EVALUATION OF A DEVICE TO REDUCE A CHILD GUIDANCE CLINIC WAITING LIST

by

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CHAPTER I

INTRODUCTION

One of the problems that concerns almost every Child Guidance Clinic in the United States is the long list of clients waiting for Clinic services. The ever-growing need for psychiatric services simply continues to exceed the supply of personnel and time available. In early 1959, the Flint Child Guidance Clinic staff began some careful consideration of their intake procedures in the light of their mounting waiting list. They were concerned about the wait between intake and staff diagnosis and the additional wait between diagnosis and treatment. They decided that various staff members should visit several Michigan child guidance clinics to study their intake procedures.

This survey disclosed many similarities among the intake procedures of the seven clinics. In five of the seven, the three disciplines, (psychiatry, psychology, and social work), were used in the intake procedure. All the Clinics used the three disciplines in intake disposition conferences. All the clinics had intake waiting lists, and six clinics had treatment waiting lists. Five clinics used the secretarial staff to gather identifying information and for rough screening at the

first contact. Most of the clinics involved the parent or parents in treatment with the child however possible. The study team leader summed up the differences among the seven intake systems.

> It is difficult to determine the difference that most of our questions arise. The waiting lists seemed determined by the demands for service, but a wide variation, from two weeks to six months, exists in the initial call-back period...Some clinics feel that our role is primarily treatment and that diagnostic services should be limited whereas others feel that the diagnostic service is equally important to the community. In regard to treatment, some clinics refuse service to the severely disturbed, to the borderline mentality, to marital problems, etc....Some participate actively in community education programs; others discourage this, partly because such education, besides being an extra service, also increases the demand for service, and we are already unable to keep up with present demands.[1]

In the fall of 1958 the Saint Clinic made several decisions concerning intake policy and adopted a new intake system. The staff decided that a treatment waiting list does more harm to both client and clinic; therefore, only those cases should be assigned to treatment that can be picked up by a therapist within sixty days. If they do not represent an emergency and cannot be picked up in sixty days, they will be referred elsewhere or refused treatment. To assist in lowering the formal waiting list of 112 cases and to handle the continuing preponderance of need over facilities, the clinic adopted

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[1]Dennis Brown, Summary Study of Intake Procedures at Seven Child Guidance Clinics, (Paper presented to Michigan Child Guidance Clinic Association, 1958.

the following system:

1) The monthly quota of new referrals that can be accepted will vary from month to month on the basis of projected staff availability.

2) The referral quota will vary from month to month on the basis of referrals held over from the preceding month which have not been acted upon.

3) In the calendar year of 1957, with a staff of 7 full time professional people, we saw diagnostically 424 cases, an average of 28.2 new and reopened cases per month. With the present staff of 6 full time people (plus one vacancy), the theoretical average per month would be 21 cases, the present quota to be based on the maximum that could be seen diagnostically in the month with all diagnostic modalities (diagnostic teams, psychological testing, individual diagnostic interviews) assuming all present staff available.

4) It is considered that it can be clinically sound and healthy to have a referral waiting list approximately double the number of new and reopened cases that can be seen in the average month. On the basis of current staff and current operations, there can be a total of 60 cases in the referral waiting list at any given time.

5) It is to be expected that some emergency or urgent cases (on the basis of the needs of the case or the needs of the referring agency) will be fitted in almost any month as a part of the monthly quota.

6) The quota of new and reopened cases to be accepted for a succeeding month is to be determined at the last administrative staff in the current month.

The quota will be based on the projected diagnostic personnel time available for the next month, the use of which would be divided as follows:
18.5% for cases already active in the clinic (e.g., additional psychological study or psychiatric study).
18.5% for "emergency" new or reopened referrals.
27.5% for referrals from the waiting list backlog starting with the oldest.
37.5% for non-emergent current new and reopened referrals.

In operation, at any point in a month that the current waiting list of new and reopened referrals reached the predetermined maximum (at present 60 cases), a referring agency or a client referring himself would be informed that because of the shortage of personnel time, no additional referrals could be accepted this month and that if they still felt the need for help, they should call back on a

> work day early in the succeeding month. (This would not apply to truly emergency or very urgent cases). As soon as the waiting list backlog (currently 418 cases) is worked off, it should be possible to increase the percentage of non-emergency new and reopened cases accepted to 75%.[2]

Since its inception, the above system has undergone many modifications, some minor and some major. One of the most important was adopted in November, 1939. This was to release those told to call back from competition with new clients calling in, and to reserve acceptance for all the applicants told to call back.

This paper is to evaluate the device described above and see (1) if it is eliminating the old waiting list and (2) if it is satisfactorily controlling current intake. It will also show some community reaction to this plan. Several referral agencies will be contacted, and the opinions of clients whose clinic service was delayed will be sampled. The study could result in better definition and control of the present system of intake or the development of a new scheme if this one is found ineffective. Since the problem of handling the preponderance of needs over services is almost universal with Child Guidance Clinics, other clinics could get a positive or negative example from the Flint Clinic's device.

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[2]Flint Child Guidance Clinic, from the proceedings of an April, 1938, staff meeting.

CHAPTER II

SETTING AND BACKGROUND OF THE STUDY PROBLEM

The first Child Guidance Clinic in America was established in Chicago in 1906. In 1916 Dr. Inch of the Kalamazoo State Hospital persuaded the Grand Rapids Probate Court and the County Commissioners to pay the expenses of the traveling clinic which examined children referred by the Court. It performed diagnostic services only.[3] In 1922, impetus was given to the Child Guidance Clinic movement with the establishment of Demonstration Clinics in Norfolk and St. Louis under the Commonwealth Fund.[4] The fast-growing Child Guidance Clinic movement embraced Flint in 1930 when the Whaley Home Foundation and Coutens Fund set up a clinic. For sixteen years this clinic served Flint and was supported by private and local community funds. The continual decrease of these funds caused corresponding cutbacks in staff until the director resigned and the Clinic was closed in June, 1946.

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[3]Hazel Erickson, The Child and His Welfare (San Francisco, California: W.H. Freeman and Co., 1950), p. 145.

[4]Ibid.

By the fall of 1946, a group of civic-minded Flint citizens had induced the State Department of Mental Health to agree to the establishment of a joint state and community-supported Child Guidance Clinic in Flint. It was opened that same year to serve Genesee, Lapeer, and Shiawassee counties. As are all State Child Guidance Clinics, the Flint Clinic was set up with the state providing certain key personnel but with housing, secretarial, and other operating expenses being provided by the local community.[5]

The structure of the Child Guidance Clinic in Michigan is based on a team composed of a child psychiatrist, clinical psychologist, and psychiatric social worker. The Flint Clinic's current staff consists of a child psychiatrist, two clinical psychologist, two full time and one part time psychiatric social workers, and a mental hygiene nurse. However, this staff, aided by several unofficial consultants in the community, is unable to keep up with the demand for its services.

The Flint Child Guidance Clinic was established for the following purposes:

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[5]Flint Child Guidance Clinic, Annual Report, 1950.

a) The primary purpose of the clinic is the diagnosis and treatment of children from birth to the age of sixteen, or until they have finished high school, who present emotional, personality or behavior problems to themselves, their parents, or the community; and to counsel and aid the parents of these children.
b) To work for the prevention of maladjustments of children through the application of preventive techniques, community education, or any other feasible means.
c) To help children and parents by cooperating with social agencies and other community organizations interested in the welfare of children.
d) To engage in research in the diagnosis, treatment, or prevention of emotional disturbance in children and their parents.
e) To cooperate with the Department of Mental Health in the overall state plan for the prevention of mental illness.[6]

Three studies have been done covering intake problems similiar to the ones considered in this paper. Li Angelo studied clients who call, but do not complete their application procedure at a Chicago treatment institution.[7] The self-referred had a greater tendency to complete intake than did the clients referred by social agencies.

Moorehead studied clients not accepted for treatment but referred elsewhere at intake. The problems of the treatment institution where her study took place would be analogous to those of the Flint Child Guidance

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[6]Flint Child Guidance Clinic, Constitution and Bylaws, Art. 2.

[7]Eleanor Li Angelo, "Parents Who Call but Do Not Apply" (unpublished thesis, Smith College, 1947), p. 68.

Clinic.[8] She found that most of the clients who accepted referral felt satisfied with the help received and positive toward the referring clinic. Several months after referral was offered, most who had not accepted it felt that their childs' symptoms had not improved. They felt quite negative toward the clinic. Many received other professional help after their initial contact with the clinic, but not, ostensibly, as a direct result of the clinic referral.

Kathryn Markkus also studied a group of clients several months after they had been referred elsewhere by the intake department of a treatment institution.[9] She found that most such patients expressed relief and satisfaction as an immediate response at the referral source.

These three studies show that some of the pressure created at intake by too much need for the services available at a given clinic, can be lessened by dynamic referral to and from that clinic, if other community resources are adequate.

Intake, since it covers a client's initial contact with an agency and the agency's assumption of case-

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[8]Janet Arlene Moorehead, "A follow-up Study of Cases Referred Elsewhere for Treatment", Smith College Studies in Social Work, XXVIII, (1958), p. 75.

[9]Kathryn Markkus, "A Psychiatric Clinic Refers Patients Elsewhere: A Follow-up Study", Smith College Studies in Social Work, XXVIII, (1958), p. 88.

work responsibility for the client, is a functional, dynamic and integral part of casework services. The following thinking concerning intake, gleaned from casework literature, seems related to the problems under study in this paper.

Scherz broadly and conceptually defines intake as the total impact of a community on an agency.[10] She further defines it as a learned process of interaction with a client that results in acceptance for service, referral, etc. Agencies can be mainly and narrowly concerned with a client's verbal request, or they can focus on the possible ramifications of that request--the needs of the client's total personality and milieu. The worker has the right to explore the client's request even if the agency cannot grant it.

Litterman described one agency's handling of the waiting list problem.[11] She cited the almost universal explanation for waiting lists--poor finances or lack of trained staff. She felt that a single caseworker for applications lessened errors in arranging appointments, made proper follow-up and interpretation more certain, and permitted a more realistic evaluation of relative emergencies.

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[10]Frances Scherz, "Intake:Concept and Process" (Social Casework, June, 1958), Vol. XXXIII, n. 6, p. 272.

[11]Catherine M. Litterman, "Serving Applicants When There Is a Waiting List" Social Casework, (June, 1958), Vol. XXXIX, n. 6.

Litterman emphasized that understanding a client's real request and making proper referral decisions take a high degree of casework skill. She advised that clients be put on a waiting list only after they have been found to be clinic material. Additional phone calls from client to clinic represent pressure in addition to other things, and therefore need to be realistically evaluated. She divided all applicants into three groups: (1) those that can only wait one or two days to be seen, (2) those that can wait up to two weeks, (3) those that can wait longer. Her plan was to arbitrarily assign two new cases to each worker each week unless the applicant requested or needed a special worker. She found that over 25% of those on the waiting list "cancelled out" before being called for a diagnostic interview. They generally waited from four to eight weeks.

Many of the intake contacts in most agencies take place over the telephone. Litterman warned that telephone interviewing takes special skills.

Hallowitz and Cutter asked if anything constructive can come of the universal problem of waiting.[12] They described an experiment in the Child Guidance Center of Buffalo. The clinic divided those accepted for treatment into three groups: (1) requiring parent con-

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[12] David Hallowitz and Albert V. Cutter, M.D., Intake and the Waiting List: A Differential Approach, Social Casework, XXXV (December, 1954), p. 479.

sultation only, (2) requiring continued work with parents only, (3) requiring the full treatment of the parents and the child. They found that 21.6% fell into the first category, 10.8% into the second, and 14 into the third. (21 of the clinic cases needed diagnosis only and were excluded from this study).

The first group included cases where the child's symptoms were aggravating but not deep; and child and parents were basically sound. A follow-up study determined that fourteen of the sixteen cases in this group were maintaining their gains a year later.

Group two was composed of children with deeper conflicts reactive to their parents' difficulties. Group three's children had deeper and more internalized disturbances. The parents had less health and treatment was expected to take more time. Except for emergencies, parents in the third group had to wait the longest for treatment. However, they were offered a chance to come to the clinic during the wait whenever they felt the need. They were told of possible emergency appointments should this need arise. Workers made follow-up contacts on a needs basis during the waiting period. It was determined that one-fifth of the parents in the third group made progress with their problems during the waiting period.

The authors felt that the above plan left with the parents the responsibility for facing and dealing with the problems of their children in accordance with their capacity to carry responsibility.

The three articles summarized above, particularly the last one, show that the usual harmful effects of waiting for service can be considerably modified. The clients' feeling of being ignored or left out can be ameliorated and the numerical waiting list can be reduced.

CHAPTER III

GATHERING AND TREATMENT OF DATA

Evaluation of the Intake Quota System

Between August 1, 1958 and January 31, 1960, parents and agencies contacted the Flint Child Guidance Clinic requesting help for 686 children. This figure averages about 48 requests per month as compared with a rate of 68 per month a year prior to this period. The exact reason for the decrease is not known. It could be conjectured that publicity concerning the clinic's new system of intake has resulted in a better conception of the clinic's functions and intake limitations. Because of the many changes in the intake system and record-keeping, it is difficult to determine the exact disposition of each case. Table 1 uses some estimated figures to show the status of some of the 712 cases three months after the study period closed. This information was compiled and estimated from clinic records. This table illustrates the various methods the clinic has for screening and handling requests for service, aside from accepting children for treatment.

When the clinic began the new intake system, they hoped to reduce gradually the waiting list existing at

TABLE 1

PARTIAL DISPOSITION OF 286 REQUESTS FOR SERVICE RECEIVED BETWEEN AUGUST 1, 1959 AND JANUARY 31, 1960[a]

Disposition	Cases	Per cent[b]
Total	286	
Intake Forms Sent	212	100
Consultation Without Opening	18	8
Opened and Waiting Appointments	37	17
Handled As Emergencies	32	14
Received Diagnostic Appointments	44	20
Applicants Did Not Complete Intake	76	34

[a]Data compiled as of April 30, 1960.

[b]Of Applicants sent intake forms.

that time. Table 8 compares that list with the number of clients waiting at the beginning of this study and the fluctuations in size of the group waiting for service during the study. Each month a varying number is removed from the waiting list and a number added. The ones removed are usually those that have waited the longest. Exceptions include those that have become emergencies or those best suited to a certain available clinic therapist. It would have been helpful to have examined and compared the waiting list, on the basis of the length of time each person on the list has been waiting at a given time. It would have been helpful to have known exactly how long each person waited between first contact and first appointment. However, this information was not available.

TABLE 8

COMPARISON OF THE INTAKE WAITING LIST ON CERTAIN DATE INTERVALS NOVEMBER 30, 1958, AND JANUARY 31, 1960.

Dates	Clients Waiting
11-30-58	218
8-1-59	203
9-1-59	221
10-1-59	229
11-1-59	228
12-1-59	218
1-1-60	189
1-31-60	184

The general conclusion regarding table 2 is that the new system has not significantly reduced the intake waiting list. The fluctuations and apparent temporary downward trends could be due to seasonal pressures or chance.

The clinic takes responsibility for clients if a telephone contact with a staff person (after the client has completed and returned the intake forms) reveals that the child is clinic material. Table 2 shows how long those accepted for service during the study period waited for their first appointment. It excludes those cases handled as emergencies and does not completely cover the rest of the universe because [illegible] had not been given diagnostic or treatment appointments three months after the end of the study period.

TABLE 2

NUMBER OF CASES WAITING FOR FIRST APPOINTMENT OF THIRTY-TWO CASES REQUIRING SERVICE BETWEEN AUGUST 1, 1959, AND JANUARY 31, 1960, AND RECEIVING APPOINTMENTS BY APRIL 20, 1960.

Number of Cases	Number of Months Waited
6	1
8	2
7	3
7	4
3	5
0	6
1	7

The median number of days the clients of the study waited for service (after being accepted) was 2.56 months. The figure is fairly close to the optimum period of waiting for service as established by the clinic. The length of time between a client's first contact with the clinic and his acceptance for service could not be measured because such statistics were unavailable. This wait could substantially increase the period applicants actually wait for appointments.

Table 3 covers only about 14% of those originally requesting service from the clinic. (see table 1). It omits consideration of about 8% of those originally accepted for service. But not accounted for in table 1. The final disposition of many of the other cases categorized in table 1 could not be finally and exactly determined. Any conjectures as to the meaning of the table cannot be made without greater knowledge of the fate of the other 86%. This table could also be more meaningful in information regarding the average rate during the pre-quota period were available.

The above information regarding some aspects of the intake quota system is not adequate or accurate enough to determine whether or not it is effective.

REACTION OF THE AGENCIES TO THE CLINIC

This study included two attempts to sample the public's feeling regarding waiting for clinic service. The first was a questionnaire requesting six responses--two dichotomous and four open-end questions. This form was sent to ten agencies who refer children to the clinic. One agency stated that it had not referred anyone for at least a year and therefore could make no meaningful contribution to the survey. Seven of the others had their forms picked up during scheduled appointments with agency heads. One was mailed in because of misunderstood directions. The following agencies replied to the questionnaire: The Flint Public Schools (through its liaison person), the Youth Bureau, Michigan Children's Aid Society, Catholic Family Service, Family Service Society, the Shaley Home, the Y. M.C.A., the County Juvenile Agent.

All the agencies serving the clinic had been sent a letter describing the new intake system when it was adopted almost two years before this study. This letter was duplicated and sent to the ten agencies included in the survey along with the questionnaires and covering letters. Copies of each item sent are included in the Appendix.

The statistical information is not scientifically accurate. However, this study does raise some questions. It appears that the system is not fulfilling its original purposes. The flow of cases is not following the prescribed percentages. The intake waiting list remains fairly constant. However, the constant pressure of referrals has necessitated many alterations in the day-to-day mechanics of the intake system. It is difficult to define or measure since it does not remain constant.

The majority of the agencies surveyed felt that the clinic's new intake system had had no significant effect on the number or types of cases they referred. One agency felt that the number of their referrals to the clinic had decreased for the last four years. Since the onset of this decline preceded the clinic's intake changes, the two events are not directly related. The clinic's definitive description of intake timing led one agency to turn to other resources for psychological testing. Another agency is still apparently not clear on how the present system works. The agency felt that its flow of referrals to the clinic was facilitated by the new plan because there would now be a chance to 'reactivate' old cases each month. One agency felt that its referral policy and flow were unchanged by the new plan because the clinic was then serving as well as it could all along.

One agency felt that it was more encouraging to talk to parents when there is a possibility of an "opening" in thirty days. This is highly unrealistic. A child seldom receives an appointment within thirty days unless he is considered an emergency.

Four of the eight agencies contacted had suggestions which they felt could improve intake. One agency felt that a "traveling" caseworker going into the homes of those interested in clinic service could evaluate the need and screen applicants more expeditiously and effectively than the intake worker in the clinic. One suggestion was that the blue and pink forms sent to parents as a part of intake were too personal and too threatening. It was felt that forms should be brief, simple and impersonal, since applicants receive them before any face-to-face contact with clinic staff members. The client should be seen and skillfully evaluated as soon as possible after the first request. This might lead to more early referrals to the family agencies.

An agency wondered if its emergency referrals were accepted at face value, or if the clinic evaluated such referrals and made its own decision about emergencies. This again indicated a lack of familiarity with the clinic's intake process, since the clinic must and does take the responsibility for such decisions.

The summarized view of the intake system includes some feeling that there are now more and longer waits than in the past. This apparent misconception has resulted from the focus on waiting and the fact that a way of waiting has been described and defined. Most of the agencies obviously do not understand what changes in intake policy the clinic has made in the last few years. They generally feel that the system has not helped or hindered referrals to the clinic. Most of the questionnaire responses were concerned with general waiting for clinic service, not specific waiting within the framework of the present system.

About three of the replies stressed the "informal" services that clinic staff members perform for various agencies. These advisory and consultative services are quite extensive and help to relieve intake pressures.

Telephone Interviews

Schedules A and B (see Appendix) were used as guides in conducting telephone interviews with parents who had waited for service. Form A was used in interviewing the group who had been accepted but did not receive appointments. Form B applied to the group who waited but were finally served by the clinic.

Thirty-five calls were attempted using Form A but only twenty interviews were completed because the parents were not at home. By the time the successful twenty

interviews were completed in April, 1960, eight of the children in this group of "not served clients" had been offered appointments. One parent had met an appointment and two more had appointments scheduled in the near future. Another parent had accepted the clinic's cancellation of her appointment and referral to another resource. One couple had had group therapy at the clinic in addition to an appointment for their child. Three parents had refused appointments because of insufficient motivation. The other twelve parents in the group were still waiting for appointments. None had formally withdrawn.

The intake quota system required all applicants beyond a certain number each month to call back the month following for acceptance for service. Part of questionnaire form A was to determine whether or not any of the twenty parents in the group were affected by this device. None of the parents mentioned calling back as a step before acceptance for service. Three of the parents did call after they had been accepted. This was because of their need for support and to put pressure on the clinic. Two parents felt that they would have called while waiting had not extenuating circumstances occupied their attention. The other fifteen parents accepted the clinic's promise to notify them of appointments as soon as time was available.

The twenty parents were asked about their feelings

regarding the clinic's handling of applicants. Two of them were vague and confused about the reasons behind waiting for appointments. They felt deflated, neglected, and hostile to the clinic, although they intellectually knew that there would be a wait and that the clinic would eventually contact them. Another parent did not like the wait, but felt that all clinics work slowly because of the delicacy of the work that they do. This expresses the general feelings of fifteen of the twenty parents toward the clinic. They resignedly accepted the long delays and slow intake process. They knew that the clinic could not meet the demand for its services. Two parents felt enthusiastic about the handling of their application. Three others felt that they had received no service.

Only three of the twenty parents felt that they knew enough about the clinic to make suggestions. One felt that the blue and pink forms sent parents as a part of the intake procedure were hard to understand and that such information could best be handled in a face-to-face interview. Another suggested that the clinic make more of an effort to handle childrens' problems during their early elementary years. A third mother wistfully suggested that her child should have been seen sooner.

The number of parents not at home on the days the

telephone interviews were attempted indicates that many of these mothers are probably working. Forty per cent of the twenty mothers interviewed as not served had been offered appointments. The clinic is, therefore, probably reaching a larger number of children than the routine statistics alone would indicate. The twenty parents did not understand and did not feel affected by the call-back system as a part of intake acceptance. Very few called the clinic while waiting for appointments. The parents generally understood and accepted the fact that the clinic is struggling with intake pressures and a waiting list. They did not like to wait but were resigned to it. But a minority did not understand the clinics pressures and felt bitter and neglected because they had to wait.

Form I was used in twenty attempted interviews with parents who waited varying periods before receiving clinic appointments, but were now obtaining clinic service. Seven were not at home when the calls were attempted.

An effort was made to find out if the call-back device at the time of the first request for service had affected the thirteen parents interviewed in this group. Three of the parents stated that they had been instructed to call back at least once at the beginning of a later month and before being sent the blue and pink intake forms. Three parents called for advice or to attempt

to speed up service while waiting for appointments. One other would have called while waiting for an appointment but family activities kept her too busy. Six of the parents felt that the school and/or the clinic had originally taken responsibility for arranging for clinic service and the parents, therefore, did not initiate any calls to the clinic.

Five parents from this group had suggestions to make regarding intake procedures. Two recommended that the clinic employ a larger staff. One questioned some procedure that excluded her daughter--she understood that the clinic could not accept a child for treatment unless they had other available children in the same age group. (She obviously must have misunderstood some interpretation of intake policy). Two parents suggested that the reasons and procedures for calling back at the time of first request for service should be explained more thoroughly. Another felt that instead of intake personnel asking clients to call back in a month, they could take an application and hold it until the usual time to call back. Another suggested that at least the name and date could be recorded when a client first requested service. (A November, 1963, change in the intake system has added this step).

Schedule B also sought to determine how the thirteen parents in this group evaluated their experience with the clinic. Three mentioned the intake worker:

two felt that she was hard to reach by telephone and the third felt that she had been quite supportive during the waiting period. Three parents felt that the system of calling back for intake acceptance had delayed their appointments. One of these felt that the appointment was too late to help her child when it finally came.

When parents were asked how long they had waited for appointments, they timed their waiting time from their first request for service. Five felt that this period had not been very long. Their estimates ran from one week, (for summer camp), to two months. Two parents definitely stated and six others implied that they felt that they had waited a long time. One estimated that she had waited ten weeks, four said they had waited three months, one had waited four months, two waited five months, and one six months.

One parent wondered if the clinic had planned the waiting period because applicants might be emotionally upset at the time of their first request. Seven parents understood that the clinic had a waiting list and was very busy; therefore, a wait was necessary. Two parents felt that service by the clinic was prompt. The majority indicated that they did not like waiting but could accept it.

Apparently many of the mothers in this group work away from home since 35% of them could not be reached

during the day. A small, but vocal minority of the group had been asked to call back during intake and were annoyed and confused by the procedure. Most of the parents seemed to leave responsibility for maintaining contact solely with the clinic. They could explain the pressured situation of the clinic and were resigned to a delay which they disliked.

Parents were almost evenly divided in their feelings about whether or not they waited a long or a short time. The group that felt they had not waited long, waited an average of a month each and the group that felt they had waited a long time averaged four months.

These parents do not understand the intake quota system but have a meager understanding of the pressures on the clinic and feel that they must accept long waiting periods.

These surveys do not definitively measure attitudes but give some general impressions of applicants' feelings about waiting for service. The thirty-three parents interviewed seemed happy to take part in a study they viewed as possible helpful to the clinic.

Both A and B forms were used very loosely as guides in the telephone interviews. Most of the questions had to be paraphrased and some were often omitted or drastically changed according to the parents' limited knowledge of clinic procedures.

The parents who received appointments and those

who did not were basically similar in their knowledge and feelings regarding clinic intake procedures.

Almost identical percentages of each group could not be reached, possibly because many of them were working. The fact that parents who had received appointments had partly been involved in the call-back system while none of those not served by the clinic mentioned it, might be significant. The former group might have been more aware of and amenable to intake procedures.

A majority of both groups at least partially understood why they had to wait. Some in each group attempted to speed up the process by telephone calls while waiting. Most parents in both groups passively accepted waiting for appointments, but the parents who received appointments seemed more resigned to the delay that neither group enjoyed.

CHAPTER IV

CONCLUSIONS AND RECOMMENDATIONS

In 1958, the Flint Child Guidance Clinic studied its own and several other clinic intake systems and established some new procedures for handling applicants. They hoped to gradually reduce a formal intake waiting list while permitting current applicants to be served without unreasonable delay.

The information presented in this study seems to indicate that neither of these goals has been reached. However, the steady pressure of needs over services has forced many day-to-day changes in the operation of the intake system so that it has become more and more complex and difficult to define. A scientifically valid study would require that the system be stabilized at some point and again carefully defined.

The intake quota system means little to clients and agencies. However, the study indicates that parents and agencies are quite understanding of the clinic's intake problems and accept the resultant waiting and inconvenience with good grace. Perhaps a little more detailed explanation of the situation at the time of the first contact with the clinic might help the few who do not understand.

A valid measurement of the length of time applicants wait for service would need to begin at the point of the first request to the clinic. Since such information was not available for this study, waiting in most instances has been measured from the time the clinic accepts the applicant for service. However, a number of changes in recording and handling applications have been instituted since the beginning of this study. These should make it easier to chart the flow of cases through the clinic and to gather statistics on dispositions and total periods of waiting for service.

Some of the writings reviewed in the study stressed more dynamic referral as a means of relieving intake pressure. A periodic evaluation of the use of other community resources should be of value to any agency. One writer emphasized the necessity of understanding the meaning behind an applicant's statements at intake. This would facilitate more definitive screening and conserve an intake worker's time.

Bitterman advised that those waiting for appointments be categorized according to the seriousness of their problems. Hallowitz and Cutter felt that those waiting should be differentiated according to the degree the parents and/or the child needed to be involved in treatment. These authors advise that several rather than one waiting list may be valuable because the dif-

ferent groups can be handled at different speeds. This suggestion and the one of planned casework contacts with waiting applicants indicate that waiting for treatment can be handled dynamically and positively. This could help prevent a small but important group of clients from being overwhelmed and neglected while waiting for appointments.

The number of requests for service at the Flint Clinic have decreased markedly in the last three years. Of course, they are still far more than the clinic can handle. It appears that putting the clinic intake problems and a planned solution down on paper has deterred some who would otherwise refer. Although the local agencies know little about the system, some do indicate that they no longer refer as freely as they used to.

A complete picture of the clinic's intake processes must include some measurement and evaluation of the many ways the clinic helps children who do not go through the formal intake procedure and become statistics. These varied consultative and advisory services take a considerable amount of time but probably reach many more children than could possibly be seen formally. Many of these informal services can be considered preventive treatment. Of course, the clinic has the inherent aim of working preventively as much as possible.

People concerned with Child Guidance have not yet done a good enough job of convincing the public that facilities and personnel necessary to meet the need are worth paying for. It appears that the preponderance of needs over services will be a serious problem for some time to come. Varied and comprehensive studies need to be made continuously to make optimum use of the clinic facilities available and to create and maintain a positive working relationship between the clinic and the various publics.

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APPENDIX

FLINT CHILD GUIDANCE CLINIC
Sponsored and Supported Jointly by the
State Department of Mental Health and the
Community

702 S. Second Avenue - - Flint 2, Michigan
Telephone CE 2-0192

Dear

The Advisory Board of the Flint Child Guidance Clinic has authorized the use of a new intake policy which we would like to share with you.

The first child guidance clinic in this country will have its golden anniversary next year and it, like all others, is plagued with a "waiting list problem." Various solutions have been tried, such as the complete closing of intake until all persons on the Waiting List have been seen diagnostically, but thus far no optimum solution has been found. The fact remains that the need for psychiatric service all over the country is greater than the supply of personnel and time. Our staff, after considering various possibilities for meeting this problem, are recommending the setting up of a monthly referral quota system which would operate as follows:

(1) The monthly quota of new referrals that can be accepted will vary from month to month on the basis of projected staff availability and will be determined on a month to month basis.

(2) The referral quota will vary from month to month on the basis of referrals held over from the preceding month which have not been acted upon.

(3) It is considered that it can be clinically sound and healthy to have a referral waiting list approximately double the number of new and reopened cases that can be seen in the average month. On the basis of current staff and current operations, there can be a total of 60 cases on the referral waiting list at any given time.

(4) It is to be expected that some emergency or urgent cases (on the basis of the needs of

the case or the need of the referring agency) will be fitted in in most any month as a part of the monthly quota.

(5) In operation it would work as follows: At any point in a month that the current Waiting List of new (non-expense) referral reached the pre-determined maximum (at present 60 cases), a referring agency or a client referring themselves would be informed that because of the shortage of personnel time, no additional referrals could be accepted this month and that if they still felt the need for help, they should call back on a work day early in the succeeding month. (This would not apply to truly emergent or very urgent cases). As soon as the Waiting List backlog (currently 218 cases) is worked off, it should be possible to increase the percentage of non-emergent new and reopened cases accepted.

To meet the ever-increasing demand for service we have seven staff positions available consisting of a psychiatrist-director, two psychologists, and four social workers. A staff this large would not successfully meet the demands from the three-county population (Genesee, Lapeer, Shiawassee) service. In fact, based on national standards and the current child population, to render adequate service, the staff should consist of four psychiatrists, four clinical psychologists, and ten psychiatric social workers. We are hoping that the Legislature will provide this year for several such needed additional positions as the continued need is demonstrated.

We trust this system which we are trying will not prove inconvenient. We would like to hear of your reactions to it as it moves along in operation. If this works as well as we hope, our intake should be on a more current basis with the waiting period being decreased considerably for the majority of clients.

Sincerely,

Paul H. Jordan, M.D.
Director

PHJ:jg

FLINT CHILD GUIDANCE CLINIC
[illegible] W. Second Ave.
Flint 3, - - Michigan

1. Do you feel that the current system has affected the flow of referrals from your agency to the Clinic?

   If so, how?

2. Has your referral policy toward the Clinic been affected by the present intake plan?

   If so, how?

3. Since this system has gone into effect, have you received any significant reactions from clients regarding it? If so, please summarize briefly.

4. What suggestions regarding the Clinic's intake policy could you make to improve our service to clients?

PROPOSED TWIN TELEPHONE SCHEDULE

"A" SCHEDULE

This is Mr. Smith from the Flint Child Guidance Clinic, we would like to find out how you feel about what has happened between you and the Clinic. This call has nothing to do with your regular Clinic appointments or what you talked about before with the Clinic.

A while back you called about an appointment for your child and you were asked to call back later.

A.

1. Our records show that we were never able to see your child at the Clinic, can you tell me why?

2. (a) Did you try again?

   1. If yes, what happened then?

   2. If no, why not?

3. How do you feel about what happened with you and the Clinic?

4. Since you have had this experience, would you have any suggestions for us?

PROPOSED THESIS TELEPHONE SCHEDULE

"B" SCHEDULE

This is Mr. Smith from the Flint Child Guidance Clinic, we would like to find out how you feel about what has happened between you and the Clinic. This call has nothing to do with your regular Clinic appointments or what you talked about before with the Clinic.

A while back you called about an appointment for your child and you were asked to call back later.

B.

1. Our records show that you did call back and later brought your child into the Clinic. As you remember, how many times did you call the Clinic before you got your first appointment?

2. How long did you wait?

3. As you understood it, why was it necessary for you to call back many times?

4. How did you feel about this?

5. Since you have had this experience, would you have any suggestions for us?