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**CLIENT CHARACTERISTICS AND WAITING TIME EFFECTS
AT A CHILD, ADOLESCENT AND FAMILY
MENTAL HEALTH SERVICE**

**Mariella Moana Trynes
1998**

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A thesis presented in partial fulfilment
of the requirements for the degree
of Masters of Arts in Psychology
at Massey University

Mariella Moana Trynes
1998

ABSTRACT

The present study was of a prospective, longitudinal design which provided a 'snap-shot' overview of a Child, Adolescent, and Family Mental Health Service (CAFS). The present study had three main objectives. The first objective was to describe the characteristics of clients referred to CAFS assigned to the different priority categories. The second objective was to determine the typical waiting times for clients attending CAFS. The third objective was to determine what changes in problem symptomatology or problem severity occur whilst clients wait for their initial appointment. Two hypotheses were tested. The first was that those who are placed on the High priority wait list will have significantly higher levels of symptomatology than those on the Medium priority wait list. The second was that as wait time increases, problem severity will also increase. Participants consisted of parents/caregivers of consecutive clients who were placed on a High or Medium priority waitlist. Parents/caregivers completed the Child Behaviour Checklist (CBCL) measure when first placed on the waitlist and again before they attended their initial appointment at the service. Clients assigned to the non-wait listed categories (Crisis or Urgent) tended to consist of older females, whereas those assigned to the wait listed categories (High and Medium priority wait list) tended to consist of younger males. Results indicated that wait time did not affect problem severity, nor did problem severity differ for High and Medium priority clients. The discussion focused on the implications of the findings with regards to managing mental health waiting lists.

This thesis is dedicated to my wonderful family, Dad, Mum, Lucielle,
Nick and Matthew.

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CHAPTER ONE

Overview

In recent years there has been a growing public awareness regarding a series of issues relating to child and adolescent mental health disorders. These concerns have been reflected in an increasing number of reports, which have focused on mental health problems experienced by youth in New Zealand. An overview of the literature has revealed that it is widely accepted in many mental health agencies that demands for services exceeds available staff resources. A common administrative procedure to deal with demands for counseling services is the waiting list (Anderson, Hogg & Magoon, 1987).

Past research has primarily focused on adult attrition or 'drop out' rates during wait lists. Little research has been conducted on possible effects that wait time itself may have on clients' problem behaviour while waiting for their initial appointment.

Long wait lists are generally regarded by practitioners as having a negative effect on clients. Few research investigations have examined the influence that waiting times may have on attrition rates after intake, or treatment attendance, as well as what happens to clients within the time span between referral and initial appointment.

Along with the development of the wait list, has come the development of categories to determine who is appropriate for agency services, and how severe the identified problem behaviour is, which in turn influences how

quickly the client will be seen for their initial appointment (ie. intake and wait list criteria). Counselling services are more aware of the increased demand for their services than in the past; thus, more effective referral and intake procedures are being developed to help those who need it the most.

The aim of this present study was to obtain information about clients at a Child, Adolescent and Family Mental Health Service located in Palmerston North, New Zealand. At present in New Zealand, public mental health services for children and adolescents are provided by Child, Adolescent and Family Mental Health Services (CAFS). These services provide specialist assessment and treatment services free of charge, and are primarily situated in urban centres (Ministry of Health, 1997).

Wait Lists

In New Zealand it is generally recognised that mental health problems among youth are increasing. This has been reflected in significant increases in a range of childhood and adolescent disorders; including conduct problems, depression, substance abuse and youth suicides (Ministry of Health, 1994; 1995; 1996a; 1996b; 1997). This increase in reported mental health problems is of special concern considering that *“young people aged between 0-19 years of age account for approximately 23% of the population and that their mental health problems can have a major impact on the community”* (Ministry of Health, 1997, p. 4).

There has been general discontent with mental health service provision due to the lack of funding and resources. Past research regarding mental health services (both in community and university settings) have focused on how

existing staff numbers cope with the vast influx of people in need of counselling services (Novick, Benson & Rembar, 1981; Parrish, Charlop & Fenton, 1986). Research has also investigated the subsequent effect of waiting lists on clients attendance and changes in problem severity (Anderson et al. 1987; Cole & Magnussen, 1967; Freund, Schweitzer & Russell, 1991; Gould, Shaffer & Kaplan, 1985; Leigh, Ogborne & Cleland, 1984; Nimgaonkar & Farrell, 1988; Stern & Brown, 1994; Viale-Val, Rosenthal, Curtiss & Marohn, 1984).

With the apparent increase of mental health problems among children and adolescents in our communities, it is more than likely that demands on our mental health services will continue to increase and overwhelm existing resources. The ability of mental health services to keep up with these demands requires a range of administrative processes such as intake and appointment procedures. These procedures include: assessment interviews, being seen without an appointment, for example, walking in off the street (Bernal & Kreutzer, 1976), referral letters/telephone calls (Hochstadt & Trybula, 1980; Kolko, Parrish & Wilson, 1985), self referrals, initial assessment and treatment sessions (Archer, 1984; Deane, 1991b; Schiller, 1976).

Before an initial appointment date can be established, potential clients must be screened by the mental health agency to determine whether referred clients do or do not meet the services' intake criteria. Intake criteria are a set of standardised descriptions of what does or does not constitute an acceptable referral into a service; such assessments are generally called intake procedures.

Waiting for treatment is a prevalent feature of many public health services across developed countries (Fraser, 1993). It is also widely accepted that in many mental health agencies, demands on existing services far out weigh available staff resources. A common administrative procedure to deal with this problem is to place people on a waiting list (Anderson et al. 1987; Archer, 1984; Stern & Brown, 1994).

It must be noted that not all CAFS within New Zealand have waiting lists, or similar intake procedures to those at the Palmerston North CAFS. Possible reasons for variations among these services can be attributed to differences in population numbers, funding, and demographic areas, as well as differing service structures.

Defining Service Wait Time

Wait time, as defined by Stern and Brown (1994) is *"the number of days between the date that the case was referred to the clinic and the date for which the first appointment was offered"* (p. 223).

The majority of articles reviewed regarding wait lists generally focus on the time between referral from a referral agent to the initial appointment contact (Freund et al. 1991; Friman, Finney, Rapoff & Christophersen, 1985; Lowman, DeLange, Roberts & Brady, 1984; Raynes & Warren, 1970; Raynes & Warren, 1971; Wolkon, 1972). Little thought has been given to the time waited before the referral to a mental health service. It could be the case that clients and their parents may already have spent a considerable amount of time 'waiting' for improvement in their child's problem behaviour, before seeking a referral to a mental health service (Fraser, 1993).

Consequently, when the problem behaviour becomes worse and the family is experiencing a Crisis, it may well be that contact is established with an agency as a 'cry for help' (Kournay, Garber & Tornusciolo, 1990). In other words, contact with the mental health service is only initiated when the problem behaviour reaches a Crisis point. Thus, the total wait time parents may experience with their child could actually be longer than anticipated by previous researchers.

Wait lists perform an important role in determining who will be seen and when. Increased demand for services, coupled with shrinking resources has created the wait list as a temporary means to deal with under resourcing (Anderson et al. 1987). However, it appears that this temporary measure has now become a standard procedure to cope with continued demand. The first step towards a client being seen by a professional at a mental health service begins with the referral procedure.

Referral Procedures

A common practice for community mental health services is to encourage referrals from a variety of sources, due to the fact that referrals are a source of income for certain agencies. In the case of the Palmerston North CAFS (a service provided free of charge), referral criteria allow potential referral agents to know what CAF services can provide for their clients. Referral sources may range from self and family referrals, General Practitioners, Schools, Special Education Services (SES), to small community youth groups (ie., One Stop Youth Shop). Frequently, a letter from a referral agent arrives requesting an assessment and/or treatment for their client. A referral is given to the mental health service when a health professional assumes

that; (I) the client is in need of help, (II) the need will continue to be felt as long as it takes for the referral letter to arrive at the service, (III) the need is concerning a mental health problem (Newnes, 1988).

Occasionally a referral is given over the telephone. When this is the case, the required information is gathered from the caller. Information collected generally includes; name, address, contact telephone number, and a detailed description of the problem behaviour (Deane, 1991a). This information allows the service to determine the nature and severity of the clients' problem behaviour. With this information an intake interview can then be arranged with the client over the telephone.

The referral agent performs a significant role in the referral process. The possible effects of referrer biases which may occur in the relationship between the referral agent and their clients should be considered. These influences have been described as 'practitioner effects' by Newnes (1988).

The following describes several biases with regards to practitioner effects that referral agents should take into account when referrals are made. Firstly, stressors in the referral agents' personal and/or professional life may decrease tolerance of a client's problem hence prompting a referral (which otherwise may not have been made). Secondly, clients may simply be complying with a professional's assessment of their problem: the need to seek treatment coming from the referrer, not the client. Finally, referral agencies (ie., General Practitioners, Schools), may differ from mental health services in their perceptions of what constitutes an appropriate referral.

Although 'practitioner effects' are an important consideration with regards to referrer bias, few studies have examined the possible influences of these effects on the referral process. Practitioner effects are important factors to consider in service provision, in that inappropriate referrals lead to waste of staff time and service resources, which otherwise divert attention from those in real need of mental health services (Newnes, 1988).

Clients who are referred to the service, yet later have to be removed are problematic, as they inadvertently delay acceptable clients from being seen and increase waiting times for existing wait listed clients (Deane, 1991a, Kournay et al. 1990). With this in mind McGeorge (1995; cited in Ministry of Health, 1997) suggested that specialist services such as CAFS develop standardised intake criteria in order to determine who is, and who is not, eligible for their services.

Intake Procedures

Intake procedures perform an important role in the service delivery of mental health agencies. They provide a standardised set of criteria which help staff determine client eligibility. This allows for a consistent basis from which to rate potential clients' problem severity and to determine at which wait list priority level the client should be placed (Stern & Brown, 1994). While intake procedures vary from service to service, clients with severe problems classified as being either Crisis or Urgent (for example, risk of self harm) are seen ahead of those on the wait list (Archer, 1984; Freund et al. 1991; Newnes, 1988; Stern & Brown, 1994).

Clients who are thought to be able to cope for some time without treatment are wait listed. So that the more severe cases can be seen first, priority is given to those clients who are in most need of treatment. Responsible services explain to clients that if the identified problem behaviour worsens to re-contact the service. Some services explain in detail potential wait lengths by providing a letter which states approximate times clients may have to wait before an initial appointment can be made (Carpenter, Morrow, Del Gaudio & Ritzler, 1981; Lefebvre, Sommerauer, Cohen, Waldron & Perry, 1983).

Clients are generally classified according to the DSM IV (American Psychiatric Association, 1994) based system, in order to classify problems which children and adolescents present. Due to the severity and nature of complaints referred to many mental health services, clients must be placed on a wait list due to service demand. To determine in what order clients should be placed on the wait list, intake criteria are usually applied. A research review of this topic has revealed that there appears to be little reported on agency intake procedures.

A crucial first step in the delivery of mental health services is the intake assessment. It must be recognised that different services do not always have similar assessment procedures. For example, some services use the initial appointment as a time to assess or diagnose problem behaviours and gather needed information, such as client's name, address, telephone number, sex, age, race, source of referral, date of referral, date of initial appointment and a brief description of the presenting problems (Hochstadt & Trybula, 1980). Other services gather this information over the telephone and/or through postal letters/questionnaires sent to clients (Deane, 1991a; Kournay et al. 1990). Intake interviews are similar to intake assessments in

that they perform the task of gathering appropriate information which is required for service inclusion and treatment.

Intake interviews are usually given within 1-7 days of requesting services (Benjamin-Bauman, Reiss & Bailey, 1984; Freund et al. 1991; Stern & Brown, 1994). Intake interviews have been described as therapeutic to the extent that they reduce the potential impact of a lengthy wait for counselling. Researchers have suggested that the intake appointment may result in the perception by clients that something is being done about their problem while they are waiting for their treatment session (Freund et al. 1991).

Intake Criteria

Given that the resources of public specialist mental health professionals are limited, these services must be targeted to those in most need. Thus, criteria are developed to determine who is eligible for services and who is in most need of help. These criteria are designed to promote efficiency and maintain the quality of services (Archer, 1984; Clack, Stone & Thurman, 1984).

Intake criteria provide clinicians with a set of standardised criteria for their service. These criteria serve as a 'screening device' which ensures that only clients who meet service criteria receive treatment (Ministry of Health, 1997). Below are guidelines published by the Ministry of Health (1997) which recommend intake criteria to determine eligibility for services in New Zealand Child, Adolescent and Family Mental Health Services.

Ministry of health's recommended intake criteria for child, adolescent and family mental health services

Eligibility for CAF services applies to children and adolescents who have:

- i) Severe behavioural difficulties and psychiatric disorders
- ii) A severe psychiatric disorder alone
- iii) Counselling or other intervention from other services that is inadequate for the child or young person's needs, or has been tried and has failed

The severity of the mental health problem is determined by:

- i) The type and duration of the mental health condition
- ii) The circumstances affecting the child or adolescent and their family/whanau
- iii) The capacity of the child or adolescent and their family/whanau to resolve the problem.

(Ministry of Health, 1997, p. 8)

When a referred client meets the intake criteria of an agency, the next step is to determine which wait type category the client should be given. Clients presented with different levels of urgency described by the referral agent are given different priority wait times for services. Thus, the more severe the problem behaviour is, the shorter the wait time should be for that individual. On the opposite end of the scale, the less severe the problem behaviour, the longer the wait time is to be expected (Fraser, 1993).

Wait List Criteria

Where a client will be ranked on the wait list depends on the severity of the identified clients' problem behaviour (Hansen, 1995). It is with this in mind that wait list criteria are developed. Wait list criteria assist an agency by providing a set of criteria which help indicate where that individual is ranked compared with others on the wait list. McGeorge (1995, cited in Ministry of Health, 1997) recommend that the following mental health disorders be used as guidelines for CAFS clinicians in determining High priority wait listings.

CAFS presenting problem considerations for the high priority wait list

- Major depression and complicated grief reactions
- Attention deficit disorders and disruptive behaviour disorders
- Eating disorders
- Substance abuse disorders
- Serious anxiety disorders
- Psychotic disorders especially bipolar mood disorder and Schizophrenia
- Serious unresolved post-traumatic stress disorders
- Emotional and behavioural problems associated with severe and/or chronic physical illness
- Situations where the child or adolescent has a serious mental health disorder and is a danger to themselves or others

(Ministry of Health, 1997, p.8)

After wait list categories have been assigned, the next step is the initial appointment treatment session. The initial appointment often referred to as the initial interview, diagnostic interview, exploratory interview or intake assessment, is the crucial first step in the delivery of services to clients. An initial appointment refers to the *"client's first face-to-face session with a staff*

member following a request for an appointment" (Hochstadt & Trybula, 1980, p. 261).

Authors have concluded that there is a significant relationship between failure to attend initial appointments and length of time between referral and appointment dates (Baekland & Lundwall, 1975; Folkins et al. 1980; Litt, 1970; Raynes & Warren, 1971; Stern & Brown, 1994; Wolkon, 1972). Client non-attendance at initial appointment has been found to cause significant problems for community mental health centres. For example, clients who do not attend their initial appointment become increasingly problematic, as these clients inadvertently delay others from being seen sooner (Deane, 1991a). Failure by clients' to keep their initial appointment is an on-going, perplexing problem for both clinicians and administrative staff.

Refer to Table 1.1 for a summary of studies investigating the effects of waiting for treatment.

Table 1.1

Summary of Studies Investigating the Effects of Waiting for Treatment.

Author(s)	Participants	Method	Results
Anderson, Hogg & Magoon (1987)	1,688 children offered treatment after intake appointment	Compared lengths of waiting lists on problem behaviour & attrition rates	Length of time spent on the wait list was not a significant factor in client attrition
Archer (1981)	35 students accepted for treatment, who refused treatment at a later date	Questionnaire requested reasons why clients refused treatment	16% stated that the wait lists was too long (71% questionnaire return rate)
Archer (1984)	59 students who were referred for treatment, yet did not attend their initial appointment	Questionnaire requested reasons why clients refused available treatment	51% felt that the intake meeting was enough to resolve the problem 19% of families stated that the wait was too long; 12% sought treatment elsewhere (88% questionnaire return rate)
Freund, Russell & Schweitzer (1991)	60 adults on wait lists waiting for treatment	Investigated the relationship between waiting for treatment and attrition rates	Waiting time before treatment session was not a factor in client attrition
Magder & Werry (1966)	87 children on wait lists waiting for treatment	Questionnaires administered to find if any changes in problem behaviour occurred over wait time	39.6% showed some degree of improvement over wait time 12.8% became much better 47.6% reported no change over wait time
Stern & Brown (1994)	411 children and adolescents assigned to either an 'Urgent' or wait listed category	Questionnaire requested family reactions of waiting for an unspecified length of time for an appointment, and whether this influences appointment attendance or not	A significant relationship was found between failure to attend initial appointments following the introduction of wait lists in a child and family mental health service

Effects Of Wait Lists

The following reasons have been suggested to explain why clients drop out from wait lists: (I) That wait times influence attrition rates, (II) the length of the wait list influences (dis)satisfaction with the services provided, (III) during wait time clients seek treatment elsewhere, (IV) symptomatic behaviour can 'spontaneously' improve over the wait time; or (V) that problem severity increases over wait time.

Length of wait time and attrition

In general, an increase in non-attendance rates at initial appointment has been associated with families who have had to wait longer periods of time for their initial treatment session. In other words, the longer the time spent on a wait list, the less likely clients will attend their scheduled initial appointment (Folkins et al. 1980; Jaffa & Griffin, 1990; Kournay, et al. 1990; Lefebvre et al. 1983; Raynes & Warren, 1971; Stern & Brown, 1994).

However, results from other studies are inconsistent with these findings: they found that the length of time on the wait list was not a significant factor in client attrition after initial intake appointment (Anderson, et al. 1987; Kluger & Karras, 1983; Lowman et al. 1984; Rodolfa, Rapaport & Lee, 1983).

Dissatisfaction with wait lists

Client satisfaction has been narrowly defined by Lebow (1983) as *"the extent to which service gratifies the wants, wishes or desires for treatment"* (p. 212). From this definition of client satisfaction it could be assumed that clients who do not have their wants, wishes or desires for treatment gratified, would become dissatisfied with the service. May (1991), reviewing the research, found that reports of dissatisfaction were higher among clients with more Urgent and severe problem behaviours.

Whilst reviewing the research regarding the time clients spend on wait lists, a common theme emerged within the methodology. Certain studies stated that clients, who had been wait listed for longer periods of time (of up to a year), tend to record a significant positive correlation between wait time and dissatisfaction (Christen, Birk, & Sedlacek, 1977; Cottrell, Hill, Walk, Dearnaley & Lerotheou, 1988; Deyo & Inui, 1980; Kournay et al. 1990; Magder & Werry, 1966; Sinnett & Danskin, 1967; Stern & Brown, 1994). It was also found that wait lists which had no significant effects on client attendance and/or dissatisfaction, tended to be relatively short in duration ie., less than a few weeks or months (Anderson et al. 1987; Archer, 1984; Freund et al. 1991).

The wait list is not the only factor which contributes to client dissatisfaction. Clients who were given an opportunity to comment on aspects of an intake procedure, cited the difficulty of obtaining an appointment as a contributing

factor for client dissatisfaction (Christen et al. 1977; Shueman, Gelso, Mendus, Hunt & Stevenson, 1980).

Sought treatment elsewhere

In a number of studies, it was reported that one of the reasons why clients did not attend their initial appointment was due to the fact that they had sought treatment elsewhere. It was suggested that this occurred among families who were more dissatisfied with the length of the waiting period than others (Archer, 1984; Magder & Werry, 1966; Stern & Brown, 1994).

Clients who stated that the waiting list was a factor in their dropping out of the service tended to use the time spent waiting for their appointment searching for an alternative service which would provide help sooner (Anderson et al. 1987; Folkins et al. 1980; Magder & Werry, 1966). It could be assumed that parents may seek alternative treatment if the problem behaviour becomes worse. On the other hand, maybe the identified problem has improved and so treatment is no longer required. May (1991) presumed that client problems or concerns which improved without treatment, may represent spontaneous remission.

Spontaneous remission or improvement

Spontaneous improvement can occur when clients are waiting for their initial appointment. This occurrence indicates that the problem behaviour

that originally led them to seek treatment has been resolved (Archer, 1984, Deyo & Inui, 1980; Leigh et al. 1984; Magder & Werry, 1966; May, 1991).

Improved problem behaviour has often been cited by clients as a reason for breaking appointments (Deyo & Inui, 1980). Spontaneous improvement is thought to occur in cases where initial contact with the service is made during a temporary Crisis, and during the waiting period (before the initial appointment) the problem behaviour subsides (Magder and Werry, 1966).

Another reason for 'spontaneous improvement' is the belief that just having an intake meeting with a clinician assists in reducing the severity of the problem behaviour. Archer (1984) stated that a significant segment of their participant population (50.8%) indicated that the intake session had been enough to clarify and resolve the problem. However, even though the problem maybe resolved, it may return later even worse than it was initially *"...the fact that problems recede in focus does not necessarily mean that they are solved"* (Archer, 1984 p. 393). It has also been suggested that 'spontaneous improvement' is a conscious or unconscious excuse by some parents. In other words, a convenient way of refusing unwanted, difficult to understand, or troublesome treatment processes (Cole & Magnussen, 1967).

Increased Problem Severity

Treatment attendance may be influenced by the severity and type of the identified clients' problem behaviour. Clients who did not attend their initial appointment were rated by intake interviewers as being more psychologically dysfunctional than those who attended their treatment session (Whittemore, 1985; cited in Anderson et al. 1987). In other words, those who refused treatment tend to have more severe symptom distress than those who continue on with their treatment.

Researchers have found that a majority of clients with problem behaviours became worse the longer they were on the waiting list (Cohen & Richardson, 1970; Deyo & Inui, 1980; Kazdin, 1990). Furthermore, due to the increase in problem severity, clients had to be moved up the wait list to a more Urgent category (Stern & Brown, 1994). A possible reason behind why client attrition rates are related to problem severity, is the likelihood that drop outs with less severe disorders would not need help as much as those with more severe symptomatology.

Clients with more severe problem behaviours appear to be more vulnerable to delays in provision of services. For example, Archer (1984) found that the urgency of the clients' concerns was related to their reactions to waiting for treatment. Clients with more severe problems were less likely to report an improvement in their problem without treatment, more likely to feel that the wait list was too long, and more likely to seek professional help elsewhere.

Attrition at Initial Appointment

It has been estimated that between 15 to 75% of clients referred to mental health services fail to keep their initial appointment (Hochstadt & Trybula 1980, Noonan 1973; Rosenburg & Raynes 1973). A further 20 to 57% of clients have been reported to drop out of treatment after their initial appointment (Baekeland & Lundwall, 1975).

While the reporting of adult out-patient non-attendance rates following the initial appointment is common place, considerably less is known about the problem of initial appointment failures in Child, Adolescent and Family Mental Health Services (Carpenter et al. 1981; Deane, 1991a; Hochstadt & Trybula, 1980; Larsen, Nguyen, Green & Attkisson, 1983; Raynes & Warren, 1971; Saltzman, 1984; Turner & Vernon, 1976). In the case of children and adolescents, failure to receive treatment is a significant problem. Attrition rates have been reported from anywhere between 41 to 85.4% (Kazdin, 1990; Kournay et al. 1990; Novick et al. 1981).

Attrition or 'drop-out' before an initial appointment cause problems for services in that attrition has been linked to lowered staff morale, waste of staff time and waste of resources (Deyo & Inui, 1980, Gould et al. 1985, Kournay et al. 1990). Time is invested in each new referral to a mental health service. Missed initial appointments can not only lead to inefficient use of professional staff time but also reduce the availability of services to others in need (Kournay et al. 1990). Thus, interventions have focused on reducing non-attendance rates to improve the delivery of mental health services to child and adolescent populations.

reducing non-attendance rates to improve the delivery of mental health services to child and adolescent populations.

The contradictory nature of the above research may be due to the different types of mental health services and/or methodology used in the data collection process. Reasons for non-attendance may be that children and adolescent services differ from adult services. Children and adolescents seeking Mental Health Services have the additional difficulty of being reliant on their parents to provide transport to and from appointments. Thus, services which cater to children and adolescents need to include the co-operation of parents in the treatment phase at the earliest possible stage (Deane, 1991a).

In conclusion, this chapter has introduced the wait list and subsequent referral procedures, intake procedures, intake criteria, wait list criteria, and emphasised the relationship between these factors and attendance at initial appointment. Attrition problems associated with wait lists were also discussed.

Results regarding wait lists and their effect on attrition rates before initial appointments have been found to be inconclusive and in some cases conflicting. However, it has been found that attrition rates before initial appointments can affect staff productivity, clinic resources and funding. It has also been considered that client attitudes may also be affected by experiencing long wait times before their initial treatment session. Consequently, these negative attitudes may impact on the service by reducing the credibility and standing it may have in the community and seriously affect valuable funding sources. A number of strategies (with

varying degrees of success) have been introduced by previous researchers, with the specific aim to reduce client attrition before initial appointment.

Few research investigations have examined the influence of waiting time on appointment keeping, as well as what happens to those people within the time span between referral (from a referral agent) to initial appointment. In short, does the clients' problem severity remain the same over the wait time, get better, become worse or are they driven, as Folkins et al. (1980) theorise, to find alternative treatment elsewhere? These issues are even more salient if as Anderson et al. (1987) states, waiting lists could impact negatively on people who are in most need of treatment.

Aims and Hypotheses

This study has three main objectives. The first objective was to describe the characteristics (eg, symptomatology, age, gender) of the client/cases which are assigned to the different priority categories. The second objective was to determine typical waiting times for clients attending the Child, Adolescent and Family Mental Health Service in different wait list priority categories. The third objective was to determine what changes in symptomatology (CBCL) or problem severity occur whilst clients wait for their initial appointment (ie., do clients problem behaviour stay the same, get worse or become better?)

Two specific hypotheses were also tested. The first was that those who are placed on the High priority (1) wait list will have significantly higher levels of symptomatology than those on the Medium priority (2) waitlist. The second was that as wait time increases, problem severity will also increase.

CHAPTER TWO

METHOD

RESEARCH SETTING

The Child, Adolescent and Family Mental Health Service (CAFS) is an outpatient facility which provides counselling and therapy for a wide range of mental health problems to children, adolescents and their families. CAFS uses a diversity of theoretical approaches, therefore, therapy is performed from a number of perspectives and with different client groups. At the time of this study there were nine clinicians: two clinical psychologists, two part time psychiatrists and five clinical social workers/family therapists. In addition, the service employed two full time and one part time receptionist/secretaries, and provides placements for two social work interns and two clinical psychology interns.

Clients seen at CAFS are located in the greater Manawatu area. Clients who fall outside this area and are in need of services are referred on to other agencies (e.g., Wanganui CAFS, Wellington CAFS). CAFS is a core service funded and contracted by the Central Regional Health Authority. CAFS clients are children and adolescents with moderate to severe mental health disorders. No fees are charged to clients for services.

Referrals to CAFS come from a wide range of sources, including Children, Young Persons and their Families service (CYPS), schools, police, paediatricians, general practitioners and Special Education Services (SES). CAFS receives approximately eight new referrals per week. Potential referral sources are sent referral forms with the aim of preventing the referral of clients who do not have a moderate to severe mental health disorder (see Appendix A for the CAFS referral form).

Part of the referral information required from the referral agent is ethnicity. Maori clients are referred on to the Specialist Maori Mental Health Service also located at the Palmerston North Hospital. Maori clients are encouraged to see the Specialist Maori Mental Health Team because of potential culturally specific issues.

CAFS Referral and Intake Procedures

The Child, Adolescent and Family Mental Health Service (CAFS) are under contractual agreement by the Regional Health Authority to assess and treat a certain amount of clients per year. Thus criteria are used which are consistent with their contractual agreement to the Central Regional Health Authority. Eligibility for CAF services apply to children and adolescents who meet the following criteria.

Intake criteria

- Clients must be less than 19 years of age. Exceptions to this rule are clients with developmental delays in physical, social and emotional areas, and when the client is not considered appropriate for Adult Mental Health Services. These clients are considered on an individual case by case basis.
- Clients not appropriate for other services such as Adult Mental Health Services, Special Education Services (SES), Accident Compensation Corporation (ACC), Children, Young Persons and their Families Service (CYPS) or private counsellors will be seen.
- The presenting problem must be a mental health issue, such as a DSM-V Axis I diagnosis.
- Self referrals are accepted by CAFS in instances of Crisis.

- Other referrals will only be accepted from an agent who has ongoing involvement with the client or family.
- Clients must reside in the CHE catchment area. Clients residing out of this catchment area will only be accepted under exceptional circumstances.
- All referrals (except Crisis clients) will be discussed at intake meeting regardless of to whom initial correspondence is addressed to.

Family situation

- Clients will not be accepted if involved in ongoing custody and/or access disputes.
- If there are likely care and protection issues, the client is referred to the appropriate Statutory Agency before acceptance into CAFS.
- If the client has been placed in a new environment they will be required to wait a period of time to establish whether there are any significant behaviour changes.
- Parents or caregivers need to be prepared to be involved with the CAFS service.
- CAFS will not accept referrals to investigate sexual abuse cases.

(CAFS Draft Intake Proposal: Dec 1996)

The Waitlist Process

The first step in the wait list process begins with the referral being received by CAFS from the referral agent. Cases are recorded by the administrative staff and the intake team into the new referral book and discussed at an intake team meeting held once a week. Each new referral is discussed on a case by case basis. At the intake meeting the referral is discussed and if there is sufficient information a decision is made about whether the referral is appropriate for CAFS or another agency. Clients who meet CAFS criteria are allocated a wait type category. Clients not categorised as either Crisis or Urgent are then placed on either wait list 1 or wait list 2, until an initial appointment can be arranged by an assigned key worker. If the referral agent does not provide sufficient information to make an informed decision, the file is placed on hold until the relevant material is available.

Information required from referral agent and parents by CAFS is name, date of birth, ethnicity, address, telephone number, school, hospital identification, family members, significant other, presenting problem, other relevant information, referral source, and date of referral. This information is recorded in clients' individual case folders for the intake team to discuss and determine which wait type category the client is eligible for.

Information is not only gathered from the referral agent but also collected by the office staff from the parents/caregivers of the client. The administrative staff contact the family member of the client with most access to the child/adolescent. That person is questioned with regards to their perception of the problem, their main concerns, why they are seeking help now,

background information, and whether there are any legal issues such as custody disputes.

If the referral does not meet CAFS criteria the client is referred on and noted in the records as a non-action referral (NAR). Non Action Referral is the terminology used by CAFS to indicate that the referral was not actioned and in most cases referred on to another agency. If the referral information is correct and the client meets CAFS criteria, they are then assigned a wait list category by the intake team.

Wait List Criteria

Information gathered from clinicians indicated that there were three groups of clients. These included those allocated to the High priority wait list, those assigned to the Medium priority wait list, and those who were not wait listed but seen in Crisis. However, during the course of data collection a fourth unofficial category was revealed. This category, labelled Urgent, referred to clients who were given an appointment to see a clinician within ten days from the intake meeting. It should be noted that at the beginning of the study the category Urgent was non-existent.

Wait list categories

Crisis

Clients in Crisis were seen by clinicians on the same day the referral was given. In most cases these clients were seen in Accident and Emergency for treatment of attempted suicides.

Urgent

Clients classified as being Urgent (seen within 10 days from intake meeting to initial appointment), were not waitlisted due to the severe nature of their presenting problem. An example of severe presenting problems were: potential family disintegration, potential expulsion of client from family, evidence of psychotic behaviour or serious risk taking behaviour.

High priority

Below is a description of wait list criteria used by clinicians to determine whether clients referred to CAFS meet the wait list criteria for the High priority wait list.

CAFS criteria for the high priority wait list

- Serious Post-Traumatic Behaviour
- Serious Eating Disorder
- Associated Somatic Features
- Depressive Features in Young Children
- Suspension from School
- Child Physically Abusive Towards Adult
- Melancholic Features of Depression

(Wait List 1 Criteria Draft Proposal: Dec 1996)

Clients who are referred to CAFS and meet the intake criteria, yet fall outside of the High priority wait list, are placed on the Medium priority wait list. However, in the letter sent to clients in response to the referral to the service, parents are encouraged to contact the service if there are changes in the problem behaviour or situation.

After waiting a period of time on either wait list 1 or 2, clients are then assigned a key worker who arranges for an appointment date to be set. The referral procedure is shown in diagram form in Figure 2.1.

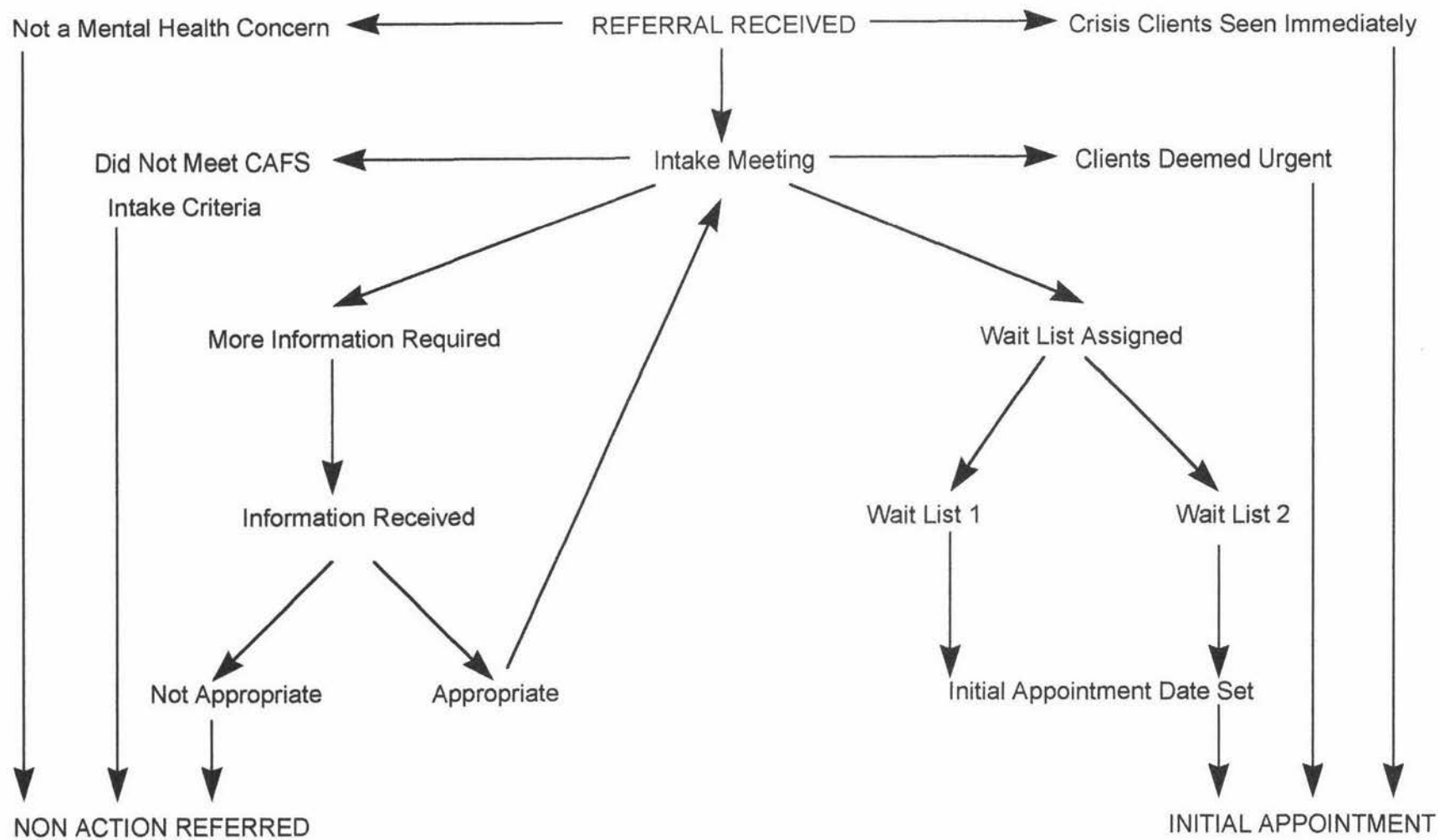


Figure: 2.1 Flow Chart Describing the Referral Process at the Child, Adolescent and Family Mental Health Service.

PARTICIPANTS

Parent(s) or caregiver(s) of CAFS clients were approached to participate in this study. Parents/caregivers of clients admitted into the service in Crisis were not included in the study due to the perceived additional distress which might result from completing the questionnaire.

Potential participants in the present study were parent(s)/caregiver(s) of children and adolescents referred to CAFS between 1st July 1996 and 30th November 1997. During this period, a total of 542 new referrals were received by CAFS.

The gender ratio of those referred to CAFS was split with 309 males and 229 females (4 missing). The average age of these clients was 10.93 years; the male average age was 10.03 (sd = 4.16), which was slightly lower than the female average age of 12.14 (sd = 4.10). Male ages ranged from 2 to 19 years of age while female ages ranged from 3 to 20 years.

Information regarding clients were obtained from several sources: the new referral book, current index file, discharge index file, non action referral (NAR) folders, and in some cases questioning the key worker regarding a particular client. These sources were used to obtain the required data to determine clients' total wait on the wait list as well as their assigned wait list priority category.

MEASURES

Child Behaviour Checklist Questionnaire (CBCL)

The Child Behaviour Checklist (CBCL) is part of a multiple assessment procedure designed by Achenbach and Edelbrock (1983). Other parts of the multi-assessment package includes the 'Youth Self Report Form' and a 'Teachers Report Form' developed for the purpose of gathering information from multiple sources.

In this study, clients' problematic behaviour was measured by using the CBCL for ages 4-18 (see Appendix B for questionnaire). The CBCL was *"designed to provide standardised descriptions of behaviour"* (Achenbach, 1991 p. iii). The questionnaire consists of 118 items describing specific behaviour problems. Parents/caregivers are asked to rate their children's behaviour using a three point response scale; ranging from 0 = not true (as far as you know), 1 = sometimes or somewhat true, or 2 = very true or often true. Scores are summed over the 118 items, so the total score ranges from 0 to 236 points.

A possible limitation of the CBCL is the three point rating checklist. Authors have found that the more steps there are in a rating scale, the more reliable it is (Kline, 1993). It has been demonstrated that this reliability quickly increases up to the point of seven steps and then gradually levels off within likert type scales. Thus, the CBCL checklist which includes only a three point scale, appears to be less reliable than a checklist that would include at least a seven point scale.

Syndrome problem scales

The CBCL was designed to identify syndromes of problems. The eight syndromes measured by the CBCL are Withdrawn, Somatic Complaints, Anxious/Depressed, Social Problems, Thought Problems, Attention Problems, Delinquent Behaviour and Aggressive Behaviour. An additional syndrome, designated as Sex Problems, can also be scored.

The syndrome problem scales can be grouped into two distinct groupings: externalised and internalised. Internalised scores incorporate three out of the eight problem scales: Withdrawn, Somatic and Anxious/Depressed scales. The possible range for internalised scores is from 0 to 62 points. Externalised scores consist of the total points gathered from two scales: Delinquent behaviour and Aggressive behaviour. The possible range for externalised scores is from 0 to 66 points.

The CBCL profiles

The CBCL profiles boys' and girls' problems separately. Each score (ie., total, internalised and externalised score) is divided into two age ranges, 4 - 11 years (children) and 12 - 18 years (adolescents). Cut off points have been established for the normal, borderline/clinical and clinical categories.

Empirical data regarding the CBCL

The CBCL is an empirically derived questionnaire which classifies child psychopathology. The CBCL comprises of a problem behaviour checklist and a social competence scale; however, in the present study only the

problem behaviour checklist section was used. The CBCL has been used frequently in past research and as it has the advantage of a large item pool; a wide range of symptom scales; good reliability; as well as norms that reflect both age and gender differences in the prevalence and pattern of problem behaviour (Cohen, Gottlieb, Kersher & Wehrspann 1985; Gould et al. 1985; Phares, Compas & Howell, 1989; Rosenberg & Joshi, 1986; Weisz, Weiss & Langmeyer, 1987). The measure includes indices of the child's adaptive competences as reflected in involvement in activities, school performance and social relationships.

Thorough psychometric evaluations has been performed on the CBCL for both boys and girls, for two main age ranges 4 - 11 and 12 - 18 years (Achenbach, 1991). The questionnaire offers good continuity for studies of outcomes over a few months to a few years. For example, the CBCL has a one week test-retest mean intraclass correlation coefficient of .89 on the problem scores. The CBCL also has good discriminant validity (Achenbach, 1991).

The CBCL was chosen as a measure because of its excellent psychometric properties and appropriateness with heterogenous client samples. In addition, it was already in use by clinicians at CAFS in order to obtain parents' descriptions of their childs' problem severity. Parents/caregivers have been found to provide the most accurate sources of information regarding their children's problem behaviour (Achenbach, 1991), and also play a significant role in the assessment process, as they are the most likely source to remain available from initial assessment to outcome (Achenbach, 1991; Achenbach & Edlebrock, 1983).

PROCEDURE

Questionnaire data was collected from parent(s)/caregiver(s) of wait listed clients from July 1996 to November 1997. As wait listed clients had to wait some time before being seen, questionnaire data collection was extended to January 1998 with the hopes of collecting as many Time 2 questionnaires as possible.

Of the 542 clients, 342 questionnaires were mailed to 171 parents/caregivers referred to CAFS at both Time 1 and Time 2. A total of 155 questionnaires were returned. Questionnaires were only given to those assigned a wait list category. Crisis and Urgent clients were excluded from this part of the study.

On average 2 questionnaires were sent to parents/caregivers of 171 clients. Exceptions to this rule was when it was known from the client's family history that there was only 1 caregiver close to the client. More than 2 questionnaires were occasionally sent when it was noted in the CAFS records that there were more parent/caregivers in contact with the client. The following procedures were adopted by the researcher for clients who met the intake and wait list criteria.

Parents/caregivers of clients were sent a letter by CAFS explaining that Massey University was conducting research regarding the waiting list. The letter explained that the study was being conducted to establish what happens to people while they are waiting to be seen for their first appointment at CAFS. The letter further explained that the study involved the completion of two questionnaires. The letter, accompanied by the

questionnaires and an information sheet, described the purpose of the study and their rights as participants (see Appendix C for the information sheet). This emphasised that if they did not wish to take part in this study they would still receive the same services from CAFS. Furthermore, it was stressed that their responses would remain anonymous.

Parents/caregivers interested in being involved in the wait list study were asked to complete and return a consent form with their questionnaire (when first referred to CAFS) in which they agreed to take part in the study (see Appendix D for the consent form).

Participants were sent another information sheet and questionnaire one week before their initial treatment phase. The information sheet reminded the participants about the focus of the research and their rights as participants. The second questionnaire was identical to the first.

A stamped return addressed envelope was included with the questionnaires, which the participant(s) were encouraged to complete and return as soon as possible.

ETHICAL ISSUES

This study was designed in accordance with the ethical guidelines of the New Zealand Psychological Society. This project had been approved by both the Massey University Human Ethics Committee and the Manawatu - Wanganui Health Ethics Committee. The main ethical issues considered were informed consent and confidentiality.

Participants were given an information sheet which briefly summarised the study and informed them that if they did not wish to take part in this study they ***“would still receive the same services from CAFS”*** (see Appendix C for the information sheet). They were then required to sign and return the consent form with the questionnaire (see Appendix D for the consent form). Participants were given another information sheet when the second questionnaire was sent in order to remind participants about their rights within the study. This was considered important because some participants waited for some time before their next contact by CAFS. Clients had the opportunity to refuse to answer any particular question or to withdraw from the study at any time.

Anonymity was assured to all clients by the researcher in writing in the information sheet. No names or other information which might make participants identifiable left CAFS.

Confidentiality was maintained by the use of code numbers which replaced names on any data which left the service. Each questionnaire when returned to the service, was immediately assigned a code number which

was transferred to a master sheet containing the client names. This master sheet was the only way the code number could be connected to the clients actual name. Two copies of the master sheet were made. One of these was kept at the researcher's home in a locked filing cabinet and the other copy in a secure drawer in the CAFS office. This procedure meant that the questionnaires themselves were identified only by a code number.

Only the primary researcher had exposure to client names as part of the data collection process. The primary researcher was required by CAFS to sign a standard MidCentral Health confidentiality form. All attempts were made to avoid using individual client "medical" records. All data used were available through the administrative records kept in the CAFS office.

CHAPTER THREE

RESULTS

Data Analysis

Data analysis was undertaken using the computer statistical package SPSS for Windows 95. Initial analysis involved descriptive analysis of 542 clients referred to the CAF service between the 1st of July 1996 and the 30th of November 1997.

The Child Behaviour Checklist (CBCL) was scored with a computer scoring program developed by Llew Richards - Ward.

Once the descriptive analysis was completed, the following statistical techniques were used to investigate the hypotheses; T-Tests, Anovas and Chi Squares. T-test and anova analyses were used to test differences between means.

The results section is divided into two parts. The first part examines the overall descriptive information of clients referred to CAFS. Such descriptive information includes wait types, wait times, gender and age distributions. The results presented have been divided into three sections: (I) clients referred to CAFS for treatment ($n = 542$), (II) clients accepted for CAFS treatment ($n = 335$) and (III) clients who attended their initial appointment session ($n = 228$).

Part two of the results section examines data from the Child Behaviour Checklist Questionnaire (CBCL). Part two is divided into several sections consisting of (I) response rates, (II) clients at Time 1 ($n = 76$) and (III) clients at Time 2 ($n = 25$).

PART ONE: Referral To CAFS

Of the 542 clients who were referred or contacted the clinic for an appointment, 335 (59%) were seen in Crisis, Urgently, or placed on the wait list. The remaining 228 clients (40.5%) were not wait listed. Many of these were referred on to other agencies. Some did not meet CAFS intake criteria, and for others information was not available. See Table 3.1 for a description of the 542 clients referred to CAFS during the 17 months duration of this study.

Table 3.1

Action Taken by the CAFS Intake Team on New Referrals.

Action Taken	Frequency	Percent
Wait Listed Clients (n = 355)		
1. Clients Accepted and Seen By CAFS	228	40.5
2. Clients Accepted but not seen By CAFS	21	3.7
3. Clients on Wait List (Still to be Seen)	56	10.0
4. No Response To Letter (Discharged)	22	4.0
5. Complaint Improved (Discharged)	8	1.4
Non Wait Listed Clients (n = 198)		
6. Referred To More Appropriate Services	69	12.2
7. Referred to Specialist Maori Mental Health	55	9.8
8. Referred on to Other CAFS	26	4.6
9. Did Not Meet CAFS Intake Criteria	48	8.5
Other (n = 30)		
10. On Hold	13	2.3
11. Nothing Noted In New Referral Book (Missing Data)	17	3.0
Total	563	100.0%

Note. The total is larger than the number of new referrals (542) due to the 21 category 2 clients who were both wait listed and subsequently referred to other services.

Table 3.1 is divided into three distinct groups. The first group consists of categories 1 to 5, which include 335 clients who met CAFS intake criteria, were accepted and wait listed for CAFS treatment.

Of the 335 clients a total of 228 (40.5%) had an initial appointment. Of the remaining 107, 21 clients were given wait type categories, but after a period of time were found to be more suitable elsewhere, found treatment elsewhere, or were simply noted as non action referred (further details were not provided by CAFS records). Of the remaining 86, 56 clients were still waiting to be seen at the end of the study period.

The remaining 30 children and adolescents were non-attenders consisting of 22 (no response to letter) and 8 (complaint improved) clients. No response to letter refers to letters sent by the intake team in November 1996 to clients on the wait list. These letters aimed to reduce the existing wait list, and asked clients whether they were still in need of CAF services. If there was no response within two weeks from the date that the letter was sent, the client was discharged (removed) from the wait list. Complaint improved referred to existing clients on the wait list contacting CAFS and stating that they were no longer in need of services due to the improvement of their child's problem behaviour.

The second group of 198 referrals were not wait listed. The majority of these (categories 6 - 8, 150 clients) were referred to other services, some times because of lengthy wait lists, cultural issues and geographic location. A minority of clients (n = 48) did not meet CAFS intake criteria.

Clients identified as Maori were referred to the Specialist Maori Mental Health Team. However, if a client requested CAF services rather than the Specialist Maori Mental Health Team, CAF services were provided. Clients who fell outside of Palmerston North's catchment area were referred on to other appropriate services located nearer to the client and family (ie., Wanganui & Wellington CAFS).

The third group, consisted of clients who were either placed on hold or for whom no information was recorded. Clients referred to CAFS with inadequate information from referral agents were discussed during an intake meeting. A key worker was assigned to the case to follow up on the missing material. Thirteen clients had their case file placed "on hold" until the additional information was gathered. Category 11, consisted of 17 clients for whom no information could be found in the clinic records to determine what had happened to them.

Wait times from referral to intake for all clients referred to CAFS

The following section describes wait times for clients referred to CAFS from the date of referral to intake meeting date. Of all clients referred to CAFS ($n = 542$) a total of 321 clients had both referral date and intake meeting dates recorded. A total of 221 clients did not have an intake date recorded. In part, this reflects the fact that those seen in Crisis did not wait for an intake meeting to discuss acceptability due to the nature and severity of clients' problem behaviours. However, Crisis clients account for only 57 of the 221 clients who did not have an intake date recorded. Therefore, it could be that the remaining 164 clients did not meet CAFS intake criteria and so were immediately referred on before the intake meeting, or that intake meeting dates were not correctly recorded.

The mean time between referral and intake meeting date was 15.50 days ($sd = 18.67$) and median time was 11 days. An explanation for the large standard deviation is that extreme outliers were affecting the distributions of the means. Outliers consisted of clients who had a long wait between referral and intake meeting date as wait time ranged from 2 to 168 days.

Table 3.2 describes further the wait times of clients referred to CAFS in three of the four wait type categories.

Table 3.2

Time Waited in Days Between Referral and Intake For All Clients Referred to CAFS in the Three Wait Type Categories.

Category	n	Wait Time (Referral to Intake)				
		Mean	SD	Median	Min	Max
Accepted	335					
Crisis	57	a				
Urgent	58	8.86	14.22	4	2	56
High Priority	81	10.48	6.36	11	2	28
Medium Priority	139	18.85	24.65	11	3	168

Note a. Crisis clients were seen within 24 hours

Clients in the Urgent category spent on average 8.86 days (sd = 14.22) waiting from referral to intake meeting date. Clients in the High priority wait list were discussed at an intake meeting on average 10.48 days (sd = 6.36) from the date of referral. Clients in the Medium priority wait list were discussed at an intake meeting within 18.85 days (sd = 24.65) from referral to intake meeting date. A total of 207 clients were not assigned a wait type category. Either they did not meet CAFS criteria or no wait type category was assigned.

Median days waited were recorded due to a few extreme outliers which have influenced the average wait times within the different wait type categories. Table 3.2 again shows that the means are being affected by extreme outliers.

Clients Accepted For CAFS Treatment

The following section will deal with wait type category, gender, and age of clients accepted for CAFS treatment. Of the 542 clients referred to CAFS a total of 335 clients met CAFS intake criteria, and were placed into one of four wait type priority groups. Those seen within 1 day (24 hours) were identified as clients in Crisis. These clients were deemed to be in need of immediate help. Clients who were slightly less problematic than Crisis clients, yet were severe enough not to be wait listed, were placed in the Urgent category. Clients noted as Urgent were assigned a key worker in the intake meeting and the key worker would then contact the family to arrange an appointment date. Clients noted as Urgent were seen within 10 days of the intake meeting date. There were two additional wait type categories for those who met CAFS criteria: High priority wait list and Medium priority wait list. Table 3.3 shows the distribution of clients across the four wait type categories, both for clients accepted for treatment ($n = 335$) as well as those eventually seen by CAFS clinicians ($n = 228$).

Table. 3.3

Wait List Categories for Clients Accepted ($n = 335$) and Seen by CAFS ($n = 228$).

Category	<u>Clients Accepted</u>		<u>Clients Seen</u>	
	n	%	n	%
Crisis	57	17.0	47	20.6
Urgent	58	17.3	57	25.0
High Priority	81	24.2	42	18.4
Medium Priority	139	41.5	59	25.9
Unknown			23	10.1
Total	335	100.0	228	100.0

Of the 335 clients who met CAF intake criteria, 57 (17%) were categorised as Crisis clients, and a further 58 clients (17.3%) were categorised as Urgent. A total of 81 clients (24.2%) were assigned to the High priority wait list, and a total of 139 (41.5%) were placed into the Medium priority wait list category. Thus a total of 220 (65.7%) children and adolescents referred to CAFS were placed on a wait list.

The gender and age distributions of all clients accepted for treatment ($n = 335$) are shown in Table 3.4. Table 3.4 shows that there are more females than males in the Crisis and Urgent wait type categories, while in the High and Medium priority wait list groups there are more males than females. The difference in gender distributions across wait type categories was significant, $\chi^2 (3, N = 333) = 28.501, p < .05$.

Table 3.4 also indicates that there is a difference in the mean age across the wait type categories: age decreases as wait type priority decreases, $F (3, 329) = 10.265, p = .0001$.

Table 3.4

Gender and Age of Clients Accepted for Treatment at CAFS in the Four Wait Type Categories.

Category	n	Gender			Age	
		Male	Female	missing	Mean	SD
Crisis	57	20	37	-	14.86	2.33
Urgent	58*	24	33	1	12.79	3.75
High Priority	81	45	36	-	11.88	3.30
Medium Priority	139*	99	39	1	8.50	3.70
Total	335	188	145	2	11.15	4.18

Note. missing gender data in the Urgent and Medium priority categories. Thus, gender numbers do not total 335.

Clients Seen By CAFS Clinicians

An average of 8 clients were referred to CAFS per week, while an average of 3.4 clients were seen by CAFS clinicians per week. This section will describe the gender and age distributions of clients seen by CAFS clinicians. Of the 542 clients referred to CAFS between the 1st of July 1996 and the 30th of November 1997, 228 clients were seen by CAFS clinicians for their initial appointment, and wait list information was available from 205 clients.

Table 3.5 provides the frequencies of wait list priority types for those seen by CAFS clinicians. Table 3.5 indicates that 47 of the clients seen by CAFS clinicians were Crisis clients. Thus, from the 57 clients who were initially noted as Crisis when newly referred to CAFS, 10 Crisis clients were referred immediately to more appropriate services (ie., Specialist Maori Mental Health Team).

Of 58 clients accepted by CAFS and categorised as Urgent, 57 of these were seen by CAFS clinicians. The 1 client noted as being Urgent who was not seen by clinicians was later referred on to other services.

Of the total 81 clients assigned to the High priority wait list, clinicians saw 42 clients during the 17 months of this study. Of the 39 clients not seen, 16 were still on the wait list, 20 were referred on to more appropriate services and 3 dropped out of the wait list.

Of the total of 139 clients assigned to the Medium priority wait list, a total of 59 clients were seen by clinicians during the study period. Of the 80 clients not seen, 37 were still on the wait list, 35 were referred on to more appropriate services and 8 dropped out of the wait list.

Table 3.5 also provides information about the gender and age of clients who attended their initial appointment. The gender distributions varied across wait type categories, with more females in the Crisis and Urgent categories, but more males in the High priority and Medium priority categories, $X^2(3, N = 204) = 28.751, p < .05$.

Table 3.5

Gender and Age of Clients Seen by CAFS Clinicians in the Four Wait Type Categories.

Category	n	Gender		missing	Age	
		Male	Female		Mean	SD
Crisis	47	15	32	-	15.04	2.03
Urgent	57*	24	32	1	12.77	3.78
High Priority	42	26	16	-	12.21	3.04
Medium Priority	59*	42	12	5	8.69	3.50
Sub Total	205	107	92	6		
Missing Data	23					
Total	228					

Note. missing gender data in the Urgent and Medium priority categories. Thus, gender numbers do not total 205.

Mean age showed a significant decrease from 15.04 years in the Crisis category to 8.69 years in the Medium priority category, $F(3,200) = 10.937, p < .001$.

Wait times for clients seen by CAFS clinicians

This section reports wait times for those clients seen by CAFS in the various wait type categories. Table 3.6 describes the total wait time in days for clients seen in each of the three wait type categories. Crisis clients are excluded from Table 3.6, as they were seen within 24 hours of referral.

Table 3.6

Total Wait Time in Days for Clients Seen in the Three Wait Type Categories.

Category	N	Mean	SD	Median	Min	Max
Urgent	55	8.27	10.71	5	1	57
High Priority	38	77.66	59.41	74	4	252
Medium Priority	53	149.96	87.69	155	13	339

Table 3.6 only contains data for 193 out of the 228 clients seen by clinicians. The present study was unable to locate time waited for 35 cases due to missing data. Clients in the category of Urgent were seen on average within 8.27 days (sd = 10.71) from the referral date. Clients seen on the high priority wait list were seen on average 77.66 days (sd = 59.41) or approximately 2.5 months after the date of referral. Clients seen on the Medium priority wait list were seen on average 149.96 days (sd = 87.69) or approximately 5 months after referral. Median days waited were recorded due to a few extreme outliers which may have influenced average wait times within the different wait type categories. Table 3.6 shows that the means and the medians are very similar, indicating a fairly normal distribution over wait time.

PART TWO : Questionnaire Data

Part 2 of the results section examines data from the Child Behaviour Checklist Questionnaire. Part 2 is divided into three sections consisting of (I) response rates, (II) description of clients at Time 1 and (III) description of clients at Time 2.

As mentioned previously in the Method section, the CBCL questionnaire was given twice to participants in this study. The first questionnaire was sent to parents/caregivers of the client when first referred to CAFS (Time 1). The second questionnaire was sent one week before the client's initial appointment (Time 2). Questionnaire data was gathered at both times to determine whether any changes occurred in symptomatology over wait time.

Response Rates

Across Time 1 and Time 2, a total of 342 questionnaires were sent to parent(s)/caregiver(s) of clients referred to CAFS. A total of 155 questionnaires were returned, yielding an overall response rate of 45.3%.

At Time 1 (date of referral), 285 questionnaires were sent and 105 questionnaires were returned by parents/caregivers of 76 clients. Thus the response rate at Time 1 was 37%. At Time 2 (before initial appointment), 57 questionnaires were sent and 50 were returned by parents/caregivers of 34 clients. Thus the response rate at Time 2 was 88%. However, 9 of the 34 clients did not complete Time 1 questionnaires. Therefore for analysis of both Time 1 and Time 2 data, a total of 25 clients were investigated.

Of the 171 clients whose parent(s)/caregiver(s) were sent a CBCL questionnaire, 138 were accepted for treatment by CAFS. Of these 138, 87 were seen by clinicians, 32 were still on the wait list, 15 were discharged while on the wait list and 4 were discharged due to their complaint improving over the wait time. Of the 33 clients not accepted by CAFS, 27 cases were referred on to more appropriate services, and 6 cases became missing in the system during the course of the study.

Scoring of questionnaires

Unfortunately not all questionnaires were completed by parents/caregivers close to their child. In most cases only one member of the family completed the questionnaire at Time 1, and occasionally a different member of the family completed the questionnaire at Time 2. To combat this inconsistency, a method was devised to use as many questionnaires as possible (due to the low return rate of questionnaires). As mothers tended to complete the questionnaires more than fathers and other members of the family, it was determined that if the mother completed the questionnaire, that data was recorded into the data file. If the father completed the questionnaire rather than the mother, that data was recorded. However, if neither mother nor father completed the questionnaire, but the questionnaire had been completed by another member of the family (ie., grandmother, grandfather or adult sibling) then their observations were recorded. This procedure was used for questionnaires returned at both Time 1 and Time 2. Data was only recorded in the data file from one individual (ie., either mother, father or other) even if three questionnaires were completed and returned. On the whole, of the 50 questionnaires completed at both Time 1 and Time 2, 24 clients had both questionnaires completed by their mothers.

Descriptions Of Clients at Time 1

At Time 1, questionnaires were returned by parents/caregivers of 76 clients. The mean age of the 76 clients was 9.4 years, there were more males ($n = 55$) than females ($n = 21$), and more cases placed in the Medium priority category ($n = 49$) than in the High priority category ($n = 23$). Demographic descriptions of the 76 clients at Time 1 are shown in Table 3.7.

Table 3.7

Demographic Description of Clients at Time 1 and Time 2.

Variable	Time 1		Time 2	
	n	%	n	%
Age	(n = 76)		(n = 25)	
4 - 11 years	51	67	16	64
12 - 18 years	25	33	9	36
Gender				
Female	21	27.6	8	32
Male	55	72.4	17	68
Wait Type				
Urgent	1	1.3	0	0
High Priority	23	30.3	19	76
Medium Priority	49	64.5	6	24
Missing	3	3.9	0	0
Action Taken				
Seen by Clinician	45	59.2	22	88
Still on Waitlist	13	17.1	1	4
Discharged	9	11.8	2	8
Referred On	4	5.3	-	-
Complaint Improved	2	2.6	-	-
Missing Data	3	3.9	-	-

Note. Unknown source: may include family or self referrals.

Of the 76 clients, 45 clients were seen by CAFS clinicians, 13 were still on the wait list, 9 were discharged while on the wait list, and 2 clients were discharged due to their complaint improving over the wait time. A total of 4 cases were referred on to more appropriate services and 3 cases became missing during the course of the study (see Table 3.7).

Table 3.8 presents the obtained CBCL mean total, externalised and internalised score at Time 1, for the 76 clients. These scores were used to categorise clients as normal, borderline clinical, or clinical.

Table 3.8

Mean Total, Externalising and Internalising Scores at Time 1 for 76 Clients

Checklist Measures	Mean	SD	Min	Max
Total Score	65.34	29.37	9	151
Externalising Score	26.37	14.35	0	54
Internalising Score	15.07	9.86	1	37

To determine whether clients placed on the High priority wait list had significantly higher levels of symptomatology than those placed on the Medium priority wait list, t-tests were conducted on the CBCL total, internalising and externalising scores. As indicated in Table 3.9, all three scores decreased from the High priority wait list to the Medium priority wait list. These scores indicate that clients placed on the High priority wait list have higher levels of symptomatology than those on the Medium priority wait list.

Table 3.9

Total, Externalising and Internalising Scores For the High and Medium Priority Wait Listed Clients at Time 1

Checklist Measure	Wait Type				<i>t</i>
	High Priority		Medium Priority		
	Mean	SD	Mean	SD	
	(n = 24)		(n = 49)		
Total Score	72.54	29.97	63.29	26.92	1.279 (ns)
Externalising Score	27.08	14.29	26.92	14.07	0.013 (ns)
Internalising Score	19.04	10.88	13.22	8.37	0.912 (ns)

Note. Crisis/Urgent and 5 missing wait typed clients were not included.

For clients placed on the High priority wait list, the mean total score was 72.54 (sd = 29.97). Those on the Medium priority wait list, the mean total score was 63.29 (sd = 26.92). The difference between means of 9.25 (sd = 7.23) was not significant, with a t-test yielding $t(df = 71) = 1.279$, ns.

For clients placed on the High priority wait list, the mean externalising score was 27.08 (sd = 14.29). Those on the Medium priority wait list, the mean externalising score was 26.92 (sd = 14.07). The difference between means of 0.16 (sd = 12.55) was not significant, with a t-test yielding $t(df = 71) = 0.013$, ns.

For clients placed on the High priority wait list, the mean internalising score was 19.04 (sd = 10.88). Clients on the Medium priority wait list, the mean internalising score was 13.22 (sd = 8.37). The difference between means of 5.8 (sd = 6.36) was not significant, with a t-test yielding $t(df = 71) = 0.912$, ns.

The distribution of clients into normal, borderline and clinical categories at Time 1 is shown in Table 3.10. For each of the three scores (total, externalising and internalising) the most frequent classification was "clinical". Table 3.10 shows the number and percent of problem severity at Time 1 for 76 clients.

Table 3.10

Classification of Clients at Time 1 (76 Clients).

Classification	Score					
	Total		Externalising		Internalising	
	n	%	n	%	n	%
Normal	18	23.7	21	27.6	28	36.8
Borderline/Clinical	3	3.9	1	1.3	7	9.2
Clinical	55	72.4	54	71.1	41	54.0

Description Of Clients at Time 2

For these 25 cases the mean age was 9.2 years, there were more males ($n = 17$) than females ($n = 8$), and more cases placed in the Medium priority category ($n = 19$) than in the High priority category ($n = 6$).

Of the 25 cases, 22 were actually seen by CAFS clinicians, 1 was still on the wait list, and 2 clients were discharged from the waiting list. Details regarding the 25 clients at Time 2 are shown in Table 3. 7.

Changes Between Time 1 and Time 2

Three different methods of assessing changes in problem behaviour between Time 1 and Time 2 were employed: comparison of mean scores at Time 1 and Time 2, examination of changes in individuals, and comparison of distributions across clinical categories.

Mean scores

The mean scores and standard deviations were calculated at both Time 1 and Time 2. To determine whether any changes occurred during the wait times experienced by clients and their families, paired t-tests were conducted on the total, internalised and externalised scores. As can be seen in Table 3.11, all three scores (total, externalising and internalising) decreased from Time 1 to Time 2. However, all decreases were small and non-significant.

Table 3.11

Total, Externalising and Internalising Scores at Time 1 and Time 2

Checklist Measure	Scores				<i>t</i>
	Time 1		Time 2		
	Mean	SD	Mean	SD	
Total Score	71.48	30.01	63.80	29.77	1.434 (ns)
Externalising Score	29.44	14.27	28.40	18.85	.389 (ns)
Internalising Score	6.04	9.21	13.92	7.54	1.179 (ns)

At Time 1 the mean total score was 71.48 (sd = 30.01) and at Time 2 the mean total score was 63.80 (sd = 29.77). The decrease of 7.68 (sd = 26.79) was not significant, with a paired sample t-test yielding $t(df = 24) = 1.434$, $p = .165$.

At Time 1 the mean externalising score was 29.44 (sd = 14.27). At Time 2 the mean externalising score was 28.40 (sd = 18.85). The difference of 1.04 (sd = 13.35) was not significant, $t(df = 24) = .389$, $p = .700$.

At Time 1 the mean internalising score was 16.04 (sd = 9.21) and at Time 2 the mean internalising score was 13.92 (sd = 7.54). The decrease of 2.12 (sd = 8.99) was not significant, $t(df = 24) = 1.179$, $p = .250$.

Individual change

Although the mean differences between Time 1 and Time 2 were not large for any of the three scores, the possibility remained that small mean differences resulted from large changes for some (or most) individuals, but with some individuals showing improvement and others deterioration. Accordingly, for each of the three scores, the 25 clients were classified as improved, no change, or deteriorated.

Assessment of improvement or deterioration was made with reference to the Time 1 mean scores. Clients were classified as deteriorated if their Time 2 score was more than .5 standard deviations larger than their Time 1 score, and as improved if their Time 2 score was more than .5 standard deviations smaller than their Time 1 score. Using total scores to illustrate, the standard deviation of the Time 1 total score was 30.01, and so clients whose Time 2

scores were more than 15 points smaller or larger than their Time 1 scores were classified as improved or deteriorated, respectively.

For all three scores, the most frequent result was "no-change". With respect to total scores, 6 clients deteriorated, 3 clients improved, and 16 showed no change. With respect to externalising scores, 4 clients deteriorated, 3 clients improved, and 18 clients showed no change. With respect to internalising scores, 8 clients deteriorated, 5 clients improved and 12 clients showed no change (see Table 3.12).

Table 3.12

Change in Problem Severity Over Time for the Total, Externalising and Internalising Scores.

Change Between Time 1 & Time 2	Total	Externalising	Internalising
No Change	16	18	12
Worse	6	4	8
Better	3	3	5
Total	25	25	25

Distribution of clients

The distribution of the 25 clients into normal, borderline and clinical categories at Time 1 is shown in the upper portion of Table 3.13 for each of the three scores (total, externalising and internalising). The parallel distribution at Time 2 is shown in the lower portion of Table 3.13. The differences between Time 1 and Time 2 distributions were negligible. For all three scores, at both Times 1 and 2, the most frequent classification was "clinical".

Table 3.13

Classification of Clients at Time 1 and Time 2 for Total, Externalising and Internalising Scores (n = 25).

Parent Rating	Score					
	Total		Externalising		Internalising	
	n	%	n	%	n	%
Time 1						
Classification						
Normal	8	32	6	24	9	36
Borderline/Clinical	1	4	1	4	4	16
Clinical	16	64	18	72	12	48
Time 2						
Classification						
Normal	8	32	6	24	10	40
Borderline/Clinical	3	12	1	4	3	12
Clinical	14	56	18	72	12	48

Wait times

The wait time interval from referral to subsequent appointment ranged from 0 to 266 days. The average total wait time for the 25 clients whose parents/caregivers completed both questionnaires was 134.24 days or 4.5 months (sd = 67.20). For 19 High priority clients the average total time waited was 86 days or 2.9 months (sd = 38.53). For 6 Medium priority clients, the average total wait time was 153.53 days or 5.1 months (sd = 67.27).

A correlation between total time waited and the change in total scores between Time 1 and Time 2, yielded a Pearson's correlation coefficient of .221, which was not significant at the 0.01 nor the 0.05 level.

DISCUSSION

CHAPTER FOUR

The present study evaluated wait lists at a Child, Adolescent and Family Mental Health Service. The primary emphases of the current evaluation was on (I) describing the characteristics of clients assigned to the various wait type priority categories, (II) determining typical wait times experienced by clients before their initial appointment, and (III) determining whether there was any change in client problem severity over the wait time. It should be remembered that clients referred to the service in Crisis or in need of Urgent treatment were excluded from (III).

Client Characteristics

The initial objective of the present study was to describe the characteristics of clients assigned to the different priority categories. Results revealed that gender and age distributions of clients accepted and seen for their initial appointment varied across the wait type categories. Older females were more likely to be placed in the Crisis and Urgent categories, while younger males were more likely to be placed in the High and Medium wait type categories.

More adolescent females aged between 13 and 16 years were placed in the Crisis and Urgent categories than adolescent males. This may reflect the potential risks experienced by females in these age groups. For example, developmental pressures, behavioural risks as well as societal pressures such as peer pressure. These findings may also be a reflection of discriminatory practice by the service. However, a more likely explanation is

that it is the nature of the presenting problem which determines the nature of the response to the referral.

Age distributions of clients accepted and finally seen for their initial appointment, indicated that the older the client was (12 - 15 years), the more likely they would be placed in Crisis/Urgent categories. Clients who were younger (8 - 12 years) tended to be placed more often in the wait listed categories.

Gender roles

Authors have investigated the extent to which gender roles and gender role ideology account for differences in presenting problem behaviour. For example, it has been found in past research that there are definite differences in how males and females exhibit behavioural problems such as internalised and externalised behaviour problems. Internalising and externalising symptoms have been defined as an alternative manifestation of distress (Gjerde, Block & Block, 1988; Horowitz & White, 1987; Huselid & Cooper, 1994).

These authors agree that gender roles are related to externalising problems among male adolescents, and internalising problems among female adolescents. Males have been said to be more likely to express distress through outward behaviour, such as drinking problems and aggression, whereas females are more likely to turn their distress inward and manifest symptoms such as low self esteem and depression (Gjerde et al. 1988; Horowitz & White, 1987).

The tendency for males to externalise and women to internalise distress is said to be consistent with cultural gender role norms (Huselid & Cooper, 1994). Traditional gender role socialisation encourages males to be active, aggressive and expressive of anger but not sadness, whereas females are encouraged to be submissive, agreeable and expressive of sadness but not anger (Block, 1983; Huselid & Cooper, 1994). These internalised disorders may be harder to detect, unless the problem behaviour becomes so severe that immediate help is sought.

Males, on the other hand, tend to exhibit more externalised behaviour, such as conduct and oppositional behaviour problems (Horowitz & White, 1987). These problem behaviours are so disruptive that they may influence parents/caregivers to seek help quickly. Although these externalised behaviours are problematic to the parent, the mental health service generally classifies these problems as less severe.

Wait Times

The second objective of this study was to determine typical waiting times for clients attending CAFS in the different wait list categories. To determine if wait type category affected the length of time a client spent waiting for their initial appointment, mean wait time in days were calculated for each wait type category. The results indicated that clients with more severe problem behaviours (ie., Crisis and Urgent clients) spent less time waiting for treatment than those with less severe problem behaviours (ie., High and Medium wait listed clients). The average time waited in the two wait list categories, indicated that those in the High priority wait list were seen twice as quickly as those on the Medium priority wait list. As noted in the Results

chapter, mean time waited for clients in the High priority wait list was on average 77.66 days (or 2.6 months). For those in the Medium priority wait list, the average wait time was 149.96 days (or approximately 5 months).

The majority of previous research reviewing wait lists generally focused on the time between referral from a referral agent to the initial appointment session (Friman et al. 1985; Lowman et al. 1984; Raynes & Warren 1970; Raynes & Warren 1971; Wolkon, 1972). The present study also focused on both the wait time between referral and intake and the wait time between referral and initial appointment date.

This division was implemented to discover the length of time waited between referral and intake appointment, in order to see whether clients were actually discussed at intake meeting date within one week from referral date, as stated by the CAFS intake team. During the course of this study, the time between referral and intake meeting date was quite varied depending on which wait type category was assigned. For instance, those deemed in immediate need of treatment (Urgent clients) were discussed during an intake meeting date within 8 days of referral. Those categorised as High priority clients were discussed on average within 10 days of referral, and those placed on Medium priority wait list were discussed on average within 18 days from referral. In other words, the less severe the problem behaviour, the longer it took to determine which wait type category the client was to be assigned.

Although authors have investigated the effects of wait times from referral to initial appointment, little thought has been given by previous researchers to the time waited before referral to a mental health service. Fraser (1993) suggested that it could be that parents/caregivers may already have spent a

considerable length of time waiting for the problem behaviour to improve. Consequently, when the behaviour does not improve, or becomes worse it is then that help is most probably sought (Kournay et al. 1990). Therefore, the total time waited by parents/caregivers may actually be much longer than measured by previous researchers.

The present study considered including the time waited before treatment was sought, however the main focus of the study was to investigate any possible effects of wait lists on problem severity waiting for treatment whilst on the service wait list. To extend existing findings, specific research regarding total wait time (including time waited before treatment was sought) would be of some interest.

Changes in Problem Severity Over Wait Time

Description of clients at Time 1

The initial hypothesis of the present study was to determine whether clients placed on the High priority wait list had significantly higher levels of symptomatology than those placed on the Medium priority wait list. This hypothesis was not accepted.

T-tests conducted on the CBCL Total, Internalising and Externalising scores did decrease, but not significantly from the High priority wait list to the Medium priority wait list. Problem severity was indexed by using the CBCL Total scores.

Differences between the mean scores did not reach a conventional level of significance when t-tests were applied. However, these results indicate that although these decreases in problem severity were not significant, the CAFS wait list criteria was correctly defining and depositing clients into the wait list category most suitable for both client and service. These findings were similar to those of Anderson et al. 1987; Archer, 1984; Freund et al. 1989; Gould, et al. 1985; Levitt 1957; May 1991; Stern and Brown, 1994; and Viale-Val, et al. 1984.

Description of clients at Time 2

The third aim of the present study was to determine what changes in symptomatology or problem severity occurred whilst clients waited for their initial appointment.

To measure changes in problem severity, the Child Behaviour Checklist scores were analysed. Severity was indexed by the Total score derived from the questionnaire, measured at both Time 1 and Time 2. Potential change in problem severity was derived by the change in total score between Time 1 and Time 2. Differences between these scores did not reach a conventional level of significance when t-tests were applied.

One reason why problem severity did not increase over wait time is that at the time of referral to CAFS, clients were already experiencing severe problems. At Time 1, the majority of clients (72.4%) were classified in the "clinical" range of the CBCL problem scale. This indicates that the majority of clients accepted for treatment at CAFS had severe problem behaviours.

From the above results it can be assumed that parents/caregivers are scoring their children highly on the Child Behaviour Checklist. It is logical to expect a certain amount of parental bias, in which parents will attempt to produce a score which will enhance their chance for quicker service (Achenbach, 1984; Archer, 1984; Cohen et al. 1985). Thus, the present study suggests that parental assessments may have been 'inflated' at Time 1 to ensure that their child was accepted for treatment, and that this initial inflation may have masked any deterioration in problem severity between Time 1 and Time 2.

The second hypothesis stated that as wait time increased, problem severity would also increase. This hypothesis of increased problem severity as a function of wait time was not supported. The results of the present study suggested that there was no relationship between change in problem severity, and the length of time waited between the date of referral and the date of initial appointment. There were neither significant differences in CBCL Total scores between referral and appointment times, nor significant correlations between wait time and change in problem severity.

Although the nature of the studies varied, the tendency for more recent studies to find fewer and less pronounced negative results is interesting. May (1991) believed that several factors may explain these trends. Firstly, counselling centres such as CAFS, with experience with high service demands, may have developed more effective administrative procedures for serving the large numbers of clients referred to the service. The development of strict intake and wait list criteria would be one such example. Secondly, clients are more aware of the high demands for services, (especially with low cost or free agencies) and may have lowered their expectations for timely service. Shueman et al. (1980) suggested that

clients' problem behaviours did not become worse because clients may perceive that something is being done about their problem as a result of their intake into the service, even though they may still have to wait for their initial treatment session. This could explain why there were no significant changes in problem behaviour over wait time.

It must be remembered that only wait listed clients were studied with regards to possible effects of wait times on change in client problem severity. It may well be that clients exhibiting more severe problems (ie., Crisis/Urgent clients) would reveal totally different findings. Previous research has found that there were decidedly different results for the High priority groups than the lower priority groups, and that more Urgent problems may persist longer over time (Archer, 1981; Archer 1984).

The present study found that clients' problem severity did not change over wait time. This finding was similar to that of a previous author (May, 1991). May (1991) suggested that clients' problem severity did not change over wait time because: (a) the service in question has developed effective administrative procedures, and (b) clients are more aware of wait lists and so expect to wait for treatment within the present health care system. Future research investigating or controlling administrative procedures and potential client expectations of wait lists may produce some interesting results.

General Implications of the Findings

The following section will discuss the implications and applications of the findings. Implications of the findings include gender role effects on problem symptomatology. Application of the referral process on service delivery and efficiency will also be discussed.

Age and gender differences

Gender differences in both internalising and externalising problem severity have been found to increase with age during adolescence (Donovan & Jessor, 1985). It has been suggested by previous research that these findings occur due to gender roles and developmental influences, especially during the adolescent stage in a young persons' life (Verhulst & Koot, 1991). In the present study, no such results were obtained, as problem severity (indexed by CBCL Total Scores) was unchanged from Time 1 to Time 2.

In the present study, significant relationships were found between age, gender and wait type category given. It is useful to examine these relationships in order to identify whether a service is neglecting the needs of a particular group of clients. For example, the service may be catering for older female clients but not for younger males. Once this has been identified, efforts could be made to adjust the service accordingly.

Application of Findings

Referral to CAFS

The present study found that a number of clients referred to CAFS were either referred on due to their problem behaviours not being severe enough to warrant treatment ($n = 48$), or were referred to other agencies due to long wait lists ($n = 150$). These findings have considerable applied implications for the service, as the referral process plays an important role not only in client service delivery, but also agency efficiency.

The present study gathered data from a total of 542 clients referred to CAFS over 17 months. On average, a total of 8 clients were referred to the agency per week. A total of 335 clients met CAFS criteria and of those 335 clients a total of 228 clients were eventually seen by clinicians. Thus, on average a total of 3.4 clients had their initial appointment per week.

During the course of data collection, it was discovered that 150 clients who met CAFS criteria were referred on to other agencies, some times because of lengthy wait lists, cultural issues or geographic location. From this it can be assumed that a fair amount of time and clinic resources are being wasted referring clients on to other agencies. It also can be assumed that referral agents are not aware of other community agencies which may provide their clients with quicker treatment.

Further research would be appropriate to discover whether these explanations were founded. Ultimately, this would be a worthwhile endeavour as it could cut wastage of staff time and resources, and free more time for clinicians to see those on the wait list, creating quicker turnover and possibly reducing wait times.

A concern related to the referral information sent to CAFS by the referral agencies should be noted. While it was hoped that all referral letters would provide the necessary information, in some cases little information was given to the intake team, and hence a small number of clients had to wait unnecessary lengths of time until the relevant material was collected. Not only does the client have to wait longer than necessary for a decision regarding their appropriateness for services, but staff time is also wasted, searching for the required information.

Wait times of clients referred to CAFS

Wait times experienced by clients from referral to intake meeting date indicate that as type of problem severity increased, wait time decreased. An assumption which could be made from this finding is that clinicians find it easier to categorise clients with more severe problem behaviour than those with moderate problem behaviour. For example, although weekly intake team meetings were held, on average it took more than a week for clinicians to assign wait type categories to those assigned to the High and Medium priority wait lists.

These findings may well be a result of clinicians not having enough time to discuss individual cases during the weekly intake team meeting. Another reason may well be that clients who were placed "on hold", awaiting further

information regarding client suitability, could affect the mean days waited. Fortunately, it appears that these reasons did not affect problem severity of those in most need of treatment, as CAFS clinicians did not wait list those referred in Crisis or in need of Urgent services.

Clients seen by clinicians

Although more than half of the clients referred to CAFS were referred on, a large proportion of clients were seen quickly by clinicians. In fact, 47% of clients accepted for treatment were seen either in Crisis or Urgently. In other words, Crisis/Urgent clients received prompt treatment. This indicates that CAFS is providing necessary treatment promptly to those with the most severe symptomatology. As mentioned previously, these clients were not included within the study investigating the effects of wait lists due to the nature and severity of their presenting problems. However, the findings of the present study regarding possible change in problem severity indicates that the service has implemented good intake and wait list procedures. Thus, it is suggested that other CAF services who use wait lists would be advised to consider implementing similar intake and wait list criteria.

General Limitations of the Study

Design and internal validity

As with most services, there were difficulties collecting relevant material regarding clients at CAFS. These included the fact that the information required was scattered among several different sources, and that the information in the intake book (which was the core information site) was not

consistently kept. This resulted in missing data and extensive searching among various records (ie., current index file, discharged index file, non action referred folders, and in some cases questioning key workers). Another factor was the nature of wait lists themselves. Due to the long wait lengths experienced by clients, data collection was a slow, time consuming process.

Due to extensive wait lists and lengthy wait times, data collection was not only slow but resulted in a small sample size. Thus, the internal validity of the findings may have been compromised. The present study predicted that as wait time increased, so would problem severity. Although a non-significant result was obtained, there was a small positive correlation between wait time and change in problem severity. Finding statistically non-significant results raises a concern about the possibility of insufficient power to detect clinically important effects. It is possible that re-testing the same hypotheses above, may have produced more significant results with a larger subject population.

A possible limitation within the present study is that of 'sampling bias'. Sampling bias may have occurred within this study as Crisis and Urgent clients were not included in the questionnaire research. Thus, it can be assumed that this exclusion would have affected the generalisability of the results.

External validity and generalisability

Comparison between services is only possible when standardised scales are used (Lebow, 1987; Tanner, 1981). Unfortunately this has not been the case with many health services. While public health services undoubtedly

monitor wait lists in an ad hoc manner, few studies were found regarding wait lists and their effects on problem symptomatology before initial appointments. Although these studies investigated problem severity, their main focus was on client attrition levels linked to wait lists (Gould et al. 1985; May, 1990; Stern & Brown, 1994).

Problems occur when comparing the results of this study to others due to differences in the methodology used to collect data. For example, questionnaire return rates differ from study to study. In the present study, only 29% of clients completed questionnaires at both Time 1 and Time 2. Such a low return rate is a problem in itself, as it affects the validity and generalisability of the results. It is highly probable that follow up procedures may have increased the return rate. It is advisable that future research include follow-up procedures in order to increase questionnaire return rates, and thus increase the generalisability of the findings.

Measurement

The present study used a longitudinal, prospective design in a field setting without any experimental manipulation of the variables. The main advantage of prospective studies of representative, general population samples is the generalisability of the findings. A weakness of general populations is that large samples are needed to catch even a few subjects with a particular problem behaviour. Unfortunately, with the small sample size of this study, the type of problem behaviour a client had could not be investigated thoroughly. Therefore, there is a possibility that the type of problem behaviour may have changed over time waited for treatment, even though problem severity did not. However, most studies report a continuity of problem behaviour across wait time. In a four year longitudinal study of

children aged 4 to 12, researchers found that parents' reports of problem behaviour were equally stable for all ages as well as for both sexes (Verhulst & Koot, 1990).

Conclusion

The present study set out to investigate wait times and their effects on clients' problem severity. Over the course of the study, the effectiveness of CAFS administrative procedures revealed that time spent waiting for the initial appointment was not found to cause any significant changes in problem severity. Thus, present intake and wait list criteria used by the agency were quite effective in determining which client was appropriate for treatment and which wait type category should be assigned.

This study has been especially timely as it has coincided with a surge of interest in the mental health sector regarding availability of services. Privatisation of health services and the increasing public demand that health services become more efficient has led to the increasing interest in wait lists.

There was no evidence in the present study that wait times affected problem severity before clients' initial appointments. However, these results should not be taken as a sign to public health services to reduce efforts to minimise waiting times for their clients. On the other hand, these results, along with those of other researchers cited earlier, suggest that there are several types of settings, client populations, and administrative procedures in which longer delays are not detrimental to clients who go on to be seen by clinicians for their initial appointment.

Ethical care of clients must include responsive delivery of treatment services. Yet increasing demands for services and limited staff resources

create difficulties for most treatment centres. When service delays are unavoidable, clinicians must continually evaluate the efficacy of how they delay and limit services. Although this study has sought to promote understanding of the effects of wait times, several contradictory and inconclusive results have been noted. Clearly additional research is necessary to better understand the effect that waiting for treatment has on client problem symptomatology.

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APPENDICES

APPENDIX A: Guidelines for Referral to CAFS

CHILD, ADOLESCENT & FAMILY MENTAL HEALTH SERVICE
Kauri House, Ruahine Street, Palmerston North Hospital
Phone: (06) 350.8373 Fax (06) 350.8374

- 1 -

GUIDELINES FOR REFERRAL TO OUR SERVICE

***N.B. Clients Need To Meet All Of The Following Criteria To Be Considered For
Acceptance To Our Service***

- Person aged between 0-18 years Yes No
 - Significant mental health disorder (client and/or family member)
 - There are no current unresolved care and protection issues or Court proceedings (e.g. access/custody)
 - Referral information completed
- ⇒ **If client identifies as Maori, refer to Oranga Hinengaro (Specialist Maori Mental Health Team)**
- ⇒ **Please provide the following information either by using this form or a letter containing the same information**
- ⇒ **If you have any questions we are available for consultation and liaison**

REFERRAL FORM

Patient's Name: _____ DOB: _____

Ethnicity: _____ Age: _____ School: _____

Address: _____

Name of parent(s) and step parent (or legal guardians)

Caregiver: (If different from above)

Address: _____

Other Family Members

Please provide all relevant telephone numbers:

CHILD, ADOLESCENT & FAMILY MENTAL HEALTH SERVICE
Kauri House, Ruahine Street, Palmerston North Hospital
Phone: (06) 350.8373 Fax (06) 350.8374

- 2 -

REASON FOR REFERRAL:

Presenting Problem (Please be specific):

How is This Disrupting Family Life?

How Long Has This Problem Been Present?

OTHER RELEVANT DETAILS:

Are there Any Other Significant Health Problems Within The Family? If So Please Specify.

Has The Child Had a Recent Medical Examination? If So What Was The Outcome?

General Practitioner: _____

Paediatrician: _____

Current Medications: _____

Form: 19/6/97

CHILD, ADOLESCENT & FAMILY MENTAL HEALTH SERVICE
Kauri House, Ruahine Street, Palmerston North Hospital
Phone: (06) 350.8373 Fax (06) 350.8374

- 3 -

Are There Any Other Services Involved? (e.g. NZ CYPFS, Special Education Service,
ACC registered private Counsellor, Respite Care Agencies, Police.

Any other relevant information:

Name of Referring Agent: _____

Agency: _____

Address (Including postal address): _____

Phone: _____ Date: _____

Form: 19/6/97

APPENDIX B: Child Behaviour Checklist Questionnaire

CHILD BEHAVIOR CHECKLIST FOR AGES 4-18

For office use only
ID #

Please Print

CHILD'S FULL NAME	FIRST	MIDDLE	LAST	PARENTS' USUAL TYPE OF WORK, even if not working now. (Please be specific—for example, auto mechanic, high school teacher, homemaker, laborer, lathe operator, shoe salesman, army sergeant.)
SEX	AGE	ETHNIC GROUP OR RACE		
<input type="checkbox"/> Boy <input type="checkbox"/> Girl				FATHER'S TYPE OF WORK: _____
TODAY'S DATE		CHILD'S BIRTHDATE		MOTHER'S TYPE OF WORK: _____
Mo. _____ Date _____ Yr. _____		Mo. _____ Date _____ Yr. _____		
GRADE IN SCHOOL	Please fill out this form to reflect <i>your</i> view of the child's behavior even if other people might not agree. Feel free to print additional comments beside each item and in the spaces provided on page 2.			THIS FORM FILLED OUT BY:
NOT ATTENDING SCHOOL <input type="checkbox"/>				<input type="checkbox"/> Mother (full name) _____ <input type="checkbox"/> Father (full name) _____ <input type="checkbox"/> Other—full name & relationship to child: _____

I. Please list the sports your child most likes to take part in. For example: swimming, baseball, skating, skate boarding, bike riding, fishing, etc. <input type="checkbox"/> None	Compared to others of the same age, about how much time does he/she spend in each?	Compared to others of the same age, how well does he/she do each one?
	Don't Know Less Than Average Average More Than Average	Don't Know Below Average Average Above Average
a. _____	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
b. _____	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
c. _____	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
II. Please list your child's favorite hobbies, activities, and games, other than sports. For example: stamps, dolls, books, piano, crafts, cars, singing, etc. (Do <i>not</i> include listening to radio or TV.) <input type="checkbox"/> None	Compared to others of the same age, about how much time does he/she spend in each?	Compared to others of the same age, how well does he/she do each one?
	Don't Know Less Than Average Average More Than Average	Don't Know Below Average Average Above Average
a. _____	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
b. _____	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
c. _____	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
III. Please list any organizations, clubs, teams, or groups your child belongs to. <input type="checkbox"/> None	Compared to others of the same age, how active is he/she in each?	
	Don't Know Less Active Average More Active	
a. _____	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
b. _____	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
c. _____	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
IV. Please list any jobs or chores your child has. For example: paper route, babysitting, making bed, working in store, etc. (Include <i>both</i> paid and unpaid jobs and chores.) <input type="checkbox"/> None	Compared to others of the same age, how well does he/she carry them out?	
	Don't Know Below Average Average Above Average	
a. _____	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
b. _____	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
c. _____	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	

Please Print

- V. 1. About how many close friends does your child have? ☐ None ☐ 1 ☐ 2 or 3 ☐ 4 or more
(Do *not* include brothers & sisters)
2. About how many times a week does your child do things with any friends outside of regular school hours?
(Do *not* include brothers & sisters) ☐ Less than 1 ☐ 1 or 2 ☐ 3 or more

VI. Compared to others of his/her age, how well does your child:

- | | Worse | About Average | Better | |
|---|--------------------------|--------------------------|--------------------------|---|
| a. Get along with his/her brothers & sisters? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Has no brothers or sisters |
| b. Get along with other kids? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| c. Behave with his/her parents? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| d. Play and work alone? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |

VII. 1. For ages 6 and older—performance in academic subjects. ☐ Does not attend school because _____

Check a box for each subject that child takes

- | | Failing | Below Average | Average | Above Average |
|--|--------------------------|--------------------------|--------------------------|--------------------------|
| a. Reading, English, or Language Arts | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. History or Social Studies | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Arithmetic or Math | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Science | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Other academic subjects — for example: computer courses, foreign language, business. Do <i>not</i> include gym, shop, driver's ed., etc. | | | | |
| e. _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| f. _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| g. _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

2. Does your child receive special remedial services or attend a special class or special school? ☐ No ☐ Yes—kind of services, class, or school: _____

3. Has your child repeated any grades? ☐ No ☐ Yes—grades and reasons: _____

4. Has your child had any academic or other problems in school? ☐ No ☐ Yes—please describe: _____

When did these problems start? _____

Have these problems ended? ☐ No ☐ Yes—when? _____

Does your child have any illness or disability (either physical or mental)? ☐ No ☐ Yes—please describe: _____

What concerns you most about your child? _____

Please describe the best things about your child: _____

Below is a list of items that describe children and youth. For each item that describes your child **now or within the past 6 months**, please circle the **2** if the item is **very true or often true** of your child. Circle the **1** if the item is **somewhat or sometimes true** of your child. If the item is **not true** of your child, circle the **0**. Please answer all items as well as you can, even if some do not seem to apply to your child.

Please Print

0 = Not True (as far as you know) 1 = Somewhat or Sometimes True 2 = Very True or Often True

0	1	2	1.	Acts too young for his/her age	0	1	2	31.	Fears he/she might think or do something bad
0	1	2	2.	Allergy (describe): _____					

0	1	2	3.	Argues a lot	0	1	2	32.	Feels he/she has to be perfect
0	1	2	4.	Asthma	0	1	2	33.	Feels or complains that no one loves him/her
0	1	2	5.	Behaves like opposite sex	0	1	2	34.	Feels others are out to get him/her
0	1	2	6.	Bowel movements outside toilet	0	1	2	35.	Feels worthless or inferior
0	1	2	7.	Bragging, boasting	0	1	2	36.	Gets hurt a lot, accident-prone
0	1	2	8.	Can't concentrate, can't pay attention for long	0	1	2	37.	Gets in many fights
0	1	2	9.	Can't get his/her mind off certain thoughts; obsessions (describe): _____	0	1	2	38.	Gets teased a lot
				_____	0	1	2	39.	Hangs around with others who get in trouble
0	1	2	10.	Can't sit still, restless, or hyperactive					
0	1	2	11.	Clings to adults or too dependent	0	1	2	41.	Impulsive or acts without thinking
0	1	2	12.	Complains of loneliness	0	1	2	42.	Would rather be alone than with others
					0	1	2	43.	Lying or cheating
0	1	2	13.	Confused or seems to be in a fog					
0	1	2	14.	Cries a lot	0	1	2	44.	Bites fingernails
					0	1	2	45.	Nervous, highstrung, or tense
0	1	2	15.	Cruel to animals					
0	1	2	16.	Cruelty, bullying, or meanness to others	0	1	2	46.	Nervous movements or twitching (describe): _____

0	1	2	17.	Day-dreams or gets lost in his/her thoughts					
0	1	2	18.	Deliberately harms self or attempts suicide	0	1	2	47.	Nightmares
0	1	2	19.	Demands a lot of attention	0	1	2	48.	Not liked by other kids
0	1	2	20.	Destroys his/her own things	0	1	2	49.	Constipated, doesn't move bowels
0	1	2	21.	Destroys things belonging to his/her family or others	0	1	2	50.	Too fearful or anxious
0	1	2	22.	Disobedient at home	0	1	2	51.	Feels dizzy
0	1	2	23.	Disobedient at school	0	1	2	52.	Feels too guilty
0	1	2	24.	Doesn't eat well	0	1	2	53.	Overeating
0	1	2	25.	Doesn't get along with other kids	0	1	2	54.	Overtired
0	1	2	26.	Doesn't seem to feel guilty after misbehaving	0	1	2	55.	Overweight
0	1	2	27.	Easily jealous				56.	Physical problems <i>without known medical cause</i> :
0	1	2	28.	Eats or drinks things that are not food — <i>don't</i> include sweets (describe): _____	0	1	2	a.	Aches or pains (<i>not</i> stomach or headaches)
				_____	0	1	2	b.	Headaches
					0	1	2	c.	Nausea, feels sick
					0	1	2	d.	Problems with eyes (<i>not</i> if corrected by glasses) (describe): _____
0	1	2	29.	Fears certain animals, situations, or places, other than school (describe): _____	0	1	2	e.	Rashes or other skin problems
				_____	0	1	2	f.	Stomachaches or cramps
					0	1	2	g.	Vomiting, throwing up
0	1	2	30.	Fears going to school	0	1	2	h.	Other (describe): _____

Please Print

0 = Not True (as far as you know) 1 = Somewhat or Sometimes True 2 = Very True or Often True

0	1	2	57.	Physically attacks people	0	1	2	84.	Strange behavior (describe): _____
0	1	2	58.	Picks nose, skin, or other parts of body (describe): _____					
					0	1	2	85.	Strange ideas (describe): _____
0	1	2	59.	Plays with own sex parts in public	0	1	2	86.	Stubborn, sullen, or irritable
0	1	2	60.	Plays with own sex parts too much	0	1	2	87.	Sudden changes in mood or feelings
0	1	2	61.	Poor school work	0	1	2	88.	Sulks a lot
0	1	2	62.	Poorly coordinated or clumsy	0	1	2	89.	Suspicious
0	1	2	63.	Prefers being with older kids	0	1	2	90.	Swearing or obscene language
0	1	2	64.	Prefers being with younger kids	0	1	2	91.	Talks about killing self
0	1	2	65.	Refuses to talk	0	1	2	92.	Talks or walks in sleep (describe): _____
0	1	2	66.	Repeats certain acts over and over; compulsions (describe): _____					
					0	1	2	93.	Talks too much
0	1	2	67.	Runs away from home	0	1	2	94.	Teases a lot
0	1	2	68.	Screams a lot					
0	1	2	69.	Secretive, keeps things to self	0	1	2	95.	Temper tantrums or hot temper
0	1	2	70.	Sees things that aren't there (describe): _____	0	1	2	96.	Thinks about sex too much
					0	1	2	97.	Threatens people
					0	1	2	98.	Thumb-sucking
					0	1	2	99.	Too concerned with neatness or cleanliness
0	1	2	71.	Self-conscious or easily embarrassed	0	1	2	100.	Trouble sleeping (describe): _____
0	1	2	72.	Sets fires					
0	1	2	73.	Sexual problems (describe): _____	0	1	2	101.	Truancy, skips school
					0	1	2	102.	Underactive, slow moving, or lacks energy
					0	1	2	103.	Unhappy, sad, or depressed
					0	1	2	104.	Unusually loud
0	1	2	74.	Showing off or clowning	0	1	2	105.	Uses alcohol or drugs for nonmedical purposes (describe): _____
0	1	2	75.	Shy or timid	0	1	2	106.	Vandalism
0	1	2	76.	Sleeps less than most kids	0	1	2	107.	Wets self during the day
0	1	2	77.	Sleeps more than most kids during day and/or night (describe): _____	0	1	2	108.	Wets the bed
					0	1	2	109.	Whining
0	1	2	78.	Smears or plays with bowel movements	0	1	2	110.	Wishes to be of opposite sex
0	1	2	79.	Speech problem (describe): _____	0	1	2	111.	Withdrawn, doesn't get involved with others
					0	1	2	112.	Worries
0	1	2	80.	Stares blankly				113.	Please write in any problems your child has that were not listed above:
0	1	2	81.	Steals at home	0	1	2		_____
0	1	2	82.	Steals outside the home	0	1	2		_____
0	1	2	83.	Stores up things he/she doesn't need (describe): _____	0	1	2		_____
					0	1	2		_____

PLEASE BE SURE YOU HAVE ANSWERED ALL ITEMS.

UNDERLINE ANY YOU ARE CONCERNED ABOUT.

APPENDIX C: Information sheet



**MASSEY
UNIVERSITY**

Private Bag 11222
Palmerston North
New Zealand
Telephone +64-6-356 9099
Facsimile +64-6-350 5608

**FACULTY OF
BUSINESS STUDIES**

**DEPARTMENT OF
HUMAN
RESOURCE
MANAGEMENT**

INFORMATION SHEET

Waiting Time Study

This research is being carried out by Mariella Trynes as part of her Masterate degree in Psychology at Massey University. This study is supervised by Dr. Frank Deane in the Department of Psychology at Massey University. This research is being carried out by request of the CHE and participants are invited by Mariella to participate.

In this study we are interested in seeing what happens to clients while they are waiting to be seen for their first appointment at the Child, Adolescent and Family Mental Health Service (CAFS). This will help to improve the service provided and hopefully help in decisions about how to best arrange the waiting list.

The questionnaire we ask you to fill out is often used at CAFS and is designed for parent(s)/caregiver(s) to describe their child's behaviour, as well as the type and severity of the problems they are having.

If you take part in this study you will be asked to fill out the questionnaire twice, first when the referral has been made to CAFS. The second time will be a week before your child's first appointment at CAFS (a stamped return addressed envelope will be provided with the questionnaire forms for your convenience). The questionnaire takes about 20 minutes to fill out.

Filling out the consent form means that you agree to take part in this study. Taking part in this study is voluntary. **If you decide not to take part you will still get the same services from CAFS.** You have the right to refuse to answer any particular question or withdraw from this study at any time. Everything you write on the questionnaire is strictly confidential and will only be used by CAFS and for a Masters thesis and future publication. No person will be identifiable. A report will be written at the end of this study summarising the findings and this will be available at CAFS or from the Department of Psychology, at Massey University at the end of the study, around December 1997.

You have the right to ask questions about the study at any time. If you have any questions, feel free to contact Mariella Trynes or Dr. Frank Deane at the Department of Psychology, Massey University, Palmerston North, telephone (06)356-9099 extension 4126 or Milja Albers-Pearce at the Child, Adolescent and Family Mental Health Service, telephone (06)350-8373.

APPENDIX D: Consent form



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UNIVERSITY**

Private Bag 11222
Palmerston North
New Zealand
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Facsimile +64-6-350 5608

**FACULTY OF
BUSINESS STUDIES**

**DEPARTMENT OF
HUMAN
RESOURCE
MANAGEMENT**

Central Health Limited
Phone (06) 355 0998
Fax (06) 355 0616
PO Box 2056
Heretaunga Street
Palmerston North
New Zealand

WAITING TIME STUDY

CONSENT FORM

This project has been approved by both the Massey University Ethics Committee and the Manawatu - Whanganui Ethics Committee. This means that the Ethics Committee may check that this study is running smoothly and that the study has followed appropriate ethical procedures. Complete confidentiality is assured.

I have read the Information Sheet and have had the details of the study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I understand I have the right to withdraw from the study at any time and to refuse to answer any particular questions. Everything I write on the questionnaire is strictly confidential and will only be used by CAFS, for a Masters thesis and future publication.

Filling out the consent form means that I agree to take part in this study. Taking part in this study is voluntary. If I decide not to take part I will still get the same services from CAFS.

I agree to provide information to the researcher on the understanding that my name on any identifiable information will not be used.

I agree to take part in this study under the conditions set out in the Information Sheet.

Signed:

Name:

Date: