A Retrospective Study of Case Attrition in a Child Psychiatric Clinic *

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Summary. The purpose of this study was to determine whether there are identifiable demographic and clinical factors which differentiate between cases which drop out of a child psychiatry clinic and those which do not. A portion of the study reported here is one in which a large number of charts of cases which did drop out were analyzed by several raters independently for the presence of 22 items of demographic information and 18 clinical factors. The results of this analysis were compared by statistical methods for the same 40 items with a control sample which did not drop out. Pre-therapy and therapy populations were considered separately. Although the findings do support several previously held tenets concerning factors contributing to attrition, there are several other beliefs which were not corroborated by the data. Although the clinic charts seemed basically adequate for retrospective study of the activity of the referral source and of the child and family, they revealed too little information, in most instances, about the activity of the professional people which may have contributed to attrition. On the basis of the presumptive findings, several recommendations are made both for restructuring clinic service and for additional necessary studies in this area.

Résumé. Le but de cette étude était de déterminer s'il y a des facteurs cliniques et démographiques identifiables qui différencient les cas qui ne continuent pas leur traitement dans une clinique de psychiatrie infantile de ceux qui le font. On rapporte ici la partie de l'étude dans laquelle un grand nombre de fiches d'informations concernant les cas ayant arrêté leur traitement ont été analysées par plusieurs observateurs indépendamment selon 22 rubriques d'information démographique et 18 facteurs cliniques. Les résultats de cette analyse ont été comparés statistiquement, pour ces mêmes 40 rubriques, à un échantillon de contrôle qui continuait le traitement. Les populations avant le traitement et sous traitement ont été examinées séparément. Bien que les résultats confirment plusieurs opinions émises antérieurement quant aux facteurs contribuant à l'arrêt du traitement, il y a plusieurs autres convictions qui ne sont pas corroborées par les données. Alors que les tableaux cliniques semblaient à la base se prêter à une étude rétrospective de l'activité de l'enfant et sa famille, ils ont révélé trop peu d'informations, dans la plupart des cas, sur l'activité des personnes du métier qui peuvent avoir contribué à l'arrêt du traitement. Sur la base des résultats présumés, plusieurs recommandations sont faites à la fois pour la restructuration des services cliniques et pour les études complémentaires nécessaires dans ce domaine.

Zusammenfassung. In dieser Studie sollte bestimmt werden, ob es erkennbare demographische und klinische Faktoren gibt, die zwischen den Fällen, die eine Behandlung in einer kinderpsychiatrischen Klinik abbrechen und jenen, die sie fortsetzen, differenzieren. In einem Teil der hier berichteten Untersuchung werden eine große Anzahl der verzeichneten abgebrochenen Behandlungsfälle unabhängig durch mehrere Beurteiler auf 22 Items über demographische Informationen und 18 klinische Faktoren hin untersucht. Die Ergebnisse dieser Analyse wurden durch statistische Methoden auf dieselben 40 Items hin mit einer Kontrollgruppe verglichen, die nicht abgebrochen hatte. Gruppen vor und in der Therapie wurden getrennt untersucht. Obwohl die Ergebnisse einige vorher bestehende Meinungen in bezug auf Faktoren, die zum Abbruch beitragen, stützten, gibt es mehrere andere Vermutungen, die durch die Ergebnisse nicht bestätigt wurden. Obwohl die klinischen Aufzeichnungen grundsätzlich für eine retrospektive Untersuchung der Aktivität der Überweisungsquellen sowie des Kindes und der Familie als adäquat erschienen, ergaben sie doch in den meisten Fällen zu wenig Information über die Aktivität der professionell damit befaßten Leute, die zum Behandlungsabbruch beigetragen haben mag. Aufgrund der mutmaßlichen Ergebnisse werden mehrere Empfehlungen sowohl für die Neugliederung des klinischen Dienstes wie für die zusätzlich notwendigen Untersuchungen auf diesem Gebiet gegeben.

Although reliable statistics are not fully available, there are many indications that the case attrition rate in child psychiatry clinics is inordinately high. The term "attrition" is used here to refer to cases where the family makes a unilateral decision (either passively or actively) to terminate service after one or more face-to-face contacts and without any discussion with or notification of the clinic.

It has seemed reasonable to assume that many, perhaps all, of these cases are ones in which the needed or desired service has not been forthcoming and that the family suspends activities aimed at helping the child or directs them elsewhere. This also suggests that a significant amount of scarce clinic facilities and professional time may have been wasted.

There are several other unanswered questions in connection with this phenomenon about which it would be helpful to have better answers. These include: Are there particular characteristics in the presenting picture of the potential dropout family which would make it easier to recognize them much earlier? In what way do referral sources contribute to high attrition rates? Are there any modifications in clinic practice or administration which might make it possible to sort out potential attrition cases earlier, or, at least might make it possible to handle attrition more productively? Is attrition automatically associated with clinical failure in a case?

These questions led us to design the current project. Our initial perusal of available literature indicated the need for a controlled study of a large group of cases which had dropped out in a child psychiatric clinic, and further, indicated the need, where possible, for follow-up of some of these cases in an effort to validate the conclusions. A field study aimed at this latter objective is reported elsewhere (Richardson and Cohen, 1968).

Review of the Literature

Several theories have been proposed to explain unilateral termination following the establishment of contact with a psychiatric clinic. It should be noted that of the following studies only those of Drucker and Greenson (1965), Gordon (1965), Inman (1956), and Tuckman and Lavell (1957), apply specifically to child psychiatric facilities. Since there

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are so many variables operating, there are strong indications that it may be invalid to apply findings from adult clinics to children's clinics [Baker and Wagner (1966), Levinger (1960)]. However, the other studies are reported for general interest.

Some studies have demonstrated that the greater the discrepancy between what patients and families expected from the clinic and what the clinic had to offer, the greater the likelihood of attrition (Overall and Aronson, 1963). Heine and Trosman (1960) state that "the aims which the patient expressed with regard to psychiatric treatment and the means by which he expected to reach his goal were highly related to continuance". Drucker and Greenson (1965) found that frequently mothers objected to the non-committal and non-directive approach since they wanted direction, advice and encouragement. When this was not supplied they left the clinic feeling unhelped. Gordon (1965) suggested that group therapy seemed to be more effective in keeping people in treatment than the traditional individual treatment approach. His study of Middlesex County, where the majority of applicants are of low socio-economic status, reported that "Defining treatments specifically as a course of twenty or more sessions, we have been able to see in treatment 65% of the applicants who have completed intake. This is in contrast to the 20% of the applicants who went into treatment under conventional intake in individual techniques".

Woodward, Patton and Pense (1961) in their survey of the New York State Mental Health Facilities, concluded that hospital clinics tended to have above average attrition rates if: (1) they were largely staffed by volunteer psychiatrists with notable turnover, or (2) if the staff was composed primarily of students who have lesser skills and frequently rotate through different services necessitating patient transfers.

Mayer and Rosenblatt (1966) studied dropout rates from a community organization point of view. They set forth the hypothesis that "the greater number of treatment alternatives perceived by the client, the more likely he will disengage himself prematurely from the mental health practitioner". After a rather extensive study comparing the size of city with, among other factors, the rate of client disengagement, they found their data supported the original hypothesis.

Inman (1956) conducted a follow-up telephone study of families in the Chicago area who had been accepted at the Institute of Juvenile Research for treatment, but did not return following a waiting period. In her conversation with the mother of the identified patient she focused on three questions: (1) Why did the family not return? (2) Did they go elsewhere for help? (3) Had they observed any changes in the problem since the application was made? Results of her study indicated that the families terminated their relationship with the agency for a variety of reasons. Some felt their problems had improved to such degree that psychiatric treatment was no longer indicated. Others had understood from the Institute they were not to return, and still others felt the waiting period was too long. Less than one-third of the families sought help elsewhere. "There was a tendency for mothers of girls to go elsewhere more often than mothers of boys. Also, when a child was severely disturbed the parents tended to seek help elsewhere." In more than half of the cases the parents felt the child had improved, though usually the mother could not explain the noted improvement.

Morris and Soroker (1953) conducted a telephone follow-up study of 72 persons who had applied for service and were placed on a waiting list varying from several weeks to six months in length. Thirty-six of the 72 persons interviewed related that their original presenting complaints were no longer problems to them. Twenty of these 36 stated their problems cleared up spontaneously and through their own resources such as greater family effort. The remaining 16 indicated they were helped by using community resources other than the clinic. The other group of 36 patients related their problems at the time of initial contact were still with them, though half of them felt the intensity of their problems had decreased. These persons had not used other community resources, and most were hoping their problems would disappear with the passage of time.

Tuckman and Lavell (1959) studied attrition in psychiatric clinics for children in an effort "to estimate attrition rate at each phase of the clinic process and to investigate the relationship between attrition at each phase and a number of personal and social factors". They define the three phases as intake, diagnostic evaluation, and treatment. Their study sample included 1,548 patients who were admitted to eleven of the twelve children's outpatient psychiatric clinics in Philadelphia. Unfortunately, the value of this study must be questioned because it was based primarily on statistical reports made by the clinics to a central data-collecting agency. The investigators had little or no access to charts, patients, clinic staffs or referral sources.

Sample

The sample of attrition cases (the experimental group) was obtained simply by selecting serially the last 250 dropouts from the caseload of the outpatient clinic of the Children's Service of the Nebraska Psychiatric Institute. A routine part of case closure involves coding for this factor so that it was a simple matter to have the sample selected automatically through the Institute's normal record-keeping procedures.

In addition, 100 control cases were selected at random. A control case was simply one in which attrition did not occur. No other variable was taken into consideration, including outcome (whether

favorable or unfavorable) as judged by the clinic team participating.

Eighty-three of the original 250 cases did not meet the strict definition of "attrition" as applied to this study and these were eliminated from the sample leaving a total of 167 cases.

Preliminary inspection of the data after collection but before statistical analyses were performed, suggested that we were dealing with two types of case populations subsumed within attrition and control cases. Cases terminated during the intake or diagnostic (pre-therapy) phase are conceivably characterized by a unique constellation of factors in contrast to those cases terminated during the treatment (therapy) phase of clinic contact. If this were so but not taken into account, an unambiguous differentiation of attrition and control on relevant factors would be precluded. We, therefore, determined to deal with these two sub-groups as separate caseloads within both the experimental and control samples. Hence, experimental and control cases could be compared for each of two stages of termination. Of the 167 experimental cases, 126 proved to be in the pre-therapy sub-group and 41 in the therapy sub-group. Of the 100 control cases, 74 were in the pre-therapy sub-group and 26 in the therapy sub-group.

Methods and Procedures

The 350 cases of the original sample were all read and scored independently by three raters using a previously designed protocol containing the 40 separate items.

Of the 40 items, 22 involved objective reporting of factual data from the chart. These 22 items included:

1. Age
2. Sex
3. Race
4. Religion
5. Type of School
6. Grade in School
7. Distance from Clinic
8. Parent Constellation
9. Family Income
10. Number of Siblings
11. Birth Order
12. Source of Referral
13. Time Elapsed Between Initial Contact and Ongoing Service
14. Time Elapsed Between Initial Contact and Last Contact
15. Time Elapsed Between Last Contact and Closing
16. Presence of Follow-up
17. Staff Turnover
18. Number of Trainees Assigned to Case
19. Total Number of Interviews
20. Total Number of Visits
21. Incidence of Re-application for Service
22. Type of Presenting Complaint

In addition, the raters were asked to make 18 judgments concerning the activity of the referral source, the family and child and the activity of the clinic itself in each case, as follows:

Observations Related to Referral Source

1. Error in diagnosis with inappropriate referral.
2. Failure to explain nature of service and properly prepare family (including coercive referrals).
3. Ambivalent referral—mixed signals given to family concerning value and competency of service.
4. "Dumping" referral—desperate move following one or more unsuccessful attempts at treatment (i. e., a negative referral rather than a positive one).
5. Gross ignorance or lack of sophistication concerning indications for service.

Observations Related to Activity of Family and Child

1. Grossly inappropriate parental motivation.
2. Family overstressed by multiple demands and unable to persist in treatment efforts for child.
3. Flight from other professional advice in which child was diagnosed as needing a type of treatment unacceptable to both parents (or as irreversibly damaged; shopping).
4. Gross ignorance or lack of sophistication concerning nature of service offered.
5. Insufficient interest in or investment in the rearing of *this* child.
6. Flight into health.

Observations Related to Activity of Clinic Staff

1. Failure to make proper "diagnosis" early enough.
2. Failure to apply previously established intake criteria.
3. Breakdown in supportive relationship with family because of lack of continuity of care.
4. Failure to resolve collaborative problems between clinical team members.
5. Mis-assignment (e. g., one or more professional people on case too inexperienced for complexity of problem).
6. Failure to assess true nature of motivation of parents and child in seeking care.
7. Excessive wait for service.

This information was then entered on punchcards and totals were obtained for each item respectively for the pre-therapy and therapy sub-groups, in the attrition and control groups. Comparison of the relative distribution of the attrition and control subjects, separately for the pre-therapy and therapy sub-groups, were performed by means of the chi-square statistic for each of the several factors.

The raters were trained on a group of 15 cases which were not included in the sample. In 43 of the 267 cases included in the study there were ratings which differed for one or more items. These differences were resolved through a series of conferences.

This high degree of rater reliability is less dramatic than it may appear on first inspection. Twenty-two of the forty items required the recording of strictly objective data from the charts. The remaining 18 items were subjective and required individual judgments. However, seven of these items occurred under the heading of "Activity of Clinic Staff", and, in many cases, could not be rated at all due to a paucity of material in the charts. Thus, they emerged as negative items in the final score which contributed to the high level of reliability.

As an additional effort to check on our findings and to add to the data available, it was decided to select a group of families and referral sources represented in the experimental group and to attempt to do a series of field interviews in order to determine by direct contact, if possible, what factors had led to attrition. This work has been reported elsewhere (Richardson and Cohen, 1968).

Findings

The results of the analyses of the data are reported in Table 1. (Detailed information concerning distribution of the population in the various categories is available by request to the senior author). Items which are not self-evident are explained in the following text.

The remainder of the 40 items studied (as listed on pages 6 and 7) did not display a significant difference in distribution between the attrition and control samples. (However, note findings in Table 2.) A few words of explanation may be useful to the reader in understanding the meaning of some of the findings reported in Table 1:

1. School: Our finding indicates that a significantly higher percentage of attrition cases attended public school. It is likely that this represents an artefact. While the discrepancy between the proportion of attrition and control subjects with respect to the public school attendance contributed to the significance of this factor, the greatest contribution appeared to be the product of a disproportionate number of "unknown" control versus attrition subjects. Our finding was that it is more likely for the name of the parochial school to be stated explicitly on initial contact than the name of the public school. This means that a much greater number of public school children were thrown into the unknown category in this factor. If this were so, then the discrepancy between attrition and control cases for unknown and public school attendance would probably be minimal or at least less than was found.

2. Parent Constellation: In this category, the sample was broken into six cells (child living with both parents, child living with one natural parent only, mother and stepfather, father and stepmother, child living with neither living parent, adoptive parents). There was a much higher percentage of control cases falling into the categories of "living with neither legal parent and adoptive parents". To a lesser degree, the significant difference between attrition and control cases were contributed to by the fewer number of control cases falling into the category of "living with both natural parents".

3. Time Elapsed Between Last Contact and Closing of Case: The apparent finding here is that fewer attrition cases as compared to the control cases were closed after a short interval of time following the last contact and more attrition cases as compared to control cases were closed after a long interval of time following the last contact.

4. Referral Source: Error in Diagnosis with Inappropriate Referral: The control cases exhibited a

Table 1. *Values of chi-square comparing the distributions of subjects in the pre-therapy and therapy attrition and control groups for those factors displaying a significant difference*

Factor	Pre-therapy sample				Therapy sample			
	Level of signif	*df*	X^2	Group showing greater frequency	Level of signif	*df*	X^2	Group showing greater frequency
Public school	> 0.01	3	26.32	Attrition				
Parent constellation	> 0.01	5	21.19	See Below				
Greater length of time last contact to closing	> 0.01	8	20.90	Attrition	0.01	3	12.44	Attrition
Presence of follow-up	> 0.01	1	10.30	Attrition	0.05	1	4.84	Attrition
Presenting complaint:								
Affective symptoms								
Anti-social behavior	> 0.05	1	4.64	Attrition	0.01	1	13.95	Attrition
Referral source:								
Error in diagnosis with inappropriate referral	> 0.01	1	16.10	Control				
Family and child:								
Inappropriate motivation	> 0.01	1	9.12	Attrition				
Low investment	> 0.01	1	9.04	Attrition	0.01	1	16.34	Attrition
Flight into health	> 0.01	1	11.06	Attrition				
Clinic activity:								
Overlong wait	> 0.01	1	6.97	Attrition				

greater percentage of error in diagnosis with inappropriate referral than did the attrition cases.

In the pre-therapy sample, there were three factors in which there is the suggestion of a significant difference between the attrition and control samples. These are reported in Table 2.

Table 2. *Values of chi-square comparing the distributions of subjects in the pre-therapy and therapy attrition and control groups for those factors suggesting a significant difference*

	Pre-therapy sample			
	Level of signif	*df*	X^2	Group showing greater frequency
Greater time elapsed between initial contact and closing	0.10	8	13.75	Attrition
Referral source: Failure to explain service and prepare family	0.10	1	3.38	Attrition
Family and child: Gross ignorance or lack of sophistication	0.10	1	2.90	Attrition

Conclusions

A. Related to "Positive" Findings

There were three factors which appeared to be significant (i. e., differentiated attrition from control cases) for both the pre-therapy and therapy subgroups. In other words, these were unrelated to the phase of termination of the case. The findings indicate that in both sub-groups the clinic staff tended to keep attrition cases on an "open" status longer and to make greater efforts at follow-up (apparently unsuccessfully); and, that the parents (or surrogates) had "insufficient interest or investment in the rearing of *this* child". Apparently, despite increased efforts to bring some dropout families back into the clinic, the parents could not or would not respond because their current relationship with the patient did not allow for further effort in that direction.

Pre-therapy Sub-group

The typical pre-therapy attrition patient tends to have parents who were not only insufficiently invested in the child's care but often came to the clinic with grossly inappropriate motivation, little knowledge or sophistication concerning the nature of the service offered and who tended to be quite symptom-oriented rather than oriented toward basic change in the child and family. This last observation is related to the significant difference between the two groups in which termination could be attributed to "flight into health" phenomena.

Parents who come to the clinic with a child who does not play an important and valued role in their lives, who harbour neurotic or psychopathic reasons for wanting to modify the child's behavior and who have little or no understanding of what the clinic staff can offer, are likely to drop out prematurely. This is especially true if the child shows some shift toward less symptomatic behavior.

Our finding that attrition rates are significantly higher in intact families where the child is living with his natural parents may indeed be related to the fact that, for many such parents, the clinic experience carries with it projections of accusation by the staff. Natural parents tend to display much more guilt in relation to unfavorable developmental outcome in their children which would make them more sensitive to the necessary historical, exploratory interviewing that usually typifies the intake period.

The finding which indicates higher incidence of presenting complaints of the affective type in the pre-therapy attritioncases is difficult to explain. One possibility is that these are more likely to show "spontaneous" improvement and may therefore be more prone to use flight-into-health defenses. Our sample does not show sufficient consistency between these two factors but the sample is probably not large enough to allow for this.

Another finding in this sub-group which permits only speculation is the higher incidence of "incorrect diagnosis" among the control cases. This may be an artefact since it was rather easy to tell if the staff agreed with the referring diagnosis but not if it disagreed (since, if it saw the child as disturbed, treatment was offered anyway). In any event, in our study, the diagnostic acumen of the referring person did not seem to be a crucial contributing factor to case attrition.

The referring source was important, however, in terms of how well it prepared the family for what services the clinic could perform and how it went about performing them. This point is strongly reinforced by our field study (Richardson and Cohen, 1968). Our findings do confirm that failure to prepare a family adequately for the clinic experience, or referral recommendations that were perceived by the family as coercive in nature proved to be heavily contributory toward high attrition rates.

As might be expected, families who were required to wait long periods of time for service tended to drop out at a significantly higher rate than those who were not. We know from our follow-up work that some parents reacted toward being put on the waiting list as if they had been rejected and immediately developed negative attitudes toward the clinic. In some instances it would appear that during the long wait the family's own adaptive mechanisms came into play and there was considerable resolution of the problem so that with one or two interviews during which the family had a chance to consider what its difficulties were currently, there was no longer the need for help. Some of our families appeared to be surprised that they were considered "dropouts" because they believed that they had been helped considerably and felt quite positively toward the clinic.

The finding of a statistically significant difference between the relative distribution of attrition and control subjects for the factor of type of school attended is not interpreted as being meaningful but rather as an artefact as explained in the previous section.

Therapy Sub-group

Beyond the positive factors noted in the opening paragraphs of this section, there was only one notable instance of significant difference between the attrition and control in the therapy sub-group: there is a greater incidence of anti-social behavior occurring as the presenting complaint in the attrition sample. This seems more understandable than the higher occurrence of affective symptoms in the attrition sample of the pre-therapy sub-group. Children and adolescents with antisocial behavior usually prove to be difficult or even explosive treatment cases. Their behavior is the most intolerable to the community and if treatment results are not forthcoming quickly, other pressures may be brought to bear on the family to seek other types of intervention. Intervention may occur through external forces over which the parents have no control and the clinic may not be notified about it. Since most of these parents seem to harbour a core of psychopathic attitudes toward authority themselves, they would be more likely to handle separation from the clinic irresponsibly rather than through mutual arrangement.

Also, many of the parents of children of this type have been coercively referred and are really quite comfortable with the child's behavior themselves. It is our belief that they tend to drop out in greater numbers because they are more comfortable with the child's behavior than the school and the community are and do not see any real problem with the child. In fact, they may indeed be consciously or unconsciously stimulating his behavior for narcissistic purposes.

On the other hand, the reason(s) for the greater variety of presenting complaints in the control sample as compared to the attrition sample seems unexplainable to us at this time.

B. Related to "Negative" Findings

The present study failed to confirm several commonly proposed theories concerning the reasons for case attrition. The theory that families who live long distances from the clinic are more likely to drop out at a higher rate was not confirmed. In fact, of 29 pre-therapy cases who lived more than 50 miles from Omaha, 20 proved to be in the control group and only 9 in the attrition sample!

Race and levels of family income (as these may be rough indices of socio-economic status) failed to differentiate attrition from control cases.

The theory that high staff turnover in cases tends to make families discouraged was not corroborated by our findings nor was the commonly held belief that large numbers of trainees make for higher attrition rates.

Lastly, the contention that some referral sources refer "better" cases than others (more highly motivated families, more appropriate types of problems, better resources for change) was also not confirmed by our findings.

The work of some investigators in this field (Tuckman and Lavell, 1959; Woodward, Patton and Pense, 1961) is in contradiction to these findings. More intensive studies are needed in order to clarify the reasons for these differences.

Recommendations

A. Related to the Design of the Overall Project

As has been indicated previously, we have not been satisfied with the research design in some respects. Recommendations for future studies would emphasize the following:

1. Projects of this type should be prospective in nature rather than retrospective. Only in this way can careful thought and preparation be given to the types of data required. Provisions can then be made for proper collection of these data and adequate record keeping. Our raters were frequently stymied by ambiguous statements concerning certain factors and, in many instances, no inferences could be drawn at all. This was especially true in relation to the several factors concerning clinic activity. It seems that we are much more adept at recording what the referral source has said, together with our observations about the patient's behavior, than we are about recording our own.

2. A larger sample both of experimental and control cases should be used. This would permit (a) more breakdown and refinement of existing categories, (b) simultaneous comparison of cases across two or more factors occurring in the same sample (If combinations of factors occur in certain constellations in attrition cases, it is quite important to identify these as early as possible because of their predictive value. Efforts were made in our study to search for such combinations but the size of our sample did not permit any conclusions to be drawn), and (c) more adequate follow-up with families and referral sources. Probably no less than 1,000 cases should constitute the total sample.

3. An independent team which has no clinical responsibilities for management of the project sample itself should be active in the clinic *during* the period in which cases are actually being seen. This team should be responsible for determining what data should be collected and how it should be recorded; for rating staff activity; and carrying out direct observations of the parents and child. One of the major defects in the present study is that, in effect, the clinic staff in compiling its records was actually rating itself. It is clear from an examination of our statistics that it did not see itself as making very

many clinical errors. The only positive finding in relation to the clinic is that some families had to wait too long for service. Experience would suggest that the clinic staff contribute heavily to case attrition in other ways, also.

B. Related to Changes in the Pattern of Services

Definitive recommendations in this area should await several such studies of the type recommended above. However, several tentative suggestions warrant emphasis as a result of this study.

1. Considerable time should be invested with the parents at the outset in an exploration of (a) their conscious and unconscious motivations in coming for service, (b) the degree to which they are symptom oriented, (c) the historical and current nature and degree of investment in the rearing of *this* child and (d) what they understand about the role and function of a child psychiatry clinic in the community. This will yield heavy dividends both in terms of reducing case attrition and increasing the eventual effectiveness of the clinic team.

2. Special effort to be made to establish clear lines of communication with referral sources so that they will be knowledgeable concerning the clinic's function in the community and will do more effective preparation of families. Constant feedback about the progress of the case may insure more support of the clinic in future referrals because referral sources are then led to draw their own objective conclusions concerning the value of the clinic.

3. Perhaps every clinic, if its size permits, should consider having a "crisis team" which can be available within 24 to 48 hours of initial contact to see those cases in which there is strong possibility that decompensation is taking place at a rapid pace in the family. Placing families of this type on a waiting list is tantamount to offering no service at all because the family will either reconstitute itself out of its own resources while it waits for service or it will decompensate to a non-functional level and require other types of emergency intervention by community resources which are more responsive than the clinic.

4. There is some suggestion that the open-ended nature of psychiatric service tends to be threatening and frustrating to some parents. It may be helpful and organizing to many families to structure the service more, to give it a time-limited design and to indicate that mutual reassessment will take place at certain milestones which will permit the family to reformulate its decision before committing itself to any further action.

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