A description of family experiences while waiting for services at the Regional Children's Centre.

Heather Lillian Snooks. McKechnie

University of Windsor

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A DESCRIPTION OF FAMILY EXPERIENCES
WHILE WAITING FOR SERVICES
AT THE REGIONAL CHILDREN'S CENTRE

by
Heather Lillian Snooks McKechnie
and
Rhoda Ethel Scott Arseneault

A Thesis submitted to the Faculty of Graduate Studies through the School of Social Work in Partial Fulfillment of the requirements for the Degree of Master of Social Work at The University of Windsor

Windsor, Ontario, Canada 1982
Research Committee

Dr. L. E. Buckley  Chairperson
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Dr. R. M. Daly  Member
ABSTRACT

The purpose of this research study was to examine the experience of waiting for families whose children were on the social work waiting list at the Regional Children's Centre. The review of the literature yielded very little information on this phenomenon as it relates to children's services. Two hypotheses were developed to examine parental perceptions of the experience of waiting and its associations with income, education and the referral person.

A purposive sample (46) was drawn from the population (115) on the social work waiting list as of September, 1981 until March, 1982 at the Regional Children's Centre. Over one-half (65%) of the sample participated in the home interviews for this study.

The researchers designed an interview schedule for the purpose of obtaining descriptive data about the parents, the children, the referral person, the process of seeking help and the experience of waiting for service.

Statistical tests indicated that the participants were typical of the total sample for a number of variables. Findings related to the hypotheses were inconclusive due to small sample size.

Based on the results of this study, recommendations were made for further research and the elimination of the waiting period. Practical suggestions were made for
increasing community awareness of available services and reviewing the referral and intake policies and procedures.
ACKNOWLEDGEMENTS

The researchers wish to express their appreciation to all those who have contributed to this research study. Some persons, in light of their particular contributions, warrant specific mention.

Without the clients of the Regional Children's Centre who took the time to meet with the researchers, this research study would not have been possible. The sharing of their experiences while waiting for services at the Regional Children's Centre provides valuable feedback to the social work profession and the Centre.

The researchers wish to express sincere appreciation to their close, personal friend, Patricia Charétte Fitzpatrick, who offered her nimble fingers to type this thesis.

Finally, the researchers wish to express appreciation to their husbands whose patience and understanding were a source of moral support throughout this research study.
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CHAPTER I

INTRODUCTION

The purpose of the research study was to examine and evaluate the "experience of waiting" and to determine if there were associations that exist between demographic data and the "experience of waiting".

Variables of interest included the characteristics of the parents, the characteristics of the children and their problems, and the characteristics of the waiting time. Of particular interest in the characteristics of the waiting time were the referral source, the parents' awareness of the waiting period, the length of time waited, and involvement with other agencies or supportive people who had been helpful to the family during the waiting period.

An interest in this topic was the result of a number of factors. The social worker's mandate is focused on the promotion of a normal adjustment and prevention of those conditions deemed detrimental or potentially detrimental to the healthy functioning of children and their families.

Both researchers specialized in intervention with children and their families in their M.S.W. programme and both had placements in a children's mental health centre. It was believed that the period of waiting for social work services for children and their families created a stressful experience. It was hoped that this
study would provide information to the Regional Children's Centre, and the Windsor-Essex County Children's Services Division of the Ministry of Community and Social Services, both of whom had expressed interest in the topic. This information would be helpful to address the needs of this client population and the community. The results of this study may be of interest to other children's mental health centres and service providers in Ontario.

An extensive review of the literature was undertaken by both manual and computer search. It was found that there was limited research on the effects of waiting for service from children's mental health centres in Canada or the United States. The contribution of general systems theory, family systems theory, crisis theory, developmental theory, and those social factors affecting child development are presented in Chapter II.

A description of the setting is presented in Chapter III. The historical background and the services available at the Regional Children's Centre are elaborated on to clarify the process of seeking help.

The research design and methodology utilized in this study is outlined in Chapter IV. Sections in this chapter include the study classification, the hypotheses, the population and sample, the method of data collection, and limitations.

Chapter V is the presentation of data and findings which has been divided into five sections. These sections describe the findings in relation to the sample, the
children, community resources, the referral person, and the hypotheses.

Finally, Chapter VI presents the conclusions based on the interpretation of the findings. As well, recommendations are made for further research, and for eliminating the waiting period. Practical suggestions for the elimination of the waiting period address the need to increase community awareness of services for children and their families, and to review the referral and intake policies and procedures at the Regional Children's Centre.
CHAPTER II

REVIEW OF THE LITERATURE

Introduction

In the development of this study, the researchers conducted an extensive review of the literature to clarify the dynamics involved in the process of seeking and receiving help for families and their children from a children's mental health centre.

Theories that were considered relevant to this study are: general systems theory, family systems theory, crisis theory, developmental theory and social factors affecting child development.

General system theory is presented to provide a frame of reference within which the community and its subsystems, specifically, the R.C.C. and the family may be viewed. This perspective highlights the interrelatedness of these subsystems within the suprasystem of society.

Crisis theory is relevant to the examination of the factors which lead people to seek help as well as the identification of variables which influence motivation to change. This theory addresses the need for immediate intervention and the implications of waiting for service.

Developmental theory provides guidelines for normal development in childhood and adolescence. Social factors affecting this development are significant in determining when and if help is sought to resolve the child's difficulties.
General Systems Theory

General systems theory was founded in the 1950's by Ludwig Von Bertalanffy. He was impressed by his observation that similar viewpoints and concepts appeared in very diverse fields. He attempted to co-ordinate these concepts into a unified form to explain how all systems operate.

General systems theory attempts to explore the interactions between systems and its component parts, the subsystems (Von Bertalanffy, 1956). It attempts to describe how a system interacts rather than why a system interacts (Watzlawick, Beavin, & Jackson, 1967).

The general systems approach to knowledge building appears to be particularly well-suited to the profession of social work for several reasons. Hearn (1969, chap.1), suggests it is based on the assumption that matter, in all its forms, living and non-living, can be regarded as systems and that systems, as systems, have certain properties that are capable of being studied. Polsky (1969, chap.3), sees social work as a system that exists to assist in the mediation and reconciliation of the conflicting demands and functions of the work and family systems.

He goes on to say:

There is often a conflict and impasse in what this system tries to serve for the larger supersystem (society) in which it is embedded while meeting the human needs of its members. And both systems may create debilitating stress for the individual. Social work helps the individual to counteract the debilitating influences of the family and work systems and to mediate the conflict between them (Polsky, 1969, p.14).
William Gordon (1969), after noting social work's dual concern for human systems and their environments, claims that the "central concern of social work technology is, therefore, the matching of people's coping patterns with the qualities of the impinging environment for the purpose of producing growth inducing and environment ameliorating transactions" (p.10). Thus to the extent that social workers may work with either the system or its environment, it is always for the purpose of producing a matching of the two. Elsewhere, it has been suggested that one of the problems that systems encounter in their external relations is the development of communication between internal and external relations (Lippitt, 1958).

It follows that Gordon (1969), would see the goals of social work as twofold - the growth and development of the human system and the development of an environment capable of sustaining the growth and development of systems dependent upon it.

General systems theory provides a framework for the examination of the Regional Children's Centre as a subsystem within the larger system of the community and its network of helping systems. As well, it may be viewed as a system itself, in which families, children and the professionals providing services are viewed as subsystems.

The community as a social system achieves stability when all of its component groups are in equilibrium. Stress occurs at times of change, and the need for reduction of stress leads to new adaptations. If symptoms of
disequilibrium persist, discomfort develops within the system, requiring interventions to restore normal growth patterns and the resolution of tensions.

In the community of Essex County, tensions dramatically increased when service providers realized that the amalgamation of funding for children's services may drastically affect their budgets and services. In 1979, The Needs Assessment Task Force for Windsor and Essex County was established by the Children's Services Division of the Ministry of Community and Social Services for the purpose of identifying the needs of the community and the extent to which those needs were being met by existing services.

One of the findings of their report, specifically, the length of wait for social work services at the Regional Children's Centre was a key factor that was instrumental in the development of this research thesis.

The readiness of the system to change has to do with pressures generated from without or from within. Helping systems per se deal with dysfunctional individuals, clients who are not able to cope with important areas of societal life. When providing services to children, it is important to remember that, in general, it is their parents or other significant adults in their life who determine whether or not a problem exists. This means, that, in the beginning, the helping system has the responsibility to protect and support such clients. But it later becomes important for the system to change as the clients gather strength and independence and become better-functioning individuals. A
balance is struck whereby individuals change as a result of the system's changing its rules, procedures, policies and structure.

An agency embodies a society's decision to protect its members against social breakdowns, to prevent their maladjustments, and to promote the development of higher levels of human functioning (Perlman, 1957).

Perlman (1957), has eloquently summarized the important variables affecting services from an agency in the community.

The social agency is established out of the community's concern to meet certain needs in people's living. Its form, its setup, its workaday philosophy, and the way it does its work are all for the purpose of meeting those needs for the greatest number with the greatest efficacy. Thus, the test of policy and procedure is in the serviceability to the agency's clients.

The social agency's relationship to other social agencies within the community affects the scope and nature of its work. The help it gives is dependent upon other basic supplementary services in the community; its single or multi-functional nature is determined by the absence or presence of other facilities, and its usefulness is likewise affected thereby. The more the administration and staff are conscious of the agency's purposes and services in relation to those of other community agencies, the greater the likelihood that individual clients as well as the general community will be well served (Perlman, p.48-49).

Thus, it becomes clear that change is an inherent part of the open system. An open system has the quality of exchanging energy between the system and the environment.

"In other words open systems manifest a great deal of two-directional traffic with the larger environment" (Kantor and Lehr, 1976, p.11).

The open system has several distinct properties which include wholeness, feedback and equifinality.
The Property of wholeness is when:

Every part of a system is so related to its fellow parts that a change in one part will cause a change in all of them and in the total system. That is, a system behaves not as a simple composite of independent elements but coherently as an inseparable whole (Watzlawick et. al., 1967, p.123).

A second property of the open system is that of feedback (Watzlawick et. al., 1967). Feedback is a process by which a system informs its component parts how to relate to one another and to the external environment in order to facilitate the correct or beneficial execution of certain system functions (Kantor and Lehr, 1975, p.12).

French states systems maintain their integrity through the use of feedback loops-arrangements of components that serve to move information from consequences to decision-maker, thus permitting the organism to correct deviations and stay on course (1977, p.20).

Another property of open systems is that of equifinality. This concept delineates when certain conditions of a system can be achieved through different means, that is, they are not determined by their original states.

Simply stated this principle of equifinality means that the same results may spring from different origins, because it is the nature of the organization which is determinate (Watzlawick et. al., 1967, p.127).

The network of social systems within the regional Children's Centre should acknowledge and engage all its subsystems, including the family, in order to meet the changing needs of their client population.

Family Systems Theory

Family systems theory developed out of a number of disciplines such as psychiatry, psychology, anthropology,
sociology, and social work. Contributions were made from the following theoretical bases: communications theory, social role theory, systems theory, and others.

Writers such as Bateson (1951), Fleck and Cornelison (1965), Haley (1971), Lidz (1965), and Wynne (1961) researched the families of schizophrenics and were able to delineate a pattern of family interaction which led to viewing the family as a system. Satir (1967) is credited with developing a theory of family process. The family became the focus of treatment, particularly when an emotionally disturbed child was the identified patient.

This reflected a major shift from the widespread previous belief that children's behaviour problems originated in underlying mental conflict states such as insecurity, unresolved oedipal conflicts or repressed hostility which resulted in a wide variety of symptoms (A. Freud, 1946). Therapy was undertaken by trained psychotherapists who usually treated the child for intrapsychic disturbances and parents and teachers played a minimal part in the child's therapy (A. Freud, 1946).

Family therapy has two major theoretical assumptions:

1. The family is a system, hence defined as two or more units relating to each other in such a way that if there is a change in one it affects the other and the reaction of the second in turn affects the first.


Minuchin states:

The individual who lives within the family is a member of a social system to which he must adapt.
His actions are governed by the characteristics of the system, and these characteristics include the effects of his own past actions. The individual responds to stresses in other parts of the system, to which he adapts; and he may contribute significantly to stressing other members of the system. The individual can be approached as a subsystem, or part of the system but the whole must be taken into account (1974, p.9).

In communications theory, the family is viewed as a rule-governed system with divisions of power and labour. Members behave among themselves in an organized, repetitive manner aimed toward maintaining family homeostasis. Family rules can be determined by the patterns of interaction and communication (Jackson, 1977; Kantor and Lehr, 1976). Rules develop over time to establish a pattern. Homeostasis describes the stabilization of these rules.

Satir (1967) writes:

The marital relationship is the axis around which all other family relationships are formed. The mates are the 'architects' of the family. A pained marital relationship tends to produce dysfunctional parenting (p.1-2).

Thus, it is suggested that the marital relationship directly shapes the character of family homeostasis which Satir (1967) elaborates further.

According to the concept of family homeostasis, the family acts so as to achieve a balance in relationships. Members help to maintain this balance overtly and covertly. The family's repetitious, circular, predictable communication patterns reveal this balance. When the family homeostasis is precarious, members exert much effort to maintain it (p.1).

From a family systems perspective, the child is viewed as the product of a dysfunctional relationship within the family unit (Vogel, 1960).
The Identified Patient is the family member who is most obviously affected by the pained parental relationship and most subjected to dysfunctional parenting.

a. His symptoms are an 'S.O.S.' about his parents' pain.
b. His symptoms are a message that he is distorting his own growth to absorb and alleviate his parents' pain (Satir, 1967, p.2).

Stachowiak writes:

In this instance, the child's symptoms are considered to be the result or the product of a disturbance in intrafamilial relationships and interactions, rather than the product of intrapsychic conflicts. Conflicts within the individual child, then, are viewed as being the end results rather than the causes of a disturbance (1968, p.123).

Watzlawick (1970) indicates that in larger families, the identified patient is more likely to be a middle child rather than the oldest or youngest. Scapegoating, in general is minimal when the identified patient is the youngest child. Also, smaller families tend to use scapegoats less than do medium or larger size families.

The function of the scapegoat is to maintain family solidarity. Vogel and Bell (1968) found that: "By focusing on one particular child, the families were able to encapsulate problems and anxieties which could potentially disrupt various family processes" (p.425).

They also found that:

Once a child was selected as a deviant, there was a circular reaction which tended to perpetuate this role assignment. Once he had responded to his parents' implicit wishes and acted in a somewhat disturbed manner, the parents could treat him as if he really were a problem (Vogel and Bell, 1968, p.422).

Vogel and Bell list several reasons why a specific child in a family is chosen to be a scapegoat. They include:
the child's position in the sibling group; certain physical or intellectual characteristics; sex; and the value orientation conflict between parents (1968, p.416).

The Menninger Clinic (1969) suggests that the factors leading up to a referral for residential treatment may relate to the entire family, especially the parents. "They (the parents) may suspect that it is they who need psychiatric help but come to get help for the child since he is the focal point of disturbance; he absorbs and reflects the conflicts in themselves" (p.24).

The contention that 'a woman's place is in the home' derived from the conviction that the family was the fundamental social unit and woman its centre. Although there has been a shift in these values, women remain the barometers of family tensions and anxieties. It should surprise no one that it is women, rather than men, who most often seek therapy for themselves, their marriages and their children (Gluck, 1980, p.296).

However, parents do not usually seek help with problems as long as they are able to cope on their own. Bell (1962) suggests that the nature of extended family relations may influence the family's ability to cope with a problem. Bonnefil (1979) writes that only when the family's own coping breaks down, when they are in a crisis themselves, do they seek help. They may feel unable to request help for themselves so they request help for their child.

The decision of parents to seek help when a child is psychologically troubled is influenced by such factors as:
- the degree of organization or disorganization of the family
- their sophistication about psychological problems
- their readiness to turn to an outside resource for help
- the nature and extent of the child's dysfunction
- the emotional pain experienced by the parents
- the degree of consensus between them that professional help is needed.
- the availability of appropriate resources (Fleck, 1972).

Again, it must be emphasized that a child's disorder may be both an expression of his own difficulties and a function of the family's disorder (Janzen, 1980).

Therefore, every helping person must realize that almost every parent will come to the decision to seek help only after some degree of struggle and pain. Such acknowledgment is inevitably accompanied by guilt, shame, helplessness, bewilderment and anger. For some, these feelings are so powerful as to be intolerable (Larson, 1977). They must be denied or extruded, often through the mechanism of seeking some external source to blame (Cooper and Wanerman, 1977; Weinstein, 1974).

The goal of treatment is to increase the understanding of all participants: adults, child and professionals. This means examining what is wrong, why and what can be done. More important than the realities is an empathic understanding of the clients' human struggles, concern for their pain and the offer of hope for the future (Lieberman, 1979). This hope must be in tune with the clients' hope because understanding is only achieved with their collaboration. When children are the focus of concern, an understanding of the child's world including everyone in it is essential.
Crisis Theory

Crisis theory represents a synthesis of a wide spectrum of concepts, empirical observations and clinical insights drawn from the behavioral and social sciences as well as from several practice fields (Parad, 1965).

Crisis theory, insofar as it requires an understanding of the individual, needs to be anchored in personality theory. Psychoanalytic theory, first as it developed as a theory of the neuroses and in its later evolution into a theory of personality with its explication of personality, structure and development of psychopathology, seems still to serve as a most useful base because of the comprehensiveness of the phenomena described. Of particular relevance is the developmental psychology of Erikson with its explication of biopsychosocial maturational stages and potential for crisis and the relevant psychosocial tasks required for subsequent maturation and growth (Erikson, 1953). All developments in ego psychology are of great significance in crisis theory. Ego psychology has moved from an explication of the dynamics of defense mechanisms to questions of synthesis, adaptation and coping (A. Freud, 1946; Hartman, 1958). The ego, viewed as either endowed with neutralized energy or endowed with intrinsic energies of its own as an autonomous force and its complex functions directed to adaptation, coping and mastery, becomes a pivotal concept in dealing with the important issue of effectiveness (White, 1963).

Stress theory contributes fundamental concepts to...
crisis theory, and indeed, the terms are often used interchangeably in some of the literature (Lazarus, 1966). The term "stress" has its origins in engineering, where its consequences are conceptualized as "strain". The concept has been adapted in physiological research, where the homeostatic model is a central concept (Selye, 1956). It has been further adapted for use in the psychological realm, where a "steady-state condition" is posited but can be less readily specified and accepted (Bower, 1964).

Other relevant and enriching sources for crisis theory are learning theories concerned with cognitive processes of functioning such as the developmental work of Piaget.

A crisis may be defined as "an upset in a steady state" (Rapoport, 1970, p.276). Three interrelated factors produce a state of crisis:

- one or a series of hazardous events which pose some threat
- a threat to current or past instinctual needs are symbolically linked to earlier threats that result in vulnerability or conflict
- an inability to respond with adequate coping mechanisms (Rapoport, 1970, p.277).

A hazardous event can be experienced by the individual as either a threat, a loss or a challenge. Each of these three states has a major characteristic affect. Threat carries with it high anxiety. Loss is experienced with affect of depression or mourning. Challenge is accompanied by some anxiety but carries with it an important ingredient of hope, release of energy for problem-solving and expectation of mastery (Rapoport, 1970).

Certain basic assumptions of crisis theory which
influence the nature of the initial interview need to be made explicit.

A state of crisis is conceptualized as a time-limited process during which there is a peak in the state of the upset. Caplan (1964), suggests this state lasts up to six weeks. The natural history of the crisis, with its built-in time limits, requires that intervention take place during this period if one wishes to influence the outcome briefly or economically. It has also been noted that the person or family in crisis is more susceptible to the influence of "significant others in the environment" (Bell, 1962). Moreover, the degree of activity of the helping person does not need to be high. A little help, rationally directed and purposefully focused at a strategic time, is more effective than more extensive help given at a period of less accessibility (Golan, 1969; Rapoport, 1970).

The principle that emerges is that in order to help people in a state of crisis, clients must have rapid and ready access to helping persons. "This then requires a structure in agencies and services that can meet requests for help within a few days, or at the most a week, from the time of request" (Rapoport, 1970, p.287). It presupposes open intake and no waiting list (Hall and Dick, 1970).

Lydia Rapoport identifies five basic needs of clients as:

- rapid and ready access to helping persons within a week from time of request
- continuity in contact with a worker, with no separation of application interviews from treatment
- considerable reduction in disabling tension and anxiety
- the acquisition of hope of improvement in his situation

The absence of hope, or hopelessness, was noted as characterizing individuals and families suffering from chronic deprivation which operated as a barrier to motivation and change (Frank, 1968; Malan, 1963; Wiltse, 1958). Redl and Wineman (1951, 1952) present an excellent analysis of the anti-social behaviour of children suffering deprivation in their lives. Many studies have examined the vicissitudes of family life under the impact of crisis (Hill, 1965).

Rapoport (1970) suggests the use of time and time limits by allowing the client to set the frequency of the encounter. This provides a means of strengthening the client's sense of autonomy and enhances hope for improvement in their life situation which complements social work values. Kaplan (1962) believes that people are more open to change because defenses are weakened, therefore, they are more receptive to help.

Crisis theory explicitly refrains from defining the state of crisis with an illness. Indeed, the crisis state, in contrast to the concept of stress, is viewed as having a growth-promoting potential if favourable factors are operating.

Crisis oriented brief treatment does not lend itself to the task of selected history taking largely because of the crucial factors of time and the need to intervene
quickly. Here, there is a strong case for the experienced and skilled clinician who can generate and test hypotheses quickly on the basis of sound theoretical knowledge and practice.

What facilitates acceptance of limited goals is increasing evidence that even minor modifications in functioning, values or attitudes may serve as a nucleus for other more profound transformations in the environment, in interpersonal relations and even in intrapsychic functioning (Bandler, 1965).

Brief treatment has the potency to do more than restore functioning. It can produce profound changes in personality by facilitating some rapid reorganization of psychic structure and energy. This is most likely to happen at times of maturational crisis, such as at adolescence, when the personality is in a greater state of flux.

Previous studies on waiting lists and children's mental health centres lend support to the efficacy of brief treatment in alleviating some problems associated with waiting for service. Other variables that are considered to be significantly associated with this phenomenon are presented.

Jaines (1975), conducted a study of the variables related to client defection by studying families who failed to keep the initial evaluation appointments in a child guidance clinic. He reports that previous studies have shown that lower socioeconomic clients have higher
rates of defection and premature termination of treatment. From Gaines' study, defection was most closely related to clients being motivated for treatment, rather than to socioeconomic status or to length of the waiting time.

The waiting list is often viewed as a device which allows a staff of limited size to decrease the influx of patients seeking help at a mental health centre. Some "dropouts" from the "list" find help elsewhere, others find treatment unnecessary when stresses are removed (Heyder, 1965).

Waiting lists are usually defended on the grounds of personnel shortage and budgetary limitations as well as there may be prestige attached to showing an excessive demand for service.

Heyder (1965), makes suggestions to reduce the waiting list which include more short-term therapy, with the focus on present conflict, an emphasis on the treatment of acute pathology as opposed to chronic and expansion in the use of related services.

Robin (1976), defends the waiting list as a useful screening mechanism which relieves the psychiatric department of ten percent of new referrals. In this study, it was found that sixty-six percent of those clients offered immediate appointments attended, while only fifty-three percent of those offered delayed appointments attended. It was also found that those who attended the first appointment attended more regularly than those who missed the first appointment.
Overbeck (1977), explored the antecedents to application for help at a mental health centre. Stress, adaptation, support and help-seeking were the major organizing variables.

The findings indicated that the subjects under study were experiencing high stress in the three year period prior to application at the mental health centre.

Simon (1967), posits that the characteristics of a case exercise the most important influence on intake decisions about which cases will be seen first. These characteristics relate to the length of time people have waited and to the degree of distress in the situation. The characteristics of the referring agent including occupation, reputation, status, influence and power, and forcefulness were also influential in intake decisions.

A new system of intake was tried at a children's centre as a means of overcoming the problems of waiting and dropout (Plante and Meloche, 1977). Each patient was seen almost immediately but very briefly. In fifteen to twenty percent of the cases, people were helped to find a solution and no further service was needed. For those non-shows, one or two families were kept on standby to fill in.

It seems appropriate at this juncture to examine the stages of development that the children in the study conducted by the researchers were passing through.

Child Development

The population of children in this study includes
the wide age span of 3 to 15 years of age, with the greatest concentration in the latency period, ages 7-11. This age span may be broken down into smaller groupings based on the age-appropriate tasks and responsibilities associated with the different developmental levels.

There are numerous theories of child and personality development. Erikson and Piaget offer useful frames of reference within which to view the emotional and cognitive development of the child. As with many other theorists, they have been influenced by Freud, and his psychoanalytic theory of development (Freud, 1910).

Freud saw man's development arising from a number of biological dilemmas or events that faced him from birth. He assumed an idealized adult psychological state and he viewed the child as passing through a number of stages in approaching that state. First is the oral period (0-2yrs.), during which satisfactions centre around sucking, putting things in the mouth, and later biting and chewing. Next is the anal period (2-4yrs.), during which bowel control is achieved and the focus of pleasure is the eliminative processes.

In the phallic-Oedipal stage, roughly between the third and the fifth year, signs of sexuality appear in the form of genital manipulation and exploration. There is a strong attraction for the parent of the opposite sex, with jealousy toward the same-sexed parent. Successful resolution of the Oedipal conflict involves giving up the fantasy of possessing the other sex parent and developing
an identification with the same-sex parent (Fraiberg, 1959).

The next phase, latency (7-11yrs.) is one in which sexual energies and conflicts lie dormant. Following upon latency, adolescence or the genital period sees the reawakening of the Oedipal conflict. The resolution of the conflict at this stage is to transfer the now more intense feelings to a member of the opposite sex among one's peers. The individual ultimately becomes emotionally emancipated from parents and achieves adult sexuality.

Freudian theory suggests that the individual's ability to adjust in later life is determined largely by his early childhood experiences. The individual must successfully complete one phase of development before moving on to the next phase without carrying a psychological deficit. Failure to do so means that one retains as predominate features, the characteristics of personality structure associated with that period of development.

Freudian theory makes much of the conflicts that develop around the sexual experience of the individual. It was developed at a time when middle class European society vigorously repressed sexuality. Subsequent theorists moved beyond Freud's concept of biological determinism in the study of human development. Greater emphasis was placed on "the role of the environment and social interaction in personality development" (Ruch, 1967, p.121).

Erik Erikson (1963) was heavily influenced by psychoanalytic theory, but he substituted eight psychosocial stages for Freud's five psychosexual ones. He
perceived human development in terms of the life tasks confronting the individual and the relationship with others with whom he is associated in carrying out the life task. The eight stages are presented as having chronological order, beginning with trust vs. basic mistrust in infancy, and extending into late adulthood. At each stage of life an individual's development is affected by those with whom one is involved.

Erikson states the main focus of development for the school-age child is the resolution of the industry vs. inferiority dilemma. He states that the child faces the potential to realize his sense of industry or worthiness in the things he does.

He now learns to win recognition by producing things.....He develops a sense of industry..... He can become an eager unit of a productive situation. To bring a productive situation to completion is an aim which gradually supersedes the whims and wishes of play (Erikson, 1963, p.259).

On the other side of this dilemma is the sense of inferiority. If the child is not able to achieve a sense of industry, he will feel inferior which may greatly affect his personality development.

The child's danger, at this stage, lies in a sense of inadequacy and inferiority. If he despairs of his tools and skills or of his status among his tool partners, he may be discouraged from identification with them...........(Erikson, 1963, p.260).

Erikson states that adolescents face an identity vs. role confusion crisis.

The sense of ego identity, then, is the accrued confidence that the inner sameness and continuity prepared in the past are matched by the sameness and continuity of one's meaning for others, as

The essential work of adolescence is the establishment of an identity in relation to occupation and sexual intimacy. The adolescent does this through a process of reintegration and reorganization of thoughts and feelings so that one might move from childhood dependency to adult responsibility.

Erikson viewed the various stages in human development not as separate events but as repetitive patterns carried throughout life. Successfully meeting one crisis builds strength for the next one, but every individual retains some of the negative aspects of early crises as a residue of immaturity.

Piaget was a developmental theorist who studied and described the stages the child passes through in approaching the end state of adult thought processes.

Mental growth for Piaget is the resolution of the tension between assimilation and accommodation – the conflict between using old responses for new situations and acquiring new (or changing old) responses to fit new growth. Intellectual growth is adaptation to new situations (Mussen, Conger, & Kagan, 1969, p.450).

According to Piaget, there are four major stages or periods of cognitive development: The sensorimotor stage (0-18 months of age), the preoperational stage (18 months – 7 years of age), the stage of concrete operations (7-12 years of age) and finally, the stage of formal operations (age 12 onward).

The ability to treat objects as symbolic of things other than themselves is an essential characteristic of
the preoperational stage. The preoperational child has difficulty taking the point of view of another child or adult. He cannot anticipate how an object will look different from the point of view of another person or realize that a scene he sees may look different in the eyes of another. Piaget regards the preoperational child as egocentric in his perspective. Although the 3-year-old is symbolic, his words and images are not necessarily organized into firmly articulated concepts and rules (Piaget, 1952, p.407-419). That process happens during the next stage of concrete operations.

There are several important differences between the preoperational child and a child in the stage of concrete operations. The child of 7 has acquired an important set of rules that he did not possess a year or two earlier. He believes that length, mass, weight and number remain constant despite superficial modification in their external appearance. He is able to produce a mental image of a series of actions and realizes that relational concepts such as darker or heavier do not necessarily refer to absolute qualities, but to a relation between two or more objects. Finally, he can reason about the whole and its parts simultaneously and can order objects on a dimension of quantity (such as size or height). In short, he has learned some central rules to aid his adaptation to his environment (Ginsburg & Opper, 1969; Inhelder & Piaget, 1958).

There are several important attributes of formal
operational thinking that differentiates it from the previous stage. First, the adolescent is capable of considering all the possible ways a particular problem might be solved and the possible forms a particular variable might assume. Second, the adolescent's thought is self-consciously deductive. The adolescent can think in terms of hypothetical propositions that may be fanciful and not fit reality. Third, the adolescent organizes his operations into higher order operations, by using abstract rules to solve a whole class of problems.

Thus, formal thought is basically a generalized orientation toward problem-solving. Formal thought is rational and systematic. The adolescent seems to reflect upon the rules one possesses, and is aware of one's own thoughts and knowledge. During adolescence, the child begins to think about one's self, one's role in life, one's plans, and the validity and integrity of one's beliefs (Inhelder & Piaget, 1958, p.334-350).

It is clear that the child has many developmental tasks which he must master as an individual and as a functioning member of a family and of society as a whole. A disturbance in the family system will result in making developmental tasks difficult for a child to carry out (Satir, 1967). The assessment of childhood disorders requires an examination of the child's developmental history and individual characteristics, the family structure and composition, and the broader socio-economic context, including school and peers.
Social Factors Affecting Child Development

Numerous studies have attested to the fact that most children show isolated psychological problems at one time or another and that many have transient periods of emotional disturbance or behavioural difficulties (Rutter, Tizard, & Whitmore, 1970; Shepherd, Oppenheim & Mitchell, 1971). Some of these difficulties or disturbances may be viewed as a normal part of growing up and are often associated with predictable crises in the biological development of the child and the acquisition of new life skills. To a considerable extent, psychological development is dependent on physical growth and maturation, as well as on life experiences. "Interference with critical periods in human development can have wide effects on later development" (Nash, 1970, p.145).

Bowlby (1951) studied children who, through hospitalization or placement in orphanages, had been deprived of normal parental relationships in the early years of life. He determined that the period between about 6 months and 3 years of age is a critical one in the formation of social relationships. Children deprived of parental affection during this time often show very intense emotional reactions. They may become incapable of normal affectional relationships with others and their social behaviour may remain abnormal. Delinquency and other behavioural disorders are also related to infantile deprivation (Spitz, 1950).

Other variables related to the presence of emotional disturbance in children include those of age, sex and
birth order, as well as family size, structure, and composition.

The majority of children referred to mental health centres or child guidance clinics are school-aged. This coincides with the demands of school, higher visibility in the community, and movement away from parents. Lurie (1974) notes that many parents minimize the seriousness of the emotional problems of pre-school aged children. When children grow older and their disturbed behaviour becomes more public, however, pressure mounts for parents to seek help.

Most disorders in children are much more prevalent in boys than girls, and boys are referred for help in a ratio of three to one to girls (Rutter, 1975). Boys are also more likely to be referred for aggressive, acting-out types of behaviour or conduct disorders. Rutter (1975) refers to conduct disorders as abnormal behaviour which gives rise to social disapproval; these may be delinquent behaviours or non-delinquent behaviours such as lying, fighting, bullying, or destructiveness. Jenkins (1968) noted that conduct disorders tend to occur more often in children of large families, particularly in those characterized by parental neglect and delegation of parental responsibilities.

"There is a slight but consistent tendency for the eldest child to have a greater likelihood of developing an emotional disorder" (Rutter, 1975, p.184). Schachter (1959) also found that first-borns are more dependent than
later born and have a greater need to affiliate with others when in stress. On the other hand, studies have also shown that firstborn children are more intelligent than those born later (Chopra, 1966; Warren, 1966) and are more often noted for their achievements.

Jenkins (1968) found that overanxious children tend to be the youngest in the family, and are likely to have an anxious, infantilizing mother. Socially delinquent and unsocialized aggressive children are found more often in one-parent families.

Gregory (1965) found delinquency among boys to be closely related to the loss of the father. The highest rate of delinquency was among those boys of divorced parents, especially when the boy was living with the mother alone. He suggests that the loss of the father is more significant, in the origins of delinquency, than the loss of the mother.

However, the absence of one parent in the home results in adverse factors which go beyond the loss of a father figure. "These adverse factors concern both the circumstances which lead to there being only one parent and also the circumstances which follow such a situation" (Kutter, 1975, p.172). It has been found that single-parent families have a lower income than do two-parent families. Lurie (1974) found that income was an overriding factor in families with emotionally impaired children. Single parents lack the emotional, social, and material support usually provided by the spouse and may turn more readily to outside
resources for help when things go wrong. Parents of children in economically deprived families look for amelioration in their life situation and resolution of their own problems as a way of resolving the child's problems. They may turn to a variety of social agencies for help prior to any referral to a mental health centre. Higher economic status parents more often reveal feelings of guilt which lead them to seek help for their children.

Families are most likely to turn to their family doctor first for assistance, so that this relationship is important in determining a successful outcome to the referral and follow-through processes. If the referral source is familiar with available resources, takes adequate time to prepare the family, and conveys accurate and high expectations for service, families are then more likely to follow through with evaluation and treatment (Caines, 1978; Plante & Meloche, 1977).

Conclusion

As a result of the survey of the literature, the researchers were concerned with examining those factors associated with the process of seeking help at a children's mental health centre. The parent(s)' expectations and feelings about waiting for service were considered important as well and led to the formulation of the hypotheses.

Previous studies (Lurie, 1974) have indicated that lower socioeconomic status families wait longer before seeking help from a children's mental health centre but
are more likely to seek help from other social agencies in the community. Thus, the researchers were interested in determining if there existed a relationship between parent(s)' income and education and their experience of waiting. The experience of waiting was defined by the researchers as comprised of the following variables: involvement with other agencies before or after the referral to R.C.C., the existence of supportive people during the waiting period, and feelings about waiting. Income was defined as the family’s combined annual income while level of education was defined as the last year of education completed by the mother. The first hypothesis is thus stated:

Hypothesis 1: Parent(s)' experience of waiting will be significantly associated with education and income.

The importance of the referral person in expectations of service has been noted by a number of researchers (Gaines, 1978; Plante & Meloche, 1977; Simon, 1967).

It was necessary to determine whether the referral person advised parents of the waiting period, how long parents expected to wait, and how parents felt about waiting.

The second hypothesis is thus stated:

Hypothesis 2: Parent(s)' expectations of the waiting period will be significantly associated with the referral person.
CHAPTER III

DESCRIPTION OF THE SETTING

The regional Children's Centre expressed interest in research examining the experiences of families on their waiting lists. Permission was granted to conduct this study utilizing the outpatient social work waiting list (Appendix A).

A recent study, the Needs Assessment Task Force report, July, 1981, published information concerning the critical state of waiting lists in Essex County for the following eight local agencies:

- Big Brothers of Windsor-Essex County
- Big Sister Association of Greater Windsor
- Catholic Family Service Bureau
- The Child's Place
- Glengarda School for Exceptional Children
- Regional Children's Centre
- Remedial Speech Clinic
- Windsor Association for the Mentally Retarded

In November, 1980, there were a total of 610 children on the waiting lists of these agencies. There were two duplications in the waiting lists, in that two of the children were awaiting services from two of the agencies.

Of the 610 children on the waiting lists at the eight surveyed agencies, 336 (55%) were receiving services from other organizations while on the waiting lists and 50 (8%) were not receiving any services. The status of the 224 remaining children (37%) was unknown to the agencies who had placed the children on their waiting lists (Windsor-Essex County Children's Service Committee, 1981, p.65).

The eight agencies had waiting lists of 100 days or over for children with behavioural/emotional difficulties as the identified problem area. The lengthiest waiting
periods were for children on the waiting lists for outpatient psychology services (an average wait of 380 days) and for outpatient social work services (an average wait of 364 days) at the Regional Children's Centre (W.E.C.C.S.C., 1981, p.73). For children experiencing family problems, the average waiting time for outpatient social work services at Regional Children's Centre was 303 days (W.E.C.C.S.C., 1981, p.77).

**Historical Background of the Regional Children's Centre**

The Regional Children's Centre was opened in November of 1970 under the Children's Mental Hospital Act 1970, and operates as a department of Windsor Western Hospital Centre. The Ontario government assumes full costs for children receiving services from Children's Mental Health Centres in Ontario through the Children's Mental Health Act, proclaimed in 1971. Presently there are 65 Children's Mental Health Centres in Ontario.

The Regional Children's Centre (hereafter R.C.C.) was funded by the Ministry of Health until July 1977 when funding was transferred to the Ministry of Community and Social Services. The Ministry allocates the budget for the R.C.C. through the Children's Services Division. This particular division was formed through the Children's Services Transfer Act 1977, and was an amalgamation of service providers to children formerly under the auspices of the Ministries of Health, Corrections, Community and Social Services, and the Attorney General. The original purpose of this amalgamation was to coordinate better
services for children by ensuring that there would not be duplications of service and that previous gaps in service would be filled.

The R.C.C. is bound by the Children's Mental Health Services Act 1978, as well as the Children's Residential Services Act 1978. It is licenced annually by the Children's Services Division of the Ministry of Community and Social Services, but is considered a department of Windsor Western Hospital Centre and is governed by the policies and by-laws of the hospital. The budget for the Centre is directly administered by the hospital as well.

The chief social worker of Windsor Western Hospital Centre maintains ultimate responsibility for the hiring of staff in the Social Work Department of R.C.C., but he does so in consultation with the social work supervisor in the Centre. Dr. J.W. Johnson, psychiatrist, acts as Executive Director of the R.C.C.

**Services and Programmes**

The R.C.C. is a diagnostic centre for emotionally disturbed children, for mentally retarded children and for children with organic, learning, and speech disabilities. It offers treatment services for children and their families, as well as consultation to other resources in the community. It serves as a secondary resource for the counties of Essex and Kent (as well as areas of Lambton County), and accepts referrals from physicians, Boards of Education and Social agencies.

Services provided at the R.C.C. include: Neuro-
psychological services, children's psychiatric services, psychological services, social work services, speech therapy, occupational therapy, child care services, recreation therapy, special education services, nursing services, and paediatric consultations (Regional Children's Centre Social Work Policy and Procedure Manual, 1982, p.4).

Programmes provided at the Centre are offered on an outpatient, day care or residential basis. The outpatient programme serves children from birth through age 17, while the residential programme serves boys from ages 6 to 17, and girls from ages 6 to 12. The day care programme serves children from ages 6 to 12.

There is a brochure available describing the existing services and programmes within the R.C.C. but the brochure is not routinely dispensed to the public (R.C.C., 1981).

Referral Process

All referrals for service are directed to the Intake Officer via the R.C.C. Referral Form (Appendix B) which delineates the presenting problems of the child referred. A Covering Letter (Appendix C) along with an Applicant Information Form (Appendix D) and a Release of Information Form (Appendix E) are then sent to the child's parent(s) or guardian(s). A School Report Form (Appendix F) is also sent to the school which the child attends. When these forms are returned to the Intake Officer, the compiled information is brought to the Intake Committee, Tier I, for assignment to specific departments or for
re-direction to the community.

On May 1, 1980, the Intake Committee was divided into two tiers. The Tier I level of Intake screens all referrals from the community, screens all referrals between programs, and assigns those referrals requiring a psychiatric assessment on a priority basis. All referrals not redirected to the community or not assigned to either Psychiatry or the Day Care program are directed to the Tier II level of Intake. The Tier II level of Intake is chaired by the Director of Outpatient Services in the Director's absence. Tier II is a multi-disciplinary outpatient service committee which assigns referrals to specific disciplines for assessment and/or treatment. The primary role of both committees is to ensure that the most appropriate services are made available to the client as soon as possible. Sometimes these services are sought from community resources rather than from the Regional Children's Centre (Social Work Policy and Procedure Manual, 1982, p.22).

A Notice of Assignment (Appendix G) to a specific department, and of the approximate length of wait, is sent to the referral source and a copy is sent to the parent(s) or guardian(s). At this point in the referral process, the child and family have not been seen at the Centre, unless the referral is an internal one from the system of services within the R.C.C. (Appendix H).

Social Work Services

The Criteria for Referral to the Outpatient Social Work Department includes any child or any family, with no evidence of psychosis, who is presenting problems in the area of:

1) interpersonal relationships,
2) conflict with community
3) understanding or expressing emotions (Appendix I)

Out-patient Services: All attempts are made to work with the child and the child's environment (family, school)
on an outpatient basis before consideration is given to either the day care or residential programme. The goal is to keep the child in his/her natural environment while attempting to assist the child and family in getting their needs met constructively. This is based on the philosophy that people have the ability to change and that there are resources within the family and community which will enable the family to resolve their difficulties (Social Work Policy & Procedure Manual, 1982, p.7).

The treatment of choice, i.e. individual psychotherapy for the child, play therapy, group therapy, teaching behaviour management techniques to parents, family therapy or counselling to parents, varies according to the child's needs, the family's strengths, and the social worker's orientation.

Day Care Services: When a child can no longer benefit from a community school and is admitted to the day care programme, an individual programme is set up to meet the needs of that child. The social worker, as part of the day care team, assumes responsibility as case manager for approximately seven of the children admitted to the programme. The role of the case manager is to co-ordinate various aspects of the child's programme, and work with both the child and the family (Social Work Policy & Procedure Manual, 1982, p.8).

Residential Services: The role of the social worker as a team member of a residential programme is similar to the role of the social worker in the day care programme.
Residential placement is viewed as a temporary measure and efforts are made to return the child to community living as soon as possible. Once a child is discharged from the residential programme, out-patient follow-up services are offered by the case manager to the child and his family (Social Work Policy & Procedure Manual, 1982, p.9).

All social workers employed at the R.C.C. have their Master of Social Work degree. In May, 1981, there was one supervising social worker; two full-time outpatient social workers; one social worker in the day care programme; one social worker for each of the two residential teams; one social worker to co-ordinate the home care programme; and one social worker to co-ordinate assessments for the Family Court (Juvenile Division). As of May, 1982, there were two social workers in the day care programme and a vacancy in outpatient services. The Social Work Department was in the process of filling this vacancy.
CHAPTER IV

RESEARCH DESIGN AND METHODOLOGY

The purpose of this research project was discussed in the opening chapter. This section on research design and methodology will present the classification of the study, the hypotheses, the population, the sample, the method of data collection, and the limitations of the study.

Classification of the Research

In developing the methodology of the study, the researchers chose to utilize a quantitative-descriptive type of design. "Descriptive designs are used to provide detailed information about a particular group or individual, as well as about the interrelationship of certain variables" (Wechsler, Reinherz & Dobbin, 1976, p.66).

In this design, the variables in question are known with some precision, but their interrelationship has not been measured. Correlations between two or more variables may be established, but causality is not usually implied. One variable may lead to changes in the other, or both may be the result of still other variables.

Of the four sub-types of quantitative-descriptive studies defined by Tripodi, Fellin & Meyer (1969, p.24), the researchers elected to use the hypothesis testing sub-type.

Hypothesis testing studies are those quantitative-descriptive studies which contain in their design of research specific hypotheses to be tested. The
hypotheses are typically derived from theory, and they may be either statements of cause-effect relationships or statements of association between two or more variables without reference to a causal relationship (Tripodi et al., 1969, p.39).

The Hypotheses

The two hypotheses related to the study are:

(1) Parent(s)' experience of waiting will be significantly associated with income and education.

(2) Parent(s)' expectations of the waiting period will be significantly associated with the referral person.

Population and Sample

With the objective of making some generalizations to social work waiting list populations in children's mental health centres in Ontario, the social work waiting list at the R.C.C. was chosen as a purposive sample of that population.

The basic assumption behind purposive sampling is that with good judgment and an appropriate strategy one can handpick the cases to be included in the sample and thus develop samples that are satisfactory in relation to one's needs (Selltiz, Johoda, Deutsch & Cook, 1959, p.520).

The time period under study was from September, 1981 to March, 1982. The number of referrals to the Social Work Department as well as the number of cancellations was compared to the previous year to determine if there were any significant changes.

It is of interest to note that the total number of referrals and cancellations were comparable over the six month period from year to year.
Table 1
Referrals and Cancellations.

<table>
<thead>
<tr>
<th>Year</th>
<th>Total number of referrals</th>
<th>Total number of cancellations</th>
</tr>
</thead>
<tbody>
<tr>
<td>September/80-March/81</td>
<td>146</td>
<td>24</td>
</tr>
<tr>
<td>September/81-March/82</td>
<td>115</td>
<td>15</td>
</tr>
</tbody>
</table>

Fifty-four families who had been referred from September, 1981 to March, 1982 but who had experienced contact with the Social Work Department were eliminated. It was believed that their perceptions of the waiting time would possibly be biased by their ability to recall their experience, by the nature of their contact and by their current perception of the Centre. Clients on waiting lists of other departments within the R.C.C. were excluded also. As a result, 46 families were contacted for participation in the study. These families were considered as likely to be typical of families who had no previous contact with social work services at similar centres in Ontario but were on the outpatient social work waiting lists at these centres.

There were 16 families who did not participate in the study. The researchers were never able to contact four families by telephone or through a Follow-up Letter (Appendix L). Reasons for not participating are listed in Table 2.
Table 2

Reasons for Non-participation in Research

<table>
<thead>
<tr>
<th>Reason</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unable to locate</td>
<td>4</td>
<td>25.0%</td>
</tr>
<tr>
<td>Too busy</td>
<td>4</td>
<td>25.0</td>
</tr>
<tr>
<td>Too personal</td>
<td>4</td>
<td>25.0</td>
</tr>
<tr>
<td>Problem no longer exists</td>
<td>2</td>
<td>12.5</td>
</tr>
<tr>
<td>Completed initial assessment</td>
<td>2</td>
<td>12.5</td>
</tr>
<tr>
<td>Total</td>
<td>16</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

The number of participants in the sample was 30, which represents 29 families since one family referred two children.

Table 3 represents the total sample, including the non-participants and the participants.

Table 3

The Total Population of the Sample Represented by Non-participants and Participants

<table>
<thead>
<tr>
<th>Total sample</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-participants</td>
<td>16</td>
<td>34.7%</td>
</tr>
<tr>
<td>Participants</td>
<td>30</td>
<td>65.3</td>
</tr>
<tr>
<td>Total</td>
<td>46</td>
<td>100.0%</td>
</tr>
</tbody>
</table>
Method of Data Collection

An Introductory Letter (Appendix J) was mailed to the parent(s) or guardian(s), outlining the purpose of the study and requesting their participation. Confidentiality was assured and parent(s) or guardian(s) were also informed that their decision to participate or not participate in the study would have no influence on their child's position on the waiting list. A Consent to Research Form (Appendix K) was included with the Introductory Letter (Appendix J) and collected at the time of the interview.

The letters were followed up within the first week by telephone contact by the researchers to elicit cooperation and to arrange interviews in the home. The home was chosen for the location of the interview as it was felt that parent(s) would be more likely to participate if their inconvenience was minimized (Grinnell, 1981).

An Interview Schedule (Appendix M) containing quantitative and qualitative data was designed by the researchers (Tripodi, 1974, p.24). The Interview Schedule (Appendix M) was intended to elicit information about the parents, the child, the nature of the problem and the experience of waiting. The Applicant Information Form (Appendix C) for the children on the waiting list was utilized to obtain names, addresses, phone numbers and basic demographic data on the parents.

A pre-test of the Interview Schedule (Appendix M) was administered to four parents. One parent had had
previous contact with the R.C.C., although not with the Social Work Department. The pre-test was intended to improve the reliability and validity of the instrument. Only one change was made as a result of the pre-test.

Question 16 was changed from 'Why was the R.C.C. suggested?' to 'Why was the K.C.C. recommended?'. It was felt by the participants of the pre-test that the word 'suggested' was not as clear in meaning as the word 'recommended'. None of these participants was included in the sample.

Personal interviews were considered advantageous for a number of reasons. They can be used with a variety of people who are more likely to respond to personal as opposed to impersonal inquiry, as in mailed questionnaires. Also interviews allow for greater flexibility and more opportunity for clarification in questions and responses. In addition, the interview assures a higher level of participation in the overall sample. It ensures that those persons to be surveyed are, in fact, the ones providing the responses (Grinnell, 1961; Polansky, 1975; Selltiz, et. al., 1959).

**Analysis of Data**

The data analysis was carried out by computer and the Statistical Analysis System (Helwig, 1978). Programmes for univariate analysis were utilized to provide descriptive statistics. This was intended to examine similarities between the participants and the total sample.

T-tests were conducted to test for significant
differences between children of the participants and the total sample.

Chi-square was used to test the existence of association between variables in the hypotheses. This was intended to result in the acceptance or rejection of the hypotheses related to the participants. Other findings related to the participants and total sample will be discussed in the following chapter.

**Limitations**

Several limitations to this study should be noted. When using personal interviews, the lack of anonymity in this situation may influence the way in which a person responds. The participant may deliberately lie if she does not know the answer or the participant may attempt to provide socially desirable responses, particularly if the questions are emotion-laden (Grinnell, 1981; Selltiz et. al., 1959). Another limitation is that of interviewer bias which occurs when there is more than one interviewer, with individual characteristics and differences in appearance, manner and presentation of the questions. The interviewer can influence participants to provide certain answers based on a difference in phrasing of questions and the tone of voice (Grinnell, 1981; Selltiz et. al., 1959).

The researchers conducted all interviews and efforts were made to minimize interviewer bias by preparing a standard introduction for the telephone contact and for the introduction and conclusion of the Interview Schedule
(Appendix M). Manner of dress for both researchers was similar also.

The study is limited in that only one parent per family was interviewed. It was the mother who volunteered to participate in all cases. It is recognized that the participating parent's perception of the problem and of the experience of waiting may be considerably different than that of the non-participating parent.

Finally, the sample of thirty participants was of minimal size which limited statistical analysis.
CHAPTER V

PRESENTATION OF DATA AND FINDINGS

To facilitate the presentation of data and findings the contents of this chapter are divided into five sections:

Findings Related to Total Sample
Findings Related to the Children
Findings Related to Community Resources
Findings Related to the Referral Person
Findings Related to the Hypothesis

The first section describes the participants and includes a discussion of the similarities of the participants to the total sample. These similarities may determine the degree to which the results can be generalized to other sample populations on waiting lists at children's mental health centres in Ontario.

The second section describes the children of the participants and includes a discussion of the degree to which these children are typical of the children in the total sample.

The section on the findings related to community resources examines the participants' awareness and expectations of services available from the R.C.C. as well as their awareness of social work services available in the community.

Variables related to the referral person are discussed in the next section. In the final section, findings
related to the hypotheses are presented and discussed.

Findings Related to Total Sample

This section examines the similarities of the participants to the total sample. This was done by comparing key variables such as mother's age and education, father's age and education, mother's marital status and parental status. This data was obtained only for those parents living in the home. The information gathered for non-participants was obtained from the Applicant Information Form (Appendix D) with the consent of the R.C.C. (Appendix A).

The age range of mothers for the participants (N=29) was from 25 to 42 years with a mean age of 32.8 years (SD=5.12). This is similar to the age range of mothers in the total sample (N=44) where the mean age was 33.2 years (SD=5.06). One of the non-participants did not provide her age.

The age range of fathers for the participants (N=19) was from 27 to 50 years with a mean age of 35.5 years (SD=6.14). The mean age for the total sample (N=25) was 35.8 (SD=6.50).

The majority of mothers (71.1%) and fathers (76%) in the total sample had completed some level of their secondary education as seen in Tables 4 and 5.

Mother's marital status is represented in Table 6. The majority of mothers who participated (62.1%) and in the total sample (57.8%) were married.

Table 7 and 8 represents mother's and father's parental status. The majority of mothers (95.6%) and
### Table 4

**Mother's Education for the Total Sample**

<table>
<thead>
<tr>
<th>Education</th>
<th>Participants n=29* (%)</th>
<th>Non participants n=16 (%)</th>
<th>Total sample n=45 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>High (post secondary)</td>
<td>3 (10.3)</td>
<td>2 (12.5)</td>
<td>5 (17.2)</td>
</tr>
<tr>
<td>Medium (secondary)</td>
<td>19 (65.5)</td>
<td>13 (81.2)</td>
<td>32 (71.1)</td>
</tr>
<tr>
<td>Low (elementary)</td>
<td>7 (24.8)</td>
<td>1 (6.3)</td>
<td>8 (29.5)</td>
</tr>
</tbody>
</table>

* one participant referred two of her children

### Table 5

**Father's Education for the Total Sample**

<table>
<thead>
<tr>
<th>Education</th>
<th>Participants n=19* (%)</th>
<th>Non participants n=8** (%)</th>
<th>Total sample n=25 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>High (post secondary)</td>
<td>1 (5.2)</td>
<td>3 (37.5)</td>
<td>1 (4)</td>
</tr>
<tr>
<td>Medium (secondary)</td>
<td>16 (84.2)</td>
<td>3 (37.5)</td>
<td>19 (76)</td>
</tr>
<tr>
<td>Low (elementary)</td>
<td>2 (10.5)</td>
<td></td>
<td>5 (20)</td>
</tr>
</tbody>
</table>

* one father referred two children

** information on two fathers was not available from the application form
Table 6
Mother's Marital Status for the Total Sample

<table>
<thead>
<tr>
<th>Marital status</th>
<th>Participants n=39* (%)</th>
<th>Non participants n=16 (%)</th>
<th>Total sample n=45 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Married</td>
<td>18 (62.1)</td>
<td>8 (50.0)</td>
<td>26 (57.8)</td>
</tr>
<tr>
<td>Divorced</td>
<td>7 (24.1)</td>
<td>5 (31.3)</td>
<td>12 (26.7)</td>
</tr>
<tr>
<td>Separated</td>
<td>2 (6.9)</td>
<td>3 (18.8)</td>
<td>5 (11.1)</td>
</tr>
<tr>
<td>Common-law</td>
<td>1 (3.4)</td>
<td></td>
<td>1 (2.2)</td>
</tr>
<tr>
<td>Single</td>
<td>1 (3.4)</td>
<td></td>
<td>1 (2.2)</td>
</tr>
</tbody>
</table>

* one participant referred two of her children
fathers (74.1%) in the total sample were the child's natural parent.

Occupation and income are two variables which were examined for the participants only. As seen in Table 9 the majority (75.8%) of mothers were homemakers. The most frequently reported occupation of fathers was that of laborer as shown in Table 10. The most frequently reported range of income was from $5,001 to $10,000 annually (see Table 11). The majority (62.0%) of participants reported a combined annual income of $20,000 or less.

Findings Related to the Children

This section examines the degree to which the children of the participants are typical of those in the total sample. This was done by comparing key variables such as age, sex, birth order and the number of children in the family.

The age of the children was collapsed into three categories for the purpose of analysis (see Table 12). The majority (63%) of the total sample were school-age with a mean age of 9.2 years (SD=3.04) for the participants' children (N=30) and a mean age of 9.7 years (SD=3.43) for the total sample (N=46). The majority (82.6%) of children referred were boys as shown in Table 13.

The majority (56.5%) of referrals were on behalf of the first-born child for the total sample as seen in Table 14. Almost half (47.8%) of the families in the total sample had two children (see Table 15).
Table 7
Mother's Parental Status for the Total Sample

<table>
<thead>
<tr>
<th>Parental status</th>
<th>Participants n=29* (%)</th>
<th>Non participants n=16 (%)</th>
<th>Total sample n=45 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Natural</td>
<td>27 (93.1)</td>
<td>16 (100.0)</td>
<td>43 (95.6)</td>
</tr>
<tr>
<td>Adoptive</td>
<td>2 (6.9)</td>
<td></td>
<td>2 (4.4)</td>
</tr>
</tbody>
</table>

* one participant referred two of her children

Table 8
Father's Parental Status for the Total Sample

<table>
<thead>
<tr>
<th>Parental status</th>
<th>Participants n=19* (%)</th>
<th>Non participants n=8 (%)</th>
<th>Total sample n=27 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Natural</td>
<td>14 (73.7)</td>
<td>6 (75.0)</td>
<td>20 (74.1)</td>
</tr>
<tr>
<td>Adoptive</td>
<td>1 (5.3)</td>
<td></td>
<td>1 (3.7)</td>
</tr>
<tr>
<td>Step-parent</td>
<td>4 (21.1)</td>
<td>2 (25.0)</td>
<td>6 (22.2)</td>
</tr>
</tbody>
</table>

* one father referred two of his children
Table 9

Mother's Occupation for the Participants

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Homemaker</td>
<td>22</td>
<td>75.8%</td>
</tr>
<tr>
<td>Salesperson</td>
<td>3</td>
<td>10.3%</td>
</tr>
<tr>
<td>Kitchen Help</td>
<td>2</td>
<td>6.9%</td>
</tr>
<tr>
<td>Bookkeeper</td>
<td>1</td>
<td>3.5%</td>
</tr>
<tr>
<td>Nurse's Aid</td>
<td>1</td>
<td>3.5%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>29</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

Table 10

Father's Occupation for the Participants

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Laborer</td>
<td>7</td>
<td>36.7%</td>
</tr>
<tr>
<td>Supervisor</td>
<td>3</td>
<td>15.8%</td>
</tr>
<tr>
<td>Mechanic</td>
<td>3</td>
<td>15.8%</td>
</tr>
<tr>
<td>Fireman</td>
<td>2</td>
<td>10.5%</td>
</tr>
<tr>
<td>Truck/Bus Driver</td>
<td>1</td>
<td>5.3%</td>
</tr>
<tr>
<td>Appliance Technician</td>
<td>1</td>
<td>5.3%</td>
</tr>
<tr>
<td>Journalist</td>
<td>1</td>
<td>5.3%</td>
</tr>
<tr>
<td>Millwright</td>
<td>1</td>
<td>5.3%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>19</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>
Table 11

Combined Income for the Participants

<table>
<thead>
<tr>
<th>Annual Income</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>under $5,000</td>
<td>3</td>
<td>10.3%</td>
</tr>
<tr>
<td>$5,001-$10,000</td>
<td>8</td>
<td>27.6%</td>
</tr>
<tr>
<td>$10,001-$15,000</td>
<td>2</td>
<td>6.9%</td>
</tr>
<tr>
<td>$15,001-$20,000</td>
<td>5</td>
<td>17.2%</td>
</tr>
<tr>
<td>$20,001-$25,000</td>
<td>5</td>
<td>17.2%</td>
</tr>
<tr>
<td>$25,001-$30,000</td>
<td>4</td>
<td>13.8%</td>
</tr>
<tr>
<td>over $30,000</td>
<td>2</td>
<td>6.9%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>29</strong></td>
<td><strong>99.9%</strong></td>
</tr>
</tbody>
</table>
Table 12

Age of Children in the Total Sample

<table>
<thead>
<tr>
<th>Child's age</th>
<th>Participants n=30 (%)</th>
<th>Non participants n=16 (%)</th>
<th>Total sample n=46 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-school (3-5 years)</td>
<td>3 (10.0)</td>
<td>2 (12.5)</td>
<td>5 (10.9)</td>
</tr>
<tr>
<td>School-age (6-12 years)</td>
<td>23 (76.7)</td>
<td>6 (37.5)</td>
<td>29 (63.0)</td>
</tr>
<tr>
<td>Adolescence (13-15 years)</td>
<td>4 (13.3)</td>
<td>8 (50.0)</td>
<td>12 (26.1)</td>
</tr>
</tbody>
</table>

Table 13

Sex of Children in the Total Sample

<table>
<thead>
<tr>
<th>Child's sex</th>
<th>Participants n=30 (%)</th>
<th>Non participants n=16 (%)</th>
<th>Total sample n=46 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>25 (83.3)</td>
<td>13 (81.3)</td>
<td>38 (82.6)</td>
</tr>
<tr>
<td>Female</td>
<td>5 (16.7)</td>
<td>3 (18.8)</td>
<td>8 (17.4)</td>
</tr>
</tbody>
</table>
Table 14
Child's Birth Order
of Children in the Total Sample

<table>
<thead>
<tr>
<th>Birth order</th>
<th>Participants n=30 (%)</th>
<th>Non participants n=16 (%)</th>
<th>Total sample n=46 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>First</td>
<td>14 (46.7)</td>
<td>12 (75.0)</td>
<td>26 (56.5)</td>
</tr>
<tr>
<td>Second</td>
<td>11 (36.7)</td>
<td>3 (18.8)</td>
<td>14 (30.4)</td>
</tr>
<tr>
<td>Third</td>
<td>3 (10.0)</td>
<td>1 (6.3)</td>
<td>4 (8.7)</td>
</tr>
<tr>
<td>Fourth</td>
<td>2 (6.7)</td>
<td></td>
<td>2 (4.3)</td>
</tr>
</tbody>
</table>

Table 15
The Number of Children in Families for the Total Sample

<table>
<thead>
<tr>
<th>Number of children</th>
<th>Participants n=30 (%)</th>
<th>Non participants n=16 (%)</th>
<th>Total sample n=46 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>One</td>
<td>5 (16.7)</td>
<td>4 (25.0)</td>
<td>9 (19.6)</td>
</tr>
<tr>
<td>Two</td>
<td>13 (43.3)</td>
<td>9 (56.3)</td>
<td>22 (47.8)</td>
</tr>
<tr>
<td>Three</td>
<td>5 (16.7)</td>
<td>2 (12.5)</td>
<td>7 (15.2)</td>
</tr>
<tr>
<td>Four</td>
<td>5 (16.7)</td>
<td></td>
<td>5 (10.9)</td>
</tr>
<tr>
<td>Five</td>
<td>1 (3.3)</td>
<td>1 (6.3)</td>
<td>2 (4.4)</td>
</tr>
<tr>
<td>Six</td>
<td>1 (3.3)</td>
<td></td>
<td>1 (2.2)</td>
</tr>
</tbody>
</table>
The Criteria for Referral to Outpatient Social Work (Appendix I) was used to categorize the child's problem as perceived by the participants. As seen in Table 16, many of the children had difficulty in all three areas.

Other variables of interest to the researchers were: who first noticed a problem existed, the child's age at that time, the child's age when help was sought at the R.C.C. and if a specific event precipitated the referral to the R.C.C.

The mothers reported being the first to notice the existence of a problem for the child in the majority (66.7%) of cases. The remaining cases were reported by: the school (19.2%), social worker (6.1%), spouse (3.0%), friends (3.0%) and doctors (3.0%).

The time between the awareness of a problem and seeking help ranged from less than 1 year to 9 years with a mean of 2.3 years (SD=2.49). A specific event which precipitated the referral to the R.C.C. was reported in 80% of the cases. Some of the crises reported by mothers were: "teacher or principal called to complain about child's behaviour"; "son caught stealing by police"; "child ran away"; "child was kicked out of school"; or "child became withdrawn".

Findings Related to Community Resources

This section examines the participants' awareness and expectations of services available from the R.C.C. and social work services in the community. Awareness of some of the services available from the R.C.C. was reported
<table>
<thead>
<tr>
<th>Type of problem</th>
<th>Frequency (n=30)</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Difficulty in interpersonal</td>
<td>23</td>
<td>76.7%</td>
</tr>
<tr>
<td>relationships</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Difficulty in community</td>
<td>23</td>
<td>76.7%</td>
</tr>
<tr>
<td>relationships</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Difficulty in showing feelings</td>
<td>17</td>
<td>56.7%</td>
</tr>
<tr>
<td>or emotions</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
by 53.3% of the participants (see Table 17). Assignment to the Social Work Department was not expected by 77.5% of the participants. Some participants indicated awareness of social work services available in the community but only three agencies were identified (see Table 18).

Findings Related to the Referral Person

The majority (76%) of referrals were from physicians for the total sample (Table 19). The majority (80%) of the participants indicated that they were advised of a waiting period. A comparison of the expected wait and the actual wait is presented in Table 20.

Findings Related to the Hypotheses

This section presents the findings of the research related to the three hypotheses. Responses to hypotheses related items on the interview schedule are presented. Chi square is used to test the null hypotheses.

Hypothesis 1: Parent(s)' experience of waiting will be significantly associated with education and income.

For the purpose of this study, mother's education was utilized because only mothers participated. Chi square testing was conducted for mother's education and the following variables: feelings about waiting for service; the existence of supportive people; and involvement with other agencies before or after referral to the R.C.C. Chi square testing was conducted for the combined annual income and the afore-mentioned variables. Chi square values were inconclusive due to the sample size
### Table 17

**Awareness of Services Offered by the R.C.C.**

<table>
<thead>
<tr>
<th>Services</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Work</td>
<td>10</td>
<td>26.3%</td>
</tr>
<tr>
<td>Psychology</td>
<td>10</td>
<td>26.3%</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>10</td>
<td>26.3%</td>
</tr>
<tr>
<td>Speech Therapy</td>
<td>5</td>
<td>13.2%</td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>1</td>
<td>2.6%</td>
</tr>
<tr>
<td>Residential Care</td>
<td>1</td>
<td>2.6%</td>
</tr>
<tr>
<td>Day Care School Programme</td>
<td>1</td>
<td>2.6%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>38</strong></td>
<td><strong>99.9%</strong></td>
</tr>
</tbody>
</table>

---

### Table 18

**Awareness of Social Work Services Offered by the Community**

<table>
<thead>
<tr>
<th>Agency</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children's Aid Society</td>
<td>11</td>
<td>47.9%</td>
</tr>
<tr>
<td>Family Service Bureau</td>
<td>7</td>
<td>30.4%</td>
</tr>
<tr>
<td>School Social Worker</td>
<td>5</td>
<td>21.7%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>23</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>
Table 19
Referral Person for the Total Sample

<table>
<thead>
<tr>
<th>Referral person</th>
<th>Participants n=30 (%)</th>
<th>Non participants n=16 (%)</th>
<th>Total sample n=46 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physicians</td>
<td>24 (80.0)</td>
<td>11 (68.8)</td>
<td>35 (76.0)</td>
</tr>
<tr>
<td>School</td>
<td>5 (16.7)</td>
<td>2 (12.5)</td>
<td>7 (15.2)</td>
</tr>
<tr>
<td>Other</td>
<td>1 (3.3)</td>
<td>3 (18.8)</td>
<td>4 (8.7)</td>
</tr>
</tbody>
</table>

Table 20
Comparison Between Expected Wait and Actual Wait

<table>
<thead>
<tr>
<th>Length of wait</th>
<th>Expected wait n=30 (%)</th>
<th>Actual wait n=30 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Short (5 months or less)</td>
<td>19 (63.3)</td>
<td>25 (83.3)</td>
</tr>
<tr>
<td>Moderate (6 months to 10 months)</td>
<td>7 (23.3)</td>
<td>5 (16.7)</td>
</tr>
<tr>
<td>Long (11 months to 15 months)</td>
<td>4 (13.3)</td>
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</table>
which resulted in small cell frequencies. Therefore, the hypothesis was neither accepted nor rejected.

Hypothesis 2: Parent(s)' expectations of the waiting period will be significantly associated with the referral person.

Chi square testing was conducted for the referral person and the responses of the participants and the following variables: advised of wait; how long they expected to wait and feelings about waiting for service. Chi square values were inconclusive due to sample size which resulted in small cell frequencies. Therefore, the hypothesis was neither accepted nor rejected.

In order to determine if there were significant differences between the participants and non-participants, t-tests were conducted on the two groups for the following variables: child's age; child's birth order and the number of children in the family. There was no significant difference between means and variances for the stated variables.

Spearman and Pearson correlation co-efficients were used to determine the strength of association between variables. These values range from -1.00 which is a perfect negative correlation to a +1.00 which is a perfect positive correlation. Thus, two variables changing together in the same direction indicates the existence of a positive association, while two variables changing in opposite directions indicates the existence of a negative association.
Those variables of interest to the researchers where Spearman correlation co-efficients were utilized are presented first. There was a low positive association between the child's age and community relationships, $r(30) = .40$, $p = .0276$. A low positive association was found between the child's relationship with father and other adults, $r(30) = .38$, $p = .0382$. This is slightly different from the moderate positive association between the child's relationship with mother and other adults, $r(30) = .55$, $p = .0013$. Furthermore, there was a moderate positive association between the child's relationship with other adults and involvement with police, $r(30) = .60$, $p = .0050$.

There was also a low positive association between the number of children in the family and community related problems, $r(30) = .45$, $p = .0109$ as well as involvement with other agencies before the referral to the R.C.C., $r(30) = .45$, $p = .0135$.

The existence of supportive people had a low positive association with involvement with other agencies before the referral to the R.C.C. was made, $r(30) = .38$, $p = .0382$.

When using Pearson's correlation co-efficient, there was a low positive association between the child's age and interpersonal relationships, $r(30) = .36$, $p = .0469$.

In the next chapter, interpretations of these findings will be discussed leading to conclusions and recommendations.
CHAPTER VI

CONCLUSIONS AND RECOMMENDATIONS

In this section, conclusions drawn from the findings of the data will be presented. This will be followed by recommendations for further research and recommendations designed to ameliorate the effects of waiting for service.

Conclusions

It was determined that the participants in this study were similar to the total sample for the variables of mother's age and education, father's age and education, marital status, and parental status. The majority (75.8%) of mothers were homemakers, while the fathers' occupation varied, with laborer most frequently reported. The majority (62.0%) of families had a combined annual income of $20,000 or less, which was indicative of the number of single income families. The large number of families who reported income at the $5,001 - $10,000 level may be accounted for by the large number of one-parent families (1/3 of the sample) who were supported by Mothers Allowance.

The children of the participants were found to be typical of the total sample for the variables of age, sex, birth order, and number of children in the family. The majority (63%) of the children referred were school-age as was expected based on the literature (Lurie, 1974), and males were referred in a ratio of 4:1 to females. The greatest number of referrals were for first-born
children (over half of the total sample). The trend toward smaller family size is reflected in the study by the predominance of families with only one or two children.

Children were reported to be experiencing difficulties in all three areas of interpersonal relationships, community relationships and difficulty in showing feelings or emotions in a large number of the cases. One weakness related to these categories was that parents may have interpreted "difficulty in showing feelings or emotions" as withdrawn behaviour and, therefore, did not report other types of communication difficulties such as temper outbursts or expressions of hostility.

In the majority of cases (66.7%), mothers indicated that they were the first to notice that their child had a problem, and the literature supports the fact that mothers are most often the first to seek help for a problem (Gluck, 1980). The time between noticing the problem and seeking help for it varied, with a mean time lapse of 2.3 years. Overbeck (1977), suggested that people experience stress for a period of 3 years prior to seeking help at a mental health centre. For the majority of the cases (80%), there was a specific event which precipitated the referral, and was very often initiated by community pressure (Lurie, 1974).

A significant number of the participants (46.7%) indicated that they had no awareness of services available at the R.C.C., and regardless of their level of awareness,
the majority (77.5%) indicated that they had not expected assignment to the Social Work Department. Although 60% of the participants indicated some awareness of social work services available in the community, they had difficulty in specifying more than one or two agencies. The agency most frequently cited was the Children's Aid Society.

The majority of referrals (76%) for the total sample were from physicians, and the literature supports the fact that the family doctor is usually the first person to whom parents turn for help (Lurie, 1974). Many people were unable to specify why the R.C.C. was recommended for their child, and responses were more often related to "who" recommended it rather than "why". This may also have been a weakness in the wording of the question itself, resulting in the inappropriate responses.

The majority of the participants (80%) were advised of the waiting period, but the wide variation in the length of time people expected to wait indicates that people are not consistently provided with a realistic appraisal of the expected time.

The majority of participants (83.3%) had actually waited 5 months or less at the time of the interview. This is considerably less time than the average of 364 days cited for outpatient social work services at the R.C.C. by the Needs Assessment Task Force report (1981, p.73).

The majority of participants (80%) had had no
personal contact with the Social Work Department during the waiting time. However, following their agreement to participate in the study, six of the participants were contacted by telephone for an assessment interview prior to the interview with the researchers. It should be noted that this contact may have influenced their perceptions of the waiting experience.

Of the participants, 70% had no prior involvement with other agencies before the referral to the H.C.C. and 76.7% had no involvement after the referral. The number of persons involved and the specific agencies noted did not remain constant, so that involvement with other agencies did not appear to be associated with the experience of waiting. The existence of supportive people noted by 63.3% of the participants may provide a partial explanation for the fact that so few people sought help from professionals or agencies in the community.

The majority of participants (73.9%) expected to wait for service but also expressed dissatisfaction with the fact that they must wait. The researchers found that patterns developed which enabled the type of responses to be categorized (see Table 21). Even for those people who indicated acceptance of the wait, their responses reflected feelings that there was no choice.

A large number of participants (66.7%) indicated that there was change in their child during the waiting period and improvement was noted in 85% of these cases. It seemed that the family had experienced a crisis at the
time of referral, and once they became aware of the required wait, were forced to rely on their own resources to resolve the problem.

In some instances, parents felt that their child may have passed through a stage and this may be accurate in terms of the theory of developmental crises associated with life stages. In one instance, improvement in the child resulted once the paternal grandmother moved out of the home. Bell (1962) addressed the issue of extended family relations and their role in preserving dysfunctioning within families.

Negative change in the child was attributed to the need for professional help for the child, and may be a reflection of the parent's sense of inadequacy and inability to communicate with the child.

The majority of participants (66.7%) offered suggestions for improving the waiting time (Table 22). Over half suggested that a brief contact at the initial referral stage would be helpful. This suggestion was further reinforced by the positive response by participants (73.3%) to the suggestion of involvement in a parents' group while on the waiting list.

The hypotheses related to the participants were developed based on the available literature, but the findings were inconclusive due to the small sample size. At the time that the hypotheses were formulated, the researchers had anticipated a larger population from which to draw the sample.
<table>
<thead>
<tr>
<th>Feelings</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
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<tbody>
<tr>
<td>Accepted</td>
<td>11</td>
<td>36.7%</td>
</tr>
<tr>
<td>Discouraged and frustrated</td>
<td>10</td>
<td>33.3%</td>
</tr>
<tr>
<td>Angry and disgusted</td>
<td>4</td>
<td>13.3%</td>
</tr>
<tr>
<td>Not fair especially when school is involved</td>
<td>4</td>
<td>13.3%</td>
</tr>
<tr>
<td>Problem getting more complicated</td>
<td>1</td>
<td>3.3%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>30</strong></td>
<td><strong>99.9%</strong></td>
</tr>
</tbody>
</table>
Table 22
Suggestions from the Participants for Improvement of the Experience of Waiting for Service

<table>
<thead>
<tr>
<th>Suggestions</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>No suggestions</td>
<td>11</td>
<td>33.3%</td>
</tr>
<tr>
<td>Would like brief interview while waiting</td>
<td>8</td>
<td>24.2%</td>
</tr>
<tr>
<td>No wait at all</td>
<td>5</td>
<td>15.2%</td>
</tr>
<tr>
<td>Shorter waiting list</td>
<td>4</td>
<td>12.1%</td>
</tr>
<tr>
<td>Hire more staff</td>
<td>3</td>
<td>9.1%</td>
</tr>
<tr>
<td>Send families to alternative services for immediate help</td>
<td>1</td>
<td>3.0%</td>
</tr>
<tr>
<td>Keep child in school while waiting for assessment</td>
<td>1</td>
<td>3.0%</td>
</tr>
<tr>
<td>Total</td>
<td>33</td>
<td>100.0%</td>
</tr>
</tbody>
</table>
Tests of strength of association were conducted for a number of variables of interest to the researchers. It was found that children who had difficulty in relationships with their parents also experienced difficulty in relationships with other adults. Furthermore, those children who experienced difficulty in their relationships with other adults also experienced difficulty with police. These particular associations may indicate problems with authority for a number of children.

There was found to be a positive association between the number of children in the family and the existence of community related difficulties, so that those children from larger families were more often likely to develop difficulties in their relationships at school, in the neighbourhood or with police. Jenkins (1968) noted that children from larger families are more likely to engage in delinquent activities.

Given this defined purposive sample, the researchers believe that it is typical of other samples defined in the same way. For this reason, it is believed that these findings may be generalized to other sample populations on waiting lists at children's mental health centres in Ontario.
Recommendations

The review of the literature revealed that there is a limited number of studies about parental expectations of service and the experience of waiting for services from a children's mental health centre. The following recommendations are based on the results of this study, the concerns expressed by parents during the home interviews and the researchers' experiences as social workers on placement at the R.C.C.

It is recommended that further study be undertaken by researchers to examine issues related to the experience of waiting. A comparison of both parents' experiences related to waiting for service for their child may be of interest in determining if differences exist. As well, families involved in group sessions while waiting for service may be compared to families drawn from a similar population who receive no service during the waiting period. This may be helpful in determining if short-term treatment reduces the anxiety associated with seeking help and waiting for service.

It is recommended that efforts to eliminate a waiting period for children and their families in need of social services be maximized.

It is recognized that elimination of waiting periods may be difficult for agencies such as the Regional Children's Centre, therefore, the following recommendations are made to provide practical suggestions to limit the debilitating effects of waiting for service.

It is recommended that efforts be made to increase community awareness of services at the Regional Children's Centre.
One way to accomplish this would be to distribute the brochure outlining services at the R.C.C. to referral sources and public places where it may be displayed in highly visible areas such as waiting rooms and bulletin boards.

It is recommended that the Regional Children's Centre's phone number and the name of a contact person be printed on the brochure.

It is recommended that a parents' association be organized for parents whose children are involved with the R.C.C., to provide a forum to share common concerns about their children, and about policies and procedures of the R.C.C. Such an association would further develop community awareness of services and provide recognition to parents that they are the most important people in their child's life (Cooper and Wanerman, 1977; Lieberman, 1979).

It is recommended that a liaison person from the R.C.C. be available to the parents' association to provide a link between parents and the administration of the Centre.

It is recommended that the Children's Services Division of the Ministry of Community and Social Services take a more active role in public education about the variety of social services available in the community through such means as advertising and developing a brochure which outlines these services. Such a brochure should be made available in public places.

It is recommended that the Ontario Association of
Professional Social Workers take a more active role in the education of the public regarding the role of social work as a helping profession.

The following recommendations are made regarding referral and intake policies and procedures.

It is recommended that parental involvement in the referral and intake process be increased.

It is suggested that parents be allowed to self refer, based on the premise that they have made a difficult decision to seek help for their child and should be recognized for their efforts (Lieberman, 1979). This would provide immediate feedback and the offer of hope for parents (Cooper and Wanerman, 1977).

It is recommended that referral sources become aware of the existence of the waiting period to provide parents with realistic expectations of the length of wait. This position is supported by the literature which indicates the referral person plays a significant role in intake assignment (Simon, 1967), and whether families follow through with initial appointments (Gaines, 1978; Plante and Meloche, 1979; Robin, 1978).

It is recommended that the Notice of Assignment Form (Appendix C) be sent directly to the parents with a copy being sent to the referral person rather than vice versa which is the current practice (Bitterman, 1958).

Based on the findings of this thesis which reported that many families reported a specific event leading to the referral to the R.C.C., it is recommended that
families have immediate access to help.

It is recommended that a brief interview be provided to families within a week of the receipt of the application form. This interview would provide an opportunity for the intake worker to assess the presenting problem and refer elsewhere, if appropriate. If this recommendation is implemented, it is suggested that one or two families be kept on stand-by for the "non-shows" (Plante and Meloche, 1979). It is recommended that group sessions be offered for those parents whose children are on the waiting list at the conclusion of the intake interview. Other researchers have found this to be a successful approach (Jilbert, 1960; Hotkins, Kriegsfield and Sands, 1958).

It is the hope of the researchers that careful consideration be given to these recommendations for assisting children, their families and service providers who are responsible for meeting the needs of the community.
APPENDIX B

WINDSOR WESTERN HOSPITAL CENTRE
REGIONAL CHILDREN'S CENTRE
REFERRAL - INTAKE DEPARTMENT

Patient's Surname ___________________ Given Names ___________________
Next of Kin ___________________ Occupation of Guardian ___________________
Address ___________________ Tel. No. ___________________
Date of Birth ___________ Age ___________ Sex ______ Place of Birth ___________
Siblings ___________________ Age ___________ Family Doctor ___________________
__________________________ Age ___________ Address ___________________
__________________________ Age ___________ Tel. No. ___________________
__________________________ Age ___________ C.H.I.P. No. ___________
School ___________________ Grade ___________ Family Religion ___________

Previous Consultations or Hospitalizations
(Include Reports if available)

Place Year

Psychological Evaluation Completed? Yes ____ No ____; If so, where? ___________

Other Agency Involvement (e.g., C.A.S. (Prot. or R.C.), P.S.B. (Prot. or R.C.))?

Medications ___________________

Referring Party's Reason for Referral

Additional Information (Developmental Milestones): Attach relevant reports, e.g., EEG, neurological examinations, physical examinations, etc. Social History, psychological reports, speech reports, etc.

Referral Source:

Address ___________________ Signature ___________________

Date ___________________

Form: 70)
Rev. Jan./77
APPENDIX D

WINDSOR WESTERN HOSPITAL CENTRE
REGIONAL CHILDREN'S CENTRE

APPLICANT INFORMATION

Your answers to the following questions will help us to understand the problems for which you are seeking help. Your answers will be regarded as confidential information, as is any information you give the Regional Children's Centre. Please write or print clearly. If more space is needed, use the back of the form or attach extra sheets. Please answer every question.

Child's Name: ___________________________ (Last) (First) (Middle)

Birthdate: ___________________________ Age: ______

Address: ___________________________ Postal Code: ______

Telephone: _______ OHIP: _______ Religion: _______

Family Physician: ___________________________ Paediatrician: ______

Date of your Child's Last Physical Examination and By Whom?

__________________________________________

Findings: ____________________________________________

Is your child presently on medication? _____ If so, what type? ______

Who referred you to the Regional Children's Centre? ___________________________

Have you been to the Centre previously? _____ If yes, for whom and when? ______

__________________________________________

Was it helpful? _______________________________________

1. Describe the concerns which led to your referral to the Regional Children's Centre.

________________________________________________________________________

________________________________________________________________________
2. When were your child's difficulties first noticed (date)?

3. By whom were they noticed (yourselves, family, friend, teacher, doctor, etc.)?

4. Describe what you believe has led to the difficulties your child is having.

5. Describe any changes since difficulties first appeared.

6. What has your family done to try to help the child with these difficulties?

7. Growth and Development History:
   A. Is your child adopted? _____ If yes, what was date of adoption placement?
      __________________________ Describe pregnancy. __________________________

   B. Describe the birth of your child, including any difficulties. __________
      __________________________

   Birth weight? __________
C. At about what age did your child begin the following? Were there any difficulties associated with them which concerned you?

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<thead>
<tr>
<th></th>
<th>AGE</th>
<th>COMMENTS</th>
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<tbody>
<tr>
<td>1.</td>
<td>Sat up unsupported?</td>
<td></td>
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<tr>
<td>2.</td>
<td>Crawled?</td>
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<tr>
<td>3.</td>
<td>Walked alone?</td>
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<td>4.</td>
<td>Spoke first word?</td>
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<tr>
<td>5.</td>
<td>Put 2-3 words together?</td>
<td></td>
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<tr>
<td>6.</td>
<td>Ate without help?</td>
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<tr>
<td>7.</td>
<td>Stopped wetting during day?</td>
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<tr>
<td>8.</td>
<td>Stopped wetting at night?</td>
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<tr>
<td>9.</td>
<td>Stopped soiling?</td>
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<tr>
<td>10.</td>
<td>Reached puberty?</td>
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</tbody>
</table>

D. In the past, or at the present time, has your child every had any difficulties with the following? Describe in detail.

1. Sleeping in the past

   -now          

2. Eating in the past

   -now          

3. Getting along with brothers and sisters in the past

   Now          
4. Getting along with playmates in the past

Now

5. Getting along with either or both parents in the past

Now


Academic achievement in the past

Now

Behaviour in the past

Now

7. In the neighbourhood in the past

Now

8. Unusual fears in the past

Now

E. Current Speech Status

YES  NO

Does your child's voice sound unusual (hoarse, nasal, too low, too high, loss of voice)? If yes, describe

Does your child repeat, hesitate, stop, and start over frequently? If yes, describe

Does your child have difficulties understanding what is said to him or her? If yes, describe
Current Speech Status continued...

YES  NO

Does your child use gestures more than words to indicate his or her wants and needs? If yes, describe ________________________________

_______________________________________________________________________

Does your child have difficulties telling you about things that have happened or are happening? If yes, describe ________________________________

_______________________________________________________________________

Is your child difficult to understand?

_______________________________________________________________________

Does your child have difficulties pronouncing sounds? If yes, describe ________________________________

_______________________________________________________________________

Have you ever had any reason to suspect that your child can't hear you? If yes, describe ________________________________

_______________________________________________________________________

Has your child ever had any ear infections? If yes, describe ________________________________

_______________________________________________________________________

F. What schools has your child attended?

<table>
<thead>
<tr>
<th>Name of School</th>
<th>Place</th>
<th>Dates Attended</th>
<th>Grades attended there</th>
<th>Reason for leaving</th>
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</table>
G. How does your child usually spend his/her leisure time?


List activities or pastimes which your child usually avoids or seems to dislike.


H. Describe any family difficulties or events which could have been upsetting to your child (e.g., deaths of family members or close relatives, moves, illness, prolonged absences of a parent, illness of another family member, financial problems, etc.).


I. List below serious illnesses, accidents, operations, seizures, etc. which your child has had. Please give the date of the illness or injury, names and addresses of any physicians, etc. who may have treated the child and if the child was hospitalized, please give the name and address of the hospital and the approximate length of the stay.


J. Does your child wear a hearing aid? ______ Eyeglasses? ______


K. Have you sought help before for yourself or your family? From a Social Agency, e.g., Children's Aid Society (state Protestant or Roman Catholic), Family Service Bureau (state Protestant or Roman Catholic), Speech Clinic, or from anyone else? Yes ( ); No ( ); If Yes, Name of Agency: ____________________________

Name of Person With Whom Involved: ____________________________
When (give dates): ____________________________

Are you presently involved? ____________________________

Was it helpful? ____________________________

9. How do you feel the Regional Children’s Centre can best help you, your child and your family?

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

10. Parents or guardians residing with the child:

Father’s name ____________________________ Birthdate ____________________________

Address ____________________________ Telephone no. ____________________________

Occupation ____________________________ Religion ____________________________

Last grade of school completed: ____________________________

Place of employment ____________________________ Telephone no. ____________________________

Is the above person natural father, stepfather, adoptive father or foster father?

____________________________________________________________________________________

If not the natural father, state name of natural father, if known ____________________________

Mother’s full maiden name ____________________________

Birthdate ____________________________ Address ____________________________

Telephone no. ____________________________ Occupation ____________________________

Religion ____________________________ Last grade of school completed: ____________________________

Place of Employment ____________________________ Telephone no. ____________________________

Is the above person natural mother, stepmother, adoptive mother or foster mother?

____________________________________________________________________________________
If not the natural mother, state name of natural mother, if known

Current marital status

Date of first marriage

MOTHER 
FATHER 

If ever remarried, date

If ever common-law, date

If ever separated, date

If ever divorced, date

If ever widowed, date

If separated or divorced does spouse have visiting privileges? __________

If yes, how often does spouse visit with children? _______________________

Who has legal custody of the child being referred?

____________________________________________________________________

11. List all your children from oldest to youngest including applicant.

<table>
<thead>
<tr>
<th>Full Name (including family name)</th>
<th>Birthdate</th>
<th>Natural or Adopted</th>
<th>Last Grade of School Completed</th>
<th>Check if Out of Home</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>


List others in the household.

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Relationship to child</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

12. Were the questions answered by:

Mother?   
Father?   \(\)    
Both?     
Other?    (Relationship to Child)   

13. Languages spoken in the home?

Do you require an interpreter to be served effectively by the Regional Children's Centre?

14. Is mother in agreement in applying to the Centre for assessment and/or treatment? If not, please explain.

_________________________________________________________________________________________

_________________________________________________________________________________________

Is father in agreement in applying to the Centre for assessment and/or treatment? If not, please explain.

_________________________________________________________________________________________

_________________________________________________________________________________________

Date: ____________________________

Signature of Mother or Legal Guardian

Signature of Father or Legal Guardian
It is frequently very helpful for the Centre to get reports from people such as teachers, doctors or others who know your child and the problem he or she is having. We only, undertake such requests with consent of the parents.

We have attached a form permitting us to request a school report, and hope that you will sign and return it to us.
APPENDIX E

WINDSOR WESTERN HOSPITAL CENTRE
REGIONAL CHILDREN'S CENTRE

RELEASE OF INFORMATION

I, ____________________________, the legal guardian of
________________________________, who attends _________ School,
hereby authorize the Regional Children's Centre to obtain School and Student
Services Reports from:
- Windsor Board of Education
- Windsor Separate School Board
- Essex County Board of Education
- Essex County Roman Catholic Separate School Board
- Kent County Board of Education
- Kent County Separate School Board

(Check relevant Board(s))

Witness: ____________________________ Signature: ____________________________
(Signature of Witness) (Signature of Guardian)

Date: ____________________________

NOTE: This form is valid only after being signed and witnessed in ink.
The witness must be an adult other than a family member. We
cannot request the above information without the consent of the
parent(s) or legal guardian.
APPENDIX F

WINDSOR WESTERN HOSPITAL CENTRE
 Regional Children’s Centre

Priority ______ Urgent ______ Routine ______ Date ________

Name

Date of Birth

Address

School

Principal

Grade/Level/Program

Teacher/Counsellor

1. Please attach a detailed anecdotal evaluation of the student’s social and academic
   behaviours, peer and authority relationships, as you have observed him at school.

2. Does this child have any learning or communication problems? Please elaborate.

3. Is the school able to meet the educational needs of this child at this time?
   Please comment as to what intervention would be helpful.

4. Are there any special interests or well developed abilities exhibited by this child?

5. Do the parents participate in school functions? Yes____ No____ In what way(s)?

6. Have you requested that parents obtain community resource help? Yes____ No____
   Where?

7. What attempts have been made by you to modify this child's behaviour in the problem
   areas? Yes?

8. Have Student Services been involved with this child? Yes____ No____ Please detail.

Principal's Comments:

Teacher's Signature ____________________ Principal's Signature ____________________

Consultant's Signature ____________________
Past Academic Achievement (Grades Repeated or Advanced)

<table>
<thead>
<tr>
<th>Attendance</th>
<th>Regular</th>
<th>Irregular</th>
<th>Excessively Late</th>
</tr>
</thead>
</table>

Intelligence Tests

<table>
<thead>
<tr>
<th>Date Tested</th>
<th>Grade</th>
<th>Name of Test</th>
<th>Test Score(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Achievement Tests

<table>
<thead>
<tr>
<th>Date Tested</th>
<th>Grade</th>
<th>Name of Test &amp; Form</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
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<tr>
<td>3.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Teacher's Estimates

<table>
<thead>
<tr>
<th>(a) Intellectual Capacity</th>
<th>Above Average</th>
<th>Average</th>
<th>Below Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>(b) General Achievement</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(c) Verbal Communication</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(d) Written Communication</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(e) Sight Vocabulary</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(f) Phonetic Skills</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(g) Sport Attack Skills</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(h) Grade Level where student can work successfully:

- Oral Reading
- Reading Comprehension
- Spelling
- Mechanical Arithmetic
- Arithmetic Problem Solving

Please include any appropriate reports.
APPENDIX I

CRITERIA FOR REFERRAL TO OUTPATIENT SOCIAL WORK

Population Served: any child or any family without evident psychosis, presenting problems of
(1) interpersonal relationships
(2) conflict with community
(3) understanding or expressing emotions

e.g. - individual children - withdrawal
    - acting out
    - low self-image
    - problems with sexuality
    - repression of feelings

- families - marriage breakdown
  - re-marriage & step-parenting
  - fostering
  - unreasonable expectations by parents
  - inadequate child management skills

Services offered:
- individual & family social assessment
- family therapy
- parental counselling
- individual psychotherapy, including bioenergetics, with persons aged 9 & over
- individual play therapy with persons under 10
- activity group therapy for pre-adolescents with relationship & self image deficits
- marital counselling

Don Deathe & Heather Doney

July 1980
CONSENT TO RESEARCH

I ______________________, do hereby give my consent to participate in the research project being conducted by Rhoda Arseneault and Heather McKechnie. I understand that all information gathered from my child's application, and from the interview, will be kept strictly confidential, and data will be presented only in summative form.

Witness ____________________

Signed ____________________

Parent ____________________

Date ____________________
April 14, 1982

Dear Parent(s):

You will have received a letter approximately a week ago requesting your participation in a research project being conducted through the Regional Children's Centre. I have been unable to contact you by telephone in order to discuss this with you further.

If you wish to participate in the project, or if you have any questions about it, please contact me at the Regional Children's Centre 253-4261, ext. 346, either Monday or Wednesday. If this is not convenient, you may reach me at my home phone number - 966-4591 in the evenings.

Your assistance is appreciated.

Sincerely Yours,

(Mrs.) Rhoda Arseneault
Social Work Dept.,
R.C.C.
APPENDIX M

To begin, we would like to check the information that we obtained from your child's application to ensure that it is accurate.

1. We have your age as:
   the last grade of school that you completed as:
   your occupation as:
   your marital status as:
   your parental status as:

2. We also have your husband or wife's age as:
   their last grade of school completed as:
   their occupation as:
   their marital status as:
   their parental status as:

3. For the purpose of our study we need to have a rough indication of the income of your family. Would you tell me in which of these classes it falls:
   under $5,000/yr.
   $5,001-$10,000/yr.
   $10,001-$15,000/yr.
   $15,001-$20,000/yr.
   $20,001-$25,000/yr.
   $25,001-$30,000/yr.
   $30,001/yr. and over

4. How old was your child on his/her last birthday?

5. What sex is your child?

6. (a) What is your child's birth order in the family?

   (b) How many children are in your family?

7. Some children have difficulty in one or more of the following areas. Is your child having difficulty in any of these areas?

   yes no

   1. Relationships with father
      mother
      brother(s)
      sister(s)
      other children
      other adults

   2. Relationships in school
      in the neighborhood
      with police
2. Do you feel your child has difficulty in showing feelings or emotions?

8. Who first noticed that your child was having a problem?
   self
   spouse
   relatives
   friends
   school

9. How old was your child at that time?

10. How old was your child when you first sought help at the Regional Children's Centre?

11. Was there a specific event which led to seeking help at the Regional Children's Centre?
   If yes, please describe it.

12. Were you aware of services offered by the Regional Children's Centre?
   if yes, which services were you aware of?
   psychiatry
   psychology
   social work
   speech therapy
   occupational therapy
   other

13. Did you expect your child's name would be assigned to the Social Work department?
   if not, what kind of help did you expect?

14. Were you aware that social work services are available at other agencies for your child's problem?
   if yes, which agencies are you aware of?

15. Who made the referral to the Regional Children's Centre?
    family doctor
    school
    other, (who?)
16. Why was the Regional Childrens' Centre recommended?

17. Were you advised by the referral person that there would be a waiting period when your child was referred to the Regional Childrens' Centre?

18. How long were you expecting to wait?

19. How long have you been waiting since the referral was made?

20. Has anyone from the Regional Childrens' Centre contacted you during this time period?
   if yes, what type of contact did you have?
   what was the purpose of the contact?

21. Were you involved with any other agency or agencies before a referral to the Regional Childrens' Centre was made for your child's problem?
   if yes, with whom?

22. Are you presently involved with any other agency or agencies for your child's problem?
   if yes, with whom?

23. Are there other people who have been helpful to you for your child's problem during this waiting period?
   if yes, who?

24. How do you feel about having to wait for help?

25. Have there been any changes in your child since the referral was made?
   if yes, what were they?
   why do you think this change occurred?
26. Do you have any suggestions which would make this wait better for you?

27. If there was a parent's group to help those families on the waiting list talk about their concerns, would you participate?
REFERENCES

Books


Articles


Freud, S. Three contributions to the sexual theory. Nervous and Mental Disease Monograph Series, 1910, No. 10.


Unpublished Materials

Regional Children's Centre of Windsor Western Hospital Centre brochure, rev. Oct. 1981.


VITA AUCTORIS

Heather Lillian Snooks McKechnie

Heather Lillian Snooks McKechnie was born on September 20th, 1951 in Toronto, Ontario. She received her elementary education from Clairlea P.S. and her secondary school Honours Graduation Diploma from Georges P. Vanier S.S.

Ms. McKechnie enrolled at The University of Windsor where she received her Bachelor of Arts in psychology in October of 1973 and her Bachelor of Social Work in May of 1974. In 1981, she enrolled in the Master of Social Work programme at The University of Windsor. Ms. McKechnie completed her field practicum with the Social Work Department of the Regional Children’s Centre. She expects to graduate in October of 1982.

Ms. McKechnie was employed by the Children's Aid Society of Essex County from 1974 until 1979. She left her position as team leader to work for the Windsor Board of Education as a school social worker in September, 1979.

In September, 1980, Ms. McKechnie left Windsor to undertake a life long goal of travelling in the South Pacific, South-East Asia and the Orient. She returned to Windsor in May, 1981 to pursue her graduate education.
VITA AUCTORIS

Rhoda Ethel Scott Arseneault

Rhoda Ethel Scott Arseneault was born August 23, 1950, in Midland, Ontario. She spent most of her childhood years living in Midland and then London, Ontario, prior to moving to Windsor in 1963. She completed her elementary education at King Edward public school and her secondary education at Walkerville Collegiate Institute in 1969.

Ms. Arseneault received her Bachelor of Social Work degree from The University of Windsor in 1973. Her undergraduate field placement was at the Addiction Research Foundation. Upon graduation, Ms. Arseneault began working at the Children's Aid Society of the County of Essex, where she was employed for eight years.

Ms. Arseneault entered the Master of Social Work programme at The University of Windsor in the fall of 1981. Her field placement was in the Outpatient Social Work Department at the Regional Children's Centre. She expects to graduate in October of 1982.