## ABSTRACT

A number of concerns about the adequacy of psychiatric services for children within the Province of Manitoba has led to a closer examination of these services. By reconstructing the careers of children receiving care from Selkirk Mental Hospital, an overview of the psychiatric service system is obtained. An analysis of the system is presented. As well, the major step within a career are discussed, and a number of factors affecting a career are isolated. The findings lead to the formulation of a Theory of Crisis Points. A number of recommendations, as well as some suggested hypotheses, are presented.

To Mary, Rae and Simone

## ACKNOWLEDGEMENT

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# TABLE OF CONTENTS

# LIST OF TABLES

Text

Appendixes

## LIST OF FIGURES

# CHAPTER I

## INTRODUCTION

This study seeks to establish the pathways and referral routes of children who have received psychiatric services within the eastern part of the Province of Manitoba. In particular, it seeks to reconstruct the histories of children who have received services from Selkirk Mental Hospital.

A number of concerns regarding child psychiatric services prompted the study. A major concern is that children are presently receiving treatment on adult wards in our psychiatric hospitals. It is the feeling of the study group that such a treatment setting is inappropriate and detrimental to the child. Support for such a position is given by the Canadian Mental Health Association in their publication, More for the Mind,

> Treatment of mentally ill or emotionally disturbed children requires methods, techniques, and skills fundamentally different from those used with adult patients. Children cannot be regarded as midget adults. [1]

The scarcity of facilities geared to treat children and adolescents is another concern. On July 1, 1970, Selkirk Mental Hospital established an adolescent ward, but only after failing in its attempts to have it established outside of its building complex. Apart from this one ward, there are no long-term psychiatric treatment settings exclusively for adolescents in the province.

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[1] Canadian Mental Health Association, More for the Mind (Toronto: Canadian Mental Health Association, 1963), p. 135

Closely related to this concern is the apparent lack of government committment to take positive steps in the field of mental health. A report by the study committee on Child and Family Service of the Winnipeg Social Service Audit states,

> ...we have no psychiatric treatment facilities for children in this province despite decades of government acknowledgement of this desperate need.[2]

An adolescent ward within the City of Winnipeg, or an increase in the number of residential treatment settings have both been advocated for a number of years, with no results.

A fourth concern is the apparent lack of preventative measures within the mental health realm, particularly for the mental health of children. Community Clinics and Child Guidance Clinics seem to reach only those already disturbed. School Counselling services seem to be primarily focused on the vocational choice of the student, with little concern for his family and home conditions.

It is also a concern that the rural areas of the province do not seem to receive the same quality of psychiatric services as do the urban areas. Members of the study group have seen families in isolated areas requiring such services but being unable to obtain them.

A final concern of the study group is that persons identified as mentally ill become stigmatized by society resulting in ostracism from many social circles. The extreme

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[2] Study Committee on Child and Family Service, An Evaluation of the Final Report of the Social Service Audit (Winnipeg: Social Service Audit Inc., 1969), p. 16.

form of this is evidenced by the large numbers of patients in our mental institutions who have been virtually deserted by their families. In our concerns with children, it has been observed that once a child begins to receive psychiatric service, this service tends to extend over a long period of time, and to influence the child in his day-to-day living. An example of this could be the "problem child" who spends his school years in special classrooms with similar children. What are the effects of such a deliberate identification and separation upon the self-identity of the child? Does such an identification reinforce the problem rather than treat it?

It was with these broad concerns that the study group was motivated to conduct research in the field of psychiatric services for children. As the field was explored more closely through talking with concerned people, reading and discussion, there evolved a more specific focus on the "system". Questions such as what services are presently offered to children, how do these services relate to one another, and how does a child enter and pass through these services, were asked. The idea of a career, being the history of a child as he works his way through the system, was formulated. The task of the study was therefore set to reconstruct the careers of children within the psychiatric service system. In order to accomplish this task, a sample of children receiving services from Selkirk Mental Hospital was chosen, and their histories studied.

As a result of this study the researchers are able to

present an analysis of the system, focusing on the agencies and the persons involved within the system. As well, the major steps within a career are discussed, and a number of factors affecting a career are isolated. The findings lead to the formulation of a Theory of Crisis Points, which is presented as a first step for future research. From these findings a number of recommendations are presented in the final chapter of this report.

The format of this report is as follows. Chapter two presents a detailed statement of the study, along with a discussion of the study's evolution, and an expansion of the key concepts involved. Methods used in conducting the research are presented in chapter three. Chapter four contains the results of the study, including the analysis of the results. The conclusions drawn from the study are presented in chapter five, with recommendations for future research and study in chapter six.

## CHAPTER II

## THE STUDY: STATEMENT, KEY CONCEPTS, AND EVOLUTION

In this chapter, a more explicit statement of the research project will be given along with a discussion of the key concepts, making reference to the related literature. A final section will present the evolution of the study, giving the reader an appreciation for the approach formulated.

### Extended Statement of the Study

The research group conducted a formulative-exploratory study of the histories of children receiving psychiatric care at Selkirk Mental Hospital. More specifically, the emphasis was on the referral, assessment and subsequent service processes; subsequent service including treatment, subsequent referral, and discharge.

The formulative-exploratory design allows for the systematic exploration of a field of study without the use of hypotheses. It is frequently used in a field that has had limited development and is described as "an essential early step in the development of knowledge".[3] Selltiz et al describe such a design as a means "to gain familiarity with a phenomenon or to achieve new insight into it, often in order to formulate a more precise research problem or to develop hypotheses".[4] It is an approach that allows for flexible methods of data collection, also allowing for focus shifting as insights

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[3] Kahn, Alfred J., "The Design of Research" in Norman A. Polansky, Ed. Social Work Research. (Chicago: University of Chicago Press, 1960) p. 51.

Selltiz, et al., Research Methods in Social Relations. Henry Holtand Co., Inc., U.S.A., 1960 p. 50.

are gained. That is, the methods used are determined by the characteristics of the subject, rather than a theoretical hypothesis. The formulative-exploratory design was chosen for this study because of a scarcity of research in the field that it was approaching, and the need for such research to be done.

Three terms in the statement of the study require further clarification. History is defined as those events of the child's past that are pertinent to the study, including the referral, assessment, treatment and discharge processes of which he was the subject. Social or family history is not of particular relevance apart from providing some background for the study. The career of the child is seen as being the sum of the various referral processes of the child's history. The concept of career will be developed later in this chapter.

A child is defined as a person who is seventeen years of age or under. For the purpose of the study, age was determined at the date of admission to Selkirk Mental Hospital. Thus, if a person was a child upon admission, but subsequently became an adult, he was still considered elegible for the study.

Rather than defining psychiatric care in technical terms, it was defined as that form of care offered by Selkirk Mental Hospital. A person must be defined as having a mental disorder under the Mental Health Act of Manitoba before he may be admitted to the hospital. Therefore it is assumed that all patients in the hospital are so defined.

Discussion of Concepts

There are five concepts that are central to the research design. Four of these are referral, assessment, treatment and

discharge. The fifth concept of labelling, embodying the ideas of diviancy and deviant career, provides an overview and a framework for the first four concepts. It is these five concepts that will receive attention here.

The referral process is that series of events by which a person with a problem, in this study an emotional problem, is made known to another person or agency for the purpose of receiving help for the problem. The person himself may make the referral, or others may make it for him; the person may or may not see the problem, and may or may not be in agreement with the referral. The referral may or may not be appropriate, may be formal or informal, professional or lay, effective or ineffective.

In a research study undertaken in New York, some principles for professional referral were drawn up as follows:

(1) referral to a community agency is a part of casework process.

(2) policies and procedures relating to interagency referral are essential for good social work practice and successful referrals.

(3) methods and procedures of referral should be made to the agency most acceptable and accessible to the client.[5]

While these are broad guidelines to be followed in the referral process, more specific factors to be aware of have been outlined in Rice's, Guide For Referral. She realizes that the human factor is often the most difficult to overcome

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[5] E.W. Wilson, and H.M. Bartlett, "Referrals from Hospitals to Social Agencies: Some Principles and Problems", Social Casework. Vol XXXVI (1955), pp. 457-465.

in making successful referrals. Thus, in making referrals, it is necessary to understand the nature of the client's problem and his willingness to work on it, to explain the service sought in the referral, to encourage the client to keep the referral appointment, to make the actual referral and to communicate with the agency.[6] Because the reason for referral is for service, follow-up to insure delivery of this service is also important.

Austin has pointed out that the need for referral is directly related to the function prescribed to the agency. Often clients have to be directed to the appropriate agency before they can get service. It is also pointed out that often deep-seated fears and psychological resistance may prevent clients from getting to the appropriate agency; the working out of these fears will be necessary before a successful referral can be made.

One finding of the New York study was that there was a lack of written policies in social service departments for referral procedures which caused confusion between agencies and led to unsuccessful referrals.[8] It was felt that the following procedures would constitute good casework practices of referrals:

(1) Consultation of supervisor for suitable referral agency.

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[6] E.P. Rice et al, Guide for Referral. (Boston: Dept. of Maternal and Child Health, Harvard School of Public Health, 1965), p.p. 6-8.

[7] Ibid., p. 7.

[8] Wilson and Bartlett, ap. cit. p. 459

(2) Method of referral should be related to the problem ie. by telephone, conference, or letter.

(3) Referral should be confirmed in writing.

(4) The division of responsibility of the two agencies should be outlined.

(5) Follow-up report should be made.[9]

It was also recognized that many of the worker's feelings and motivations entered into the referral process. Attitudes towards the referral agency affect the nature of the referral as does the referring worker's opinion of his agency and his position. Another inherent difficulty in referral is that by nature one agency seems to be imposing its interpretation of the problem on the other. These factors may often create conflict in the referral process. However, if successful referral is made, it is natural for the referral agency to reassess the problem in its own terms.

The opposite procedure than the one described might also be prevalent. Workers in an agency may be conditioned to see a problem in terms that are consistent with the definitions prevalent in the agencies to which they make referrals. That is, rather than use their own frame of reference they use that of the receiving agency.

Two questions posed by the New York study are perhaps relevant to the present study. First of all, are the referrals made entirely in terms of the client's need? Are there other factors influencing referral, such as work loads, special

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[9]Ibid., p. 460

casework interests, finances, etc.? As well, how can co-operation between agencies be developed?

Another aspect of the referral process that has not been discussed, is that of the lay referral. Professional referrals can only be made after the client has come to an agency. Prior to this, a number of possible events may have taken place. The client may have attempted to solve his own problem, or those around him may have made suggestions for a solution. Resources such as teachers or clergy may have been consulted. When the decision is made to seek professional help, the client may seek to discover, through informal channels, the nature and the effectiveness of the various services available. Once the agency is contacted and one visit is made, the client generally has the option of continuing service or not. Thus, the lay referral system has a great deal of control over the clientele of an agency. This is particularly true of agencies that rely on direct lay referrals for its clients. A discussion of such a system within the medical field may be found in Eliot Freidson's article "Client Control and Medical Practice".[10]

The assessment process is that series of events by which the person or agency receiving the referral, studies the "case" and comes to some decision regarding subsequent services. That is, it is the period of time commencing with the receipt of a referral by an agency and ending with the beginning of treatment. This period of study may be short, consisting of a

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[10] Eliot Friedson, "Client Control Medical Practice", The American Journal of Sociology, Vol LXV (January, 1960).

quick assessment and a referral to a more appropriate agency. On the other hand, it may involve long interviews, conferences, testing, consultation and history taking before a decision is reached. In some instances it may be found that assessment continues throughout the treatment process, or that treatment is begun before a complete assessment is made.

A number of outlines used in making an assessment or diagnosis have been suggested. Here we shall look at two such suggestions. Florence Hollis, in her book, Casework: A Psychosocial Therapy, sees the diagnosis period as lasting five or six interviews and consisting of three major steps: assessment, establishment of dynamic and etiological interrelationships, and categorization.[11] In the assessment step, the worker collects all the facts and organizes them, studies them and attempts to find where the problems are. External pressure such as housing, income, religion, and education are studied as are the physical condition of the client and the internal factors of his personality, particularly the client's libidinal and agressive characteristics. The client's ego is examined along with his super-ego. "The assessment process provides the worker with a workable knowledge of the client's strengths and weaknesses, the pressures, gratifications and potentials of his situation, based on a study of his current life, pertinent aspects of his past life, and his ways of acting in the casework interviews".[12]

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[11] Florence Hallis, Casework: A Psychosocial Therapy. New York: (Random House, 1964), p. 178

[12] Ibid., p. 187

Having established the 'facts' the worker then studies the interaction patterns of environment and personality. Certain characteristic patterns thus emerge which will give the worker clues as to the cause of the problem being studied. "Together the assessment and the dynamic, etiological diagnosis should define as clearly as possible the key points toward which treatment must be directed".[13]

The final step of the diagnosis is termed categorization. That is, the placing of the problem into a classification. Hollis feels such a classification is necessary as it makes a concise and specific description of the problem, and facilitates easy communication for referrals. It also gives clues as to what symptons are common to various classifications. "If one knows enough about some characteristics of a person to designate his clinical diagnosis, one immediately has the key to a great deal of other knowledge that will be useful in the process of helping him".[14]

English and Finch, in Introduction to Psychiatry, see the assessment process as consisting of three steps: history taking, examination, and diagnosis. History taking is designed to "bring out dominant personality traits, the focal points of vulnerability in association with the defense techniques used by the individual, and the emotional conflicts".[15] The examination focuses on the present circumstances, part processes such as perception, intellection, emotion and

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13 Ibid., p. 192

14 Ibid., p. 198

15 S. English and S. Finch, Introduction to Psychiatry. New York: (W.W. Norton and Co., Inc., 1954), p. 77

action, integrative functioning with the self and others, and finally reactions to threats. The final step of diagnosis, is seen as a means for a more general understanding of the patient's underlying conflict and allows for a clearer and more accurate estimation of prognosis.

The standard method of classification of the American Psychiatric Association is then presented. Two broad classifications distinguish between organic disorders and non-organic disorders. The organic disorders are divided into acute, chronic and mental deficiency. The non-organic disorders include psychotic disorders, psychophysiologic autonomic and visceral disorders, psychoneurotic disorders, personality disorders and transient situational personality disorders. Of particular interest is the psychotic disorders which include affective reaction (manic-depressive), schizophrenic reactions, and paranoid reactions as well as general psychotic reactions. All together there are over ninety different classifications presented.

The discussion of catagorization or diagnosis leads into the concept of labelling to be discussed below.

Subsequent service is the actual events or steps taken following the referral and assessment processes. This may be service offered by the assessing agency or it may consist of another referral to another agency. It may also consist of no service at all, the case being discuarged as not in need of treatment or classified as untreatable.

In discussing treatment as a major factor of subsequent service, there are a number of variables to consider.

The nature of the treatment may vary from medication and shock treatment (E.C.T.), to therapeutic counselling such as psychotherapy, to social rehabilitation such as offered by schools, Skills Unlimited, and the Open Door Club of the Canadian Mental Health Association. The setting for the treatment may be through the out-patient department of a hospital, a quasi-treatment setting such as a foster home or in-patient treatment within a restricted setting, such as Selkirk Mental Hospital. The length of treatment may very from one day to several years, although the study done by Wooley and Neiman indicates that the length of treatment is generally less than one year.[16]

By discharge the study means the termination of services to a client without simultaneously involving another agency to continue the service. An example of such a situation would be the releasing of a child to his parents, without follow-up being determined.

Having examined the concepts of referral, assessment, treatment and discharge, let us now turn to the more general concepts of deviance, deviant careers, and labelling. These concepts are discussed by Howard Becker in his book Outsiders. Deviancy, he feels, "is not a quality of the act a person commits, but rather a consequence of the application by others of rules and sanctions to an offender".[17] That is, an act is

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[16] P. Wooley and M. Neiman. Assessment of Treatment Results in Six Residential Treatment Centres for Children in Manitoba March 30, 1967. Department of National Health and Welfare, Government of Canada, Research Project 556-21-1. Unpublished.

[17] H.S. Becker, Outsiders: Studies in the Sociology of divance. New York: (The Free Press, 1963), p. 9

only deviant when it has been so labelled by people. People who then commit these labelled acts of deviance, become labelled deviant themselves. Once so labelled, the person is virtually forced into a deviant role, and he soon learns the rules. Thus, the person starts on a deviant career during which time he assumes more of the characteristics of the role. He associates with other similarly labelled and learns through this social experience.

In applying these ideas to this thesis, one might postulate that if a child exhibits some behaviour such as hyperactivity, he will not be considered abnormal until someone labels him as such. If he is in an environment where such behaviour is acceptable there will be no problem. However, if for example, his school teacher cannot control him in the classroom and calls him a "bad boy", that is, labels him as deviant, then suddenly a new concept of himself is presented to this boy. If he sees himself as "bad" then he will begin to act in what he considers a bad way. He begins to be singled out more often as being bad and may be ostracized by his play mates. This ostracism forces the boy to turn to other "bad" boys for companionship and new forms of deviance are learned. Thus the boy is started on a deviant career.

If, instead of being labelled as bad, the boy had been labelled as "disturbed", he would perhaps have received much different treatment. He would suddenly be given attention by psychologists, social workers and perhaps psychiatrists.

He might receive preferential treatment in the classroom and at home, or may even be sent to a special school. If he is placed in a treatment centre, he associates with other children labelled "disturbed" and is then socialized into the abnormal role. The child soon learns what types of behaviour are expected of him and he will be seen as exhibiting these behaviours, even if he does not manifest them. An example of how a child might respond to an atmosphere that expects him to fail or progress is given in Pygmalion in the Classroom.[18] Children in a school system are placed in special classrooms on an arbitrary basis but supposedly according to their ability. It is found that they respond to the level of expectation made for them rather than to the level of their actual ability. One might postulate that a child placed in a home for distrubed children will soon act disturbed, even if there is no basis for the disturbance.

Eliot Fredson, in the article "Disability as Social Deviance" discusses the process of labelling and the deviant role.[19] Medical or social control institutions define deviancy or disability by specifiying the attributes that they term deviant. They then seek out people who conform to these specifications and in treatment attempt to change their behaviour to conform with what they believe to be their potential. That is, a deviance is "an imputed condition, and the imputation may or may not rest on the physical reality".[20]

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18 R. Rosenthal and L. Jacobson, Pygmalion in the Classroom. New York: (Hold, Rinehart and Winston, Inc., 1968).

19 Eliot Friedson, "Disability and Social Deviance", Sociology and Rehabilitation, M.B. Sussman, ed.: (American Sociological Association, 1965).

20 Ibid., p. 71

With the deviant label goes a deviant role until he has been identified by others or by himself as deviant. Friedson feels that agencies, although they "may not actually create deviant roles, do by the nature of their activities refine and clarify their boundries, (and) add elements to the roles that may not have existed previously".[21] Thus, people may be included that at first were excluded, and others excluded that at first were included. These ideas are supported in the article by Thomas Scheff, "Typification in the Diagnostic Practices of Rehabilitation Agencies".[22]

The concept of a "good deviant" is one who fits the attributes of the label and plays the role of deviant well. When an agency is assessing an individual they will seek out information confirming the label and will ignore evidence to contrary. There is also the possibility that some information will be "read into" the behaviour in order to make the deviance "fit better".

Having examined these processes of labelling and deviant careers, one initially becomes sceptical of the system. However, Thomas Scheff defends the process, claiming that by such methods, deviancies become more precisely defined and the definitions become more valid. As more scientifiic knowledge is gained, the classifications become more accurate. With this accuracy comes better judgement in assessment and subsequently better treatment.[23]

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21 Ibid., p. 83

22 Thomas J. Scheff, "Typification in the diagnostic Practices of Rehabilitation Agencies", Sociology and Rehabilitation. M.B. Sussman, ed.: (American Sociological Association, 1965).

23 Ibib.

In this section, material ranging from the very specific and concrete to the general abstract level has been presented. The concrete material proved to be invaluable, particularly in the formulation of questionaires and schedules. The abstract material, particularly concerning careers and labelling, provides a conceptual framework that allows one to see continuity in the process being studied.

Evolution of the Study

The formulation of the study as stated in the first part of this chapter, was arrived at through different phases of development. It would seem appropriate, at this point, to explain these phases, thus allowing the reader to appreciate the course of development the study subsequently undertook.

Soon after the formation of the research group, the members of the group discussed and shared their concerns pertaining to psychiatric services for youth within the province of Manitoba. These concerns have been summarized in Chapter I of this report. A series of interviews were then conducted with a number of persons having interest in this field, for the purpose of seeking a suitable focus for the study. * It was suggested that a survey of the number

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* The research group is indebted to the following persons who willingly gave their time and their ideas, in order to assist in the formulation of the research topic:

Mr. Clive Bate, Executive Director, Children's Home of Winnipeg.

Miss Patricia Desjardins, Executive Director, Manitoba Branch, Canadian Mental Health Association.

Prof. Mary Easterbrook, School of Social Work, University of Manitoba.

Prof. Gerald Erickson, School of Social Work, University of Manitoba.

Prof. Joseph Ryant, School of Social Work, University of Manitoba.

Mr. Ben Rykiss, Director, Social Service Department, Selkirk Mental Hospital.

Prof. Pat Wooley, School of Social Work, University of Manitoba.

of children requiring psychiatric care in the province would be beneficial, particularly as such statistics are needed to provide weight to the argument for increased services. A second suggestion focused on referral practices, suggesting that often referrals are made as a matter of convenience or least expence rather than being based on an assessment of need. A concern for the lack of facilities for agressively acting out children was also expressed.

The research group tentatively formulated a study that would evaluate the referral, assessment and treatment processes of a sample of children receiving pyschiatric services using case histories as the source of information. However, upon discussion of this topic with a seminar consisting of a number of similar research groups, it was recognized that an evaluative study presents difficulties for social workers entering the psychiatric field. As a result the focus of the study was redirected to being a descriptive study of the pyschiatric system, using similar sources for information as before.

Further consultation and discussion, reintroduced the idea of the stigma. This led to the concepts of labelling and deviant careers presented earlier in this chapter.

Due to the nature of the field being studied, and lack of related research, it was felt that an exploratory design rather than a descriptive design would provide greater flexibility and be more appropriate. Thus, the purpose set

for the research group was to conduct a formulative-exploratory study of the histories of children receiving pyschiatric care at Selkirk Mental Hospital. It was with this orientation that the research group began its study.

# CHAPTER III

## METHOD

In Chapter II an outline of the evolution of the study was given up to the formation by the formation of a research proposal. In this chapter, the methods used to accomplish the task outlined will be discussed.

Having obtained permission from the Hospital for Mental Diseases at Selkirk to conduct the study, it was decided that a file questionnaire would be used to gather data from a sample of case files of children receiving care from that institution. * The case histories of these children would then be traced back through each agency with which they had been in contact. The same file questionnaire being applied at each point. As well, interviews were to be conducted with parents and relevant professionals; these being a further source of information. It was soon recognized that the task set forth was too extensive in view of the time available. It was therefore, modified in that professional interviews were to be replaced by a self-administered questionnaire.

Data collection for this study began at the Hospital for Mental Diseases at Selkirk, where the Medical Records initial contact with this department, we endeavoured to become

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* The research group wishes to acknowledge the co-operation received from Dr. S. Kovacs, Medical Superintendent of the Hospital for Mental Diseases at Selkirk and the assistance of his staff including: Dr. W. Nakielny, Dr. A. Pacher, Dr. D. Bednard, Mrs. F. Landygo and Mr. Wm. Wills.

familiar with the recording and filing system used and to discover a system of recording which would allow us to tabulate all admissions of patients seventeen years and under during the last four years.

It was learned that admissions up to April, 1969 had been recorded in ledger type books from which all admissions of young people from January, 1967 to April, 1969 could be drawn. These ledgers recorded all data on the admission, discharge, and limited information on the illness itself for each patient admitted in the history of the Hospital.

In order to list all admissions from April, 1969, to the present, a second method was necessary. This was found to exist in the form of admission slips filed by the accounting department. These slips were filed at admission for the purpose of expense billing and included limited statistical data on age, date of birth, etc. From a review of these records we were able to complete our listing of admissions and to cross-check the data gathered from the ledger records.

In choosing a sample from this listing, the following factors were considered:

(1) the number of files desired for the study.
(2) possible difficulties in tracing temporally remote admissions.
(3) the necessity of having a sample with similar characteristics for pretesting.

It was decided that two choices existed: to study all admissions from September 30, 1969 to September 30, 1970 - a one year period, or to include in our sample only admissions

from January 1, 1970 to September 30, 1970. After an orderly preview of five files randomly drawn from the period January 1, 1969 to September 1, 1969; by which a rough estimate of the work involved in tracing files was made, it was decided to use the thirty-one admissions from January 1, 1970 to September 30, 1970 as our sample. At the same time, a pre-test sample was selected which included all admissions during 1969.

Following this, the initial file questionnaire was developed and applied to a second group of five randomly drawn files. This initial pretest was evaluated and the questionnaire was revamped slightly by making items more explicit and by allowing more room for responses to be made. The questionnaire was then pretested a second time on a second randomly selected pretest sample. As a result of this second pretesting, it was felt that the questionnaire was acceptable for data collection. Data collection from Selkirk files was then begun.

At the same time, a letter to parents was developed requesting permission to include their child in the study and to conduct an interview with them. This was pretested using the first pretest sample without positive results. Three of the five letters mailed were returned, unable to be delivered, while replies to the other two were never received.

A second pretest with a revised letter, requesting permission to study each child's case only and not a personal

interview with parents, was then undertaken. The results of this showed that only one positive reply was made, while three letters were returned undelivered.

At this point, it was decided that it would not be possible to conduct parental interviews. As well, following discussion with the research advisor, it was felt that the concern of the researchers over confidentiality was perhaps over-emphasized and that parental permisson was not necessary. This position was found to be acceptable to the agencies concerned. However, data was of course to be treated ethically and confidentially. That is, the case source of all data was to remain anonymous in all phases of the research study and its consequent reporting.

Similarly, a letter of introduction for agencies to be contacted was developed but not used. Instead all agencies were contacted by telephone or in person by one of the three research members. Each agency was informed of the study, its purposes and nature and was asked to co-operate in data collection. All agencies were contacted once file data collection at Selkirk was completed and a list of agencies to be contacted could be tabulated. A list of cases to be studied at each agency was also compiled.

Data collection at agencies involving a number of case contacts was undertaken by all three researchers. At others, only one member of the research team was involved. At each agency involving more than one researcher, files were randomly

assigned for study. As well, while data collection was thought to be fairly well standardized across researchers, no one person followed a case throughout data collection, ensuring that the effects of any bias between researchers could be avoided. At all times, any problems encountered in data collection were discussed and resolved.

Following the completion of file data collection, a personnel questionnaire, to be used in obtaining information from staff, was developed. While the data obtained through this questionnaire was felt to be complementary to that of the file questionnaire, it will not be presented in this present paper but will form the content of a supplement to follow. The questionnaire was then pretested with the assistance of three psychiatrists and three social workers at two of the agencies contacted earlier. The results of the pretest demonstrated that the questionnaire was explicitly and clearly stated and applicable to various disiplines to be tested. Only minor changes in spacing were consequently necessary.

As previously decided, this questionnaire was to be given to staff presently found in agencies contacted earlier in the study. These staff members included psychiatrists, psychologists and social workers. In determining the actual sample to be studied, it was decided that the number of people to be tested in each agency should be roughly proportionate to the number of cases in our study found to be in contact with

each. Following this, each research member undertook to personally contact staff members at various agencies and gain their co-operation in completing the self-administered questionnaire.

Simultaneous with the administration of the personnel questionnaire, the analysis of file questionnaire data was begun. All questionnaires within each individual case were first chronologically ordered from the earliest data to the most recent according to the date of referral.

As all data was to be coded to allow for frequency tabulation and analysis, a system for coding was developed. This resulted in the file questionnaire items being divided into forty-seven separate units based upon the data originally sought and contained in the responses to the questionnaire items. In order to develp an accurate system for coding items on assessment, assemment items on all questionnaires were studied and listed. These were grouped and regrouped until a workable coding system for assessment items was derived. The completed coding system was then applied to all the file questionnaires. At the same time, items needing clarification were edited to facilitate the coding being undertaken. Combinations of response categories according to our coding system were recorded for later study. These were then recorded or grouped with similar combinations and recorded. With the addition of these combinations to our initial coding system, a completed coding system was developed.

In preparation for tabulation of the coded file material, all file questionnaires within a case were divided into units of analysis. A unit was defined as being one complete contact with an agency beginning with the receipt of a referral, through assessment, treatment and referral to another agency or discharge. In so doing, all data was divided into one hundred and sixty-three units.

The concept of unit of analysis was largely developed to provide a method for treating out-patient service. Through its use, out-patient service was included as one component of subsequent service and thus did not warrant a separate unit of analysis. By applying the concept of unit of analysis to the data, more than one file questionnaire could be grouped into each unit if the data recorded occured during a continuous period of contact.

Prior to tabulation, a further point of clarification was felt to be necessary concerning referrals. When more than one referral was made by an agency, the final referral resulting in termination of contact was to be recorded as part of the original unit. Any other referrals were to be recorded as a separate unit, with all questions not concerning referral answered, "not applicable". These units were to follow the unit containing the terminating referral.

Following the division of file data into units, all units were numbered in sequence from one to one hundred and sixty-three. The data from each unit was then recorded on

forms along with the unit number, the agency letter and the case number. Face sheet coded items, one to ten were recorded on separate sheets for all thirty-one cases. Following this process, the actual analysis of data was undertaken. The steps taken in this analysis will be outlined in detail in the following chapter.

Following analysis a number of conclusions were drawn on the basis of the observations made. These conclusions in turn, lead to the making of recommendations for the agencies and personnel giving psychiatric services, and for future research. Where possible, hypotheses were also put forth. This concludes the chapter on method.

# CHAPTER IV

# DATA ANALYSIS

## Introduction

This chapter will present the results of the analysis of the file data gathered in the study. As well as presenting these results, an attempt will be made to interpret and discuss them.*

This chapter itself is to be divided into seven sections, the first of which will give an outline of the methods and procedure used in the analysis. The remaining six sections will present the actual results and their interpretation.

It should be mentioned that the data actually presented, represents only that which is relevant to the analysis undertaken. A more complete presentation of the data, listing both frequencies and precentages for all categories, may be found elsewhere in this paper.**

## Section A: Techniques of Data Analysis

Following the development of the final coding system, the division of the data into units, and the actual coding of these units; data analysis was undertaken. It was decided to first calculate the frequencies with which each coded category in the overall data occurred. This was accomplished by tabulating every coded response to each of the 47 items found

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* The approach follows the pattern used by A.B. Hollingshead and F.C. Redlich in Social Class and Mental Illness: A Community Study. (New York: Wiley, 1958)

** See Appendix B.

in every unit of the overall data. The frequencies which resulted, were then transformed into percentages to permit for easier comparisons.

It should be noted here that throughout data analysis, percentages were calculated on the basis of the total data minus any not applicable responses. An example may prove useful: (Table II in Appendix), 47 not applicable responses were recorded; thus, for this item, percentages were calculated on the basis of 116 units (the total 163 units minus the 47 not applicables).

Following the calculation of frequencies and percentages in the overall data, it was decided to limit further analysis to five main blocks of data as follows:

(a) The data describing the sample (questions 1-10 for each case studied).

(b) First referral data on the 31 cases studied.

(c) The data resulting from the classification of agencies into major and minor categories.

(d) The data resulting from a comparison of long trip and short trip cases.

(e) Data studied in a comparison of urban and rural cases.

Clarification of the concepts used to define each of these blocks of data will follow in their respective sections.

As outlined earlier, percentages calculated from frequency tabulations form the basis for analysis in each section. Throughout analysis, the emphasis has been on the detection of trends or patterns within or between various components of

the data. Along with the presentation of the data to follow, an attempt has been made to interpret and discuss the significance of these trends. This discussion in turn, leads to the conclusions formulated later in Chapter V.

Section B: Description of the sample.

The sample chosen for the study consisted of 31 adolescents who had received service from the Hospital for Mental Diseases at Selkirk between January 1, 1970 and September 30, 1970. This was the total population that met the requirements set forth. As such, the total population was chosen for study and not a sample of it.

The birthdates of the study population ranged from 1952 to 1956, placing all cases in their adolescent years, as of the time of the study. Table I summarizes the birthdates:

| BIRTHDATE | NUMBER | % |
|---|---|---|
| 1952 | 7 | 22.5 |
| 1953 | 8 | 25.8 |
| 1954 | 7 | 22.5 |
| 1955 | 6 | 19.4 |
| 1956 | 3 | 9.7 |

TABLE I: BIRTHDATES

Within the sample there were 17 boys and 14 girls, all of whom were single, apart from one, whose marital status was not known.

74.5% of the sample was from metropolitan Winnipeg, 19.4% from the southern rural part of Manitoba, and 6.5% from northern Manitoba. (See Table 2)

| ADDRESS | NUMBER | % |
|---|---|---|
| URBAN | 23 | 74.2 |
| SOUTH RURAL | 6 | 19.4 |
| NORTH RURAL | 2 | 6.5 |
| TOTAL | 31 | 100.1 |

TABLE 2: ADDRESS

Anglo-saxon background was found in 51.6% of the cases studied. Other European backgrounds, including German, French and Slavic, accounted for another 32.3%. Canadian Indian background was evident in 9.7% of the cases. (See Table 3)

| ETHNIC ORIGIN | NUMBER | % |
|---|---|---|
| ANGLO-SAXON | 16 | 51.6 |
| GERMAN | 5 | 16.1 |
| FRENCH | 3 | 9.7 |
| SLAVIC | 2 | 6.5 |
| TREATY INDIAN | 3 | 9.7 |
| OTHER | 1 | 3.2 |
| UNKNOWN | 1 | 3.2 |
| TOTAL | 31 | 100.0 |

TABLE 3: ETHNIC ORIGIN

Guardianship of child was with an agency in five cases or 16.1% of the sample, the remainder being with their parents (See Table 4). In seven cases, or 22.6%, the child was not living with his parents. (See Table 5)

| GUARDIANSHIP | NUMBER | % |
|---|---|---|
| OWN PARENTS | 26 | 83.9 |
| AGENCY | 5 | 16.1 |
| TOTAL | 31 | 100.0 |

TABLE 4: GUARDIANSHIP

| ADDRESS | NUMBER | % |
|---|---|---|
| SAME AS CASE | 23 | 74.2 |
| DIFFERENT FROM CASE | 7 | 22.6 |
| UNKNOWN | 1 | 3.2 |
| TOTAL | 31 | 100.0 |

TABLE 5: ADDRESS OF PARENTS

Four-fifths of the sample were students, another 12.9% were unemployed; while only one case or 3.2% actually listed an occupation. (See Table 6)

| OCCUPATION | NUMBER | % |
|---|---|---|
| STUDENT | 25 | 80.6 |
| UNEMPLOYED | 4 | 12.9 |
| EMPLOYED | 1 | 3.2 |
| UNKNOWN | 1 | 3.2 |
| TOTAL | 31 | 99.9 |

TABLE 6: OCCUPATION OF CASE

Slightly over one half of the sample was Protestant with about one third being Roman Catholic. There were no Jewish children in the sample. (See Table 7)

| RELIGION | NUMBER | % |
|---|---|---|
| PROTESTANT | 17 | 54.8 |
| ROMAN CATHOLIC | 11 | 35.5 |
| JEWISH | 0 | 0.0 |
| OTHER | 1 | 3.2 |
| UNKNOWN | 2 | 6.5 |
| TOTAL | 31 | 100.0 |

TABLE 7: RELIGION OF CASE

Limited data was available on the occupation of the parents. However, from the data available, over one half of the parents worked as labourers. (See Table 8)

| OCCUPATION | NUMBER | % |
|---|---|---|
| PROFESSIONAL | 2 | 6.5 |
| SEMI-PROFESSIONAL | 3 | 9.7 |
| LABOURER | 9 | 29.0 |
| SELF-EMPLOYED NON-PROFESSIONAL | 1 | 3.2 |
| UNEMPLOYED | 0 | 0.0 |
| UNKNOWN | 16 | 51.6 |
| TOTAL | 31 | 100.0 |

TABLE 8: OCCUPATION OF PARENTS

These findings would indicate that there is a tendancy for a child receiving services from Selkirk to be between 15 and 17 years old, living in Winnipeg with his own parents, of Anglo-Saxon, Protestant origin, still in school, with parents working in a labouring position.

Section C: Overall Data

(i) Referrals:

From Table 9 it can be seen that there was a gradual

| YEAR OF REFERRAL | % |
|---|---|
| 1954 | 0.7 |
| 1955 | 0.7 |
| 1956 | |
| 1957 | |
| 1958 | 1.4 |
| 1959 | 2.0 |
| 1960 | 4.1 |
| 1961 | 3.4 |
| 1962 | 3.4 |
| 1963 | 4.1 |
| 1964 | 4.1 |
| 1965 | 2.0 |
| 1966 | 2.7 |
| 1967 | 8.9 |
| 1968 | 7.5 |
| 1969 | 19.9 |
| 1970 | 34.2 |
| Unknown | 0.7 |

Table: 9: Year of Referral - Overall Data

increase in the number of referrals per year beginning in 1954, the greatest number being made in 1970, (34.2 per cent). This pattern is interrupted in 1965 when there was a decrease in the number of referrals. The decrease in 1965 will be partly explained below when age at referral is explored.

It is interesting to note the months that referrals are made. (See Table 10)

| MONTH OF REFERRAL | % |
|---|---|
| January | 8.0 |
| February | 7.4 |
| March | 10.4 |
| April | 7.4 |
| May | 5.5 |
| June | 8.6 |
| July | 8.6 |
| August | 3.1 |
| September | 11.7 |
| October | 6.7 |
| November | 4.9 |
| December | 6.7 |

TABLE 10: MONTH OF REFERRAL - OVERALL DATA

March and September have the highest number of referrals, with 10.4 per cent and 11.7 per cent of the referrals respectively. The lowest month is August with only 3.1 per cent of the referrals.

The establishment of an adolescent ward at Selkirk Mental Hospital in July 1970 seems to have had little effect on the number of referrals, however, only a limited time period after this date is under consideration.

The information regarding age at the date of referral is presented in Figure Number 1.

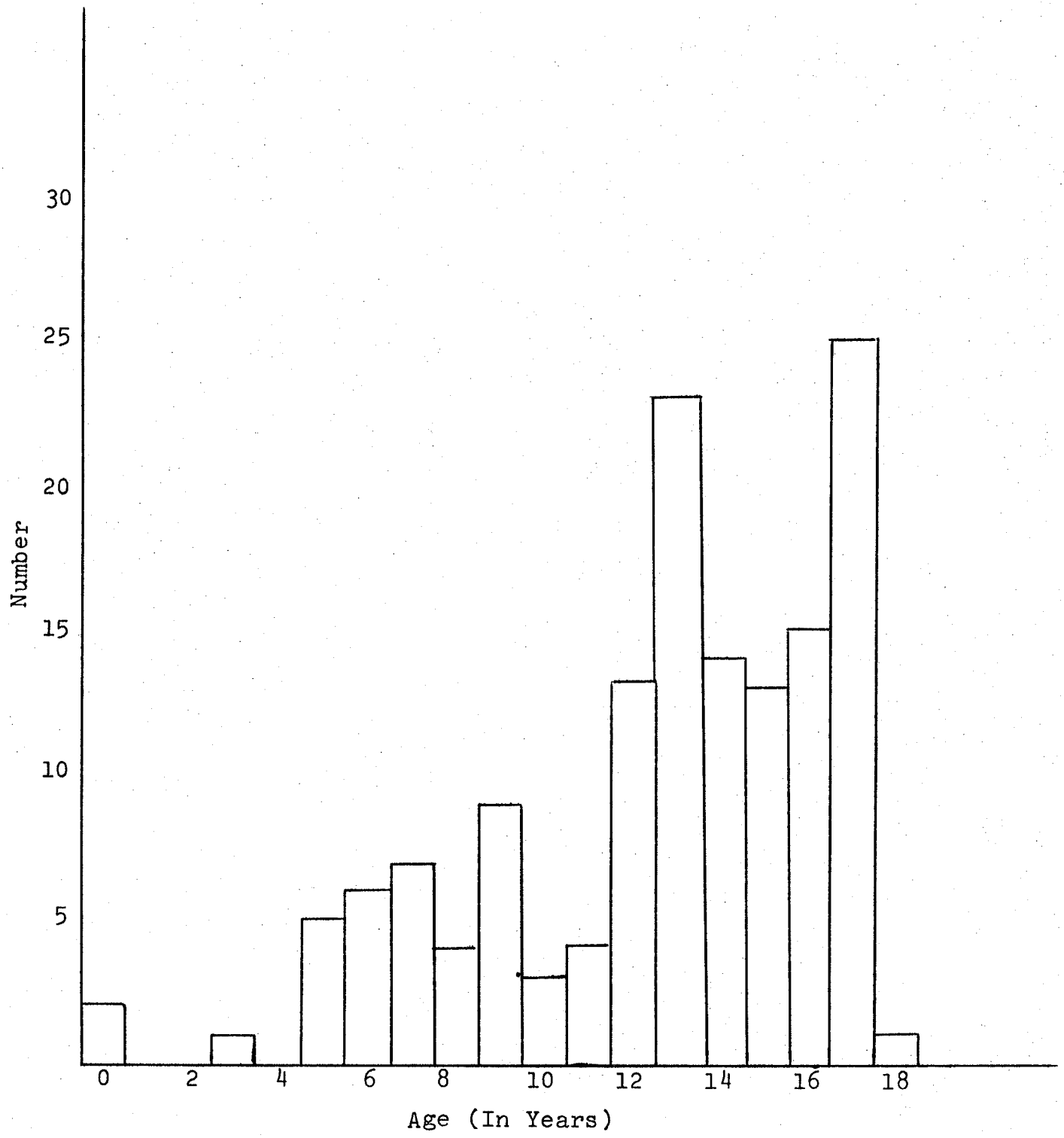


FIGURE 1: AGE AS OF DATE OF REFERRAL - OVERALL DATA

There were few referrals prior to age five, although one was received at age 2 months. There was a general increase in referral through the years 5 to 9, with a decrease for years 10 and 11. The adolescent years from 12 to 17 show an increase again with two peaks, one at age 13 and one at age 17. Data beyond age 17 was not collected and thus no way of knowing what further pattern exists is available.

Within a unit, as defined by the study, there are two points at which the question of referral is considered. First, when an agency receives a referral and secondly, when an agency subsequently makes a further referral to another agency. In each of these referrals there are two agencies and two persons (at least) involved.

Of 147 referrals received by agencies, 64.6 per cent were made by a professional person, and 25.2 per cent were made by a lay person. The question of professional referral will be dealt with shortly.

Table number 11 shows a breakdown of the lay referrals.

| LAY PERSON MAKING REFERRAL | PER CENT |
|---|---|
| SELF | 26.3 |
| PARENTS | 42.1 |
| RELATIVES | 2.6 |
| OTHER | 23.7 |
| PARENTS AND PROFESSIONAL | 5.3 |

TABLE 11: LAY REFERRALS

The two points of referral within a unit have been examined according to the agency making or receiving the referral, the profession of the person making or receiving the referral, and the position on agency staff that the person holds. These findings are summarized in Tables 12, 13 and 14, respectively. From Table 12, it is seen that

| Agency | Making Referral % | Receiving Referral % | Making Subsequent Referral % | Receiving Subsequent Referral % |
|---|---|---|---|---|
| Selkirk Mental Hosp. | 2.6 | 23.8 | 12.0 | 23.0 |
| Wpg. Psychiatric Inst. | 16.4 | 13.6 | 15.0 | 12.0 |
| Wpg. Children's Hosp. | 12.1 | 19.0 | 16.0 | 9.0 |
| Child Guidance Clin. | 6.9 | 11.6 | 16.0 | 5.0 |
| C.A.S. of Winnipeg | 11.2 | 7.5 | 16.0 | 7.0 |
| Wpg. General Hosp. | 2.6 | 6.1 | 6.0 | 3.0 |
| Schools | 15.5 | | | |
| C.A.S. of East. Man. | 2.6 | 2.0 | 1.0 | 4.0 |
| Children's Home | | 1.4 | 2.0 | 3.0 |
| Family Bureau | 0.9 | 0.7 | 1.0 | 2.0 |
| General Practitioner | 5.2 | 0.7 | | |
| Juvenile & Family Court | 2.6 | 2.7 | 3.0 | 2.0 |
| Man. Home For Retardates | | 0.7 | 1.0 | 2.0 |
| Private Psychiatrists | 2.6 | | | |
| Roslyn House | | 0.7 | | 1.0 |
| St. Agnes School | 0.9 | 2.0 | 2.0 | 4.0 |
| St. Boniface Hosp. | 1.7 | 2.7 | | 1.0 |
| St. Joseph's Voc. School | | 2.0 | 1.0 | 4.0 |
| Other | 8.6 | 2.7 | 2.0 | 8.0 |
| Unknown | 6.9 | | 6.0 | 10.0 |

TABLE 12: AGENCIES MAKING AND RECEIVING REFERRALS - OVERALL DATA

there were four main agencies making referrals, Winnipeg Psychiatric Institute, Children's Hospital, Children's Aid Society of Winnipeg and schools. The large role played by shools here, should be particularly noted.

Agencies that received the most referrals were Selkirk Mental Hospital, Children's Hospital, Winnipeg Psychiatric Institute, The Child Guidance Clinic and the Children's Aid Society of Winnipeg. This group of agencies, along with the Winnipeg General Hospital form the core of those offering psychiatric services to the study sample. Agencies making subsequent referrals were of this core group as well. In comparing subsequent referrals made with referrals received, Child Guidance Clinic and Children's Aid made as many or more subsequent referrals as they received. With Children's Aid, this could be an indication that they make multiple referrals on one case, perhaps to a number of agencies. Psychiatric Institute and Children's Hospital made fewer subsequent referrals, using treatment themselves rather than referring for treatment. Selkirk Mental Hospital made only about one-quarter as many subsequent referrals as referrals received, indicating a high tendency to maintain treatment. The agencies receiving subsequent referrals offer an interesting pattern in that Selkirk Mental Hospital received 23 per cent. There is a definitive trend in the referral process towards Selkirk which is not unexpected, as this was the source of the sample.

It is interesting to note that although schools play a large part in the making of referrals they are not involved

at all in any other part of the process.

The role played by the general practitioners also seems to follow this same pattern. Closed treatment centres such as Children's Home, Manitoba Home for Retardates, Roslyn House, St. Anges School and St. Joseph's Vocational School all tend to only receive referrals, frequently only a subsequent referral. It would seem then, that some other agency must first be involved before these institutions are used.

Minor agencies such as the Children's Aid Society of Eastern Manitoba, Family Bureau, Juvenile and Family Court and St. Boniface Hospital tended to follow a pattern similar to the major core agencies discussed above. Further comparison between the major and minor agencies will be given later in this report.

The data concerning the professional status of and staff position held by individuals making and receiving referrals will now be presented and discussed. Tables 13 and 14 contain the relevant data.

| Professional Person Making or Receiving Referral | Making Referral % | Receiving Referral % | Making Subsequent Referral % | Receiving Subsequent Referral % |
|---|---|---|---|---|
| Psychiatrist | 42.1 | 62.6 | 44.0 | 44.0 |
| Social Worker | 23.2 | 12.9 | 29.0 | 18.0 |
| General Practitioner | 8.4 | 2.0 | 1.0 | |
| Psychologist | | 4.8 | | 1.0 |
| Teacher | 15.8 | | | |
| Other | 4.2 | 1.4 | 1.0 | 3.0 |
| Psychiatrist + --- | | 0.7 | 1.0 | |
| Unknown | 6.3 | 15.6 | 24.0 | 34.0 |

TABLE 13: PROFESSIONAL PERSON MAKING OR RECEIVING REFERRALS - OVERALL DATA

| Position of Person Making or Receiving Referral | Making Referral % | Receiving Referral % | Making Subsequent Referral % | Receiving Subsequent Referral % |
|---|---|---|---|---|
| Chief Administrator | 8.5 | 6.1 | 6.3 | 12.2 |
| Supervisor | 6.6 | 3.4 | 4.2 | 2.1 |
| Staff Member | 58.5 | 71.4 | 60.4 | 47.9 |
| Other | 2.8 | 0.7 | | 1.0 |
| Unknown | 23.6 | 18.4 | 29.2 | 36.5 |

TABLE 14: POSITION OF PERSON MAKING OR RECEIVING REFERRAL - OVERALL DATA

In all cases psychiatrists were the most active with social workers playing the next most active part. Again, teachers play an important role in the making of referrals but are not involved beyond that point. General practitioners repeat this pattern. It would seem that the social workers' role in making referrals is more important than in receiving them. The large unknown factor (as high as 34 per cent) make conclusive results difficult.

By far, most referrals were handled by staff members rather than supervisory or administrative personnel.

The data on how referrals are made is summarized in Table 15. Referrals tended to be made by application forms or by personal contact. However, letters were used more often on subsequent referrals with personal contact and application forms being used less. A high unknown factor 35.4 per cent and 55.4 per cent diminishes the validity of results. (See Table 15)

| Method used in Making Referrals | Referral % | Subsequent Referral % |
|---|---|---|
| Telephone | 6.3 | 5.9 |
| Letter | 6.3 | 15.8 |
| Personal Contact | 19.4 | 10.9 |
| Application Form | 26.4 | 8.9 |
| Other | 2.1 | 2.0 |
| Telephone & Letter | 1.4 | |
| Telephone & Personal Contact | | 1.0 |
| Letter & Personal Contact | 0.7 | |
| Letter & Application Form | 1.4 | |
| Telephone & Letter & Personal Contact | 0.7 | |
| Unknown | 35.4 | 55.4 |

TABLE 15: METHOD USED IN MAKING REFERRALS - OVERALL DATA

The question of whether the agency making the referral, followed up the referral was only asked of the subsequent referrals. These results are summarized in Table 16.

| Follow Up to subsequent referrals | % |
|---|---|
| No Follow Up | 20.4 |
| Telephone | 2.0 |
| Letter | 4.1 |
| Personal Contact with Client | 9.1 |
| Personal Contact with Agency | 4.1 |
| Other | 5.1 |
| Unknown | 55.1 |

TABLE 16: FOLLOW UP TO SUBSEQUENT REFERRALS - OVERALL DATA

It was found that in 20.4 per cent of the cases, no follow up was evident. Personal contact with the client was the most

common form of follow up. The high unknown factor, 55 per cent, again makes conclusion questionable.

Intake is defined as that point or event by which a client makes contact with an agency and the agency responds with some procedure to determine, first of all whether they will offer further service or not, and if so, what form that service will take. The results of two questions: what was intake procedure and what were the results of the intake procedure are summarized in Tables 17 and 18 respectively.

| Intake Procedure | % |
|---|---|
| Personal Interview with appointed Intake Worker | 11.6 |
| Personal Interview with Rotating Intake Worker | 34.1 |
| Collateral Person Interview with appointed Intake Worker | 1.4 |
| Collateral Person interview with Rotating Intake Worker | 1.4 |
| Personal & Collateral Person Interview with Rotating Worker | 6.1 |
| Direct Admission without Interview | 8.8 |
| Other | 5.4 |
| Unknown | 31.3 |

TABLE 17: INTAKE PROCEDURE - OVERALL DATA

| Results of Intake | % |
|---|---|
| No Case Made | 2.1 |
| Admission | 68.5 |
| Referral to Other Agency | 2.1 |
| Out-Patient Department | 21.9 |
| Referral & Out-Patient | 0.7 |
| Unknown | 5.5 |

TABLE 18: RESULTS OF INTAKE - OVERALL DATA

The main form that intake took was a personal interview with a rotating intake worker. This was sometimes combined with an interview of a collateral person. Only one agency was found that had an appointed intake person on staff, this being Selkirk Mental Hospital. Direct admission without an interview was evident in 8.8 per cent of the units as shown in Table 17, perhaps a reflection of the young age of the clients and their inability to participate in an interview.

68.5 per cent of referrals resulted in an admission with another 21.9 per cent receiving out-patient service. Only 2.1 per cent were referred to another agency without further service, and only 2.1 per cent were not given service. It would thus seem evident that in over 90 per cent of the cases, an attempt was made to meet the clients' needs.

(ii) Assessment:

A topic that is key to this study and closely related to the concept of labelling is that of assessment. Within the study two main questions were asked regarding assessment. The first concerned its form, the second the actual assessment made. There were four points at which the study looked at assessment: 1) intake 2) the one that was used in treatment or "working" assessment 3) assessment at referral and 4) assessment at discharge. The results of this are summarized in Tables 19 and 20.

| Form of Assessment | At Intake % | Working % | At Subsequent Referral % | At Discharge % |
|---|---|---|---|---|
| Label | 35.4 | 61.2 | 28.6 | 17.2 |
| Cause | 2.8 | 3.7 | 3.1 | |
| Symptom | 29.9 | 10.4 | 10.2 | 7.8 |
| Comparison | 1.4 | 0.7 | 9.1 | 23.4 |
| None Made | 11.8 | 11.9 | 7.1 | 4.7 |
| Other | 2.1 | | 5.1 | 3.1 |
| Label & Cause | | 1.5 | | |
| Label & Symptom | 6.9 | 2.2 | 4.1 | |
| Label & Comparison | | | 1.0 | 9.4 |
| Cause & Symptom | 0.7 | | | |
| Label & Cause & Symptom | | | 1.0 | |
| Label & Symptom & Comparison | | | 1.0 | 1.6 |
| Unknown | 9.0 | 9.0 | 29.6 | 32.8 |

TABLE 19: FORM OF ASSESSMENT - OVERALL DATA

The pattern that emerges in Table 19 is interesting. At intake symptoms and labels were used about equally as often. However, working assessment was predominantly a label, symptoms being used only 10 per cent of the time. During a subsequent referral, labels were commonly used, but more often in conjunction with symptoms. At discharge, comparison with other assessments was the predominant form used with labels used next most frequently.

Table 20 shows the breakdown of the actual assessments. Within the section on labels, it is found that schizophrenia was the most commonly used label. It was often used in conjunction with other labels. In working assessment schizophrenia accounted for 42.6 per cent of all assessments made. The labels of personality disorder, behavior disorder and thought disorder together accounted for between 8 per cent and 13 per cent of units. The consistency of their use could indicate that little improvement occurred throughout the treatment process.

Only 3 units (3 per cent) were assessed as having drug induced or drug related problems.

The use of a comparison with other assessments tended to be used most often in making subsequent referrals and discharges.

There were three other questions asked regarding assessment: how was the assessment determined, who made the assessment, and how long was the period between intake and the formation of a working assessment. This information was

| Actual Assessment | At Intake % | Working % | At Subsequent Referral % | At Discharge % |
|---|---|---|---|---|
| Schizophrenia | 15.1 | 32.0 | 19.8 | 8.3 |
| Psychotic | 5.6 | 4.1 | 4.4 | |
| Mental Disorder With Organic Base | 2.4 | 6.6 | 2.2 | 1.7 |
| Epilepsy | 3.2 | 0.8 | | |
| Personality Disorder | 1.6 | 4.9 | 1.1 | 6.7 |
| Behavior Disorder | 7.1 | 8.2 | 6.6 | 5.0 |
| Thought Disorder | 0.8 | | | |
| Family - Cause | 1.6 | 1.6 | | |
| Drug - Cause | 1.6 | 1.6 | 3.3 | |
| Description of Behavior | 31.7 | 13.1 | 8.8 | 8.3 |
| No Change | | | 4.4 | 6.7 |
| Improved | 0.8 | | 8.8 | 18.3 |
| Deterioration | | 0.8 | | |
| Other | 3.2 | | 1.1 | 1.7 |
| Schizophreniz + -- | 9.6 | 10.6 | 4.4 | 5.0 |
| Psychotic & Mental Disorder-Organic Base | 0.8 | | | |
| Epilepsy & Behavior Disorder-Organic Base | 1.6 | 0.8 | | |
| Personality Disorder & Mental Disorder - Organic Base | | 0.8 | | |
| Controlled & Mental Disorder - Organic Base | | | | 1.7 |
| Improved & Mental Disorder - Organic Base | | | | 1.7 |
| Epilepsy & Psychotic | | 0.8 | | |
| Epilepsy & Behavior Disorder | 0.8 | | | |
| Epilepsy & Drug | | 0.8 | | |
| Epilepsy & No Change | | | | 1.7 |
| Behavior Disorder & Descrip. of Behav. | | 1.6 | | |
| Thought Disorder & Descrip. of Behav. | 1.6 | | 3.3 | |
| Drug & Descrip. of Behavior | 0.8 | | | |
| Unknown | 10.3 | 10.6 | 33.0 | 33.3 |

TABLE 20: ACTUAL ASSESSMENT - OVERALL DATA

gathered only on the working assessment and is tabulated in Tables 21, 22, and 23.

| Method of Determining Working Assessment | % |
|---|---|
| Consultation & Collaboration | 5.8 |
| Case Conference | 3.3 |
| Observation | 13.2 |
| Testing | 2.5 |
| Interview & Observation | 11.6 |
| Observation & ----- | 23.2 |
| Interview & ----- | 9.1 |
| Other | 4.1 |
| Unknown | 27.3 |

TABLE 21: METHOD USED TO DETERMINE WORKING ASSESSMENT - OVERALL DATA

Table 21, indicates that observation, either alone or with some other method was involved in 48 per cent of the units. Interviewing was involved in 20.7 per cent of the units. Consultation, case conferencing or testing was used in less than 6 per cent of the units.

The vase majority of the assessments were made by psychiatrists with other professionals playing a minor role here (see Table 22).

| Person Making Working Assessment | % |
|---|---|
| Psychiatrist | 67.2 |
| Social Worker | 3.3 |
| General Practitioner | 1.6 |
| Psychologist | 2.5 |
| Psychiatrist & Psychologist | 0.8 |
| Psychiatrist & Psychologist & Social Worker | 0.8 |
| Other | 2.5 |
| Unknown | 21.3 |

TABLE 22: PERSON MAKING WORKING ASSESSMENT - OVERALL DATA

Table 23 indicates that most assessments were made within 60 days, and a high proportion (32.5 per cent) were made within 14 days. A high degree of unknowns make conclusions difficult.

| Length of Assessment Period | % |
|---|---|
| 1 Day | 4.2 |
| 2 - 7 Days | 15.8 |
| 8 - 14 Days | 12.5 |
| 15 - 21 Days | 5.8 |
| 22 - 28 Days | 8.3 |
| 29 - 60 Days | 10.8 |
| 61 - 90 Days | |
| Other | 5.0 |
| Unknown | 37.5 |

TABLE 23: LENGTH OF ASSESSMENT PERIOD - OVERALL DATA

(iii) Subsequent Service:

Having accepted a client on as in-patient or out-patient basis and subsequently having made a working assessment, the client is then given some form of what the study calls sub-

sequent service. In subsequent service, there are basically three options: to give treatment, to make a referral, or to discharge. In many cases a combination of these may be used such as the giving of treatment and then discharging. Table 24 summarizes the study's findings regarding such subsequent service.

| Subsequent Service | % |
|---|---|
| Treatment | 27.3 |
| Referral | 7.2 |
| Discharge | 1.4 |
| None Given | 0.7 |
| Other | 0.7 |
| Treatment & Referral | 15.8 |
| Treatment & Discharge | 31.7 |
| Treatment & Referral & Discharge | 9.4 |
| Treatment & Other | 0.7 |
| Referral & Discharge | 1.4 |
| Unknown | 3.6 |

TABLE 24: SUBSEQUENT SERVICE - OVERALL DATA

Treatment alone was given in 27.3 per cent of the units and 57.6 per cent of the units in conjunction with some other form of service resulting in a total of 84.9 per cent of all units. Referrals, either alone or in conjunction with another service were made in 33.8 per cent of the units, while discharges were made in 43.9 per cent of the units. Of those discharged only 1.4 per cent were given no other form of treatment.

Of the three factors isolated, referrals have already been discussed in the first part of this discussion. The question of treatment and discharge will be examined here.

Three questions were asked regarding treatment: length of treatment, nature of treatment and the treatment setting. The results are found in Tables 25, 26, and 27.

| Length of Treatment | % |
|---|---|
| 1 Day | 1.6 |
| 7 Days | 11.6 |
| 1 Month | 22.1 |
| 3 Months | 15.7 |
| 6 Months | 5.8 |
| 1 Year | 12.4 |
| 2 Years | 4.1 |
| 4 Years | 0.8 |
| Other | 6.6 |
| Unknown | 19.0 |

TABLE 25: LENGTH OF TREATMENT - OVERALL DATA

| Nature of Treatment | % |
|---|---|
| Medication & ECT | 18.9 |
| Therapeutic Counselling | 10.7 |
| Social Rehabilitation | 7.4 |
| Other | 5.7 |
| Medication & Therapy & Social Rehabilitation | 9.8 |
| Medication & Therapeutic | 23.8 |
| Medication & Social Rehabilitation | 9.0 |
| Therapy & Other | 0.8 |
| Medication & Other | 1.6 |
| Medication & Therapy & Other | 0.8 |
| Therapy & Social Rehabilitation | 1.6 |
| Unknown | 9.8 |

TABLE 26: NATURE OF TREATMENT - OVERALL DATA

It was found that 69.2 per cent of the units had a treatment period of less than one year with half being less than 3 months. Only 11.5 per cent had a treatment period longer than one year. The most common length of treatment was one month.

The common form of treatment (Table 26) is that of medication, which was used either alone or with some other form of treatment in 63.9 per cent of the units. Therapeutic counselling was given in 47.5 per cent of the units, social rehabilitation in 27.8 per cent of the units. The most common combination of treatment was medication with therapeutic counselling, used in 23.8 per cent of the units.

The favoured treatment setting (Table 27) seems to be treatment in-patient which was used in 72.5 per cent of the units. Out-patient service was given in 26.6 per cent of the units. The use of non-treatment in-patient facilities such as foster homes was low, only 3.2 per cent of the units.

| Treatment Setting | % |
|---|---|
| Out-Patient Department | 21.8 |
| Non-Treatment - In-Patient | 2.4 |
| Treatment - In-Patient | 68.5 |
| OPD & Treatment In-Patient | 4.0 |
| OPD & Non-Treatment In-Patient | 0.8 |
| Unknown | 2.4 |

TABLE 27: TREATMENT SETTING - OVERALL DATA

(iv) Other Data:

The last question to be considered is that of discharge. Two questions were posed here: the first, to whom was the patient discharged, and secondly, what was the assessment at discharge. The question of assessment was dealt with in an earlier section.

When discharged, 60.9 per cent of the units were discharged to their own parents. Another 9.4 per cent were discharged to substitute parents such as foster parents. Of interest is the fact that only 3.1 per cent were discharged to themselves, in other words, to their own responsibility and not some other person's.

Section D: First Referral Data

(i) Referral:

An interesting group of data is obtained when one isolates the first referrals, that is, at the point that the patient makes his first contact with the "system".

Figure number 2, shows the age of the patient at the date of the first referral. This would indicate that there are two points at which first referrals are made, the first around age six or seven and the second in the mid teens, with a maximum at age 15. A comparison of this graph with figure number one yields some interesting findings. In the overall data there were peaks at ages 13 and 17, that are not evident in the first referral data. A possible explanation is that those who are referred early in the system also are those who are referred again at age 13 and again at 17.

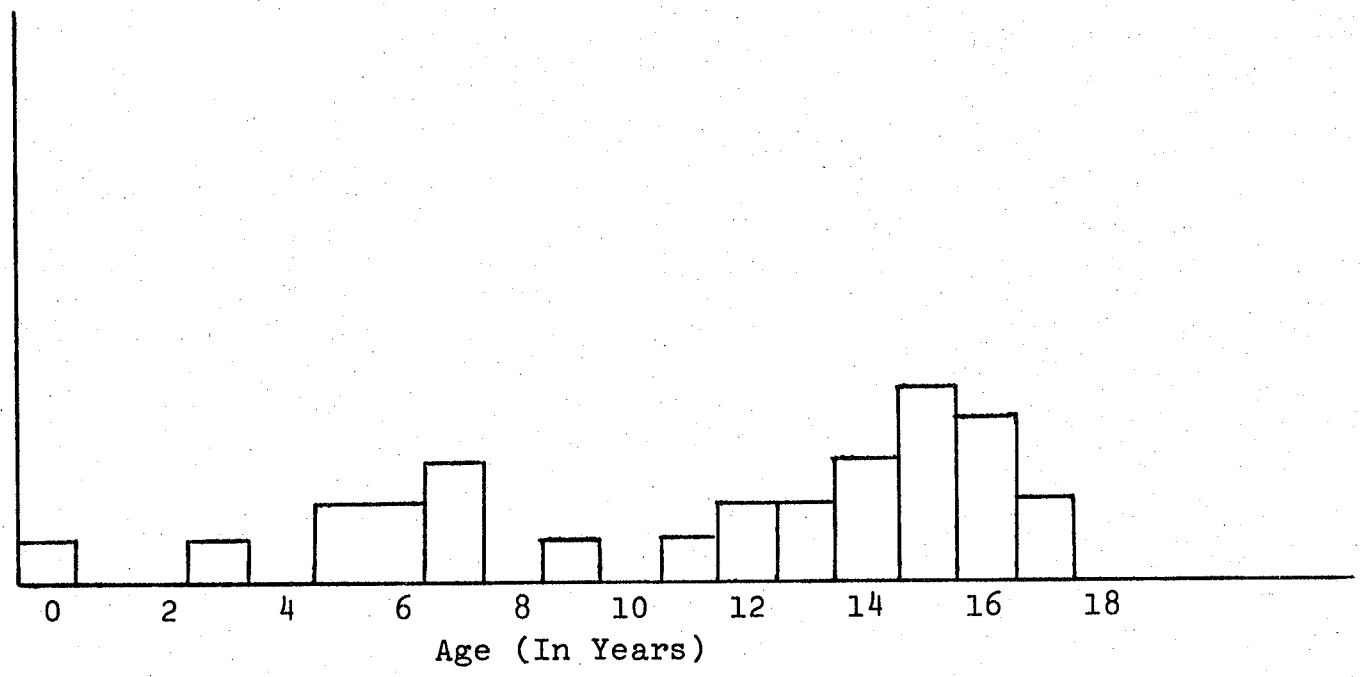


FIGURE 2: AGE AS OF DATE OF FIRST REFERRAL

One could hypothesize that the peaks at 13 and 17 were due to the life cycle crisis of pubacence and of adulthood, which will be discussed later in the chapter on conclusions. Thus, a person already in the system would be more inclined to use the services at these points. This could be the result of greater familiarity with problems, and consequently quicker detection of same, a greater inclination to identify problems, or a dependency on the system. The peak at 15 in the first referrals might be seen as a time lag in the 13 year crisis. People may be less knowledgeable of the system, less inclined to use it, or unable to recognize symptoms as quickly when they have not been exposed to these previously. Thus they are slower

to make referrals to the system. It would be interesting to determine if a similar time lag exists in the 17 year crisis.

Lay referrals accounted for 29 per cent of the first referrals and professional, 61.2 per cent. These figures are not very different from those of the overall referral system. It might have been anticipated that the lay referral system would play a larger part here, but this was not born out. Of the eight lay referrals made three were made by parents and only one was a self-referral.

Table 28 summarizes the data on the agencies that were involved at the various points of the study in the first referrals.

| Agency | Making Referral % | Receiving Referral % | Making Subsequent Referral % | Receiving Subsequent Referral % |
|---|---|---|---|---|
| Selkirk Mental Hosp. | - | 12.9 | 5.3 | 10.5 |
| Winnipeg Psych. Inst. | - | 3.2 | 5.3 | 15.8 |
| Children's Hospital | 8.0 | 16.1 | 15.8 | 5.3 |
| Child Guidance Clinic | - | 22.6 | 21.1 | - |
| C.A.S. of Winnipeg | - | 6.5 | 5.3 | 5.3 |
| Winnipeg Gen. Hosp. | - | 9.7 | 10.5 | - |
| Schools | 28.0 | - | - | - |
| C.A.S. of Eastern | - | 3.2 | - | - |
| Children's Home | - | - | - | 5.3 |
| Family Bureau | - | 3.2 | 5.3 | - |
| General Pract. | 24.0 | 3.2 | - | - |
| Juv. & Fam. Court | - | 6.5 | 5.3 | - |
| St. Agnes | - | - | - | 5.3 |
| St. Boniface Hosp. | - | 6.5 | - | - |
| Other | 24.0 | 6.5 | 5.3 | 15.8 |
| Unknown | 16.0 | - | 21.1 | 26.3 |

TABLE 28: AGENCY MAKING AND RECEIVING FIRST REFERRAL

About one-quarter of the referrals are made by schools and another one-quarter by general practitioners. The large proportion of "other" would indicate a wide variety of sources of referrals. Again the importance of the school is emphasized.

Of the agencies receiving first referrals the Child Guidance Clinic is most frequently used. This is in line with the high percentage of school referrals. The Children's Hospital of Winnipeg, Selkirk Mental Hospital and Winnipeg General Hospital were all central recipients of first referrals. A number of minor agencies were also involved at this point, including the Children's Aid Society of Eastern Manitoba, Family Bureau, Juvenile and Family Court and St. Boniface Hospital.

Most agencies were inclined to make subsequent referrals on at least some of the referrals received, the Child Guidance Clinic being most inclined to do so.

Those agencies receiving the subsequent referrals, tended to be the Winnipeg Psychiatric Institute, Selkirk Mental Hospital and Family Bureau. As there was a large number of agencies involved, with only a few units, positive conclusions are difficult to make.

In comparing Table 28 with 12, there are a number of interesting points. The drift towards Selkirk is not as marked on the first referrals. All referrals from general practitioners were on first referrals. The vast majority of Family Bureau involvement was also on first referrals.

Tables 29 and 30 present the data on the person involved in making and receiving first referrals.

| | Making Referral % | Receiving Referral % | Making Subsequent Referral % | Receiving Subsequent Referral % |
|---|---|---|---|---|
| Psychiatrist | 12.5 | 48.4 | 31.6 | 21.1 |
| Social WorKer | 8.3 | 12.9 | 21.6 | 21.1 |
| General Pract. | 25.0 | 3.2 | | |
| Psychologist | | 12.9 | 5.3 | |
| School Teacher | 20.8 | | | |
| Other | 8.3 | | 5.3 | |
| Unknown | 25.0 | 22.6 | 36.8 | 57.9 |

TABLE 29: PROFESSIONAL PERSON RECEIVING OR MAKING FIRST REFERRALS

| | Making Referral % | Receiving Referral % | Making Subsequent Referral % | Receiving Subsequent Referral % |
|---|---|---|---|---|
| Chief Admin. | 8.7 | | | 5.6 |
| Supervisor | 4.3 | 6.5 | 5.9 | 5.6 |
| Staff Member | 47.8 | 67.7 | 58.8 | 27.8 |
| Other | 8.7 | 3.2 | | 5.6 |
| Unknown | 30.4 | 22.6 | 35.3 | 55.6 |

TABLE 30: POSITION OF PERSONS MAKING OR RECEIVING FIRST REFERRALS

Again evidence holds that general practitioners and school teachers are key persons in making first referrals. In comparison to Table 13 in the overall data, the trend towards the involvement of psychiatrist and social workers continues. Similarly, the use

of staff members rather than supervisory and administrative staff is noted.

Method of referral gave preference (as shown in Table 31) to the application form and personal contact, as was the preference in the overall data.

| Method | Referral % | Subsequent Referral % |
|---|---|---|
| Telephone | 10.0 | 11.1 |
| Letter | 6.7 | 11.1 |
| Personal Contact | 20.0 | 5.6 |
| Application Form | 23.3 | |
| Other | | 5.6 |
| Unknown | 40.0 | 66.7 |

TABLE 31: METHOD USED IN MAKING FIRST REFERRALS

One difference is that there was no combinations used on the first referral, indicating perhaps a more direct form of request for help on the first referral.

Follow-up to referrals was still poor, although a greater use of personal contact is evident than was the case in the overall data. A small sample and large unknown factor make conclusions difficult. This data is found in Table 32.

| Follow-up | % |
|---|---|
| No follow-up | 26.3 |
| Personal Contact with Client | 10.5 |
| Letter | 5.3 |
| Personal Contact with Agency | 10.5 |
| Unknown | 47.4 |

TABLE 32: FOLLOW-UP TO FIRST SUBSEQUENT REFERRAL

Table 33 concerns itsself with intake procedure.

| Intake Procedure | % |
|---|---|
| Interview with rotating intake worker | 35.5 |
| Collateral person interview & appointed intake worker | 3.2 |
| Personal interview & collateral person intake & rotating intake worker | 16.1 |
| Direct admission without intake | 6.5 |
| Other | 6.5 |
| Unknown | 32.3 |

TABLE 33: INTAKE PROCEDURE ON FIRST REFERRAL

It would seem that on first referral either a personal interview alone or a collateral person with a rotating intake worker is the most common form of intake. There seems to be a greater reliance upon using collateral persons on first referral than in the overall data (19.3 per cent compared with 8.9 per cent), perhaps due to the generally younger age of the patient being considered and also to later referrals having information previously gained from collateral persons.

The results of intake on the first referral are shown on Table 34.

| Results | % |
|---|---|
| No case made | 6.7 |
| Admission | 40.0 |
| Referral to other agency | 6.7 |
| OPD | 40.0 |
| Unknown | 6.7 |

TABLE 34: RESULTS OF INTAKE ON FIRST REFERRAL

There seems to be equal preference to admission and giving out-patient service, both being offered 40 per cent of the time. Compared with the overall data there is a much greater tendency to use out-patients rather than admissions on first referral. Also, there are proportionately more referrals. It is interesting to note that 2 of 3 units that were registered as "no case made" were on the first referral.

(ii) Assessment:

Table 35 indicates that at intake on first referrals there is a marked tendency to use labels over symptoms (46.5 per cent compared with 17.9 per cent). This is contrasted with the overall data that showed these two figures to be much closer. The increase in the use of tables for working assessment was not found in the first referral, rather the figures remained close to those of intake assessment. The data for discharge assessment is limited but indicates greater similarity in the use of symptoms and labels.

| Form | Intake % | Working % | Subsequent Referral % | Discharge % |
|---|---|---|---|---|
| Label | 46.4 | 45.8 | 27.2 | 23.5 |
| Cause | 7.1 | 8.3 | 5.6 | - |
| Symptom | 17.9 | 20.8 | 11.1 | 17.7 |
| Comp. & Other Assessment | - | - | - | 5.9 |
| None Made | 7.1 | 16.7 | 22.2 | 5.9 |
| Label & Symptom | 7.1 | - | - | 5.9 |
| Other | - | - | 5.6 | 5.9 |
| Unknown | 14.3 | 8.3 | 27.2 | 35.3 |

TABLE 35: FORM OF ASSESSMENT ON FIRST REFERRALS

Table 36 summarizes the actual assessments made on first referrals. The data is very limited but indicates trends similar to those of the overall data (Table 20). Again there is a pronounced use of the label of schizophrenia and of description of behaviour.

| Assessment | Intake % | Working % | Subsequent Referral % | Discharge % |
|---|---|---|---|---|
| Schizophrenia | 24.0 | 23.8 | 14.3 | 6.7 |
| Psychotic | 8.0 | 4.8 | 7.1 | - |
| Ment. Dis. and Organic Base | 8.0 | 9.5 | 14.3 | 6.7 |
| Personality Dis. | - | 4.8 | - | 6.7 |
| Behaviour Disorder | 12.0 | 9.5 | - | 6.7 |
| Family | 8.0 | 9.5 | - | - |
| Drug | - | - | 7.1 | - |
| Description of Beh. | 20.0 | 28.6 | 7.1 | 20.0 |
| No Change | - | - | - | 6.7 |
| Thought Disorder & Desc. of Beh. | 4.0 | - | - | - |
| Pschotic & Mental Dis. & Org. Base | 4.0 | - | - | - |
| Drug & Desc. of Beh. | - | - | - | 6.7 |
| Unknown | 12.0 | 9.5 | 50.0 | 40.0 |

TABLE 36: ACTUAL ASSESSMENT AT FIRST REFERRAL

The data on how the working assessment was determined and who made the working assessment on first referrals was limited, but confirmed the results found in the overall data. It thus has not been reproduced here. Similarly, for length of assessment period data for only half of the units was available. This followed a similar pattern to the overall data.

(iii) Subsequent Service:

Subsequent service (Table 37) follows a pattern similar to the overall data, that is, a high use of treatment (77.7 per cent) and frequent use of referral (44.4 per cent), although there seems to be a greater tendency to use referral, perhaps indicating that not all first referrals are to be appropriate agency.

| Subsequent Service | % |
|---|---|
| Treatment | 29.6 |
| Referral | 14.8 |
| Discharge | - |
| Treatment & Referral | 14.8 |
| Treatment & Discharge | 22.2 |
| Treatment & Referral & Discharge | 11.1 |
| Referral & Discharge | 3.7 |
| None Given | 3.7 |

TABLE 37: SUBSEQUENT SERVICE OF FIRST REFERRALS

Table 38, showing length of treatment, indicates that most treatment is less than one year (62.5 per cent) while none was less than seven days. Up to three months is the most frequent length of treatment. Compared to the overall data, it is seen that generally first referrals receive longer treatment than the overall referrals but rarely over one year.

| Length of Treatment | % |
|---|---|
| 1 Day | - |
| 7 Days | - |
| 1 Month | 17.4 |
| 3 Months | 21.7 |
| 6 Months | 8.7 |
| 1 Year | 17.4 |
| 2 Years | 4.3 |
| 4 Years | 4.3 |
| Other | 4.3 |
| Unknown | 21.7 |

TABLE 38: LENGTH OF TREATMENT - FIRST REFERRALS

The nature of the treatment offered (Table 39) tended to be therapeutic counselling (77.1 per cent) and the use of medication (54.4 per cent), social rehabilitation being used least (18.1 per cent). These are in sharp contrast to the overall figures which showed medication being used more frequently than counselling.

| Nature of Treatment | % |
|---|---|
| Medication | 13.6 |
| Therapeutic Counselling | 31.8 |
| Social Rehabilitation | - |
| Other | 9.1 |
| Medication & Ther. Coun. & Social Reh. | 13.1 |
| Medication & Ther. Counselling | 22.7 |
| Medication & Social Rehabilitation | 4.5 |
| Unknown | 4.5 |

TABLE 39: NATURE OF TREATMENT - FIRST REFERRAL

To complete the treatment picture, treatment setting (Table 40) indicates a high use of out-patient service (56.5 per cent) compared with the overall data (26.6 per cent). In-patient treatment was given in 43.5 per cent of the units compared with 72.5 per cent of the overall units.

| Setting Type | % |
|---|---|
| Out-Patient | 56.5 |
| Treatment In-Patient | 43.5 |
| Not Applicable | -- |
| Unknown | -- |

TABLE 40: TREATMENT SETTING - FIRST REFERRAL

It would thus seem that on first referrals there was a tendency to use out-patient service over an extended period of time of up to one year, offering predominantly counselling as the form of treatment. Subsequent to this there was a tendency towards greater use of medication and in-patient service.

(iv) Other Data:

The data on discharge on first referrals applied to only 17 units of which five were unknown. Nine, or 52.9 per cent were discharged to own parents, one to self, and one to substitute parents. These findings follow the pattern of the overall data, although limited data makes conclusions difficult.

Section E: Major Agency - Minor Agency Data

In this section, the relevant data from the study of major and minor agencies will be presented and discussed. This will be accomplished by presenting the data in either tabular form or written form as felt to be appropriate for clarity and precision. Tables will be used, generally speaking, to group related data into a coherent and manageable form, as has been the pattern followed previously.

Two series of tables will be used in all: the first to present only major agency data thus allowing for comparisons between individual major agencies. The second series will outline the data compiled separately for all major agencies and for all minor agencies which will allow for comparisons to be made between the two.

Major agencies were defined as being those with which nin or more units of study had been in contact. In all, six agencies were classified as major agencies having up to 35 units of study. One hundred and thirty-two units comprised the major agency data.

Minor agencies on the other hand, were defined as those with which four or less units of study had been in contact. Nine agencies were included in this category, comprising a total of 22 units of study.

(a) Major Agency Data

(i) Referrals:

From Table 41, it can be seen that the six major agencies

can be ranked according to their importance in making and receiving referrals and subsequent referrals.

| Agency | Making Referral % | Receiving Referral % | Making Subsequent Referral % | Receiving Subsequent Referral % |
|---|---|---|---|---|
| S.M.H. | 3.1 | 26.5 | 11.3 | 26.5 |
| W.P.I. | 20.0 | 15.1 | 17.0 | 13.3 |
| W.G.H. | 3.1 | 7.5 | 6.8 | 4.8 |
| C.A.S. WPG. | 8.4 | 15.1 | 15.8 | 7.2 |
| CH. HOSP. | 13.6 | 20.4 | 17.0 | 9.6 |
| C.G.C. | 8.4 | 15.1 | 15.8 | 3.6 |

TABLE 41: MAJOR AGENCIES MAKING AND RECEIVING REFERRALS

Selkirk, as was to be expected, received most referrals and subsequent referrals; 26.5 per cent in each case. However, Selkirk did not make many referrals or subsequent referrals. In other words, Selkirk is a receiver rather than initiator of referrals and subsequent referrals.

The Winnipeg Psychiatric Institute appears to play an important role in both receiving and making referrals and subsequent referrals. The Institute made 20.0 per cent of all agency referrals and 17.0 per cent of the subsequent referrals. This indicates that an important role is held by the Institute in making referrals and hence facilitating the delivery of psychiatric service to young people.

Children's Hospital also appears to play an important role both in making referrals and receiving referrals and

subsequent referrals. This role parallels that of the Psychiatric Institute; however, the percentage figures shown in Table 41 indicate that except for receiving referrals, Children's Hospital is not quite as important as the Institute.

The Children's Aid Society and Child Guidance Clinic appear to play almost identical roles in the referral process, at least in the magnitude of interaction in the referral and subsequent referral process. Both agencies made a similar number of subsequent referrals to the number they received, with 15.8 per cent subsequent referrals made and 15.1 per cent referrals received. This indicates that both of these agencies play an important role in facilitating the delivery of psychiatric services, as do the Psychiatric Institute and the Children's Hospital.

The Winnipeg General Hospital ranks the lowest on the hierarchy of importance in the referral process, making and receiving a relatively small percentage of referrals and subsequent referrals.

The data of Table 42 concerning the person receiving and making referrals and subsequent referrals, indicates that psychiatrists play the most important role in this referral process. Some significant details of the data largely exceptions to the rule, should be commented on.

| | MAKING REFERRAL TO | | | | | | RECEIVING REFERRAL FROM | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| PERSON | S.M.H. | W.P.I. | W.G.H. | C.A.S. WPG. | C.H. HOSP. | C.G.C. | S.M.H. | W.P.I. | W.G.H. | C.A.S. WPG. | C.H. HOSP. | C.G.C. |
| Psychiatrist | 74.2 | 30.0 | | 27.2 | | | 100.0 | 100.0 | | | 77.7 | 11.1 |
| Social Worker | | | | | 23.0 | | | | | 72.7 | | 17.6 |
| General Pract. | | | | | | | | | 88.8 | | | |
| Teacher | | | | | | 64.4 | | | | | | |
| | MAKING SUBSEQUENT REFERRAL FROM | | | | | | RECEIVING SUBSEQUENT REFERRAL FROM | | | | | |
| PERSON | S.M.H. | W.P.I. | W.G.H. | C.A.S. WPG. | C.H. HOSP. | C.G.C. | S.M.H. | W.P.I. | W.G.H. | C.A.S. WPG. | C.H. HOSP. | C.G.C. |
| Psychiatrist | 54.5 | 87.5 | 85.7 | 93.7 | 53.3 | 47.0 | 18.1 | 53.3 | 71.5 | 63.7 | 46.6 | 27.5 |
| Social Worker | | | | | | | 45.5 | 6.6 | | 12.5 | 20.0 | 11.0 |
| General Pract. | | | | | | | | | | | | |
| Treacher. | | | | | | | | | | | | |

TABLE 42: PERSON MAKING AND RECEIVING REFERRALS

Of the referrals made to the Child Guidance Clinics, 64.0 per cent were made by teachers, and 23.0 per cent of those to Children's Hospital were made by social workers.

Referrals at the General Hospital were mainly received by general practitioners (88.8 per cent). At the Children's Aid Society, social workers received 72.7 per cent of the referrals, but most subsequent referrals made by C.A.S. were made by psychiatrists (93.7 per cent). Why this reversal occurs is speculation, but it may be that referrals are more readily accepted by other major agencies when made by a psychiatrist. Thus, when necessary, C.A.S. will have a psychiatrists make a needed referral.

The only other finding is that Selkirk tended to direct subsequent referrals to social work personnel. This occured at discharge and likely was intended to provide for follow-up service by social workers after discharge.

The data concerning the position of the person involved in the referral process is found in Table 43. The major trend observed in this data is that staff members, not chief administrators or supervisory staff, are mainly active in referral. This pattern is reflected primarily in the data on receiving referrals and on making subsequent referrals.

Within these two quadrants of Table 43, minimal activity by the chief administrator was found at the Psychiatris Institute (10.0 per cent) and at Children's Hospital (10.0 per cent). At the W.P.I. the chief administrator made 12.5 per cent of the subsequent referrals. At the Children's

| | PERSON MAKING REFERRAL TO ..... % | | | | | | PERSON RECEIVING REFERRAL At ..... % | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| STAFF POSITION | S.M.H. | W.P.I. | W.G.H. | C.A.S. WPG. | C.H. HOSP. | C.G.C. | S.M.H. | W.P.I. | W.G.H. | C.A.S. WPG. | C.H. HOSP. | C.G.C. |
| Chief Admin. | 15.1 | 7.6 | | | | 20.0 | | 10.0 | | | 7.4 | 5.8 |
| Supervisor | | 15.2 | | 11.6 | | 13.3 | | 5.0 | | | 11.1 | |
| Staff Member | 75.7 | 46.1 | 80.0 | 50.0 | 64.7 | 60.0 | 100.0 | 85.0 | 88.8 | 63.3 | 66.6 | 58.8 |
| | PERSON MAKING SUBSEQUENT REFERRAL FROM ..... % | | | | | | PERSON RECEIVING SUBSEQUENT REFERRAL FROM ..... % | | | | | |
| STAFF POSITION | S.M.I. | W.P.I. | W.G.H. | C.A.S. WPG. | C.H. HOSP. | C.G.C. | S.M.H. | W.P.I. | W.G.H. | C.A.S. WPG. | C.H. HOSP. | C.G.C. |
| Chief Admin. | | 12.5 | | | | | 18.4 | | | 6.2 | 21.3 | |
| Supervisor | | | 14.3 | | 8.3 | 5.9 | 9.2 | | | | | 6.2 |
| Staff Member | 81.8 | 75.0 | 71.4 | 62.5 | 66.5 | 58.8 | 45.4 | 57.1 | 71.3 | 81.2 | 42.8 | 37.5 |

TABLE 43: POSITION OF PERSON MAKING AND RECEIVING REFERRALS - MAJOR AGENCY DATA

Hospital 11.1 per cent of the referrals were received by supervisory staff.

The data concerning the making of referrals to major agencies, show that 15.1 per cent of the referrals to Selkirk were made by chief administrators. This parallels the data on subsequent referrals from the Psychiatric Institute. 20.0 per cent of the referrals made to the Child Guidance Clinic were by chief administrators.

The general trend toward staff activity in the referral process, is reflected in the data on the receiving of subsequent referrals, but to a lesser degree. Generally, the overall finding stands that staff members are mainly involved in the referral process in major agencies.

Table 44 presents the data on the method of making referrals and subsequent referrals. No pattern or trend can be seen in this data across major agencies or within agencies at the two points of referral.

The only observation to be made concerning the method of referral is that there appears to be a fair amount of personal contact in the major agency referral process. This is substantiated by the data on referral to the Winnipeg Psychiatric Institute and the General Hospital (25.0 per cent and 55.5 per cent respectively by personal contact). Many subsequent referrals by both the C.A.S. of Winnipeg and the Child Guidance Clinic were made by personal contact (28.5 per cent and 22.2 per cent respectively).

| | AGENCY RECEIVING REFERRAL % | | | | | | AGENCY MAKING SUBSEQUENT REFERRAL % | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| METHOD OF REFERRAL | S.M.H. | W.P.I. | W.G.H. | C.A.S. WPG. | C.H. HOSP. | C.G.C. | S.M.H. | W.P.I. | W.G.H. | C.A.S. WPG. | C.H. HOSP. | C.G.C. |
| Application Form | 51.4 | 10.0 | | | | 69.1 | | 43.7 | | | 7.6 | |
| Letter | 2.8 | | 22.2 | | 8.0 | | 45.4 | | 14.3 | | 23.0 | 11.1 |
| Personal Contact | 14.0 | 25.0 | 55.5 | | 56.0 | | | | | 28.5 | 15.4 | 22.2 |
| Telephone | | 5.0 | | 36.3 | 12.0 | | | 18.6 | 14.3 | 6.2 | | 5.5 |

TABLE 44: METHOD OF REFERRAL - MAJOR AGENCY DATA

Application forms were used to make referrals to both Selkirk and to the Child Guidance Clinic (51.4 per cent and 64.1 per cent respectively). The Psychiatric Institute used applications to make subseqntial referrals 43.7 per cent of the time.

Letters were used predominantly by Selkirk and the Children's Hospital to make subsequent referrals (45.4 per cent and 23.0 per cent of the time respectively). However, referrals were not made to major agencies by letter.

Telephone calls were used 36.3 per cent of the time in making referrals to the Children's Aid Society of Winnipeg.

In summary, personal contact seems to be the most common method of making referrals to major agencies and in making subsequent referrals from the same. Applications follow in importance, in turn followed by the use of letters, confined mainly to subsequent referrals. The use of telephone calls was of minimal importance in the referral process.

Table III * presents the data on the professional status of referrals. Almost without exception, professional referral to all major agencies greatly outnumber lay referral. The only exception was the Winnipeg General Hospital where 44.9 per cent of all referrals were lay; a greater percentage than that of professional referrals which was 33.3 per cent. At Selkirk 88.5 per cent of all referrals were professional, at the Psychiatric Institute 50.0 per cent, Children's Hospital 55.5 per cent, C.A.S. of Winnipeg 63.6 per cent, and the Guidance Clinic 94.1 per cent.

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* See Appendix

In the major agencies, the most common and almost universal intake procedure was to have a personal interview with a rotating intake worker. Personal interview were used 40.0 per cent of the time at Selkirk, 40.0 per cent of the time at the Psychiatric Institute, 66.6 per cent at the Winnipeg General Hospital, and 33.3 per cent at the Child Guidance Clinic. Only at Selkirk, were personal interviews held with a permanent intake worker; these occured in 48.5 per cent of the units.

Collateral interviews were held at the Psychiatric Institute, Children's Hospital, and C.A.S. of Winnipeg, but to a limited extent: 10.0 per cent, 18.5 per cent, and 18.1 per cent respectively.

Direct admission without an interview occured very frequently.

The data on the results of intake in the major agencies show that of the 132 units studied, only one resulted in a case not being made upon referral. This occured in a referral to Children's Hospital. All four of the major hospitals studied admitted the majority of referrals to in-patient care. The figures for in-patient admittance on intake were: 100 per cent at Selkirk, 85.0 per cent at the Psychiatric Institute, 77.7 per cent at the Winnipeg General Hospital, and 66.6 per cent at Children's Hospital.

At the Child Guidance Clinic and C.A.S. of Winnipeg figures representing in-patient admittance were much lower: 11.7 per cent and 27.2 per cent respectively. Correspondingly, out-patient service was given by these two agencies as follows:

Child Guidance Clinic - 70.5 per cent and C.A.S. 54.5 per cent.

The data on the follow-up of subsequent referrals in major agencies is present in Table XXIX. * This table shows that there was a large unknown factor concerning follow-up which makes it difficult to make well-documented and valid observations.

The major observation made is that follow-up did not occur in many instances in each agency except at the Child Guidance Clinic where follow-up took place usually in the form of personal contact with the client. Personal contact was the most common method of following up referrals. It is important to reiterate the fact that data on referral follow-up is so incomplete that observations made were misleading.

(ii) Assessment:

The data on the form of intake, working, subsequent referrals and discharge assessments is found in Table 45. The Psychiatric Institute, General Hospital and the Children's Hospital used mainly labels in making this assessment: 60.0 per cent 55.5 per cent and 44.4 per cent respectively. In comparison, Selkirk, the C.A.S. of Winnipeg and the Child Guidance Clinic used labels much less often in intake assessments. These agencies tended instead to use symptoms as assessments: 37.1 per cent, 45.4 per cent, and 35.3 per cent of the time respectively. The Children's Hospital also used symptoms 25.9 per cent of the time in intake assessments.

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* See Appendix

| | AT INTAKE % | | | | | | WORKING % | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| FORM OF ASSESSMENT | S.M.H. | W.P.I. | W.G.H. | C.A.S. WPG. | C.H. HOSP | C.G.C. | S.M.H. | W.P.I. | W.G.H. | C.A.S. WPG. | C.H. HOSP. | C.G.C. |
| Label | 28.5 | 60.0 | 55.5 | 27.2 | 44.4 | 17.6 | 88.5 | 70.0 | 55.5 | 27.2 | 72.0 | 23.0 |
| Symptom | 37.1 | 15.0 | 11.1 | 45.4 | 25.9 | 35.3 | 8.4 | | | 27.2 | 8.0 | 30.7 |
| Comparison | | | | | 3.7 | | | | | | | |
| Label & Sym. | 8.6 | 10.0 | 33.3 | | 7.4 | | | 10.0 | | | | |
| Label & Comp. | | 10.0 | | | | | | | | | | |
| None Made | 17.1 | 10.0 | | 9.0 | 3.7 | 23.5 | | 10.0 | 11.1 | 36.3 | 4.0 | 7.6 |
| | AT SUBSEQUENT REFERRAL % | | | | | | AT DISCHARGE % | | | | | |
| FORM OF ASSESSMENT | S.M.H. | W.P.I. | W.G.H. | C.A.S. WPG. | C.H. HOSP. | C.G.C. | S.M.H. | W.P.I. | W.G.H. | C.A.S. WPG. | C.H. HOSP. | C.G.C. |
| Label | 36.3 | 50.0 | 85.7 | 13.3 | 50.0 | | 14.2 | 60.0 | 33.3 | 16.6 | 18.1 | |
| Symptom | | 6.2 | | | | | 7.2 | | | 33.3 | | 14.3 |
| Comparison | 36.3 | 6.2 | | | 28.5 | 17.6 | 76.1 | | | | 27.2 | |
| Label & Sym. | | 12.4 | | 13.3 | | | | | | | | |
| Label & Comp. | | 6.2 | | | | | 7.2 | 20.0 | 66.6 | | 18.4 | |
| None Made | 9.2 | | | 13.3 | 7.1 | 11.8 | | | | | | |

TABLE 45: FORM OF ASSESSMENT - MAJOR AGENCY DATA

Both the Psychiatric Institute and the General Hospital also used labels and symptoms in combination to make assessments at intake. The data on the intake assessments show a trend in some agencies to use labels more often than in others.

The working assessment data of Table 45 shows a greater tendency in all major agencies, except Children's Aid to use labels in these assessments. A great increase in the application of labels at working assessment in comparison to their use at intake was found at Selkirk (88.5 per cent from 28.5 per cent), the Children's Hospital (72.0 per cent from 44.4 per cent) and the Child Guidance Clinic (73.0 per cent from 17.6 per cent). Both Psychiatric Institute and the Winnipeg General Hospital used labels with approximately the same frequency in working assessments as at intake.

The Children's Aid Society tended to make less working assessments than at intake. Those assessments were made equally in the form of symptoms and labels. The difference between the Children's Aid Society and the other major agencies is perhaps the result of the difference in personnel, the Children's Aid Society differing in that there are no psychiatrists on staff.

The data on assessment at subsequent referral indicates much less of a tendency to use labels in all major agencies except at the Winnipeg General Hospital where 85.7 per cent of the assessments were made in the form of labels. This finding results from a comparison of the data on assessments at subsequent referral with that of working assessments.

Why this trend occurs may be because referrals are more readily accepted when a label is not attached. Agencies making subsequent referrals may thus drop negatively conceived labels when trying to initiate successful referrals.

The data on discharge assessments show a tendency to use labels or a combination of labels and symptoms in making discharge assessments at the Winnipeg Psychiatric Institute and at the Winnipeg General Hospital. There was a general tendency at discharge to use comparisons in assessments at Selkirk and Children's Hospital. The Children's Aid Society, however, made nore discharge assessments in the form of symptoms than at other times or by other agencies.

The data concerning the actual assessments made by the major agencies is presented in Table 46. No significant trends can be detected in this data which is consistent across all assessments. There did appear to be a tendency at the four hospitals studied to assess in terms of schizophrenia as seen in Table 46. The Psychiatric Institute was the most consistent here, using schizophrenia as assessment significantly often at all points of assessment. Descriptions of behavior were used fairly extensively by the C.A.S. and by the Child Guidance Clinic, although not consistently across all assessments as seen in Table 46. Selkirk also tended to use a description of behavior at intake much more than at any other time or then any other agency. The classification behavior disorder, was used fairly extensively and consistently by the Psychiatric Institute and Children's Hospital. At Children's there was a decrease in its use from intake to discharge assessments:

| | AT INTAKE % | | | | | | WORKING % | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ACTUAL ASSESSMENT | S.M.H. | W.P.I. | W.G.H. | C.A.S. WPG. | C.H. HOSP. | C.G.C. | S.M.H. | W.P.I. | W.G.H. | C.A.S. WPG. | C.H. HOSP. | C.G.C. |
| Schizophrenia | 16.6 | 33.3 | 44.4 | | | 7.1 | 45.7 | 47.3 | 62.5 | 14.2 | 25.0 | |
| Psychotic | 3.3 | 5.5 | | 10.0 | 4.0 | | 5.6 | 5.3 | | 14.2 | 4.2 | |
| Personal. Dis. | | 5.5 | | 10.0 | | | 8.4 | 5.3 | | 14.2 | | 8.3 |
| Behavior Dis. | | 5.5 | | | 28.0 | | 15.2 | 10.6 | | | 19.5 | |
| Desc. of Beh. | 40.0 | 11.1 | 11.1 | 40.0 | 24.0 | 50.0 | 8.4 | | | 28.5 | 8.4 | 41.6 |
| Schizophrenia + | 9.9 | 22.2 | 33.3 | | 4.0 | | 5.6 | 15.9 | 25.0 | | 16.8 | |

| | AT SUBSEQUENT REFERRAL % | | | | | | AT DISCHARGE % | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ACTUAL ASSESSMENT | S.M.H. | W.P.I. | W.G.H. | C.A.S. WPG. | C.H. HOSP. | C.G.C. | S.M.H. | W.P.I. | W.G.H. | C.A.S. WPG. | C.H. HOSP. | C.G.C. |
| Schizophrenia | 20.0 | 25.0 | 71.3 | 7.6 | 30.7 | 5.9 | | 20.0 | 33.3 | | 9.1 | |
| Psychotic | | 6.2 | | 7.6 | 7.6 | | | | | | | |
| Personal. Dis. | 10.0 | | | | | | 14.8 | 20.0 | | 16.6 | | |
| Behavior Dis. | 20.0 | 6.2 | 14.3 | | 7.6 | | 7.4 | 20.0 | | | 9.1 | |
| Desc. of Beh. | | | | | | 23.5 | 7.4 | | | 33.3 | | 14.2 |
| Schizophrenia + | | 18.7 | | | 7.6 | | | 20.0 | 33.3 | 16.6 | | 6.5 |
| Improved | 40.0 | | | | 30.7 | | 42.8 | | | | 18.1 | 17.4 |

TABLE 46: ACTUAL ASSESSMENT - MAJOR AGENCY DATA

28.0 per cent to 9.1 per cent as seen in Table 46; while at the Psychiatric Institute there was an increase in its use from 50.0 per cent to 20.0 per cent.

As can be seen from Table 47 no one method of making

| Method of Determining Working Assessment | S.M.H. % | W.P.I. % | W.G.H. % | CHILD. HOSP. % | C.A.S. WPG. % | C.G.C. % |
|---|---|---|---|---|---|---|
| Consultation and Collaboration | 8.5 | | | 4.1 | 25.0 | |
| Observation | 25.7 | 11.1 | 25.0 | 4.1 | | |
| Observation, Personal Interview & Other | 5.7 | 16.6 | | 20.7 | | 25.0 |
| Observation and Other (not Pers. Interview) | 25.7 | 25.7 | 37.5 | 45.8 | 12.5 | 16.6 |

TABLE 47: METHOD OF DETERMINING WORKING ASSESSMENT - MAJOR AGENCY DATA

working assessments was used predominately in any one major agency. Observation alone was used 25.7 per cent of the time at Selkirk and 25.0 per cent of the time at the Winnipeg General Hospital. Observation in combination with a personal interview was used 20.7 per cent of the time at Children's Hospital and 25.0 per cent of the time at Child Guidance Clinic. Observation in combination with another method other than a personal interview was used frequently by all major agencies except the C.A.S. of Winnipeg and the Child Guidance Clinic. In other words, observation alone or in combination with other methods proved to be the mode for making working assessments in major agencies.

The following paragraph concerns the length of time required to make working assessments. Generally speaking, working assessments were made within a period of sixty days by all six of the major agencies. Children's Hospital, C.A.S. of Winnipeg, and the Child Guidance Clinic all had one assessment made over the sixty day period. Selkirk had 77.2 per cent of its assessments made within twenty-eight days of a referral being made, while the Psychiatric Institute had 50.0 per cent of the assessments completed in fourteen days. The figures quoted here can be found in Table XVIII.

The data concerning the person making assessment shows that in all major agencies, psychiatrists made the actual assessment almost without exception - the exceptions being at Children's Hospital where 8.3 per cent of the assessments were made by general practitioners, and at the Child Guidance Clinic where 16.6 per cent of the assessments were made by psychologists and another 16.6 per cent were made by psychiatrists, social workers, and psychologists together. At Selkirk, the Psychiatric Institute, and the Winnipeg General Hospital, all assessments were made by psychiatrists. The data cited here can be found in Table XVII.

(iii) Subsequent Services:

The nature of the services offered (treatment, referral and discharge) varied from one major agency to another in the proportion of each type of service given. For example, at both Selkirk and the Children's Aid Society of Winnipeg, a

large proportion of treatment alone was offered: 48.5 per cent and 45.4 per cent respectively. On the other hand, the Psychiatric Institute, Winnipeg General Hospital, Child Guidance Clinic and Children's Hospital offered little treatment alone, but did make a large number of referrals either alone or in combination with treatment, as can be seen from Table 48. The Children's Aid Society also made a large number of referrals in combination with treatment and discharge (27.2 per cent); while Selkirk made only a limited number of referrals (18.0 per cent).

| Nature of Subsequent Service | S.M.H. % | W.P.I. % | W.G.H. % | CHILD. HOSP. % | C.A.S. WPG. % | C.G.C. % |
|---|---|---|---|---|---|---|
| Treatment | 48.5 | 5.0 | 11.1 | 15.3 | 45.4 | 20.0 |
| Referral | 2.8 | | 11.1 | 3.8 | | 26.6 |
| Discharge | | 5.0 | | | | |
| Treatment & Referral | 5.7 | 55.5 | 33.3 | 26.9 | | 26.6 |
| Treatment & Discharge | 28.5 | 35.0 | 33.3 | 46.1 | 9.2 | |
| Treatment, Referral & Discharge | 8.5 | | 11.1 | 7.7 | 27.2 | 23.3 |

TABLE 48: NATURE OF SUBSEQUENT SERVICE - MAJOR AGENCY DATA

It can be seen that two types of agencies exist in the major agency set: those that offered treatment almost exclusively, and those offering both treatment and referral services. Selkirk represents the first type and the other five agencies the second type.

The general finding concerning treatment is that virtually all treatment is given within a one year period. Certain patterns exist within agencies, with some agencies, however, offering longer or shorter terms of treatment than others.

The Winnipeg General Hospital and the Psychiatric Institute both offered short term treatment with the majority occuring within a month: 75.0 per cent and 57.8 per cent respectively. The Psychiatric Institute provided 31.5 per cent of its treatment within a seven day period. Similarly, the Children's Hospital offered a fairly high percentage of treatment (24.0 per cent) within seven days. However, Children's Hospital tended to provide treatment of varying lengths with a tendency toward shorter term treatment within one month, as can be seen in Table 49.

| Length of Treatment | S.M.H. % | W.P.I. % | W.G.H. % | CHILD. HOSP. % | C.A.S. WPG. % | C.G.C. % |
|---|---|---|---|---|---|---|
| 1 Day | | | | 8.0 | | |
| 7 Days | | 31.5 | | 16.0 | | |
| 1 Month | 11.1 | 26.3 | 75.0 | 32.0 | | 8.3 |
| 3 Months | 18.5 | 26.3 | 25.0 | 12.0 | 22.2 | |
| 6 Months | 7.4 | 5.2 | | 8.0 | 11.1 | |
| 1 Year | 22.2 | 5.2 | | 4.0 | 11.1 | 16.6 |
| 2 Years | 3.7 | | | 4.0 | | 16.6 |
| 4 Years | | | | 4.0 | | 8.3 |

TABLE 49: LENGTH OF TREATMENT - MAJOR AGENCY DATA

The Child Guidance Clinic tended to provide a longer term of treatment extending over a period of years as seen in Table 49.

The Children's Aid Society of Winnipeg offered treatment ranging in length from three months to one year. This represents a mid range type of treatment length. At Selkirk, treatment length ranged from one month to two years with the majority of treatment being offered between three months and one year.

From these observations, it would seem that the various major agencies studied offer a wide range of treatment lengths. Some agencies (the Psychiatric Institute and the Winnipeg General Hospital) offer mainly short term treatment within a three month period, while the others such as the Child Guidance Clinic offer much longer term treatment extending over a period of years. Between these two positions lie agencies such as Selkirk and the Children's Aid Society which offer treatment services extending generally over a period of months but within a year.

Children's Hospital seems to possess a unique role in that it offers treatment over various periods of time ranging from one day to four years, with a tendency to shorter term care.

Two trends in the nature of treatment seem to exist in the major agencies: one being a trend toward the use of medication alone or in combination with other methods of treatment; the other toward the use of treatment methods other than medication. Both the Children's Aid Society of Winnipeg and the Child Guidance Clinic are agencies representing the latter trend while the other four major agencies, actually hospitals, tend more toward the use of medication.

The data of Table 50 lends evidence to this statement with

| Nature of Treatment | S.M.H. | W.P.I. | W.G.H. | CHILD. HOSP. | C.A.S. WPG. | C.G.C. |
|---|---|---|---|---|---|---|
| Medication | 9.3 | 57.8 | | 41.6 | | |
| Therapeutic Couns. | 3.1 | | | | 40.0 | 33.3 |
| Social Rehabilitation | 3.1 | 10.5 | | 4.2 | 20.0 | 11.1 |
| Med., Ther. Couns., & Social Rehab. | 21.8 | | 14.2 | 4.2 | | 11.1 |
| Med. & Ther. Couns. | 31.2 | 5.3 | 57.1 | 41.6 | 10.0 | |
| Med. & Soc. Rehab. | 15.6 | | 14.2 | 4.2 | 10.0 | |
| Ther. Couns. & Other | 3.1 | | | | | |
| Med., Ther. Couns. & Other | | 10.5 | | | | 11.1 |
| Ther. Couns. & Soc. Rehab. | 6.2 | | | | | |

TABLE 50: NATURE OF TREATMENT - MAJOR AGENCY DATA

the majority of treatment at Selkirk, Winnipeg Psychiatric Institute Winnipeg General Hospital and Children's Hospital involving the use of medication. Compiled percentages for each agency show medication to be used: 77.9 per cent of the time at Selkirk, 73.6 per cent at Psychiatric Institute, 85.5 per cent at Winnipeg General Hospital and 91.6 per cent at Children's Hospital. Except at the Psychiatric Institute and the Children's Hospital where medication was used alone 57.8 per cent of the time and 41.6 per cent respectively, most medication was used in conjunction with other methods of treatment.

At Selkirk Mental Hospital, the Winnipeg General Hospital and the Children's Hospital the majority of treatment given was in the form of various combinations of methods, as shown in Table 50.

At the Children's Aid Society and the Child Guidance Clinic

treatment mainly involved therapeutic counselling or social rehabilitation. Combinations with medication were also evident but, to a limited extent.

The results cited above lead to some questionning of present treatment methods; mainly, the use of medication alone as a means of attempting to rehabilitate patients.

The data presented in Table XXII indicates that major agencies utilized two types of facilities to provide service; these being out-patient service and in-patient treatment facilities.

The major hospitals: the Winnipeg General, the Children's and the Psychiatric Institute used in-patient treatment resources a large majority of the time; 78.9 per cent, 85.7 per cent and 72.0 per cent respectively. However, out-patient services were also used by each. The Children's Aid Society and the Child Guidance Clinic mainly relied on out-patient service. The Children's Aid Society also used what has been defined as non-treatment in-patient settings, such as, foster home care, but only 20.0 per cent of the time.

(b) Comparison of major agency - minor agency

(i) Referrals:

The data of Table 51 concerning the agency sets (major and minor), making referrals and receiving subsequent leads to some interesting observations concerning major agency - minor agency interaction. Of all the referrals made to the major agencies 53.6 per cent were inititated by other major

| AGENCY INVOLVED IN REFERRAL PROCESS | AGENCY MAKING REFERRAL | AGENCY RECEIVING REFERRAL | AGENCY MAKING SUBSEQUENT REFERRAL | AGENCY RECEIVING SUBSEQUENT REFERRAL |
|---|---|---|---|---|
| | (DATA TAKEN FROM MAJOR AGENCY FILES) | | | |
| MAJOR AGENCY | 53.6 | 99.7 | 83.7 | 65.0 |
| MINOR AGENCY | 10.4 | ---- | ---- | 16.8 |
| | (DATA TAKEN FROM MINOR AGENCY FILES) | | | |
| MAJOR AGENCY | 30.0 | ---- | ---- | 49.8 |
| MINOR AGENCY | 46.7 | 99.4 | 91.4 | 41.4 |

TABLE 51: AGENCIES MAKING AND RECEIVING REFERRALS MAJOR AND MINOR AGENCY DATA

agencies, while only 10.4 per cent were made by minor agencies. As well, of all subsequent referrals made by major agencies, 65.0 per cent were to other major agencies and only 16.8 per cent to minor agencies. These results indicate that there is a great deal of referral activity among the major agencies studied, but very little major agency initiated interaction with minor agencies.

The data from the minor agency files indicates that 46.7 per cent of the referrals to minor agencies were made by other minor agencies. Major agencies made 30.0 per cent of the referrals to minor agencies. Of the subsequent referrals made by minor agencies, 41.5 per cent were to other minor agencies and 49.8 per cent were directed to major agencies. These figures

indicate that there is a good deal of minor agency referral activity to both minor agencies and to major agencies.

Another finding is that major agencies do refer often to minor agencies as demonstrated by the 30.0 per cent figure. However, it should be noted that all but 5.0 per cent of the referrals represented in the 30.0 per cent figure quoted, were made by the Children's Aid Society of Winnipeg, as found in Table I. This being so, if the Children's Aid Society were to be reclassified as a "minor agency", then one again there would be evidence to suggest that there is little major agency initiated referral activity with minor agencies.

It should be remembered that major agency status is dependent only on an agency having a large number of units serviced by it. As such, the reclassification of agencies according to similarity in function might lead to interesting findings. These similarities have been pointed out in other data. Speculation concerning the interaction between various agencies and the role of various agencies such as the Children's Aid Society of Winnipeg will be undertaken in the next chapter of this paper.

The data of Table 52 indicates that there is a great deal more involvement of psychiatrists in the major agency referral process than in the minor agencies. However minor agency referrals involved a much greater proportion of social workers than the major agencies.

These statements are backed up consistantly by all the data except in the receiving of subsequent referrals in the minor

| CATEGORY | MAKING REFERRAL | | RECEIVING REFERRAL | | MAKING SUBSEQUENT REFERRAL | | RECEIVING SUBSEQUENT REFERRAL | |
|---|---|---|---|---|---|---|---|---|
| | MAJ | MIN. | MAJ. | MIN. | MAJ. | MIN. | MAJ. | MIN. |
| PSYCHIATRIST | 33.9 | 4.5 | 65.5 | 22.7 | 69.5 | 8.3 | 45.7 | 33.3 |
| SOCIAL WORKER | 11.9 | 27.2 | 9.2 | 36.3 | 7.3 | 75.0 | 15.6 | 33.3 |
| GEN. PRACTITIONER | | | 10.9 | 0.0 | | | | |
| OTHER LAY | 4.2 | 18.1 | | | | | | |

TABLE 52: PERSON MAKING AND RECEIVING REFERRALS - MAJOR AND MINOR AGENCY DATA

agencies where psychiatrists and social workers received an equal proportion of referrals. The data on the making of subsequent referrals best supports the above statement concerning the differential involvement of psychiatrists and social workers in the two agencies.

Another finding in this data is that minor agencies received more lay referrals than did the major agencies. This perhaps indicates that minor agencies are more assessible to non-professionals.

It was also found that major agencies received all the referrals from general practitioners. This again may indicate greater professional involvement in major agencies and the converse - less lay involvement.

Concerning the position of the person making or receiving referrals and subsequent referrals, the data of Table 53 shows

| CATEGORY | MAKING REFERRAL | | RECEIVING REFERRAL | | MAKING SUBSEQUENT REFERRAL | | RECEIVING SUBSEQUENT REFERRAL | |
|---|---|---|---|---|---|---|---|---|
| | MAJ. | MIN. | MAJ. | MIN. | MAJ. | MIN. | MAJ. | MIN. |
| CHIEF ADMIN. | | | 4.2 | 5.5 | 2.0 | 33.3 | 8.8 | 33.3 |
| STAFF MEMBER | 61.8 | 37.5 | 80.0 | 31.8 | 68.3 | 33.3 | 55.1 | 33.3 |

TABLE 53: POSITION OF PERSON MAKING AND RECEIVING REFERRALS - MAJOR AND MINOR AGENCY DATA

that staff members and not chief administrators are mainly responsible for referral activity in both major and minor agencies. Subsequent referrals in minor agencies did however involve chief administrators as often as staff members. This is so mainly because chief administrators in minor agencies often carry duel roles as staff members with a case load and as directors.

The data of Table 54 concerning the method of referral and

| CATEGORY | REFERRAL | | SUBSEQUENT REFERRAL | |
|---|---|---|---|---|
| | MAJOR | MINOR | MAJOR | MINOR |
| LETTER | 4.2 | 18.0 | 13.6 | 33.3 |
| PERSONAL CONTACT | 24.7 | 0.0 | 9.8 | 9.0 |
| APPLICATION FORM | 26.5 | 22.7 | | |

TABLE 54: HOW REFERRAL WAS MADE - MAJOR AND MINOR AGENCY DATA

subsequent referral indicate some differences between major agencies and minor agencies. Personal contact was used much more

often by major agencies in referral (24.7 per cent of the time) than in minor agencies (0.0 per cent). Letters, on the other hand, were used more often in referral by minor agencies - 18.0 per cent compared to 4.2 per cent by major agencies. This pattern was maintained in subsequent referral. The use of application forms was comparable between major and minor agencies (26.5 per cent and 22.7 per cent respectively).

These findings indicate that minor agencies generally use letters and application forms to make referrals while the major agencies rely on personal contact and application forms for their referrals.

As seen in Table III more of the referrals made to the major agencies were professional (65.6 per cent compared to 54.5 per cent to the minor agencies). Conversely, there were less lay referrals in the major agencies (19.5 per cent) as compared to the minor agencies (27.2 per cent). These findings lead to the observation that access to the major agencies by non-professional people may be more difficult than to minor agencies.

The data on intake procedure within the minor agencies contains such a high unknown quantity (68.0 per cent) that valid comparison with major agency data is difficult. However, the data on Table X shows that the most common method of intake in major agencies is a personal interview with a rotating intake worker (37.8 per cent) while the most common in the minor agencies was direct admission without an interview (13.6 per cent). A valid comparison between the two agency sets cannot be made as a

result of the lack of minor agency data.

The data on the results of the intake procedure as found in Table XI shows that both major and minor agencies accept almost all cases referred to them either on an out-patient basis or in-patient. Only one 'no case made' is found in the major agency data, and two in the minor agency data. In the major agencies, referrals were accepted on an in-patient basis more often than out-patients (68.9 per cent and 23.5 per cent respectively). This same pattern is found in the minor agencies. Minor agencies made appreciably more referrals at intake than major agencies did (19.0 per cent and 1.6 per cent respectively).

The above observations suggest that perhaps a slightly different role exists for the minor agencies than for the major, this being a referring type role. Minor agencies and major agencies however, seem to differ very little in their procedures.

No significant findings resulted from a comparison of follow-up procedure in major and minor agencies. In the major agencies 23.4 per cent of the referrals made were not follow-up, compared to 16.6 per cent in the minor agencies. These figures are found in Table XXIX.

(ii) Assessment:

The data of Table 55 indicates that differences exist in the form assessments take at the four intervals of time, both between the major and minor agencies and the intervals. At

intake, labels and symptoms were used as assessments with relatively similar frequencies by both major and minor agencies.

| CATEGORY | INTAKE | | WORKING | | SUBSEQUENT REFERRAL | | DISCHARGE | |
|---|---|---|---|---|---|---|---|---|
| | MAJ. | MIN. | MAJ. | MIN. | MAJ. | MIN. | MAJ. | MIN. |
| LABEL | 37.8 | 30.0 | 67.2 | 11.6 | 30.0 | 8.3 | 19.9 | 7.6 |
| SYMPTOMS | 29.4 | 35.0 | 7.0 | 11.6 | 1.1 | 25.0 | -- | -- |
| COMPARISON | | | | | | | 26.0 | 23.0 |
| NONE MADE | | | 7.1 | 35.2 | 6.6 | 16.6 | 0.0 | 23.0 |

TABLE 55: FORM OF ASSESSMENT - MAJOR AND MINOR AGENCY DATA

Working assessments present a different picture. Labels were used much more often than symptoms by major agencies to make working assessments. Labels were used as assessments much more often by major than minor agencies. Minor agencies also did not make working assessments 35.2 per cent of the time compared to 7.1 per cent by the major. This pattern of not making assessments also occurred at subsequent referral and discharge.

Assessments at subsequent referral were made in the form of a label more often by major agencies (30.0 per cent) than by minor agencies (8.3 per cent). However, appreciably less labels were used by major agencies at subsequent referral than in working assessments. This trend carried over into discharge assessments where even fewer labels were used by the major agencies. Minor agencies predominately used symptoms in making assessments

at subsequent referrals while major agencies used virtually no symptoms in this set of assessments.

At discharge, both major and minor agencies made assessments on the basis of comparison with other assessments with relatively the same frequency; 26.0 per cent and 23.0 per cent respectively.

The results cited indicated that labels are used more frequently by major agencies than minor agencies. Minor agencies generally speaking, use symptoms in their assessments more often than major agencies. It is also significant that minor agencies had a greater tendency not to make assessments than major agencies did. It is also interesting that major agencies use fewer labels at referral than at working assessment. One explanation for this is that agencies may hope to avoid negatively affecting a referral by removing a potentially negative label at referral.

More labels may be used by major agencies because most of the major agencies have psychiatrists on staff who are trained in making psychiatric diagnosis involving labels. Minor agencies, on the other hand, may refrain from using labels and also in making difficult assessments because of the lack of specially trained personnel, i.e. psychiatrists.

Table 56 presents the data concerning the actual assessments made at the four intervals of time mentioned earlier. At intake, major agencies diagnosed schizophrenia 16.9 per cent of the time and schizophrenia plus something else 11.3 per cent of the time; while minor agencies diagnosed schizophrenia 11.6 per cent of

| CATEGORY | INTAKE | | WORKING | | SUBSEQUENT REFERRAL | | DISCHARGE | |
|---|---|---|---|---|---|---|---|---|
| | MAJ. | MIN. | MAJ. | MIN. | MAJ. | MIN. | MAJ. | MIN. |
| SCHIZOPHRENIA | 16.9 | 11.6 | 35.2 | 0.0 | 22.3 | 11.1 | 6.5 | 11.1 |
| PSYCHOTIC | 4.7 | 11.6 | | | | | | |
| DESCRIPTION OF BEHAVIOR | 30.1 | 35.2 | 11.4 | 25.0 | 5.2 | 22.2 | 8.6 | 11.1 |
| SCHIZ + | 11.3 | 0.0 | 10.4 | 0.0 | | | | |
| NO CHANGE | | | | | | | 6.5 | 11.1 |
| IMPROVED | | | | | | | 17.4 | 22.2 |

TABLE 56: ACTUAL ASSESSMENT - MAJOR AND MINOR AGENCY DATA

the time. Major agencies thus seem to use the diagnosis of schizophrenia more often than minor agencies. This trend is carried over to both the working and subsequent referral assessments but is reversed at discharge with less schizophrenia assessed at discharge by major agencies than minor.

The trend throughout, is for minor agencies to use descriptions of behavior in assessments much more often than major agencies. The data in Table 56 supports this statement with minor agencies using descriptions of behavior 35.2 per cent of the time at intake, 25.0 per cent in working assessments and 22.2 per cent at referral. Major agencies did use descriptions of behavior 30.1 per cent of the time at intake, a comparable figure to minor agencies at this point.

The differences outlined between the major and minor agencies in using schizophrenia and descriptions of behavior, perhaps also reflect the difference in personnel on staff in the two types of agencies.

Table XVI shows that very little data on the method of making working assessments is available for minor agencies. As such, no real comparison between the major agencies and the minor agencies method of making assessments can be made. The data from Table XVII, however, points out that psychiatrists made 72.3 per cent of the working assessments in the major agencies, while only 25.0 per cent in the minor agencies. This reflects a greater involvement of psychiatrists in major agencies than in minor. On the other hand, social workers make 16.6 per cent of the assessments in the minor agencies and only 1.9 per cent in the major. Again, these observations must be qualified because of the lack of an adequate amount of data.

Concerning the length of the assessment period, it was noted that within sixty days of admission, 60.0 per cent of all working assessments had been made by major agencies, while only 25.0 per cent had been made by the minor agencies during the same period of time. In the major agencies, 33.6 per cent of all the working assessments were made within a period of fourteen days; in the minor agencies only 8.3 per cent had been made.

These findings point out that major agencies appear to make working assessments much more quickly than do minor agencies.

(iii) Subsequent Service

Differences between major and minor agencies appear to exist in the delivery of Service. More treatment alone was

provided by major agencies than minor (26.7 per cent compared to 16.6 per cent). Treatment, in combination with referral occurred 23.2 per cent of the time in major agencies and 11.1 per cent of the time in minor. However, treatment and discharge occur with greater frequency in the minor agencies (44.4 per cent) than in the major agencies (28.4 per cent). Comparable figures for treatment referral and discharge in combination were found 9.4 per cent for the major agencies and 11.1 per cent for the minor agencies. All these figures can be found in Table 57.

| SERVICE GIVEN | MAJOR | MINOR |
|---|---|---|
| TREATMENT | 26.7 | 16.6 |
| TREATMENT AND REFERRAL | 23.2 | 11.1 |
| TREATMENT AND DISCHARGE | 28.4 | 44.4 |
| TREATMENT, DISCHARGE, REFERRAL | 9.4 | 11.1 |

TABLE 57: NATURE OF SERVICE GIVEN - MAJOR AND MINOR AGENCY DATA

The observations made indicate that major agencies are involved in providing treatment but they also make many referrals in providing service. While it appears that minor agencies are more apt to discharge following treatment than are the major agencies, it should be pointed out that a large number of patients under study were still receiving treatment from Selkirk and thus were not discharged. Hence, more treatment alone is

recorded and correspondingly less treatment and discharge in combination than may be the true pattern in the major agencies.

Very little difference in the length of the treatment period was found between the major and minor agencies as can be seen from the data on Table XX. Of significance is the fact that in both major and minor agencies most treatment was given within a one year period: 70.0 per cent in the minor agencies and 69.0 per cent in the major agencies.

Concerning the nature of the treatment per se, a significant difference between major and minor agencies is the fact that medication as a sole means of treatment was used 23.0 per cent of the time in major agencies and only 0.59 per cent of the time in minor agencies. In combination with therapeutic counselling, medication was used 25.0 per cent and 23.5 per cent by the major and minor agencies respectively. There was a greater tendency in minor agencies than in major to employ methods of social rehabilitation (17.6 per cent and 8.7 per cent respectively). These figures can be seen in Table XXI.

The main observation here is that medication alone is used more often by major agencies than by minor agencies. While this may be the result of greater accessibility of drugs to major agencies the practice of using drugs as a sole means of treatment is questioned.

In both major and minor agencies, the most common treatment setting used was a treatment in-patient facility. Major

agencies used this type of setting 67.0 per cent of the time while minor agencies used it 76.4 per cent of the time. The next most common setting was an out-patient facility used 23.3 per cent of the time by major agencies and 11.7 per cent of the time in minor agencies. Overall, very little difference in treatment settings was found between major and minor agencies as shown in Table XXII.

(iv) Other Data:

In both major and minor agencies, discharges were made predominantly to natural parents (60.8 per cent and 69.2 per cent respectively). Similarly, 10.8 per cent and 9.8 per cent of the discharges made by major and minor agencies respectively were made to parents substitutes.

Generally speaking, many similarities exist within the data of the major agencies and the minor agencies. Where differences have been found to exist they have been outlined and discussed.

## Section F: Comparison of long trip and short trip data

This part of our study will attempt to identify any similarities and differences between the 'short trip' and the 'long trip'. Table 58 attempts to look at the comparison between the number of referrals and the number of cases. For our purposes, a short trip shall be defined as: any case having three referrals or less. A long trip, on the other hand, shall include any case having eight referrals or more. Thus, short trips represent a total of twelve cases and long trips, six cases.

| COMPARISON BETWEEN NUMBER OF TRIPS AND NUMBER OF CASES | |
|---|---|
| TRIPS | NUMBER OF CASES |
| 1 | 3 |
| 2 | 5 |
| 3 | 4 |
| 4 | 4 |
| 5 | 4 |
| 6 | 2 |
| 7 | 3 |
| 8 | 1 |
| 10 | 2 |
| 12 | 1 |
| 13 | 1 |
| 16 | 1 |

TABLE 58: COMPARISON BETWEEN NUMBER OF TRIPS AND NUMBER OF CASES

(i) Referral:

Before continuing with the discussion of our findings, it would seem appropriate at this point to briefly center our discussion around first referrals. In the short trip data all first referrals were received by psychiatrists. One might conclude that, if first contact is with a psychiatrist, the changes of having a short trip are good.

In the long trip, four from a possible six first referrals were received by psychologists, while one was received by a psychiatrist and one by a general practitioner. In looking at the number of psychologists receiving referrals, one might conclude that these referrals were made for testing only. While in a short trip, the reasons for referral to a psychiatrist would more probably be for treatment.

Marked differences between long and short trip data covering age as of date of referral occur. In a short trip, the mean age was sixteen years three months as is illustrated in Table 59.

| SHORT TRIP | | LONG TRIP | |
|---|---|---|---|
| Number of Cases | Age as of Data of Referral | Number of Cases | Age as of Date of Referral |
| 3 | 14 Years | 2 | Less than 1 yr. |
| 6 | 15 Years | 1 | 5 Years |
| 8 | 16 Years | 3 | 6 Years |
| 8 | 17 Years | 5 | 7 Years |
| | | 3 | 8 Years |
| | | 7 | 9 Years |
| | | 1 | 10 Years |
| | | 3 | 11 Years |
| | | 6 | 12 Years |
| | | 15 | 13 Years |
| | | 6 | 14 Years |
| | | 2 | 15 Years |
| | | 1 | 16 Years |
| | | N.A. 14 | |
| Mean: 16 Years/3 Mo.<br>Median: 16 Years<br>Mode: 16 Years/17 Yrs. | | Mean: 11 Years/1 Mo.<br>Median: 7 Years/3 Mo.<br>Mode: 13 Years | |

TABLE 59: AGE AS OF DATE OF REFERRAL - LONG TRIP - SHORT TRIP DATA

It would seem then that the older the individual, the shorter the trip.

Looking at the results of the long trip, the mean age of eleven years and one month was much lower than in the short trip. Consequently, the younger the age of first referral the

longer the trip. It should be noted here that the mode, 13 years, is higher than the mean by approximately two years in the long trip.

Our next point of discussion deals with agencies making referrals, with agencies receiving referrals, agencies making subsequent referrals and with agencies receiving subsequent referrals. (See Table 60)

| | Agency Making Referral | | Agency Receiving Referral | | Agency Making Subsequent Referral | | Agency Receiving Subsequent Referral | |
|---|---|---|---|---|---|---|---|---|
| | Short % | Long % | Short % | Long % | Short % | Long % | Short % | Long % |
| C.A.S. of East. | | | 4.0 | | | | | |
| C.A.S. of Wpg. | | 22.0 | | 10.5 | | 21.0 | | 4.2 |
| Child G. Clinic | | 11.0 | | 15.7 | | 27.3 | | 6.3 |
| Children's Home | | | | | | | | |
| Children's Hosp. | 10.0 | 15.0 | 8.0 | 28.0 | 18.0 | 23.1 | | 14.7 |
| Family Bureau | | | | | | 2.1 | | 2.1 |
| General Pract. | 25.0 | | | | | | | |
| Indian Affairs | | 4.0 | 4.0 | 3.5 | 9.0 | 4.2 | | 4.2 |
| Juvenile Court | | | | | | | | 2.1 |
| Man. Sch. Ret. | | | | | | | | |
| Private Psych. | 5.0 | | | | | | | |
| Roslyn House | | | | 1.7 | | | | 2.1 |
| Sir Hugn John MacDonald Host. | | | | | | | | |
| Selkirk Hosp. | | 4.0 | 52.0 | 10.5 | 27.0 | 2.1 | 3.6 | 18.9 |
| St. Agnes Sch. | | 2.0 | | 5.2 | | 4.2 | | 8.4 |
| St. Boniface H. | | | 12.0 | 1.7 | | | | 2.1 |
| St. Joseph Sch. | | | | 3.5 | | | | 4.2 |
| WPG Gen. Hosp. | 5.0 | | 12.0 | 3.5 | 18.0 | 4.2 | | 4.2 |
| WGH Psych. Inst. | 20.0 | 11.0 | 8.0 | 8.7 | 18.0 | 8.4 | 9.0 | 12.6 |
| Other | 15.0 | 4.0 | | 3.5 | 9.0 | 2.1 | 36.0 | 4.2 |
| School | 15.0 | 15.0 | | | | | | |
| Unknown | 5.0 | 11.0 | | 3.5 | | | 18.0 | 8.4 |

TABLE 60: AGENCY MAKING AND RECEIVING REFERRALS - LONG TRIP - SHORT TRIP DATA

Concerning agency making referral, general practitioners made the most referrals in a short trip but non at all in a long trip. It must also be pointed out that while general practitioners made referrals, they never received a referral. Schools made a equal amount of referrals both in short and in long trips. Unclassified "others" made more referrals in a short trip than in a long trip. The Winnipeg Psychiatric Institute did so as well. In the long trip, agencies such as C.A.S. of Winnipeg and Child Guidance Clinic made a large per cent of referrals as compared to none in a short trip. This suggests perhaps that the sources of these agencies were not utilized in a short trip. Children's Hospital interestingly enough, made almost an identical number of referrals both in short and long trips. This is one of the few agencies involved, both in short and long trips illustrating the important role it can have. Of importance as well is the fact that all agencies making referrals in short trip have psychiatrists on staff except for schools.

Generally speaking the same agencies as previously mentioned were involved in receiving referrals. The agency receiving most of the referrals in the short trip was Selkirk Mental Hospital while in the long trip, Children's Hospital received the most. This substantiates our previous finding that Children's Hospital does indeed have an important role in the long trip.

Concerning agencies making subsequent referral it was found that in a short trip, the agencies involved made more subsequent referrals than they had received. Reasons for this might be due to the inappropriateness of the treatment provided, lack of physical space, etc. Although it was possible to identify this trend in the long trip, there were instances where the percentage of the subsequent referrals were less than the percentage found in receiving referrals. One might conclude that some form of treatment was provided. Another possible reason for the high percentage of these subsequent referrals might be because of multiple referrals being made; this possibility definitely cannot be overlooked.

Selkirk Mental Hospital had the highest percentage of all the agencies concerning agency receiving subsequent referral. It must be noted that a high percentage of not applicables in the short trip limits the making of significant conclusions on such a small body of data.

In looking at professional status of referral, identical information was found in both short and long trips. Nevertheless it is of importance and should not be overlooked.

Our next area of concern focuses on the person making the referral, the person receiving the referral, the person making the subsequent referral and the person receiving the subsequent referral (See Table 61).

Of those making referrals, 32 per cent were made by psychiatrists in the short trip and 19.8 per cent by psychiatrists

| | Person Making Referral | | Person Receiving Referral | | Person Making Subsequent Referral | | Person Receiving Subsequent Referral | |
|---|---|---|---|---|---|---|---|---|
| | Short | Long | Short | Long | Short | Long | Short | Long |
| Self | 8.0 | 1.8 | | | | | | |
| Psychiatrist | 32.0 | 19.8 | 92.0 | 49.0 | 54.6 | 41.0 | 18.1 | 53.3 |
| Social Worker | 4.0 | 21.6 | 4.0 | 14.5 | 18.1 | 30.0 | 9.0 | 13.3 |
| General Pract. | 16.0 | 3.6 | | 3.6 | | | | |
| Psychologist | | | | 5.9 | | | | |
| School Teacher | 4.0 | 10.8 | | | | | | |
| Other Prof. | 8.0 | | | | | | | |
| Parents | 12.0 | 10.8 | | | | | | |
| Relatives | | 1.8 | | | | | | |
| Friends/Neigh. | | | | | | | | |
| Priest/Minister | | | | | | | | |
| Other Lay | 4.0 | 7.2 | | | | | | |
| Psych & Parents | | | | | | 2.1 | | |
| Psych. & Other | | | | | | | | |
| Parents & Other Lay | | | | | | | | |
| Psychiatrist & Self & Gen. Practitioner | | | | | | | | |
| Other | | | | 5.9 | | 2.1 | 9.0 | 4.4 |
| Unknown | 12.0 | 18.0 | 4.0 | 20.0 | 27.3 | 24.0 | 63.0 | 28.8 |

TABLE 61: PERSON MAKING AND RECEIVING REFERRALS - LONG TRIP - SHORT TRIP DATA

in the long trip. 4 per cent of the referrals were made by social worker in the short trip and 21.6 per cent by social worker in the long trip. These results confirm the fact that in short trips, psychiatrists were involved primarily. In long trips, we found that five times more social workers were involved. Thus if contact with psychiatrists had been initiated, the changes of having a short trip is greater than if contact had been made

with a social worker. One must also note that the percentage of psychiatrists making referrals is equal to that of social workers. The high percentage of general practitioners and parents in short trip should also be noted.

Concerning the person receiving referral, 92 per cent of all referrals were received by psychiatrists. In looking through our data, it was found that all referrals made by general practitioners were received by psychiatrists. This suggests that a person will have a short trip if a local general practitioner is contacted as he will then contact a psychiatrist who will be able to refer the person to Selkirk Mental Hospital if this is the service required. In the long trip, psychiatrists received approximately half the referrals, with social workers and psychologists receiving almost equal amount. Thus in looking at person making referrals, social workers made more referrals than they received which is contrary to the trend found with psychiatrists. It must also be noted that psychologists did not make referrals, but did receive several as can be seen in Table 61.

Psychiatrists in both short and long trips have the highest percentage of those making subsequent referrals. This is understandably so because of the high percentage found in person receiving referral. Social workers also made subsequent referrals with more of them being made in the long trip. Other conclusions are difficult to make because of the high percentage of unknowns and not applicables.

In looking at the person receiving subsequent referral, 18.1 per cent were received by psychiatrist in short trips with 53.3 per cent by psychiatrists in long trips. This figure represents the highest involvement of psychiatrists to be found in the long trip. Again, further interpretation is difficult because of the amount of not applicables and unknowns.

The position of the person making or receiving a referral and making and receiving a subsequent referral was found to be a staff member both in short trip and in long trip. This is shown in the data of Table 62.

| | Position of Person Making Referral | | Position of Person Receiving Referral | | Position of Person Making Subsequent Referral | | Position of Person Receiving Subsequent Referral | |
|---|---|---|---|---|---|---|---|---|
| | Short | Long | Short | Long | Short | Long | Short | Long |
| Chief Admin. | 11.8 | 4.6 | | 7.4 | | 4.6 | | 9.2 |
| Supervisor | | 9.2 | | 3.7 | 10.0 | 4.6 | | 2.3 |
| Staff Member | 64.7 | 52.9 | 96.0 | 64.8 | 70.0 | 62.1 | 40.0 | 55.2 |
| Other | 5.9 | 2.3 | | | | | | 2.3 |
| Unknown | 17.7 | 29.9 | 4.0 | 24.0 | 20.0 | 27.6 | 60.0 | 32.2 |

TABLE 62: POSITION OF PERSON MAKING AND RECEIVING REFERRALS - LONG TRIP - SHORT TRIP DATA

Chief Administrators and supervisor were involved quite frequently in a long trip as compared to a short trip.

In looking at how the initial referral was made, application forms were used more in a short trip as opposed to a long trip. (See Table 63)

| | How Referral was Made | | How Subsequent Referral was Made | |
|---|---|---|---|---|
| | Short | Long | Short | Long |
| Telephone | 4.0 | 3.8 | 20.0 | 4.3 |
| Letter | 8.0 | 5.7 | 30.0 | 10.5 |
| Personal Contact | 16.0 | 19.0 | | 14.7 |
| Application Form | 32.0 | 22.6 | | 8.4 |
| Other | | 1.9 | 10.0 | 2.1 |
| Letter & Applic. Form | 4.0 | | | |
| Unknown | 36.0 | 47.5 | 40.0 | 56.7 |

TABLE 63: METHOD USED IN MAKING REFERRALS - LONG TRIP - SHORT TRIP

In subsequent referral, in the short trip, personal contact and application form were not used at all; instead telephone calls and letters were used. As a result of a large percentage of not applicables and unknowns, it is impossible to arrive at any conclusions that could be substantiated by our data.

Our results on intake procedure are quite identical, with the short trip having a slightly higher percentage generally. The percentage of personal interviews with appointed intake worker is high in the short trip data, mainly because Selkirk Mental Hospital has this type of intake worker.

The data on the results of intake show that 80 per cent were admitted in a short trip while only 61.8 per cent were

admitted in a long trip. These percentages have affected the percentage of people receiving out-patient service with the short trip having less people in out-patient service and the long trip having more people receiving this type of treatment.

(ii) Assessment:

The data on the form of assessment at intake, in working assessment at referral, and at discharge show that labels were used throughout indicated by the high percentage found in Table 64. Generally labels were not used as often in the long trip as in the short trip.

| | Form of Assess. at Intake | | Working Assess. Form | | Form of Assess. at Referral | | Form of Assess. at Discharge | |
|---|---|---|---|---|---|---|---|---|
| | Short | Long | Short | Long | Short | Long | Short | Long |
| Label | 44.0 | 34.3 | 81.7 | 53.8 | 50.0 | 25.2 | 15.3 | 15.0 |
| Cause | | 3.6 | 4.3 | 3.8 | 10.0 | 2.1 | | |
| Symptom | 32.0 | 29.0 | 4.3 | 7.6 | 10.0 | 14.7 | 23.1 | 5.0 |
| Comparison | 4.0 | | | | 10.0 | 6.3 | 30.8 | 15.0 |
| Other | | 1.8 | | | | 6.3 | | |
| None Made | 8.0 | 9.0 | 8.6 | 13.4 | 10.0 | 8.4 | | 5.0 |
| Label & Symp. | 8.0 | 5.4 | | 1.9 | | | | |
| Cause & Symp. | | 1.8 | | | | | | |
| Label & Cause | | | | 1.9 | | | | |
| Label & Compar. | | | | | | | 15.3 | 5.0 |
| Label & Cause & Symptom | | | | | | 2.1 | | |
| Unknown | 4.0 | 14.5 | | 17.3 | 10.0 | 31.5 | 15.3 | 55.0 |

TABLE 64: FORM OF ASSESSMENT - LONG TRIP - SHORT TRIP

In form of assessment at intake labelling and symptoms were used almost an identical amount of time in both short and long

trip. In working assessment form, we find that labels were used almost twice as often as in the form of assessment at intake in short trip. Although the same can be said for the long trip, the difference in the percentages is not nearly as great.

In looking at form of assessment at referral, labelling again occurs twice as often in short trips as in long. We find that symptoms are used here quite often as well. Contrary to the three other assessment forms, in form of assessment at discharge labels were used only 15.3 per cent of the time in short trips and 15 per cent of the time in long trips. Here we find that symptoms were used instead, as well as comparison.

Thus, labels were used most often at working assessment and consistently within a case. They were used also half of the time in making referrals. This may be due to the fact that these referrals were usually made to other professionals. Labels were used more often in a short trip than in a long trip. Consequently the particular disorder the person was suffering from could be identified more readily. Hence, service was given faster resulting in a shorter trip.

The low percentage of labels used at discharge might be because of the fact that the person was discharged to lay people who would generally not be familiar with the terminology; or because of the fact that actual treatment has been given which has led to an actual positive change in behavior. Perhaps by looking at actual assessment made, these reasons may be

validated or refuted.

Concerning actual assessment at intake, actual working assessment, assessment at subsequent referral and actual assessment at discharge, it is possible to make additional conclusions. The data for this discussion is shown in Table 65.

In short trips, the data shows that schizophrenia was used far more extensively in the actual working assessment and at assessment at referral than at intake. In actual assessment at intake, it is also used but description of behavior has a slightly higher percentage than schizophrenia. This follows somewhat the same pattern that was found in form of assessment discussed earlier.

Looking at actual assessment at discharge the comparison "improved" is used three times more often than any other category. This seems to be the only time that an actual comparision has been made. This substitutes the interpretation made earlier that actual improvement could have been achieved through treatment.

The long trip data showed that the label schizophrenia was used very little compared to the number of times it was used in a short trip. When one looks at schizophrenia plus another form of assessment, different results ensue. This is found in the data on assessment made at intake and that of the working assessment. In these assessments schizophrenia in combination with another diagnosis was used more often in long trips than in short. The form of assessment "description of behavior" was also used extensively except in actual assessment at discharge. It must

| | Actual Assessment At Intake | | Actual Working Assessment | | Assessment At Subseq. Referral | | Actual Assessment at Discharge | |
|---|---|---|---|---|---|---|---|---|
| | Short | Long | Short | Long | Short | Long | Short | Long |
| Schizophrenia | 26.0 | 6.0 | 47.6 | 8.6 | 55.5 | 12.1 | 9.0 | |
| Psychotic | 9.6 | 8.0 | 9.4 | 6.3 | | 9.6 | | |
| Mental Disorder | | | 14.1 | 4.2 | | | | 5.2 |
| Epilepsy | | 8.0 | | 2.1 | | | | |
| Pers. Disorder | | | 4.7 | 2.1 | | | 9.0 | |
| Behavior Dis. | 9.6 | 10.0 | 4.7 | 10.7 | | 4.8 | | 10.4 |
| Thought Dis. | | 2.0 | | | | | | |
| Family | | 2.0 | 4.7 | 2.1 | | | | |
| Drug | | 2.0 | | 2.1 | 11.1 | 2.4 | | |
| Desc. of Behav. | 30.3 | 30.0 | 4.7 | 10.7 | | 14.5 | 9.0 | 5.2 |
| No Change | | | | | | 4.8 | 9.0 | 10.4 |
| Improved | | | | | 11.1 | 7.2 | 27.0 | 5.2 |
| Detioration | | | 4.7 | | | | | |
| Other | 9.6 | | | | | | | |
| Schizophrenia + Thought Dis. | | 12.0 | | 14.5 | | 2.4 | | |
| Desc. of Behav. | 9.6 | | | | | 2.4 | | |
| Psychotic & Mental Disorder | 4.3 | | | | | | | |
| Drug & Desc. of Behavior | | 2.0 | | | | | | |
| Epilepsy & Beh. Disorder | | 2.0 | | | | | | |
| Behav. Disorder & Desc. of Behav. | | | 4.7 | 2.1 | | | | |
| Mental Dis. & Person. Disorder | | | | 2.1 | | | | |
| Epilepsy & Drug | | | | 2.1 | | | | |
| Psychotic & Epilepsy | | | | 2.1 | | | | |
| Epilepsy & No Change of Desc. | | | | | | | | 5.2 |
| Thought Dis. & Family & Desc. of Behavior | | | | | | 2.4 | | |
| Mental Dis. & Contolled | | | | | | | 9.0 | |
| Mental Dis. & Improved | | | | | | | 9.0 | |
| Unknown | 4.3 | 16.0 | | 21.6 | 22.2 | 36.5 | 18.0 | 57.2 |

TABLE 65: ACTUAL ASSESSMENT - LONG TRIP - SHORT TRIP DATA

be mentioned also, that in the long trip, there was quite a variety of assessments used. This was not at all characteristic of a short trip which perhaps validates that the particular illness was more readily identifiable than in a long trip.

Concerning the method used in making working assessments, the same similarities between the short and the long trip can be seen as found in the percentage of observation used alone and the percentage of time observation was used in combination with another method.

Of importance here, as well, is the few times that consultation and collaboration were used as a means to arrive at a decision. It is used somewhat in the long trip but is non existent in the short trip. A reason for this might be because of the complexity of the disease in the long trip, thus requiring consultation as opposed to the clear cut disorder found in the short trip.

In length of assessment period, the short trip had more assessments made in the same length of time as the long trip. Within twenty eight days, 56.4 per cent of the assessments in short trips were made while only 50.8 per cent were made in the long trip. In the short trips, still 18.8 per cent of the assessments were made between 29-60 days. This suggests that the majority of the assessments in short trips are completed within three months.

One might conclude from these results that when assessments were made rather quickly, treatment might be given more rapidly.

(iii) Subsequent Service:

In looking at subsequent service, treatment is given 45.8 per cent of the time as compared to only 26.4 per cent in a long

trip. This perhaps can be explained by the fact that in a short trip, the agencies involved were mainly institutions which could provide treatment. It must also be noted that, in both short and long trips, identical results were found in looking at treatment and discharge combined and treatment and referral combined.

Considering the length of treatment, in the short trip data, 60 per cent of treatment was given within three months as opposed to 46.2 per cent in long trips. The same difference was found when the percentage of treatment received within a year in short trips (85.0 per cent) is compared to that found in the long trip (60.9 per cent).

Perhaps a correlation can be made between length of treatment and treatment setting. This will be discussed a little further in our discussion.

The data on the nature of treatment shows that in the short trip, medication and therapeutic counselling were used 36 per cent of the time as compared to only 14.5 per cent in long trips. Medication was used twice as often in the long trip as in the short trip. One might suspect that a reason for this is that, in a short trip, the treatment would be in a closed setting where either therapeutic counselling or social rehabilitation would be used as well. On the other hand it was found that in a long trip more of the children were treated on an out-patient basis thus possibly accounting for the high percentage of medication used. Nevertheless the widespread use

of medication as demonstrated in both the short trip and the long trip is an important finding.

The results concerning the treatment setting, are for both short and long trips with the higher percentage of in-patient treatment being used in the short trip, and the higher percentage of out-patient in the long trip. Again these findings do concur with our previous interpretations, that institutional care is primarily used in a short trip, but not in a long trip. Our interpretations made concerning nature of treatment, length of treatment and subsequent service are thus validated.

(iv) Other Data:

In follow-up to referral, less follow-up was made in short trip as opposed to long trip. To interpret these findings would be erroneous due to the amount of unknowns and not applicables.

Finally our findings illustrate that a large percentage of the people involved were discharged to parents. To make any further interpretations is difficult because of the nature of our results.

## Section G: Comparison of urban and rural data

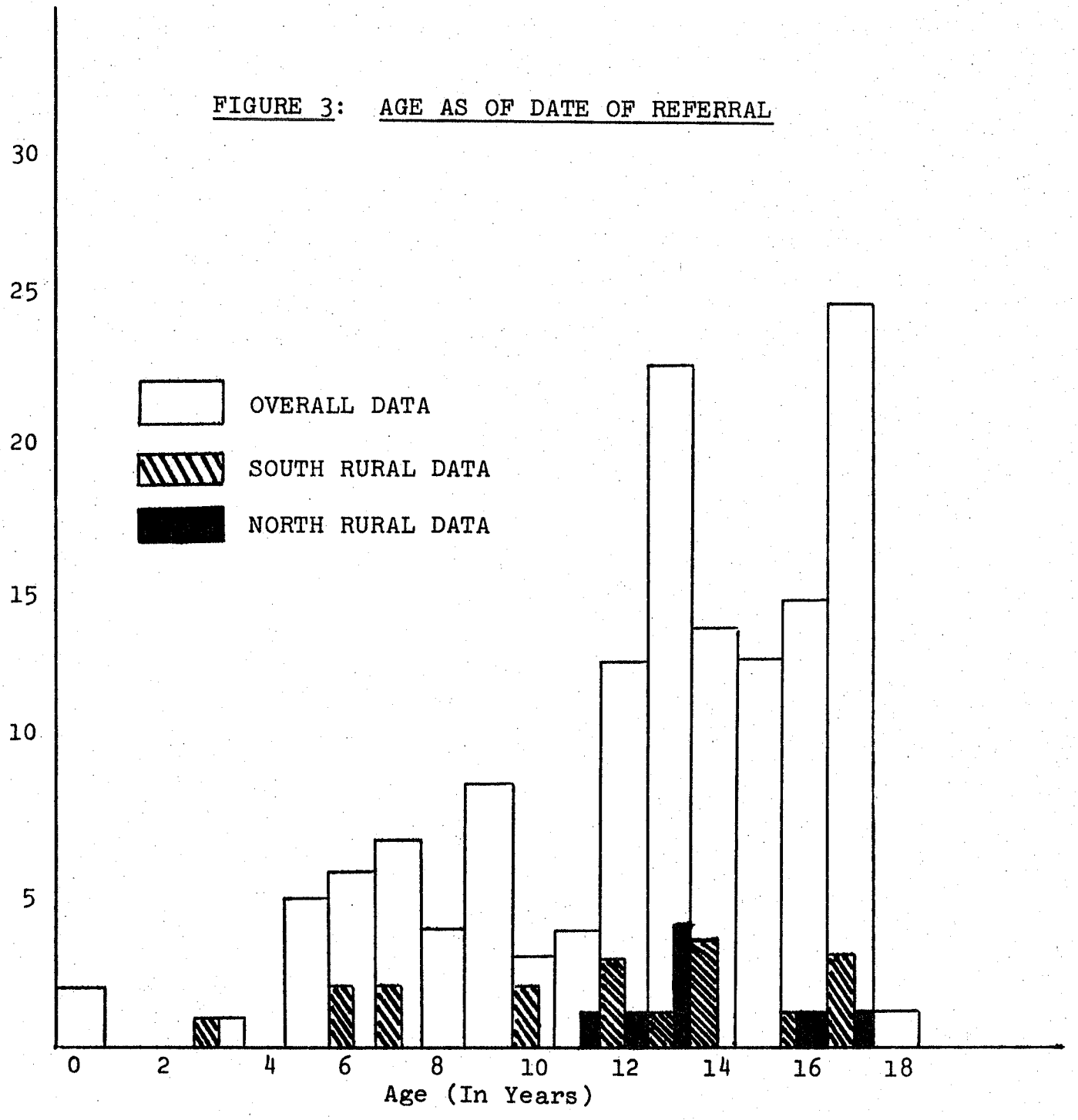
One of the concerns that was isolated in chapter one was that of the apparent discrepancy in service between the urban and rural areas of the province. Attempts were made to determine if such a discrepancy actually existed, but results were inconclusive.

There were eight cases (25.8 per cent) that were classified as rural, two of these form the northern rural areas of the

province. These accounted for 30 units (18.4 per cent) of the sample. Generally, the patterns found in the overall data were also evident in this data, and when differences were found, the actual number of units actually determining the difference was small.

An example of the problems faced is given on Figure 3,

FIGURE 3: AGE AS OF DATE OF REFERRAL



in which a comparison of the age at the date of referral is made between the overall data, the south rural data and the north rural data. One is first struck by the similarity in pattern between these groupings, such as a broad age range and concentration at ages 13 and 17. A conclusion that one might be tempted to draw from the fact that there were no north rural referrals before age 11, is that the northern areas are not receiving the service. However, a closer examination reveals that there are only two cases in question, in one of these the child was away from his northern home and in the southern area. Throughout the data dealing with rural cases such problems arise. As a result, no conclusions will be drawn for the purpose of this study.

Conclusion:

It is recognized that the analysis undertaken in this chapter was limited; at least, it was not exhaustive. Pressures of time being what they are, further analysis was not considered possible. As well, it was felt that the stated purpose of the study (to explore areas of concern with a view to uncovering apparent trends and developing direction for further research) was well served by the present analysis. As such, analysis in greater depth was not considered to be warranted in this study.

# CHAPTER 5

## CONCLUSIONS

Throughout chapter four conclusions were drawn directly from the data, as the data was being presented. In this chapter these conclusions will be drawn together, and presented in a more systematic manner. It would seem appropriate to divide these into a number of sections, beginning with a discussion of the "system", isolating the roles of the various agencies and the communication patterns between each. The question of access routes to the system will also be considered. The second focus will be on the people within the system, examining the role of the various professional and lay persons involved.

Five sections will then be present, one on each of the major phases of the referral-intake-assessment-treatment-discharge flow. These were found to be key concepts for the study, and warrant some attention.

Three groups of data that were isolated for particular study were first referrals, long and short trips, and urban and rural referrals. Much of the results of these has been incorportated in the above material, but there are unique points in each, and these shall be presented.

A theory of crisis points will be presented, this theory having developed out of the material studied, and is given only as the first step towards a more refined approach.

Finally, a brief section on the limitation of the study will be given.

The System

From the observations made in the major-minor agency analysis and other findings, it has been concluded that four major functional roles are identifiable in the structure within which present psychiatric services are delivered. The first of these roles is characterized by the delivery of, comparatively speaking, long-term psychiatric services. This role is exemplified by the service given by the Selkirk Hospital for Mental Diseases. The second major role combines the delivery of short-term psychiatric services with the provision of referral services to other psychiatric facilities. Agencies found to be performing this role were: the Psychiatric Institute, the Winnipeg General Hospital, the Children's Hospital and the St. Boniface Hospital. These constitute what will later be called the core agencies in the delivery of adolescent psychiatric services.

The third role identified introduces a new concept, that of para psychiatric services. These are defined as being subsidiary and accessory to those services commonly viewed as being psychiatric services. Services of the nature offered by the Children's Aid Societies and Children's Home may be classified as being of the para psychiatric type. The third role then is identified by the combination of the delivery of para psychiatric services with the provision of referral services. This role is performed by the agencies mentioned above and the Juvenile and Family Court, the Family Bureau, Roslyn House, St. Joseph's

Vocational School and St. Agnes School.

The fourth role identified is strictly one of referral, exemplified in this study by general practitioners, schools and teachers, and parents. Occupiers of this role make referrals only but do not receive them.

On the basis of these four identifiable roles and other findings the following conclusion is made: that the agencies currently offering psychiatric services to young adults are hierarchically arranged according to professional prestige and unchallenged expertise in the field of mental illness.

This hierarchical structure is diagrammed in figure four, which outlines the positions and roles held by the various agencies studied. This diagram conveys an impression of the possible difficulties in communication experienced in such a multitiered structure, without opportunity having been made for necessary communication and interaction.

## The People Within The System

Five major professions were found to be involved in the field of psychiatric services for children, these being psychiatrists, social workers, general practitioners, school teachers, and psychologists. Another group of people which the study termed collaterals, include such persons as parents, other family members, clergy and friends. The roles played by each of these will be examined here.

Psychiatrists, as would be expected, dominated the services given, particularly in the major agencies, as these are psychiatric

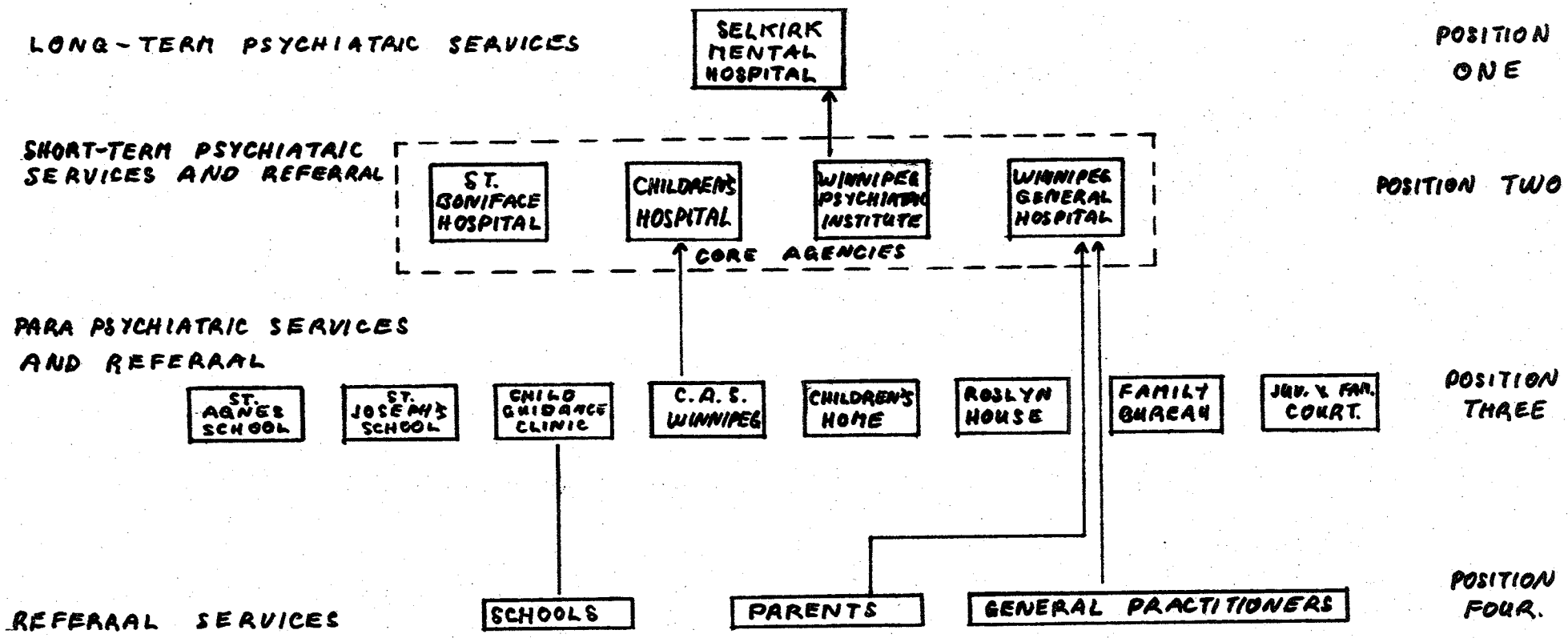



FIGURE 4 : THE STRUCTURAL ORGANIZATION OF THE VARIOUS COMPONENTS INVOLVED IN THE DELIVERY OF PSYCHIATRIC SERVICES; OUTLINING IN PARTICULAR THE ROLES PLAYED BY, AND HIERACHIRAL POSITIONS HELD BY, THESE COMPONENTS.

settings. Each step of service from referral, to intake, to assessment, to treatment and finally to discharge, was accomplished primarily by psychiatrists.

Social workers were found to play a major role, particularly in the making of referrals. In the longer trips, social workers were more actively involved, particularly when a minor agency was offering a service. Although these results are not unexpected, other findings do raise questions. Social workers were rarely involved in making assessments, and in some social work agencies, the question of assessment was not dealt with, leaving this process to other resources, such as a psychiatrist. Even within the referral process, an agency such as the Children's Aid Society of Winnipeg arranged for a psychiatrist to make their referrals. The treatment process rarely involved a social worker even within psychiatric settings that had social workers on staff. The fact that social workers were involved in the longer trips might indicated a more complex problem, involving social conditions as well as emotional proplems of the client. On the other hand it might also suggest that social workers do not have ready access to more effective services or do not possess sufficient tools themselves for adequate service.

General practitioner doctors were involved only in the referral system, and then only on referrals to psychiatrists. This relatively restricted role may be a result of a closer identification of doctors with the psychiatric field than with the social

work field. It may also reflect a greater awareness of services and a more accurate accessment of need, as well as a greater proneness to use the specialist.

The role of the school teacher followed the pattern of the doctors, in that teachers were only involved in the referral system. The Child Guidance Clinic received most of these referrals, as would be expected, as the C.G.C. is part of the school system. First referrals show a high incidence of teacher involvement, indicating an important place for the teacher in identifying emotional disturbances in children. The sudden increase in referrals at ages five to seven, as children begin school, might be a reflection of this role.

Psychologists, it was found, play only a minor role within the system, and generally only for the purpose of making assessments. They were rarely involved in the making of referrals or in the treatment process.

The use of collateral persons, and in particular, parents, was found to be low, and generally restricted to intake interviews early in the client's history, most frequently on first referrals. Parents were involved frequently at discharge, but there was little evidence that they were involved in the treatment process. From this, one might conclude that psychiatrists see themselves as treating individuals rather than families. There was no evidence within the study of the use of clergy at any point within the sytem, and rarely were other collateral resources used.

Referral

The study of referral methods and patterns was central to the research, and the results of these form the basis of much of the earlier discussion of the system. In addition to these results, four other points are worthy of mention.

The lay referral system, although suggested in chapter two as being influential, was found to play a very minor role within the total structure. Even first referrals, where one might have expected a high use of lay referrals, showed a high use of professional referrals instead. This lack of lay involvement might indicate a resistance upon the part of parents to make referrals, and it therefore becomes necessary for other persons, such as school teachers, to make the referral. If this is so, the school teacher becomes a key person in the detection of emotional disturbance. On the other hand, a second explanation for lack of lay involvement, may be inaccessibility to the system. The fact that psychiatric settings tend only to accept referrals from other psychiatrists, might indicate a closed system that excludes the lay referral.

A second point concerning referrals is the methods used in making referrals. The two most common methods are application forms and personal contact. Application forms are a reflection of formalized procedures and as such ensure an efficient use of the system. They ensure a permanent record and an accurate exchange of information from one agency to another. However, because of the formality, this procedure is generally restricted

to the professional and interagency referral, again excluding the lay person. Personal contact in the making of referrals would seem to reflect a more personal involvement of those concerned, and also provides a means of lay referrals. Also, due to the close geographical proximity of many of the agencies, the procedure of rotating psychiatric residents and the sharing of staff among agencies, allows for familiarity among the psychiatrists. The fact that only a very small percentage of the referrals received no service would seem to indicate that the referral system is effective.

Follow-up to referrals by the referring agency was found to occur in only about twenty percent (20%) of the referrals, but limited data make definite conclusions difficult. However, there does appear to be a weakness at this point in the process.

A final point concerning referrals is the time of year at which they were made. Most referrals were made in March and September, with very few being made in August. The remaining months had a moderate number of referrals. One might postulate that the August low is due to summer vactions, with agencies, and particularly the Child Guidance Clinic, modifying their services for a few weeks. The high point in September may be due to the start of the school term with many assessments being made to determine educational plans, and these detecting other problems, including emotional difficulties. The high point in March remains somewhat unexplained. It is perhaps due to increased pressure within the school as the year-end draws near, or the change in weather with the coming of spring, but

these explanations leave the writers somewhat dissatisfied.

## Intake

The process of intake was not studied in detail but one factor was isolated, and that was the use of appointed intake workers rather than rotating intake workers. The only agency to consistently use an appointed worker was Selkirk Mental Hospital where one psychiatrist performed all initial interviews. Incidently, Selkirk Mental Hospital was also the only agency to follow a reasonably consistent pattern in their methods of making assessments. The study data does not permit conclusions to be drawn concerning the effectiveness of either procedures, the alternatives being presented simply as a finding.

## Assessment

The question of assessments was one which presented some difficulty for the study. It was not the intention of the study to examine the pathology of the clients concerned, but to focus on the system; but the concept of labelling discussed in chapter two links the pathology to the system by suggesting that the pathology is somewhat determined by the system. It is with this orientation that the following comments are made.

A comparison of assessments at the four points isolated by the study indicate a pattern or flow. At intake there was a tendency to use labels and symptoms equally as much, perhaps reflecting a hesitancy to make a specific assessment. Working

assessments tended to be labels, perhaps to facilitate a more focused approach to treatment. At the point of subsequent referral there was a greater tendency towards descriptions of behavior, with less reliance on labels. It would seem that agencies allow the receiving agencies to apply their own labels, presenting only the symptoms. This might also reflect an attempt to temper the assessment so as to insure acceptance by the receiving agency. At discharge, a comparison with other assessments was used more often, reflecting an attempt to evaluate the effectiveness of treatment.

Whether the process of labelling is a factor in the career of a client is only a matter of conjecture at this point, as the data gathered did not yield conclusive evidence. There was some evidence that similar labels were used throughout a career, particularly in the cases of behavior disorders. However, this may be due to accurate assessment rather than any labelling process. The fact that there is a decrease in the use of labels at subsequent referrals might be seen as counter-indicating such a process. If labels are seen as facilitating treatment then the high use of labels for working assessment would be a reflection of this viewpoint.

Although the purpose of the study was not to examine particular diseases, some general impressions were formed by the research members which should be shared. The label Schizophrenia was used in a large proportion of the cases. It is recognized that this label covers a broad area of problems, and may be mani-

fested in a number of different ways. However, it still seems valid to conclude that Schizophrenia is the major illness of concern within childhood and adolescent psychiatric problems. A second label that deserves mention is that of Behavior Disorder. Although occurring in only a small portion of the sample it would seem to present particular difficulties for treatment. Children so labelled tended towards longer careers and tended to respond less to treatment, their assessments remaining more or less constant throughout their history. Also of interest is a third class of assessments, this dealing with drug-induced disorders. It had been anticipated by the research group that such disorders would be a factor in the study. However, in only three of the one hundred and sixty-three units were drugs listed as a problem, and in one of these the problem was with drugs prescribed by the psychiatrist. Selkirk Mental Hospital, then, is not offering treatment to persons suffering the effects of drug abuse. This raises the question as to where such persons are receiving treatment. Are the short-term treatment facilities carrying the full responsibility or are the services being given at all?

A final point concerning assessment that arose from our observations is the fact that patients are frequently placed on some form of medication upon admittance to a hospital. After a period of time an assessment is made of their problem, usually within a few weeks. The question that comes up is whether a valid assessment of a patient can be made while his under the

influence of medication. On the other hand, perhaps his response to medication can serve as a guideline for assessment, or is necessary to control the patient's behavior.

Treatment

As with assessment, the focus of the study was not to evaluate treatment but only to deal with it as it related to the system. As a result, conclusions are few, dealing with treatment setting, method of treatment and length of treatment.

It was found that there was a high use of in-patient treatment settings, reflecting this as the main form of treatment offered by the major agencies. Out-patient treatment was given more often early in the career of the client, particularly on first referrals. The combination of a series of short-term in-patient periods with out-patient service between these was a common pattern of the Psychiatric Institute. There appears to be some resistance upon the part of the agencies to use in-patient services, perhaps a reflection of the belief that this is the least-desired form of treatment. The use of Community Clinics by Selkirk Mental Hospital would seem to substantiate this stand. On the other hand, one in-patient service was offered, this tended to determine the setting for subsequent treatment. This is reflected in the low use of out-patient service later in the careers of the sample.

Methods of treatment tended to be of three forms, medication, therapeutic counselling and social rehabilitation. Medication

was the most popular form of treatment, with social rehabilitation the least. The low use of social rehabilitation may be a reflection of a low need for this form of treatment, perhaps only necessary for those patients assessed as behavior disorders, or with organic disabilities. The high use of medication may reflect two lines of thought; either mental illness is seen as having a physiological base and may be cured by drugs and other forms of treatment, or it may be seen as needing control rather than treatment and one deals with the symptoms rather than the problem. Either stand is open to question, and perhaps reflects some of the key issues within the field of psychiatry.

In the majority of cases, treatment lasted for less than one year, and often less than three months. In some incidents where treatment was longer than one year, this was on an out-patient basis and is not necessarily a reflection of instance treatment. One incidence of a four-year treatment was in the quasi-treatment setting of a boarding school. This tendency towards short-term treatment may again be a reflection of the belief of the undesirability of in-patient treatment.

A question which was raised in the first chapter of this report, dealing with the treatment of children on adult wards was not answered in this study. Although Selkirk Mental Hospital opened an adolescent ward in July, 1970, this change was not reflected in the number of admissions in the three months following. This may be due to the fact that there were

sufficient patients within the hospital itself at that time to fill the ward, to the selectivity used in admissions to this ward, and to difficulties common to any process of change.

Discharge

Very little data was collected concerning discharge but two points are of interest.

First, there were very few actual discharges throughout the study. This is partly due to the fact that most of the sample were in-patients at the time of the selection. On short trips this would be the expected pattern, However, this trend also held true for long careers, reflecting a need in such cases for continuous service, rarely reaching a point of independence. On the other hand, it might also reflect a resistance on the part of the patient or his parents to sever the dependency, or as a resistance upon the part of the system to relinquish this dependency. A continuation of service or a referral to another agency seems to be the pattern.

Secondly, most discharges were to the patient's own parents. Little use was made of substitute parents, perhaps reflecting a desire to maintain the family unit, or else a lack of alternate resources. This second possibility was suggested in a number of cases, particularly in long trips and with behavior disorders. The fact that few clients were discharged without some one being responsible for them, reflects positively upon the system.

First Referrals

Much of the data gathered on first referrals has been incorporated into the above discussion. A general impression of first referrals is that they tend to be very specific referrals, that is, by personal contact with a particular agency with a well-defined problem. However, they frequently result in a subsequent referral to a more appropriate agency. The fact of specificity perhaps reflects the hesitancy to refer a person until the problem becomes acute and thus easily identifiable.

Long Trip - Short Trip

Again much of the information on long and short careers has been given above. The key point that seems to be central is the specificity of the problem to be treated. If it is easily identifiable and quickly labelled a short trip would seem to result. The involvement of a psychiatrist early would also seem to be a key factor.

Long trips tended to have a much more general assessment, with frequent use of symptoms rather than a label. Many other professionals, particularly social workers, were involved. All time periods, including the length of assessment periods tended to be long. Whether the multitude of social problems presented by a long trip necessitated the use of social workers, or whether the use of social workers led to a long trip is a question not answered by this study.

Urban - Rural

As suggested in chapter four, the data on urban versus rural services was inconclusive and leaves many questions unanswered.

Theory of Crisis Points

One group of results that has led the study group to formulate a more refined conclusion is that concerning the age of the client at the point of referral. Figure one on page 37 shows a dramatic increase in the number of referrals at age thirteen and again at age seventeen. It is suggested that these increases are due to particular stresses in the maturation of children and adolescents. Thirteen is the point of pubescence, involving gross physical and emotional changes. Seventeen marks the approach of adulthood and individual responsibility, and coincides with high school graduation. Children are particularly vulnerable at these points and therefore experience a greater incidence of emotional disturbance.

Looking next at figure two on page 55, dealing with age at first referral, one is first struck by the absence of the peaks at ages thirteen and seventeen. However there is a peak at age fifteen. We would suggest that this is actually a lag from the age thirteen crisis. The fact that first referrals are made only after the problem has become acute and easily identified, might explain this lag in referral. There is also likely a hesitation upon the part of parents to seek help from an agency with which they have had no previous contact.

The majority of the referrals at age thirteen were subsequent referrals, that is, there has been contact with the system prior to our suggest point of crisis. Not only would one predict that such patients might be more prone to break down at such a point, but they also might be more prone to use the services offered, either due to familiarity, or due to dependence.

The crisis at age seventeen was the last year included in this study. As a result nothing is known as to the history of such referrals after this age. One might predict that there would be a similar lag at age nineteen or twenty as with the previous crisis point.

Carrying these thoughts one step further, one might suggest that throughout the life cycle, and not just in adolescence, there are a number of crisis points at which one becomes particularly vulnerable. Some of these might include marriage, loss of a spouse, loss of employment and retirement. The idea being expressed is that the point of crisis is part of a normal life expectation, and it is the response to the crisis that is the abnormality.

Using this orientation, it thus becomes possible to predict when and where people may require psychiatric services. Our schools can observe the childhood crisis, our places of employment can observe job vulnerability, including retirement, hospitals can observe incidents of loss of a spouse through death. It would therefore seem to be vital that such institutions

be in a position where they can quickly identify persons who are unable to cope with their crises.

This study indicated that the school system presently serves to some degree this function of identifying emotional problems, and thus gives support for the present argument.

This theory of crisis points, involving the concept of the use of a variety of resources for the detection of maladaption to predictable crisis points, is presented as a first step towards the development of a more refined theory.

## Limitations of the Study

In doing any form of research, but particularly in an exploratory study such as this, there are numerous limitations that are discovered as one proceeds. In this study the limitations centered on the choice of the sample and on the research methods chosen.

By choosing the sample from Selkirk Mental Hospital, only those clients who had severe psychiatric problems became part of the study. The system of psychiatric services is far broader and meets a much larger population than that of Selkirk. The study has no way of knowing how many patients are seen by the other institutions that never get to Selkirk Mental Hospital. If one assumes that the study chose the "hard core" cases being seen by the "system" then it would seem unfair to judge the entire system by these few. If a representative sample had

been chosen from each agency, of those clients receiving psychiatric care, a more accurate picture might have been drawn.

A second limitation to the study was the defining of the maximum age to be seventeen, in order to qualify for the sample. A number of trends relating to age were identified and an examination of the cases above age seventeen would have provided useful information regarding these trends. The number of referrals between eighteen and twenty-one might have confirmed or reject the study's hypothesis around crisis points.

The fact that only thirty-one cases were chosen for the sample also posed a limitation. By breaking this data into urban and rural cases, the number of rural cases were minor. When looking at the data within the rural cases, the amount of data was so small that legitimate conclusions became difficult. Similarly, when a minor agency is involved in only two or three cases, it is again difficult to make conclusions on the limited data. Had a larger sample been chosen, much of this data would have been more adequate. On the other hand, even with the small number of cases, excessive amounts of data were collected, and perhaps an increase in the size of sample would have made the study unmanageable.

A fourth limitaiton of the study centered on the techniques used to gather the data. The exploratory design called for an open, general form of questionnaire which allowed some freedom in interpretation. This led to inconsistencies in data collection among the group members and from one agency to another.

As a result, when the coding system was devised following the data collection, it had to be broad enough to include the various forms of interpretation used. An example of this phenomena would center on the question, "Who made the referral?" This was sometimes answered simply as the name of some person, other times as a position such as a supervisor, or sometimes as a professional person, or again as the name of some person, other times as a position such as a supervisor, or sometimes as a professional person, or again as the name of an agency. Frequently some combination of these was used. As a result, one question on the file questionnaire became four on the coding system. A great many unknowns was the final consequence.

A final limitation to be discussed here is the limited sources of data tapped. All the data used for this study came from the files of various agencies, which in many cases were incomplete and only contained a portion of the data sought. Other sources such as interviewing the clients themselves or their parents or doctors, had been given consideration but were eventually dropped, as outlined in chapter three. This is unfortunate, as a valuable source of information was lost here. It could be noted that a self-administered questionnaire was given to a sample of workers throughout the system and the results of this questionnaire will be forthcoming, in a subsequent study.

## Summary

This chapter has summarized the major findings of the research conducted, including the presentation of a theory regarding crisis points that gains support from the study's findings. In the last chapter recommendations will be made that are based on these findings.

# CHAPTER 6

## RECOMMENDATIONS

In this chapter a number of recommendations will be made that arise out of the study. Some of these will be followed by hypotheses that derive support from the study data. It is such recommendations and hypotheses that are the culmination of an exploratory design, and are thus the purpose for the study.

The recommendations presented concern a broad range of topics, with varying degrees of applicability and abstraction. It would be hoped that as the reader studies each of these, he will attempt to apply the ideas presented to his particular situation, and evaluate them in his own terms. It is recognized that many of the recommendations presented will require extensive further research. However, in this light, this study provides some guidelines as to what direction that research should take.

The following recommendations are presented for consideration:

### Concerning the System

1. It is recommended that an examination of the psychiatric service system be undertaken to determine its structure and to determine the effects of this structure upon the clients of the system.

The discussion of the service system in chapter five suggests the following hypothesis:

Hypothesis I: The agencies offering psychiatric services function as a closed system to which access by outside agencies is limited.

Concerning People Within The System

2. It is recommended that an examination of the roles of psychiatrists, social workers and psychologists within the psychiatric service system be undertaken to determine whether their skills are being used most effectively.

The apparent inbalance in the use of these three professions within the psychiatric field is of concern. Drawing from this, the following hypothesis is suggested:

Hypothesis II: The profession of psychiatry tends to function as a closed system, and this closure not only affects the layman, but also other professionals such as social workers and psychologists.

3. It is recommended that an examination of the role of social workers in non-psychiatric settings be undertaken to determine their relationship to the field of psychiatry.

The involvement of social workers from non-psychiatric setting was found to be greatest in cases of long-term treatment. It is of concern that such a role is not

clearly defined, and that social workers do not have the skills and resources sufficient to meet the expectations placed on them.

4. It is recommended that an examiniation of the role of school teacher be undertaken to determine its relationship to the field of psychiatry.

The high level of involvement of school teachers in the making of referrals to the psychiatric system would suggest the following hypothesis:

Hypothesis III: School teachers are the only professionals that come into contact with every child, and are in the most favored position to provide a child with access to psychiatric services when required.

From this one is led to the conclusion that school teachers must be trained to be able to accurately assess such needs in their pupils.

5. It is recommended that an examination of the role of parents within the treatment process of psychiatric services by undertaken.

The sparce use of parents in the treatment process raises some concern as to their role, particularly in the light of much current thought which places mental illness in the realm of family pathology. *

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* One is referred to writings by Don Jackson for an account of this approach: The Etiology of Schizophrenia, (New York: Basic Books, 1960)

Concerning the Process of Referral

6. It is recommended that an examination of the lay referral system might be undertaken to determine the reasons for its apparent lack of accessibility to or its resistance to use of the psychiatric service system.

7. It is recommended that an examination of the procedure of follow-up to referrals by the referring agency be undertaken to determine its effect upon the successful completion of a referral.

8. It is recommended that an examination of the cyclical pattern of referrals be undertaken to determine the cause of the increase in referrals during particular months of the year, in particular March and September.

   Such an examination may lead to a redistribution of services during certain months to allow for the increase, or may lead to steps that would offset such a pattern.

Concerning Intake Procedures

9. It is recommended that an examination of the two forms of intake procedure, being an appointed intake worker and a rotating intake worker, be undertaken to determine the effects of each upon client service.

Concerning Assessment

10. It is recommended than an examination of the process of assessment be undertaken, in order to test the validity of the following hypotheses.

    Hypothesis IV: The form an assessment takes is a function of the purpose for which it is to be used. Its form may be a label, a description of symptoms, a description of the cause, or a comparison with other assessments. The purpose may be for referral to another resource, for treatment or for discharge.

    Hypothesis V: The more specific an assessment, in terms of the use of a label, the shorter will be the treatment period.

    Hypothesis VI: The earlier an assessment is made after the receipt of a referral, the shorter will be the treatment period.

11. It is recommended that a further examination of the disorder of schizophrenia be undertaken in order to better meet the needs of those persons so assessed.

    The high incidence of this disorder within the study would indicate it to be of high priority in terms of seeking effective treatment.

12. It is recommended that an examination of the disorder of Behavior Disorder be undertaken in order to better meet the needs of those persons so assessed.

The apparent lack of effective treatment techniques for this disorder is of particular concern.

13. It is recommended that an examination of treatment provisions for those suffering from the effects of drugs be undertaken to determine where such service is being given and to assess its effectiveness.

14. It is recommended that an examination of the procedure of making assessments while the person is under the influence of medication be undertaken to determine the validity of such a procedure.

Concerning Treatment

15. It is recommended that an examination of the effectiveness of out-patient treatment as compared to in-patient treatment be undertaken.

16. It is recommended than an examination of Community Mental Health Clinics be undertaken to determine their effects upon the admission rates to the psychiatric hospitals.

17. It is recommended that an examination of the use of drugs as a form of treatment be undertaken to determine their long-term effects and their effectiveness as a form of treatment.

18. It is recommended that an examination of the effects of separation of adolescents from adults within a treatment

setting be undertaken.

The recently-established adolescent ward at Selkirk Mental Hospital provides an ideal setting for such a study.

Concerning the Process of Discharge

19. It is recommended that an examination of the low discharge rates by undertaken to determine the cause of such low rates.

The following hypothesis is suggested as one explanation for the low rates:

Hypothesis VII: As a person enters the psychiatric treatment system, a dependency upon the system develops which makes termination of contact difficult.

20. It is recommended that an examination of resources that are available to discharge patients be undertaken to determine their adequacy. Such resources would include foster homes and alternate treatment settings.

Concerning Urban and Rural Services

21. It is recommended that an examination of services in the rural parts of the province be undertaken to determine their adequacy. *

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* There is currently a study being made of such services in the northern part of the province by Prof. G. Erickson, School of Social Work, University of Manitoba.

Concerning the Theory of Crisis Points

22. It is recommended that the following hypothesis concerning the presented Theory of Crisis Points be tested for their validity, and the theory be explored for its possible application.

Hypothesis VIII: During the normal course of life there are a number of predictable crisis points at which a person becomes particularly vulnerable to breakdown.

Hypothesis IX: The family is not a reliable source of referral in the event of the occurance of a psychiatric problem.

Hypothesis X: The major institutions of society must become the sources of referrals for psychiatric problems.

Summary

This report has presented the findings of a research study in the field of child psychiatric services in the Province of Manitoba. The histories of a sample of children receiving service from Selkirk Mental Hospital were reconstructed, focusing on the various phases of the referral-assessment-treatment system. As a result of this study the researchers have presented an analysis of the system, including the agencies and persons within the system. The major steps in the career of a patient are discussed, with a number of factors affecting a career

isolated. A Theory of Crisis Points is presented for future refinement. A number of recommendations arise out of the study and these are presented in the last chapter.

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# APPENDIX A

# RESEARCH TOOLS

## LIST OF AGENCIES

| Agency | Code | Letter |
|---|---|---|
| The Children's Aid Society of Eastern Manitoba | C.A.S. East. | a |
| The Children's Aid Society of Winnipeg | C.A.S. Wpg. | b |
| Child Guidance Clinic | C.G.C. | c |
| Children's Home | Ch. Home | d |
| Children's Hospital | Ch. Hosp. | e |
| Family Bureau | Fam. Bur. | f |
| General Practitioner | G.P. | g |
| Indian Affairs | Ind. Af. | h |
| Juvenile and Family Court | Juv. & Fam. Crt. | i |
| Manitoba School for Retardates | Man. Sch. | j |
| Private Psychiatrist | Pri. Psy. | k |
| Roslyn House | Ros. Ho. | l |
| Sir Hugh John MacDonald Hostel | Sir H.J. Mac. | m |
| Hospital for Mental Diseases, Selkirk | S.M.H. | n |
| St. Agnes School | St. Ang. | o |
| St. Boniface Hospital | St. B. | p |
| St. Joseph's Vocational School | St. Jos. | q |
| Winnipeg General Hospital | W.G.H. | r |
| Winnipeg Psychiatric Institute | W.P.I. | s |

# FILE QUESTIONNAIRE

Date _____

A. Identifying Information

Name _____ SMH File No. _____

Study File No. _____

Examiner _____

B. Study Data Agency _____

Referral:

1. Date of referral _____
2. Who made referral _____
3. How was referral made (phone, letter, etc.) _____

_____

4. Who received referral (first contact) _____
5. Brief description of "Intake" procedure:

_____

_____

6. What were the results of "Intake" procedure

_____

_____

7. Initial assessment of "Intake" (if any)

_____

_____

Assessment:

8. What was "working" assessment (if any)

_____

9. How was assessment arrived at

_____

10. Who made the assessment

_____

Page 2

FILE QUESTIONNAIRE

11. How long was assessment period _____

Subsequent Service:

12. What subsequent service was given (treatment, referral, discharge)

_____

_____

13. If treatment, describe (type, length, etc.) _____

_____

_____

_____

14. If referral, date _____

15. Who made referral _____

_____

16. How was referral made _____

_____

17. Who received referral _____

18. Was follow-up made by referring agency _____

If so, how _____

19. What was assessment at point of referral _____

_____

_____

20. If discharge, date _____

21. Discharged to whom _____

_____

FILE QUESTIONNAIRE

22. What was assessment at point of discharge _____

_____

_____

C. Comments:

## CODING SYSTEM

CASE - capital Roman Numeral I

AGENCY - capital Arabic Letter A

QUESTION - Arabic Numbers 1

REFERRAL - small Roman Numeral i

CATEGORIES - small Arabic Numbers a

---

1. address

   a. urban
   b. south rural
   c. north rural
   d. other
   y. unknown

2. birth date

   year/month

3. sex

   a. male
   b. female

4. marital status

   a. single
   b. married
   c. other
   y. unknown

5. racial origin

   a. German
   b. Anglo-saxon
   c. French
   d. Slavic
   e. Canadian treaty Indian
   f. Canadian non-treaty Indian
   g. other _____
   y. unknown

6. guardianship

   a. own parents
   b. relatives
   c. agency
   d. other _____
   y. unknown

7. address of parents

   a. same as case
   b. different from case
   y. unknown

8. occupation of case

   a. student
   b. unemployed
   c. employed
   d. other _____
   y. unknown

9. religion

   a. protestant
   b. Roman Catholic
   c. Jewish
   d. other _____
   y. unknown

10. occupation of parents

    a. professional
    b. semi-professional
    c. labourer
    d. self-employed non-professional
    e. unemployed
    f. other _____
    y. unknown

11. date of referral

    year/month/day

12. age as of date of referral

    year/month

13. agency making referral

a. C.A.S. of Eastern Manitoba
b. C.A.S. of Winnipeg
c. Child Guidance Clinic
d. Children's Home
e. Children's Hospital
f. Family Bureau
g. General Practitioner - Dr.
h. Indian Affairs
i. Juvenile & Family Court
j. Manitoba School for Retardates.
k. Private Psychiatrist
l. Roslyn House
m. Sir Hugh John MacDonald Hostel
n. Selkirk Mental Hospital
o. St. Agnes School
p. St. Boniface Hospital
q. St. Joseph's Vocational School
r. Winnipeg General Hospital
s. Winnipeg Psychiatric Inst.
t. Other _____
u. Schools
x. Not applicable
y. Unknown

14. Professional status of referral

a. professional
b. lay (including self)
c. a. and b.
x. not applicable
y. unknown

15. person making referral

a. self
b. psychiatrist
c. social worker
d. general practitioner
e. psychologist
f. school teacher
g. other professional ____
h. parents
i. relatives
j. friends/neighbours
k. priest/minister
l. other lay
m. b. and h.
o. h. and l.
x. not applicable
y. unknown

16. position of person making referral, if professional

a. chief administrator
b. supervisor
c. staff member
d. other _____
x. not applicable
y. unknown

17. how referral was made

a. telephone
b. letter
c. personal contact
d. application form
e. other _____
f. a. and b.
g. b. and c.
h. b. and d.
i. a. & b. & d.
x. not applicable
y. unknown

18. agency receiving referral

same as for question 13.

19. person receiving referral

a. psychiatrist
b. social worker
c. general practitioner
d. psychologist
e. other _____
f. a. & b. & d.
x. not applicable
y. unknown

20. position of person receiving referral

a. chief administrator
b. supervisor
c. staff member
d. other _____
x. not applicable
y. unknown

21. intake procedure

a. personal interview with appointed intake worker
b. personal interview with rotating intake worker
c. collateral person interview with appointed intake worker

21.
d. collateral person interview with rotating intake worker
e. a. and c.
f. b. and d.
g. direct admission without interview
h. other
x. not applicable
y. unknown

22. results of intake

a. no case made.
b. admission
c. referral to other agency
d. out-patient service
e. placed on waiting list for admission
f. other
g. c. and d.
x. not applicable
y. unknown

23. form of assessment at intake

a. label
b. cause
c. symptoms
d. comparison with other assessment
e. none made
f. other _____
g. a. and c.
h. b. and c.
x. not applicable
y. unknown

24. actual assessment at intake

a. schizophrenia
b. psychotic
c. mental disorder with organic base (retardation & brain damage)
d. epilepsy
e. personality disorder
f. behavior disorder
g. thought disorder
h. family
i. drug related
j. description of behavior
k. no change
l. improved
m. controlled
n. deteriorated
o. other _____
p. a and _____
q. g. and j.
r. b. and c.
s. i. and j.
t. c. and d.
u. d. and f.
x. not applicable
y. unknown

25. working assessment: form

a. label
b. cause
c. symptom
d. comparison
e. other _____
f. none made
g. a. and b.
h. a. and c.
x. not applicable
y. unknown

26. actual working assessment

a. - p. see question 24.
q. d. and f.
r. d. and j.
s. f. and j.
t. c. and e.
u. c. and d.
v. b. and i.
w. d. and i.
x. not applicable
y. unknown

27. how working assessment was arrived at

a. consultation & collaboration
b. case conference
c. observation
d. testing (biological & psychological)
e. history review
f. personal interview
h. c. and f. and _____
i. other _____
j. c. and _____
l. b. and f. and ____
x. not applicable
y. unknown

28. person making working assess.

a. psychiatrist
b. social worker
c. general practitioner
d. psychologist
e. other _____
f. a. and d.
g. a. and b. and d.
x. not applicable
y. unknown

29. length of assessment period

a. 1 day
b. 2-7 days
c. 8-14 days
d. 15-21 days
e. 22-28 days
f. 29-60 days
g. 61-90 days
h. other _____
x. not applicable
y. unknown

30. subsequent service

a. treatment
b. referral
c. discharge
d. none given
e. other _____
f. a. and b.
g. a. and c.
h. a. and b. and c.
i. a. and e.
j. b. and c.
x. not applicable
y. unknown

31. length of treatment

a. 1 day
b. 7 days
c. 1 month
d. 3 months
e. 6 months
f. 1 year
g. 2 years
h. 4 years
i. other _____
x. not applicable
y. unknown

32. nature of treatment

a. medication (including E.C.T.)
b. therapeutic counselling
c. social rehabilitation
d. other
e. a. and b. and c.
f. a. and b.
g. a. and c.
h. b. and d.
i. a. and d.
j. a. and b. and d.
k. b. and c.
x. not applicable
y. unknown

33. treatment setting

a. out-patient
b. non-treatment in-patient
c. treatment in-patient
d. other _____
e. a. and c.
f. a. and b.
x. not applicable
y. inknown

34. date of referral

a. year/month/day
x. not applicable
y. unknown

35. person making referral

a. psychiatrist
b. social worker
c. general practitioner
d. psychologist
e. other
f. a. and e.
x. not applicable
y. unknown

36. position of person making referral

a. chief administrator
b. supervisor
c. staff member
d. other _____
x. not applicable
y. unknown

37. how referral was made

a. telephone
b. letter
c. personal contact
d. application form
e. other ____
f. a. and c.
x. not applicable
y. unknown

38. agency receiving referral

see question 13.

39. person receiving referral

a. psychiatrist
b. social worker
c. general practitioner
d. psychologist
e. other ____
x. not applicable
y. unknown

40. position of person receiving referral

a. chief administrator
b. supervisor
c. staff member
d. other
x. not applicable
y. unknown

41. follow-up to referral

a. no follow-up
b. telephone
c. letter
d. personal contact with client
e. personal contact with agency
f. other ____
x. not applicable
y. unknown

42. form of assessment at referral

a. label
b. cause
c. symptom
d. comparison
e. other ____
f. none made
g. a. and c.
h. a. and d.
i. a. and b. and c.

42. cont.

j. a. and c. and d.
x. not applicable
y. unknown

43. actual assessment at referral

a. - q. see question 24.
r. g. and h. and j.
x. not applicable
y. unknown

44. date of discharge

a. year/month/day
x. not applicable
y. unknown

45. discharge to whom

a. self
b. parents (natural)
c. relatives
d. parents (substitute)
e. other ____
x. not applicable
y. unknown

46. form of assessment at discharge

a. - f. see question 42.
g. a. and d.
h. a. and c. and d.
x. not applicable
y. unknown

47. actual assessment at discharge

a. - p. see question 24.
q. d. and f.
r. d. and k.
s. c. and m.
t. c. and l.
x. not applicable
y. unknown

DDRESS REPLY TO
P.O. BOX 9600
LKIRK, MANITOBA



PROVINCE OF MANITOBA

DEPARTMENT OF HEALTH
DIVISION OF PSYCHIATRY
HOSPITAL FOR MENTAL DISEASES
SELKIRK, MANITOBA

First Letter

Address

City

Date

Dear ;

We have contacted you with the hope of obtaining your cooperation in collecting information about psychiatric services in Manitoba. We are conducting a study which focuses on young people receiving help from Selkirk Mental Hospital, with specific interest in the events leading up to their admission to the hospital.

This study will be presented as our thesis for our Masters of Social Work degree at the University of Manitoba. Selkirk Hospital has granted us permission to conduct the study, and we are now asking for your permission to include your child in it.

As part of the study we would like to interview you at your convenience. In addition, we would like to examine files and interview workers or doctors in agencies that may have given help to your child before admittance to the hospital. We will be looking at the type of service that was given, not your child's problem itself.

In the interest of all concerned, all information will be treated as confidential, and will be used only for the purpose of the study.

We are very concerned about the services available for young people and hope this study might enhance the quality of such services. Your cooperation in returning this letter with the lower portion completed would be greatly appreciated.

Yours sincerely,

---

Please check and return in the enclosed envelope:

| | Yes | No |
|---|---|---|
| 1. I would like to have my child included in the study | _____ | _____ |
| 2. I am prepared to participate in a personal interview | _____ | _____ |

Signature _____

DDRESS REPLY TO
P.O. BOX 9600
LKIRK, MANITOBA



PROVINCE OF MANITOBA

DEPARTMENT OF HEALTH
DIVISION OF PSYCHIATRY
HOSPITAL FOR MENTAL DISEASES
SELKIRK, MANITOBA

Second Letter

Dear ;

We have contacted you with the hope of obtaining your cooperation in collecting information about psychiatric services in Manitoba. We are conducting a study which focuses on young people receiving help from Selkirk Mental Hospital, with specific interest in the events leading up to their admission to the hospital.

This study will be presented as our thesis for our Masters of Social Work degree at the University of Manitoba. Selkirk Hospital has granted us permission to conduct the study, and we are now asking for your permission to include your child in it.

In collating data for our study we would like to examine files and interview workers or doctors in agencies that may have given help to your child before admittance to the hospital. We will be looking at the type of service that was given, not your child's problem itself. In the interest of all concerned, all information will be treated as confidential, and will be used only for the purpose of the study.

We are very concerned about the services available for young people and hope this study might enhance the quality of such services. Your cooperation in returning the enclosed form would be greatly appreciated.

Yours sincerely,

PLEASE SIGN AND RETURN IN THE ENCLOSED ENVELOPE AS SOON AS POSSIBLE

I would like to have my child _____ included in the study realizing that all information will be treated in a ethical and confidential manner.

Signature: _____

Date: _____

# APPENDIX B

# TABLES

| | MAJOR AGENCY DATA | | | | MINOR AGENCY DATA | | | |
|---|---|---|---|---|---|---|---|---|
| | MAKING REFERRAL | RECEIVING REFERRAL | MAKING SUBSEQUENT REFERRAL | RECEIVING SUBSEQUENT REFERRAL | MAKING REFERRAL | RECEIVING REFERRAL | MAKING SUBSEQUENT REFERRAL | RECEIVING SUBSEQUENT REFERRAL |
| SELKIRK MENTAL HOSPITAL | 3.1 | 26.5 | 11.3 | 26.5 | | | | 8.3 |
| PSYCHIATAIC INSTITUTE WINNIPEG | 20.0 | 15.1 | 17.0 | 13.3 | | | | 8.3 |
| GENERAL HOSPITAL | 3.1 | 7.5 | 6.8 | 4.8 | | | | |
| C.A.S. OF WINNIPEG | 8.4 | 15.1 | 15.8 | 7.2 | 25.0 | | | 8.3 |
| CHILD GUIDANCE CLINIC | 8.4 | 15.1 | 15.8 | 3.6 | | | | 16.6 |
| CHILDREN'S HOSPITAL | 13.6 | 20.4 | 17.0 | 9.6 | 5.0 | | | 8.3 |
| TOTAL | 53.6 | 99.7 | 83.7 | 65.0 | 30.0 | | | 49.8 |
| CHILDREN'S HOME | | | | 2.4 | | 9.0 | 16.6 | 8.3 |
| FAMILY BUREAU | | | | 1.2 | 5.0 | 4.5 | 8.3 | 8.3 |
| JUVENILE & FAMILY COURT | 2.1 | | | 1.2 | 5.0 | 18.1 | 25.0 | |
| MANITOBA SCHOOL FOR RETARDATES | 1.0 | | | 1.2 | 4.5 | 4.5 | 8.3 | 8.3 |
| ROSLYN HOUSE | | | | | | 9.0 | | 8.3 |
| ST. AGNES SCHOOL | 1.0 | | | 3.6 | 18.1 | 18.1 | | |
| ST. BONIFACE HOSPITAL | 2.1 | | | | | | | |
| C.A.S. OF EASTERN MAN. | 4.2 | | | 2.4 | 5.0 | 13.6 | 8.3 | 8.3 |
| ST. JOSEPH SCHOOL | | | | 4.8 | 13.6 | 13.6 | 8.3 | |
| TOTAL | 10.4 | | | 16.8 | 46.7 | 99.4 | 91.4 | 41.5 |

TABLE I: SHOWING THE RELATIONSHIP BETWEEN THE MAJOR AGENCY AND MINOR AGENCY SETS IN THE PROCESS OF MAKING AND RECEIVING REFERRALS AND SUBSEQUENT REFERRALS.

| AGENCY | OVERALL DATA | | MAJOR AGENCY DATA | | | | | | | | | | | | | | MINOR AGENCY DATA | | LONG TRIP SHORT TRIP DATA | | | | FIRST REFERRAL | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | S.M.H. | | W.P.I. | | W.G.H. | | W.C.H. | | C.A.S. WPG. | | C.G.C. | | TOTALS | | | | LONG TRIP | | SHORT TRIP | | | |
| | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % |
| C.A.S. EAST. | 3 | 2.6 | 1 | 3.0 | 1 | 7.1 | | | | | | | 2 | 11.6 | 4 | 4.2 | 1 | 5.0 | | | | | | |
| C.A.S. WPG. | 13 | 11.2 | | | 2 | 14.2 | | | 5 | 29.4 | | | 1 | 5.8 | 8 | 8.4 | 5 | 25.0 | 10 | 22.0 | | | | |
| CHILD G. CLINIC | 8 | 6.9 | | | 3 | 21.3 | 1 | 25.0 | 2 | 11.6 | 2 | 20.0 | | | 8 | 8.4 | | | 5 | 11.0 | | | | |
| CHILDREN'S HOME | | | | | | | | | | | | | | | | | | | - | | | | | |
| CHILDREN'S HOSP. | 14 | 12.1 | 4 | 12.1 | 5 | 35.7 | | | 1 | 5.8 | 3 | 30.0 | | | 13 | 13.6 | 1 | 5.0 | 7 | 15.0 | 2 | 10.0 | 2 | 8.0 |
| FAMILY BUREAU | 1 | 0.9 | | | | | | | | | | | | | | | 1 | 5.0 | | | | | | |
| GENERAL PRACT. | 6 | 5.2 | 1 | 3.0 | | | 1 | 25.0 | 2 | 11.6 | | | | | 4 | 4.2 | 1 | 5.0 | | | 5 | 25.0 | 6 | 24.0 |
| INDIAN AFFAIRS | | | | | | | | | | | | | | | | | | | | | | | | |
| JUVENILE COURT | 3 | 2.6 | | | | | | | 1 | 5.8 | 1 | 10.0 | | | 2 | 2.1 | 1 | 5.0 | 2 | 4.0 | | | | |
| MANITOBA SCHOOL FOR RETARDATES | | | 1 | 3.0 | | | | | | | | | | | 1 | 1.0 | | | | | | | | |
| PRIVATE PSYCHIATRISTS | 3 | 2.6 | 1 | 3.0 | | | | | 1 | 5.8 | 1 | 10.0 | | | 3 | 3.1 | | | | | 1 | 5.0 | | |
| ROSLYN HOUSE | | | | | | | | | | | | | | | | | | | | | | | | |
| SIR HUGH JOHN MACDONALD HOSTEL | | | | | | | | | | | | | | | | | | | | | | | | |
| SELKIRK HOSP. FOR MENTAL DIS. | 3 | 2.6 | 1 | 3.0 | | | | | 1 | 5.8 | 1 | 10.0 | | | 3 | 3.1 | | | 2 | 4.0 | | | | |
| ST. AGNES SCHOOL | 1 | 0.9 | | | | | | | 1 | 5.8 | | | | | 1 | 1.0 | | | 1 | 2.0 | | | | |
| ST. BONIFACE SCHOOL | 2 | 1.7 | 1 | 3.0 | | | | | 1 | 5.8 | | | | | 2 | 2.1 | | | | | | | | |
| ST. JOSEPH SCHOOL | | | | | | | | | | | | | | | | | | | | | | | | |
| WPG. GEN. HOSP. | 3 | 2.6 | 2 | 6.1 | 1 | 7.1 | | | | | | | | | 3 | 3.1 | | | | | 1 | 5.0 | | |
| WPG. PSYCHIATRIC INST. | 19 | 16.4 | 18 | 54.5 | | | | | 1 | 5.8 | | | | | 19 | 20.0 | | | 5 | 11.0 | 4 | 20.0 | | |
| OTHER | 10 | 8.6 | 2 | 6.1 | | | | | 1 | 5.8 | | | 1 | 5.8 | 4 | 4.2 | 6 | 30.0 | 2 | 4.0 | 3 | 15.0 | 6 | 24.0 |
| SCHOOL | 18 | 15.5 | | | 1 | 7.1 | 2 | 50.0 | | | 1 | 10.0 | 11 | 64.7 | 15 | 15.8 | 1 | 5.0 | 7 | 15.0 | 3 | 15.0 | 7 | 28.0 |
| NOT APPLICABLE | 47 | | 2 | | 6 | | 5 | | 10 | | 10 | | 4 | | 37 | | 2 | | 23 | | 5 | | 6 | |
| UNKNOWN. | 8 | 6.9 | 1 | 3.0 | 1 | 7.1 | | | | | 1 | 10.0 | 2 | 11.6 | 5 | 5.2 | 3 | 15.0 | 5 | 11.0 | 1 | 5.0 | 4 | |
| | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | |
| | 163 | 99.3 | 35 | 99.8 | 20 | 99.6 | 9 | 100.0 | 27 | 99.0 | 20 | 100.0 | 21 | 99.5 | 132 | 99.5 | 22 | 100.0 | 69 | 99.0 | 25 | 100.0 | 31 | 100.0 |

TABLE II : AGENCY MAKING REFERRAL.

| | OVERALL DATA | | MAJOR AGENCY DATA | | | | | | | | | | | | | | MINOR AGENCY DATA | | LONG TRIP SHORT TRIP DATA | | | | FIRST REFERRAL | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | S.M.H. | | W.P.I. | | W.G.H. | | W.C.H. | | C.A.S. WPG. | | C.G.C. | | TOTALS | | | | LONG TRIP | | SHORT TRIP | | | |
| PROFESSIONAL STATUS | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % |
| PROFESSIONAL | 95 | 64.6 | 31 | 88.6 | 10 | 50.0 | 3 | 33.3 | 15 | 55.5 | 7 | 33.3 | 16 | 94.1 | 82 | 65.6 | 12 | 54.5 | 35 | 64.0 | 16 | 64.0 | 18 | 58.0 |
| LAY | 37 | 25.2 | 2 | 5.7 | 8 | 40.0 | 4 | 44.4 | 9 | 33.3 | 2 | 18.1 | | | 25 | 20.0 | 6 | 27.2 | 11 | 20.0 | 6 | 24.0 | 8 | 25.8 |
| PROF. & LAY | 3 | 2.0 | | | | | 2 | 22.2 | 2 | 7.4 | | | | | 4 | 3.2 | | | 2 | 4.0 | 1 | 4.0 | 1 | 3.2 |
| NOT APPLICABLE | 16 | | | | | | | | | | 9 | | 4 | | 13 | | | | 14 | | | | | |
| UNKNOWN | 12 | 8.1 | 2 | 5.7 | 2 | 10.0 | | | 1 | 3.7 | 2 | 18.1 | 1 | 5.8 | 8 | 6.4 | 4 | 18.2 | 7 | 13.0 | 2 | 8.0 | 4 | 12.9 |
| | 163 | 99.9 | 35 | 99.9 | 20 | 100.0 | 9 | 99.9 | 27 | 99.9 | 20 | 99.8 | 21 | 99.9 | 132 | 99.2 | 22 | 99.9 | 69 | 101.0 | 25 | 100.0 | 31 | 99.9 |

TABLE III : PROFESSIONAL STATUS OF REFERRAL.

| | OVERALL DATA | | MAJOR AGENCY DATA | | | | | | | | | | | | | | MINOR AGENCY DATA | | LONG TRIP SHORT TRIP DATA | | | | FIRST REFERRAL | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | S.M.H. | | W.P.I. | | W.G.H. | | W.C.H. | | C.R.S. W.P.C. | | C.G.C. | | TOTALS | | | | LONG TRIP | | SHORT TRIP | | | |
| PERSON | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % |
| SELF | 10 | 6.8 | 5 | 14.0 | 2 | 10.0 | 1 | 11.1 | 2 | 7.6 | | | | | 10 | 8.5 | | | 1 | 1.8 | 2 | 8.0 | | |
| PSYCHIATRIST | 40 | 27.4 | 26 | 74.2 | 6 | 30.0 | 1 | 11.1 | 4 | 15.2 | 3 | 27.2 | | | 40 | 34.0 | 1 | 4.5 | 11 | 19.8 | 8 | 32.0 | 3 | 12.5 |
| SOCIAL WORKER | 22 | 15.0 | | | 3 | 15.0 | 1 | 11.1 | 6 | 23.0 | 1 | 9.0 | 3 | 17.4 | 14 | 12.4 | 6 | 27.2 | 12 | 21.6 | 1 | 4.0 | 2 | 8.3 |
| GENERAL PRACT. | 8 | 5.5 | 1 | 2.8 | | | 1 | 11.1 | 4 | 15.2 | | | 1 | 5.8 | 7 | 6.0 | 1 | 4.5 | 2 | 3.6 | 4 | 16.0 | 6 | 25.0 |
| PSYCHOLOGIST | | | | | | | | | | | | | | | | | | | | | | | | |
| SCHOOL TEACHER | 15 | 10.3 | | | | | | | | | 1 | 9.0 | 11 | 64.1 | 12 | 10.2 | 1 | 4.5 | 6 | 10.8 | 1 | 4.0 | 5 | 20.8 |
| OTHER PROF. | 4 | 2.7 | 1 | 2.8 | 1 | 5.0 | 1 | 11.1 | | | | | | | 3 | 2.6 | 2 | 9.0 | | | 2 | 8.0 | 2 | 8.3 |
| PARENTS | 16 | 11.0 | | | 2 | 10.0 | 2 | 22.2 | 6 | 23.0 | 1 | 9.0 | | | 11 | 9.4 | 2 | 9.0 | 6 | 10.8 | 3 | 12.0 | | |
| RELATIVES | 1 | 0.7 | | | | | | | 1 | 3.8 | | | | | 1 | 0.9 | | | 1 | 1.8 | | | | |
| FRIENDS | | | | | | | | | | | | | | | | | | | | | | | | |
| PRIEST/MINISTER | | | | | | | | | | | | | | | | | | | | | | | | |
| OTHER LAY | 9 | 6.2 | | | 3 | 15.0 | | | 1 | 3.8 | 1 | 9.0 | | | 5 | 4.3 | 4 | 18.1 | 4 | 7.2 | 1 | 4.0 | | |
| PSYCHIATRIST PARENTS | 2 | 1.4 | | | | | 2 | 22.2 | | | | | | | 2 | 1.7 | | | 2 | 3.6 | | | | |
| PSYCHIATRIST SOCIAL WORKER PARENTS OTHER LAY | | | | | | | | | | | | | | | | | | | | | | | | |
| NOT APPLICABLE | 17 | | | | | | | | 1 | | 9 | | 4 | | 14 | | | | 14 | | | | | |
| UNKNOWN | 19 | 13.0 | 2 | 5.7 | 3 | 15.0 | | | 2 | 7.6 | 4 | 36.4 | 2 | 11.6 | 13 | 11.1 | 5 | 22.6 | 10 | 18.0 | 3 | 12.0 | 6 | 25.0 |
| | | | | | | | | | | | | | | | | | | | | | | | | |
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| | | | | | | | | | | | | | | | | | | | | | | | | |
| | 163 | 100.0 | 35 | 99.5 | 20 | 100.0 | 9 | 99.9 | 27 | 99.9 | 20 | 99.2 | 21 | 98.9 | 132 | 101.1 | 22 | 99.8 | 69 | 98.8 | 25 | 100.0 | 31 | 99.9 |

TABLE IV : PERSON MAKING REFERRAL.

| POSITION | OVERALL DATA | | MAJOR AGENCY DATA | | | | | | | | | | | | | | MINOR AGENCY DATA | | LONG TRIP SHORT TRIP DATA | | | | FIRST REFERRAL | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | S.M.H. | | W.P.I. | | W.G.H. | | W.C.H. | | C.A.S. WPG. | | C.G.C. | | TOTALS | | | | LONG TRIP | | SHORT TRIP | | | |
| | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % |
| CHIEF ADMINISTRATOR | 9 | 8.5 | 5 | 15.1 | 1 | 7.6 | | | | | | | 3 | 20.0 | 9 | 9.9 | | | 2 | 4.6 | 2 | 11.8 | 2 | 8.7 |
| SUPERVISOR | 7 | 6.6 | | | 2 | 15.2 | | | 2 | 11.6 | | | 2 | 13.3 | 6 | 6.6 | 1 | 6.3 | 4 | 9.2 | | | 1 | 4.3 |
| STAFF MEMBER | 62 | 58.5 | 25 | 75.7 | 6 | 46.1 | 4 | 80.0 | 11 | 64.7 | 3 | 50.0 | 6 | 40.0 | 55 | 61.5 | 6 | 37.5 | 23 | 52.9 | 11 | 64.7 | 11 | 47.8 |
| OTHER | 3 | 2.8 | | | 1 | 7.6 | | | 1 | 5.8 | | | | | 2 | 2.2 | 1 | 6.3 | 1 | 2.3 | 1 | 5.9 | 2 | 8.7 |
| NOT APPLICABLE | 57 | | 2 | | 7 | | 4 | | 10 | | 14 | | 6 | | 43 | | 6 | | 26 | | 8 | | 8 | |
| UNKNOWN | 25 | 23.6 | 3 | 9.0 | 3 | 23.8 | 1 | 20.0 | 3 | 17.4 | 3 | 50.0 | 4 | 26.6 | 17 | 18.7 | 8 | 50.0 | 13 | 29.9 | 3 | 17.7 | 7 | 30.4 |
| | 163 | 100.0 | 35 | 99.8 | 20 | 99.3 | 9 | 100.0 | 27 | 99.5 | 20 | 100.0 | 21 | 99.9 | 132 | 98.9 | 22 | 100.1 | 69 | 98.9 | 25 | 100.1 | 31 | 99.9 |

TABLE V : POSITION OF PERSON MAKING REFERRAL.

| METHOD | OVERALL DATA | | MAJOR AGENCY DATA | | | | | | | | | | | | | | MINOR AGENCY DATA | | LONG TRIP SHORT TRIP DATA | | | | FIRST REFERRAL | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | S.M.H. | | W.P.I | | W.G.H. | | W.C.H | | C.A.S. W.P.G. | | C.G.C. | | TOTALS | | | | LONG TRIP | | SHORT TRIP | | | |
| | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % |
| (a) TELEPHONE | 9 | 6.3 | | | 1 | 5.0 | | | 3 | 12.0 | 4 | 36.3 | | | 8 | 6.8 | 1 | 4.5 | 2 | 3.8 | 1 | 4.0 | 3 | 10.0 |
| (b) LETTER | 9 | 6.3 | 1 | 2.8 | | | 2 | 22.2 | 2 | 8.0 | | | | | 5 | 4.4 | 4 | 18.0 | 3 | 5.7 | 2 | 8.0 | 2 | 6.7 |
| (c) PERSONAL CONTACT | 28 | 19.4 | 5 | 14.0 | 5 | 25.0 | 5 | 55.5 | 14 | 56.0 | | | | | 29 | 24.7 | | | 10 | 19.0 | 4 | 16.0 | 6 | 20.0 |
| (d) APPLICATION FORM | 38 | 26.4 | 18 | 51.4 | 2 | 10.0 | | | | | | | 11 | 69.1 | 31 | 26.4 | 5 | 22.7 | 12 | 22.6 | 8 | 32.0 | 7 | 23.3 |
| (e) OTHER | 3 | 2.1 | | | | | | | 1 | 4.0 | 2 | 18.2 | | | 3 | 2.6 | | | 1 | 1.9 | | | | |
| (f) b. + a. | 2 | 1.4 | 1 | 2.8 | 1 | 5.0 | | | | | | | | | 2 | 1.7 | | | | | | | | |
| (g) b + c | 1 | 0.7 | | | | | 1 | 11.1 | | | | | | | 1 | .9 | | | | | | | | |
| (h) b + d | 2 | 1.4 | 2 | 5.6 | | | | | | | | | | | 2 | 1.7 | | | | | 1 | 4.0 | | |
| (i) b + a + d | 1 | 0.7 | | | 1 | 5.0 | | | | | | | | | 1 | .9 | | | | | | | | |
| (X) not applicable | 19 | | | | | | | | 2 | | 9 | | 4 | | 15 | | | | 16 | | | | 1 | |
| (Y) UNKNOWN | 51 | 35.4 | 8 | 22.9 | 10 | 50.0 | 1 | 11.1 | 5 | 20.0 | 5 | 45.5 | 6 | 33.3 | 35 | 29.9 | 12 | 54.0 | 25 | 47.5 | 9 | 36.0 | 12 | 40.0 |
| | 163 | 100.1 | 35 | 99.0 | 20 | 100.0 | 9 | 99.9 | 27 | 100.0 | 20 | 100.0 | 21 | 99.3 | 132 | 100.0 | 22 | 99.2 | 69 | 100.5 | 25 | 100.0 | 31 | 100.0 |

TABLE VI : HOW REFERRAL WAS MADE

| AGENCY | OVERALL DATA | | MAJOR AGENCY DATA | | | | | | | | | | | | | | MINOR AGENCY DATA | | LONG TRIP SHORT TRIP DATA | | | | FIRST REFERRAL | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | S.M.H. | | W.P.I. | | W.G.H. | | W.C.H. | | C.A.S. WPG. | | C.G.C. | | TOTALS | | | | LONG TRIP | | SHORT TRIP | | | |
| | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % |
| C.A.S. EAST | 3 | 2.0 | | | | | | | | | | | | | | | 3 | 13.5 | | | 1 | 4.0 | 1 | 3.2 |
| C.A.S. WPG | 11 | 7.5 | | | | | | | | | 20 | 100.0 | | | 20 | 15.1 | | | 6 | 10.5 | | | 2 | 6.5 |
| CHILD G. CLINIC | 17 | 11.6 | | | | | | | | | | | 21 | 100.0 | 21 | 15.8 | | | 9 | 15.7 | | | 7 | 22.6 |
| CHILDREN'S HOME | 2 | 1.4 | | | | | | | | | | | | | | | 2 | 9.0 | | | | | | |
| CHILDREN'S HOSPITAL | 28 | 19.0 | | | | | | | 27 | 100.0 | | | | | 27 | 20.4 | | | 16 | 28.0 | 2 | 8.0 | 5 | 16.1 |
| FAMILY BUREAU | 1 | 0.7 | | | | | | | | | | | | | | | 1 | 4.5 | | | | | 1 | 3.2 |
| GENERAL PRACT. | 1 | 0.7 | | | | | | | | | | | | | | | | | | | | | 1 | 3.2 |
| INDIAN AFFAIRS | | | | | | | | | | | | | | | | | | | | | | | | |
| JUVENILE COURT | 4 | 2.7 | | | | | | | | | | | | | | | 4 | 18.0 | 2 | 3.5 | 1 | 4.0 | 2 | 6.5 |
| MANITOBA SCHOOL FOR RETARDATES | 1 | 0.7 | | | | | | | | | | | | | | | 1 | 4.5 | | | | | | |
| PRIVATE PSYCHIATRISTS | | | | | | | | | | | | | | | | | | | | | | | | |
| ROSLYN HOUSE | 1 | 0.7 | | | | | | | | | | | | | | | 1 | 4.5 | 1 | 1.7 | | | | |
| SIR HUGH JOHN MACDONALD HOSTEL | | | | | | | | | | | | | | | | | | | | | | | | |
| SELKIRK HOSPITAL FOR MENTAL DISEASES | 35 | 23.8 | 35 | 100.0 | | | | | | | | | | | 35 | 26.5 | | | 6 | 10.5 | 13 | 52.0 | 4 | 12.9 |
| ST. AGNES SCHOOL | 3 | 2.0 | | | | | | | | | | | | | | | 3 | 13.5 | 3 | 5.2 | | | | |
| ST. BONIFACE SCHOOL | 4 | 2.7 | | | | | | | | | | | | | | | 4 | 18.0 | 1 | 1.7 | 3 | 12.0 | 2 | 6.5 |
| ST. JOSEPH SCHOOL | 3 | 2.0 | | | | | | | | | | | | | | | 3 | 13.5 | 2 | 3.5 | | | | |
| WPG. GENERAL HOSP. | 9 | 6.1 | | | | | 9 | 99.9 | | | | | | | 9 | 7.5 | | | 2 | 3.5 | 3 | 12.0 | 3 | 9.7 |
| WPG. PSYCHIATRIC INST. | 20 | 13.6 | | | 20 | 100.0 | | | | | | | | | 20 | 15.1 | | | 5 | 8.7 | 2 | 8.0 | 1 | 3.2 |
| OTHER | 4 | 2.7 | | | | | | | | | | | | | | | | | 2 | 3.5 | | | 2 | 6.5 |
| SCHOOL | | | | | | | | | | | | | | | | | | | | | | | | |
| NOT APPLICABLE | 16 | | | | | | | | | | | | | | | | | | 12 | | | | | |
| UNKNOWN | | | | | | | | | | | | | | | | | | | 2 | 3.5 | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | |
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| | | | | | | | | | | | | | | | | | | | | | | | | |
| | 163 | 99.9 | 35 | 100.0 | 20 | 100.0 | 9 | 99.9 | 27 | 100.0 | 20 | 100.0 | 21 | 100.0 | 132 | 100.4 | 22 | 99.0 | 69 | 99.5 | 25 | 100.0 | 31 | 100.1 |

TABLE VII : AGENCY RECEIVING REFERRAL

| | OVERALL DATA | | MAJOR AGENCY DATA | | | | | | | | | | | | | | MINOR AGENCY DATA | | LONG TRIP SHORT TRIP DATA | | | | FIRST REFERRAL | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | S.M.H. | | W.P.I | | W.G.H | | W.C.H | | C.A.J. WPG. | | C.G.C. | | TOTALS | | | | LONG TRIP | | SHORT TRIP | | | |
| PERSON | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % |
| (a) PSYCHIATRIST | 92 | 62.6 | 35 | 100 | 20 | 100 | | | 21 | 77.7 | | | 2 | 11.6 | 78 | 66.5 | 5 | 22.7 | 27 | 49.0 | 23 | 92.0 | 15 | 48.4 |
| (b) SOCIAL WORKER | 19 | 12.9 | | | | | | | | | 8 | 72.7 | 3 | 17.6 | 11 | 9.2 | 8 | 36.3 | 8 | 14.5 | 1 | 4.0 | 4 | 12.9 |
| (c) GENERAL PRACT. | 3 | 2.0 | | | | | 8 | 88.8 | 2 | 7.4 | | | 3 | 17.6 | 13 | 10.0 | | | 2 | 3.6 | | | 1 | 3.2 |
| (d) PSYCHOLOGIST | 7 | 4.8 | | | | | | | | | | | 4 | 23.5 | 4 | 3.7 | | | 5 | 9.0 | | | 4 | 12.9 |
| (e) OTHER | 2 | 1.4 | | | | | | | 1 | 3.7 | | | | | | | 1 | 4.5 | 2 | 3.6 | | | | |
| (f) a + b + d | 1 | 0.7 | | | | | | | | | | | | | | | | | | | | | | |
| (y) UNKNOWN | 23 | 15.6 | | | | | | | | | 9 | | 4 | | 13 | | 8 | 36.3 | 11 | 20.0 | 1 | 4.0 | 7 | 22.6 |
| (x) NOT APPLICABLE | 16 | | | | | | 1 | 11.1 | 3 | 11.1 | 3 | 27.3 | 5 | 29.0 | 12 | 10.1 | | | 14 | | | | | |
| | 163 | 100.0 | 35 | 100 | 20 | 100 | 9 | 99.9 | 27 | 99.9 | 20 | 100 | 21 | 98.6 | 132 | 98.5 | 22 | 99.8 | 69 | 99.7 | 25 | 100.0 | 31 | 100.0 |

TABLE VIII: PERSON RECEIVING REFERRAL

| | OVERALL DATA | | MAJOR AGENCY DATA | | | | | | | | | | | | | | MINOR AGENCY DATA | | LONG TRIP SHORT TRIP DATA | | | | FIRST REFERRAL | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | S.M.H. | | W.P.I. | | W.G.H. | | W.C.H. | | C.A.S. WPG. | | C.G.C. | | TOTALS | | | | LONG TRIP | | SHORT TRIP | | | |
| POSITION | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % |
| CHIEF ADMINISTRATOR | 9 | 6.1 | | | 2 | 10.0 | | | 2 | 7.4 | | | 1 | 5.8 | 5 | 4.3 | 4 | 4.5 | 4 | 18.0 | | | | |
| SUPERVISOR | 5 | 3.4 | | | 1 | 5.0 | | | 3 | 11.1 | | | | | 4 | 3.4 | 1 | 4.5 | 2 | 3.7 | | | 2 | 6.5 |
| STAFF MEMBER | 105 | 71.4 | 35 | 100 | 17 | 85.0 | 8 | 88.8 | 18 | 66.6 | 7 | 33.3 | 10 | 58.8 | 95 | 81.7 | 7 | 31.8 | 35 | 64.8 | 24 | 96.0 | 21 | 67.7 |
| OTHER | 1 | 0.7 | | | | | | | | | | | | | | | | | | | | | 1 | 3.2 |
| UNKNOWN | 27 | 18.4 | | | | | | | | | 9 | | 4 | | 13 | 11.2 | 10 | 45.0 | 13 | 24.0 | 1 | 4.0 | 7 | 22.6 |
| NOT APPLICABLE | 16 | | | | | | 1 | 11.1 | 4 | 14.8 | 4 | 36.4 | 6 | 34.8 | 15 | | | | 15 | | | | | |
| | 163 | 100.0 | 35 | 100 | 20 | 100.0 | 9 | 99.9 | 27 | 99.1 | 20 | 99.7 | 21 | 99.4 | 132 | 100.6 | 22 | 99.3 | 69 | 99.9 | 25 | 100.0 | 31 | 100.0 |

TABLE IX : POSITION OF PERSON RECEIVING REFERRAL

| PROCEDURE | OVERALL DATA | | MAJOR AGENCY DATA | | | | | | | | | | | | | | MINOR AGENCY DATA | | LONG TRIP SHORT TRIP DATA | | | | FIRST REFERRAL | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | S.M.H. | | W.P.I. | | W.G.H. | | W.C.H. | | C.A.S. W.P.G. | | C.G.C. | | TOTALS | | | | LONG TRIP | | SHORT TRIP | | | |
| | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % |
| (a) PERSONAL INTERVIEW WITH APPOINTED INTAKE WORKER | 17 | 11.6 | 17 | 48.5 | | | | | | | | | | | 17 | 14.2 | | | 3 | 5.4 | 5 | 20.0 | | |
| (b) PERSONAL INTERVIEW WITH ROTATING INTAKE WORKER | 50 | 34.1 | 14 | 40.0 | 8 | 40.0 | 6 | 66.6 | 8 | 29.5 | 2 | 18.1 | 7 | 41.1 | 45 | 37.8 | 2 | 9.0 | 19 | 34.3 | 12 | 48.0 | 11 | 35.5 |
| (c) COLLATERAL PERSON INTERVIEW WITH APPOINTED INTAKE WORKER | 2 | 1.4 | | | | | 1 | 11.1 | 1 | 3.7 | | | | | 2 | 1.6 | 1 | 4.5 | 1 | 1.8 | | | 1 | 3.2 |
| (d) COLLATERAL PERSON INTERVIEW WITH ROTATING INTAKE WORKER | 2 | 1.4 | | | | | | | 2 | 7.4 | | | | | 2 | 1.6 | | | 1 | 1.8 | 1 | 4.0 | | |
| (e) a + c | | | | | | | | | | | | | | | | | | | | | | | | |
| (f) b + d | 9 | 6.1 | | | 2 | 10.0 | | | 5 | 18.5 | 2 | 18.1 | | | 9 | 7.5 | | | 2 | 3.6 | 2 | 8.0 | 5 | 16.1 |
| (g) DIRECT ADMISSION WITHOUT INTERVIEW | 13 | 8.8 | 3 | 8.4 | 3 | 15.0 | | | 1 | 3.7 | 2 | 18.1 | 1 | 5.8 | 10 | 8.4 | 3 | 13.6 | 3 | 5.4 | 1 | 4.0 | 2 | 6.5 |
| (h) OTHER | 8 | 5.4 | | | 1 | 5.0 | | | 1 | 3.7 | 3 | 27.3 | 2 | 11.1 | 7 | 5.9 | 1 | 4.5 | 4 | 7.2 | | | 2 | 6.5 |
| (Y) UNKNOWN | 46 | 31.3 | 1 | 2.8 | 6 | 30.0 | 2 | 22.2 | 9 | 33.3 | 2 | 18.1 | 7 | 40.1 | 27 | 22.6 | 15 | 68.0 | 22 | 40.0 | 4 | 16.0 | 10 | 32.3 |
| (X) NOT APPLICABLE | 16 | | | | | | | | | | 9 | | 4 | | 13 | | | | 14 | | | | | |
| | 163 | 100.1 | 35 | 99.8 | 20 | 100.0 | 9 | 99.9 | 27 | 99.8 | 20 | 99.7 | 21 | 98.6 | 132 | 99.6 | 22 | 99.6 | 69 | 99.5 | 25 | 100.0 | 31 | 100.1 |

TABLE X : INTAKE PROCEDURE

| RESULTS | OVERALL DATA | | MAJOR AGENCY DATA | | | | | | | | | | | | | | MINOR AGENCY DATA | | LONG TRIP SHORT TRIP DATA | | | | FIRST REFERRAL | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | SMH. | | W.P.I. | | W.G.H. | | W.C.H. | | C.A.S. WPG. | | C.G.C. | | TOTALS | | | | LONG TRIP | | SHORT TRIP | | | |
| | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % |
| (a) NO CASE MADE | 3 | 2.1 | | | | | | | 1 | 3.7 | | | | | 1 | .8 | 2 | 9.5 | | | 1 | 4.0 | 2 | 6.7 |
| (b) ADMISSION | 99 | 68.5 | 35 | 100.0 | 17 | 85.0 | 7 | 77.7 | 18 | 66.6 | 3 | 37.2 | 2 | 11.7 | 82 | 68.9 | 11 | 52.3 | 39 | 61.8 | 20 | 80.0 | 12 | 40.0 |
| (c) REFERRAL TO OTHER AGENCY | 3 | 2.1 | | | | | 1 | 11.1 | | | | | 1 | 5.8 | 2 | 1.7 | 4 | 19.0 | 1 | 1.8 | 1 | 4.0 | 2 | 6.7 |
| (d) OUT-PATIENT SERVICE | 32 | 21.9 | | | 3 | 15.0 | 1 | 11.1 | 6 | 22.2 | 6 | 54.5 | 12 | 70.5 | 28 | 23.5 | 1 | 4.7 | 14 | 25.4 | 2 | 8.0 | 12 | 40.0 |
| (e) PLACED ON WAITING LIST FOR ADMISSION | | | | | | | | | | | 1 | 9.1 | | | 1 | .8 | | | | | | | | |
| (f) OTHER | | | | | | | | | | | | | | | | | | | | | | | | |
| (g) c+d | 1 | 0.7 | | | | | | | | | 1 | 9.1 | | | 1 | .8 | | | 1 | 1.8 | | | | |
| (x) NOT APPLICABLE | 17 | | | | | | | | | | 9 | | 4 | | 13 | | 1 | 4.7 | 14 | | | | 1 | |
| (y) UNKNOWN | 8 | 5.5 | | | | | | | 2 | 7.4 | | | 2 | 11.6 | 4 | 3.4 | 3 | 14.1 | 5 | 9 | 1 | 4.0 | 2 | 6.7 |
| | 163 | 100.8 | 35 | 100.0 | 20 | 100.0 | 9 | 99.9 | 27 | 99.9 | 20 | 99.9 | 21 | 99.6 | 132 | 99.9 | 22 | 99.6 | 69 | 99.8 | 25 | 100.0 | 31 | 100.1 |

TABLE XI : RESULTS OF INTAKE

| | OVERALL DATA | | MAJOR AGENCY DATA | | | | | | | | | | | | | | MINOR AGENCY DATA | | LONG TRIP SHORT TRIP DATA | | | | FIRST REFERRAL | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | S.M.H. | | W.P.I. | | W.G.H. | | W.C.H. | | C.A.S. HPG. | | C.G.C. | | TOTALS | | | | LONG TRIP | | SHORT TRIP | | | |
| FORM | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % |
| (a) LABEL | 51 | 35.4 | 10 | 28.5 | 12 | 60.0 | 5 | 55.6 | 12 | 44.4 | 3 | 27.2 | 3 | 17.6 | 45 | 37.8 | 6 | 30.0 | 19 | 34.4 | 11 | 44.0 | 13 | 46.4 |
| (b) CAUSE | 4 | 2.8 | | | 1 | 5.0 | | | 1 | 3.7 | 1 | 9.0 | 1 | 5.8 | 4 | 3.4 | | | 2 | 3.6 | | | 2 | 7.1 |
| (c) SYMPTOM | 43 | 29.9 | 13 | 37.1 | 3 | 15.0 | 1 | 11.1 | 7 | 25.9 | 5 | 45.4 | 6 | 35.3 | 35 | 29.4 | 7 | 35.0 | 16 | 29.0 | 8 | 32.0 | 5 | 17.9 |
| (d) COMPARISON WITH OTHER ASSESSMENT | 2 | 1.4 | | | | | | | 1 | 3.7 | | | | | 1 | .8 | 1 | 5.0 | | | 1 | 4.0 | | |
| (e) NONE MADE | 17 | 11.8 | 6 | 17.1 | 2 | 10.0 | | | 1 | 3.7 | 1 | 9.0 | 4 | 23.5 | 14 | 11.8 | 1 | 5.0 | 5 | 9.0 | 2 | 8.0 | 2 | 7.1 |
| (f) OTHER | 3 | 2.1 | 1 | 2.9 | | | | | 1 | 3.7 | | | | | 2 | 1.7 | 1 | 5.0 | 1 | 1.8 | | | | |
| (g) a + c | 10 | 6.9 | 3 | 8.6 | 2 | 100 | 3 | 33.3 | 2 | 7.4 | | | | | 10 | 8.4 | | | 3 | 5.4 | 2 | 8.0 | 2 | 7.1 |
| (h) b + c | 1 | 0.7 | | | | | | | | | | | | | | | 1 | 5.0 | 1 | 1.8 | | | | |
| (x) NOT APPLICABLE | 19 | | | | | | | | | | 9 | | 4 | | 13 | | 2 | | 14 | | | | 3 | |
| (y) UNKNOWN | 13 | 9.0 | 2 | 5.7 | | | | | 2 | 7.4 | 1 | 9.0 | 3 | 17.6 | 8 | 6.7 | 3 | 15.0 | 8 | 14.5 | 1 | 4.0 | 4 | 14.3 |
| | 163 | 100.0 | 35 | 99.9 | 20 | 100.0 | 9 | 99.9 | 27 | 99.9 | 20 | 99.6 | 21 | 99.8 | 132 | 100.0 | 22 | 100.0 | 69 | 99.5 | 25 | 100.0 | 31 | 99.9 |

TABLE XII : FORM OF ASSESSMENT AT INTAKE

| ASSESSMENT | OVERALL DATA | | MAJOR AGENCY DATA | | | | | | | | | | | | | | MINOR AGENCY DATA | | LONG TRIP SHORT TRIP DATA | | | | FIRST REFERRAL | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | SMH | | W.P.I. | | WCH | | WCH | | CAS WPG. | | CGC | | TOTALS | | | | LONG TRIP | | SHORT TRIP | | | |
| | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % |
| (a) SCHIZOPHRENIA | 19 | 15.1 | 5 | 16.6 | 6 | 33.3 | 4 | 44.4 | 2 | 8.0 | | | 1 | 7.1 | 18 | 16.9 | 2 | 11.6 | 3 | 6.0 | 6 | 26.0 | 6 | 24.0 |
| (b) PSYCHOTIC | 7 | 5.6 | 1 | 3.3 | 2 | 11.1 | | | 1 | 4.0 | 1 | 10.0 | | | 5 | 4.2 | 2 | 11.6 | 4 | 8.0 | 2 | 8.6 | 2 | 8.0 |
| (c) MENTAL DISORDER WITH ORGANIC BASE | 3 | 2.4 | | | | | | | | | | | 1 | 7.1 | 1 | .9 | 1 | 5.8 | | | | | 2 | 8.0 |
| (d) EPILEPSY | 4 | 3.2 | | | 1 | 5.5 | | | 3 | 12.0 | | | | | 4 | 3.8 | | | 4 | 8.0 | | | | |
| (e) PERSONALITY DISORDER | 2 | 1.6 | | | 1 | 5.5 | | | | | 1 | 10.0 | | | 2 | 1.9 | | | | | | | | |
| (f) BEHAVIOR DISORDER | 9 | 7.1 | | | 1 | 5.5 | | | 7 | 28.0 | | | | | 8 | 7.5 | 1 | 5.8 | 5 | 10.0 | 2 | 8.6 | 3 | 12.0 |
| (g) THOUGHT DISORDER | 1 | 0.8 | | | | | | | | | 1 | 10.0 | | | 1 | .9 | | | 1 | 2.0 | | | | |
| (h) FAMILY | 2 | 1.6 | | | | | | | | | 1 | 10.0 | 1 | 7.1 | 2 | 1.9 | | | 1 | 2.0 | | | 2 | 8.0 |
| (i) DRUG | 2 | 1.6 | | | 1 | 5.5 | | | 1 | 4.0 | | | | | 2 | 1.9 | | | 1 | 2.0 | | | | |
| (j) DESCRIPTION OF DISORDER | 40 | 31.7 | 12 | 40.0 | 2 | 11.1 | 1 | 11.1 | 6 | 24.0 | 4 | 40.0 | 7 | 49.7 | 32 | 30.0 | 6 | 35.2 | 15 | 30.0 | 7 | 30.3 | 5 | 20.0 |
| (K) NO CHANGE | | | | | | | | | | | | | | | | | | | | | | | | |
| (l) IMPROVED | 1 | 0.8 | | | | | | | 1 | 4.0 | | | | | 1 | .9 | | | | | | | | |
| (m) CONTROLLED | | | | | | | | | | | | | | | | | | | | | | | | |
| (n) DETIORATION | | | | | | | | | | | | | | | | | | | | | | | | |
| (o) OTHER | 4 | 3.2 | 4 | 13.2 | | | | | | | | | | | 4 | 3.8 | | | | | 2 | 8.6 | | |
| (p) a + | 12 | 9.6 | 3 | 9.9 | 4 | 22.2 | 3 | 33.3 | 1 | 4.0 | | | 1 | 7.1 | 12 | 11.3 | | | 6 | 12.0 | | | | |
| (q) g + j | 2 | 1.6 | 2 | 6.6 | | | | | | | | | | | 2 | 1.9 | | | | | 2 | 8.6 | 1 | 4.0 |
| (r) b + c | 1 | 0.8 | | | | | 1 | 11.1 | | | | | | | 1 | .9 | | | | | 1 | 4.3 | 1 | 4.0 |
| (s) i + j | 1 | 0.8 | | | | | | | | | | | | | | | 1 | 5.8 | 1 | 2.0 | | | | |
| (t) c + d | 2 | 1.6 | 1 | 3.3 | | | | | 1 | 4.0 | | | | | 2 | 1.9 | | | | | | | | |
| (u) d + f | 1 | 0.8 | | | | | | | | | 1 | 10.0 | | | 1 | .9 | | | 1 | 2.0 | | | | |
| (x) NOT APPLICABLE | 37 | | 5 | | 2 | | | | 2 | | 10 | | 7 | | 26 | | 5 | | 19 | | 2 | | 6 | |
| (y) UNKNOWN | 13 | 10.3 | 2 | 6.6 | | | | | 2 | 8.0 | 1 | 10.0 | 3 | 4.3 | 8 | 7.5 | 4 | 23.2 | 8 | 16.0 | 1 | 4.3 | 3 | 12.0 |
| | 163 | 100.3 | 35 | 99.5 | 20 | 99.7 | 9 | 99.9 | 27 | 100.0 | 20 | 100.0 | 21 | 99.9 | 132 | 99.0 | 22 | 99.0 | 69 | 100.0 | 25 | 99.3 | 31 | 100.0 |

TABLE XIII : ACTUAL ASSESSMENT AT INTAKE

| | OVERALL DATA | | MAJOR AGENCY DATA | | | | | | | | | | | | | | MINOR AGENCY DATA | | LONG TRIP SHORT TRIP DATA | | | | FIRST REFERRAL | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | S.M.H. | | W.P.I. | | W.G.H. | | W.C.H. | | C.A.S WPG. | | C.G.C. | | TOTALS | | | | LONG TRIP | | SHORT TRIP | | | |
| FORM | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % |
| (a) LABEL | 82 | 61.2 | 31 | 88.6 | 14 | 70.0 | 7 | 77.7 | 18 | 78.0 | 3 | 27.2 | 3 | 23.0 | 76 | 67.2 | 2 | 11.6 | 28 | 53.8 | 19 | 81.7 | 11 | 45.8 |
| (b) CAUSE | 5 | 3.7 | 1 | 2.8 | 1 | 5.0 | | | 1 | 4.0 | 1 | 9.2 | 4 | 30.7 | 8 | 7.1 | 1 | 5.8 | 2 | 3.8 | 1 | 4.3 | 2 | 8.3 |
| (c) SYMTOM | 14 | 10.4 | 3 | 8.4 | | | | | 2 | 8.0 | 3 | 27.2 | | | 8 | 7.1 | 2 | 11.6 | 4 | 7.6 | 1 | 4.3 | 5 | 20.8 |
| (d) COMPARISON | 1 | 0.7 | | | | | | | | | | | | | | | 1 | 5.8 | | | | | | |
| (e) OTHER | | | | | | | | | | | | | | | | | | | | | | | | |
| (A) NONE MADE | 16 | 11.9 | | | 2 | 10.0 | 1 | 11.1 | 1 | 4.0 | 4 | 36.3 | 1 | 7.6 | 9 | 8.0 | 6 | 35.2 | 7 | 13.4 | 2 | 8.6 | 4 | 16.7 |
| (g) a + b | 2 | 1.5 | | | | | 1 | 11.1 | 1 | 4.0 | | | | | 2 | 1.8 | | | 1 | 1.9 | | | | |
| (h) a + c | 3 | 2.2 | | | 2 | 10.0 | | | | | | | | | 2 | 1.8 | 1 | 5.8 | 1 | 1.9 | | | | |
| (x) NOT APPLICABLE | 29 | | | | | | | | 2 | | 9 | | 8 | | 19 | | 5 | | 17 | | 2 | | 7 | |
| (y) UNKNOWN | 12 | 9.0 | | | 1 | 5.0 | | | 2 | 8.0 | | | 5 | 38.4 | 8 | 7.1 | 4 | 23.2 | 9 | 17.3 | | | 2 | 8.3 |
| | 163 | 100.6 | 35 | 99.7 | 20 | 100.0 | 9 | 99.9 | 27 | 100.0 | 20 | 99.9 | 21 | 99.3 | 132 | 100.1 | 22 | 99.0 | 69 | 99.7 | 25 | 98.9 | 31 | 99.9 |

TABLE XII : WORKING ASSESSMENT FORM

| ASSESSMENT | OVERALL DATA | | MAJOR AGENCY DATA | | | | | | | | | | | | | | MINOR AGENCY DATA | | LONG TRIP SHORT TRIP DATA | | | | FIRST REFERRAL | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | S.M.H. | | W.A.I. | | W.G.H. | | W.C.H. | | C.A.S. WPC. | | C.G.C. | | TOTALS | | | | LONG TRIP | | SHORT TRIP | | | |
| | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % |
| (a) SCHIZOPHRENIA | 39 | 32.0 | 16 | 44.3 | 9 | 47.3 | 5 | 62.5 | 6 | 25.1 | 1 | 14.3 | | | 37 | 35.2 | | | 4 | 8.6 | 10 | 47.6 | 5 | 23.8 |
| (b) PSYCHOTIC | 5 | 4.1 | 2 | 5.6 | 1 | 5.3 | | | 1 | 4.2 | 1 | 14.3 | | | 5 | 4.8 | | | 3 | 6.3 | 2 | 9.4 | 1 | 4.8 |
| (c) MENTAL DISORDER WITH ORGANIC BASE | 8 | 6.6 | 2 | 5.6 | | | 1 | 12.5 | 3 | 12.5 | | | 1 | 8.3 | 7 | 6.7 | 1 | 8.3 | 2 | 4.2 | 3 | 14.1 | 2 | 9.5 |
| (d) EPILEPSY | 1 | 0.8 | | | | | | | 1 | 4.2 | | | | | 1 | 1.0 | | | 1 | 2.1 | | | | |
| (e) PERSONALITY DISORDER | 6 | 4.9 | 3 | 8.4 | 1 | 5.3 | | | | | 1 | 14.3 | 1 | 8.3 | 6 | 5.7 | | | 1 | 2.1 | 1 | 4.7 | 1 | 4.8 |
| (f) BEHAVIOR DISORDER | 10 | 8.2 | 4 | 11.2 | 2 | 10.6 | | | 3 | 12.5 | | | | | 9 | 8.6 | 1 | 8.3 | 5 | 10.7 | 1 | 4.7 | 2 | 9.5 |
| (g) THOUGHT DISORDER | | | | | | | | | | | | | | | | | | | | | | | | |
| (h) FAMILY | 2 | 1.6 | | | | | | | | | 1 | 14.3 | | | 1 | 1.0 | 1 | 8.3 | 1 | 2.1 | 1 | 4.7 | 2 | 9.5 |
| (i) DRUG | 2 | 1.6 | | | 1 | 5.3 | | | 1 | 4.2 | | | | | 2 | 1.9 | | | 1 | 2.1 | | | | |
| (j) DESCRIPTION OF BEHAVIOR | 16 | 13.1 | 3 | 8.4 | | | | | 2 | 8.9 | 2 | 28.5 | 5 | 41.5 | 12 | 11.4 | 3 | 25.0 | 5 | 10.7 | 1 | 4.7 | 6 | 28.6 |
| (k) NO CHANGE | | | | | | | | | | | | | | | | | | | | | | | | |
| (l) IMPROVED | | | | | | | | | | | | | | | | | | | | | | | | |
| (m) CONTROLLED | | | | | | | | | | | | | | | | | | | | | | | | |
| (n) DETERIORATED | 1 | 0.8 | 1 | 2.8 | | | | | | | | | | | 1 | 1.0 | | | | | 1 | 4.7 | | |
| (o) OTHER | | | | | | | | | | | | | | | | | | | | | | | | |
| (p) a + | 13 | 10.6 | 2 | 5.6 | 3 | 15.9 | 2 | 25.0 | 4 | 16.8 | | | | | 11 | 10.5 | | | 9 | 19.5 | | | | |
| (q) d + f | | | | | | | | | | | | | | | | | | | | | | | | |
| (r) d + j | | | | | | | | | | | | | | | | | | | | | | | | |
| (s) f + j | 2 | 1.6 | | | | | | | | | | | | | | | 2 | 16.2 | 1 | 2.1 | 1 | 4.7 | | |
| (t) c + e | 1 | 0.8 | 1 | 2.8 | | | | | | | | | | | 1 | 1.0 | | | 1 | 2.1 | | | | |
| (u) c + d | 1 | 0.8 | 1 | 2.8 | | | | | | | | | | | 1 | 1.0 | | | | | | | | |
| (v) b + i | | | | | | | | | | | | | | | | | | | | | | | | |
| (w) d + i | 1 | 0.8 | | | | | | | 1 | 4.2 | | | | | 1 | 1.0 | | | 1 | 2.1 | | | | |
| (x) NOT APPLICABLE | 41 | | | | 1 | | 1 | | 3 | | 13 | | 9 | | 27 | - | 18 | - | 23 | -- | 4 | | 10 | |
| (y) UNKNOWN | 13 | 10.6 | | | 2 | 10.6 | | | 2 | 8.2 | | | 5 | 41.5 | 9 | 8.6 | 4 | 33.2 | 10 | 21.6 | | | 2 | 9.5 |
| (z) b + d | 1 | 0.8 | | | | | | | | | 1 | 14.3 | | | 1 | 1.0 | | | 1 | 2.1 | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | |
| | 163 | 99.7 | 35 | 97.5 | 20 | 100.3 | 9 | 100.6 | 27 | 100.9 | 20 | 100.0 | 21 | 99.6 | 132 | 100.4 | 22 | 99.3 | 69 | 98.4 | 25 | 99.3 | 31 | 100.0 |

TABLE XV : ACTUAL WORKING ASSESSMENT

| METHOD | OVERALL DATA | | MAJOR AGENCY DATA | | | | | | | | | | | | | | MINOR AGENCY DATA | | LONG TRIP SHORT TRIP DATA | | | | FIRST REFERRAL | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | S.M.H. | | W.P.I. | | W.G.H. | | W.C.H. | | C.A.S. WPG. | | C.G.C. | | TOTALS | | | | LONG TRIP | | SHORT TRIP | | | |
| | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % |
| (a) CONSULTATION + COLLABORATION | 7 | 5.8 | 3 | 8.5 | | | | | 1 | 4.1 | 2 | 25.0 | | | 6 | 5.7 | 1 | 9.0 | 3 | 6.6 | | | 1 | 4.5 |
| (b) CASE CONFERENCE | 4 | 3.3 | 3 | 8.5 | 1 | 5.5 | | | | | | | | | 4 | 3.8 | | | 2 | 4.4 | 1 | 4.7 | 1 | 4.5 |
| (c) OBSERVATION | 16 | 13.2 | 9 | 25.7 | 2 | 11.1 | 2 | 25.0 | 1 | 4.1 | | | | | 14 | 13.3 | 2 | 18.0 | 3 | 6.6 | 5 | 23.5 | 2 | 9.0 |
| (d) TESTING | 3 | 2.5 | 1 | 3.8 | | | | | | | | | 2 | 16.6 | 3 | 2.9 | | | 2 | 4.4 | 1 | 4.7 | 1 | 4.5 |
| (e) HISTORY REVIEW | | | | | | | | | | | | | 1 | 8.4 | 1 | 1.0 | | | | | | | | |
| (f) PERSONNAL INTERVIEW | 11 | 9.1 | | | | | | | | | | | | | | | | | | | | | | |
| (h) C+f + | 14 | 11.6 | 2 | 5.7 | 3 | 16.6 | | | 5 | 20.7 | | | 3 | 25.0 | 13 | 12.4 | | | 3 | 6.6 | | | 1 | 4.5 |
| (k) OTHER | 5 | 4.1 | | | | | | | 1 | 4.1 | 2 | 25.0 | | | 3 | 2.9 | 1 | 9.0 | 1 | 2.2 | | | 2 | 9.0 |
| (j) C+ | 28 | 23.2 | 9 | 25.7 | 4 | 22.2 | 3 | 37.5 | 11 | 45.8 | 1 | 12.5 | 2 | 16.6 | 30 | 28.5 | | | 13 | 28.8 | 6 | 28.2 | 2 | 9.0 |
| (l) b+f + | | | 2 | 5.7 | | | | | 2 | 8.3 | 1 | 12.5 | | | 5 | 4.8 | | | 4 | 8.8 | 2 | 9.4 | 7 | 31.5 |
| (X) NOT APPLICABLE | 42 | | | | 2 | | 1 | | 3 | | 12 | | 9 | | 27 | | 11 | | 24 | | 4 | | 9 | |
| (Y) UNKNOWN | 33 | 27.3 | 6 | 17.0 | 8 | 44.0 | 3 | 37.5 | 3 | 12.3 | 2 | 25.0 | 4 | 33.3 | 26 | 24.7 | 7 | 63.0 | 14 | 31.0 | 6 | 28.2 | 5 | 22.5 |
| | 163 | 100.1 | 35 | 100.1 | 20 | 99.7 | 9 | 99.0 | 27 | 99.4 | 20 | 100.0 | 21 | 99.8 | 132 | 100.0 | 22 | 99.0 | 69 | 99.4 | 25 | 98.7 | 31 | 99.0 |

TABLE XOI : HOW WORKING ASSESSMENT ARRIVED AT

| PERSON | OVERALL DATA | | MAJOR AGENCY DATA | | | | | | | | | | | | | | MINOR AGENCY DATA | | LONG TRIP SHORT TRIP DATA | | | | FIRST REFERRAL | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | S.M.H. | | W.P.I. | | W.G.H. | | W.C.H. | | C.A.S. WPG. | | C.G.C. | | TOTALS | | | | LONG TRIP | | SHORT TRIP | | | |
| | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % |
| o | | | | | | | | | | | | | | | | | | | | | | | | |
| (a) PSYCHIATRIST | 82 | 67.2 | 35 | 100.0 | 14 | 77.8 | 5 | 62.5 | 19 | 79.8 | 1 | 12.5 | 2 | 16.6 | 76 | 72.2 | 3 | 25.0 | 23 | 50.6 | 20 | 100.0 | 13 | 58.5 |
| (b) SOCIAL WORKER | 4 | 3.3 | | | | | | | | | 1 | 12.5 | 1 | 8.3 | 2 | 1.9 | 2 | 16.6 | 1 | 2.2 | | | 1 | 4.5 |
| (c) GENERAL PRACT. | 2 | 1.6 | | | | | | | 2 | 8.4 | | | | | 2 | 1.9 | | | 1 | 2.2 | | | | |
| (d) PSYCHOLOGIST | 3 | 2.5 | | | | | | | | | | | 2 | 16.6 | 2 | 1.9 | | | 2 | 4.4 | | | 2 | 9.0 |
| (e) OTHER | | | | | | | | | | | 1 | 12.5 | | | 1 | 1.0 | 2 | 16.6 | 1 | 2.2 | | | 3 | 13.5 |
| (f) a + d | 1 | 0.8 | | | | | | | | | | | 1 | 8.3 | 1 | 1.0 | | | | | | | 1 | 4.5 |
| (g) a + b + d | 1 | 0.8 | | | | | | | | | | | 1 | 8.3 | 1 | 1.0 | | | 1 | 2.2 | | | 1 | 4.5 |
| (X) NOT APPLICABLE | 41 | | | | 2 | | 1 | | 3 | | 12 | | 9 | | 27 | | 10 | | 24 | | 5 | | 9 | |
| (Y) UNKNOWN | 26 | 21.3 | | | 4 | 22.2 | 3 | 37.5 | 3 | 12.6 | 5 | 62.5 | 5 | 41.5 | 20 | 19.0 | 5 | 41.5 | 16 | 35.2 | | | 1 | 4.5 |
| | 163 | 100.0 | 35 | 100.0 | 20 | 99.0 | 9 | 100.0 | 27 | 100.8 | 20 | 100.0 | 21 | 99.1 | 132 | 99.9 | 22 | 99.7 | 69 | 99.0 | 25 | 100.0 | 31 | 99.0 |

TABLE XVII : PERSON MAKING WORKING ASSESSMENT

| | OVERALL DATA | | MAJOR AGENCY DATA | | | | | | | | | | | | | | MINOR AGENCY DATA | | LONG TRIP SHORT TRIP DATA | | | | FIRST REFERRAL | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | S.M.H. | | W.P.I. | | W.G.H. | | W.C.H. | | C.A.S. WPG. | | C.G.C. | | TOTALS | | | | LONG TRIP | | SHORT TRIP | | | |
| TIME | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % |
| 1 DAY | 5 | 4.2 | 1 | 2.8 | 1 | 5.5 | | | 1 | 4.3 | | | 1 | 8.3 | 4 | 3.8 | | | 1 | 2.2 | | | 1 | 4.5 |
| 2-7 DAYS | 19 | 15.8 | 6 | 17.1 | 5 | 27.7 | 1 | 12.5 | 2 | 8.7 | 2 | 25.0 | 1 | 8.3 | 17 | 16.3 | | | 6 | 13.2 | 3 | 14.1 | 5 | 22.5 |
| 8-14 DAYS | 15 | 12.5 | 9 | 25.7 | 3 | 16.6 | | | 1 | 4.3 | | | 1 | 8.3 | 14 | 13.4 | 1 | 8.3 | 2 | 4.4 | 4 | 18.8 | 2 | 9.0 |
| 15-21 DAYS | 7 | 5.8 | 5 | 14.2 | | | 1 | 12.5 | 1 | 4.3 | | | | | 7 | 6.7 | | | 3 | 6.6 | 2 | 9.4 | 1 | 4.5 |
| 22-28 DAYS | 10 | 8.3 | 6 | 17.1 | | | | | 2 | 8.7 | | | 1 | 8.3 | 9 | 8.6 | 1 | 8.3 | 2 | 4.4 | 3 | 14.1 | 4 | 18.0 |
| 29-60 DAYS | 13 | 10.8 | 8 | 22.8 | 2 | 11.1 | | | 1 | 4.3 | | | 1 | 8.3 | 12 | 11.5 | 1 | 8.3 | 2 | 4.4 | 4 | 18.8 | 1 | 4.5 |
| 61-90 DAYS | | | | | | | | | | | | | | | | | | | | | | | | |
| OTHER | 6 | 5.0 | | | | | | | 1 | 4.3 | 1 | 12.5 | 1 | 8.3 | 3 | 2.9 | 2 | 16.6 | 2 | 4.4 | 1 | 4.7 | 2 | 9.0 |
| NOT APPLICABLE | 43 | | | | 2 | | 1 | | 4 | | 12 | | 9 | | 28 | | 10 | | 25 | | 4 | | 9 | - |
| ONKNOWN | 45 | 37.5 | | | 7 | 38.8 | 6 | 75.0 | 14 | 60.2 | 5 | 62.5 | 6 | 49.8 | 38 | 36.5 | 7 | 58.1 | 25 | 60.2 | 4 | 18.8 | 6 | 27.0 |
| | 163 | 99.9 | 35 | 99.7 | 20 | 99.4 | 9 | 100.0 | 27 | 99.1 | 20 | 100.0 | 21 | 99.6 | 132 | 99.7 | 22 | 99.6 | 69 | 97.6 | 25 | 98.7 | 31 | 99.0 |

TABLE XVIII: LENGTH OF ASSESSMENT PERIOD

| SERVICE | OVERALL DATA | | MAJOR AGENCY DATA | | | | | | | | | | | | | | MINOR AGENCY DATA | | LONG TRIP SHORT TRIP DATA | | | | FIRST REFERRAL | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | S.M.H. | | W.P.I. | | W.G.H. | | W.C.H. | | C.A.S. WPC. | | C.G.C. | | TOTALS | | | | LONG TRIP | | SHORT TRIP | | | |
| | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % |
| (a) TREATMENT | 38 | 27.3 | 17 | 38.5 | 1 | 5.0 | 1 | 11.1 | 4 | 15.3 | 5 | 45.4 | 3 | 20.0 | 31 | 26.7 | 3 | 16.6 | 14 | 26.4 | 11 | 45.8 | 8 | 29.6 |
| (b) REFERRAL | 10 | 7.2 | 1 | 2.3 | | | 1 | 11.1 | 1 | 3.8 | | | 4 | 26.6 | 7 | 6.0 | 2 | 11.1 | 3 | 5.6 | 1 | 4.5 | 4 | 14.8 |
| (c) DISCHARGE | 2 | 1.4 | | | 1 | 5.0 | | | | | | | | | 1 | .9 | | | | | | | | |
| (d) NONE GIVEN | 1 | 0.7 | | | | | | | | | | | | | | | | | 1 | 1.8 | | | | |
| (e) OTHER | 1 | 0.7 | | | | | | | | | 2 | 18.1 | | | 2 | 1.7 | | | 1 | 1.8 | | | | |
| (f) a + b | 22 | 15.8 | 2 | 5.7 | 11 | 55.0 | 3 | 33.3 | 7 | 26.9 | | | 4 | 26.6 | 27 | 23.2 | 2 | 11.1 | 11 | 19.8 | 3 | 13.5 | 4 | 14.8 |
| (g) a + c | 44 | 31.7 | 10 | 28.5 | 7 | 35.0 | 3 | 33.3 | 12 | 46.1 | 1 | 9.2 | | | 33 | 28.4 | 8 | 44.4 | 17 | 30.6 | 8 | 36.0 | 6 | 22.2 |
| (h) a + b + c | 13 | 9.4 | 3 | 8.5 | | | 1 | 11.1 | 2 | 7.7 | 3 | 27.2 | 2 | 13.3 | 11 | 9.5 | 2 | 11.1 | 4 | 7.2 | 1 | 4.5 | 3 | 11.1 |
| (i) a + e | 1 | 0.7 | 1 | 2.8 | | | | | | | | | | | 1 | .9 | | | | | | | | |
| (j) b + c | 2 | 1.4 | 1 | 2.8 | | | | | | | | | | | 1 | .9 | 1 | 5.5 | | | | | 1 | 3.7 |
| (X) NOT APPLICABLE | 24 | | | | | | | | 1 | | 9 | | 6 | | 16 | | 4 | | 16 | | 1 | | 4 | |
| (y) UNKNOWN | 5 | 3.6 | | | | | | | | | | | 2 | 13.3 | 2 | 1.7 | | | 2 | 3.6 | | | 1 | 3.7 |
| | 163 | 99.9 | 35 | 99.6 | 20 | 100 | 9 | 99.9 | 27 | 99.8 | 20 | 99.9 | 21 | 99.8 | 132 | 99.9 | 22 | 99.8 | 69 | 97.8 | 25 | 100.3 | 31 | 99.9 |

TABLE XIX : SUBSEQUENT SERVICE

| TIME | OVERALL DATA | | MAJOR AGENCY DATA | | | | | | | | | | | | | | MINOR AGENCY DATA | | LONG TRIP SHORT TRIP DATA | | | | FIRST REFERRAL | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | S.M.H. | | W.P.I. | | W.C.H. | | W.C.H. | | C.A.S. W.P.G. | | C.G.C. | | TOTALS | | | | LONG TRIP | | SHORT TRIP | | | |
| | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % |
| 1 DAY | 2 | 1.6 | | | | | | | 2 | 8.0 | | | | | 2 | 2.0 | | | | | | | | |
| 7 DAYS | 14 | 11.6 | | | 6 | 31.5 | | | 4 | 16.0 | | | | | 10 | 10.0 | 2 | 11.6 | 8 | 16.8 | | | | |
| 1 MONTH | 27 | 22.1 | 3 | 11.1 | 5 | 26.3 | 6 | 75.0 | 8 | 32.0 | | | 1 | 8.3 | 23 | 23.0 | 4 | 23.4 | 10 | 21.0 | 6 | 30.0 | 4 | 17.4 |
| 3 MONTHS | 19 | 15.7 | 5 | 18.5 | 5 | 26.3 | 2 | 25.0 | 3 | 12.0 | 2 | 22.2 | | | 17 | 17.0 | 2 | 11.6 | 4 | 8.4 | 6 | 30.0 | 5 | 21.7 |
| 6 MONTHS | 7 | 5.8 | 2 | 7.4 | 1 | 5.2 | | | 2 | 8.0 | 1 | 11.1 | | | 6 | 6.0 | 1 | 5.8 | 1 | 2.1 | 1 | 5.0 | 2 | 8.7 |
| 1 YEAR | 15 | 12.4 | 6 | 22.2 | 1 | 5.2 | | | 1 | 4.0 | 1 | 11.1 | 2 | 16.6 | 11 | 11.0 | 3 | 17.6 | 6 | 12.6 | 4 | 20.0 | 4 | 17.4 |
| 2 YEARS | 5 | 4.1 | 1 | 3.7 | | | | | 1 | 4.0 | | | 2 | 16.6 | 4 | 4.0 | 1 | 5.8 | 3 | 6.3 | | | 1 | 4.3 |
| 4 YEARS | 1 | 0.8 | | | | | | | 1 | 4.0 | | | 1 | 8.3 | 2 | 2.0 | | | | | | | 1 | 4.3 |
| OTHER | 8 | 6.6 | 2 | 7.4 | | | | | 1 | 4.0 | 1 | 11.1 | 1 | 8.3 | 5 | 5.0 | 3 | 17.6 | 5 | 10.5 | | | 1 | 4.3 |
| NOT APPLICABLE | 42 | | 8 | | 1 | | 1 | | 2 | | 11 | | 9 | | 32 | | 5 | | 20 | | 5 | | 8 | |
| UNKNOWN | 23 | 19.0 | 8 | 29.6 | 1 | 5.2 | | | 2 | 8.0 | 4 | 44.4 | 5 | 41.5 | 20 | 20.0 | 1 | 5.8 | 11 | 23.1 | 3 | 15.0 | 5 | 21.7 |
| | 163 | 99.7 | 35 | 99.7 | 20 | 99.7 | 9 | 100.0 | 27 | 100.0 | 20 | 99.9 | 21 | 99.6 | 132 | 100.0 | 22 | 99.2 | 69 | 99.0 | 25 | 100.0 | 31 | 99.8 |

TABLE XX : LENGTH OF TREATMENT

| | OVERALL DATA | | MAJOR AGENCY DATA | | | | | | | | | | | | | | MINOR AGENCY DATA | | LONG TRIP SHORT TRIP DATA | | | | FIRST REFERRAL | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | S.M.H. | | W.P.I. | | W.G.H. | | W.C.H. | | C.A.S. WPC. | | C.G.C. | | TOTALS | | | | LONG TRIP | | SHORT TRIP | | | |
| TREATMENT | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % |
| (a) MEDICATION (ECT etc.) | 23 | 18.9 | 3 | 9.3 | 11 | 57.8 | | | 10 | 41.6 | | | | | 24 | 23.0 | 1 | 5.9 | 13 | 27.1 | 3 | 13.5 | 3 | 13.6 |
| (b) THERAPEUTIC COUNSELLING | 13 | 10.7 | 1 | 3.1 | | | | | | | 4 | 40.0 | 4 | 33.3 | 9 | 8.6 | 3 | 17.6 | 2 | 4.1 | 3 | 13.5 | 7 | 31.8 |
| (c) SOCIAL REHABILITATION | 9 | 7.4 | 1 | 3.1 | 2 | 10.6 | | | 1 | 4.2 | | | 1 | 8.3 | 5 | 4.8 | 2 | 11.7 | 5 | 10.4 | 1 | 4.5 | | |
| (d) OTHER | 7 | 5.7 | | | 1 | 5.3 | | | | | 2 | 20.0 | 1 | 8.3 | 4 | 3.8 | 3 | 17.6 | 5 | 10.4 | | | 2 | 9.1 |
| (e) a+b+c | 12 | 9.8 | 7 | 21.8 | | | 1 | 14.3 | 1 | 4.2 | 2 | 20.0 | 1 | 8.3 | 12 | 11.5 | | | 4 | 8.2 | 2 | 9 | 3 | 13.6 |
| (f) a+b | 29 | 23.8 | 10 | 31.3 | 1 | 5.3 | 4 | 57.1 | 10 | 41.6 | 1 | 10.0 | | | 26 | 25.0 | 4 | 23.5 | 7 | 14.5 | 8 | 36.0 | 5 | 22.7 |
| (g) a+c | 11 | 9.0 | 5 | 15.6 | | | 1 | 14.3 | 1 | 4.2 | 1 | 10.0 | | | 8 | 7.7 | 3 | 17.6 | 6 | 12.5 | 1 | 4.5 | 1 | 4.5 |
| (h) b+d | 1 | 0.8 | 1 | 3.1 | | | | | | | | | | | 1 | 1.0 | | | | | 1 | 4.5 | | |
| (i) a+d | 2 | 1.6 | | | 2 | 10.5 | | | | | | | | | 2 | 1.9 | | | | | | | | |
| (j) a+b+d | 1 | 0.8 | | | | | | | | | | | 1 | 8.3 | 1 | 1.0 | | | 1 | 2.0 | | | | |
| (k) b+c | 2 | 1.6 | 2 | 6.3 | | | | | | | | | | | 2 | 1.9 | | | | | 1 | 4.5 | | |
| (x) NOT APPLICABLE | 41 | | 3 | | 1 | | 2 | | 3 | | 10 | | 9 | | 28 | | 5 | | 21 | | 3 | | 9 | |
| (y) UNKNOWN | 12 | | 2 | 6.3 | 2 | 10.5 | 1 | 14.3 | 1 | 4.2 | | | 4 | 33.3 | 10 | 9.6 | 1 | 5.9 | 5 | 10.4 | 2 | 9.0 | 1 | 4.5 |
| | 163 | 99.9 | 35 | 99.6 | 20 | 99.9 | 9 | 99.7 | 27 | 100.0 | 20 | 100.0 | 21 | 99.2 | 132 | 99.8 | 22 | 99.8 | 69 | 99.9 | 25 | 99.0 | 31 | 99.8 |

TABLE XXI: NATURE OF TREATMENT

| SETTING | OVERALL DATA | | MAJOR AGENCY DATA | | | | | | | | | | | | | | MINOR AGENCY DATA | | LONG TRIP SHORT TRIP DATA | | | | FIRST REFERRAL | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | SMH. | | W.P.I. | | W.G.H. | | W.C.H. | | C.A.S. UPG. | | C.G.C. | | TOTALS | | | | LONG TRIP | | SHORT TRIP | | | |
| | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % |
| (a) OUT-PATIENT | 27 | 21.8 | | | 2 | 10.5 | 1 | 14.9 | 4 | 16.0 | 7 | 70.0 | 10 | 83.3 | 24 | 23.3 | 2 | 11.7 | 11 | 22.4 | 4 | 18.1 | 13 | 56.5 |
| (b) NON-TREATMENT IN-PATIENT | 3 | 2.4 | | | | | | | | | 2 | 20.0 | | | 2 | 1.9 | 1 | 5.8 | 1 | 2.0 | | | | |
| (c) TREATMENT IN-PATIENT | 85 | 68.5 | 30 | 100.0 | 15 | 78.9 | 6 | 85.7 | 18 | 72.0 | | | | | 69 | 66.9 | 13 | 76.4 | 31 | 62.0 | 18 | 81.8 | 10 | 43.5 |
| (d) OTHER | | | | | | | | | | | | | | | | | 1 | 5.8 | | | | | | |
| (e) a+c | 5 | 4.0 | | | 2 | 10.5 | | | 3 | 12.0 | | | | | 5 | 4.9 | | | 3 | 6.0 | | | | |
| (f) a+b | 1 | 0.8 | | | | | | | | | 1 | 10.0 | | | 1 | 1.0 | | | 1 | 2.0 | | | | |
| (x) NOT APPLICABLE | 39 | | 5 | | 1 | | 2 | | 2 | | 10 | | 9 | | 29 | | 5 | | 20 | | 3 | | 8 | |
| (y) UNKNOWN | 3 | 2.4 | | | | | | | | | | | 2 | 16.7 | 2 | 1.9 | | | 2 | 4.0 | | | | |
| | 163 | 99.9 | 35 | 100.0 | 20 | 99.9 | 9 | 100.0 | 27 | 100.0 | 20 | 100.0 | 21 | 100.0 | 132 | 99.9 | 22 | 99.7 | 69 | 98.4 | 25 | 99.9 | 31 | 100.0 |

TABLE XXII: TREATMENT SETTING

| | OVERALL DATA | | MAJOR AGENCY DATA | | | | | | | | | | | | | | MINOR AGENCY DATA | | LONG TRIP SHORT TRIP DATA | | | | FIRST REFERRAL | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | S.M.H. | | W.P.I. | | W.G.H. | | W.C.H. | | C.A.S. WPG. | | C.G.C. | | TOTALS | | | | LONG. TRIP | | SHORT TRIP | | | |
| PERSON | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % |
| (a) PSYCHIATRIST | 44 | 44.0 | 6 | 54.5 | 14 | 87.5 | 6 | 85.7 | 8 | 53.3 | 15 | 93.7 | 8 | 47.1 | 57 | 68.4 | 1 | 8.3 | 19 | 41.0 | 6 | 54.6 | 6 | 31.6 |
| (b) SOCIAL WORKER | 29 | 29.0 | 4 | 36.3 | | | | | | | | | 2 | 11.8 | 6 | 7.2 | 9 | 75.0 | 14 | 30.0 | 2 | 18.1 | 4 | 21.1 |
| (c) GENERAL PRACT. | 1 | 1.0 | | | | | | | | | | | 1 | 5.9 | 1 | 1.2 | | | | | | | | |
| (d) PSYCHOLOGIST | | | | | | | | | | | | | | | | | | | | | | | 1 | 5.3 |
| (e) OTHER | 1 | 1.0 | | | | | | | | | 1 | 6.2 | | | 1 | 1.2 | | | 1 | 2.1 | | | 1 | 5.3 |
| (f) a + e | 1 | 1.0 | | | | | | | | | | | | | | | | | 1 | 2.1 | | | | |
| (X) NOT APPLICABLE | 63 | | 24 | | 4 | | 2 | | 12 | | 4 | | 4 | | 50 | | 10 | | 23 | | 14 | | 12 | |
| (Y) UNKNOWN | 24 | 24.1 | 1 | 9.2 | 2 | 12.4 | 1 | 14.3 | 7 | 46.8 | | | 6 | 35.9 | 17 | 20.4 | 2 | 16.6 | 11 | 24.0 | 3 | 27.3 | 7 | 36.8 |
| | 163 | 100.0 | 35 | 99.7 | 20 | 99.9 | 9 | 100 | 27 | 99.5 | 20 | 99.9 | 21 | 100.1 | 132 | 98.4 | 22 | 99.9 | 69 | 99.2 | 25 | 100.0 | 31 | 100.1 |

TABLE XXIII : PERSON MAKING REFERRAL

| POSITION | OVERALL DATA | | MAJOR AGENCY DATA | | | | | | | | | | | | | | MINOR AGENCY DATA | | LONG TRIP SHORT TRIP DATA | | | | FIRST REFERRAL | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | SMH. | | W.P.I. | | W.G.H. | | W.C.H. | | C.A.S. WPG. | | C.G.C. | | TOTALS | | | | LONG TRIP | | SHORT TRIP | | | |
| | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % |
| CHIEF ADMINISTRATOR | 6 | 6.3 | | | 2 | 12.5 | | | | | | | | | 2 | 2.6 | 4 | 33.3 | 2 | 4.6 | | | | |
| SUPERVISOR | 4 | 4.2 | | | | | 1 | 14.3 | 1 | 8.3 | | | 1 | 5.9 | 3 | 3.9 | 1 | 8.3 | 2 | 4.6 | 1 | 10.0 | 1 | 5.9 |
| STAFF MEMBER | 58 | 60.4 | 9 | 81.8 | 12 | 75.0 | 5 | 71.4 | 8 | 66.6 | 10 | 62.5 | 10 | 58.8 | 54 | 70.2 | 4 | 33.3 | 27 | 62.1 | 7 | 70.0 | 10 | 58.8 |
| OTHER | | | | | | | | | | | | | | | | | | | | | | | | |
| NOT APPLICABLE | 67 | | 24 | | 4 | | 2 | | 15 | | 4 | | 4 | | 53 | | 10 | | 26 | | 15 | | 14 | |
| UNKNOWN | 28 | 29.2 | 2 | 18.2 | 2 | 12.5 | 1 | 14.3 | 3 | 25.0 | 6 | 37.5 | 6 | 35.3 | 20 | 26.0 | 3 | 24.9 | 12 | 27.6 | 2 | 20.0 | 6 | 35.3 |
| | 163 | 100.1 | 35 | 100.0 | 20 | 100.0 | 9 | 100.0 | 27 | 99.9 | 20 | 99.7 | 21 | 99.1 | 132 | 102.7 | 22 | 99.8 | 69 | 98.9 | 25 | 100.0 | 31 | 100.0 |

TABLE XXIV: POSITION OF PERSON MAKING REFERRAL

| | OVERALL DATA | | MAJOR AGENCY DATA | | | | | | | | | | | | | | MINOR AGENCY DATA | | LONG TRIP SHORT TRIP DATA | | | | FIRST REFERRAL | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | SMH. | | W.P.I. | | W.G.H. | | W.C.H. | | C.A.S. WPG. | | C.G.C. | | TOTALS | | | | LONG TRIP | | SHORT TRIP | | | |
| METHOD | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % |
| (a) TELEPHONE | 6 | 6.9 | | | 3 | 18.8 | 1 | 14.3 | | | 1 | 6.2 | 1 | 5.5 | 6 | 7.4 | | | 2 | 4.3 | 2 | 20.0 | 2 | 11.1 |
| (b) LETTER | 16 | 15.8 | 5 | 45.4 | | | 1 | 14.3 | 3 | 23.1 | | | 2 | 11.1 | 11 | 13.5 | 4 | 33.3 | 5 | 10.5 | 3 | 30.0 | 2 | 11.1 |
| (c) PERSONAL CONTACT | 11 | 10.9 | | | | | | | 2 | 15.4 | 2 | 12.4 | 4 | 22.2 | 8 | 9.8 | 2 | 16.6 | 7 | 14.7 | | | 1 | 5.6 |
| (d) APPLICATION FORM | 9 | 8.9 | | | 7 | 43.7 | | | 1 | 7.6 | | | | | 8 | 9.8 | | | 4 | 8.4 | | | | |
| (e) OTHER | 2 | 2.0 | 1 | 9.1 | | | | | | | | | 1 | 5.5 | 2 | 2.5 | | | 1 | 2.1 | 1 | 10.0 | 1 | 5.6 |
| (f) a + c | 1 | 1.0 | 1 | 9.1 | | | | | | | | | | | 1 | 1.2 | | | | | | | | |
| (x) NOT APPLICABLE | 62 | | 24 | | 4 | | 2 | | 14 | | 4 | | 3 | | 51 | | 10 | | 23 | | 15 | | 13 | |
| (y) UNKNOWN | 56 | 55.4 | 4 | 36.4 | 6 | 37.2 | 5 | 70.5 | 7 | 53.5 | 13 | 80.6 | 10 | 55.5 | 45 | 55.4 | 6 | 49.8 | 27 | 56.7 | 4 | 40.0 | 12 | 66.7 |
| | 163 | 99.9 | 35 | 100.0 | 20 | 99.5 | 9 | 99.1 | 27 | 99.2 | 20 | 99.5 | 21 | 99.3 | 132 | 99.6 | 22 | 99.7 | 69 | 97.7 | 25 | 100.0 | 31 | 100.1 |

TABLE XXV : HOW REFERRAL WAS MADE

| | OVERALL DATA | | MAJOR AGENCY DATA | | | | | | | | | | | | | | MINOR AGENCY DATA | | LONG TRIP SHORT TRIP DATA | | | | FIRST REFERRAL | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | S.M.H. | | W.P.I. | | W.G.H. | | W.C.H. | | C.A.S. WPG. | | C.G.C. | | TOTALS | | | | LONG TRIP | | SHORT TRIP | | | |
| AGENCY | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % |
| C.A.S. EAST | 4 | 4.0 | 1 | 9.1 | 1 | 6.1 | | | | | | | | | 2 | 2.4 | 1 | 8.3 | | | | | | |
| C.A.S. WPG. | 7 | 7.0 | 3 | 27.2 | 1 | 6.1 | | | 1 | 6.7 | | | 1 | 5.5 | 6 | 7.2 | 1 | 8.3 | 2 | 4.2 | | | 1 | 5.3 |
| CHILD G. CLINIC | 5 | 5.0 | | | | | 2 | 28.5 | | | 1 | 6.2 | | | 3 | 3.6 | 2 | 16.6 | 3 | 6.3 | | | | |
| CHILDREN'S HOME | 3 | 3.0 | | | 1 | 6.1 | | | 1 | 6.7 | | | | | 2 | 2.4 | 1 | 8.3 | | | | | 1 | 5.3 |
| CHILDREN'S HOSP. | 9 | 9.0 | | | | | | | | | 4 | 25.1 | 4 | 22.1 | 8 | 9.6 | 1 | 8.3 | 7 | 14.7 | | | 1 | 5.3 |
| FAMILY BUREAU | 2 | 2.0 | | | | | | | | | | | 1 | 5.5 | | | 1 | 8.3 | 1 | 2.1 | | | 2 | 10.5 |
| GENERAL PRACT. | | | | | | | | | | | | | | | | | | | | | | | | |
| INDIAN AFFAIRS | | | | | | | | | | | | | | | | | | | | | | | | |
| JOUENILE COURT | 2 | 2.0 | | | | | | | | | 1 | 6.2 | | | 1 | 1.2 | | | 2 | 4.2 | | | | |
| MANITOBA SCHOOL FOR RETARDATES | 2 | 2.0 | 1 | 9.1 | | | | | | | | | | | 1 | 1.2 | 1 | 8.3 | 1 | 2.1 | | | | |
| PRIVATE PSYCHIATRISTS | | | | | | | | | | | | | | | | | | | | | | | | |
| ROSLYNN HOUSE | 1 | 1.0 | | | | | | | | | | | | | | | 1 | 8.3 | 1 | 2.1 | | | | |
| SIR HUGH JOHN MACDONALD HOSTEL | | | | | | | | | | | | | | | | | | | | | | | | |
| SELKIRK HOSP. FOR MENTAL DISEASES | 23 | 23.0 | | | 11 | 68.7 | 4 | 57.1 | 5 | 33.3 | 1 | 6.2 | 1 | 5.5 | 22 | 26.5 | 1 | 8.3 | 9 | 18.9 | 4 | 36.0 | 2 | 10.5 |
| ST. AGNES SCHOOL | 4 | 4.0 | | | | | | | 3 | 20.0 | | | | | | | | | 4 | 8.4 | | | 1 | 5.3 |
| ST. BONIFACE SCHOOL | 1 | 1.0 | | | | | | | | | | | | | | | | | 1 | 2.1 | | | | |
| ST. JOSEPH SCHOOL | 4 | 4.0 | | | | | | | 1 | 6.7 | 3 | 18.6 | | | 4 | 4.8 | | | 2 | 4.2 | | | | |
| WPG. GENERAL HOSP. | 3 | 3.0 | 1 | 9.1 | | | | | | | | | 3 | 16.6 | 4 | 4.8 | | | 2 | 4.2 | | | | |
| WPG. PSYCHIATRIC INST. | 12 | 12.0 | | | | | 1 | 14.3 | 2 | 13.7 | 5 | 31.0 | 3 | 16.6 | 11 | 13.2 | 1 | 8.3 | 6 | 12.6 | 1 | 9.0 | 3 | 15.8 |
| OTHER | 8 | 8.0 | 5 | 45.5 | | | | | | | 1 | 6.2 | | | 6 | 7.2 | | | 2 | 4.2 | 4 | 36.0 | 3 | 15.8 |
| SCHOOL | | | | | | | | | | | | | | | | | | | | | | | | |
| NOT APPLICABLE | 63 | | 24 | | 4 | | 2 | | 12 | | 4 | | 3 | | 49 | | 10 | | 22 | | 14 | | 12 | |
| UNKNOWN | 10 | 10.0 | | | 2 | 12.2 | | | 2 | 13.7 | | | 5 | 27.5 | 19 | 15.7 | 1 | 8.3 | 4 | 8.4 | 2 | 18.0 | 5 | 26.3 |
| | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | |
| | 163 | 100.0 | 35 | | 20 | 99.2 | 9 | 100.2 | 27 | 100.3 | 20 | 99.4 | 21 | 99.2 | 132 | 100.0 | 22 | 99.6 | 69 | 98.7 | 25 | 100.0 | 31 | 100.1 |

TABLE XXVI : AGENCY RECEIVING REFERRAL

| | OVERALL DATA | | MAJOR AGENCY DATA | | | | | | | | | | | | | | MINOR AGENCY DATA | | LONG TRIP SHORT TRIP DATA | | | | FIRST REFERRAL | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | S.M.H. | | W.P.I. | | W.G.H. | | W.C.H. | | C.A.S. WPG. | | C.G.C. | | TOTALS | | | | LONG TRIP | | SHORT TRIP | | | |
| PERSON | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % |
| (a) PSYCHIATRIST | 44 | 44.0 | 2 | 18.1 | 8 | 53.3 | 5 | 71.5 | 7 | 46.6 | 11 | 68.7 | 5 | 27.7 | 38 | 45.7 | 4 | 33.3 | 34 | 53.3 | 2 | 18.1 | 4 | 21.1 |
| SOCIAL WORKER | 18 | 18.0 | 5 | 45.4 | 1 | 6.6 | 3 | | 3 | 20.0 | 2 | 12.5 | 2 | 11.1 | 13 | 15.6 | 4 | 33.3 | 6 | 13.3 | 1 | 9.0 | 4 | 21.1 |
| GENERAL PRACT. | | | | | | | | | | | | | | | | | | | | | | | | |
| PSYCHOLOGIST | 1 | 1.0 | | | | | | | | | 1 | 6.2 | | | 1 | 1.2 | | | | | | | | |
| OTHER | 3 | 3.0 | 1 | 9.2 | | | | | | | | | 1 | 5.5 | 2 | 2.4 | | | 2 | 4.4 | 1 | 9.0 | | |
| NOT APPLICABLE | 63 | | 24 | | 5 | | 2 | | 12 | | 4 | | 3 | | 50 | | 10 | | 24 | | 14 | | 12 | |
| UNKNOWN | 34 | 34.0 | 3 | 27.5 | 6 | 40.0 | 2 | 28.5 | 5 | 33.3 | 2 | 12.5 | 10 | 55.5 | 28 | 33.6 | 4 | 33.3 | 13 | 28.8 | 7 | 63.0 | 11 | 57.9 |
| | 163 | 100.0 | 35 | 99.9 | 20 | 99.9 | 9 | 100.0 | 27 | 99.9 | 20 | 99.9 | 21 | 99.8 | 132 | 98.5 | 22 | 99.9 | 69 | 99.8 | 25 | 99.1 | 31 | 100.1 |

TABLE XXOII : PERSON RECEIVING REFERRAL

| POSITION | OVERALL DATA | | MAJOR AGENCY DATA | | | | | | | | | | | | | | MINOR AGENCY DATA | | LONG TRIP SHORT TRIP DATA | | | | FIRST REFERRAL | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | S.M.H. | | W.P.I. | | W.G.H. | | W.C.H. | | C.A.S. WPG. | | C.G.C. | | TOTALS | | | | LONG TRIP | | SHORT TRIP | | | |
| | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % |
| CHIEF ADMINISTRATOR | 12 | 12.2 | 2 | 18.4 | | | | | 3 | 21.3 | 1 | 6.2 | | | 6 | 7.7 | 4 | 33.3 | 4 | 9.2 | | | 1 | 5.6 |
| SUPERVISOR | 2 | 2.1 | 1 | 9.2 | | | | | | | | | 1 | 6.2 | 2 | 2.6 | | | 1 | 2.3 | | | 1 | 5.6 |
| STAFF MEMBER | 46 | 47.9 | 5 | 45.4 | 8 | 57.1 | 5 | 71.3 | 6 | 42.8 | 13 | 81.7 | 6 | 37.5 | 43 | 55.0 | 4 | 33.3 | 24 | 55.2 | 4 | 40.0 | 5 | 27.8 |
| OTHER | 1 | 1.0 | | | | | | | 1 | 7.1 | | | | | 1 | 1.3 | | | 1 | 2.3 | | | 1 | 5.6 |
| NOT APPLICABLE | 67 | | 24 | | 6 | | 2 | | 13 | | 4 | | 5 | | 54 | | 10 | | 25 | | 15 | | 13 | |
| UNKNOWN | 35 | 36.5 | 3 | 27.2 | 6 | 42.1 | 2 | 28.6 | 4 | 28.4 | 2 | 12.4 | 9 | 55.8 | 26 | 33.3 | 4 | 33.3 | 14 | 32.3 | 6 | 60.0 | 10 | 55.6 |
| | 163 | 99.7 | 35 | 100.4 | 20 | 99.7 | 9 | 99.9 | 27 | 99.6 | 20 | 100.3 | 21 | 99.5 | 132 | 99.9 | 22 | 99.9 | 69 | 101.2 | 25 | 100.0 | 31 | 100.0 |

TABLE XIOIII: POSITION OF PERSON RECEIVING REFERRAL

| METHOD | OVERALL DATA | | MAJOR AGENCY DATA | | | | | | | | | | | | | | MINOR AGENCY DATA | | LONG TRIP SHORT TRIP DATA | | | | FIRST REFERRAL | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | S.M.H. | | W.P.I. | | W.G.H. | | W.C.H. | | C.A.S. WPG. | | C.G.C. | | TOTALS | | | | LONG TRIP | | SHORT TRIP | | | |
| | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % |
| NO FOLLOW UP | 20 | 20.4 | 4 | 36.3 | 3 | 42.9 | 3 | 42.8 | 7 | 46.6 | 2 | 13.3 | | | 19 | 23.4 | 2 | 16.6 | 10 | 22.0 | 4 | 36.0 | 5 | 25.5 |
| TELEPHONE | 2 | 2.0 | | | | | 1 | 14.3 | | | | | 1 | 5.8 | 2 | 2.5 | | | | | | | | |
| LETTER | 4 | 4.1 | 2 | 18.1 | | | | | | | | | | | 2 | 2.5 | 1 | 8.3 | 1 | 22 | 1 | 9.0 | 1 | 5.2 |
| PERSONAL CONTACT WITH CLIENT | 9 | 9.1 | | | | | | | 2 | 13.3 | 3 | 20.0 | 3 | 17.6 | 8 | 9.8 | 1 | 8.3 | 5 | 11.0 | | | 2 | 10.4 |
| PERSONAL CONTACT WITH AGENCY | 4 | 4.1 | 2 | 18.1 | | | | | | | 1 | 6.6 | | | 3 | 3.7 | 1 | 8.3 | 1 | 22 | 1 | 9.0 | | |
| OTHER | 5 | 5.1 | | | 1 | 14.2 | | | | | | | 2 | 11.7 | 3 | 3.7 | 1 | 8.3 | 5 | 11.0 | | | 2 | 10.4 |
| NOT APPLICABLE | 65 | | 24 | | 4 | | 2 | | 12 | | 5 | | 4 | | 51 | | 10 | | 24 | | 14 | | 12 | |
| UNKNOWN | 54 | 55.1 | 3 | 27.3 | 12 | 71.4 | 3 | 42.8 | 6 | 39.6 | 9 | 57.4 | 11 | 64.9 | 44 | 54.1 | 6 | 49.8 | 23 | 50.6 | 5 | 45.0 | 9 | 46.8 |
| | 163 | 99.1 | 35 | 99.7 | 20 | 99.3 | 9 | 99.9 | 27 | 99.5 | 20 | 99.3 | 21 | 100 | 132 | 99.7 | 22 | 99.6 | 69 | 99.0 | 25 | 99.0 | 31 | 98.3 |

TABLE XXIX: FOLLOW-UP TO REFERRAL

| FORM | OVERALL DATA | | MAJOR AGENCY DATA | | | | | | | | | | | | | | MINOR AGENCY DATA | | LONG TRIP SHORT TRIP DATA | | | | FIRST REFERRAL | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | S.M.H. | | W.P.I. | | W.G.H. | | W.C.H. | | C.A.S. WPG. | | C.G.C. | | TOTALS | | | | LONG TRIP | | SHORT TRIP | | | |
| | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % |
| (a) LABEL | 28 | 28.6 | 4 | 32.3 | 8 | 50.0 | 6 | 85.7 | 7 | 50.0 | 2 | 13.3 | | | 27 | 30.0 | 1 | 8.3 | 12 | 25.2 | 5 | 50.0 | 5 | 27.2 |
| (b) CAUSE | 3 | 3.1 | 1 | 9.2 | 1 | 6.2 | | | 1 | 7.1 | | | 1 | 5.9 | 4 | 4.4 | | | 1 | 2.1 | 1 | 10.0 | 1 | 5.6 |
| (c) SYMTOM | 10 | 10.2 | | | 1 | 6.2 | | | | | | | | | 1 | 1.1 | 3 | 25.0 | 7 | 14.7 | 1 | 10.0 | 2 | 11.1 |
| (d) COMPARISON | 9 | 9.1 | 4 | 36.3 | 1 | 6.2 | | | 4 | 28.6 | | | 3 | 17.6 | 12 | 13.3 | | | 3 | 6.3 | 1 | 10.0 | | |
| (e) OTHER | 5 | 5.1 | 1 | 9.2 | | | | | | | 1 | 6.6 | | | 2 | 2.2 | 2 | 16.6 | 3 | 6.3 | | | 1 | 5.6 |
| (f) NONE MADE | 7 | 7.1 | 1 | 9.2 | | | | | 1 | 7.1 | 2 | 13.3 | 2 | 11.8 | 6 | 6.6 | 2 | 16.6 | 4 | 8.4 | 1 | 10.0 | 4 | 22.2 |
| (g) a + c | 4 | 4.1 | | | 2 | 12.4 | | | | | 2 | 13.3 | | | 4 | 4.4 | | | | | | | | |
| (h) a + d | 1 | 1.0 | | | 1 | 6.2 | | | | | | | | | 1 | 1.1 | | | | | | | | |
| (i) a + b + c | 1 | 1.0 | | | | | | | | | | | | | | | | | 1 | 2.1 | | | | |
| (j) a + c + d | 1 | 1.0 | | | | | | | | | | | | | | | | | | | | | | |
| (X) NOT APPLICABLE | 65 | | 24 | | 4 | | 2 | | 13 | | 5 | | 4 | | 42 | | 10 | | 23 | | 15 | | 13 | |
| (y) UNKNOWN | 29 | 29.6 | | | 2 | 12.4 | 1 | 14.3 | 1 | 7.1 | 8 | 53.8 | 11 | 64.9 | 23 | 25.5 | 4 | 33.2 | 15 | 31.5 | 1 | 10.0 | 5 | 27.2 |
| | 163 | 99.9 | 35 | 100.0 | 20 | 99.6 | 9 | 100.0 | 27 | 99.8 | 20 | 99.3 | 21 | 100.0 | 132 | 98.6 | 22 | 99.7 | 69 | 97.6 | 25 | 100.0 | 31 | 99.9 |

TABLE XXX : FORM OF ASSESSMENT AT REFERRAL

| | OVERALL DATA | | MAJOR AGENCY DATA | | | | | | | | | | | | | | MINOR AGENCY DATA | | LONG TRIP SHORT TRIP DATA | | | | FIRST REFERRAL | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | S.M.H. | | W.P.I. | | W.G.H. | | W.C.H. | | C.A.S. WPG. | | C.G.C. | | TOTALS | | | | LONG TRIP | | SHORT TRIP | | | |
| ASSESSMENT | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % |
| (a) SCHIZOPHRENIA | 18 | 19.8 | 2 | 20.0 | 4 | 25.0 | 5 | 71.3 | 4 | 30.4 | 1 | 7.6 | 1 | 5.9 | 17 | 22.4 | 1 | 11.1 | 5 | 12.1 | 5 | 55.5 | 2 | 14.3 |
| (b) PSYCHOTIC | 4 | 4.4 | | | 1 | 6.2 | | | 1 | 7.6 | 1 | 7.6 | | | 3 | 4.0 | 1 | 11.1 | 4 | 9.6 | | | 1 | 7.1 |
| (c) MENTAL DISORDER WITH ORGANIC BASE | 2 | 2.2 | | | | | | | | | | | 1 | 5.9 | 1 | 1.3 | | | | | | | 2 | 14.3 |
| (d) EPILEPSY | | | | | | | | | | | | | | | | | | | | | | | | |
| (e) PERSONALITY DISORDER | 1 | 1.1 | 1 | 10.0 | | | | | | | | | | | 1 | 1.3 | | | | | | | | |
| (f) BEHAVIOR DISORDER | 6 | 6.6 | 2 | 20.0 | 1 | 6.2 | 1 | 14.3 | 1 | 7.6 | | | | | 5 | 6.6 | 1 | 11.1 | 2 | 4.8 | | | | |
| (g) THOUGHT DISORDER | | | | | | | | | | | | | | | | | | | | | | | | |
| (h) FAMILY | | | | | | | | | | | | | | | | | | | | | | | | |
| (i) DRUG | 3 | 3.3 | 1 | 10.0 | 1 | 6.2 | | | 1 | 7.6 | | | | | 3 | 4.0 | | | 1 | 2.4 | 1 | 11.1 | 1 | 7.1 |
| (j) DESCRIPTION OF BEHAVIOR | 8 | 8.8 | | | | | | | | | | | 4 | 23.5 | 4 | 5.3 | 2 | 22.2 | 6 | 14.5 | | | 1 | 7.1 |
| (k) NO CHANGE | 4 | 4.4 | | | 3 | 18.7 | | | | | 1 | 7.6 | | | 4 | 5.3 | | | 2 | 4.8 | | | | |
| (l) IMPROVED | 8 | 8.8 | 4 | 40.0 | | | | | 4 | 30.7 | | | | | 8 | 10.6 | | | 3 | 7.2 | 1 | 11.1 | | |
| (m) CONTROLLED | | | | | | | | | | | | | | | | | | | | | | | | |
| (n) DETERIORATED | | | | | | | | | | | | | | | | | | | | | | | | |
| (o) OTHER | 1 | 1.1 | | | | | | | | | | | | | | | | | | | | | | |
| (p) a + | 4 | 4.4 | | | 3 | 18.7 | | | 1 | 7.6 | | | | | 4 | 5.3 | | | 1 | 2.4 | | | | |
| (q) g + j | 2 | 2.2 | | | | | | | | | 2 | 15.2 | | | 2 | 2.6 | | | 1 | 2.4 | | | | |
| (r) g + h + j | 1 | 1.1 | | | | | | | | | | | 1 | 5.9 | 1 | 1.3 | | | 1 | 2.4 | | | | |
| (s) NOT APPLICABLE | 72 | | 25 | | 4 | | 2 | | 14 | | 7 | | 4 | | 56 | | 13 | | 28 | | 16 | | 17 | |
| (t) UNKNOWN | 29 | 33.0 | | | 3 | 18.7 | 1 | 14.3 | 1 | 7.6 | 8 | 60.8 | 10 | 59.1 | 23 | 30.4 | 4 | 44.4 | 15 | 36.5 | 2 | 22.2 | 7 | 50.0 |
| | 163 | 101.2 | 35 | 100.0 | 20 | 99.7 | 9 | 99.9 | 27 | 98.8 | 20 | 98.8 | 21 | 100.5 | 132 | 100.4 | 22 | 99.9 | 69 | 99.1 | 25 | 99.9 | 31 | 99.9 |

TABLE XXII: ACTUAL ASSESSMENT AT REFERRAL

| | OVERALL DATA | | MAJOR AGENCY DATA | | | | | | | | | | | | | | MINOR AGENCY DATA | | LONG TRIP SHORT TRIP DATA | | | | FIRST REFERRAL | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | S.M.H. | | W.P.I. | | W.G.H. | | W.C.H. | | C.A.S. WPG. | | C.G.C | | TOTALS | | | | LONG TRIP | | SHORT TRIP | | | |
| PERSON | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % |
| SELF | 2 | 3.1 | | | 1 | 20.0 | | | | | | | 1 | 14.3 | 2 | 4.3 | | | | | | | 1 | 5.8 |
| PARENTS (NATURAL) | 39 | 60.9 | 9 | 64.3 | 3 | 60.0 | 3 | 100.0 | 9 | 81.8 | 4 | 66.6 | | | 28 | 60.8 | 9 | 69.2 | 12 | 60.0 | 9 | 81.8 | 9 | 52.2 |
| RELATIVES | 1 | 1.6 | 1 | 7.1 | | | | | | | | | | | 1 | 2.2 | | | | | | | | |
| PARENTS (SUBSTITUTE) | 6 | 9.4 | 4 | 28.5 | | | | | 1 | 9.0 | | | | | 5 | 10.8 | 1 | 7.6 | 1 | 5.0 | 1 | 9.0 | 1 | 5.8 |
| OTHER | 3 | 4.7 | | | | | | | | | 1 | 16.6 | 1 | 14.3 | 2 | 4.3 | 1 | 7.6 | 1 | 5.0 | | | 1 | 5.8 |
| NOT APPLICABLE | 99 | | 21 | | 15 | | 6 | | 16 | | 14 | | 14 | | 86 | | 9 | | 99 | | 14 | | 14 | |
| UNKNOWN | 13 | 20.3 | | | 1 | 20.0 | | | 1 | 9.0 | 1 | 16.6 | 5 | 71.5 | 8 | 17.4 | 2 | 15.2 | 6 | 30.0 | 1 | 9.0 | 5 | 29.8 |
| | 163 | 100.0 | 35 | 99.8 | 20 | 100.0 | 9 | 100.0 | 27 | 99.8 | 20 | 99.8 | 21 | 99.9 | 132 | 99.8 | 22 | 99.6 | 69 | 100.0 | 25 | 99.8 | 31 | 98.6 |

TABLE XXXII : DISCHARGE TO WHOM

| FORM | OVERALL DATA | | MAJOR AGENCY DATA | | | | | | | | | | | | | | MINOR AGENCY DATA | | LONG TRIP SHORT TRIP DATA | | | | FIRST REFERRAL | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | S.M.H. | | W.P.I. | | W.G.H. | | W.C.H. | | C.A.S. WPG. | | C.G.C. | | TOTALS | | | | LONG TRIP | | SHORT TRIP | | | |
| | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % |
| (a) LABEL | 11 | 17.2 | 2 | 14.4 | 3 | 60.0 | 1 | 33.3 | 5 | 18.4 | 1 | 16.6 | | | 9 | 19.9 | 1 | 7.6 | 3 | 15.0 | 2 | 15.3 | 4 | 23.5 |
| (b) CAUSE | | | | | | | | | | | | | | | | | | | | | | | | |
| (c) SYMPTOM | 5 | 7.8 | 1 | 7.2 | | | | | | | 2 | 33.2 | 1 | 14.3 | 4 | 8.7 | 1 | 7.6 | 1 | 5.0 | 3 | 23.1 | 3 | 17.7 |
| (d) COMPARISON | 15 | 23.4 | 9 | 64.4 | | | | | 3 | 27.6 | | | | | 12 | 26.1 | 3 | 23.0 | 3 | 15.0 | 4 | 30.8 | 1 | 5.9 |
| (e) OTHER | 2 | 3.1 | | | | | | | 1 | 9.2 | | | | | 1 | 2.2 | 1 | 7.6 | | | | | 1 | 5.9 |
| (f) NONE MADE | 3 | 4.7 | | | | | | | | | | | | | | | 3 | 23.0 | 1 | 5.0 | | | 1 | 5.9 |
| (g) a + d | 6 | 9.4 | 1 | 7.2 | 1 | 20.0 | 2 | 66.6 | 2 | 18.4 | | | | | 6 | 13.2 | | | 1 | 5.0 | 2 | 15.3 | | |
| (h) a + c + d | 1 | 1.6 | | | | | | | | | 1 | 16.6 | | | 1 | 2.2 | | | | | | | 1 | 5.9 |
| (x) NOT APPLICABLE | 99 | | 21 | | 15 | | 6 | | 16 | | 14 | | 14 | | 86 | | 9 | | 99 | | 12 | | 14 | |
| (y) UNKNOWN | 21 | 32.8 | 1 | 7.2 | 1 | 20.0 | | | 3 | 27.6 | 2 | 33.2 | 6 | 85.8 | 13 | 28.3 | 4 | 30.4 | 11 | 55.0 | 2 | 15.3 | 6 | 35.3 |
| | 163 | 100.0 | 35 | 100.2 | 20 | 100.0 | 9 | 99.9 | 27 | 100.2 | 20 | 99.6 | 21 | 100.1 | 132 | 100.3 | 22 | 99.2 | 69 | 100.0 | 25 | 99.8 | 31 | 100.1 |

TABLE XXXIII: FORM OF ASSESSMENT AT DISCHARGE

| | OVERALL DATA | | MAJOR AGENCY DATA | | | | | | | | | | | | | | MINOR AGENCY DATA | | LONG TRIP SHORT TRIP DATA | | | | FIRST REFERRAL | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | SMH | | W.P.I. | | W.G.H | | W.C.H | | C.A.S. WPC. | | C.G.C. | | TOTALS | | | | LONG TRIP | | SHORT TRIP | | | |
| ASSESSMENT | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % | # | % |
| (a) SCHIZOPHRENIA | 5 | 8.3 | | | 1 | 20.0 | 1 | 33.3 | 1 | 9.1 | | | | | 3 | 6.5 | 1 | 11.1 | | | 1 | 9.0 | 1 | 6.7 |
| (b) PSYCHOTIC | | | | | | | | | | | | | | | | | | | | | | | | |
| (c) MENTAL DISORDER WITH ORGANIC BASE | 1 | 1.7 | | | | | | | 1 | 9.1 | | | | | 1 | 2.2 | | | | | | | 1 | 6.7 |
| (d) EPILEPSY | | | | | | | | | | | | | | | | | | | | | | | | |
| (e) PERSONALITY DISORDER | 4 | 6.7 | 2 | 14.8 | 1 | 20.0 | | | | | 1 | 16.6 | | | 4 | 8.6 | | | 1 | 5.2 | 1 | 9.0 | 1 | 6.7 |
| (f) BEHAVIOR DISORDER | 3 | 5.0 | 1 | 7.4 | 1 | 20.0 | | | 1 | 9.1 | | | | | 3 | 6.5 | | | 2 | 10.4 | | | 1 | 6.7 |
| (g) THOUGHT DISORDER | | | | | | | | | | | | | | | | | | | | | | | | |
| (h) FAMILY | | | | | | | | | | | | | | | | | | | | | | | | |
| (i) DRUG | | | | | | | | | | | | | | | | | | | | | | | | |
| (j) DESCRIPTION OF BEHAVIOR | 5 | 8.3 | 1 | 7.4 | | | | | | | 2 | 33.3 | 1 | 14.2 | 4 | 8.6 | 1 | 11.1 | 1 | 5.2 | 1 | 9.0 | 3 | 20.0 |
| (k) NO CHANGE | 4 | 6.7 | 2 | 14.8 | | | | | 1 | 9.1 | | | | | 3 | 6.5 | 1 | 11.1 | 2 | 10.4 | 1 | 9.0 | 1 | 6.7 |
| (l) IMPROVED | 11 | 18.3 | 6 | 42.8 | | | | | 2 | 18.1 | | | | | 8 | 17.4 | 2 | 22.2 | 1 | 5.2 | 3 | 27.0 | | |
| (m) CONTROLLED | | | | | | | | | | | | | | | | | | | | | | | | |
| (n) DETERIORATED | | | | | | | | | | | | | | | | | | | | | | | | |
| (o) OTHER | 1 | 1.7 | | | | | | | 1 | 9.1 | | | | | 1 | 2.2 | | | | | | | 1 | 6.7 |
| (p) a + | 3 | 5.0 | | | 1 | 20.0 | 1 | 33.3 | | | 1 | 16.6 | | | 3 | 6.5 | | | | | | | | |
| (q) d + f | | | | | | | | | | | | | | | | | | | | | | | | |
| (r) a + k | 1 | 1.7 | | | | | | | 1 | 9.1 | | | | | 1 | 2.2 | | | 1 | 5.2 | | | | |
| (s) c + m | 1 | 1.7 | | | | | 1 | 33.3 | | | | | | | 1 | 2.2 | | | | | 1 | 9.0 | | |
| (t) c + L | 1 | 1.7 | 1 | 7.4 | | | | | | | | | | | 1 | 2.2 | | | | | 1 | 9.0 | | |
| (X) NOT APPLICABLE | 103 | | 21 | | 15 | | 6 | | 16 | | 14 | | 19 | | 86 | | 13 | | 50 | | 14 | | 16 | |
| (Y) UNKNOWN | 20 | 33.3 | 1 | 7.4 | 1 | 20.0 | | | 2 | 27.2 | 2 | 33.3 | 6 | 85.6 | 13 | 28.6 | 4 | 44.4 | 11 | 57.2 | 2 | 18.0 | 6 | 40.0 |
| | 163 | 100.1 | 35 | 102.2 | 20 | 100.0 | 9 | 99.9 | 27 | 99.9 | 20 | 99.8 | 21 | 99.8 | 132 | 100.2 | 22 | 99.9 | 69 | 98.8 | 25 | 99.0 | 31 | 100.2 |

TABLE XXXIO : ACTUAL ASSESSMENT AT DISCHARGE