spend time		1		1						*SERVICE ATTITUDE*
STORY	Tell story				1						*SERVICE ATTITUDE*
STR	Strengths				1						*SERVICE ATTITUDE*
S/V	Supervision				1						*SERVICE ATTITUDE*
TRI+/-	Enhanced triage		-		+			J			*SERVICE ATTITUDE*
TRND	Intake worker trained				1				D		*SERVICE ATTITUDE*
UF	User friendly	1						J		PVS	*SERVICE ATTITUDE*

Table B7-5

Alphabetical listing of codes for transcripts for retrospective study concerning assessment and treatment, with frequencies reported for intake workers at each agency (IY & IZ), directors at each agency (DY & DZ), team leader clinician (TL), intake clinician (IC), senior clinicians (SCL), junior clinicians (JCL), and parents.

CODES	MEANING	IY	IZ	DY	DZ	TL	IC	SCL	JCL	PARENT	CATEGORY
CHLKD	Child liked									MeV-JC	*ASSESS & TREAT*
DEVTPROB	Developmental problem diagnosed			K		W		PVMi		WPVSMiK	*ASSESS & TREAT*
FBKRECS	Feedback recommendations							P			*ASSESS & TREAT*
GOOD	Quality help		1								*ASSESS & TREAT*
MUTTERM	Mutual termination							P	Me	MeP	*ASSESS & TREAT*
NOTENGH	Not enough service										*ASSESS & TREAT*
PUNC	Parent uncomfortable							P			*ASSESS & TREAT*
RGATT	Regular attender								D	J	*ASSESS & TREAT*
SCHLSUP	School supportive					W		VJ		VJ	*ASSESS & TREAT*
SETEXPECS	Set expectations									K-	*ASSESS & TREAT*
SPECASS	Specialist assessment									WPVKMi	*ASSESS & TREAT*
SPECTMS	Specialist teams			1				JA			*ASSESS & TREAT*
STANASS	Standard assessment	1		1	1		1	PVJC	Me	WD	*ASSESS & TREAT*
TXCONS	Treatment consistency							J		JMe	*ASSESS & TREAT*
UNSAT	Unsatisfactory service							C			*ASSESS & TREAT*

Table B7-6

Alphabetical listing of codes for transcripts for retrospective study concerning office issues, with frequencies reported for intake workers at each agency (IY & IZ), directors at each agency (DY & DZ), team leader clinician (TL), intake clinician (IC), senior clinicians (SCL), junior clinicians (JCL), and parents.

CODES	MEANING	I Y	I Z	D Y	D Z	TL	I C	SCL	JCL	PARENT	CATEGORY
AH	After hours service access							J			*OFFICE ISSUES*
ANSMAC	Answer machine as barrier							J			*OFFICE ISSUES*
IWUNAV	Intake worker unavailable, message taken			1							*OFFICE ISSUES*
PHACC	Phone access to service problematic							J			*OFFICE ISSUES*
RCPTATT	Receptionist's attitude disliked							J			*OFFICE ISSUES*

Table B7-7

Alphabetical listing of codes for transcripts for retrospective study concerning the impact of the research upon informants, with frequencies reported for intake workers at each agency (IY & IZ), directors at each agency (DY & DZ), team leader clinician (TL), intake clinician (IC), senior clinicians (SCL), junior clinicians (JCL), and parents.

CODES	MEANING	I Y	I Z	D Y	D Z	TL	I C	SCL	JCL	PARENT	CATEGORY
HLPOTHS	Help others									JD	*RESEARCH*

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Table B7-8

Alphabetical listing of codes for transcripts for retrospective study concerning parent attitudes about referral and intake, with frequencies reported for intake workers at each agency (IY & IZ), directors at each agency (DY & DZ), team leader clinician (TL), intake clinician (IC), senior clinicians (SCL), junior clinicians (JCL), and parents.

CODES	MEANING	IY	IZ	DY	DZ	TL	IC	SCL	JCL	PARENT	CATEGORY
ACCISS	Access issues				1			J	Me	Me	*PARENT ATTITUDE*
AMBIVP	Ambivalence							V		MeCA	*PARENT ATTITUDE*
ANX	Anxiety provoked				1			Mi		P[FF]	*PARENT ATTITUDE*
ATHOME	Feeling at home with the service									WCA	*PARENT ATTITUDE*
BOPAR	Both parents										*PARENT ATTITUDE*
CHFCS	Child focus							PVS		PSMeKDAJ MiC	*PARENT ATTITUDE*
CHKG	Checking				1						*PARENT ATTITUDE*
CMTMT	Commitment							JV		PVMeAKS	*PARENT ATTITUDE*
CMTLVL	Commitment level		1								*PARENT ATTITUDE*
COMFTBC	Comfortable to be confronted		1								*PARENT ATTITUDE*
COMPL	Complaints				1						*PARENT ATTITUDE*
CONSCI	Conscientious							J			*PARENT ATTITUDE*
DANG	Dangerous									Me	*PARENT ATTITUDE*
DAUNT	Daunted in calling						1				*PARENT ATTITUDE*
DESP	Desperate					1	1			WVSJMeCMiA	*PARENT ATTITUDE*
DET	Determined			K		W		PVJ		WVSJMeKA	*PARENT ATTITUDE*
?ENT	Unsure if entitled to use service									C	*PARENT ATTITUDE*
EXAGPROB	Exaggerate problem to ensure response									C	*PARENT ATTITUDE*
FAIL	Felt failure as a parent									WVKJMe	*PARENT ATTITUDE*
FASUP+/-	Paternal support +/-					W-		A-	Me- D-	W-P+Me- A-D-	*PARENT ATTITUDE*

CODES	MEANING	IY	IZ	DY	DZ	TL	IC	SCL	JCL	PARENT	CATEGORY
FRBLM	Fear Blame				1				D		*PARENT ATTITUDE*
FRCONQS	Fear consequences (of not getting help)									V	*PARENT ATTITUDE*
FRJDG	Fear judgement of others									Sme	*PARENT ATTITUDE*
FRLOR	Fear loss of respect							A		S	*PARENT ATTITUDE*
GLT	Guilty feelings in parent				1						*PARENT ATTITUDE*
GRTFL	Grateful						S	J	D	WJKCAD	*PARENT ATTITUDE*
HAP	Happy									PJCA	*PARENT ATTITUDE*
HAPSTRT	Happy to start							J			*PARENT ATTITUDE*
HLPFL	Helpful							A		WJMiCD	*PARENT ATTITUDE*
HOPE	Found hope				1	W		V		PMeKDJA	*PARENT ATTITUDE*
INDEP	Independent									MeA	*PARENT ATTITUDE*
LOWSC	Low self confidence							J			*PARENT ATTITUDE*
MOVULN	Mother vulnerable					W			D		*PARENT ATTITUDE*
NDYFAM	Needy family					W					*PARENT ATTITUDE*
NOCOMPL	No complaints							J		WD	*PARENT ATTITUDE*
NOOPTN	No other option but to seek help					1		A		V	*PARENT ATTITUDE*
PAINMNR	Minor pain									V	*PARENT ATTITUDE*
PDECD	Parent decided							P	Me	WSJMeCA	*PARENT ATTITUDE*
PERS	Persistent							P			*PARENT ATTITUDE*
PERSFIT	Personality fit with clinicians							J		W+P+S+	*PARENT ATTITUDE*
POL	Polite							A		P	*PARENT ATTITUDE*
RLVD	Relieved							J	D	JMeKMiDA	*PARENT ATTITUDE*
SATSERV	Satisfied with service							P			*PARENT ATTITUDE*
SCRDCH	Scared for child									SMeCMi	*PARENT ATTITUDE*
SERVFIT	Service fit					+		V+			*PARENT ATTITUDE*
SKG	Seeking help				1			P		K	*PARENT ATTITUDE*
SRCH	Long search for help						S	PJ		JMeKC	*PARENT ATTITUDE*
TENS	Tense										*PARENT ATTITUDE*
UPS	Upset									WC	*PARENT ATTITUDE*
USEFL	Useful								D		*PARENT ATTITUDE*
WEND	At wit's end, end of tether		1			1		P	D		*PARENT ATTITUDE*

CODES	MEANING	IY	IZ	DY	DZ	TL	IC	SCL	JCL	PARENT	CATEGORY
WORR	Worried about child	1			1			P		WKJC	*PARENT ATTITUDE*

Table B7-9

Alphabetical listing of codes for transcripts for retrospective study concerning parental experience before referral, with frequencies reported for intake workers at each agency (IY & IZ), directors at each agency (DY & DZ), team leader clinician (TL), intake clinician (IC), senior clinicians (SCL), junior clinicians (JCL), and parents.

CODES	MEANING	IY	IZ	DY	DZ	TL	IC	SCL	JCL	PARENT	CATEGORY
ASKLATE	Seek help at last moment									Me	*PARENT BEFORE*
BFCONCS	Before concerns		1					J			*PARENT BEFORE*
CLUNAW	Clinician unaware				1						*PARENT BEFORE*
NOKNLRI	No knowledge of referral & intake policy						1	A		WPVSJCD	*PARENT BEFORE*
NOKNLSER	No knowledge of services available									JA	*PARENT BEFORE*
PAIN	Hidden emotional pain concerning pre-referral circumstances and events							J		WMiKJ	*PARENT BEFORE*
REFMGR	Referral merry-go-round									JMe	*PARENT BEFORE*
THTFL	Thoughtful						P				*PARENT BEFORE*

Table B7-10

Alphabetical listing of codes for transcripts for retrospective study concerning pre-referral status of parent, with frequencies reported for intake workers at each agency (IY & IZ), directors at each agency (DY & DZ), team leader clinician (TL), intake clinician (IC), senior clinicians (SCL), junior clinicians (JCL), and parents.

CODES	MEANING	IY	IZ	DY	DZ	TL	IC	SCL	JCL	PARENT	CATEGORY
BEHPROB	Behaviour problem					W	S	PVJMi	DMe	WPVJMeKSDA	*Pre-referral STATUS*
CHDIE	Child wanting to die									SMeAMiC	*Pre-referral STATUS*
CHPROB	*Child with problems*		1			1		V	D	VSMeD	*Pre-referral STATUS*
CHTRB	Child troubles	1				1				WP	*Pre-referral STATUS*
CONTPER*	Contemplation period in years							J1C1		W1V1.5J3Me.5C1 D.4A.5	*Pre-referral STATUS*
EDPROB	Educational problem			K		W		PVMi		WPVKMi	*Pre-referral STATUS*
FAMTRB	Family troubles		1			W		A	Me	WA	*Pre-referral STATUS*
KNOS	Knowledge of services				1	W				P	*Pre-referral STATUS*
POTC	Potential client		1		1	1			Me		*Pre-referral STATUS*
PWRND	Parent warned about child need				1	1		VA			*Pre-referral STATUS*
SKG	Seeking help						S				*Pre-referral STATUS*
TOC	Recognized from time of contact				1						*Pre-referral STATUS*
VARP	Variety of parental positions										*Pre-referral STATUS*

Table B7-11

Alphabetical listing of codes for transcripts for retrospective study concerning attitudes of parents toward mental health professionals, with frequencies reported for intake workers at each agency (IY & IZ), directors at each agency (DY & DZ), team leader clinician (TL), intake clinician (IC), senior clinicians (SCL), junior clinicians (JCL), and parents.

CODES	MEANING	IY	IZ	DY	DZ	TL	IC	SCL	JCL	PARENT	CATEGORY
MORNDD	More needed									A	*ATTITUDE ABOUT MH PROFESSIONALS*
MSTGD	Most are good									MeD	*ATTITUDE ABOUT MH PROFESSIONALS*
POS	Positive				1	W				WPVSJMeCA	*ATTITUDE ABOUT MH PROFESSIONALS*
VAR	Varies										*ATTITUDE ABOUT MH PROFESSIONALS*

Table B7-12

Alphabetical listing of codes for transcripts for retrospective study concerning reasons for discontinuance, with frequencies reported for intake workers at each agency (IY & IZ), directors at each agency (DY & DZ), team leader clinician (TL), intake clinician (IC), senior clinicians (SCL), junior clinicians (JCL), and parents.

CODES	MEANING	I Y	I Z	D Y	D Z	TL	I C	SCL	JCL	PARENT	CATEGORY
ACCPROB	Access problem, usually transport							PJA	MeD	Me	*DROP OUTS*
AMBIV	Ambivalence					1					*DROP OUTS*
ASSUSFL	Assessment was useful							JC			*DROP OUTS*
BETR	Improved					W		JC	Me		*DROP OUTS*
COERC	Coerced referral	1	1					VC	MeD		*DROP OUTS*
CONTYROS-	Lack of continuity							PJAC			*DROP OUTS*
DECNOT	Decide not proceed with referral							C			*DROP OUTS*
ELSW	Attended elsewhere		1								*DROP OUTS*
EXTCHG	External change of circumstances							J			*DROP OUTS*
HLPUSAT	Help unsatisfactory							V			*DROP OUTS*
IEXPECS +/-	Intake expectations not met				-						*DROP OUTS*
INTKLONG	Intake process was too long							C			*DROP OUTS*
IPRO +/-	Intake procedure satisfaction			-	-			J-		V-J-	*DROP OUTS*
JNRSTF	Junior staff					1					*DROP OUTS*
LIFCHG	Life change							J	D		*DROP OUTS*
ND/VAL+/-	Recognize need, question value of effort				+		+	J			*DROP OUTS*
NORAPP	No rapport								Me		*DROP OUTS*
NOTRUSH	Not in a hurry to get help				1						*DROP OUTS*
PCHGR	Parent change during referral				-						*DROP OUTS*
PCHGT	Parent change in treatment				-						*DROP OUTS*
PERSFIT-	Fit with clinicians unsatisfactory							JCA	D		*DROP OUTS*
PRIV	Private services accessed							PV	D		*DROP OUTS*

CODES	MEANING	IY	IZ	DY	DZ	TL	IC	SCL	JCL	PARENT	CATEGORY
REASON	Drop out has reason							J			*DROP OUTS*
REFDON	Referred on							C			*DROP OUTS*
SCHLRPT +/-	Request for school report influence				-	-		J+A-		J+	*DROP OUTS*
SERVFIT-	Fit with service unsatisfactory							J-C-	D-		*DROP OUTS*
SMLPROB	Small problem not worth effort								D		*DROP OUTS*
UPSET	Parent upset with service							V			*DROP OUTS*
WQFIX	Want quick fix				1						*DROP OUTS*
WTPROB	Problem with waiting				1			C	D	WPMe	*DROP OUTS*
WTRSLV	Waiting resolved issue							PJ	D		*DROP OUTS*

Table B7-13

Alphabetical listing of codes for transcripts for retrospective study concerning waiting for first appointments, with frequencies reported for intake workers at each agency (IY & IZ), directors at each agency (DY & DZ), team leader clinician (TL), intake clinician (IC), senior clinicians (SCL), junior clinicians (JCL), and parents.

CODES	MEANING	IY	IZ	DY	DZ	TL	IC	SCL	JCL	PARENT	CATEGORY
LTE	Less than expected									P	WAITS
MIN	Minimal wait needed									PVMe	WAITS
SEASON	Seasonal variations in waits							P			WAITS
WILWET	Willing to wait										WAITS
WT*	Waiting period				13	15		P8A1	Me2	W13K29A1	WAITS
WTBRF	Brief wait occurred							A	D	APC	WAITS
WTINDIC	Indication of length of wait		1				1			V	WAITS
WTLONG	Long wait	1	1							VK	WAITS
WTLST	Waiting list	+					1	P		P	WAITS
WT O/F	Other factors in wait period				1		+				WAITS
WTVARS	Waiting time varies							P			WAITS

FINAL CODING OF RETROSPECTIVE STUDY RESPONSES UNDER SUMMARY HEADINGS

Table B8-1

Referral and intake procedures noted by staff with frequencies reported for intake workers at each agency (IY & IZ), directors at each agency (DY & DZ), team leader clinician (TL), intake clinician (IC), senior clinicians (SCL), junior clinicians (JCL), and parents (corresponds to Table 4 of Chapter 9, page 214).

PRACTICES	IY	IZ	DY	DZ	TL	IC	SCL (N=7)	JCL (N=2)	TOTAL (N=12)
Task characteristics									
Hurdles and barriers to access						1			1
Telephone interview							1		1
Style of undertaking the work		1							1
Handwritten notes by IW		1							1
Referral by personal contacts				1	1				2
Crises are rare							1		1
Referral purpose clarified				1					1
Secondary consultation				1	1				2
Tertiary consultation				1					1
IW able to predict if complete assessment		1							1
Caller can re-contact prior to appointment	1	1			1	1			4
Non-attendance procedure for clinician					1		1		2
Actual tasks of referral and intake									
Assess urgency				1	1		1	1	4
Information gathering	1	1	1	1	1	1			5
Problem description				1			1	1	3
Assess severity							2		2
Assess appropriateness for service							1	1	2
Assess likelihood of benefit for family					1				1
Information provision about service	1				1	1			3
Referred on		1		1	1		1		4
Send letters with relevant information	1	1			1		1	1	5
Letter sent to confirm allocated clinician							1		1
Letter to referrer prior to appointment				1			1		2

PRACTICES	IY	IZ	DY	DZ	TL	IC	SCL (N=7)	JCL (N=2)	TOTAL (N=12)
Registration of cases							2		**2**
Chronological procedures									
Intake worker contacted	1				1		1		**3**
Telephone contact form or sheet		1		1			1		**3**
Intake form or sheet	1	1				1	3	1	**7**
Demographic data	1	1		1	1		1		**5**
Criteria	1	1		1			3	1	**7**
Team meeting	1		1	1	1		2		**6**
Referral acceptance					1				**1**
Clinician takes case							1		**1**
Clinician phones to make appointment	1		1		1		1	1	**5**
Confirmation letter						1			**1**
Handover to allocated clinician		1							**1**
First appointment							1		**1**
Organizational issues									
Impact upon clinical load +/-	+	-	+						**2+, 1-**
Feedback from team to IW +/-		+		-					**1+, 1-**
Team Leader liaison							2		**2**
Team leader supervises R&I work							1		**1**
Team response				1					**1**
Voluntary allocation of cases							1		**1**
TOTAL RESPONSES	**11**	**14**	**4**	**15**	**15**	**6**	**32**	**7**	**103**

Notes: +/- indicates that informants could have positive or negative views concerning the issue.

Table B8-2

Attitudes of staff toward referral and intake process under summary headings with frequencies reported for intake workers at each agency (IY & IZ), directors at each agency (DY & DZ), team leader clinician (TL), intake clinician (IC), senior clinicians (SCL), junior clinicians (JCL), and parents (corresponds to Table 5of Chapter 9, page 216).

ATTITUDES	IY	IZ	DY	DZ	TL	IC	SCL (N=7)	JCL (N=2)	TOTAL (N=12)
Access issues									
Adolescents have rights of referral				1			1		**2**
Available			1						**1**
Flexible		1							**1**
Former patient							1	1	**2**
Purpose									
Most disturbed persons	1						1		**2**
Not administrative function				1			1		**2**
Not Advice Line							1		**1**
Not case disposal system				1					**1**
High Priority	1	1		1	1		4		**8**
First step	1	1	1				2		**5**
Provided clarity	1	1					1		**3**
Continuity of contact and support +/-		+	+		+		+3		**6+**
Connect services with persons				1			1		**2**
Influence later				1					**1**
Quality of relationship									
Avoids blame				1					**1**
Avoids stereotyping				1					**1**
Not labelling				1					**1**
Begins trust		1					1		**2**
Empathic stance	1			1			1		**3**
Inclusive not isolating		1		1					**2**
Family focus				1				1	**2**
Family strengths				1					**1**
Family support				1					**1**
Listened to and heard	1	1		1					**3**
Organizational issues									
Maximum cases to be seen								1	**1**

ATTITUDES	IY	IZ	DY	DZ	TL	IC	SCL (N=7)	JCL (N=2)	TOTAL (N=12)
New case as burden								1	**1**
Intake worker experienced person			1	1					**2**
Intake worker mature person			1	1					**2**
Intake worker supported by teams				1					**1**
Intake worker feedback from teams +/-		+		-					**1+, 1-**
Optimal resourcing		1			1			1	**3**
TOTAL RESPONSES	**6**	**10**	**5**	**19**	**3**		**18**	**5**	**66**

Notes: +/- indicates that informants could have positive or negative views concerning the issue.

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Table B8-3

Referral and intake policy under summary headings with frequencies reported for intake workers at each agency (IY & IZ), directors at each agency (DY & DZ), team leader clinician (TL), intake clinician (IC), senior clinicians (SCL), and junior clinicians (JCL) (corresponds to Table 6 of Chapter 9, page 217).

POLICY ISSUES	IY	IZ	DY	DZ	TL	IC	SCL (N=7)	JCL (N=2)	TOTAL (N=12)
Tertiary referral agency					1				**1**
Clarity of procedure							1	1	**2**
Clinician's name provided							1		**1**
Community resources guide				1				1	**2**
Confidential process				1					**1**
Tracking of linked callers				1					**1**
Referral and intake worker role has specific limits		1							**1**
Referral and intake worker liaises with network				1					**1**
Legal issues cases are not accepted					1-				**1-**
Referral and intake policy stable		1							**1**
Readiness of agency to receive referral enquiry									
All referrers have an anticipated place in program							1		**1**
Agency has protocols for being ethno-sensitive				1	1				**2**
Protocols exist for responding to cases involving a language other than English		1			1				**2**
Parent referral		1			1				**2**
Professional referral	1				1		3		**5**
Re-referral								1	**1**
Local agency support has been negotiated					1				**1**
Protocols exist for multiple agency involvement in complex					1		1		**2**
Team leader monitors & allocates cases					1		1		**2**
Organizational issues									
Referral and intake centralized in CAMHS							2		**2**
Combined adult and child referral and intake can be positive (+) or negative (-)				1-				1-	**2-**
Crisis response roster								2	**2**
Dedicated referral and intake worker		1	1		1		3	1	**7**
Reliever does referral and intake role when referral and intake worker on leave							1		**1**

POLICY ISSUES	IY	IZ	DY	DZ	TL	IC	SCL (N=7)	JCL (N=2)	TOTAL (N=12)
Referral and intake worker reliever for leave							1		**1**
Rostering of staff for referral and intake system can be positive (+) or negative (-)			1-				5-		**6-**
Not roster system		1			1		1		**3**
Current referral and intake system evolved		1		1					**2**
No written policy known to staff							1		**1**
Team leader available for referral and intake worker liaison				1					**1**
Procedure									
First point of contact	1		1	1	1		2		**6**
Crisis appointment	1	1		1			3		**6**
Urgent appointment	1	1		1	1		1		**5**
Intake worker team response				1					**1**
Name of clinician to be given		1		1					**2**
Ordinary appointment				1					**1**
Ordinary appointment prioritized				1					**1**
Parent to confirm professional referral	1			1		1	2		**5**
Standard procedure			1	1			5		**7**
TOTAL RESPONSES	**5**	**10**	**4**	**17**	**13**	**1**	**35**	**7**	**92**

Table B8-4

Attitudes about parents at time of referral under summary headings with frequencies reported for intake workers at each agency (IY & IZ), directors at each agency (DY & DZ), team leader clinician (TL), intake clinician (IC), senior clinicians (SCL), junior clinicians (JCL), and parents (corresponds to Table 7 of Chapter 9, page 220).

PRACTICES	IY	IZ	DY	DZ	TL	IC	SCL (N=7)	JCL (N=2)	STAFF (N=12)	PARENT (N=11)
Access										
Access issues				1			1	1	3	1
Unsure if entitled to use service									0	1
Seeking help				1			1		2	1
Long search for help						1	2		3	4
Needy family					1				1	0
Affect in parent before referral										
Ambivalence							1		1	3
Anxiety provoked				1			1		2	1
Felt failure as a parent									0	5
Mother vulnerable					1			1	2	0
Guilty feelings in parent				1					1	0
Scared for child									0	4
Conscientious							1		1	0
Dangerous									0	1
Daunted in calling					1				1	0
Desperate				1		1			2	8
At wit's end, end of tether		1				1	1	1	4	0
Worried about child	1			1			1		3	4
Upset									0	2
Fear Blame				1				1	2	0
Fear consequences (not get help)									0	1
Fear judgement of others									0	2
Fear loss of respect							1		1	1
Low self confidence							1		1	0
Persistent							1		1	0
Determined			1		1		3		5	7
Affect in parent after referral										
Relieved							1	1	2	6
Feeling at home with the service									0	3
Commitment							2		3	7

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PRACTICES	IY	IZ	DY	DZ	TL	IC	SCL (N=7)	JCL (N=2)	STAFF (N=12)	PARENT (N=11)
Comfortable to be confronted		1							**1**	*0*
Grateful						1	1	1	**3**	*6*
Happy									**0**	*4*
Happy to start							1		**1**	*0*
Found hope				1	1		1		**3**	*6*
Service fit +/-					1+		1+		**2+**	*0*
No complaints							1		**1**	*2*
Focus of parent at referral										
Child focus							3		**3**	*9*
Checking				1					**1**	*0*
Independent									**0**	*2*
Complaints				1					**1**	*0*
Minor pain									**0**	*1*
Parent decided							1	1	**2**	*6*
No other option but to seek help					1		1		**2**	*1*
Paternal support +/-					1-		1-	2-	**4-**	*1+,4-*
Satisfied with service							1		**1**	*0*
Quality of relationship										
Exaggerate problem to ensure response									**0**	*1*
Helpful							1		**1**	*5*
Polite							1		**1**	*1*
Useful								1	**1**	*0*
Personality fit with clinicians							1		**1**	*3+*
TOTAL RESPONSES	**1**	**3**	**1**	**10**	**10**	**2**	**33**	**10**	**70**	*113*

Notes: +/- indicates that informants could have positive or negative views concerning the issue.

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Table B8-5

Attitudes about parents prior to referral under summary headings with frequencies reported for intake workers at each agency (IY & IZ), directors at each agency (DY & DZ), team leader clinician (TL), intake clinician (IC), senior clinicians (SCL), junior clinicians (JCL), and parents (corresponds to Table 8 of Chapter 9, page 222).

CONCERNS	IY	IZ	DY	DZ	TL	IC	SCL (N=7)	JCL (N=2)	STAFF (N=12)	*PARENT (N=11)*
Knowledge										
Clinician unaware				1					1	*0*
No knowledge of referral & intake policy					1		1		2	*7*
No knowledge of services available									0	*2*
Parental state before referral										
Before referral concerns		1					1		2	*0*
Hidden emotional pain concerning pre-referral							1		1	*4*
Referral merry-go-round									0	*2*
Focus										
Seek help at last moment									0	*1*
Thoughtful							1		1	*0*
TOTAL RESPONSES	**0**	**1**	**0**	**1**	**1**	**0**	**4**	**0**	**7**	*16*

Table B8-6

Concerns prior to referral under summary headings with frequencies reported for intake workers at each agency (IY & IZ), directors at each agency (DY & DZ), team leader clinician (TL), intake clinician (IC), senior clinicians (SCL), junior clinicians (JCL), and parents (corresponds to Table 9 of Chapter 9, page 224).

CONCERNS	IY	IZ	DY	DZ	TL	IC	SCL (N=7)	JCL (N=2)	STAFF (N=12)	PARENT (N=11)
Child problem										
Behaviour problem					1	1	4	2	8	9
Child wanting to die									0	5
Child with problems		1			1		1	1	4	4
Child troubles	1				1				2	2
Educational problem			1		1		3		5	5
Parental position										
Family troubles		1			1		1	1	4	2
Potential client		1		1	1			1	4	0
Parent warned about child need				1	1		2		4	0
Seeking help						1			1	0
Knowledge										
Knowledge of services				1	1				2	1
Recognized from time of contact				1	1				1	0
TOTAL RESPONSES	**1**	**3**	**1**	**5**	**9**	**2**	**11**	**5**	**37**	**29**

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Table B8-7

Reported reasons for discontinuance under summary headings with frequencies reported for intake workers at each agency (IY & IZ), directors at each agency (DY & DZ), team leader clinician (TL), intake clinician (IC), senior clinicians (SCL), junior clinicians (JCL), and parents (corresponds to Table 17 on page 242).

REASONS FOR DISCONTINUANCE	IY	IZ	DY	DZ	TL	IC	SCL (N=7)	JCL (N=2)	STAFF (N=12)	*PARENT (N=11)*
Access										
Access problem, usually transport							3	2	**5**	*1*
Intake procedure satisfaction			1-	1-			1-		**3**	*2-*
Motivation of parent										
Drop out has reason							1		**1**	*0*
Ambivalence				1					**1**	*0*
No rapport								1	**1**	*0*
Not in a hurry to get help				1					**1**	*0*
Parent upset with service							1		**1**	*0*
Alternate referral										
Attended elsewhere		1							**1**	*0*
Referred on							1		**1**	*0*
Private services accessed							2	1	**3**	*0*
Life changes										
Life change							1	1	**2**	*0*
Referred on							1		**1**	*0*
External change of circumstances							1		**1**	*0*
Parent change during referral				1-					**1**	*0*
Parent change in treatment				1-					**1**	*0*
Positive referral and contact										
Waiting resolved issue							2	1	**3**	*0*
Assessment was useful							2		**2**	*0*
Improved					1		2	1	**4**	*0*
Negative referral and contact										*0*
Coerced referral	1	1					2	2	**6**	*0*
Lack of continuity							4		**4**	*0*

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REASONS FOR DISCONTINUANCE	IY	IZ	DY	DZ	TL	IC	SCL (N=7)	JCL (N=2)	STAFF (N=12)	PARENT (N=11)
Help unsatisfactory							1		1	0
Intake expectations not met				1-					1	0
Decide not proceed with referral							1		1	0
Intake process was too long							1		1	0
Recognize need, question value of effort				1+	1+		1		3	0
Fit with clinicians unsatisfactory							3	1	4	0
Junior staff					1				1	0
Request for school report influence				1-	1-		1+1-		4	1+
Fit with service unsatisfactory							2-	1-	3	0
Small problem not worth effort								1	1	0
Want quick fix				1					1	0
Problem with waiting				1			1	1	3	3
TOTAL RESPONSES	**1**	**2**	**1**	**9**	**5**	**0**	**35**	**13**	**66**	**7**

Notes: +/- indicates that informants could have positive or negative views concerning the issue.

APPENDICES C (PROSPECTIVE ENQUIRY)

The forms and letters were printed onto agency letterhead, as requested. The set of forms and information letters replicates that which was used for the retrospective study, with name substituted as appropriate and the relevant research liaison officer given with a contact telephone.

Victoria University
Department of Psychology

INVITATION LETTER TO PARENTS TO PARTICIPATE IN RESEARCH PROJECT:
Referral and Intake to Child and Adolescent Mental Health Services

Researcher: Jo Grimwade   Supervisor: Dr Suzie Dean

Dear Parent,

You recently spoke to an intake worker at Travancore clinic (RCH MHSKY CAMHS) about concerns you are experiencing in your family. You were told that a university study was being conducted into what is involved, from the consumer's point of view, in getting help from the clinic. You were probably asked if you would be interested in finding out more about the research. We write to inform you about the project and to invite you to take part.

The research asks referring parents to fill out some questionnaires on four occasions over the next twelve to eighteen months, even if contact with the clinic is finished. We want to know what it is like to approach the clinic, to meet with them initially, to come to a plan for action, and to reflect on progress after one year; whether or not the contact is what you hoped for.

It is important to note that:
- this research occurs independently of the service you will receive (your agency) (we are Psychology lecturers at Victoria University)
- participation in the research will not give you any particular advantage with the clinic in terms of extra service or priority
- **you can decide to withdraw from the study at any time, without any disadvantages for yourselves or for the service you might be receiving from the clinic**
- participation involves the filling out of questionnaires and answering a few questions on three occasions over nine to twelve months.

The purpose of the research is to understand how service provision is received by consumers. This will change over time and this is why there will be contacts with the researcher over nine to twelve months. As you may already know, trying to get help with child troubles can be troublesome of itself, because of finding where to go, or even saying that you need help. **By participating, you will assist in improving the beginning phases of service provision in CAMHS clinics across Victoria.**

As far as we know, this is the first attempt, world-wide to understand the processes of CAMHS referral and how these impact on parents and their perceptions of what is provided. The first part of the study has been completed and you are invited to help complete the second part of the study. The research information will be gathered in the following way. **First, you need to agree to participate and sign the consent form that allows the researcher to contact you by telephone to discuss any concerns about the research.**

Jo Grimwade will visit you at a convenient time and place of your choosing, as arranged by telephone. At this meeting, the purposes and processes of the research will be discussed and, if you agree, you will sign your

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consent to participate. Then, Jo would leave the first set of questionnaires with you (which may take an hour to fill out) and leave you with an arrangement to come back at a convenient time to collect them and to clarify any other issues. If necessary, Jo can help you answer the questions by reading them to you. You will notice that some questionnaires and some specific questions are repeated on several of the occasions when you fill out the information. This is to see if certain issues, events, or circumstances have changed or remained the same over the time of the study and if there is any connection to the service received.

To find out more about the research, please sign the consent form and give it to the receptionist, who would then release the contact information to the researcher. The researcher will then contact to arrange the first visit at the next convenient time for you. The first round of questionnaires is the most comprehensive, with subsequent occasions involving shortened versions of some questionnaires with some questionnaires repeated. Help in filling out the forms will be provided.

Also, you may think some of the questionnaires and individual questions do not seem as relevant as others, but all have been chosen to help us understand how people react to the referral process. The questionnaires have been chosen carefully and checked by Research Ethics Committees. These issues can be discussed with the researcher.
The third round of questionnaires will occur three months after you first contacted CAMHS. The same procedure will apply. Jo will drop off the questionnaires and collect them a day or so later. The final round of information gathering will occur one year from when you first contacted CAMHS, with the same procedure applying, again.

Participation is by your consent and can be withdrawn at anytime without disadvantages for yourself or for you access to CAMHS' services. The aim is not to take up lots of your time, but once you consent to participate, it is hoped that you would remain with the research over the next nine to twelve months.

At all times, the process of the research will remain independent of the clinic services. If you have any difficulty with the research, you would be encouraged to speak with the researcher, the supervising researcher (Dr Suzanne Dean), and/or the Director of the service, ____. You are also encouraged to take concerns to the (research liaison officer), Human Ethics Committee, (administering hospital) on **03 9--- ---**

To repeat, this research is aimed at improving the quality of service provided to CAMHS' consumers and has been supported already by other CAMHS services in Victoria. Your participation would assist this research, greatly. If you wish to join this project, please fill out the attached consent form and return to the researcher using the enclosed reply paid envelope,

Yours sincerely,

Jo Grimwade,   Suzanne Dean, PhD,
Researcher,   Supervising researcher,

Any queries about your participation in this project may be directed to the researcher (Jo Grimwade, ph. 9365 2620). If you have any queries or complaints about the way you have been treated, you may contact the Secretary, University Human Research Ethics Committee, Victoria University of Technology, PO Box 14428 MCMC, Melbourne, 8001 (telephone no: 03-9688 4710).

**APPENDIX C2   CONSENT FOR THE CLINIC TO RELEASE CONTACT
             INFORMATION TO THE RESEARCHER**

Victoria University
Department of Psychology

**CONSENT FOR THE CLINIC TO RELEASE CONTACT INFORMATION TO THE
RESEARCHER**

Title of Research Project:

Practices and Perceptions: Referral and Intake to Child and Adolescent Mental Health Services

Name of Researcher: Jo Grimwade

Consent of Participant:
I, _____ ,
of_____ ,
certify that I have the legal ability to give valid consent and that I voluntarily consent to the
Receptionist providing a contact telephone number to the researcher, Mr Jo Grimwade:

Contact Telephone Number: _____

The purpose of this Release of Contact Information has been fully explained to me and I have read the
attached explanatory statement of aims (Invitation to participate in research).

I have been informed that the confidentiality of the information I provide will be safeguarded.

Signed:**..**   **}**

Witness other than the researcher: **Date: ....**

...}

Any queries about your participation in this project may be directed to the researcher (Jo Grimwade,
ph. 9365 2620). If you have any queries or complaints about the way you have been treated, you may
contact the Secretary, University Human Research Ethics Committee, Victoria University of
Technology, PO Box 14428 MCMC, Melbourne, 8001 (telephone no: 03-9688 4710).

Victoria University, Department of Psychology
INVITATION TO PARENTS TO PARTICIPATE IN RESEARCH PROJECT:
Referral and Intake to Child and Adolescent Mental Health Services
Researcher: Jo Grimwade   Supervisor: Dr Suzie Dean

Thankyou for agreeing to read about this project.

The aim of the project is to study what actually happens when a family seeks help from a child mental health agency. The research is particularly concerned with the events that happen between families and agency from the time of first contact and over the subsequent nine to twelve months. This includes contact with reception staff by telephone, letter, or face-to-face, contact with several clinical staff, and other activities intended to assist family members. A lot happens during this time that might be important in a family receiving the most appropriate help and how quickly this help is gained.

You have been approached to participate because you recently referred a member or members of your family (your agency)and have now come for your first appointment. The Director of the service, ___, has agreed to this project being undertaken and has given permission to the researcher to approach parents of clients of the service. Participation in this research will not help you in gaining assistance, but the results are likely to help others in the future.

Participation in the research will involve some time on your part, but the research is not intended to intrude on what is a very private arrangement that you and your family have with the agency. I will be asking, by means of questionnaires mostly, questions that may overlap with matters discussed with clinic staff. Please feel free to answer as you see fit. This is independent research and your answers will not be reported to clinic staff and your work with clinic staff will not be reported to me. You will not be disadvantaged, with respect to the clinic, by participating in this research.

It is important to note that the researcher cannot actually advise parents or improve the procedures during the research project, itself. If such issues arise, parents will be encouraged to discuss these issues with staff.

Participation is voluntary: parents will only be involved with their signed consent. You are free to withdraw from the research at any time and without any disadvantages for yourself or the service you are receiving from the agency.

The next step after consenting to participate will be to receive and fill out the questionnaires. These will be collected by the researcher at a later date, when you might like to clarify details of the questionnaires or of the progress of the research.

Should you have any questions about this research, you are welcome to contact myself or Suzie Dean on **03 9365 2336**. Thankyou for giving this project your careful consideration,
Yours Sincerely,

Jo Grimwade
Researcher

Any queries about your participation in this project may be directed to the researcher (Jo Grimwade, ph. 9365 2620). If you have any queries or complaints about the way you have been treated, you may contact the Secretary, University Human Research Ethics Committee, Victoria University of Technology, PO Box 14428 MCMC, Melbourne, 8001 (telephone no: 03-9688 4710).

Victoria University, Department of Psychology
CONSENT TO PARTICIPATE IN A RESEARCH PROJECT

Title of Research Project:
Practices and Perceptions: Referral and Intake to Child and Adolescent Mental Health Services

Name of Researcher: Jo Grimwade
Consent of Participant:
I, _____ ,
of_____ ,
certify that I have the legal ability to give valid consent and that I am voluntarily giving my consent to participate in the study entitled:
Practices and Perceptions: Referral and Intake to Child and Adolescent Mental Health services being conducted at Victoria University by Jo Grimwade.

The purpose of the above project has been fully explained to me and I read the attached explanatory statement of aims (Invitation to participate in research).

I certify that the objectives of the study, together with any risks to me associated with the procedures listed hereunder to be carried out in the study, have been fully explained to me by the researcher, Jo Grimwade;

and that I freely consent to participation in the interview procedures.

Procedures: Receiving and filling out sets of questionnaires on three occasions over nine to twelve months. At the time of collection of the questionnaires, the researcher will ask for general impressions about contact with the clinic up to that time.

I certify that I have had the opportunity to have any questions answered and that I understand that I can withdraw from this experiment at any time and that this withdrawal will not jeopardise me in any way.

I have been informed that the confidentiality of the information I provide will be safeguarded.

Signed:**..**   **}**

Witness other than the researcher: **Date: ....**

...}

Any queries about your participation in this project may be directed to the researcher (Jo Grimwade, ph. 9365 2620). If you have any queries or complaints about the way you have been treated, you may contact the Secretary, University Human Research Ethics Committee, Victoria University of Technology, PO Box 14428 MCMC, Melbourne, 8001 (telephone no: 03-9688 4710).

Victoria University, Department of Psychology

INVITATION TO STAFF TO PARTICIPATE IN RESEARCH PROJECT:
Referral and Intake to Child and Adolescent Mental Health Services

Researcher: Jo Grimwade   Supervisor: Dr Suzie Dean
Thankyou for agreeing to read about this project.

The aim of the project is to study what actually happens when a family seeks help from a child mental health agency. The research is particularly concerned with the events that happen between client families and agency from the time of first contact and over the subsequent twelve months. This includes contact with reception staff by telephone, letter, or face-to-face, contact with several clinical staff, and other activities intended to assist family members. A lot happens during this time that might be important in a family receiving the most appropriate help and how quickly this help is gained.

You have been approached to participate because you are a staff member significant to the administration and conduct of referral and intake within (your agency). The Director of (your agency), _____, has agreed to this project being undertaken and has given permission to the researcher to approach parents of clients of the service and significant staff members.

Participation in the research will involve some time on your part, but the research is not intended to intrude on the very private arrangements between professionals and their clients. This is independent research.

Your contribution would be to participate in a semi-structured interview designed to understand how the various policies, practices, steps, and stages of referral and intake affect casework and change in clients and their families. Participation is voluntary: staff will only be involved with their signed consent. You are free to withdraw from the research at any time and without any consequences.

Should you have any questions about this research, you are welcome to contact myself or Suzie Dean on **03 9365 2336**. Thankyou for giving this project your careful consideration,

Yours Sincerely,

Jo Grimwade
Researcher

Any queries about your participation in this project may be directed to the researcher (Jo Grimwade, ph. 9365 2620). If you have any queries or complaints about the way you have been treated, you may contact the Secretary, University Human Research Ethics Committee, Victoria University of Technology, PO Box 14428 MCMC, Melbourne, 8001 (telephone no: 03-9688 4710).

APPENDIX C6   SEMI-STRUCTURED INTERVIEW SCHEDULE FOR PARENTS

1. Background
1.1 What is your position at the agency?
1.2 How long have you been there?
1.3 What is your role in the Referral and Intake process?
1.4 What is your agency's general philosophy about Referral and Intake?
1.5 Who has responsibility for management, co-ordination and delivery of these services?
1.6 Is there a standard procedure for Referral and Intake?
1.7 Is there a special kit for Referral and Intake?

2. Intake Procedure
2.1 What is the first question you ask a referrer?
2.2 What are the steps in the referral and Intake process?
2.3 Could you give time lengths for each of the steps?
2.4 Are there particular strategies or techniques you employ when receiving a referral?
2.5 What things make for an irregular referral?
2.6 Would the parent regard Referral and Intake differently to you? In what ways?
2.7 Not all referrals lead to client families, what happens that people do not come for a first face-to-
        face contact?

3. Opinions about Intake
3.1 Why do you think dropping out occurs?
3.2 Are agency procedures implicated?
3.3 Why do client families continue?
3.4 Among all the services provided by your agency, what priority or importance is given to Referral
        and Intake?
3.5 Have you had the opportunity to work under a different Referral and Intake system?
3.6 Where was this?
3.7 What are the differences?
3.8 How significant do you consider these?
3.9 In the mind of the parent, when does Intake begin?
3.10 A parent of client is somebody who has agreed to attend your agency, how would you describe
        such a person before they become a parent of a client?
3.11 What else would you like to tell me about Referral and Intake?

4. This Research Process :
4.1 What were the effects on parents of the research?
4.2 What were the effects on staff of the research?
4.3 Is there something more that I should know about the conduct of this research?

APPENDIX C7   SEMI-STRUCTURED INTERVIEW SCHEDULE FOR STAFF

1. Background
1.1 What is your position at the agency?
1.2 How long have you been there?
1.3 How did you come to chose to do intake work?
1.4 What is your role in the Referral and Intake process?
1.5 What is your agency's general philosophy about Referral and Intake?
1.6 Who has responsibility for management, co-ordination and delivery of these services?
1.7 Is there a standard procedure for Referral and Intake?
1.8 Is there a special kit for Referral and Intake?
2. Intake Procedure
2.1 What is the first question you ask a referrer?
2.2 What are the steps in the referral and Intake process?
2.3 Could you give time lengths for each of the steps?
2.4 Are there particular strategies or techniques you employ when receiving a referral?
2.5 What things make for an irregular referral?
2.6 Would the parent regard Referral and Intake differently to you? In what ways?
2.7 Not all referrals lead to client families, what happens that people do not come for a first face-to-
      face contact?
3. Opinions about Intake
3.1 Why do you think dropping out occurs?
3.2 Are agency procedures implicated?
3.3 Why do client families continue?
3.4 Among all the services provided by your agency, what priority or importance is given to Referral
      and Intake?
3.5 Have you had the opportunity to work under a different Referral and Intake system?
3.6 Where was this?
3.7 What are the differences?
3.8 How significant do you consider these?
3.9 In the mind of the parent, when does Intake begin?
3.10 A parent of client is somebody who has agreed to attend your agency, how would you describe
      such a person before they become a parent of a client?
3.11 The following are innovations that have been suggested in the literature, how useful might these
      be in your workplace (letter reminders, telephone reminders, coming to fill out forms, group
      intake, videotape orientation sessions, telephoning to confirm attendance)?
3.12 Are there innovations you can suggest?
3.13 Brown described the process of intake as analogous to mystery novel writing, does this metaphor
      fit with your experience?
3.14 How do you think clinically? Would this be like using computer drop-down menus?
3.15 What else would you like to tell me about Referral and Intake?
4. This Research Process
4.1 What were the effects on parents of the research?
4.2 What were the effects on staff of the research?
4.3 Is there something more that I should know about the conduct of this research?

Victoria University, Department of Psychology
PROTOCOL FOR INTAKE WORKERS TO RECRUIT PARTICIPANTS INTO THE RESEARCH PROJECT

Referral and Intake to Child and Adolescent Mental Health Services
Researcher: Jo Grimwade   Supervisor: Dr Suzie Dean

After taking referral information and providing CAMHS service information to the referrer, the Intake Worker should inform the referrer about the research, as follows:

"As part of the ongoing research into service delivery, this clinic is collaborating with Victoria University in studying referral and intake and the effects these processes have on service delivery and effectiveness.

"All parents are invited to participate in a research project that will last 15 to 18 months and involve four contacts with the researcher, Mr Jo Grimwade of Victoria University. The information collected in the research will be confidential to the researcher. This clinic will not have access to the research data. It is hoped that those who agree to participate for the four contacts with the researcher, even when the work with this clinic has finished.

"As the research is independent of this clinic there is no obligation to participate in the research and participation in the research has no advantages in the service received from this clinic. Participants can withdraw from the research at any time.

"The first step is to receive some more information about the research and to sign a consent to release contact information to the researcher. Initially, this will be just name and telephone number. Soon after you return this consent form, the researcher will telephone you to make arrangements for visiting you to discuss participation. This clinic recognises that this is a big commitment and values the cooperation of clients in all its research work.

"Should you want more information about the project before agreeing to the release of the telephone number, questions could be answered by an Intake Worker, the (research liaison officer), Human Ethics Committee, (administering hospital) on 03 9--- ---. Questions could also be directed to Jo Grimwade on 9365 2620 or his research supervisor Associate Professor Suzanne Dean of Victoria University on 9365 2336.

"To repeat, if you think you would like to take part in this research program, I will send you some information and a Consent Form to release your telephone number to Jo Grimwade. Return the Consent Form in the enclosed Reply Paid envelope and, soon after, Jo Grimwade will contact you to begin the process. Your participation in this research project has to be voluntary. This clinic is thankful for your consideration of this invitation to participate."

APPENDIX C9   PROTOCOL FOR RECEPTIONISTS TO RECRUIT PARTICIPANTS INTO THE RESEARCH PROJECT

Victoria University, Department of Psychology
PROTOCOL FOR RECEPTIONISTS TO RECRUIT PARTICIPANTS INTO THE RESEARCH PROJECT

Referral and Intake to Child and Adolescent Mental Health Services
Researcher: Jo Grimwade   Supervisor: Dr Suzie Dean

Preparatory steps

1. Intake Worker takes details and provides a first appointment, according to current practices. NOTE: only ordinary cases will be researched; mandated referrals and crisis referrals will not be included in the research, thank you

2. First appointment is recorded in front diary with a special mark to indicate to the Receptionist that the parent needs to be approached about the research

3. Adequate supplies of consent forms to be available at reception. There are TWO Information Sheets and one Consent Form. Both <u>Information Letter and Sheet</u> need to be handed out because this was required in the original ethics approved process. They say similar things. The letter is longer and more detailed. The <u>Consent Form</u> allows for the Receptionist to release contact details (telephone number) to the researcher (Jo Grimwade at 9337 4964; participant enquiries should be directed to 9365 2620)

On the day

1. When parent attends for the first appointment, after they have been confirmed as having an appointment, the following request should be made (in words to the effect): *"As part of the ongoing research program, an independent university researcher is conducting a project on referral and intake procedures and their clinical effects. Please take care to read the information letter. If you decide that you want to participate, please sign the Release of Information Consent Form and give it back to me before your appointment. You may take the information with you and then contact the researcher yourself.*

2. Where possible and appropriate, the Consent Form should be collected before the appointment, unless the parent wants to discuss the research with the allocated clinician. Ask the parent to bring it back when completed, the Consent Form should be <u>collected before</u> the appointment, unless the parent wants to discuss the research with the allocated clinician. Ask the parent to bring it back when completed.

3. Once completed and handed back, contact Jo Grimwade by leaving a message at 9337 4964, or by email to <u>jo.grimwade@vu.edu.au</u>. Please keep a record of the rate at which Release Forms are received. That is, how many are handed out and how many are returned. Thanks.

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APPENDIX C10   BACKGROUND INFORMATION (a)

Background information

Please indicate to which group you belong, for each of the following questions:

- Referrer's **age**:   ___ yrs   **Gender**: M / F
- **Occupation**: _____   Length of time at current status: ____months
       How many changes of job have you had in the last two years? _____

- Current **marital status**: _____(married/widowed/separated/de facto relationship)
Has your marital status changed in the last two years?   **Y / N**
   if so, in what way ? (married/widowed/separated/ formed de facto relationship)
_____

- Referrer's **country of birth**: _____ Ethnicity: _____
Countries of birth of parent's parents: _____(mo)_____ (fa)

- **Education**: how much schooling did you complete? year 6, 7, 8, 9, 10, 11, 12
undergraduate course begun, finished undergraduate course, completed further study

- **Residence**: house/flat/unit/ other _____Time at current address: _____months
   How many changes of address have their been in past two years? ___

- When you first referred, did you know where the **CAMHS service** is? **Y / roughly / N**
Did you know how to get to the service?   **Y / N**
How long does it take? ___ **minutes**   Is access for you? **easy, okay,   difficult**

   Do you need another person to assist with **travel** to the service?   **Y / N**
Are there particular concerns or issues for you or your family that make access difficult? (these could
be disabilities, bus routes, employment hours, child care availability, etc.)
_____

   _____
- How big an issue are the **financial costs** of gaining service? **nil, small, significant**
While the service is free, costs for transport, in time, childcare, time off work, . . .
   may affect your ability to attend, will these affect how long you are willing to attend at the service?
                    Y / N
   if so, which factors will affect your attendance? _____

- Has **seeking help** been a trouble for you, before you came to CAMHS?

not at all	1	2	3	4	5	I hate it
I feel bad about asking	1	2	3	4	5	asking is part of getting help
there is stigma	1	2	3	4	5	there is no stigma
my friends or relatives	1	2	3	4	5	I am unworried by what
will think badly of me						others think

- Was **seeking help** from CAMHS a trouble for you, at your first visit?

not at all	1	2	3	4	5	I hate it
I feel bad about asking	1	2	3	4	5	asking is part of getting help
there is stigma	1	2	3	4	5	there is no stigma
my friends or relatives will think badly of me	1	2	3	4	5	I am unworried by what others think

-
- **Past contact** with mental health services for **children**?   Y / N

if so, please indicate if service was *private* (psychiatrist, psychologist, social worker, family therapist, or other) or *public* (hospital outpatient, hospital inpatient, community health service, voluntary or non-government service)

Who was this service for?   child of current concern, other of own children, partner's child,

friend's child, relative's child

How **long** were you in contact with this service?   ___ **months**
If inpatient service was involved, how long was this?   ___ **months**
Was **medication** involved ?   **Y / N**
What was the medication, what was it for, and for how long was the child on the medication?

_____

_____

- **Past contact** with mental health services for **adults** ?   **Y / N**

if so, please indicate if service was *private* (psychiatrist, psychologist, social worker, family therapist, or other) or *public* (hospital outpatient, hospital inpatient, community health service, voluntary or non-government service)

Who was this service for?   child, partner, friend, relative

How **long** were you in contact with this service?   ___ **months**
If inpatient service was involved, how long was this?   ___ **months**
Was **medication** involved ?   **Y / N**
What was the medication, what was it for, and for how long was the person on the medication?

_____

_____

Was alcohol or **substance abuse** one of the concerns for the past service contact?

Y / N

Is alcohol or substance abuse one of the concerns for the current service contact?

Y/ N

- Did the past contact involve **legal issues**?   **Y / N**
- Does the present contact involve legal issues?   **Y / N**

- **Who suggested the referral**, this time? family doctor, psychiatrist, private psychologist, private social worker, other private health professional, hospital doctor, hospital health professional, community health centre professional, school principal, school teacher, school counsellor, voluntary welfare agency professional, public child welfare professional, other

_____

- How did you feel about the suggestion to refer?

relieved	1	2	3	4	5	annoyed
unhappy in self	1	2	3	4	5	happy in self
sad for child	1	2	3	4	5	happy for child

- How much time was there between suggestion for referral and making the first contact?
    __minutes, *or* __hours, *or* ___days, *or* ___weeks

- How did you feel about making the **first telephone contact** at that time?

relieved	1	2	3	4	5	annoyed
unhappy in self	1	2	3	4	5	happy in self
sad for child	1	2	3	4	5	happy for child

- How did you feel about the contact with the person to whom you spoke?

| satisfied | 1 | 2 | 3 | 4 | 5 | unsatisfied |

- What did you think about the person to whom you made the referral?

pleasant	1	2	3	4	5	unpleasant
good listener	1	2	3	4	5	poor listener
too formal	1	2	3	4	5	too informal
too rushed	1	2	3	4	5	too slow
informative	1	2	3	4	5	withheld information
supportive	1	2	3	4	5	unsupportive

- How did you feel about future contacts with the agency?

| negative | 1 | 2 | 3 | 4 | 5 | positive |

What were you looking for <u>*when first referring*</u> (circle as many of the following that are relevant, then give below the three most important):   advice for managing child,   a way of getting other service from worrying about you or your child,   understanding of child,   personal understanding, relief of child behaviour problem,   relief of child learning problem,   happier family life,   support in ongoing difficulties,   validation of your self as a person,   validation of yourself as a parent, recovery of child from trauma,   help for family with respect to child,   other
_____

1._____ **2.**_____ **3.**_____

- Who was the **person of most concern** in this referral? _____
-
- How did you feel about making the **first telephone contact**, *now,* <u>after the first interview</u>?

relieved	1	2	3	4	5	annoyed
unhappy in self	1	2	3	4	5	happy in self
sad for child	1	2	3	4	5	happy for child

- How did you feel about future contacts with the agency?

negative   1   2   3   4   5   positive

What are you looking for, *now,* after the first interview (circle as many of the following that are relevant, then give below the three most important):   advice for managing child, a way of getting other service from worrying about you or your child, understanding of child, personal understanding, relief of child behaviour problem, relief of child learning problem, happier family life, support in ongoing difficulties, validation of your self as a person, validation of yourself as a parent, recovery of child from trauma, help for family with respect to child, other _____

Most important : 1._____ 2._____ 3._____

- Who is the **person of most concern** in this referral, *now,* after the first interview? _____

- In the course of your contact with CAMHS, have you been informed that your child may have a physical, developmental or **neurological difficulty** that is associated with the troubles you contacted CAMHS about?   **Y / N**

What is this difficulty?_____

THANKYOU FOR COMPLETING THESE QUESTIONS

APPENDIX C11   BACKGROUND INFORMATION (b)

Background information (indicate changes only, please)

Please indicate to which group you belong, for each of the following questions:

- *Change* in **Occupation**: _____Length of time at current status: ____**months**
How many changes of job have you had in the last two years? _____

- *Change* in **marital status**: _____
 (married/widowed/separated/formed de facto relationship)

- *Change* in **Residence**:   **house/flat/unit/ other** _____
Time at current address: _____**months**
How many changes of address have their been in past two years?   ___

- *Change* in the **financial costs** of gaining service?   **nil,   small,   significant**
While the service is free, costs for transport, in time, childcare, time off work
may affect your ability to attend, will these affect how long you are willing to attend at the service?
                              Y / N
if so, which factors will affect your attendance ? _____

- Is **seeking help** a trouble for you, **now**?

not at all	1	2	3	4	5	I hate it
I feel bad about asking	1	2	3	4	5	asking is part of getting help
there is stigma	1	2	3	4	5	there is no stigma
my friends or relatives	1	2	3	4	5	I am unworried by what
will think badly of me						others think

Is alcohol or **substance abuse** one of the concerns for the current service contact?
                              Y / N

- Does the present contact involve **legal issues**?   **Y / N**

- **Who suggested the referral**, this time? family doctor, psychiatrist, private psychologist, private social worker, other private health professional, hospital doctor, hospital health professional, community health centre professional, school principal, school teacher, school counsellor, voluntary welfare agency professional, public child welfare professional, other _____

- How did you feel about the suggestion to refer, **now** ?

relieved	1	2	3	4	5	annoyed
unhappy in self	1	2	3	4	5	happy in self
sad for child	1	2	3	4	5	happy for child

- How did you feel about making the **first telephone contact**, *now*?

relieved	1	2	3	4	5	annoyed
unhappy in self	1	2	3	4	5	happy in self
sad for child	1	2	3	4	5	happy for child

- How did you feel about future contacts with the agency?

negative	1	2	3	4	5	positive

What are you looking for, *now* (circle as many of the following that are relevant, then give below the three most important):   advice for managing child,   a way of getting other service from worrying about you or your child,   understanding of child,   personal understanding,   relief of child behaviour problem,   relief of child learning problem,   happier family life,   support in ongoing difficulties,   validation of your self as a person,   validation of yourself as a parent,   recovery of child from trauma,   help for family with respect to child,   other
_____

Most important : 1._____ **2.**_____ **3.**_____

- Who is the **person of most concern** in this referral, *now*? _____

- In the course of your contact with CAMHS, have you been informed that your child may have a physical, developmental or **neurological difficulty** that is associated with the troubles you contacted CAMHS about?   **Y / N**
What is this difficulty?_____

- How does such news affect your view of your child? _____
_____
- How does such news affect your view of your self? _____
_____

THANKYOU FOR COMPLETING THESE QUESTIONS

BARRIERS TO TREATMENT PARTICIPATION SCALE (MODIFIED)

BARRIERS TO TREATMENT PARTICIPATION SCALE (MODIFIED)

Please answer the following items by circling a number on line below each question.

1.   My child refuses/refused to come to the clinic for a session
         never a problem   1   2   3   4   5   very often a problem

2.   Transportation (getting a ride, driving, taking a bus) to the clinic for a session
         may be/is/was
         never a problem   1   2   3   4   5   very often a problem

3.   My child is/was in other activities (sports, music lessons) that makes/made
         it hard to come to the clinic
         never a problem   1   2   3   4   5   very often a problem

4.   Scheduling of appointment times for treatment may be/is/was
         never a problem   1   2   3   4   5   very often a problem

5.   Treatment will last/is lasting/ lasted too long (too many weeks)
         never a problem   1   2   3   4   5   very often a problem

6.   Treatment may be/is/was in conflict with another of my activities
         (classes, job, friends)
         never a problem   1   2   3   4   5   very often a problem

7.   Treatment does not/did not seem necessary
         never a problem   1   2   3   4   5   very often a problem

8.   I do not/did not/ like the primary worker (Intake Worker/therapist/case manager)
         never a problem   1   2   3   4   5   very often a problem

9.   The financial cost of getting to the clinic may be/is/was too much
         never a problem   1   2   3   4   5   very often a problem

10.   I have been/was wrongly informed about a detail by clinic administration
         never a problem   1   2   3   4   5   very often a problem

11.   Treatment may be/is/was not what I expected
         never a problem   1   2   3   4   5   very often a problem

12.   Information in the session and handouts seem/seemed confusing
         never a problem   1   2   3   4   5   very often a problem

13. My child may have/has/had trouble understanding treatment
       never a problem   **1**   **2**   **3**   **4**   **5**   **very often a problem**

14. During the course of the treatment I may experience/have experienced a lot of stress in my life
       never a problem   **1**   **2**   **3**   **4**   **5**   **very often a problem**

15. I may lose/lost interest in coming to sessions
       never a problem   **1**   **2**   **3**   **4**   **5**   **very often a problem**

16. I maybe/was sick on the day when treatment was scheduled
       never a problem   **1**   **2**   **3**   **4**   **5**   **very often a problem**

17. My child maybe/was sick on the day when treatment was scheduled
       never a problem   **1**   **2**   **3**   **4**   **5**   **very often a problem**

18. Crises at home may make/made it hard for me to get to a session
       never a problem   **1**   **2**   **3**   **4**   **5**   **very often a problem**

19. I feel I will have/felt I had to give up too much personal information to the staff member
       never a problem   **1**   **2**   **3**   **4**   **5**   **very often a problem**

20. Treatment will add/added another stressor to my life
       never a problem   **1**   **2**   **3**   **4**   **5**   **very often a problem**

21. I feel treatment may not seem/ I felt treatment did not seem as important as sessions continued
       never a problem   **1**   **2**   **3**   **4**   **5**   **very often a problem**

22. I feel this treatment may be/ I felt this treatment was more work than expected
       never a problem   **1**   **2**   **3**   **4**   **5**   **very often a problem**

23. The atmosphere at the clinic may make/makes it uncomfortable for appointments
       never a problem   **1**   **2**   **3**   **4**   **5**   **very often a problem**

24. I do not feel that I will have / I did not feel that I had enough to say about what goes on in treatment
       never a problem   **1**   **2**   **3**   **4**   **5**   **very often a problem**

25. I feel treatment may/did not focus on my life and problems
       never a problem   **1**   **2**   **3**   **4**   **5**   **very often a problem**

26. The primary worker (Intake Worker/therapist/case manager) did not seem confident that treatment would work for my child
       never a problem   **1**   **2**   **3**   **4**   **5**   **very often a problem**

27.   The primary worker (Intake Worker/therapist/case manager) did not seem
confident in my ability to carry out programs
        never a problem   1   2   3   4   5   very often a problem

28.   My child now has new or different problems
        never a problem   1   2   3   4   5   very often a problem

29.   My child's behaviour seems to have improved, therefore, treatment no longer
seems necessary
        never a problem   1   2   3   4   5   very often a problem

30.   Treatment did not seem likely to work/to be working
        never a problem   1   2   3   4   5   very often a problem

31.   Bad weather may make/ made coming to treatment a problem
        never a problem   1   2   3   4   5   very often a problem

32.   I do not feel the primary worker (Intake Worker/therapist/case manager)
supported me or my efforts
        never a problem   1   2   3   4   5   very often a problem

33.   The assigned work for me to do as part of this treatment seems/was much
too difficult
        never a problem   1   2   3   4   5   very often a problem

34.   I may/do/did not have time for the assigned work
        never a problem   1   2   3   4   5   very often a problem

35.   My child may be/is/was never home to do the assigned homework
        never a problem   1   2   3   4   5   very often a problem

36.   There is/was always someone sick in my home
        never a problem   1   2   3   4   5   very often a problem

37.   The primary worker (Intake Worker/therapist/case manager) may/did not contact
often enough
        never a problem   1   2   3   4   5   very often a problem

38.   Getting a baby-sitter so that I can/could come to the sessions may be/is/was
        never a problem   1   2   3   4   5   very often a problem

39.   Finding a place to park at the clinic may be/is/was
        never a problem   1   2   3   4   5   very often a problem

40.   I had a disagreement with my partner (or relative) about whether we should come
to treatment at all

never a problem   1   2   3   4   5   very often a problem

41.   I may be/was to tired after work to come to a session
        never a problem   1   2   3   4   5   very often a problem

42.   My job may get/got in the way of coming to a session
        never a problem   1   2   3   4   5   very often a problem

43.   Treatment may take/took time away from spending time with my children
        never a problem   1   2   3   4   5   very often a problem

44.   I may have/had trouble with other children at home which may make/made it hard
 to come to treatment
        never a problem   1   2   3   4   5   very often a problem

THANKYOU

CRITICAL LIFE EVENTS SCALE

Please answer the following items by circling an answer (YES or NO) below each question, or by
    writing how many times this event has happened in the last two years.

1.   I moved to another house or address during the time my child during referral or treatment ?
                  YES   **NO**
      how many moves have you had in the last two years ?
                  1   2   3   4   5   more

2.   I moved too far away from the clinic to come to treatment sessions (out of area)
                  YES   **NO**
      did you try to find a clinic more convenient to you to continue the work ?
                  YES   **NO**

My family changed in size (another baby or someone moved in or out of the home)
YES   **NO**
      how many changes (more and less) in the number at home have you had in the last
      two years ?
                  1   2   3   4   5   more

4.   I lost my job or dropped in income
                  YES   **NO**
      how many negative income changes have you had in the last two years ?
                    1   2   3   4   5   more

5.   I got a job or changed jobs
                  YES   **NO**
      how many job changes have you had in the last two years ?
                  1   2   3   4   5   more

6.   There was an alcohol or drug problem in my family during the time of referral or treatment
                  YES   **NO**
      There was an alcohol or drug problem in my family in the last two years
                  YES   **NO**

7.   There was physical or sexual abuse in my family during the time of
      referral or treatment
                  YES   **NO**

      There was physical or sexual abuse in my family in the last two years
                  YES   **NO**

8.   A close friend or relative got very sick or died during referral or treatment
                        YES   **NO**
        A close friend or relative got very sick or died during the last two years
                        YES   **NO**

9.   My child moved out of home
                        YES   **NO**
        how many times has this happened in the last two years ?
                        1   2   more

10.   My child was put into an inpatient program or residential program
                        YES   **NO**
        how many times has this happened in the last two years ?
                        1   2   more

11.   My child changed schools during referral or treatment
                        YES   **NO**
        how many school changes has your child had in the last two years ?
                1   2   3   4   5   more

12.   I had legal problems (arrest, serious driving violations, etc.)
                        YES   **NO**
        how many problems with the law have you had in the last two years ?
                1   2   3   4   5   more

13.   I got separated (or divorced) from a live-in partner during referral or treatment
                        YES   **NO**
        how many times has this happened in the last two years ?
                        1   2   more

14.   how regular is your family life in terms of meal times, bed times, getting children to school,
        getting to places on time ?
                very regular   1   2   3   4   5   very spontaneous

        considering the last two years, would you say, thinking about the regularity of family life now,
        that how things are now, is how you would like things to be ?
                        YES   **NO**

        would you like to see family life
                more regular   1   2   3   4   5   more spontaneous

THANKYOU

FEEDBACK QUESTIONNAIRE ON CAMHS SERVICE ACCESS AND STAFFING

This is the first of several brief questionnaires that ask you about your experience with the
CAMHS staff with whom you have been in contact, recently, <u>when referring</u>. The questions will
be similar to those at other stages of the research. Please circle appropriate answers.

- It is assumed that you first spoke with a **receptionist**, or someone undertaking that role, how did
  you find the manner in which this work was done?

  friendly   1   2   3   4   5   unfriendly

  helpful   1   2   3   4   5   unhelpful

  too slow   1   2   3   4   5   7   too rushed

- The reception person was: **M / F**   Age range: **16-29,   30-45,   46+**

- What happened as you were passed on to another staff member?
Person not available   YES/NO
                Placed on hold for extended period   YES/NO
                Cut off whilst speaking   YES/NO
Passed on to more than one person   YES/NO

Estimated length of wait to speak with appropriate staff member _____mins

- The referral person was: **M / F**   Age range: **16-29,   30-45,   46+**
When you spoke to the person who received your referral information, how did you find the manner

  in which this work was done?

  friendly   1   2   3   4   5   unfriendly

  helpful   1   2   3   4   5   unhelpful

  too slow   1   2   3   4   5   7   too rushed

  unsupportive 1   2   3   4   5   supportive

  professional   1   2   3   4   5   unprofessional

  dismissive   1   2   3   4   5   compassionate

  trustworthy   1   2   3   4   5   untrustworthy

  informative   1   2   3   4   5   withheld information

- Who knows about your CAMHS contact and how important are they to you getting to sessions?
- Think of the people important to you in deciding to seek help for your child and family.

Parents, parents-in-law, spouse, other child, aunt/uncle, other relative, family friend, neighbour, acquaintance, family doctor, psychiatrist, private psychologist, private social worker, other private health professional, hospital doctor, hospital health professional, community health centre professional, school principal, school teacher, school counsellor, voluntary welfare agency professional, public child welfare professional, other _____

List the three most in favour?   and rate how strongly in favour they were

weakly   **strongly**

a. _____   **1   2   3   4   5**

b. _____   **1   2   3   4   5**

c. _____   **1   2   3   4   5**

List the three least in favour?   and rate how strongly against they were

weakly   **strongly**

a. _____   **1   2   3   4   5**

b. _____   **1   2   3   4   5**

c. _____   **1   2   3   4   5**

- Overall, how would you rate the quality of the CAMHS service?

helpful   1   2   3   4   5   unhelpful

informative   1   2   3   4   5   withheld information

unsupportive 1   2   3   4   5   supportive

professional 1   2   3   4   5   unprofessional

unsatisfactory 1   2   3   4   5   satisfactory

Any final comments ? _____

_____

THANKYOU

FEEDBACK QUESTIONNAIRE ON CAMHS SERVICE ACCESS AND STAFFING

This is the **second** of several brief questionnaires that ask you about your experience with the

CAMHS staff with whom you have been in contact, recently, <u>at your first interview</u>. The

questions will be similar to those at other stages of the research. Please circle appropriate answers.

- When you arrived for your first interview with a clinical staff member, it is assumed that you first spoke with a **receptionist**, or someone undertaking that role, how did you find the manner in which this work was done?

friendly	**1**	**2**	**3**	**4**	**5**	**unfriendly**
helpful	**1**	**2**	**3**	**4**	**5**	**unhelpful**
too slow	**1**	**2**	**3**	**4**	**5**	**too rushed**

- The reception person was: **M / F**   Age range: **16-29,   30-45,   46+**

- What happened as you were passed on to another staff member?

Person not available   YES/NO

Placed on hold for extended period   YES/NO
Cut off whilst speaking   YES/NO

Passed on to more than one person   YES/NO

Estimated length of wait to speak with staff member who interviewed you____mins
- Was this the same person who interviewed you for your first interview? **YES/NO**

- Do you know the reasons, if any, for the change of staff member? _____
_____
- The interview person was: **M / F**   Age range: **16-29,   30-45,   46+**

How did you find the manner in which the work of the last (most recent) interview was done?

friendly	**1**	**2**	**3**	**4**	**5**			**unfriendly**
helpful	**1**	**2**	**3**	**4**	**5**			**unhelpful**
too slow	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**too rushed**
unsupportive	**1**	**2**	**3**	**4**	**5**			**supportive**
professional	**1**	**2**	**3**	**4**	**5**			**unprofessional**
dismissive	**1**	**2**	**3**	**4**	**5**			**compassionate**

<div align="center">

trustworthy   1   2   3   4   5   **untrustworthy**

informative 1   2   3   4   5   **withheld information**

</div>

- Who knows about your CAMHS contact and how important are they to you getting to sessions?
- Think of the people important to you in deciding to seek help for your child and family.

Parents, parents-in-law, spouse, other child, aunt/uncle, other relative, family friend, neighbour, acquaintance, family doctor, psychiatrist, private psychologist, private social worker, other private health professional, hospital doctor, hospital health professional, community health centre professional, school principal, school teacher, school counsellor, voluntary welfare agency professional, public child welfare professional, other _____

List the three most in favour?   and rate how strongly in favour they were

                                     weakly   **strongly**

a. _____   **1**   **2**   **3**   **4**   **5**

b. _____   **1**   **2**   **3**   **4**   **5**

c. _____   **1**   **2**   **3**   **4**   **5**

List the three least in favour?   and rate how strongly against they were

                                       weakly   **strongly**

a. _____   **1**   **2**   **3**   **4**   **5**

b. _____   **1**   **2**   **3**   **4**   **5**

c. _____   **1**   **2**   **3**   **4**   **5**

- Overall, how would you rate the quality of the CAMHS service?

<div align="center">

helpful   **1**   **2**   **3**   **4**   **5**   **unhelpful**

informative   **1**   **2**   **3**   **4**   **5**   **withheld information**

unsupportive   **1**   **2**   **3**   **4**   **5**   **supportive**

professional   **1**   **2**   **3**   **4**   **5**   **unprofessional**

unsatisfactory   **1**   **2**   **3**   **4**   **5**   **satisfactory**

</div>

Any final comments ? _____

_____

<div align="center">

THANKYOU

</div>

FEEDBACK QUESTIONNAIRE ON CAMHS SERVICE ACCESS AND STAFFING

This is the **third** of several brief questionnaires that ask you about your experience with the

CAMHS staff with whom you have been in contact, recently. The questions will be similar to

those at other stages of the research. Please circle appropriate answers.

- When you arrived for your first interview with a clinical staff member, it is assumed that you first spoke with a **receptionist**, or someone undertaking that role, how did you find the manner in which this work was done?

friendly	**1**	**2**	**3**	**4**	**5**	**unfriendly**
helpful	**1**	**2**	**3**	**4**	**5**	**unhelpful**
too slow	**1**	**2**	**3**	**4**	**5**	**too rushed**

The reception person was: **M / F**   Age range: **16-29,   30-45,   46+**

What happened as you were passed on to another staff member?
Person not available   **YES/NO**
        Placed on hold for extended period   YES/NO
        Cut off whilst speaking   YES/NO
Passed on to more than one person   YES/NO

Estimated length of wait to speak with staff member who interviewed you ____mins
Was this the same person who interviewed you for your first interview?   **YES/NO**

Do you know the reasons, if any, for the change of staff member? _____
_____
The interview person was: **M / F**   Age range: **16-29,   30-45,   46+**

How did you find the manner in which the work of the first interview was done?

friendly	**1**	**2**	**3**	**4**	**5**			**unfriendly**
helpful	**1**	**2**	**3**	**4**	**5**			**unhelpful**
too slow	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**too rushed**
unsupportive	**1**	**2**	**3**	**4**	**5**			**supportive**
professional	**1**	**2**	**3**	**4**	**5**			**unprofessional**
dismissive	**1**	**2**	**3**	**4**	**5**			**compassionate**

trustworthy   1   2   3   4   5   untrustworthy

informative   1   2   3   4   5   withheld information

Who knows about your CAMHS contact and how important are they to you getting to sessions?
Think of the people important to you in deciding to seek help for your child and family.
Parents, parents-in-law, spouse, other child, aunt/uncle, other relative, family friend, neighbour,
acquaintance, family doctor, psychiatrist, private psychologist, private social worker, other private
health professional, hospital doctor, hospital health professional, community health centre professional,
school principal, school teacher, school counsellor, voluntary welfare agency professional, public child
welfare professional, other _____

List the three most in favour?   and rate how strongly in favour they were
                                       weakly   strongly
a. _____   **1   2   3   4   5**

b. _____   **1   2   3   4   5**

c. _____   **1   2   3   4   5**

List the three least in favour?   and rate how strongly against they were
                                       weakly   strongly
a. _____   **1   2   3   4   5**

b. _____   **1   2   3   4   5**

c. _____   **1   2   3   4   5**

Overall, how would you rate the quality of the CAMHS service?

helpful   1   2   3   4   5   unhelpful

informative   1   2   3   4   5   withheld information

unsupportive   1   2   3   4   5   supportive

professional   1   2   3   4   5   unprofessional

unsatisfactory 1   2   3   4   5   satisfactory

Any final comments ? _____

_____

THANKYOU

FEEDBACK QUESTIONNAIRE ON CAMHS SERVICE ACCESS AND STAFFING

This is the **fourth** of several brief questionnaires that ask you about your experience with the

CAMHS staff with whom you have been in contact, recently. The questions will be similar to

those at other stages of the research. Please circle appropriate answers.

When you arrived for your first interview with a clinical staff member, it is assumed that you first
spoke with a **receptionist**, or someone undertaking that role, how did you find the manner in which
this work was done?

friendly	**1**	**2**	**3**	**4**	**5**	**unfriendly**
helpful	**1**	**2**	**3**	**4**	**5**	**unhelpful**
too slow	**1**	**2**	**3**	**4**	**5**	**too rushed**

The reception person was: **M / F**   Age range: **16-29,   30-45,   46+**

What happened as you were passed on to another staff member?
Person not available   YES/NO
      Placed on hold for extended period   YES/NO
      Cut off whilst speaking   YES/NO
Passed on to more than one person   YES/NO

Estimated length of wait to speak with staff member who interviewed you___mins
Was this the same person who interviewed you for your first interview?   **YES/NO**

Do you know the reasons, if any, for the change of staff member? _____
_____
The interview person was: **M / F**   Age range: **16-29,   30-45,   46+**

How did you find the manner in which the work of the last (most recent) interview was done?

friendly	**1**	**2**	**3**	**4**	**5**			**unfriendly**
helpful	**1**	**2**	**3**	**4**	**5**			**unhelpful**
too slow	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**too rushed**
unsupportive	**1**	**2**	**3**	**4**	**5**			**supportive**
professional	**1**	**2**	**3**	**4**	**5**			**unprofessional**
dismissive	**1**	**2**	**3**	**4**	**5**			**compassionate**

trustworthy	**1**	**2**	**3**	**4**	**5**	**untrustworthy**
informative	**1**	**2**	**3**	**4**	**5**	**withheld information**

Who knows about your CAMHS contact and how important are they to you getting to sessions? Think of the people important to you in deciding to seek help for your child and family. Parents, parents-in-law, spouse, other child, aunt/uncle, other relative, family friend, neighbour, acquaintance, family doctor, psychiatrist, private psychologist, private social worker, other private health professional, hospital doctor, hospital health professional, community health centre professional, school principal, school teacher, school counsellor, voluntary welfare agency professional, public child welfare professional, other _____

List the three most in favour?   and rate how strongly in favour they were

	weakly				**strongly**
a. _____	1	2	3	4	5
b. _____	1	2	3	4	5
c. _____	1	2	3	4	5

List the three least in favour?   and rate how strongly against they were

	weakly				**strongly**
a. _____	1	2	3	4	5
b. _____	1	2	3	4	5
c. _____	1	2	3	4	5

Overall, how would you rate the quality of the CAMHS service?

helpful	**1**	**2**	**3**	**4**	**5**	**unhelpful**
informative	**1**	**2**	**3**	**4**	**5**	**withheld information**
unsupportive	**1**	**2**	**3**	**4**	**5**	**supportive**
professional	**1**	**2**	**3**	**4**	**5**	**unprofessional**
unsatisfactory	**1**	**2**	**3**	**4**	**5**	**satisfactory**

Any final comments ? _____

_____

THANKYOU

OPTIMISM SCALE (MODIFIED)

Please *circle A or B* for each question to indicate which would best apply to you.

1. The project you are in charge of is a great success.

    A. *I kept a close watch over everyone's work.*
    B. *Everyone devoted a lot of time and energy to it.*

2. You and your spouse (boyfriend/girlfriend) make up after a fight.

    A. *I forgave him/her.*
    B. *I'm usually forgiving.*

3. You get lost driving to a friend's house.

    A. *I missed a turn.*
    B. *My friend gave me bad directions.*

4. Your spouse (boyfriend/girlfriend) surprises you with a gift.

    A. *He/she just got a raise at work.*
    B. *I took him/her out to a special dinner the night before.*

5. You forget your spouse's (boyfriend's/girlfriend's) birthday.

    A. *I'm not good at remembering birthdays.*
    B. *I was preoccupied with other things.*

6. You get a flower from a secret admirer.

    A. *I am attractive to him/her.*
    B. *I am a popular person.*

7. You run for a community office position and you win.

    A. *I devote a lot of time and energy to campaigning.*
    B. *I work very hard at everything I do.*

8. You miss an important engagement.

    A. *Sometimes my memory fails me.*
    B. *I sometimes forget to check my appointment book.*

9. You run for a community office position and you lose.

    A. *I didn't campaign hard enough.*
    B. *The person who won knew more people.*

10. You host a successful dinner.

    A. *I was particularly charming that night.*
    B. *I am a good host.*

11. You stop a crime by calling the police.

    A. *A strange noise caught my attention.*
    B. *I was alert that day.*

12. You were extremely healthy all year.

    A. *Few people around me were sick, so I wasn't exposed.*
    B. *I made sure I ate well and got enough rest.*

13. You owe the library ten dollars for an overdue book.

    A. *When I am really involved in what I am reading, I often forget when it's due.*

    B. *I was so involved in writing the report that I forgot to return the book.*

14. Your shares make you a lot of money.

    A. *My stockbroker decided to take on something new.*
    B. *My stockbroker is a top-notch investor.*

15. You win an athletic contest.

    A. *I was feeling unbeatable.*
    B. *I train hard.*

16. You fail an important examination.

    A. *I wasn't as smart as the other people taking the exam.*
    B. *I didn't prepare for it well.*

17. You prepared a special meal for a friend and he/she barely touched the food.

    A. *I wasn't a good cook.*
    B. *I made the meal in a rush.*

18. You lose a sporting event for which you have been training for a long time.

   A. *I' m not very athletic.*
   B. *I'm not good at that sport.*

19. Your car runs out of petrol on a dark street late at night.

   A. *I didn't check to see how much petrol was in the tank.*
   B. *The petrol gauge was broken.*

20. You lose your temper with a friend.

   A. *He/she is always nagging me.*
   B. *He/she was in a hostile mood.*

21. You are penalized for not returning your income tax forms in time.

   A. *I always put off doing my taxes.*
   B. *I was lazy about getting my taxes done this year.*

22. You ask a person out on a date and he/she says no.

   A. *I was a wreck that day.*
   B. *I got tongue-tied when I asked him/her on the date.*

23. A game-show host picks you out of the audience to participate on the show.

   A. *I was sitting in the right seat.*
   B. *I looked the most enthusiastic.*

24. You are frequently asked to dance at a party.

   A. *I am outgoing at parties.*
   B. *I was in perfect form that night.*

25. You buy your spouse (boyfriend/girlfriend) a gift and he/she doesn't like it.

   A. *I don't put enough thought into things like that.*
   B. *He/she has very picky tastes.*

26. You do exceptionally well in a job interview.

   A. *I felt extremely confident during the interview.*
   B. *I interview well.*

27. You tell a joke and everyone laughs.

    A. *The joke was funny.*
    B. *My timing was perfect.*

28. Your boss gives you too little time in which to finish a project, but you get it finished anyway.

    A. *I am good at my job.*
    B. *I am an efficient person.*

29. You've been feeling run-down lately.

    A. *I never get a chance to relax.*
    B. *I was exceptionally busy this week.*

30. You ask someone to dance and he/she says no.

    A. *I am not a good enough dancer.*
    B. *He/she doesn't like to dance.*

31. You save a person from choking to death.

    A. *I know a technique to stop someone from choking.*
    B. *I know what to do in crisis situations.*

32. Your romantic partner wants to cool things off for a while.

    A. *I'm too self-centred.*
    B. *I don't spend enough time with him/her.*

33. A friend says something that hurts your feelings.

    A. *She always blurts things out without thinking of others.*
    B. *My friend was in a bad mood and took it out on me.*

34. Your employer comes to you for advice.

    A. *I am an expert in the area about which I was asked.*
    B. *I am good at giving useful advice.*

35. A friend thanks you for helping him/her through a bad time.

    A. *I enjoy helping him/her through tough times.*
    B. *I care about people.*

36. You have a wonderful time at a party.

   A. *Everyone was friendly.*
   B. *I was friendly.*

37. Your doctor tells you that you are in good physical shape.

   A. *I make sure I exercise regularly.*
   B. *I am very health-conscious.*

38. Your spouse (boyfriend/girlfriend) takes you away for a romantic weekend.

   A. *He/she needed to get away for a few days.*
   B. *He/she likes to explore new areas.*

39. Your doctor tells you that you eat too much sugar.

   A. *I don't pay much attention to my diet.*
   B. *You can't avoid sugar, it's in everything.*

40. You are asked to head an important project.

   A. *I just successfully completed a similar project.*
   B. *I am a good supervisor.*

41. You and your spouse (boyfriend/girlfriend) have been fighting a great deal.

   A. *I have been feeling cranky and pressured lately.*
   B. *He/she has been hostile lately.*

42. You fall down a great deal while skiing.

   A. *Skiing is difficult.*
   B. *The trails were icy.*

43. You win a prestigious award.

   A. *I solved an important problem.*
   B. *I was the best employee.*

44. You shares are at an all-time low.

   A. *I didn't know much about the business climate at the time.*
   B. *I made a poor choice of shares.*

45. You win the lottery.

   A. *It was pure chance.*
   B. *I picked the right numbers.*

46. You gain weight over the holidays and you can't lose it.

   A. *Diets don't work in the long run.*
   B. *The diet I tried didn't work.*

47. You are in the hospital and few people come to visit.

   A. *I'm irritable when I am sick.*
   B. *My friends are negligent about things like that.*

48. They won't honour your credit card at a store.

   A. *I sometimes overestimate how much money I have.*
   B. *I sometimes forget to pay my credit-card bill.*

THANKYOU

Strengths and Difficulties Questionnaire

For each item, please mark the box for Not True, Somewhat True, or Certainly True. It would help us if you answered all the items as best you can, even if you are not absolutely certain or the item seems daft! Please give your answers on the basis of the child's behaviour over the last six months.

Date of Birth ……………………………………………………...

	Not true	Somewhat true	Certainly True
Considerate of other people's feelings.	ρ	ρ	ρ
Restless, overactive, cannot stay still for long.	ρ	ρ	ρ
Often complains of headaches, stomachaches or sickness.	ρ	ρ	ρ
Shares readily with the other children (treats, toys, pencils etc).	ρ	ρ	ρ
Often has temper tantrums or hot tempers.	ρ	ρ	ρ
Rather solitary, tens to play alone.	ρ	ρ	ρ
Generally obedient, usually does what adults request.	ρ	ρ	ρ
Many worries, often seems worried.	ρ	ρ	ρ
Helpful if someone is hurt, upset or feeling ill.	ρ	ρ	ρ
Constantly fidgeting or squirming.	ρ	ρ	ρ
Has at least one good friend.	ρ	ρ	ρ
Often fights with other children or bullies them.	ρ	ρ	ρ
Often unhappy, downhearted or tearful.	ρ	ρ	ρ
Generally liked by other children.	ρ	ρ	ρ
Easily distracted, concentration wanders.	ρ	ρ	ρ
Nervous or clingy in new situations, easily loses confidence.	ρ	ρ	ρ
Kind to younger children.	ρ	ρ	ρ
Often lies or cheats.	ρ	ρ	ρ
Picked on or bullied by other children.	ρ	ρ	ρ
Often volunteers to help others (parents,teachers,other children)	ρ	ρ	ρ
Thinks things out before acting.	ρ	ρ	ρ
Steals from home, school or elsewhere.	ρ	ρ	ρ
Gets on better with adults than with other children.	ρ	ρ	ρ
Many fears, easily scared.	ρ	ρ	ρ
Sees tasks through to the end.	ρ	ρ	ρ

Do you have any other comments or concerns?

Please turn over – there are a few more questions on the other side.

Overall, do you think that your child has difficulties in one or more of the following areas: emotions, concentration, behaviour or being able to get on with other people?

No	Yes – minor difficulties	Yes – definite difficulties	Yes – severe difficulties
ρ	ρ	ρ	ρ

If you have answered "Yes", please answer the following questions about these difficulties:

How long have these difficulties been present?

Less than a month	1 – 5 months	6 – 12 months	Over a year
ρ	ρ	ρ	ρ

- Do the difficulties upset or distress your child?

Not at all	Only a little	Quite a lot	A great deal
ρ	ρ	ρ	ρ

- Do the difficulties interfere with your child's everyday life in the following areas?

	Not at all	Only a little	Quite a lot	A great deal
HOME LIFE	ρ	ρ	ρ	ρ
FRIENDSHIPS	ρ	ρ	ρ	ρ
CLASSROOM	ρ	ρ	ρ	ρ
LEISURE ACTIVITIES	ρ	ρ	ρ	ρ

- Do the difficulties put a burden on you or the family as a whole?

Not at all	Only a little	Quite a lot	A great deal
ρ	ρ	ρ	ρ

Signature …………………………………..   Date …………………………………..

Mother / father / Other (please specify:)

Thank you for your time

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APPENDIX C20   **FAMILY ENVIRONMENT SCALE**

APPENDIX C21   GENERAL HEALTH QUESTIONNAIRE

APPENDICES D (PROSPECTIVE ENQUIRY FINDINGS)

APPENDIX D1   SAMPLE PAGE OF PARENT INFORMANT TRANSCRIPT

APPENDIX D2   SAMPLE PAGE OF INTAKE WORKER INFORMANT TRANSCRIPT

APPENDIX D3   CODES

APPENDIX D4   PROVISIONAL BANDING FOR IDENTIFYING SCALE SCORES ON STRENGTHS AND DIFFICULTIES QUESTIONNAIRE (GOODMAN, 1997)

APPENDIX D5   TABLES

Table D1

Table D2

Table D3

Table D4

APPENDIX D1   SAMPLE PAGE OF PARENT INFORMANT TRANSCRIPT

Interviewer	Informant		CODES	Comments
DATA COLLECTION AFTER FIRST INTERVIEW				
The first contact was a telephone referral, how important was that contact?	Of <u>limited importance</u>, really, <u>you call up</u> and <u>give your details</u>		FSTSTP	*Limited, give details*
How was the person you contacted?	Fine, <u>very professional</u>, <u>very clear</u>, <u>warm</u>, <u>friendly</u>.		PROFREF, EMPSTNC	***Professional, empathic***
What was the purpose of the call?	Well, we were <u>determined</u> to go past the problem that Ben was having.		DET	*Determined*
How did you feel about needing to refer?	It's all a matter of . . we weren't afraid. <u>Something was wrong and we needed to attend to it</u>. We're not afraid my husband and I, we have done something in the <u>past, couple counseling</u>, and it was very helpful.		CHPROB	*Child focus Past contact with counseling*
Were you concerned about what members of your family or friends might think about needing to get help?	You can be worried about what others might think, but if <u>something needs to be done, you can learn from it,</u> that's how we look at it.		CMTMT	***Committed to getting help for son***
How was the person you spoke with?	She was <u>warm</u>, friendly, <u>efficient</u>.		SMTH	*Smoothly handled referral*
Would it have made a difference to you if she was rude?	It wouldn't make much difference. I would <u>just push on</u>. I might say to myself "she was rude", but the thing was the aim in view.		DET	*Not to be diverted*
What was that?	We knew <u>we wanted help</u>, this was what the call was for.		CMTMT	*Determined, committed*
Could you have been put off in any way?	No. It was <u>an important stage, and we needed to do it</u>. I would not allow myself to be put off.		FSTSTP	*Important, first step*
DATA COLLECTION THREE MONTHS AFTER REFERRAL				
So now, how important was the referral?	As I said at least once before, it was of limited importance. <u>I needed to do it and wanted to do it</u>. I was <u>determined</u> to go past the referral stage.		DET	*Not to be diverted*
What if the intake worker had been rude?	Yes, you asked me this last time. I wouldn't make much of it, if it had been different. I mean the lady was <u>pleasant and efficient</u>, if she wasn't I would have just pushed on.		PROFREF, EMPSTNC	*Professional and pleasant*

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Interviewer	Informant		CODES	*Comments*
What about the work, demands suit you?	You mean like the level of demand?			
Anything, the hours, the sort of cases you have, the affects it had on you.	I suppose the best thing I like, what I've always said I liked about it, if you're good you don't walk out with anything on your shoulders, you should be able to deal with it and package it up and hand it on to the next step along the field management before <u>you leave at 5pm</u>, because I remember thinking when you had ongoing responsibilities with cases, taking them home, talking about them over dinner and stuff like that.		NHOME	*Work finishes at end of day*
And you're glad not to have that?	Absolutely, it affects you a little bit but not as much as if I had responsibility for a caseload as a clinician.			
Is that why you kept them, you probably could have opportunities to go elsewhere.	Yes, I'd say so, because the other thing is I find it really quite <u>challenging</u>.		CHL	*Work is challenging*
Tell me about the challenges.	You virtually have to make something that you can sit and ponder about when you are making your formulation and you've not got five hours to do it and stuff like that. You've got to do it within a few <u>short period of time</u>.		QKDM	*Quick decision-making needed*
And so you are saying that's obviously demanding but that's actually a pleasure.	Yes, it's a challenge to try and pull the threads together to try and figure out what the <u>best way of managing it</u>, whether they do get through intake into <u>our service</u> or whether they need to go <u>somewhere else</u> and if they get <u>threads to start to think about the whole process</u> of what might be happening within that family and environment and so on. There was something else I was going to say, what was that?		PROBSLV	*Problem solving Help parent to start thinking*
The challenges.	What you do need in the environment is <u>really good backup</u> and the ability to debrief pretty effectively pretty quickly.		IWSUP	*Need good backup*
Do you have that?	Yes I really feel <u>most of the people I work with I do</u>, yes and it's, therefore, yes, it means a lot in terms of who you do work with because if you are working with <u>someone who is less experienced</u> and particularly about the system you can be on a call where you have got to have half your ear listening to their call so they're not going to make a big mess, you don't have top spend time <u>helping them to clean up</u>, so it's demanding in that way as well. I mean I like working with different people because it's different and it's challenging in different ways. It <u>can be hard</u> if they're new and don't know the system.		DEBRF TRN TRNS/V HRDLRN	*Colleagues debrief well* *Trainees* *Supervising trainees, cleaning up messes* *Training is hard*

APPENDIX D3   **PROVISIONAL BANDING FOR IDENTIFYING SCALE SCORES ON STRENGTHS AND DIFFICULTIES QUESTIONNAIRE (GOODMAN, 1997)**

The Strengths and Difficulties Questionnaire was provisionally banded for clinical judgement on the assumption that 80 per cent of children in the community are normal, 10 per cent are borderline, and 10 per cent are abnormal (Goodman, 1997).

Table D3-1

Provisional banding for identifying scale scores on strengths and difficulties questionnaire (Goodman, 1997)

Parent completed questionnaire rating	Normal	Borderline	Abnormal
Total Difficulties Score	0-13	14-16	17-40
Emotional Symptoms Score	0-3	4	5-10
Conduct Problems Score	0-2	3	4-10
Hyperactivity Score	0-5	6	7-10
Peer problems Score	0-2	3	4-10
Prosocial Behaviour Score	6-10	5	0-4

APPENDICES E   (FURTHER ENQUIRY FINDINGS)

Victoria University, Department of Psychology

INVITATION TO STAFF TO PARTICIPATE IN RESEARCH PROJECT:
Referral and Intake to Child and Adolescent Mental Health Services

          Researcher: Jo Grimwade   Supervisor: Dr Suzie Dean
Thankyou for agreeing to read about this project.

The aim of the project is to study what actually happens when a family seeks help from a child mental health agency. The research is particularly concerned with the events that happen between client families and agency from the time of first contact and over the subsequent twelve months. This includes contact with reception staff by telephone, letter, or face-to-face, contact with several clinical staff, and other activities intended to assist family members. A lot happens during this time that might be important in a family receiving the most appropriate help and how quickly this help is gained.

You have been approached to participate because you are a staff member significant to the administration and conduct of referral and intake within (your agency). The Director of (your agency), _____, has agreed to this project being undertaken and has given permission to the researcher to approach parents of clients of the service and significant staff members.

Participation in the research will involve some time on your part, but the research is not intended to intrude on the very private arrangements between professionals and their clients. This is independent research.

Your contribution would be to participate in a semi-structured interview designed to understand how the various policies, practices, steps, and stages of referral and intake affect casework and change in clients and their families. Participation is voluntary: staff will only be involved with their signed consent. You are free to withdraw from the research at any time and without any consequences.

Should you have any questions about this research, you are welcome to contact myself or Suzie Dean on **03 9365 2336**. Thankyou for giving this project your careful consideration,

Yours Sincerely,

Jo Grimwade
Researcher

Any queries about your participation in this project may be directed to the researcher (Jo Grimwade, ph. 9365 2620). If you have any queries or complaints about the way you have been treated, you may contact the Secretary, University Human Research Ethics Committee, Victoria University of Technology, PO Box 14428 MCMC, Melbourne, 8001 (telephone no: 03-9688 4710).

Victoria University, Department of Psychology
CONSENT TO PARTICIPATE IN A RESEARCH PROJECT

Title of Research Project:
Practices and Perceptions: Referral and Intake to Child and Adolescent Mental Health Services

Name of Researcher: Jo Grimwade
Consent of Participant:
I, _____ ,
of_____ ,
certify that I have the legal ability to give valid consent and that I am voluntarily giving my consent to
participate in the study entitled:
Practices and Perceptions: Referral and Intake to Child and Adolescent Mental Health services being
conducted at Victoria University by Jo Grimwade.

The purpose of the above project has been fully explained to me and I read the attached explanatory
statement of aims (Invitation to participate in research).

I certify that the objectives of the study, together with any risks to me associated with the
procedures listed hereunder to be carried out in the study, have been fully explained to me by the
researcher, Jo Grimwade;

and that I freely consent to participation in the interview procedures.

Procedures: Participation in a semi-structured interview continuing referral and intake work of length
between half to one hour.

I certify that I have had the opportunity to have any questions answered and that I understand that I can
withdraw from this experiment at any time and that this withdrawal will not jeopardise me in any way.

I have been informed that the confidentiality of the information I provide will be safeguarded.

Signed:**..**   **}**

Witness other than the researcher: **Date: ....**

...}

Any queries about your participation in this project may be directed to the researcher (Jo Grimwade,
ph. 9365 2620). If you have any queries or complaints about the way you have been treated, you may
contact the Secretary, University Human Research Ethics Committee, Victoria University of
Technology, PO Box 14428 MCMC, Melbourne, 8001 (telephone no: 03-9688 4710).

APPENDIX E3   PROTOCOL FOR SEMI-STRUCTURED INTERVIEW SCHEDULE FOR STAFF

1. Background
1.1 What is your position at the agency?
1.2 How long have you been there?
1.3 How did you come to chose to do intake work?
1.4 What part of your original training bears on your work in referral and intake?

2. Intake Procedure
2.1 What changes have there been in your referral and intake practices or policies since first interviewed?
2.2 What effects have these changes caused?
2.3 A long list of the practices, skills, and procedures was produced in the retrospective study, do you think this list covers most of what you do?

3. Opinions about Intake
3.1 The following are innovations that have been suggested in the literature, how useful might these be in your workplace (letter reminders, telephone reminders, coming to fill out forms, group intake, videotape orientation sessions, telephoning to confirm attendance)?
3.2 Are there innovations you can suggest?
3.3 Do you think Brown's analogy of the mystery story to intake work applies?
3.4 Do you refer to alternate strategies with respect to particular facts or information given in the course of a referral call, as if you are using a computer drop-down menu? Is this a sound analogy for the way you do your work?
3.5 Is referral and intake analogous to triage?

3.6 What are the basic skills of referral and intake work?
3.7 How are the basic skills best passed on to trainee referral and intake workers?
3.8 What are the best qualifications for a trainee referral and intake worker?
3.9 The literature review through up the idea that referrers are of different types, that is, three categories of applicants were described, committed, containable, and crisis reactive [describe categories], can you think of examples of these?

4. This Research Process
4.1 What were the effects on parents of the research?
4.2 What were the effects on staff of the research?
4.3 Is there something more that I should know about the conduct of this research?

APPENDIX E4   SAMPLE PAGE OF INFORMANT TRANSCRIPT

Interviewer	Informant (*from notes*)	CODES	*Comments*
Provided feed back on categories of applicant and the three categories.	Applicant is an interesting word; I just tend to use the term caller.		*Caller*
Described committed category:	Knew about these and usually were easy to handle, however, some committed and determined parents wanted only CAMHS when, arguably they might be seen sooner and with as much effect if seen elsewhere, but had decided CAMHS was it and would not be moved. Mostly easy to deal with and did not require much effort or time. Would be willing to wait		*Committed are easy* *Except of only want CAMHS* *Willing to wait*
Described crisis-reactive category:	In dealing with reactivity, there is a sort of hierarchy of skills, with the very anxious it can be very useful to get some things clear like: "where do you live" and "who are you worried about"; such questions can get clear, unequivocal answers and have a calming down effect and let the caller know that it is safe to talk; the easy things make the harder questions possible.		*C-R hierarchy of skills* *V. Anxious use simple questions* *Calming effect, Safe* *Harder questions later*
Observed two sorts of crisis: those judged by Intaker to be so and those not disclosed, but referral made in reactive way, if not a crisis needing CAMHS urgent attention.	Felt that crisis cases for CAMHS were obvious and in some ways the easiest to deal with. But the reactive cases were difficult, involved a lot of ambivalence, confusion, hostility, and could require a lot of listening	CRI	*CAMHS crisis obvious, quick* *C-R difficult* *Ambivalence* *Need lots of listening*
Asked if distinction between inclusiveness and exclusiveness seen between professions of social work and mental health nursing was of importance	Always try to be inclusive, but, yes, know that other places have a more exclusive attitude and that there is a general push from the government to have services as tertiary; will resist this. Don't know how it could really be done.	INC/ISO	*Aim to be inclusive* *Not tertiary* *Difficult to do*
Discussed the access merry go round and how this might impact on personality, professions, institutions	Agreed that it was important to stop the access problems and get the person to the appropriate service.	RFMGR REFERON	*Stop merry go round* *Refer to best service*
Described containable category:	First wondered if this meant that the family could be moved to the community		*Misheard, slip; off to the community*

TABLES FROM THE FURTHER ENQUIRY

Table E5-1

Pre-call readiness role functions or practices identified from referral and intake worker interviews with inferred order of importance of the role functions or practices

ROLE FUNCTIONS OR PRACTICES	Item type	order
Referral and intake worker available to listen and receive referrals	Policy	A
There is an anticipated place in program for referrers	Policy	B
High priority for referral and intake work within agency	Policy	C
Prevention by early intervention	Policy	D
Most disturbed persons to be seen	Policy	E
Tertiary referral agency	Policy	F
Referral and intake worker engenders initial trust with agency	Attitude	G
Referral and intake work recognized as crucial to process	Attitude	H
Avoidance of a referral merry-go-round for the client	Attitude	I
Processes to facilitate subsequent referrals from a family are in place	Policy	J
Referral and intake centralized function of agency	Role description	K
Referral and intake worker as specialist role	Role description	L
Dedicated referral and intake worker	Role description	M
Referral and intake worker role has specific limits	Role description	N
Referral and intake worker liaises with services in external network	Network	O
Referral and intake worker maintains community resources guide	Network	P
Referral and intake worker reliever for leave	Role description	Q

Table E5-2

During call role attitudes

ROLE ATTITUDES
First point of contact
Confidential process
Inclusive not isolating
Take seriously
Empathic stance
Sensitivity to ethnicity and community languages
Language other than English
Sensitive to parental needs
Family focus
Family strengths
Family support
Friendly
Flexible structure
No written policy
Continuity of contact and support
Avoid blaming/ stereotyping/ labelling
Crises are rare
Hurdles and barriers to access
Awareness of length of waiting list or of waiting period
Style of undertaking the work
Continuity of contact and support
Tell story
Strengths
Provided clarity
Tracking of linked callers
Referral and intake worker able to predict if complete assessment

Table E5-3

During call practices of referral and intake workers with chronological order of steps indicated; where no order is indicated the step is likely to occur at the proposed chronological position, but does not always occur

PRACTICES	order
Telephone interview	1
Adolescents have rights at referral	
Referral by personal contacts to Director or team leader	
Standard procedure	
Assess severity	2
Assess urgency	3
Referral purpose clarified	4
Listened to and heard	
Telephone contact form or sheet	5
Handwritten notes by referral and intake worker	
Crisis response roster	6
Parent referral	7
Professional referral	8
Local agency support	9
Parent to confirm professional referral	10
Referral and intake worker contacted parent	11
Referral and intake form or sheet	12
Criteria	13
Demographic data	14
Information gathering	15
Problem description	16
Spend time	
Assess appropriateness for service	17
Assess likelihood of benefit for family	18
Legal issues cases	19
Referred on	20
Connect services with persons	21
Information provision about service	22
Set expectations of assess and treatment	23
Parent consulted	24
Parent as decision maker	25
Telephone referral time length	

TableE5-4

Post-call role functions or practices of referral and intake workers with chronological order of steps indicated; where no order is indicated the step is likely to occur at the proposed chronological position, but does not always occur

ROLE FUNCTION OR PRACTICE	order
Ordinary appointment	
Ordinary appointment prioritized	
Feedback from team to referral and intake worker	
Caller can re-contact prior to appointment	26
Allocate case to clinician	
Voluntary allocation of cases	
Team leader monitors and allocates cases	
Match of resources to needs	
Handover to allocated clinician	27
Confirmation letter	28
Send letters with relevant information	29
Letter sent to confirm allocated clinician	30
Referrer contacted	31
Letter to referrer prior to appointment	32