# A STUDY OF PRE-INTAKE DROPOUT AT ST. LAWRENCE COMMUNITY MENTAL HEALTH CENTER

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Elsie Berdach Woodyard

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Bill L. Kell
Major professor

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# ABSTRACT

## A STUDY OF PRE-INTAKE DROPOUT AT ST. LAWRENCE COMMUNITY MENTAL HEALTH CENTER

By

Elsie Berdach Woodyard

A study of pre-intake dropout at St. Lawrence Community Mental Health Center was undertaken to investigate (1) the referral process and its relationship to pre-intake dropout, (2) the extent of help-seeking after pre-intake dropout, (3) the help-seeking patterns, precipitating problems, prior mental health experience, and expectations of service of pre-intake dropouts, and (4) demographic variables in relationship to pre-intake dropout. In addition, (5) information was given the pre-intake dropout about the mental health center. The study was further aimed at (6) providing feed-back to the clinic administration in regard to how policy and procedure affect dropout rate and attitudes of pre-intake dropouts.

In the year 1969 there was a 17% pre-intake dropout rate at St. Lawrence Community Mental Health Center Out-Patient Clinic. Forty pre-intake dropouts interviewed in their homes yielded the following information.

Referrals to the Out-Patient Clinic were made predominantly by persons working with the patient over an extended period of time or by a relative. Persons referred to the Emergency Service were referred primarily by physicians. At the time of referral, 50% of pre-intake dropouts were involved with other community agencies.

Prior mental health experience was significantly related to use of Emergency Services and agreement with a mental health referral. Fifty percent of pre-intake dropouts had had prior mental health experience and one-half had close relatives who had had prior mental health experience.

The chronicity of a case was unrelated to the service used or to follow-through elsewhere. Thirty-two percent of the dropouts turned to other agency help sources after pre-intake dropout.

The population interviewed tended to be young, predominantly women, and ten cases were on Aid to Dependent Children or Welfare. Income was unrelated to follow-through elsewhere.

Reasons persons gave for not following-through with the original referral centered on the clinic not contacting them, alleviation of symptoms (either through active attempts to reduce symptoms or a passive disappearance of symptoms), and the use of other help sources including friends and relatives.

Pre-intake dropouts tended to be uninformed about the services offered by the Mental Health Center and were especially ignorant of cost and services provided. A major request for service was that persons be seen right away.

Suggestions to reduce pre-intake dropout include setting up guidelines with other agencies concerning appropriate referrals and reducing waiting time for first appointments.

The majority of pre-intake dropouts are seeking help through a critical period of time in their life and use mental health resources in a manner similar to how others may use a minister or family physician as a help source.

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# INTRODUCTION

## Statement of the Problem

Pre-intake dropout is a problem that exists in mental health clinics. A pre-intake dropout is an individual who makes an appointment at the clinic and then fails to keep it. Pre-intake dropout presents a problem to the clinic for several reasons.

First of all, it is somewhat expensive in terms of professional staff time when people fail to keep scheduled appointments.

Second, with little or no information concerning the need for service these pre-intake dropouts may have, it is difficult for the clinic administration to know whether or not to plan other services not presently available.

Third, the rate of pre-intake dropouts may reflect upon a clinic's reputation in the community. For this reason, it behooves a clinic to evaluate their policies, procedures, and initial contacts with potential patients in an effort to determine if clinic practices may be contributing to pre-intake dropout.

## Relevant Research

Research in the area of pre-intake dropout is very limited. Only one study has addressed itself to this problem.

Errera, Davenport, and Decker, in 1964, followed-up through interviews and phone contacts 81 pre-intake dropouts from an out-patient clinic connected with a hospital in New Haven, Connecticut. The reasons given for dropout by the individuals contacted were classified into five major categories.

Group I Helped Elsewhere: 16%

(Those who obtained psychiatric assistance elsewhere prior to their appointment)

Group II Talked Into It: 39%

(Those for whom coming to the clinic was from the start someone else's idea and not their own)

Group III Afraid: 28%

(Applicants who initially wanted to come to the clinic but then, for a variety of reasons, became afraid of the idea)

Group IV Spouse-Maneuvered: 7%

(Those who applied with the intent of also maneuvering their spouse into treatment but then the spouse refused to cooperate)

Group V Administrative Barriers: 11%

(Those whose coming was hindered by administrative structure and policies)

The authors of the study speculated about the referring process. They suggested that in some cases the referring agent for one reason or another is not able or willing to be the recipient of communications of personal concerns of the patient and therefore proposes a psychiatric referral. Errera et al. suggests this type of person had actually hoped for such a referral but when the actual time of the appointment came up all of the person's initial reluctance returned. The authors also describe a second group of referred individuals as being "angered and confounded" at the idea of the referral. These individuals were not prepared for such a referral and the referring agent was unable to help them facilitate the referral over a period of time with discussion. Errera suggested, on the basis of his study, that home calls be made as an outreach service to the pre-intake dropouts.

## Research Objectives

The objectives of the present study were to:

1. Explore the referral process and its relationship to pre-intake dropout.
2. Determine the extent of help-seeking after pre-intake dropout.
    a. The extent of use of other community agencies.
    b. The reliance on friends and relatives.
3. Obtain descriptive information on the individuals who are pre-intake dropouts.

a. Help-seeking patterns.

b. Precipitating problems.

c. Extent of contact with mental health services.

d. Expectations in regards to service.

4. Provide information concerning demographic variables.

5. Provide a service to the pre-intake dropout in terms of informing him or her of available services and clearing up any misunderstandings that may exist between the clinic and the individual involved.

6. Provide a service to the clinic in terms of; first, feed-back concerning the effect of policies and procedures upon the rate of dropout; and second, the attitudes of pre-intake dropouts toward the clinic.

# CHAPTER II

# RESEARCH SETTING AND PROCEDURES

## Description of Research Setting

St. Lawrence Community Mental Health Center, the clinic used in the study, is a community mental health center located in Lansing, Michigan. It is approximately two years old, established in 1968. It serves the northern part of Ingham County, including north Lansing and East Lansing, and all of Clinton County. The facility includes 40 adult in-patient psychiatric beds located in St. Lawrence General Hospital, 12 partial-care beds, a day center, a 24 hour emergency service, and an out-patient clinic. St. Lawrence Hospital, prior to the advent of the Community Mental Health Center, was the only facility in the community having specifically designated psychiatric beds, the so called "5th floor," a psychiatric ward of the hospital. St. Lawrence Hospital applied for a federal grant to develop the community mental health center. The center is now partially under the jurisdiction of the Community Mental Health Board, the "Act 54" board, the board governing Community Mental Health in the tri-county area of Clinton, Eaton, and Ingham counties.

In September of 1968 the Community Mental Health Center began accepting out-patients. At that time there was a merger with two established out-patient agencies, Lansing Child Guidance and Lansing Adult Mental Health Clinic. Some of the staff from these two established clinics joined the staff of the new Community Mental Health Center. At the time of the merger there was a good deal of staff turnover and, initially, a good deal of confusion about the policies of the new out-patient clinic. Some of the members of the old clinics had established relationships in the community in regards to referrals and case loads. These staff members were initially unsure of new policies and procedures of the Community Mental Health Center and, at times, reluctant to adopt new practices. There was, for instance, much debate over the practice of having a waiting list. The old clinics had operated under the assumption a waiting list was accepted practice. The administration of CMHC, however, felt there should be no such waiting list.

Also in the fall of 1968, a 24 hour emergency service was begun. Initially, staff were assigned to be on-call at night and over weekends with no pay. At the first of the year 1969, however, the on-call person was paid and the service was moved out of the general hospital's medical emergency room into its own quarters in another building apart from the general hospital. The emergency

service is now considered a part of the out-patient service. People are seen on an emergency basis and dispositions, such as hospitalization, referral to the out-patient clinic, or being sent home are made. The emergency service is staffed by paid volunteers who are psychology interns, psychiatric social workers, and a psychiatric resident, most of whom are regular staff members of CMHC during the day.

## Clinic Procedure in Regards to Out-patient Referrals

Originally, when the out-patient service opened, new referrals were handled as follows. First, the referral secretary handled the call, obtained referral information from the patient (see Appendix I), and made out a new patient folder. The referral secretary informed the potential patient that someone would be contacting him shortly. Next, the case was assigned to a therapist, and it was this person's responsibility to call the patient and set up an appointment. Finally, if an appointment was made and the person did not show for the appointment, a follow-up letter was sent offering another appointment or asking the person to phone in for another appointment. It was found, under this system, that some therapists had their own individual waiting lists, i.e., they would not call the person back right away, as the referral secretary had indicated would happen, but would contact the patient after several weeks or even months had passed.

In the fall of 1969, in October and November, this original procedure was gradually changed. Rather than the therapist being given the case and made responsible for setting up an appointment, each therapist was required to do three intakes per week. Thus, when a potential patient called in he was given an appointment immediately, and the appointment often, and usually, was within a week. This procedure was adopted to eliminate both individual and agency waiting lists.

The procedure involved in accepting referrals from the Emergency Service to the out-patient clinic is similar to the procedure involved in accepting referrals from other outside community referral sources. If the therapist on-call indicates the person he has seen on an emergency basis is interested in out-patient service a note is made to the out-patient referral secretary to contact the patient and set up an appointment. If the patient refuses an out-patient appointment when the referral secretary calls, she deletes the case. If the patient has no phone, he is asked to phone into the out-patient clinic. In such cases the case is opened as a self-referral to the out-patient service. The case would be deleted if the patient did not keep his appointment or did not respond to a follow-up letter.

A follow-up letter is routinely sent out to patients who do not show up for their initial appointments in the

clinic. The letter requests the patient to phone in for another appointment if he wishes one, or, in some instances an actual appointment time is given in the letter. If there is no response to a follow-up letter by a certain date which is mentioned in the letter, the case is deleted.

Deletion Procedure

All of the forms and statistics of the clinic are based on the Michigan Department of Mental Health's data processing system. There is a special deletion form (see Appendix I) which is used in cases where the individual has not been seen in person in the clinic. There are several categories of deletions and these categories indicate from the clinic's standpoint the reasons for pre-intake dropout. The categories are:

1. Patient was never contacted.
2. Patient refused service.
3. Service not required.
4. Patient referred elsewhere.
5. Other.

By far the most frequently used category is "patient refused service." Cancellations of service, not showing up for initial appointments, and not responding to a follow-up letter are examples of "patient refused service" deletions. Deletion forms are filled out on cases which are never opened and the responsibility for filling out the form rests with the therapist assigned to the case.

### Number of Deletions

In 1969, the deletion rate of new referrals was 17.2% at St. Lawrence out-patient clinic. This includes all types of deletions, i.e., the patient refused service, the patient was never contacted, service not required, patient referred elsewhere, and other. There were 1,777 referrals, new and re-referred, and 306 deletions.

A 17.2% deletion rate compares favorably with the 31.3% deletion rate reported by Errera (1964) in his follow-up study of out-patient mental health referrals. A comparison can also be made between mental health and medical dropouts. A study by Walsh, Benton, and Arnold (1967) of 15 medical out-patient clinics found a 10% rate of cancellations and no shows. This suggests mental health dropout rates are somewhat higher than medical dropouts.

## Procedure

### Sample Selection

This study was based on data obtained from 40 pre-intake dropouts who were interviewed in their homes. These 40 interviews were obtained in the following manner.

First, an attempt was made to account for all deletions recorded in the months of July, August, and September of 1969. There were 81 deletions recorded for these three months; 33 in July, 28 in August, and 20 in September. Based on clinic data, 33 of these cases were eliminated as follow-up cases. In instances of re-referrals, a person

living out-of-town, or no phone or address being available, the case was eliminated for follow-up. After case elimination was done 48 cases remained, 28 of whom had no phone. An attempt was made to contact all 48 of these individuals to obtain an interview. The result of this procedure yielded 20 full interviews.

It was decided beforehand that there should be at least 40 interviews so it became necessary to select a second sample. The deletions recorded in December of 1969 and January 1970 were selected for the second sample. There were 27 deletions in December and 25 in January, totaling 52 cases. An additional 17 interviews were obtained from this second sample.

By taking these two samples 37 full interviews had resulted. Therefore, the last 3 interviews obtained in a pilot study were included to reach 40 interviews. The pilot data obtained in April of 1969 did not differ from the interviews obtained in the two subsequent samples.

Table 1 presents the reasons cases were eliminated and the condition at follow-up.

## Procedure Used in Obtaining Interviews

Interviews were conducted in the individual's home. If a phone number was available, the person was called at home and an appointment time scheduled that was convenient for him. Often, several attempted contacts by phone were

TABLE 1.--Reasons cases were eliminated and the condition at follow-up.

| Basis of Case Elimination (N=58) | |
|---|---|
| Case re-referred to clinic | 9 |
| Referred elsewhere by clinic | 10 |
| Self-referred elsewhere | 2 |
| Out of town St. Lawrence Mental Health Catchment area | 7 |
| Out of town Ingham County Mental Health Catchment area | 11 |
| Moved, no address | 8 |
| No folder or name available | 9 |
| Non-cases | 2 |

| Situation at Follow-up (N=78) | |
|---|---|
| Full interview obtained | 40[a] |
| Partial interview[b] | 1 |
| Refusals | 12 |
| Moved or no such address | 16 |
| Hospitalized at time of follow-up[c] | 4 |
| Unavailable for interview[d] | 2 |
| Unable to contact | 2 |
| Incorrect clinic information | 1 |

[a]Includes three pilot data interviews.

[b]Parents spoke only Italian, friend provided information over the phone. It was not included as an interview.

[c]Hospitals included St. Lawrence Hospital, Ingham County Hospital, Veterans Hospital in Battle Creek, and Mercywood in Ann Arbor.

[d]Both of these individuals were in jail. One female was in Mason county jail and one male was jailed by the Navy in regards to the draft.

made before the person was reached. Interviews were usually scheduled during the day and in a few instances in the evening.

Over the phone it was explained to the patient that St. Lawrence Community Mental Health Center was conducting a follow-up research project on the people who might need the service of the Center. It was explained that the Center was interested in people's attitudes toward mental health, and finding out more about the people who might need the Center's service. Further, the Center was interested in how informed the community was about the services now provided by the clinic. It was further explained the interview takes 45 minutes to one hour and they were asked if they would mind being interviewed in their homes at their convenience. Even after this introduction, it was sometimes necessary to repeat the information just given, answer questions, and in some instances persuade people to agree to an interview. In most instances, people quite voluntarily provided information as to why they did not return to the clinic.

If, as was the case in many instances, there was no phone, a trip was made to the address available. This was successful in many instances as people were home and agreed to an interview on the spot or, in three cases, return appointment times were arranged. Through driving to addresses it was also learned that many people had moved.

There were instances of deserted houses, condemned houses, and people who had moved out of apartments. In some instances two, three or more trips were made to addresses without phones. Neighbors or new tenants would provide information that the person had moved. In four cases, there were face-to-face refusals to be interviewed. The individuals contacted directly in their home were provided the same introduction to the interview as those contacted over the phone.

In administering the questionnaire, each interview was begun with a restatement of the purpose of the interview and the person was asked if he had any questions. Questions were answered and then the interview was begun. The interview took approximately 45 minutes to one hour, depending on how talkative the interviewee was. In some instances, other family members, especially young children or a husband, were present. Other family members who were sometimes present were parents, a sister, step-mother, or other relative. When children were present there were interruptions in the interview. Many women had young children and some took time out to attend to their children during the interview. When another adult was present the respondent usually did not consult that person in providing answers to questions.

A copy of the questionnaire is found in Appendix II.

Description of Final Sample

Tables 2 and 3 present the ages and sex of the final 40 pre-intake dropouts interviewed. In the case of a child, the mother was interviewed but the age and sex of the child are given.

TABLE 2.--Sex and age of pre-intake dropouts.

| Children (N=11) | | | | Adults (N=29) | | | |
|---|---|---|---|---|---|---|---|
| Age Group | Sex M | Sex F | Total Number in Age Group | Age Group | Sex M | Sex F | Total Number in Age Group |
| 2-7 years | 4 | - | 4 | 17-21 | 6 | 7 | 13 |
| 8-12 | 1 | 1 | 2 | 22-30 | - | 7 | 7 |
| 13-16* | 1 | 4 | 5 | 31-40 | - | 7 | 7 |
| | | | | 41-50 | - | 1 | 1 |
| | | | | 51+ | - | 1 | 1 |
| Total | 6 | 5 | 11 | Total | 6 | 23 | 29 |

*One 13 year old girl was seen in the emergency service. All other children were out-patient referrals.

TABLE 3.--Sex, age, and service used: adults.

| Emergency Service (N=11) | | | | Out-Patient Service (N=18) | | | |
|---|---|---|---|---|---|---|---|
| Age Group | Sex M | Sex F | Total Number in Age Group | Age Group | Sex M | Sex F | Total Number in Age Group |
| 17-21 | 2 | 3 | 5 | 17-21 | 4 | 4 | 8 |
| 22-30 | - | 3 | 3 | 22-30 | - | 4 | 4 |
| 31-40 | - | 1 | 1 | 31-40 | - | 6 | 6 |
| 41-50 | - | 1 | 1 | 41-50 | - | - | - |
| 51+ | - | 1 | 1 | 51+ | - | - | - |
| Total | 2 | 9 | 11 | Total | 4 | 14 | 18 |

Social Class Variables

Table 4 presents information concerning the social class variables of income, education, and housing of pre-intake dropouts. The information is presented separately for the Emergency Service and the Out-Patient Service. Information is also presented concerning the marital status of adult patients and the parents of children. In the instance of dependent teen-agers the information relates to their parents.

Table 4 indicates the fact that divorced and separated women tend to have low incomes and that they are often on ADC or Welfare. Eight such women had dependent children. There were 22 people who had not completed high school, including four teenagers.

Although some authors (Atkins, 1967; Chafetz, 1965; Errera, Wyshak, Jarecki, 1963; Kadushin, 1957) have suggested that the lower social class tends to use emergency services while the middle class tends to use out-patient services, this distinction does not seem as clear cut in the pre-intake dropout population. People using the emergency service were comparable to the out-patient pre-intake dropout population on income, education, housing, and marital status.

The mobility of pre-intake dropouts is reflected in the greater number of persons who rent compared to those who are buying their homes. The difficulty in locating persons for the follow-up study was another indication of mobility. At least 20% of pre-intake dropouts moved after

TABLE 4.--Income, education, housing, and marital status of emergency service adults, adult out-patients, and parents of children.

| Service | Income | | | | | | |
|---|---|---|---|---|---|---|---|
| | Unemployed | ADC Welfare | Below $3,000 | $3,000-$5,000 | $5,000-$7,000 | $7,000-$10,000 | Above $10,000 |
| Emergency Service (N=11) | 1 | 2 | 1 | 2 | 1 | 3 | 1 |
| Adult Out-Patients (N=18)[a] | 1 | 5 | 2 | 1 | 2 | 4 | 2 |
| Parents of Children (N=11) | 1 | 3 | | | 2 | 3 | 2 |
| Total | 3 | 10 | 3 | 3 | 5 | 10 | 5 |

| | Education | | | |
|---|---|---|---|---|
| | Below 8th Grade | Grades 9-11 | Completed High School | Above High School |
| Emergency Service (N=11) | - | 6 | 3 | 2 |
| Adult Out-Patients (N=18) | 2 | 9 | 3 | 4 |
| Mothers of Children (N=11) | - | 5 | 4 | 2 |
| Total | 2 | 20[b] | 10 | 8 |

| | Housing | |
|---|---|---|
| | Buying | Renting |
| Out-Patients--Adults and Children (N=29) | 12 | 17 |
| Emergency Service (N=11) | 3 | 8 |
| Total | 15 | 25 |

| | Marital Status | | | |
|---|---|---|---|---|
| | Married | Single | Separated | Divorced |
| Emergency Service (N=11) | 3 | 4 | 3 | 1 |
| Adult Out-Patients (N=18) | 8[c] | 3 | 3 | 4 |
| Mothers of Children (N=11) | 5 | 1 | 1 | 4 |
| Total | 16 | 8 | 7 | 9 |

[a]One woman refused to give information concerning income.

[b]Number includes four teenagers still in school.

[c]The parents of three dependent teenaged girls were remarried and the remarriage had something to do with the problems the girls were experiencing. Since the girls were still dependent the marital status of their parents is given. The girls themselves were single.

contacting the clinic. Errera (1965) had been unable to locate 27% of his pre-intake dropout population. Men, especially, seem to move. This accounts, partially, for the greater number of women in the follow-up sample.

# CHAPTER III

# RESULTS

## Referral Sources

The final sample of 40 individuals included eleven cases of children and 29 cases of adults. Of the 29 adult cases, eleven were initially seen by the emergency service and subsequently referred to the out-patient service. They are treated separately as emergency service patients. One of the child cases was also seen in the emergency service, but she is treated as a child case rather than an emergency service case. Referral sources in the community were involved in all of the eleven child cases and in 20 of the adult cases. In the adult cases, twelve were referred to the out-patient service and eight to the emergency service. All of the children were referred to the out-patient clinic. There were nine self-referrals, all adults over 16; and three referred themselves to the emergency service and six referred themselves to the out-patient service.

It should be mentioned here that oftentimes more than one agency or person is involved with a referral. For instance, in some cases involving children the teacher might have suggested the referral, but the school social worker, the school psychologist, and the principal of the school

might all be involved at the same time in trying to get the parents to take the child to the clinic. In other instances, the juvenile court and the ADC worker as well as the school might be trying to convince the mother about the referral. And, if the referral is not carried through in a relatively short time, the referral agent changes. For instance, a new teacher or new social worker takes over the case and may continue to try implementing the referral. Also in the cases involving adults, more than one person or agency might be trying to implement a referral. Relatives, ADC workers, friends, a doctor, or someone else might be involved in encouraging a referral. Keeping in mind that more than one person or agency might be involved in trying to implement a referral, the source mentioned by the person as the referring agent is the source listed in Table 5.

## Previous Mental Health Agency Experiences: Pre-Intake Dropout

It was of interest to note previous mental health agency experience of the individual interviewed. It was thought that previous experience might indicate a predisposition to use mental health resources as opposed, say, to other help sources in the community. Mental health services were defined as being hospitalized for an emotional or psychological problem, having used out-patient services of a mental health clinic, seeing a private psychiatrist, or going to an agency such as Family Service. The critical

TABLE 5.--Referral sources.

| Mental Health Emergency Service | |
|---|---|
| Referral Source | N=11 |
| Sparrow Hospital Emergency Room | 1 |
| Medical Doctor St. Lawrence General Hospital | 1 |
| Emergency Room Doctor St. Lawrence Hospital | 5 |
| Family Doctor | 1 |
| Self Referred | 3 |

| Out-Patient Service: Adults | |
|---|---|
| | N=18 |
| Family Doctor | 2 |
| Ingham County Health Nurse | 2 |
| ADC Caseworker | 1 |
| Judge | 1 |
| Lawyer | 1 |
| Doctor, University Hospital, Ann Arbor | 1 |
| In-Patient Therapist St. Lawrence | 1 |
| Friend | 1 |
| Relative (stepmother, sister) | 2 |
| Self Referred | 6 |

| Out-Patient Service: Children | |
|---|---|
| | N=11 |
| Family Doctor | 1 |
| Unemployment Securities Commission | 1 |
| School Counselor | 1 |
| School (teacher, social worker, psychologist, etc.) | 4 |
| Director Headstart | 1 |
| Juvenile Court | 2 |
| Mental Health Emergency Service St. Lawrence | 1 |

distinction was that the person sought out treatment for a psychological or emotional problem and that treatment involved either verbal out-patient treatment or hospitalization. There were a number of women who consistently used medical doctors for cases of "nerves." This was not considered mental health experience. Table 6 indicates the previous experience of individuals according to the service they contacted. In the cases of children, if the mother or the child had experience, this was counted as previous mental health experience. A $x^2$ analysis indicates that the individuals serviced by the emergency service had a significantly higher rate of previous mental health experience than did those contacting the out-patient service.

TABLE 6.--A comparison of the prior mental health experience of persons using the Emergency Service with those using the Out-Patient Service.

| Service | No Prior Mental Health | Prior Mental Health |
|---|---|---|
| Out-Patients: Adults and Children (N=29) | 20 | 9 |
| Emergency Service (N=11) | 1 | 10 |
| Total (N=40) | 21 | 19 |

$x^2 = 9.21$, significant at .01 level, df = 1.

More persons using the emergency service had had prior mental health experience then those using the out-patient service.

Also presented, in Table 7, is the relationship between being self-referred or other-referred and previous mental health experience. There were five out of nine self-referred individuals who had had prior mental health contact while 14 out of 31 other-referred individuals had had prior experience. There was no significant difference between these two groups. Almost 50% of the pre-intake dropout sample had had prior mental health contact, i.e., 19 out of 40 individuals.

TABLE 7.--Comparison of the previous mental health experience of self-referred with other-referred individuals.

| Type of Referral | No Prior Mental Health | Prior Mental Health |
|---|---|---|
| Self-Referred (N=9) | 4 | 5 |
| Other-Referred (N=31) | 17 | 14 |
| Total (N=40) | 21 | 19 |

$x^2 = .027$, not significant.

There is no significant difference between the self-referred and other-referred individuals in terms of their prior mental health experience.

## Mental Health Experiences of Close Relatives

Since there is some evidence that people's attitudes toward mental health change if a relative becomes involved with such resources (Phillips, 1967), an effort was made to determine how familiar the respondent was with other persons using mental health resources.

Twenty people mentioned a close relative of theirs who had been treated at one time or another for emotional or psychological problems. Of the 20 relatives mentioned, 16 had been hospitalized either in a hospital such as St. Lawrence or in an institution. The remaining four relatives mentioned had had some type of out-patient treatment. In addition to the persons mentioning a relative, six persons mentioned close friends of theirs who had been hospotalized. Those who mentioned close friends tended to be young people who knew of friends being treated for drug abuse or friends who had been in institutions or hospitals. At least 50% of the pre-intake dropouts, then, have had close contact with persons involved with mental health resources.

Table 8 presents the number of individuals in each service who said they had a close relative involved in mental health at one time or another. A close relative was defined as someone in the immediate family such as a spouse, parent, child, in-law, or sibling. It is possible that the actual number of involved persons might be slightly higher since no probing was done to make sure all relevant persons were mentioned.

TABLE 8.--Number of persons mentioning a close relative involved with mental health.

| Service | Relative Involved | No Relative Involved |
|---|---|---|
| Emergency Service (N=11) | 7 | 4 |
| Out-Patient Adults (N=18) | 9 | 9 |
| Out-Patient Children (N=11) | 4 | 7 |
| Total | 20 | 20 |

## Follow-Through Elsewhere

After contact with the clinic, 13 cases became involved with other help sources not used prior to their contact with the clinic. In some instances this was a voluntary searching out for another help source, in other cases it was involuntary.

None of the eleven cases seen in the Emergency Service became involved with other help sources after their contact in the Emergency Service.

There were six out of 18 adults contacting the out-patient service who became involved with other help sources. The sources used by these persons were as follows:

United Ministries
Police Department
Ingham County Mental Health Clinic
Michigan State University Psychological Clinic
Private Doctor (2 cases)

There were seven of the eleven cases involving children who followed through elsewhere. In some instances more than

one agency became involved. The sources used were as follows:

Juvenile Court (State Department of Social Service)
Family Minister
Michigan State University Psychological Clinic
Private Pediatrician
Private Psychiatrist
St. Lawrence Mental Health as Consultant to Case
Another School (Juvenile Court)

Table 9 indicates follow-through rates according to the service used. A significantly larger number of out-patients tend to follow-through elsewhere compared to those using the emergency service.

TABLE 9.--A comparison of follow-through rate of Emergency Service patients and Out-Patient Service patients.

| Service | Follow-Through | No Follow-Through |
|---|---|---|
| Emergency Service (N=11) | - | 11 |
| Out-Patient Service (N=29) | 13 | 16 |
| Total (N=40) | 13 | 27 |

$x^2 = 5.43$, df = 1, significant at .05 level.

Out-patients follow-through significantly more than emergency service patients in seeking help elsewhere.

Follow-through elsewhere seems unrelated to whether a person is self-referred or other-referred. This comparison is presented in Table 10.

TABLE 10.--A comparison of follow-through rate of self-referred and other-referred patients.

| Type of Referral | Follow-Through | No Follow-Through |
|---|---|---|
| Self-referred patients (N=9) | 2 | 7 |
| Other-referred patients (N=31) | 11 | 20 |
| Total (N=40) | 13 | 27 |

$x^2 = .115$, df = 1, no significant difference.

There is no significant difference in the rate of follow-through of self-referred and other referred individuals.

Comparing the follow-through rates of adults and children there is no significant difference indicated in Table 11.

TABLE 11.--A comparison of follow-through rates of adults and children contacting the out-patient clinic.

| Patients | Follow-Through | No Follow-Through |
|---|---|---|
| Adults (N=18) | 6 | 12 |
| Children (N=11) | 7 | 4 |
| Total (N=29) | 13 | 16 |

$x^2 = 1.16$, df = 1, not significant.

There is no significant difference in the rate of follow-through of adults and children.

Income, as a rough measure of social class, also is unrelated to the rate of follow-through. This is demonstrated in Table 12.

TABLE 12.--Follow-through rates based on income.

| Income | Follow-Through | No Follow-Through |
|---|---|---|
| Below $5,000 per year (N=19) | 5 | 14 |
| Above $5,000 per year (N=20) | 8 | 12 |
| Total (N=39) | 13 | 26 |

$x^2 = .32$, df = 1, not significant.

There is no difference in the rate of follow-through elsewhere based upon income.

It has been suggested in the literature (Atkins, 1967; Chafetz, 1965; Gurin, Veroff, and Feld, 1960) that the middle class is more resourceful and able to follow-through obtaining help elsewhere than the lower class. If $5,000 is taken as a cut-off figure separating middle from low income persons, there was no difference in their ability to follow-through elsewhere.

## Friends, Relatives, and the Decision to Come to the Clinic

In most instances, families encouraged the potential patient to go to the clinic. There were only five instances in all 40 cases where someone, in any way, discouraged the

person from going to the clinic. Children were involved in two of these cases. In one instance involving a ten year old boy, the family seemed to be split in their opinion about the need for the child to go to the clinic. Strong, threatening statements were made by the patient's maternal grandmother, paternal grandparents, and one aunt. The maternal grandfather, however, supported the patient's mother and her desire to get some help for the boy. This was the only case which seemed to reflect the family's fear of mental illness and the stigma that might go along with it. In the other case involving a child, the father wanted to wait a year before going to the clinic. He felt nothing was wrong with his son, a sentiment the mother shared.

In the three instances of adults being talked out of going to the clinic, one case involved a minister trying to handle the counseling, suggesting the woman talk with him rather than the clinic. The woman, however, did not believe he could help and eventually went to a mental health clinic. A second case involved a husband telling his wife she really didn't need to go to the clinic. The third case, a young man, said a female friend had said some negative things about psychologists and psychiatrists, "that they put strange thoughts in your mind," and this had influenced him against going to the clinic.

In general, it seemed that most people contacting the clinic were not talked out of going to the clinic but rather

encouraged to go by friends and relatives. In most instances, then, the decision not to follow through with treatment was made by the individual after he considered his own need. Even though he might have obtained the opinions of others and the support of others in deciding to come to the clinic, actions were taken according to the person's own evaluation rather than his following the advice or encouragement offered by other persons.

## Help Sources: Relatives versus Outside the Family

It is interesting to note that the majority of pre-intake dropouts preferred talking to people outside of the family when they had problems rather than with their relatives. The question asked was: "Would you say that you prefer talking to relatives when you need help with problems or do you prefer talking to people outside of the family; what is your usual pattern?" Although some individuals responded by saying it depended upon the problem, what they usually tended to do was taken as their answer. The results of this question were as follows:

| | |
|---|---|
| Relatives | 11 |
| Outside | 25 |
| Self | 3 |
| No One | 1 |

Outside the family meant friends in many instances. The response to this question was interesting in that people often felt very strongly against talking with people in the family. They would comment that a family never understands

or they would mention poor relationships with their parents. In a few instances, people said that a family has good intentions but that they actually are unable to help or to understand.

Of the eleven people who mentioned that they talked to relatives, all but one had consulted or talked with relatives about their clinic contact.

Of the 25 people who said that they prefer talking with people outside the family, 14 at some point still talked over going to the clinic with some relative. This might have been a spouse, sibling, parent, or child. This suggests for some pre-intake dropouts, 28%, the family is a help source. For another 35% of persons, someone in the family is consulted or talked with in regard to decisions such as going to a mental health clinic. However, these relatives are not necessarily seen as a help source with problems.

## Reasons People Dropout Before Intake

People gave various reasons for not keeping their appointments or cancelling their appointments in the outpatient clinic. Table 13 presents a list of the reasons given and the number of persons in each service that gave each reason. The categories listed are definitely not mutually exclusive. For instance, a woman who had previous negative mental health experience also wanted to work things out for herself. Another woman who took a trip,

TABLE 13.--Reasons given by persons for not keeping their appointments in the out-patient clinic.

| Reason | Emergency Service (N=11) | Out-Patient | |
|---|---|---|---|
| | | Adults (N=18) | Children (N=11) |
| Wanted marriage counseling, husband unwilling | 2 | - | - |
| Husband disapproved of treatment | 1 | - | - |
| Negative previous mental health experience | 2 | 1 | - |
| No admission of problem | 1 | - | 2 |
| Got better in passive way (symptoms gone, i.e., depression over, anxiety gone) | 3 | 1 | - |
| Helped self in active way (took trip, made decision to help self, etc.) | 2 | 3 | 2 |
| Helped sufficiently over the phone | - | 1 | - |
| Needed unavailable parental permission | - | 1 | - |
| Talked out of it | - | 2 | - |
| Did not know of appointment | - | 2 | 1 |
| Did not hear from the clinic | - | 3 | - |
| Helped elsewhere in the meantime | - | 1 | 3 |
| Fear of treatment | - | - | 1 |
| Did not want help | - | 1 | 1 |
| Work interferred | - | 1 | 1 |
| No transportation | - | 1 | - |

helping herself in an active way, said she would have come to the clinic if they had returned her call. In another case, a young man who was talked out of going to the clinic tried to solve the problem in an active way himself. These examples are numerous suggesting a number of factors working together culminating in the decision to follow-through or not to follow-through with out-patient treatment. These factors vary from individual to individual depending upon their circumstances. The number of factors a given individual may consider also varies.

One factor that seemed a strong influence in decision making was the strong desire of many persons to work things out for themselves if they could. Older women in their 40's who had had many problems over many years still wished to cope with things on their own. Younger people wanted to resolve things by talking to peers, siblings, or step-siblings, or making special efforts to change their way of life if they did not like the way things were going in their lives. In some instances this meant controlling symptoms, such as headaches or temper, going through with a divorce, changing living conditions, giving up drugs, or coping with difficult interpersonal situations. This desire to work things out by themselves fits in with what Gurin (1964) found in the general population as a strong American ethic. He found that many Americans handle their problems by themselves and that this is thought to be the most desirable way to handle things.

Being Afraid

Although Errera attributed dropout in 28% of the cases in his population to "being afraid," this did not seem to be a major reason for dropout in the present study. One mother interviewed did say the main reason she did not follow-through was because she was afraid of leaving her two year old son alone in the clinic, a misconception on her part. That is not to say that fear plays no part in dropout, however, it probably must be combined with other circumstances to lead to pre-intake dropout.

In the present study people were asked the following: "Sometimes people are afraid of meeting someone new or talking with a strange person about personal matters. Do you remember being afraid at all of the idea of coming to the clinic? Were you afraid of anything at all?" Anything that even resembled fear, such as being anxious, nervous, or embarrassed was coded as a fear response. Also classified as "fear" responses were fear of being locked-up (on 5th floor), and fear of being put in jail (drug abuse cases). Examples of responses given and coded as fear are: "Just had some kind of fear," "I was afraid of being put in jail and nervous," and, "I wanted help but I didn't want to talk to any stranger."

There were a total of 17 people who expressed some type of fear. Both the self-referred group and the other-referred group of individuals expressed fear. Despite

being afraid, seven people followed through with service elsewhere. Of the eleven people using the Emergency Service, five stated they were afraid of something and yet they all received service and spoke to a stranger about their problems. In the instance of children, four out of eleven mothers expressed fear. Two of these mothers followed-through with private help sources. There were eight out of 18 adult out-patients that expressed being afraid. Two of these followed-through elsewhere. Table 14 presents the number of individuals who expressed fear and the rate of follow-through elsewhere. There was no significant difference between those who expressed fear and those who did not in terms of the rate of follow-through.

TABLE 14.--Statement of fear and follow-through rates.

| Statement | Follow-Through | No Follow-Through |
|---|---|---|
| Expressed Fear (N=17) | 4 | 13 |
| No Expressed Fear (N=23) | 9 | 14 |
| Total (N=40) | 13 | 27 |

$x^2 = .049$, df = 1, not significant.

There is no significant difference in follow-through rates of those who express fear as compared to those who do not express fear.

Table 15 presents data on the number of self-referred and other-referred individuals and their expression of fear. There is no significant difference between these two groups.

TABLE 15.--Self-referred and other-referred individuals and the statement of fear.

| Statement | Self-Referral | Other-Referral |
|---|---|---|
| Expressed Fear (N=17) | 5 | 12 |
| No Expressed Fear (N-23) | 4 | 19 |
| Total (N=40) | 9 | 31 |

$x^2 = .27$, df = 1, not significant.

Being self-referred or referred by others is not related to the expression of fear.

This suggests that if pressure to seek help is greater than the fear a person has of seeking help, he will seek help. Fear in itself cannot predict if a person will follow-through with the original referral or an alternate help source. It may be recalled that eleven people stated they preferred relying on relatives rather than outside sources when they have problems. It is interesting to note that of these eleven people, eight expressed fear of talking with someone new. These persons may trust their family more than they do outside-the-family sources. They may have a fear of professional help sources. There were also expressions of fear specific to psychiatric help by a few persons.

A second interesting observation is that people expressing fear, nervousness, or anxiety about talking with a stranger about personal problems were very open, talkative, and usually at ease during the follow-up interview

conducted in their own homes. Although this may have been due to a difference in content, it might also have something to do with feeling more secure at home.

## Helped by Clinic Contact

There were eight cases in which the individuals said they were helped by their contact with the clinic. This number includes those helped by talking over the phone and those seen in the emergency service. Of these eight, one was a case involving a child. Her mother said her adolescent girl changed at the threat of having to go to the clinic, which the mother thought of as help from the clinic. The other cases involved adults.

It is possible to look at those helped in terms of whether they were self-referred or other-referred, and also which service helped them. There were nine self-referred individuals in the sample, three to the emergency service and six to the out-patient service. Four of these self-referred individuals expressed being helped, two by the emergency service and two by their phone conversations with therapists in the out-patient clinic.

There were 31 cases, including 11 child cases, that were other-referred. Only four of these cases said they were helped, three by the emergency service and one, the child case mentioned above, by the out-patient service. Table 16 shows that self-referred individuals are helped more than other-referred individuals.

TABLE 16.--Being helped as a function of being self-referred or other-referred.

| Type of Referral | Helped | Not Helped |
|---|---|---|
| Self-referred (N=9) | 4 | 5 |
| Other-referred (N=31) | 4 | 27 |
| Total (N=40) | 8 | 32 |

$x^2 = 3.46$, df = 1, significant at .10 level.

Self-referred individuals show a tendency to be helped more than other-referred individuals.

Looking at the emergency service more closely, there were eleven cases seen in the emergency service and five of the cases said they were helped. Some of these individuals expressed at least some temporary relief by being seen even though they felt their problems were still in existence at the time of follow-up. If the problem was still in existence, the person would assume responsibility himself for not following-through with out-patient treatment, or, in two instances wives blamed their husbands for having not followed-through. There was no case in which the person gave an unpleasant occurrence in the Emergency Service as the reason for their not following-through with out-patient treatment.

Table 17 presents the number of people who were helped according to the service they used. There is a significant difference between those who used the Emergency

Service as opposed to those who contacted the Out-Patient Service. A greater number of Emergency Service patients felt their contact was helpful. These results suggest people who refer themselves expect help and recieve help whereas those referred by others are not as open to being helped. There seems to be no doubt that being seen, as in the Emergency Service, is more helpful than are contacts with Out-Patient Services. However, some people seen in the Emergency Service do not acknowledge being helped and some people calling the Out-Patient Clinic are helped over the phone. In at least four instances involving the Emergency Service, the patient was very resistant at the time he was being seen as an emergency and the patient left prematurely or was actually unaware of having a mental health contact. None of these individuals mentioned being helped, but neither did they feel the Emergency Service was responsible. They felt it was their own behavior and decision which precluded their being helped.

TABLE 17.--Help as a function of service used.

| Service | Helped | Not Helped |
|---|---|---|
| Emergency Service (N=11) | 5 | 6 |
| Out-Patient Service (N=29) | 3 | 26 |
| Total (N=40) | 8 | 32 |

$x^2 = 4.14$, df = 1, significant at .05 level.

The emergency service shows a significantly greater number of individuals being helped than the out-patient service.

## Problems

People had many different problems that precipitated calling the mental health center. Following is a list of problems, according to the service used.

Emergency Service (N=11)

| Problem | |
|---|---|
| Suicide attempts (One mentioned marital problems also) | 3 |
| Drugs (One said it was not a problem) | 2 |
| Depression or nervousness | 3 |
| Argument with husband | 2 |
| Came in with girlfriend (Prior contact had been for suicide attempt) | 1 |

Out-Patient Service: Adults (N=18)

| Problem | |
|---|---|
| Suicide attempt | 1 |
| Drug Abuse | 1 |
| Depression (One related this to a divorce) | 4 |
| Emotional outbursts | 2 |
| "Freak sessions" | 1 |
| Blackouts | 1 |
| Truant from home, afraid to go back | 1 |
| Family problems | 1 |
| Confusion in regard to placing daughter in an institution | 1 |
| Headaches | 1 |
| Marital problems, nerves | 1 |
| Drunkenness, upset | 1 |
| No problem | 1 |
| Sexual thoughts | 1 |

| Out-Patient Service: Children | (N=11) |
|---|---|
| Problem | |
| School problem | 1 |
| Hyperactivity | 1 |
| Disturbed attention, slow, temper | 1 |
| Hit teacher in school | 1 |
| Suicide attempt | 1 |
| Temper tantrums | 1 |
| School truancy, underachievement | 1 |
| Delinquency | 1 |
| Arguing and disagreeing with mother | 1 |
| Low self-concept | 1 |
| Unknown, court referral | 1 |

Since suicide, drug abuse, and alcoholism are frequent and recurrent social problems, their occurrence within the population sampled is discussed in more detail.

## Suicide

There were five cases of attempted suicide mentioned as precipitating incidents. In addition to this, two women mentioned previous attempts, one attempt having been within the past year. All the attempts were by women, and six of the women were under 30 years of age. The ages were 13, 17, 18, 22, 23, and 27 years old. The estimate of suicide attempts in this population may be low since some women mentioned previous hospitalizations for nervous conditions and these hospitalizations may have come about through suicide attempts. However, since no probing was done to determine this accurately during the interview, it is only speculation. Some of the individuals being referred because of suicide attempts had had previous attempts and/or hospitalizations.

Drugs

There were three instances of drug abuse referrals. All were young men, ages 18, 19, and 20. One was a part-time employed student, the other two were employed. One had been hospitalized previously for drug abuse. Two were cases of involvement with LSD and perhaps other drugs of that nature. One was a case of heroin.

Alcoholism

Although there were no instances of alcoholism in the final sample, four women who were divorced or separated mentioned the alcoholism of their spouses or ex-spouses as related to their own problems. Sparrow Hospital is the community resource for alcoholics which may account for the lack of their presence in the present sample. Research (Atkins, 1967; Errera, Wyshak, and Jarecki, 1963; Schwartz and Errera, 1963) has shown that alcoholics use Emergency Services. The study done here indicates that at least some wives of alcoholics also feel a need for mental health services.

## Chronic Versus First Time and Acute Conditions and Rate of Follow-Through

In the course of the interview it was possible to determine to a certain extent if the person felt the problem was a chronic one. In other words, some people felt their situation was one of long duration. Opposed to this, some persons indicated that this was the first time they

had needed help. There was one question that tended to elicit such comments. Persons were asked, "Had this occurred before?" Some sample answers indicating chronic conditions were, "Quite awhile," "I've been nervous since I was a little girl," "Since 1967 I have been nervous," "Never has stopped; in the last five years I have had more trauma than ordinary people have," "Been going on five years," "Yes, felt down and out a lot of times," and so forth. Based on the answers to this question and the information in the interview, people were classified into chronic or first time or acute cases. It was found that 23 cases tended to be chronic and 17 were first time or acute. Looking at the possibility of first time or acute cases tending to follow-through elsewhere more than chronic cases, this did not seem to be so. Table 18 presents this information for the different services. The adult first time or acute cases do tend to follow-through elsewhere more than the adult chronics, but the child chronics tend to follow-through more than the child first time or acute. There is evidence, also, that there are individuals who feel they have chronic conditions but who are unwilling to follow-through as out-patients. Rather, they tend to use the Emergency Service as a way of coping when things get out of hand or, on occasion, they may become hospitalized. Table 19 indicates there is no significant difference in the service contacted based on whether a condition is chronic or a first time or acute condition.

TABLE 18. Follow-through rates based on chronic and first time or acute conditions.

| Condition | Follow-Through | No Follow-Through |
|---|---|---|
| Chronic (N=23) | 7 | 16 |
| Acute or First Time (N=17) | 6 | 11 |
| Total (N=40) | 13 | 27 |

$x^2 = .439$, df = 1, not significant.

There is no difference in follow-through rates based on chronic or acute conditions.

TABLE 19.--Number of chronic and acute cases using different services.

| Condition | Emergency Service | Out-Patient |
|---|---|---|
| Chronic (N=23) | 5 | 18 |
| First Time or Acute (N=17) | 6 | 11 |
| Total (N=40) | 11 | 29 |

$x^2 = .33$, df = 1, not significant.

There is no difference in the service used based on chronic or acute conditions.

## Referral Process

### Agreeing with Referral and Follow-Through Elsewhere: Children

Errera, Davenport and Decker (1965), based on their study of pre-intake dropouts, speculated that the referral process had something to do with dropout. For this reason,

an attempt was made to explore this area to determine in what way the referral process itself might be related to dropout. Several questions were asked concerning the referral process. Since the individuals were pre-intake dropouts it was thought that they probably did not agree with the referral. For this reason the following question was asked: "At the time (name of referral source) referred you to the clinic do you remember if you agreed or disagreed with them that you needed service?"

In the eleven cases involving children, seven of the mothers interviewed responded to this question by saying they agreed with the referral. However, in two of these instances the responses of the mothers indicated that there was not unqualified agreement. For instance, one mother had become very anxious when it was first suggested to her, and she said she "agreed" only after the proposed treatment was explained to her in detail. Another mother said she did not like the idea when it was suggested to her in response to another question, "What is your opinion about a child going to a mental health clinic or child guidance clinic." Of these seven women who agreed with the referral, all except one had worked out some type of solution to the problem involving the child. This meant turning to other agencies or private help sources in four cases. In two cases the adolescent girls involved refused to go to the clinic. However, the mothers felt things had worked out

satisfactorily without the need for clinic service. In the remaining case the problem still existed.

In the four remaining child cases the mothers did not answer directly whether they agreed or disagreed with the referral. Rather, they gave such indirect answers as: "At first I didn't like the idea," "I only did it because I was told to," "I have no trouble with Bonnie," and, "I didn't disagree." In two of these cases where the mother gave such indirect answers there was some follow-through. One mother took her son to a private psychiatrist and another mother agreed to let her son be observed in the school situation.

Since the mother's response could not be taken at face value, Table 20 presents the data on follow-through in two ways. First, the mother's response of agreement or disagreement is accepted as true and this response is related to follow-through. Second, the clinical impression of the interviewer as to the mother's agreement or disagreement with the referral is related to follow-through. In either case, it can be seen that agreement or disagreement cannot predict what the mother will do since in both ways of classifying the responses some disagreeing women tend to follow-through.

Errera suggested that in some instances of referrals, the person making the referral has not been able to discuss the referral at length with the individual involved to

TABLE 20.--Agreement with referral and follow-through elsewhere.

| Degree of Agreement | Follow-Through | No Follow-Through |
|---|---|---|
| Mother's Response: | | |
| Agreed (N=7) | 4 | 3[a] |
| No direct answer (N=4) | 2 | 2 |
| Total (N=11) | 6 | 5 |
| Clinical Impression: | | |
| Agreed (N=5) | 3 | 2[b] |
| Disagreed or ambivalent (N=6) | 3 | 3 |
| Total (N=11) | 6 | 5 |

[a]Two of these mothers felt that there was no need for service, the problem was solved.

[b]These two mothers felt there was no need for service, the problem was solved.

implement the referral. In at least three cases, where there was disagreement or ambivalence, there had been extensive efforts by referral sources to work with the parents to implement such a referral. In some instances, efforts had been made over several years by school personnel, such as teachers and social workers, to get the parents to take their child to a mental health clinic. These efforts had been to no avail. In at least two other cases there also was involvement of the juvenile court and ADC worker, as well as the school. Of the six cases which could be considered as the parent really being ambivalent or tending

to disagree with the referral source, aside from what their actual response was to the question, two followed-through with private sources, a private psychiatrist and a private pediatrician. A third resistant mother allowed her child to be observed in the school setting. Three other cases had no follow-through. The lack of discussion about the referral did not really seem to be the critical factor involved in pre-intake dropout of these resistant mothers. Rather, what seemed more important was their expectations of treatment, their evaluation of the problem, and what they thought should be the solution.

Disagreement with Referral and Expectations of Treatment, Evaluation of Problem, and Solution: Children

What a mother expected as treatment for her child, what she thought the problem was, if any, and what her solution was, all seemed to be related to pre-intake dropout of resistant mothers.

In four cases there definitely was concern about what would be done in treatment with the child. For instance, one mother was told by school personnel that they wanted the boy to be on Ritalin, a drug used with hyperactive children. She was not convinced she should let her boy take any drug as she worried about addiction. Another mother thought a number of people would be involved in the treatment of her son, and had a vague idea about the clinic.

She seemed to think her son would actually stay at the clinic for a period of time. She felt a one-to-one relationship where her boy could trust one person would be better for him. Another mother thought the clinic would only be interested in determining if her daughter was "crazy" or not, and she knew her daughter wasn't, so she did not want to take her there. A fourth mother thought she would have to leave her 2 1/2 year old boy at the clinic alone and also, because he was such a problem, the staff would eventually spank him.

Also involved in pre-intake dropout was the mother's evaluation of the problem. Evaluations included: there was no problem; the babysitter was mean, causing the child to have problems; there was no father in the home; the attention span of the boy was short, his temper, combined with his mother's lack of patience. The mothers in these cases did not see how going to a mental health clinic could help these situations.

The solutions or attempts to solve the problem varied. One woman did not know what would help and was not convinced the clinic could do anything about the situation. Another woman thought changing babysitters and quitting work would help the situation. Sending the child to stay with an aunt was a solution in another case. And, consulting a medical doctor seemed the thing to do for yet another mother.

It seems, then, that a mother considers a number of factors in deciding to take her child to a mental health clinic after it is suggested to her. In "agreeing" with a referral she may only be acknowledging that there may be a problem, and in some instances the problem may not be hers but the school's. From this point on, she then has to decide if the mental health clinic she is referred to, and the treatment recommended, is what she wants for her child; i.e., if she thinks it will help the situation. The last stage in decision making occurs if she decides against the original referral source. If the problem persists or pressure is maintained by outside sources she then has to choose another help source more to her liking, one which she feels is more appropriate or which she is more comfortable with. If she decides against another help source she then has to consider another solution. Solutions may include involving other relatives or waiting to see if the problem works itself out.

It seemed that a number of mothers had gone through the decision making process previously and had decided to wait things out. The situations did not become better and this resulted in continued pressure by referral agents. Since the mother's solution of waiting had not succeeded, she was forced into reconsideration each time referral agents called the problem to her attention. It is at

these times that a mother may decide reluctantly to follow-through with the original referral or to choose another help source.

To summarize, a pre-intake dropout involving a child seemed to involved several factors. In some instances a mother had to be convinced by the referring agent that there was a problem. Then, if the mother acknowledged a problem, she then had to be further convinced treatment was needed or that it would help her child. If she became convinced of these two premises, she then still had a choice of treatment alternatives and she might choose one not originally recommended. Pre-intake dropout occurs at any stage in decision making. Either because the mother does not acknowledge a problem, does not see how treatment will help the problem, or, believes in another solution not involving treatment, or, chooses another help source, a form of treatment not originally recommended.

Agreement with Referral, Reasons for Dropout, and Previous Mental Health Experience: Children

The reasons given for dropout by the five mothers who agreed unequivocally with the referral mainly had to do with the clinic. Three of the mothers said they would have come but the waiting time was too long. Another two mothers felt the problem was solved. One of the women, who said she would have come to the clinic, was referred directly to a therapist on the staff who told her he had a long

waiting list. She therefore turned to her minister in the meantime. A second mother did not hear from the clinic right away and her son became involved with the juvenile authorities and was sent to a training school. This mother was very upset with the clinic. A third mother, also very upset with the clinic, stated her records were lost by the clinic and she had to make repeated calls. Eventually she went to the Michigan State University Psychological Clinic for family therapy with her daughter. In the cases where there was no need, one mother said the threat of having to go to the clinic made her daughter change her behavior. The second case described as "no need" involved the girl seen in the emergency room. Her mother evaluated the situation as over with, the girl being back to normal.

A factor that seems to be involved in the agreement or disagreement of a mother to the referral is the previous mental health experience of the mother. In four of the five cases where the mother agreed with the referral she herself had been in treatment or one of her other children had been. In the fifth case the woman's husband had been hospitalized for mental illness. These mothers then were more predisposed to accept a verbal type of treatment as a way of solving problems. In contrast, none of the six women who disagreed or were ambivalent had had prior mental health agency experience. In four of the five cases where the

woman had experience with a mental health problem, there was a strong positive feeling towards handling problems in this way, by talking. The one case not expressing such a feeling was a woman who had sought help previously for her son but had terminated prematurely and he was now, again, in trouble. Table 21 indicates a significant difference in the previous mental health experience of mothers agreeing or disagreeing with a mental health referral.

Table 21.--Prior mental health experience of mothers and agreement or disagreement with a mental health referral.

| Degree of Agreement | Prior Mental Health | No Prior Mental Health |
|---|---|---|
| Agreed (N=5) | 5 | 0 |
| Disagreed (N=6) | 0 | 6 |
| Total (N=11) | 5 | 6 |

$x^2 = 54.95$, df = 1, significa-t at .05 level.

Agreeing with a mental health referral for her child is significantly related to the prior mental health experience of the mother.

Agreement or Disagreement with Referral and Follow-Through: Emergency Service

There were eleven cases treated by the emergency service, eight were referred to the service by other persons and three were self-referred. Similar to what was found in the cases of mothers interviewed, what an individual said about agreeing or disagreeing with a referral

could not be taken at face value. What the patient said, taken at face value, yielded four cases in which the person agreed with the referral, two cases in which the person said they neither agreed nor disagreed, and two cases of disagreement. The clinical impression, however, was that there were six agreement cases and two disagreements. As far as following-through with treatment, none of the cases seen in the emergency service followed-through regardless of whether they were self or other-referred, or agreed or disagreed with the referral.

The three cases in which the patient and clinical impression did not coincide can be looked at more closely. In one case, a young man recalled that while he was under the influence of drugs he had disagreed with the referral. At the time, his relatives took him to the emergency service. His responses to the interview indicated he really wanted help, he wanted to come down from his "trip," and he accepted the decision to go to the hospital. He was afraid he was losing his mind. He did accept help from the person on call and remembered the experience in a positive way. Because of all of these factors, the clinical impression was that he agreed with the referral and emergency service.

In a second case, a young man seen in the hospital while recovering from an overdose of heroin, said he neither agreed nor disagreed with the referral to the Mental Health

Clinic and that he had no knowledge of the referral. Clinically, he was more a case of disagreement. He did not look at the use of heroin as a problem, and repeatedly throughout the interview insisted there was no problem. He said he was not sure what the referral was about and suggested it might have been made because the Mental Health Clinic wanted him to work there. Considering that he had almost died from the overdose and that he had been seen by a mental health therapist while in the hospital, his answers suggested he really disagreed and was resistant to a mental health referral to the Out-Patient Service.

A third case which clinically looked different from what the person said was a teenaged girl who was brought into the Emergency Service due to an overdose of pills. She said she did not have much to say about the referral, her father just brought her over. She was clinically an agreement case since she did not resist the referral to the Emergency Service and mentioned she was nervous and needed help. She said, also, she felt better after talking about her problems.

There are several things that seem involved in the cases that were seen in the Emergency Service. First of all, the person himself, or someone else, feels the need for the patient to obtain some emergency treatment. Second, the person is usually referred by a person who has had relatively little contact with the patient and a limited knowledge of the patient. This is oftentimes a medical doctor

who is not the family doctor. Third, the symptoms are serious such as suicide attempts, severe anxiety, or severe drug reactions. Also, often the symptoms are an acute exacerbation of a chronic condition.

In the instances where the patient agrees with the referral the patient is agreeing to a one time visit for relief of acute symptoms. He wants a "shot" to calm him or he wants to talk with someone immediately. The person, while being seen on an emergency basis, is asked if he would like continued help as an out-patient and often the patient says yes at that critical time. He agrees with the referral to the Emergency Service and also the referral to the Out-Patient clinic as he feels he needs help. However, if the symptoms are relieved, often due to the Emergency Service treatment, or if there is a change in environmental circumstances, the patient will not follow-through with the out-patient treatment he agreed to previously while under stress.

In the cases of clinical disagreement, the person initially does not acknowledge a problem or the need for help. For example, one young girl attempted suicide and said it was her business, no one else's, if she wanted to die. The young man described previously who had taken an overdose of heroin is another example. Neither acknowledged need for emergency service nor out-patient service. Neither referral is their own idea.

Although none of the patients seen in the Emergency Service wanted to follow-through with out-patient treatment, ten of the eleven had been involved with mental health services before, and at least six of them had been hospitalized for serious emotional problems. Table 22 indicates the number of persons seen in the Emergency Service who had been previously involved with mental health and their agreement or disagreement with a mental health referral. Although there is no significant difference, probably due to the small number who disagreed, it is interesting to note the large number of emergency service patients who had had prior mental health experience. Most emergency service patients had prior experience and most agreed with the referral.

TABLE 22.--Previous mental health experience and agreement or disagreement with a mental health referral: Emergency Service.

| Degree of Agreement | Previous Mental Health Experience | No Previous Mental Health Experience |
|---|---|---|
| Agreement and Self-Referred (N=9) | 9 | 0 |
| Disagreed (N=2) | 1 | 1 |
| Total (N=11) | 10 | 1 |

$x^2 = .744$, df = 1, not significant.

Prior mental health experience of Emergency Service patients is not related to agreement or disagreement with a mental health referral.

Agreeing with Referral, Follow-Through Elsewhere, and Previous Mental Health Experience: Adult Out-Patients

There were twelve persons referred to the out-patient clinic who were age 17 or above. Of these twelve people, nine readily agreed with the referral to the clinic. There were three instances of non-agreement--that is, in one case of a teenaged girl, the girl said she did not know about the referral, her stepmother had made the call to the clinic; in a second case a young man was ordered by the probate court to go and he said he would but felt he neither agreed not disagreed; in a third case the woman said she did not know what going to the clinic could do to help her solve her family problems. It seemed that perhaps her ADC worker had tried to talk her into going. In addition to these twelve persons referred by others, there were six self-referrals.

What seems to be more typical in the out-patient referral process is that the person doing the referring has had a longer duration of contact with the patient in comparison to the referring agent in the case of the Emergency Service and that person may actually be a person the patient talks to often about his or her problems. Such referral persons may be an ADC caseworker, a close friend, or a relative. In at least eight cases this seemed to be so. This would fit in with Errera's notion that in some instances a referral comes about because the referring

agent for one reason or another is not able or willing to be the only recipient of communications about the personal concerns of the patient and therefore proposes a psychiatric referral.

In the remaining four cases of out-patient referrals there was a lesser degree of previous involvement over an extended period of time and all of these referrals were made by professional people--a lawyer, a doctor, an in-patient therapist, and a judge. In the first three cases the patient had sought out professional help himself or herself, but not necessarily mental health help however.

In terms of following-through elsewhere the out-patient other-referred individuals turned to other professional sources in four cases--two of these cases were of the non-agreement type and two were agreement cases. There were, in addition to these four other-referred patients, two self-referred individuals who also followed-through elsewhere. Table 23 presents the data on out-patients in regard to agreement or disagreement with the referral source and follow-through elsewhere. There is no greater tendency of persons who are self-referred or who agree with the referral to follow-through compared with those who disagree with the referral.

The patients who agreed with the referral resemble the parents in the child cases who agree with the referral in their solutions. Thus, the clinic was at fault in some

TABLE 23.--Clinical impression of agreement or disagreement with referral and follow-through: Adult Out-Patients.

| Degree of Agreement | Follow-Through | No Follow-Through |
|---|---|---|
| Self-Referred and Agreed with Referral (N=15) | 4 | 11 |
| Disagreed with Referral (N=3) | 2 | 1 |
| Total (N=18) | 6 | 12 |

$x^2 = .45$, df = 1, not significant.

There is no significant difference in the number of individuals who seek help elsewhere based on self-referral and agreement with referral or disagreement with referral.

of these cases. In others, persons worked things out themselves and turned to non-professional help sources such as friends and relatives.

In terms of prior mental health experience, three of the other-referred patients had received some form of treatment before and two of the self-referreds had also been involved with mental health resources before. Table 24 indicates there is no greater tendency of persons with prior mental health experience to follow-through elsewhere.

Table 25 summarizes for all of the services how agreement with the referral is related to follow-through. Of a total of 29 persons, self-referred or agreeing with a referral, seven followed-through elsewhere. Of a total of eleven disagreeing with the referral, five followed through elsewhere. Thirty-two percent of the group interviewed

turned to other help sources. Follow-through was not significantly related to the referral process in terms of agreement or disagreement with the referral.

TABLE 24.--Previous mental health experience and follow-through rates: Adult Out-Patients.

| Experience | Follow-Through | No Follow-Through |
|---|---|---|
| Previous mental health experience (N=5) | 1 | 4 |
| No previous mental health experience (N=13) | 5 | 8 |
| Total (N=18) | 6 | 12 |

$x^2 = .036$, df = 1, not significant.

There is no greater tendency of adult out-patients having prior mental health to follow-through elsewhere compared to those who have not had prior mental health experience.

TABLE 25.--Follow-through rates based on agreement or disagreement with referral: combined data on Emergency Service, Out-Patient adults and Out-Patient children.

| Degree of Agreement | Follow-Through | No Follow-Through |
|---|---|---|
| Self-referred and agreed with referral (N=29) | 7 | 22 |
| Disagreed with referral (N=11) | 5 | 6 |
| Total (N=40) | 12 | 28 |

$x^2 = .72$, df = 1, not significant.

There is no difference in follow-through rates of individuals who agree with a referral compared to those who do not for Emergency Service patients, adult Out-Patients, and child Out-Patient referrals.

## Change in Clinic Policy and Effect on Follow-up Study

It will be recalled from the description of how subjects were obtained for the study that it was necessary to draw two samples and these were obtained several months apart. The first sample, resulting in 20 interviews, was obtained when the clinic policy was to let the individual staff therapists schedule and be responsible for their own new cases. The second sample was obtained when the policy was changed so as to give the potential patient an appointment immediately, usually scheduled within a week, at the time of his initial phone call. This major change in clinic policy between the time the two samples were drawn affected the study in several ways. The study itself, in turn, allowed for an evaluation of the policy change in terms of its effect on pre-intake dropout rate, and also, how the attitudes of pre-intake dropouts toward the clinic might differ at two different time periods--before and after a policy of immediate scheduling of appointments was instituted.

The first major effect upon the study can be seen in the shorter amount of time it took between the initial phone contact of the patient with the clinic and the time of the follow-up interview for the second sample as compared to the first sample. The duration of time between initial contact and follow-up interview of the second sample was

much less than the time involved for the first sample. The difference was a function of several factors.

Before the policy of giving appointments immediately was instituted, the average wait between time of referral and the date of the appointment was 16 days. The range was 0 to 86 days, meaning some people did not receive appointments until almost three months after their initial phone contact. After the change in policy, however, the average wait was 10 days and the range was 3 to 30 days. No one had to wait more than one month to be seen.

The fact that appointments were given sooner, in turn affected the rate at which deletions could be recorded. Under the old system, a case took on the average 55 days to delete, the time between the initial call and the filling out of the deletion form by the therapist. Under the new system deletions were recorded on the average within 35 days, a 36% reduction in the amount of time a case was in the data processing system. Part of this decrease reflects the shorter waiting time for appointments and part of it the fact that therapists tended to delete cases sooner in the second sample after a patient did not show up for an appointment. In other words, deleting cases became a more efficient procedure under the new policy.

The fact the deletion time was reduced in turn affected how soon after an initial contact the follow-up interview took place. For instance, when the first sample

was drawn, some cases were deleted in August of 1969 that were referred as long ago as February of 1969. This meant that the follow-up interview might have been obtained as much as nine, ten, or eleven months after the initial contact. Under the newer procedure, however, the follow-up interview was more likely to occur within two or three months after the initial contact.

A second major effect resulting from the policy change was upon the percentage of each sample to be interviewed that could be located for a follow-up interview. Thirty-four percent of the first sample could not be located as compared to 7% of the second sample. Specifically, 13 people in the first sample had moved by the time of the follow-up study as compared with two people in the second sample.

The change in policy also seemed to affect the rate of refusals to the follow-up interview. Twenty-seven percent of the second sample refused interviews compared to 10% of the first sample. There were twelve refusals in all and eight were from the second sample.

It can only be speculated as to why persons contacted for a follow-up interview relatively shortly after their own inquiry was made of the clinic would tend to refuse an interview more often than those who had made contact long ago. Several possibilities suggest themselves. First of all, it seemed that those who refused were trying to work things out by themselves. A common misconception concerning

the follow-up interview was that the interview offered the person help with his problems. The persons who refused might have been refusing help. It is possible that once they had worked things out, when their problems were not so near to them, perhaps when they had forgotten them, they would have agreed to an interview. A second explanation could be that the persons refusing shortly after contacting the clinic in the second sample resembled the group of individuals who had moved in the first sample. Thus, if the people who had moved in the first sample had been located they might have refused interviews also, resulting in a similar percentage of refusals for the two samples. Yet a third possibility exists. It is possible that the population serviced by the clinic is changing. This may actually be so, considering that as time passes, more and more people know about the mental health center. The first sample, it seems, tended to have people in it who were actually referred to the since-merged Lansing Child Guidance Center or referred to persons on that staff, whereas the second sample consisted of people referred to St. Lawrence Mental Health Center. The two clinics may have different images and therefore attract different clientele. For instance, persons that use the Emergency Service or find out about the center through friends may differ from the population that would have used the Lansing Child Guidance Clinic or the Lansing Adult Mental Health Clinic.

## Evaluation of Change in Appointment Policy and Procedure

One can take, as a rough estimate of the effectiveness of the clinic's new policy, the percentage of people who turned elsewhere before and after the change was instituted. There will be a certain number of persons who turn elsewhere for help due to personal preference regardless of the waiting time at the clinic. However, there are some persons who turn elsewhere due to the waiting time. In the first sample, 48% of the people interviewed followed-through elsewhere whereas in the second sample 18% followed-through elsewhere. This is a substantial reduction, 30%, in the number of people who turn elsewhere for service. This suggests the new policy change is reaching persons previously having to go elsewhere for help.

Another effect of the change was noticed in the attitudes of some pre-intake dropouts toward the clinic. In the first sample, six persons complained about having to wait for appointments. There was no such complaint from persons in the second sample. Not only was the wait mentioned by persons in the first sample, there were also complaints that the clinic never called them back. It appears that perhaps under the first procedure, the referral secretary promised the patient they would be called back by the therapist in a short while but the therapist did not do so, leaving the patient with negative feelings toward the clinic. It was this group of people, those desiring

immediate help but having to wait and those who were not called back who expressed the most negative attitudes toward the mental health center. All of these individuals were from the first sample, thus suggesting that the change in policy reduced the number of persons having negative attitudes toward the clinic.

It would seem that giving immediate appointments provides speedier data processing and it also has a more positive effect upon potential patients. The newer procedure probably improves the relationship between the center and the community at large, as well.

## Interaction Between Pre-Intake Dropout and Clinic: The Question of Reliability

Statements of patients in regard to what happened in the interaction between themselves and the clinic show some degree of unreliability. In some instances, the clinic records may be inaccurate, in other instances the recall of the patient may be inaccurate. For instance, some people said they were not phoned back by the clinic and the clinic record shows that the patient himself phoned in to cancel an appointment. Or, some persons said they were not contacted and yet they might not have shown up for given appointments two or three times. In other instances, a patient might not have recalled the follow-up letter that is routinely sent out to patients who do not show up for their first appointment or who cancel. This letter offers

another appointment or requests that the patient phone in if he wishes another appointment. The patients would say the clinic never contacted them and yet they themselves did not respond to the follow-up letters. Another type of interaction between clinic and client involved a woman who said she herself sought out Ingham County Mental Health as an alternative agency. The clinic record, on the other hand, indicated she was referred there by St. Lawrence Mental Health. It is interesting to note that in some of the cases where there are strong negative feelings held by the patient toward the clinic their description of what happened does not coincide with the clinic records.

In trying to account for this discrepancy, it is possible that people who cancel a particular appointment wish another appointment but this is not clear to the person handling the call in the clinic. Perhaps a secretary takes the cancellation message, but the therapist does not realize the patient wishes to make arrangements for another appointment. Another possible explanation is that recall of the patient may be better for the time centering on his initial phone contact, when anxiety was high, whereas recall for subsequent events, such as other appointments or a follow-up letter, are lost to recall because it is no longer critical to the person to obtain help.

An attitude that seemed to be present in the people who had several appointments but kept none of them was that the clinic should continue pursuing them.

In general, it seemed the clinic did extend itself to the pre-intake dropouts. There were few instances of no follow-up letters and there were many instances where two or more appointments had been made.

## Awareness of Community Mental Health Center's Services

A section of the interview dealt with determining how aware pre-intake dropouts were of services offered by the St. Lawrence Mental Health Center. Not one individual interviewed knew the full range of services offered by the Center. This includes individuals who had been in the hospital, those who had been to the Emergency Service, those who had contact with the Out-Patient services, and those who read about the center in the newspaper. People were especially unaware of the Emergency Service. Those seen in the Mental Health Emergency Service, it should be remembered, were referred mainly by the Hospital Emergency Room, suggesting that they were unaware of the Mental Health Emergency Service beforehand. Two specific questions people asked about services were whether the clinic offered family therapy, and group therapy. Another concern mentioned a few times was whether the police were contacted in the cases of drugs.

## Services Requested

Individuals interviewed most often requested as a service that the clinic see people right away, when they

need help, not three weeks or a month later. Other services mentioned as desired besides being seen immediately were the following: a babysitting service (nursery) within the hospital so mothers could visit or be visited while in the hospital (this person meant the medical hospital), meeting the professional mental health therapist in the school rather than the clinic, family therapy, group therapy, better communication between agencies (referring to the school and the mental health clinic), "circle" type of therapy, some kind of follow-up (a phone call to see how you are), being able to contact someone outside of regular 8:00 A.M. to 5:00 P.M. hours, emergency service, more money to rehabilitation agencies (this woman was upset because she had to wait to receive dentures), a full-time job, a job for $10.00 an hour. Some of the requests, then, were for services already available and others were for services not directly handled by mental health centers. The variety of requests suggests some confusion in the minds of people as to the actual services offered by the mental health center.

Home Calls

Since Errera, Davenport and Decker (1965) had indicated that making home calls might be a possible out-reach service to pre-intake dropouts, the persons interviewed were asked specifically if they would prefer home calls to clinic visits. There were 17 persons who indicated they

would prefer home calls, 19 who preferred clinic visits, and four who said it made no difference to them. This suggests a routine home call might not be particularly welcome by perhaps 50% of the pre-intake dropout population.

In an effort to determine if home call preference could be linked to some other variable, several variables thought possibly to be related were looked at. It was thought, for instance, that if a person was self-referred, he might prefer clinic appointments as opposed to home visits compared to other-referred individuals. Table 26 presents this information and suggests that this is not a critical factor in home call preference. Another variable looked at in terms of home call preference was the service used. This also did not seem critical as indicated in Table 26. In the case of children, the parents who agreed and those who disagreed with the referral were looked at in terms of preference and this also did not seem to be related to home call preference. As is also presented in Table 26, fear was also unrelated. The factor that seemed to have some relationship was the factor of a condition being acute or chronic. Adult chronic cases tended to want home visits whereas chronic child cases tended to want clinic visits. Since there is also concern about poor persons and outreach programs, preference for home or clinic calls was looked at for persons on ADC and Welfare. There was no difference at all, four preferring home calls and four clinic calls and two expressing no preference.

TABLE 26.--Preference for home call visits.

| | | Home Call | Clinic Visit | Makes No Difference |
|---|---|---|---|---|
| | Self-referred (N=9) | 5 | 4 | 0 |
| | Other-referred (N=29) | 12 | 15 | 0 |
| | Total (N=36) | 17 | 19 | 0 |
| | Emergency Service (N=10) | 4 | 6 | 0 |
| | Out-Patient Service (N=26) | 13 | 13 | 0 |
| | Total (N=36) | 17 | 19 | 0 |
| | Mother agreed with referral (N=6) | 2 | 3 | 1 |
| | Mother disagreed with referral (N=5) | 1 | 2 | 2 |
| | Total (N=11) | 3 | 5 | 3 |
| | Stated fear (N=17) | 8 | 7 | 2 |
| | No fear (N=23) | 9 | 12 | 2 |
| | Total (N=40) | 17 | 19 | 4 |
| Adults | Chronic condition (N=14) | 10 | 4 | 0 |
| Adults | Acute condition (N=13) | 4 | 9 | 0 |
| Adults | Total (N=27) | 14 | 13 | 0 |
| Children | Chronic condition (N=5) | 1 | 4 | 0 |
| Children | Acute, first time (N=3) | 1 | 2 | 0 |
| Children | Total (N=8) | 2 | 6 | 0 |
| | ADC or Welfare | 4 | 4 | 2 |

Reasons people preferred home visits included: they thought the professional person could get a better idea of the home situation, mentioned especially in the cases of children; difficulty in getting to the clinic due to transportation or babysitters; and, it is easier to talk to someone when you are at home. The possibility of invalidism mentioned by two older women was another instance in which there would be a preference for home visits. The reason mentioned by people preferring the clinic was they felt it is sometimes better to get out of the house. They would use the trip in a therapeutic manner.

If a home call program were begun, then, it would seem necessary to ask persons their preference beforehand. Pre-intake dropout in itself does not imply a person would respond favorably to a home-call program.

An alternative to home calls in the form of a mobile unit coming into the neighborhood was rejected as a preference by almost all persons interviewed. Very few persons indicated they thought a clinic closer to their home was necessary.

## Practical Problems in Getting to the Clinic

One part of the interview was devoted to determining what practical reality problems pre-intake dropouts might have in getting to the clinic. They were asked what specific problems they might have such as cost, transportation, babysitters, inconvenient appointment times, being unable

to get away from a job, and, in addition, were asked to comment about any other condition that might interfere with their being able to come to the clinic. Some conditions mentioned were transient situations such as transportation. Some persons were temporarily without a car and therefore were unable to keep appointments. Other conditions were conditional. A major conditional factor mentioned was work. If the person started working this made keeping appointments more difficult. Persons felt appointments would have to be made so as not to interfere with work. Some individuals had long work days making this impossible. Table 27 presents the answers given to inquiries about possible obstacles in keeping appointments at the clinic.

TABLE 27.--Reality problems persons mentioned as obstacles to keeping clinic appointments.

| Problem | Yes | No | Depends |
|---|---|---|---|
| Cost | 23 | 11 | 6 |
| Transportation | 15 | 24 | 1 |
| Babysitters | 7 | 32 | 1 |
| Inconvenient appointment times | 19 | 21 | 0 |
| Unable to leave job | 6 | 30 | 4 |
| Possibility of invalidism | 2 | 0 | 0 |
| Distance | 2 | 0 | 0 |
| Frequency of appointments | 1 | 0 | 0 |

The most often mentioned problem was cost. This was mentioned by some women on ADC or Welfare who apparently did not know the service was free to them. Persons were asked to guess what they thought the fee was if they did not already know. Estimates ranged from free to $25.00 with a good many persons guessing higher than what the actual cost would be for themselves. It seems the image of the high cost of seeing a private psychiatrist has been transferred to mental health clinics in the view of the public since those over-estimating often mentioned the high cost of seeing a psychiatrist as the basis for their guess. There were, in addition to over-estimates, a few people who thought the service was free and they were surprised to learn there was a fee. Very few people knew of the existence of the State Sliding Scale on which the out-patient fee is based. This was true even of people who had relatives being seen in the out-patient clinic. The scale considers income and number of persons in the family as a basis for fee assessment. The fee for being seen in the Emergency Service is $25.00. In two instances, patients complained this fee was too high and one woman said she would not have gone to the service if she had known of the cost beforehand. There was some indication that persons being billed for Emergency Service assume the out-patient fee is the same cost per visit.

The second most frequently mentioned problem was inconvenient appointment times. This was not so much a problem for people as an expression of preferences for afternoon or morning appointments. Having children in school or working allowed only certain times of the day to be free. Only one person requested evening appointments suggesting that most persons could make some daytime appointment.

The third most frequently mentioned problem was transportation. Women on ADC most frequently had this problem. Considering that a good number of people with transportation problems live within a two mile radius of the mental health center, it might be possible to have home calls or to provide transportation for these people.

Babysitter problems and being unable to get away from a job were mentioned less frequently than cost, inconvenient appointment times, or transportation problems. The possibility of illness and distance were each mentioned twice as problems.

The conditional nature of the responses to this part of the questionnaire indicates that the decision to come for service is dependent upon daily living conditions. Thus, available money, available transportation, right appointment times, available babysitters, and so on, are factors people consider in their decision to keep an appointment. Often people did not keep their initial

appointments because something they felt was more urgent came up. Examples of such urgent matters are starting a new job, having to take a child to the hospital, the car breaking down, or a refrigerator breaking down. Other reasons were forgetting about the appointment and having no transportation.

## Service Provided by Follow-up Study

One of the purposes of the follow-up study was to provide a service to the pre-intake dropout in terms of information about the center and, also, clear up any misunderstandings between the patient and the center. There were many areas in which information was requested by persons being interviewed. The follow-up study was very well received with many persons spontaneously saying they thought it was a good idea for the clinic to follow-up people. Many persons were thankful for someone coming to their homes to see how they were getting along. (Tea, coffee, etc. were offered by many persons.) Although it is difficult to predict or determine how the follow-up interview will facilitate persons in getting themselves to the clinic, it seems certain that it did not hinder such actions. All except one person said they would contact the clinic in the future if they needed help. This one person had established herself with another clinic. The follow-up study was definitely good in terms of public relations.

The areas of information provided to the individuals interviewed included the following:

1. Explaining the different catchment areas and referring individuals in the Ingham County Mental Health Center catchment area to that center.

2. Explaining the state sliding scale used by the Out-Patient Clinic in assessing fees.

3. Explaining the Emergency Service and providing the phone number.

4. Explaining the change in policy in regard to patients now being given appointments immediately.

5. Explaining the function of the psychiatrist on the staff (i.e., how medication is provided).

6. Explaining the various treatment programs and techniques used such as day care, partial care, group therapy, marriage counseling, and so forth.

7. Providing information in regard to other help sources the person might use (one referral was implemented to another clinic closer to the patient's home).

8. Answering specific questions a person may have in regard to himself, i.e., if he returned to the clinic would he have to see the same therapist again or, in another instance, providing the name or someone the person had seen and wished to contact again.

Several persons attempted to use the interview situation to obtain advice for their specific situations. An effort was made to circumvent, whenever possible, giving any such advice. It seemed that in most such instances other professional people were involved. It was deemed somewhat unethical, considering the purpose of the interview, as well as other factors, to offer advice. This advice was especially sought in cases with children when

the mothers were ambivalent and perhaps confused as to what course of action to take. They were usually presently engaged in some sort of help-seeking or treatment but they were not convinced that it was the appropriate action for them to take. On the whole, however, most persons interviewed seemed to have their situations under control sufficiently and they followed the format of the interview.

# CHAPTER IV

# DISCUSSION

The following discussion will center upon the results as they pertain to the original objectives of the study. The original objectives were: (1) to obtain information in regard to the referral process, (2) to obtain information in regard to help-seeking after pre-intake dropout, (3) to provide information on descriptive variables, (4) to provide information on demographic variables. In addition, the study was to provide a service to the pre-intake dropout and to the clinic in terms of feed-back.

## Referral Process

Errera (1964), based on his study of pre-intake dropouts, speculated that in some instances a referral is initiated by someone who is the recipient of communications of personal concerns of the patient and therefore proposes a psychiatric referral. This seemed to be the case in a number of instances in the present study, and seemed especially true of persons involved with ADC caseworkers and health nurses. Errera believed what happens is that the person actually hoped for such a referral but when the time of the appointment came the person's initial reluctance

returned. In the present study, however, it did not seem that people became reluctant. Rather, they engaged in other help seeking activities so that by the time of their appointment they felt there was no further need for service. For one thing, although people do not necessarily refer to caseworkers as help sources it was clear they are used as such. Women on ADC often tell their workers all about their family problems. In addition to this type of help, people talk with close friends and relatives about their situations. It would seem that for at least a number of people referral to an out-patient mental health center would be redundant, since they already talk to a number of people about their problems. These people who already have help sources probably do not feel the pressure to become out-patients.

Errera also described a second group of referred individuals as being "angered and confounded" at the idea of a mental health referral. The referral is taken by these people as being out of context or out of place. In the present study, a few mothers of children had this type of reaction to the referral. Errera's population was adults. No adult referrals in the present follow-up study indicated they felt this way when referred. Parents of children, however, did say they were confused, disagreed, did not understand the reasons for the referral, and so on. Errera believed these individuals were not prepared for such a

referral and further believed that the referring agent was unable to help facilitate the referral over a period of time with discussion. What was more typical of referral agents in the present study, however, was not a lack of discussion, but rather a good deal of pressure being put on the parents over a good length of time in an effort to get the parents to take their child to the clinic. The parents, though, often resisted such attempts by the referral agent. The referral agent, then, tried in vain to facilitate a referral.

Another notion that did not seem to hold up in the present study was the idea that if a person agreed or disagreed with the referral this would indicate what subsequent actions he would take. It seems, rather, that other factors besides agreeing or disagreeing with a referral enter into the decision to obtain out-patient services. One of the factors, for instance, is the patient's evaluation of "need."

Most people, it seems, have an internal feeling of when they "need" help. Some people may feel "need" often, and perhaps seek professional help with minor things such as an argument with a spouse. Others may suffer long and hard and yet not see a "need." They may seek help only after things become unbearable. Still other people may have socially defined serious problems, e.g., psychosis, suicide attempts, heroin addiciton, and yet may not themselves feel "need" at all. In any case, the decision to

seek help is based on felt "need." Since this may be a rather transient feeling the person may make the decision to seek help on one day; however, as symptoms dissipate, "need" dissipates and he does not follow-through at a later date with obtaining service. In the case of referrals, the referring agent is being consulted on days the person "needs" help, and the agent makes a referral on that basis, but the patient does not follow-through as symptoms fade away or there is a change in circumstances. This can be seen fairly clearly in the case of persons seen in the Emergency Service. They feel "need" to obtain service, are seen by the referring agent, usually a doctor (who does not wish to treat the person for his emotional upsets), and he is then referred to mental health. After being seen in the Emergency Service the precipitating circumstances change and the person does not care to follow-through with out-patient treatment. The symptoms have subsided and there is no further "need." Examples of this phenomenon can be given. The case of the youth on drugs, for instance, once recovered from his "trip" feels no further "need." A woman who had an argument with her husband felt "need" at the time but when her husband subsequently became hospitalized and was out of the home, i.e., a change in circumstances, there was no further "need."

An analogy can be made in the cases of chronic conditions. These persons resemble someone with a chronic

back-ache. At times the pain becomes severe enough to need treatment and the person may make an appointment with a doctor. If, however, on the day of the appointment the person feels better, he may not keep his appointment. The back-ache is not cured, the patient may continue to complain to those around him and yet he will not become a patient to the point of allowing a cure. He will suffer chronically for years. There may be intermittent attempts at half solutions over a period of time. Really seeing to the problem only occurs when the pain is unbearable and must be taken care of. Negative factors against seeking help must be outweighed by positive factors for seeking help.

## Follow-Through Elsewhere

Looking at the 32% of the pre-intake dropouts who followed-through elsewhere, it seems there are two qualitatively different types of follow-through with other agencies or help sources. The first type of follow-through, more typical of child cases, is one in which the parents are put under a good deal of pressure to do something about their child. In some instances, threat may be used, such as suspending the child from school. The follow-through of the parents is done with trepidation, and they are not particularly pleased with any type of treatment they become involved in. They remain ambivalent and uncertain concerning any of the steps they may take in regard to the original pressure for a referral.

A second type of follow-through, more typical of adults, is done when symptoms persist, and "need" is still felt. Because of this felt need, another help source is necessarily sought out. This type of follow-through is also present in a few instances of parents who feel they are part of a child's or adolescent's problems.

Comparing the second type of follow-through case to pre-intake dropouts who stop help-seeking, the problems seem to be more of an interpersonal nature rather than the problems of symptoms such as depression, nervousness, or tension more typical of dropouts who stop seeking help. Thus, persons with family problems and marital problems which did not improve after contact with the clinic tended to follow-through elsewhere. There also seemed to be more involvement of other family members in the follow-through as compared to dropouts who stopped help-seeking. Thus, a husband would go with his wife, a mother with her child, and so forth. With dropouts, those who did not go elsewhere, the husbands did not wish to participate with their wives and parents did not seem to want to be involved with the treatment of their children. Further, considering the high number of single, divorced, and separated individuals, some of these persons did not have a close relative such as a spouse who could become involved enough emotionally to support the patient or participate in follow-through as an out-patient. If the problem was with a spouse or ex-spouse this person was unlikely to become involved in treatment.

## Use of Other Agencies

Fully one half of the pre-intake dropout population was involved with at least one other community agency at the time of follow-up, and some were involved with a number of such agencies. The juvenile court, the probate court, welfare, vocational rehabilitation, Aid to Dependent Children, health nurses, Ingham County Mental Health Center, etc., were some of the agencies already providing services to the pre-intake dropout. It was interesting to note that persons using these various agencies did not particularly look upon them as help sources with emotional or psychological problems. They tended to rely on caseworkers a good deal, excluding perhaps court workers, yet these caseworkers were not viewed as help sources to go to with problems.

On the other hand, individuals who sought out help on their own, not under pressure, tended to see those agencies or persons sought out as helpful. This suggests that when people decide to go for help they expect help, accept help, and are satisfied with results. If they go to help sources under duress, not having decided for themselves to go for help, they are not fully expecting to be helped and they remain dissatisfied.

Applying this notion to individuals involved with caseworkers over extended periods of time, it seems they do not use their caseworkers in the sense that the caseworker can really help them with their emotional or

psychological problems. They do not expect help in that way. Rather, they expect help with other problems such as housing, money, jobs, health, and so on. They talk to their workers about problems but do not expect that person to help but rather to be a listener. The caseworker, also, has probably defined his or her role as providing a rather specific type of service which does not particularly include listening to emotional problems. Thus, the potential possible relationship of the patient with workers in other agencies is not fully developed in terms of mental health.

Why these particular individuals do not perceive caseworkers, health nurses, and others serving them as help sources for their emotional problems is an interesting question. It may be that caseworkers and other individuals involved for long periods of time with a person or family elicit both resentment and gratitude. For instance, one woman spoke very highly of a health nurse who was instrumental in having her retarded child placed in an institution. This woman was very upset about having this child placed. As a result, she apparently did not accept any emotional support from the health nurse who was trying to be helpful but who was also the cause of the problem. In another instance a woman's ADC caseworker made arrangements for her to come to the clinic. It was apparent, however, that the woman had very strong negative feelings toward the ADC program. She felt they were not giving her enough

money. More examples could be given concerning the dual role of caseworkers which may account for people not viewing them as help sources with emotional problems.

In order to reduce referrals which do not materialize, it would be possible to work with and develop already existing relationships a person has with caseworkers along mental health lines. Training or consulting with caseworkers involved in programs such as ADC or the courts concerning the mental health needs of persons they are already working with is a possible way of avoiding making an additional referral to a mental health clinic. This would mean efforts would be made toward expanding an already existing relationship resulting in a reduced pre-intake dropout rate. Implementing this idea would probably involve interagency discussion and program planning.

## Friends and Relatives as Help Sources

There is no doubt that the pre-intake dropout usually has a number of friends or relatives to talk with as help sources. Very few persons had no one. Those that said they had no one tended to use the Emergency Service more than the Out-Patient service. Pre-intake dropouts use these friends and relatives as help sources after deciding against going to the clinic as well as before the original contact with the clinic is made in an effort to obtain emotional support and understanding. A mutual sharing of problems with close friends or relatives such as a special girlfriend

with similar problems or a relative in a similar situation, often a sibling, were used as confidants.

Levinger (1960), in a review of continuance or discontinuance in casework mentioned, among other things, that little attention is paid to the environment of the patient as a variable related to dropout. The fact that some pre-intake dropouts in the present study had relatives and friends to talk with definitely seemed to be a contributing factor in their decision not to follow-through as out-patients. If the person had someone to talk to, regardless of whether that person encouraged going to the clinic, the patient seemed to feel better. It was as if someone understood, someone was willing to listen to him. Talking about problems with someone seemed in itself an act of relieving anxiety.

## Help-Seeking Patterns

The help-seeking patterns of the pre-intake dropout population can be compared to a representative cross section of Americans, 21 years or older, studied by Gurin, Veroff, and Feld in 1960. They found in their study of how Americans view their mental health that one seventh of the general population say they have gone for help with psychological problems at some time in their lifetime. Of the total population, 6% went to ministers, 4% to doctors, 4% to psychiatrists, psychologists, social agencies or clinics. Of those seeking help, 42% went to the clergy, 29% went to

physicians, 28% to psychiatrists, psychologists, social agencies or marriage clinics.

In comparison to the general population and Gurin's help-seekers, 15% of the pre-intake dropout population studied here go to ministers, 27.5% go to doctors, and 50% have had prior mental health experience. This leaves 7.5% who have not used any such resources prior to their contact with St. Lawrence Mental Health Center. These percentages suggest that as a whole this group consults professionals more than the general population, and specifically, there is a much higher number who use mental health resources such as mental health clinics, social agencies, psychiatric beds in general hospitals, psychiatrists, and so forth. A $x^2$ analysis comparing the populations in this study with that of Gurin, Veroff and Feld was significant at the .05 level ($x^2 = 10.16$, df = 1) indicating a significantly greater number of pre-intake dropouts have used mental health resources as compared to the help seekers in Gurin's population. This is an especially interesting finding considering the young age of many patients who had already recieved mental health services and the number of persons under 25 who had already been hospitalized, i.e., 10%. On the other hand, significantly fewer of the dropouts use the clergy as help sources compared to Gurin's help-seekers. Using an $x^2$ analysis again ($x^2 = 17.88$, df = 1), there was a significant difference beyond the .05 level in

the direction of Gurin's population making greater use of the clergy. This may be related to the young age of the pre-intake dropouts studied here as compared to the sample studied by Gurin which had more older persons in the sample.

Gurin, Veroff and Feld postulated a three stage process in going for help. The first stage a person goes through is defining the problem in mental health terms, the second stage is deciding to go for help, and the third stage is seeking a resource. These authors related these decision-making steps to demographic variables. An intervening variable between the demographic variables and the psychological factors is "readiness for help." They picture an interaction between available resources and the psychological factors, with demographic factors important at stages one and two, and availability of resources important at stages two and three. Thus, psychological factors carry more weight with women and the young, while facilitating factors are more important in the case of income, religion, and regional groups. This interaction of the psychological factors and the availability of resources, they believe, produces more use of mental health by the higher educated and non-rural groups. The less educated, they believe, do not seek help because they do not define the problem in psychological terms and the need is less often translated into actual use of help. Distress, however, is the same or worse in the less educated group of people.

The study of pre-intake dropouts done here indicates some of Gurin's notions do apply; however, some do not seem to be typical of this group of people. One aspect seems to be the same, namely, that the young and women tend to be more psychologically oriented since they are a good percentage of the pre-intake dropout population group. The importance of demographic factors at stage one, i.e., defining the problem in psychological terms, is questionable however. For instance, of the people who were low income or lower class, they still defined the problem in psychological terms, contrary to what Gurin, Veroff and Feld would say of low income persons.

Actually, in the present study there were few instances in which the person did not define the problem as a psychological one. Some research (Shyne, 1957) has implied that dropout from treatment is due to the patient's externalizing rather than internalizing the problem. Lack of acceptance of responsibility for the existence of the problem, lack of realization of the need to participate in its solution, low motivation for a solution, resistance to caseworker's exploration, and attitude of other family members are some of the reasons given in the research for people dropping out of treatment or casework. The dropouts interviewed in this study did not seem to fit this description. Even in the cases of chronic conditions the person wanted a solution but was perplexed as to what would help

or how to obtain a solution. The instances where the problem was not defined as psychological were the cases where there was disagreement with the referral source, as in the child cases.

What seemed more important in dropout than defining the problem in psychological terms, the first stage in decision-making, was the second stage, the decision to go for help. What seems to happen at the second stage of decision-making is that the person decides to go for help but a change in his situation makes this a transitory decision which is later reversed. The reversal is often based on alleviation of symptoms.

Various researchers have found that patients have "spontaneous remission" of symptoms (Goldstein, 1960) or improve while on a waiting list (Endicott and Endicott, 1963; Shorer, Lowinger and Sullivan, 1969). Some authors (Goldstein, 1960) argue that the patients' expectation of help is sufficient to alleviate symptoms and cause improvement. Friedman (1963) has found, for instance, in studying expectations and symptom reduction that certain specific symptoms usually associated with anxiety and depression are more related to symptom reduction after one interview than other symptoms. From his study of out-patients he concluded that the first contact, as intake, can reduce anxiety and symptoms in neurotic out-patients and that the relief from the belief of getting help would be immediate and lasting across therapy techniques. This seemed to be what happened

to people seen by the Emergency Service as well as two or three people who talked with therapists over the phone through the Out-Patient service. These considerations, that patients actually are helped by emergency service and the expectation of help plus the finding of this study that people activly engage in trying to feel better, suggests that for pre-intake dropouts the second stage of decision-making, the actual decision to go for help, is the critical stage in dropout. This stage of decision-making is dependent upon variables such as availability of other help sources, not necessarily mental health help resources, severity of symptoms, and the "felt need."

Other research done which indicates that the first step in decision-making (i.e., defining the problem in psychological terms) does not vary according to social class variables (such as income or demographic factors)is that done by Overall and Aronson (1963 and 1966). They found no difference in sophistication in regard to psychodynamics or expectations of treatment based on social class. They derived their hypotheses from a study done by Hollingshead and Redlich in 1958 which predicted differences. The two social classes in the Overall and Aronson studies differed also on race and religion. From their findings it seems that social class or demographic variables alone cannot be used as explanatory concepts in accounting for the use or non-use of mental health services, as Gurin, Veroff

and Feld might imply. Demographic variables cannot be used alone especially if one wants to link social class with psychological sophistication.

As far as demographic and social class variables go in the present study, the sample tended to be low-income. There was a high incidence of previous hospitalizations of patients and their relatives. It seems that treatment preference for low-income individuals is hospitalization or use of emergency services and, all things considered, the previous use of mental health resources by the patient himself or the familiarity through association of friends and relatives may be more critical than demographic variables. The Out-Patient clinic, for instance, is just as available to low income individuals as is the hospital. Yet, the previous high rate of hospitalization of patients and their relatives suggests the low income individual tends to seek hospitalization as help rather than out-patient treatment.

The situation with lower class dropouts, then, is not that they do not define problems psychologically as Gurin, Veroff, Feld, and Shyne suggest, but rather that they have various solutions that do not necessarily include out-patient treatment. In some instances perhaps they may wait longer than a middle-class person to seek professional help, becoming more desperate, resulting in the need for immediate help such as emergency treatment or

hospitalization. Other solutions are talking with friends or relatives, working, or consulting caseworkers.

The finding that the pre-intake dropout group was in general of the lower socio-economic class was in keeping with findings that this group of people have a higher drop-out rate after intake in out-patient treatment as compared to the middle-class (Shyne, 1957). What seems to happen for a majority of this group of pre-intake dropouts is that they may receive various types of treatment for emotional problems from several sources, and at various times enter and leave some type of mental health treatment. Thus, a patient may have a combined history of a number of treatments such as being treated by a physician with tranquilizers, hospitalization as a medical patient for emotional problems (i.e., a "nervous breakdown" or a suicide attempt) or being seen in a mental health emergency service or a general hospital emergency service when emotionally upset. The hospitals used may be different over time as are the emergency services and the physicians consulted. Other treatments attempted may include instances of the person being an out-patient for a short period of time or being hospitalized as a psychiatric patient for a short time on a psychiatric ward. Since persons are in and out of treatment several times over the years, it seems that viewing mental health in terms of helping persons through a particular problem or critical time may be more valuable than

viewing mental health in terms of "cure." It is also well to consider when giving treatment that pre-intake dropouts do not seem to have agency or therapist loyalty. They may at different times contact different physicians, different agencies, different hospitals, or different therapists rather than return to a previously established contact. There was, for instance, an awareness of many pre-intake dropouts of the other mental health center, Ingham County Mental Health Center, and an easy exchange made from one center to the other, St. Lawrence. Along the lines of no agency or therapist loyalty, it was rare for someone to recall the name of someone with whom the person had been in treatment. This particular pattern of lack of agency loyalty did not seem linked to social class in the present study but seemed typical of pre-intake dropouts regardless of socio-economic considerations.

## Feedback to the Clinic Administration

If the expressed desires for service of the pre-intake dropouts can be taken as an expression of the desires of the community at large, it is clear that being seen right away is an important aspect of mental health services. There is no doubt that long delays in providing service, i.e., a waiting list, causes negative attitudes toward the agency. In terms of the out-patient clinic's new policy of giving appointments immediately, this is a desirable policy. This policy also affected dropout rate favorably.

In evaluating the Emergency Service, people were satisfied with the treatment they received even if they opposed going there. What occurred in the Emergency Service was not a contributing factor to dropout in a negative sense although it was in some instances in a positive sense. Thus, if a person was helped enough by being seen on an emergency basis he did not feel a need for further service and became a pre-intake dropout of Out-Patient service. There were no complaints about the Emergency Service.

One aspect of the Emergency Service that might be considered for evaluation is the fact that some individuals did not know they were being referred to a mental health service. In other words, a mental health therapist was called in to help in a situation at the request of a medical doctor but the patient did not know the person he was talking to was from mental health.

Another aspect of the Emergency Service that might be evaluated is the service charge. Since the people using the service are relatively poor financially it might be wise to evaluate the present fee of $25.00. It would seem that this charge would discourage use of Emergency Services by lower income individuals. Research has shown that it is the lower-class individual who is most likely to use this type of service (Atkins, 1967; Chafetz, 1965; Errera, 1963; Kadushin, 1957).

## Possible Services to Pre-Intake Dropouts

It was evident that most pre-intake dropouts were not aware of the services offered by the mental health center, the cost involved, the professions of the staff, nor the treatment possibilities. At first, printing a little brochure explaining some of the aspects of the center seemed a good way in which to inform the community about the mental health center. This brochure could be distributed to new patients and sent by mail with the follow-up letter to pre-intake dropouts. Considering, however, that the follow-up letter did not impress some of the pre-intake dropouts another approach to informing the public might be better.

In approximately 90% of the homes visited the television set was on regardless of the time of day. This suggests the best approach to educating the community about mental health services might be through the television medium. Although this might be expensive, it is the medium most likely to reach the lower social class and the population studied here.

In terms of the agency following-up pre-intake dropouts, a possible plan would be to provide home calls. Since not all pre-intake dropouts wanted such calls, these could be provided only at the request of the patient. When a follow-up letter is sent the patient could be asked to specify if he wished such a home call. This would be

expansion of a traditional approach to mental health, i.e., treatment in the home instead of the clinic.

Considering new approaches to the delivery of mental health services, another possibility presents itself. Since fully one-half of the pre-intake dropouts were involved with other community agencies, it seems that some coordination with these other agencies might be in line. The mental health worker might be of more service in some instances as a consultant to the caseworker already involved with a person or family. Another possibility is that the mental health professional actually becomes a member of the staff of another agency, such as the ADC program or the courts, as the person who delivers mental health services through that agency. Or, the professional person might be on the staff of another agency as a consultant so that workers can consult the mental health professional if they have cases involving mental health problems. This would reduce the number of agencies a given person became involved with, thus reducing redundancy. Also, it would reduce the number of referrals that do not materialize. What seems to make the most sense is that the mental health professional be used as a consultant rather than that he be involved in direct service when another agency or caseworker is already involved with a person or family and could give some types of mental health help.

Although the present study did not deal with those individuals who do keep their appointments in relationship to the referral source, Errera, Davenport and Decker (1965) did look into this relationship. They found in their clinic that 70% of the persons who referred themselves eventually kept their appointments, in 60% of the cases where the family made inquiry, appointments were kept. In 75% of cases where the family doctor made the referral, the patients kept their appointments. In the case of law or social agency referrals, 50% came into the clinic. Only one-half of the referrals made by agencies already involved with a person materialized. The present study found that one-half of the pre-intake dropouts were already involved with other agencies or school personnel. This suggests that to cut down on pre-intake dropouts it may be necessary to look at the inter-agency referral process more closely.

Chafetz (1965) makes several suggestions in regard to inter-agency or inter-professional referrals after he comments that they are often ill considered and poorly carried out. First, knowledge of administrative policies and clinical organization of the participating agencies is developed. Second, key personnel work out what is an appropriate referral and a referral procedure. Third, a reciprocal referral system, informal training, or consultation is developed, i.e., offer something to the receiving agency.

Fourth, constant re-evaluation is made to reinforce mutually acceptable referral patterns. And fifth, follow-through of referrals, i.e., an agency then gets feedback of its own treatment planning. The present study indicates that these might be desirable steps to take in regard to at least the ADC program and juvenile court referrals. The clinic is already making such steps in the direction of school referrals.

In terms of servicing reluctant parents, meeting them at the school or in the home rather than in the clinic might prove fruitful. On the other hand, acting as a consultant to the school personnel already involved might also be a way of providing service.

## Implications for Clinic Practice to Reduce Pre-Intake Dropout Rate

The present study suggests that giving patients service immediately is preferable to having them wait for an appointment. There are several effects of this policy. There is a reduction in the number of persons turning elsewhere for help if they are seen at the time of their crisis. There is also a reduction in staff time lost in trying to locate persons through letters or phone calls after a period of time has elapsed in an effort to give them appointments after a waiting period. Writing letters after a period of three months is often wasted time due to the mobility of pre-intake dropouts and their having found other solutions

to the problem. The attitude of persons not seen when they need help is negative toward the clinic, which is also a reason to give service immediately. The delay in data processing in the clinic is reduced when cases are handled immediately.

A second area that needs to be looked at is the need to inform the community about the available services, the cost of various services, and how the mental health center operates. There were many misconceptions in this regard. People calling the Out-Patient service should probably routinely be informed about the Emergency Service and the fact that they may phone into the service rather than come in. Adequate and accurate information concerning the mental health center should cut down on pre-intake dropouts who do not come because of misconceptions concerning the center.

A third method of reducing pre-intake dropouts is to form some type of liaison with ADC workers and the juvenile and probate courts, in terms of referrals to the mental health center. Since half of the pre-intake dropouts were involved with caseworkers it might be preferable to work something out with these workers to reduce either inappropriate referrals or dropouts. A suggestion would be that the caseworker handle mental health needs if possible with support from the mental health center. Or, that the caseworker discuss the referral with the patient and then with

the mental health worker to see if the mental health center can really be helpful. In some instances the caseworker may already be doing everything possible to help the person. Helping the caseworker to formulate the problem with the patient, and what the patient thinks is a solution, might help eliminate the persons who do not feel out-patient treatment would help them. Another approach to implementing reluctant referrals would be to have the mental health worker make a home visit, perhaps with the worker from another agency, to establish a relationship with the patient which may then subsequently be transferred into the clinic setting.

Another method of reducing staff time lost through pre-intake dropouts could be to request that patients making appointments call in to cancel if they cannot keep their appointments. An educational approach to the client impressing upon him the need to keep appointments or let the therapist know he cannot keep the appointment should reduce staff time lost through "no show" of the patient.

In general it seemed that after the change in policy to seeing persons right away was instituted, the clinic followed through adequately. A home visit plan if feasible could be offered through the follow-up letter but a routine follow-up in terms of house calls or interviews as was done in this study seems uncalled for. Most persons seemed satisfied with their individual solutions. The amount of time

it would take to do a routine follow-up on pre-intake dropouts would not be worth the service given.

# CHAPTER V

## SUMMARY

A study of pre-intake dropout at St. Lawrence Community Mental Health Center Out-Patient Clinic was undertaken to investigate (1) the referral process and its relationship to pre-intake dropout, (2) the extent of help-seeking after pre-intake dropout, (3) the help-seeking patterns, precipitating problems, prior mental health experience and expectations in regard to service of pre-intake dropouts, and (4) demographic variables in relationship to pre-intake dropout. In addition, the method of home interviews used in the study was to (5) provide a service to the pre-intake dropout by providing information about the mental health center and clear up any misunderstandings between client and clinic that might have led to pre-intake dropout. The study was also aimed at (6) providing feed-back to the clinic administration in regard to how policy and procedure affect dropout rate and attitudes of pre-intake dropouts.

Through examining clinic statistics and conducting 40 home interviews of pre-intake dropouts, the following information was obtained.

There was a 17% pre-intake dropout rate of new and re-referred individuals to the out-patient clinic during the year 1969. There was a high degree of mobility of the pre-intake dropout population.

Persons referred to the out-patient clinic were often referred either by a relative or by persons working with the client over an extended period of time. Persons referred to the emergency service were referred by physicians who had limited prior contact with the client. Fifty percent of pre-intake dropouts were involved with other community agencies such as the courts, welfare, Aid to Dependent Children, or the schools. One-half of the pre-intake dropout population had close relatives involved with mental health at some time. One-half of the pre-intake dropout population had themselves been involved with mental health resources prior to this contact. Persons using the Emergency Service had a significantly higher rate of prior experience than those using the Out-Patient Service. Mothers of children referred to the Out-Patient clinic who agreed with the referral had a significantly higher rate of prior experience than those who disagreed with the referral. The rate of follow-through with other help sources after contact with the mental health center was unrelated to prior mental health experience of pre-intake dropouts.

Persons contacting the Out-Patient Clinic and the Emergency Service had both chronic and acute or first time

conditions. Chronicity was unrelated to follow-through elsewhere.

The population interviewed tended to be young, predominantly women, and ten cases were on ADC or Welfare. Using $5,000 as an estimate of low or high income, one-half of the population had incomes below $5,000 and one-half had incomes above $5,000. Income was unrelated to follow-through elsewhere.

Reasons persons gave for not following-through at the Community Mental Health Center Out-Patient Clinic centered on the clinic not contacting them, alleviation of symptoms (either through active attempts to reduce symptoms or a passive disappearance of symptoms), and the use of other help sources including friends and relatives.

The population sampled tended to be uninformed about the services offered by the Mental Health Center and were especially ignorant of cost and services provided. A major request for service was that persons be seen right away rather than being forced to wait. Also requested were emergency service and a phone-in emergency service.

Pre-intake dropout rate can be expected to be reduced if there is no waiting list. Furthermore, the attitude of pre-intake dropouts toward the clinic improves if they are seen right away since they do not become dropouts due to a waiting list. There were no complaints about the Emergency Service and the Emergency Service given to persons does not

lead to pre-intake dropout in a negative sense. However, Emergency Service does lead to dropout in the Out-Patient Clinic in that the person feels better after being seen resulting in his no longer needing or wanting service.

The present follow-up procedure of the Out-Patient clinic, sending a letter to persons who do not keep their appointments, seems adequate.

Several suggestions to reduce pre-intake dropout can be made. First, working with agencies already involved with a person or family to determine if a referral is necessary. Second, the setting up of guidelines for referrals from other agencies would be helpful. Third, to lessen time wasted on "no shows," emphasize to the client the importance of calling in and cancelling appointments. Fourth, seeing persons immediately is preferable to having a waiting list. It reduces negative attitudes toward the clinic and the dropout rate.

It is suggested that the majority of pre-intake dropouts are not seeking psychotherapy in the traditional sense of long-term treatment. Most are seeking help through a critical period of time and use mental health resources in a manner similar to how others may use a minister or family physician. In addition, some referrals were redundant in that the person already had a caseworker, visiting nurse, or doctor who was consulted by the person and who was actually a help source.

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# APPENDICES

# APPENDIX I

## FORMS: OUTPATIENT DATA SYSTEM

# PERSONAL DATA

## Outpatient Data System

| 1. CASE NUMBER | FAM. |
|---|---|
| | |

FACILITY CODE AND NAME 580 - CMHC - St. Lawrence

| 2. NAME (Last, First, Middle) | 3. TYPE OF PROBLEMS * 1st / 2nd / 3rd | 4. CENSUS TRACT |
|---|---|---|
| | | |

| 5. SEX | 6. REFERRAL DATE | 7. REF. SOURCE CODE * | 8. REFERRAL SOURCE (Optional) |
|---|---|---|---|
| ☐ 1. Male ☐ 2. Female | | | |

| 9. SCHOOL CODE | 10. EDUCATION (No. of Grades Completed) | 11. SCHOOL CLASS ATTENDED |
|---|---|---|
| | | ☐ 01 Graded ☐ 02 Ungraded |

| 12. SOCIAL SECURITY NO. | 13. BIRTHDATE | 14. BIRTH PLACE (Mich. County Code) ** |
|---|---|---|
| | | |

**15. MARITAL STATUS**

- ☐ 01 Never Married
- ☐ 02 Married
- ☐ 03 Separated
- ☐ 04 Widowed
- ☐ 05 Divorced
- ☐ 06 Widowed & Remarried
- ☐ 07 Divorced & Remarried
- ☐ 08 Unknown

**16. LIVING GROUP (MAX. 4 CHOICES)**

- ☐ 01 Alone
- ☐ 02 Spouse
- ☐ 03 Children
- ☐ 04 Parents
- ☐ 05 Other Relatives
- ☐ 06 Friends
- ☐ 07 Foster Home
- ☐ 08 Institution
- ☐ 09 Unknown

**17. LIVING SITUATION**

- ☐ 01 Own Home
- ☐ 02 Rented Home
- ☐ 03 Rented Room/Apt.
- ☐ 04 Boarding Home
- ☐ 05 Hotel
- ☐ 06 Nursing Home
- ☐ 07 Contract Home
- ☐ 08 Family Care
- ☐ 09 Halfway House
- ☐ 10 Institution
- ☐ 11 Other
- ☐ 12 Unknown

| 18. MILITARY SERVICE | 19. NO. OF DEPENDENTS OF HEAD OF HOUSE | 20. PATIENT'S PROFESSION Code * | 21. PATIENT'S CURR. OCCUPATION Code * |
|---|---|---|---|
| ☐ 01 Yes ☐ 02 No ☐ 03 Unknown | | 22. SPOUSE'S PROFESSION Code * | 23. SPOUSE'S CURR. OCCUPATION Code * |

| 24. GROSS ANNUAL FAMILY INCOME | 25. PRIOR MENTAL HOSPITALIZATION | 26. HOSPITAL CODE ** | |
|---|---|---|---|
| | ☐ 01 Yes ☐ 02 No ☐ 03 Unknown | 27. RELEASE CODE * | 28. RELEASE DATE |

| 29. PREV. SERVICE * | 31. VOCATIONAL TRAINING | 32. ETHNIC GROUP | 33. RELIGION |
|---|---|---|---|
| | ☐ 01 None | ☐ 0 Caucasian | ☐ 0 Catholic |
| | ☐ 02 Div. of Vocational Rehab. | ☐ 1 Negro | ☐ 1 Jewish |
| 30. CURR. SERVICE * | ☐ 03 Mich. Employment Security Comm. | ☐ 2 Am. Indian | ☐ 2 Protestant |
| | ☐ 04 Other | ☐ 3 Oriental | ☐ 3 Other |
| | ☐ 05 Unknown | ☐ 4 Mexican | ☐ 4 None |
| | | ☐ 5 Other | ☐ 5 Unknown |

34. REMARKS

*See Reverse Side

**See Instruction Manual

. OFFICE

ON ALL ITEMS TO BE FILLED IN (RATHER THAN X'ed) USE:

"NA" for Not Applicable
"NK" for Not Known
"NO" for None

## TYPE OF RELEASE

31. Withdrew
41. Family Care
51. Convalescent Status
61. Leave of Absence
71. Escape
81. Discharge

## CATEGORY OF PROBLEM

01. Academic Underachievement
02. Agitated Depression
03. Alcoholism
04. Anxiety
05. Bizarre Behavior
06. Compulsive Behavior
07. Confusion
08. Cruelty
09. Daydreaming
10. Defiance
11. Delusions
12. Depression
13. Drug Addiction
14. Eating Problems
15. Enuresis
16. Excessive Guilt Feelings
17. Fatigue
18. Fire Setting
19. Hallucinations
20. Hyperactivity
21. Indecisiveness
22. Inferiority Feelings
23. Marital Problems
24. Masturbation
25. Nailbiting
26. Obsessions
27. Occupational Maladjustment
28. Phobias
29. Physical Complaints Related to, or Caused by Psychological Disturbances
30. Poor Social Adjustment
31. Problems Arising from Neurological Impairment
32. Reading
33. Retardation
34. Sexual Offenses
35. Sexual Problems
36. Speech
37. Stealing
38. Suicide Attempt
39. Suicide Gesture
40. Suicide Thoughts
41. Suspiciousness
42. Temper Tantrums
43. Thumbsucking
44. Truancy
45. Withdrawal
46. Other Bladder or Bowel Control P
47. Other Antisocial Behavior Not L
48. Other Destructiveness Not Listed
49. Other Agressive Behavior Not L
50. Other Problems Not Listed

## REFERRAL SOURCE, PREVIOUS SERVICE, CURRENT SERVICE

01. Alcoholics Anonymous
02. Boarding Care
03. Children's Residential Treatment Center
04. Clergy
05. Court(s)
06. Day Care Center
07. Employment Service
08. Employer
09. Foster Parent(s)
10. Friend(s)
11. Guardian(s)
12. General Hospital
13. Local Health Department
14. Nursing Home
15. Parent(s)
16. Private Mental Hospital
17. Private Physician
18. Private Psychiatrist
19. Private Psychologist
20. Psychiatric General Hospital
21. School
22. School for Retarded
23. Self
24. Sibling(s)
25. Social Service Agency
26. Spouse
27. State Mental Hospital
28. Vocational Rehabilitation
29. Other Health Agency
30. Other Psychiatric Outpatient
31. Other Psychological Service
32. Other Public Mental Hospital
33. Other Relatives
34. Other
35. Center for Forensic Psychiatry
36. Child Care Center
37. Court, Circuit
38. Court, Probate
39. Court, Recorders
40. Day Training Center (MR)
41. Marital Counselor
42. Police Agency or Agent(s)
43. Prison or Other Correctional F
44. Private Social Worker

## OCCUPATION

01. Professional, Technical and Managerial
02. Clerical and Sales
03. Service Occupations
04. Farming, Fishing, Forestry (Laborers)
05. Processing Occupations
06. Machines, Trades
07. Bench Work
08. Structural Work
09. Miscellaneous
10. Student
11. Unemployable Child
12. Unemployable (Other)
13. Unemployed
14. Homemaker
15. Retired

Back

# T E R M I N A T I O N / D E L E T I O N N O T I C E

## Outpatient Data System

FACILITY CODE & NAME: 580 - CMHC - St. Lawrence

| 1. CASE NUMBER | FAM | 2. NAME (Last, First, Middle) | 3. EFF DATE |
|---|---|---|---|
| ___ ___ ___ ___ ___ ___ | ___ | | |

**Deletions Only (Item 4)**

4. REASON FOR DELETION

- ___ 01 Patient was not contacted or could not be contacted.
- ___ 02 Patient refused service.
- ___ 03 Service not required.
- ___ 04 Patient referred elsewhere.
  ___ ___ *(Referral Code)
- ___ 05 Other (Specify here)

**Terminations Only (Items 5 thru 9)**

5. REASON FOR TERMINATION

- ___ 01 Required service completed.
- ___ 02 (Do not use.)
- ___ 03 Further service refused.
- ___ 04 Service needed - Not available
- ___ 05 Other community service needed.
- ___ 06 Referred elsewhere.
  ___ ___ *(Referral Code)
- ___ 07 Moved out of service area
- ___ 08 Stopped coming without notice.
- ___ 09 Natural or accidental death.
- ___ 10 Death by suicide.
- ___ 11 Other (Specify here)

6. CONDITION ON TERMINATION

- ___ 1 Markedly improved
- ___ 2 Somewhat improved
- ___ 3 Condition unchanged
- ___ 4 Condition worsening
- ___ 5 Not treated

7. DIAGNOSIS *Enter 333.33 if undiagnosed. Use APA Diagnostic and Statistical Manual, II 1968.

___ ___ ___ • ___ ___

8. I.Q. SCORE

___ ___ ___ ← Enter 0 0 0 if no test given.

9. I.Q. TEST GIVEN (Check ONE only)

- ___ 01 Stanford Binet
- ___ 02 Hayes - Binet
- ___ 03 W A I S Full scale
- ___ 04 W A I S Verbal Scale Only
- ___ 05 W A I S Performance Scale only
- ___ 06 W I S C Full Scale
- ___ 07 W I S C Verbal scale only
- ___ 08 W I S C Performance scale only
- ___ 09 Cattel
- ___ 10 Peabody
- ___ 11 Columbia
- ___ 12 Other (Specify here)

*For referral and diagnostic codes see the reverse of this sheet.

MICHIGAN DEPARTMENT OF MENTAL HEALTH
D M H -0203 (1/70)

# MICHIGAN DEPARTMENT OF MENTAL HEALTH – DIAGNOSTIC CODES

## I MENTAL RETARDATION

317. Mild I.Q. 52-67
318. Moderate I.Q. 36-51
319. Severe I.Q. 20-35
319. Profound I.Q. under 20
315. Unspecified

With each, following or associated with
.0 Infection or intoxication
.1 Trauma or physical agent
.2 Disorders of metabolism, growth or nutrition
.3 Severe brain disease postnatally
.4 Unknown prenatal influence
.5 Chromosomal abnormality
.6 Prematurity
.7 Major psychiatric disorder
.8 Psychosocial (environmental) deprivation
.9 Other condition

## II ORGANIC BRAIN SYNDROMES (OBS)

### A PSYCHOSES

Senile and presenile dementia
290.0 Senile dementia
290.1 Presenile dementia

**Alcoholic psychosis**
291.0 Delirium tremens
291.1 Korsakov's psychosis
291.2 Other alcoholic hallucinosis
291.3 Alcohol paranoid state
291.4 Acute alcohol intoxication
291.5 Alcoholic deterioration
291.6 Pathological intoxication
291.9 Other alcoholic psychosis

**Psychosis associated with intracranial infection**
292.0 General paralysis
292.1 Syphilis of central nervous system
292.2 Epidemic encephalitis
292.3 Other and unspecified encephalitis
292.9 Other intracranial infection

**Psychosis associated with other cerebral condition**
293.0 Cerebral arteriosclerosis
293.1 Other cerebrovascular disturbance
293.2 Epilepsy
293.3 Intracranial neoplasm
293.4 Degenerative disease of the CNS
293.5 Brain trauma
293.9 Other cerebral condition

**Psychosis associated with other physical condition**
294.0 Endocrine disorder
294.1 Metabolic and nutritional disorder
294.2 Systemic infection
294.3 Drug or poison intoxication (other than alcohol)
294.4 Childbirth
294.8 Other and unspecified physical condition

### B NON-PSYCHOTIC OBS

309.0 Intracranial infection
309.13 Alcohol (simple drunkenness)
309.14 Other drug, poison or systemic intoxication
309.2 Brain trauma
309.3 Circulatory disturbance
309.4 Epilepsy
309.5 Disturbance of metabolism, growth, or nutrition
309.6 Senile or presenile brain disease
309.7 Intracranial neoplasm
309.8 Degenerative disease of the CSN
309.9 Other physical condition

## III PSYCHOSES NOT ATTRIBUTED TO PHYSICAL CONDITIONS LISTED PREVIOUSLY

Schizophrenia
295.0 Simple
295.1 Hebephrenic
295.2 Catatonic
295.23 Catatonic type, excited
295.24 Catatonic type, withdrawn
295.3 Paranoid
295.4 Acute schizophrenic episode
295.5 Latent
295.6 Residual
295.7 Schizoaffective
295.73 Schizoaffective, excited
295.74 Schizoaffective, depressed
295.8 Childhood
295.90 Chronic undifferentiated
295.99 Other schizophrenia

**Major affective disorders**
296.0 Involutional melancholia
296.1 Manic-depressive illness, manic
296.2 Manic-depressive illness, depressed
296.3 Manic-depressive illness, circular
296.33 Manic depressive, circular, manic
296.34 Manic depressive, circular, depressed
296.8 Other major affective disorder

**Paranoid states**
297.0 Paranoia
297.1 Involutional paranoid state
297.9 Other paranoid state

**Other psychoses**
298.0 Psychotic depressive reaction

## IV NEUROSES

300.0 Anxiety
300.1 Hysterical
300.13 Hysterical, conversion type
300.14 Hysterical, dissociative type
300.2 Phobic
300.3 Obsessive compulsive
300.4 Depressive
300.5 Neurasthenic
300.6 Depersonalization
300.7 Hypochondrical
300.8 Other neurosis

## V PERSONALITY DISORDERS AND CERTAIN OTHER NON PSYCHOTIC MENTAL DISORDERS

**Personality disorders**
301.0 Paranoid
301.1 Cyclothymic
301.2 Schizoid
301.3 Explosive
301.4 Obsessive compulsive
301.5 Hysterical
301.6 Asthenic
301.7 Antisocial
301.81 Passive-aggressive
301.82 Inadequate
301.89 Other specified types

**Sexual deviation**
302.0 Homosexuality
302.1 Fetishism
302.2 Pedophilia
302.3 Transvestitism
302.4 Exhibitionism
302.5 Voyeurism
302.6 Sadism
302.7 Masochism
302.8 Other sexual deviation

**Alcoholism**
303.0 Episodic excessive drinking
303.1 Habitual excessive drinking
303.2 Alcohol addiction
303.9 Other alcoholism

**Drug dependence**
304.0 Opium, opium alkaloids and their derivatives
304.1 Synthetic analgesics with morphine-like effects
304.2 Barbiturates
304.3 Other hypnotics and sedatives or "tranquilizers"
304.4 Cocaine
304.5 Cannabis sativa (hashish, marihuana)
304.6 Other psychostimulants
304.7 Hallucinogens
304.8 Other drug dependence

## VI PSYCHOPHYSIOLOGIC DISORDERS

306.0 Skin
306.1 Musculoskeletal
306.2 Respiratory
306.3 Cardiovascular
306.4 Neurologic and sympathic
306.5 Gastrointestinal
306.6 Genitourinary
306.7 Endocrine
306.8 Organ of special sense
306.9 Other type

## VII SPECIAL SYMPTOMS

307.0 Speech disturbance
307.1 Specific learning disturbance
307.2 Tic
307.3 Other psychomotor disorder
307.4 Disorders of sleep
307.5 Feeding disturbance
307.6 Enuresis
307.7 Encopresis
307.8 Cephalalgia
307.9 Other special symptoms

## VIII TRANSIENT SITUATIONAL DISTURBANCES

307.20 Adjustment reaction of infancy
307.21 Adjustment reaction of childhood
307.22 Adjustment reaction of adolescence
307.23 Adjustment reaction of adult life
307.24 Adjustment reaction of late life

## IX BEHAVIOR DISORDERS OF CHILDHOOD AND ADOLESCENCE

308.0 Hyperkinetic reaction
308.1 Withdrawing reaction
308.2 Overanxious reaction
308.3 Runaway reaction
308.4 Unsocialized aggressive reaction
308.5 Group delinquent reaction
308.9 Other reaction

## X CONDITIONS WITHOUT MANIFEST PSYCHIATRIC DISORDER AND NON SPECIFIC CONDITIONS

**Social maladjustment without manifest psychiatric disorder**
316.0 Marital maladjustment
316.1 Social maladjustment
316.2 Occupational maladjustment
316.3 Dyssocial behavior
316.9 Other social maladjustment

**Non-specific conditions**
317 Non-specific conditions

**No Mental Disorder**
318 No mental disorder

## XI NON DIAGNOSTIC TERMS FOR ADMINISTRATIVE USE

319.0 Diagnosis deferred
319.1 Boarder
319.2 Experiment only
319.3 Other

333.30 Not examined
333.33 Undiagnosed

## FIFTH DIGIT QUALIFYING PHRASES

| Section II | Section III | Sections IV through IX | All disorders |
|---|---|---|---|
| .X1 Acute | .X6 Not psychotic now | .X6 Mild | .X5 In remission |
| .X2 Chronic | | .X7 Moderate | |
| | | .X8 Severe | |

## REFERRAL SOURCE

01. Alcoholics Anonymous
02. Boarding Care
03. Children's Residential Treatment Center
04. Clergy
05. (Deleted)
06. Day Care Center
07. Employment Service
08. Employer
09. Foster Parent(s)
10. Friend(s)
11. Guardian(s)
12. General Hospital
13. Local Health Department
14. Nursing Home
15. Parent(s)
16. Private Mental Hospital
17. Private Physician
18. Private Psychiatrist
19. Private Psychologist
20. Psychiatric General Hospital
21. School
22. School for Retarded
23. Self
24. Sibling(s)
25. Social Service Agency
26. Spouse
27. State Mental Hospital
28. Vocational Rehabilitation
29. Other Health Agency
30. Other Psychiatric Outpatient
31. Other Psychological Service
32. Other Public Mental Hospital
33. Other Relatives
34. Other
35. Center for Forensic Psychiatry
36. Child Care Center
37. Court, Circuit
38. Court, Probate
39. Court, Recorders
40. Day Training Center (MR)
41. Marital Counselor
42. Police Agency or Agent(s)
43. Prison or Other Correctional Facility
44. Private Social Worker

# APPENDIX II

## PRE-INTAKE DROPOUT FOLLOW-UP QUESTIONNAIRE

PRE-INTAKE DROPOUT FOLLOW-UP QUESTIONNAIRE

Hello (name). I am interviewing a number of people as part of a research project connected with St. Lawrence Community Mental Health Center. We are interested in people's attitudes toward mental health and finding out more about the people who may need our services. The answers you give are, of course, confidential. We hope to use the information we get from this survey to improve our services. The interview takes about 30 to 45 minutes. Do you have any questions?

All right, let us begin. Most people in their lifetime are faced with different types of problems. Sometimes they have a personal problem such as feeling nervous, irritable, depressed, or unhappy. At other times they might have problems within their marriage or with their children. People tend to handle these problem times in different ways. Some talk to other people, such as their doctor, minister, friends, relatives, or psychiatrist. Others tend to keep things to themselves, trying to work things out by themselves. I am going to ask you a few questions now so that I might know what you might tend to do at times like these.

1) Let us say you were concerned, worried, troubled, or nervous about something, you had a personal problem; who do you think would be best able to help you at a time like this?

1a) Is this the person you usually talk to? Y___N___

1b) Is there anyone else you might talk to? Y___N___

2) What if you were having a problem within your marriage, who do you think you would talk to?

2a) Is there anyone else you might talk to? Y___N___

3) What if you were having some type of problem with your children, who would you tend to talk to?

3a) Is there anyone else you might talk to? Y___N___

3b) Have you ever had occasion to talk with anyone about your children?

4) Would you say that you prefer talking to relatives when you need help with problems or do you prefer talking to people outside of the family; what is your usual pattern?

5) Do you think that most of your friends follow the same pattern that you do when they have problems? Y___N___

5a) How do they do things?

5b) Which way would you say is better?

6) Do you think that most people handle their problems the same way that you do? Y___N___

6a) How do you think most people handle their problems?

6b) Which way would you say is better? Yours or theirs?

People have many different attitudes toward someone with emotional or psychological problems. Some people feel that such a person is weak, sick, or weak of character. Other people feel such a person should go for help.

7) If you knew that a person was seeing a psychiatrist or going to a mental health clinic do you think this would affect your attitude toward that person in any way?

7a) Do you happen to know anyone that is seeing a psychiatrist or going to such a clinic?

8) If you knew that a person had been in a mental hospital or had been in a hospital such as St. Lawrence for a nervous breakdown, emotional or psychological problems, do you think your attitude would change toward that person?

8a) Do you happen to know of anyone that has been hospitalized for such reasons?

9) Have you yourself ever had occasion to be in treatment with a psychiatrist or other mental health professional or have you ever been hospitalized for emotional upsets?

10) What is your opinion about a child going to a mental health clinic or child guidance clinic?

10a) Do you know of anyone who has had to take their children to such a clinic, or have you ever had occasion to take your own children?

People have many different ways in which they find out about mental health services and different reasons for contacting an agency. I believe you contacted St. Lawrence Mental Health Clinic in (month). Is that correct?

11) Can you tell me how you found out about the clinic?

11a) Were you actually referred there? Y___N___

11b) Had you heard about the clinic from any other source, any other person or say the newspaper?

If referred: At the time (name of person) referred you to the clinic do you remember if you agreed or disagreed with them that you needed service?

Agree _____
Disagree_____

11c) What was their idea of the problem?

11d) What was your idea of the problem?

If disagreed about referral: What did you think should be done?

12) Had this occurred before? Y___N___

If occurred before: What did you do about it the last time?

How did things turn out the last time?

I am very interested in how people make up their mind to get in touch with a clinic. How they feel at the time, what things go through their mind, what things they consider. I would appreciate it if you could tell me in detail how you made up your mind to call (or come in) when you did.

13) What would you say you were most concerned about?

14) Did you consider anything else that you haven't mentioned?

19) Did you talk to anyone else?

20) Did anyone try to talk you out of going to the clinic?

21) If seen in emergency: often times women tend to become upset just before or during their menstrual period, do you happen to recall if it was close to your period when you called (or came in)? Y___N___

22) Were you helped at all by your contact?

Oftentimes, after a person makes an initial phone call or comes in one time they change their mind about wanting to come to the clinic for service. For one reason or another they decide against further service. As I mentioned before, I am interested to know how people make up their minds to come or not to come to the clinic. Can you tell me in detail how and why you decided not to come to the clinic?

23) What lead you to change your mind; what things did you consider?

26) Was there anything else you thought of or did?

27) Did you talk with anyone else about your problem after you got in touch with the clinic?

Did they help?
Did anyone try and talk you out of going to the clinic after your first call?

28) How did the problem you called about get worked out? How are things now?

29) Sometimes people are afraid of meeting someone new or talking with a strange person about personal matters. Do you remember being afraid at all of the idea of coming to the clinic? Were you afraid of anything at all?
Y___N___

Different people want, need, and expect different things from a clinic. For instance, different types of services or a particular type of professional help.

15) Can you tell me what you wanted from the clinic when you called?

16) When you contacted the clinic did you want to see a particular type of professional person?

17) Did you ask to see anyone in particular when you called? Y___N___

18) Did you have a preference for seeing a man or woman?
Y___N___

19) Did you have an age preference?

20) Can you tell me what happened when you contacted the clinic?

21) How did you feel about what happened, about your contact with the clinic?

As I mentioned before, one of the reasons for this survey is to find out if there is some type of service we might provide that we are not presently providing which you might want. We also would like to know how informed the community is about our services and what obstacles may stand in the way of a person such as yourself taking advantage of the services we do provide now. I would like to ask you a few questions now about these areas.

28) Did you have some idea of the cost involved in coming to the clinic when you called? Y___N___

29) Did you have some idea of how long it would take before you would be seen? Y___N___

29) Once you were seen did you have some idea of how long it would take to solve the problem? Y___N___
Guess___

30) Are you familiar with all of the services offered by the Community Mental Health Center? Y___N___

31) Is there any service you can think of that you would like that we do not have presently?

32) If it were available, would you prefer someone coming to your home or do you prefer appointments in the clinic?
Home___
Clinic___

33) What is your preferred time for appointments?
Day___
Evening___
Weekend___

34) If there were a mobile unit coming into your neighborhood would you prefer this to clinic or home appointments?

35) Would you prefer going to a clinic that is closer than St. Lawrence?

36) Other

I would like to know what might be particular problems for you in coming to the clinic. I will mention a few things and you can let me know if these are problems for you.

Cost

Transportation

Babysitters

Inconvenient appointment times

Can't get away from job

Anything else?

If in the future you should be having some trouble do you think you would contact the clinic again?

Now, if you don't mind, I would like to ask you a few personal questions which you may feel free not to answer if you wish. As I mentioned before, all of the information you give me is strictly confidential.

About how old are you? Age___
About how old is your spouse? Age___
Are you: Married___Single___Divorced___Separated___
Were either you or your spouse married before? Husband___
Wife___
How many children do you have? ___ Ages_____
What is the occupation of the head of the household?_____
Does spouse work?___ Occupation_____
Can you give me an estimate of the family income
$3-5,000, $5-7,000, $7-10,000, over $10,000
How much education do you have? Grade_____
How much education does your spouse have? Grade_____
Do you rent or are you buying your home? _____

Can you think of anything else that might be helpful to us in any of the areas we have talked about today?

Thank you very much for your cooperation.

Interviewer's impressions: