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Clerking Mental Health Cases:
The Construction and Importance of a Sequential Order.

This paper presents an analysis of the routine decision-making of staff working in a Community Mental Health Centre (CMHC), from the time cases are first brought to the attention of the Centre up to the point at which Centre staff either reject, or alternatively allocate the case for assessment. In particular I will be aiming to illustrate the social organisation which provides for this decision-making ***as*** routine. Since much of the routineness of these operations proceeds via the completion of forms, notes and other documents, these will feature heavily in this paper. These locally produced data were gathered during an eight month period of observation in a CMHC in the north west of Britain.

Questioning Sequentiality

Many writers have invoked a stage-based model to describe the movement of clients through health and welfare organisations. However, for the majority, the sequentiality so described is inextricably tied to the way it has significance for them as researchers, rather than in its local production by members, (i.e. they are 'second order' constructs). Thus for example Goffman (1961) uses his pre-patient to in-patient to post-patient trichotomy to demonstrate the progressive subjugation of a person's private, family, work and leisure life to the public domain by different agents and mediators. The ***'effect upon'*** the patient is the denial of self-concept, identity, possessions and legal rights and ultimately their disculturation. Similar sequential models which examine the ***'effects upon'*** patients include Jones (1972) 24-stage model of admission and Taylor's (1972) 7-stage model.

In contrast to the above studies, when the theorist's interest changes to the ***'reasons for'*** selection, rather than the ***'effects upon'*** patients and clients, the nature of the sequence described altogether changes. The most characteristic method used in locating the ***'reasons for'*** selecting a patient is to take snapshots of those selected for treatment as opposed to those who are not, (see for example Lubin, et al, 1973; Lipsius, 1973; Feigelson et al, 1978; Apsler and Bassuk, 1983) comparing each cohort in terms of various characteristics such as age, race, gender, diagnosis, previous hospitalisation and so forth. Garfinkel (1967) and later Mishler and Waxler (1968) use a similar comparison, but do so at a number of stages which are described as clinic staffs', '...successive types of interest in potential patients', (Garfinkel, 1967:233). These include data collected on the 'original cohort', after 'first contact', after 'intake conference' and then after 'admission'.

Not surprisingly then, when the interest of the theorist changes, so too does the second order construct used in describing the sequential pattern of activity relating to the client's movement through the organisation. Garfinkel begins to recognise the limitations of this approach in suggesting that, '...treating 'ins' and 'outs' as essentially discrete events, the

researcher may thereby be imposing a characteristic upon the data...[which]...does not accord at all with the features of selection procedures', (ibid: 254).

Taken in its own terms, Garfinkel's analysis may provide one of the more discerning models for identifying 'reasons for' selecting patients, and certainly Goffman's partisan account of the moral aspects of the patient's career still stands as a savage indictment of the worst possible scenario for the 'unwilling' patient passing through his three stages. But neither account takes as its focus members' methods for accomplishing career and sequence, and I take this as the central theme of the following analysis.

A further characteristic of the above models is worthy of note. Treating each stage as a discrete event does not allow for an analysis of how movement occurs between the stages. If we accept that there are gaps that exist in descriptions at these 'nodal points', then versions which methodically exclude descriptions of such nodal point activity are missing (at least) part of the phenomenon that they set out to describe. This criticism may also be made of Rees' (1981), whose ethnomethodological analysis of the 'clerking process' and the 'allocation process' treats the two as separate and discrete events. In reading accounts which exclude such nodal point activity there is an overwhelming feeling of 'staccato' movement or step-start. Yet this impression may be more an artefact of the analysis than a reflection of how the organisations under study actually function, an impression created because the reader is not made aware of the way in which movement of cases between the stages is accomplished by members. From my own observations the selection work of staff in the CMHC was, in contrast, characterised by a consummate 'legato', or 'fluidity' of movement.

Clerking Cases

In order to examine how prospective CMHC clients moved from the point of first contact to the point at which they were accepted as legitimate cases to be considered for assessment, I initially set out to familiarise myself with the documents used in the process and asked staff 'how?', 'when?' and 'why?' such documents were produced. Below a summary is made of staff descriptions of their clerking work.

Any prospective case referred to the CMHC is termed a 'referral' and it is usually processed as part of the 'referrals system'. Clients may be referred to the Centre from the local mental hospital, by friends, neighbours, family, police and so forth, or indeed may self-refer. The Centre is required to have a person 'on duty' between 9.00 a.m. and 5.00 p.m. between Monday and Friday to receive the referrals which may come by phone, letter or self-presentation at the Centre.

For Duty Rota staff, doing taking referrals involves filling in a 'Referral Form' (Data 1) in the case of 'phone or self-presentation referrals, or, in the case of referral by letter (Data 2), the attachment of the letter to the referral form. At the end of each half-day Duty Rota the details of each referral taken are written into the Duty Book, (Data 3).

By talking to the secretaries I was able to ascertain that as well as providing for such long term aims, the Duty Book (Data 3) is also used in accomplishing the more immediate needs regarding the processing of referrals. Each Friday the secretaries compare the names of the prospective clients listed in the Duty Book who have been referred over the past week

Data 1:- Centre Referral Form with details taken by a Duty Officer Included. (Italics represent what was written in this particular form).

REFERRAL FORM

Date *12.10.'87*	**Referred by** **Tel no**. *no*	**FORMAT:- 1. LETTER 2. PHONE 3. CALLER 4. WARD MEETING 5. OTHER**
NAME **ADDRESS ...** **POST CODE**	**SEX** **M (F)** **Tel no. ...**	**DATE OF BIRTH** *11.04.'60* **MARITAL STATUS** **OCCUPATION** **RELIGION**
G.P. *Dr V...*	**FAMILY MEMBERS (or others giving support)**	
PRESENTING PROBLEM *Feeling very down. Has various debt problems one H.P. debt and is due to appear in court in fourteen days.* *Feels very low and needs someone to talk to.* *Has been ill before and has lived in 'y' unit . Didn't say why -not under a Consultant now. Work P T. Working Thursday and Friday next week. Wants to see. someone soon.*	**CATEGORY** **01 ELDERLY** **02 CHILDREN** **03 BLIND** **04 DEAF, HH** **05 OTHER PHYS** **06 MENTALLY ILL** **07 HANDICAP** **08 ADULT** **09 FAMILY**	**PRESENTING NEED** **01 HOUSING** **02 HOME HELP** **03 OTH DOMES SERV** **04 AIDS** **05 ADAPTATIONS** **06 TELEPHONE** **07 SICK BED** **08 FINANCIAL AID** **09 POT CASEWORK** **10 RES LONG STAY** **11 RES SHORT STAY** **12 HOLIDAY** **13 DAY CARE** **14 HOSP DISCHARGE** **15 SPEC INVESTIGATE** **16 SUSP. CHILD ABUSE** **99 OTHER**
PRELIMINARY ACTION *Can phone her neighbour - not on phone - leave a message with appointment* *FOR ALLOCATION*		
Officer Taking Referral		
Client's Ref No.		**Allocated to**

Data 2:- Example letter of Referral from G.P.

Dr. X
Address

**** Centre
Address

Ref:- Mrs. Y
Address

Dear Dr.

This lady had obesity, and went on drastic diets to reduce her weight and has developed Anorexia. She is hardly eating anything and has got into an obsessional state. I shall be obliged if you can see her.

Yours sincerely,

Dr. X

Data 3:- Page from the Duty Book

Duty officer	Date	am/pm	Name of client	Address and phone	referred by	Problem	Referral Form Complete	allocated to	Action taken	

with the Referral Forms (Data 1) in the Referral Forms File. (The Duty Officers should have placed all the referral forms taken during their duty rota into this A4 file.) Any missing Referral Forms are chased up by the secretary, in the first instance usually by requesting it from the person listed in the Duty Book as having taken the referral, since they will know whether the case has been withdrawn, whether it required immediate attention, and so on. In this way the Duty Book acts as an essential reference point through which the secretaries ensure that all cases are duly processed, that none slip through the net, that all are considered at the earliest possible date. This is crucial because the referrals in the Referral Form File act as an agenda for the Allocation Meeting on a Monday morning, each case in the file being considered in turn. If either the Duty Book has not been filled

out for the case, or referral forms are missing, then it is likely that referred clients cannot be processed any further.

In preparing for the Allocation Meeting then, the secretaries take with them the Referral Form File which should contain all the referrals taken by the Duty Officers in the previous week. Moreover they are aware that for each referral a number of decisions regarding the prospective client are possible: s/he may be rejected, allocated for assessment to different therapies, placed on a waiting list, and so on. Retrospectively such decisions will occasion relevant courses of activity amongst a number of different staff members. The secretaries prepare for such contingencies by taking another piece of paper to the Allocation Meeting, (Data 4), in which only the 'name of the client' column is filled out. I will go on to consider the relevance of Data 4 shortly.

Data 4 - Form taken by Secretaries to Allocation Meeting and completed as the cases are discussed and decisions made.

Name of Client	Allocated to.....	Reason Allocated...

Staff explained that there were several reasons for duplicating work by filling in the Duty Book when much of the information was already available on the referral. The referral form is in triplicate form, the top copy being placed in the relevant client's file when that is made, the second copy being filed to be sent to Social Services who require the data for statistical purposes, and the third to the epidemiologists. Without the Duty Book there exists no central record of the referrals taken in any one given time period for use by the Centre. Such data is necessary in compiling reports to management and funding bodies, for writing the Centre's Yearly Report, for display material at Open Days and so on. The Duty book is therefore far more accessible than individual files, providing a centrally located data source, and evidence of the work of the Centre over any specified time period. In the long run then, the Duty Book provides for a more efficient use of organisational time.

For the present, however, and barring contingencies such as the withdrawal of the application, or the immediate rejection of the prospective case, we have now considered the documentary evidences constitutive of members' activities for providing for the possibility of further processing of prospective cases between the referral point and the Allocation Meeting. Members have oriented their activities intentionally to the production of material upon which the relevant staff can come together to make further collective decisions in regards to each case at Monday morning's Allocation Meeting. To aid the following account of the processing of cases I will use the transcript shown in Data 5. As we will see this transcript will also prove useful in the analysis provided later.

You will remember that the secretary has taken to the meeting the week's referrals. These provide an agenda for the meeting, each case being presented for discussion in turn. The secretary is in the position of chairperson, reading out details of each referral form after which the case is discussed, and relevant decisions made. In the present example the secretary reads out a letter of referral (similar to Data 2), which is attached to a Referral Form. The details of Data 2 are presented at the Allocation Meeting as shown in Data 5. As you will recall, the secretary also takes Data 4, the three-columned A4 sheet to the meeting with prospective clients' names listed in the left hand column. Entries are made in the two right hand columns of this sheet as the talk unfolds. Hence the right hand column is completed on the basis of the reading of the client's problem (l 3-11), and the confirmation of this problem by the mental health practitioners (l 13-17). In this case it was completed as 'Anorexia/Can't cope'. The centre column identifying the member of staff 'allocated to' assess her is completed on the basis of the subsequent talk which identifies a person to take on the case.

Data 5 - Transcript Form an Allocation Meeting.

Secretary a	1	Uhhm (.) Debra [surname and address given],
	2	a let< a referral from Dr. [name given]. This
	3	lady had obesity and went on drastic diets to
	4	reduce her weight and has developed a
	5	conscience, she's hardly eating anything and
	6	has got into
Secretary b	7	Anorexia
Secretary a	8	Oh Anorexia, ha ha, sorry
	9	(Laughter 7.0 seconds)
	10	She's hardly eating anything and has got into
	11	an obsessional state. I should be obliged if
	12	you can see her.
Consultant	13	I think that is one (.) probably that ought to be
	14	one for us..its going to be a long while before
	15	we can see her...

The completion of Data 4 is vital for secretarial staff in that it provides for a number of contractually necessary courses of activity on her part. It sets the agenda for her day's work, and once the Allocation Meeting is finished the Referral Forms considered in the meeting are placed in her in-tray, while the completed Data 4 ***is pinned on the wall*** behind her desk. Each case in the secretary's in-tray is dealt with in turn, and after processing is complete it is crossed out on Data 4.

The first question addressed by the secretary is whether it has been found that the prospective case is 'known to the service', which effectively means that a Case History file already exists for the client. This is usually the case for those

clients discharged from the local mental hospital, all of whom are immediately referred to the Centre. If the client has been accepted for assessment, and if ‘known to the service’, the secretary phones the relevant Records Department and requests the file to be forwarded.

It is often the case that such files take some days to arrive, so in the interests of efficiency in completing the relevant material upon which the assessment officer can work, the secretary continues to process the case. Once the file is forwarded, the previous notes are sectioned off with a card so that personnel can easily locate the commencement of the client's treatment within the Centre. Case History files may, therefore, be characterised by repeated career documentation relating to each of the mental health organisations that have dealt with that client.

Having proceeded to this point, the secretary then ensures that the case under consideration has not been 'referred but rejected' over the past few months by looking in a cardex file for 'pending cases'. Each card lists the client's name, address and date upon which the referral was rejected, and if one exists for the case being processed it is taken out of this file. If this is the case the original Referral Form, which is kept in a drawer for pending referrals, is also fished out. If rejected again, the second date of referral is placed on the cardex, and it is placed back with the other ‘pending cases’ cardex cards, whilst the referral form (with the pink duplicates) is attached to the first one and filed in the 'pending referrals' drawer. Letters are typed to the prospective client and his/her GP relating the decision of the Centre giving reasons for the rejection.

If the case has been accepted however, the name of the ‘key worker’, i.e. the person who is to assess the client, is added to the details of the cardex, and the already existing Referral Form is placed with the new one. The pending cardex and pending referral files serve several purposes. Firstly, since many initially rejected cases are later re-referred and accepted, the pending cardex makes for efficient and faster case processing. Secondly, because the two Referral Forms are filed together at the front of the Case History file, it will leave a clue to mental health practitioners dealing with the case regarding the client's case history.

For all accepted cases, whether they be 'known to the service', 'previously referred but rejected', or simply ‘new referrals’, a cardex is therefore completed and placed in the 'Alive Cases’ cardex file. A cardboard A4 file is also made, placing the client's name on the outside in black marker pen, surname first. The relevant referral form is then taken from the in-tray. Using both the Referral Form and the completed Data 4, the secretary can now fill in the last two columns of the Duty Book (Data 3), naming the person the client is 'allocated to', and the 'action taken'. The two duplicates of the Referral Form are torn off and placed in files which are sent regularly to social services and the epidemiology department, while the top copy is placed in the front of the Case History file. This file is placed in the alive cases filing cabinet in alphabetical order, where it is readily available and locatable to the next member of staff who needs to use it, usually the officer doing the client's assessment.

As the Allocation Meeting provides courses of action necessary for secretaries in accomplishing their secretarial obligations, so in turn does the secretary's work occasion relevant courses of action for others, which effectively make their jobs doable. On the day of the assessment the client's Case History file is collected from the alive files cabinet. Out of all the disparate documentations of the case

which already exist; the cardex, the Duty Book, the now discarded Data 4, diary entries, and so on, it is the Case History file which is used by the assessment officer. The practical activity of secretaries in generating the necessary documentation and completion of this record accomplishes the case as a case for further processing, as opposed to a pending or rejected one, and occasions necessary courses of action by the assessment officer.

The assessment officer too, by the time the Case History file is collected, will have pursued several courses of action since the Allocation Meeting. S/he will have made a note of the case taken on and, taking the address of the client from one of many different sources, will have contacted the client to arrange a date for the assessment. If this cannot be done by 'phone, a letter is drafted inviting the client for assessment, and the secretary types it in duplicate. Replies to such letters are placed in the assessment officer's pigeon hole by the secretary, and the assessor confirms the date in his/her diary. Both the copy of the letter inviting the client for assessment, and any written reply are filed ***behind*** the referral Form in the Case History file. Moreover, the client's G.P. is kept in touch with developments also. The assessment officer drafts a letter to the G.P. letting him/her know that the client is being assessed and this is typed in duplicate, once again the copy being placed with any other correspondence behind the Referral Form in the Case History file.

Having outlined the bureaucratic activities which constitute the assembling of a case for assessment, I now return to the methodological issues posed at the outset.

The Accomplishment of 'Career' as a Normative Construct.

On the basis of members' descriptions as outlined above I might have been led to take the view, as are Erikson and Gilbertson (1968) and Rees (1981) that the sequential Case History file reflected a similar pattern of activities in producing them. I might also have accepted Zimmerman's contention that, '...the process of assembling a case record proceeds over a series of steps, each one informing the proceeding', (1968: 325). After all, the 'referral stage' leads to nodal activity which leads to completing the 'referral form' followed by nodal point activity leading to the completion of the 'duty book' and so forth. However, there remained a problem with members' descriptions of the sequentiality of the process as opposed to my observations of its accomplishment.

The crux of my problem as a researcher lay in the fact that Case History files ***as*** completed documents are sequentially organised. By asking staff to clarify the ways in which such documentation was produced, and by observing the activities surrounding the document production, I was effectively colluding with the ways in which imagined ideal-typical cases were constructed as sequential. And what my observations had demonstrated was that the activities surrounding the processing of actual cases did not necessarily tie in with members' descriptions of the sequentiality of these imagined ideal-typical cases. By taking actual cases passing through the Centre as the focus of my observations I became struck by the multitude of contingencies such cases actually posed to staff.

While posing an analytical problem for me, such contingencies did not seem to be reflected in any corresponding practical problem for staff, and I was led to ask why this should be the case. In my

observations of actual cases passing through the Centre I came to think of the contingencies of such cases in terms of the notions of 'overlapping', 'inversion' and 'exclusion' (Note1).

Below it is argued that staff actively seek to preserve a sense of 'right order' to the events surrounding case-processing by 'rehistoricising' the temporal sequence of such events so that they appear in the public record as a right order, despite the contingencies of overlap or inversion.

This argument very much mirrors Cicourel's (1967) consideration of police work and the juvenile justice system in which he argues that,

> '...the police...operate with background expectancies and norms or a 'sense of social structure'...The skills which the police acquire to enable them to decide 'normal' and 'unusual' circumstances, become crucial elements of their sense of social structure.' (ibid: 328),

Contention is taken with Erikson and Gilbertsons' (op cit, 1968) view that each stage is completed with the necessary prior completion of facts. Rather, it will be argued that this fact production itself is contingently accomplished to-all-intents-and-purposes despite information gaps existing. Such contingently encountered retrospective activity to complete files such as the Referral Form, I will call 'overlapping'.

An example of such contingently encountered overlap in terms of Zimmerman's (1968 and 1974) material on applications for assistance from a welfare agency may be the prospective client who has demonstrated both 'need' and 'eligibility' for welfare assistance, but who still needs to produce a marriage certificate that she has misplaced. Having seen a recently dated letter addressed to both the applicant and her marriage partner, the member of staff might well continue processing the case rather than hold it in abeyance.

Such overlaps were a common feature of case processing in the Centre under study. For example, consider again if you will, the transcript presented earlier in Data 5 and Data 2. In this case the information in the referral letter disallows the Duty Officer from either completing the Referral Form, or ticking the column marked 'Referral Form Completed' in the Duty Book. The letter does not contain details such as the prospective client's age, marital status, occupation, and whether the client is previously known to the service. As the transcript shows though, the decision to allocate this client for assessment and treatment was made by staff at the Allocation Meeting with what information was available, and despite the fact that aspects of the Referral Form documentation were incomplete. The details of the case presented at the meeting were sufficient for all practical purposes, despite absences.

The first point to note is that the absences must be dealt with. In the present case this was done ***after*** the Allocation Meeting, and after a member of staff had been allocated to assess the case. The secretary attached a note to the Referral Form asking this member of staff to complete the case details in the Referral Form when possible, to tick the appropriate form in the Duty Book, and to place the pink duplicate of the Referral form in her in-tray, (ready for forwarding to social services). In this example then, the activities surrounding the execution of all the necessary documentation and processing of the Referral Form is completed after the Allocation Meeting, after the letters are written to the

prospective client for an appointment and her GP informing him/her of the decisions being taken.

The temporal overlap of events and activities in processing the case does not however lead to a spatial inversion of the documentation in the Case History file. By placing the completed Referral Form in a 'rightful place' at the start of the file despite the overlap, staff are actively accomplishing a case's accountable career by rehistoricising events to fit this order. Staff are actively doing the accomplishment of the 'normal case' sequence, and I will return to this theme shortly.

What is practically necessary at any given point in order to provide for the continued processing of cases is not therefore coterminus with what is administratively required as a final product of case-processing. Staff are making plain in what they do that the priority in regards any case is providing at any one point enough, sufficient, or adequate information upon which decisions can be made in terms of the case, as-a-possible-case-for-treatment. Administrative and actuarial aspects of the processing such as sending duplicate Referral Forms to Social Services or completing the Duty Book, while necessary, are perceived as secondary to this pursuit. Thus 'overlap' therefore acts as a device which promotes administrative and organisational efficiency in doing work with cases. In dealing with cases as cases for treatment, time is of the essence.

It is interesting to note here also that studies referred to earlier such as Feigelson et al (1978), Windle et al (1988) use criteria such age, gender, presenting problem, i.e. those appearing in the Case History notes to describe 'reasons for' selection. They invoke a reconstructed logic of members' methods for doing case selection. These criteria appear in their model despite having virtually nothing to do with the reasoned decision-making of mental health staff themselves. Such reconstructed logic works on the erroneous assumption that the 'adequate' factual grounds for selection correspond with the 'necessary administrative documentation' of cases.

A further point needs to be made in relation to the present example. In accepting that the incomplete data on the referral form is sufficient grounds for the continued processing of the case the Duty Officer is demonstrating for all to see, her competence. She is accomplishing her expertise and status as a 'suitable' and 'expert' Duty Officer. This is retrospectively confirmed in the ways in which staff manage to make a decision on the case with the facts made available to them.

As can be seen in Data 6, it is a matter of great importance that the Duty Officer is seen to fulfil his or her contractual obligations by providing sufficient factual grounds for the continued processing of the case.

Data 6:- Transcript from an Allocation Meeting

Consultant
1 I-I think we need to be careful what we write on
2 these forms because as I see it, this is an
3 allocation-for-assessment, isn't it? She hasn't
4 been assessed unless she's been assessed by the
5 Drug Team. (.) Can you or [name of clinical
6 psychologist given] get onto the Drug Team an-and
7 make sure what's happened about her (.) and if
8 she hasn't been assessed [name of clinical
9 psychologist], would you want to do an assessment
10 anyway and therefore duplicating the work if you
11 did it and somebody else did it, or would you
12 want somebody else to see her first, an-and they
13 ask you?

In this transcript it is clear that, despite having discussed the case twice, staff cannot work out whether the Community Alcohol Team (the referring agency) has already undertaken an assessment. This would obviate the need for the Centre to repeat this work. The Consultant's rhetorical question, '...this is an Allocation for Assessment meeting, isn't it?' (l. 2 to 3) is at the same time a criticism of the Duty Officer's breach in not providing sufficient factual grounds for the continued processing of the case as well as a reconfirmation of the normative character of the Allocation Meeting as just-such-a-decision-making-meeting. It is a matter of moral sanction that the character of the meeting is accomplished. Such accomplishment is reliant upon relevant staff fulfilling their contractual duties as attested to in lines 1 and 2, 'I think we should be careful what we write on these forms'.

What the present example illustrates is the inability of staff to make sense of this case in terms of future treatment possibilities on the basis of the administrative data available. But why should this be so? What I want to suggest is that what is being invoked here is a duty and obligation for Duty Officers to provide in their referral recordings information through which staff can deal with cases in mutually recognisable, intelligible, and shared ways. I want to argue that in making sense of cases on the basis of administrative data made available to them by the Duty Officer in the allocation meeting, staff need to be able to construe the case as having reached some particular, and mutually recognisable point in terms of a normal career sequence.

However, what constitutes right and proper information is itself contingent. Take the two transcripts that appear in Data 7 and Data 8, in which there is an 'inversion' to the normative sequence accomplished in the Case History File in terms of the activities undertaken to produce it, and yet the file still appears

Data 7:- Transcript from an Allocation Meeting

Secretary 1 '...and she's [i.e. the senior social worker] asked me to
2 mention [name] of [address]. I don< uh [senior S\W's
3 name] did go out to visit her that afternoon.

Consultant 4 That's right. I think she's telling us she's dealt with it.

Secretary 5 Well it sez 'ere she's arranged to visit for the 30th, so
6 she must have...

Consultant 7 Yeh [name] saw her G.P. with slashed wrists (.) and
8 she sa< she di< and she couldn't remember how she'd
9 received them. I< I think she's just telling us that
10 she's dealt with it.

Secretary 11 Right, uh next....

Data 8:- Transcript from an Allocation Meeting.

Registrar 1 ((1.0)) [name]. He's likely to be discharged ((
2 1.0)) in the future. [name] was admitted on Friday.

Secretary 3 Do you want to run through it so that(.)< while we've
4 got sort of time and we'll...

Registrar 5 Yeh sure. He was admitted on Friday. His wife has
6 finally left him and he sort of said he was having
7 problems with [consultant's name] and his people< drying
8 out. But he said he's got no drink problems...

Community 9 I suppose there's no reason why we can't allocate
Nurse 10 him before discharge.

in a 'correct' order when produced.

In Data 7 the secretary has received a note from the social worker. She had not filled in a referral form or the duty book before the Allocation Meeting. However, the category-bound activity 'slashed wrists' (l. 7) is enough to point to the device 'attempted suicide', i.e. an emergency that had to be dealt with immediately. The social worker's right and proper duties and obligations in self-allocating, assessing and providing a service input may be taken to have out-weighed the administrative necessities of completing the referral form. It may not have been an opportune time to be asking the client for these details, or perhaps she hadn't taken a referral form with her and so forth.

In Data 8 staff are recognising the category ‘discharged’ as doing adequate reference to a psychiatric hospital 'in-patient', and as is the case with all in-patients, one who will be a Centre case. The patient file and discharge summary will be sent on to the Centre in due course, and although the referral form will ultimately have to be completed, it will have no bearing on whether the case is to be accepted. In other words, for discharged cases, the career is assured. The necessity to 'know where you're at', as a means of further processing regarding selection is redundant as all such discharged patients will reach the treatment phase. That there will be an input is in no doubt. Thus the inversion of activities poses no problem in terms of the accomplishment of the proper sequence. The allocation of a member of staff prior to discharge (l. 9-10) can be justified in terms of efficiency in handling the case once the person has been discharged.

Conclusions

The analysis in this paper might be viewed as exhibiting two interests. On the one hand the interest has been on the case history file as a 'product', and in its sequential order. On the other it has been on the 'production' of that file.

Garfinkel (1967) has argued that the product, i.e. the clinic file is, '...assembled with regard to the possibility that the relationship [between client and clinic] may have to be portrayed as having been in accord with expectations of sanctionable performances by clinicians and patients', (ibid: 199). Such 'contractual' data, as he terms it, is designed for a medico-legal involvement, for entitled readers such as mental health staff. Thus, '...the folder contents much less than revealing an order of interaction, presuppose an understanding of that order for a correct reading', (ibid: 201). In large part the primacy of contractual data over any other data explains the deficiencies of actuarial or standardised data which is observed in such files.

The ‘correct reading’ to which Garfinkel refers above was shown earlier in this paper to reflect the ways in which Centre staff themselves described the sequence of events leading to its creation as a sequentially organised document. The file itself may be spasmodically used by staff for decision-making about cases. It is therefore consequential that relevant information is made available in that file for a 'next use'.

For example, once the file has been completed prior to assessment the assessment officer will use the referral form data in setting up that assessment. Thus it would be deemed odd were a case referred for anorexia nervosa to be assessed for anxiety. The file will also carry confirmation of the appointment which if broken will lead to particular courses of action. And so forth. The file is therefore produced for a rendering in which it might be retrospectively interpreted for the purposes of a prospective use, that is, used reflexively. The creation of the Case History file also proceeds in this reflexive manner.

The fulfilment of duties and obligations by different staff members provides for courses of action through which other mental health staff can accomplish their own duties and obligations in relation to the case. Thus it is the task of duty rota staff to characterise a case in sufficient detail to allow for further decision-making as argued in relation to Data 6. Indeed it was seen as a matter of contractual necessity that this was the case.

It does not matter if the duty officer has self-allocated the case and provided treatment before the allocation meeting, as described in Data 7. It is part of their job

to know what to do when confronted with any mental health problem that is referred. Indeed, were the officer to have arrived at the Allocation Meeting saying that there was a referral taken from a call three days ago from a person threatening suicide and that nothing had been done in the mean time, it might be seen as a dereliction of his duty.

Despite such inversions in the right order of dealing with cases, what is important is that the duty officer makes clear that the case has reached a recognisable point, and that it has done so through the right and proper action of the member of staff concerned. As long as correct sequence in terms of the contractual obligations of mental health staff can be seen to be preserved, the case history file is produced as a proper order, for a further reading despite the sequential inversion of activities in its production.

It has been shown that what is contractually necessary for mental health staff in making decisions about cases is, in terms of the information provided, not coterminus with all the possible data for which the referral form provides. There are therefore cases of overlap in which the completion of the referral form post-dates the contractual work of decision-making in the Allocation Meeting. I am going to suggest that it is part of the secretary's' duties in providing for the completion of this actuary.

More accurately, the data points to a number of identifiable tasks and duties on the part of the secretaries. Firstly the secretaries seek to 'facilitate contractual work' at any time during the clerking process by collating the information upon which further contractual work of mental health staff rests. It will not have escaped the reader's attention that such 'contractual work' is mental health staff work, and not that of the secretaries. However, the secretary facilitates this contractual work by collating the week's referral forms; by checking against the Duty Book that all the referral forms are available for the Allocation meeting so that none fall through the net; and by using the referral forms to set the agenda for the Allocation Meeting. If after the meeting the case is taken on, it involves: the creation of a case history file in a proper sequence; ensuring that for a proper reading files for any previous contact with the psychiatric services are ordered; placing the file in a known place, in alphabetical order for easy retrieval. The secretaries therefore facilitate the work of mental health staff in decision-making about cases.

The second category of secretarial duties might be described as 'fulfilling actuarial needs', both formal and informal. If referral form data is incomplete after the Allocation meeting the relevant section in the Duty Book will show up that this data is missing. Since cases taken by the Duty Officer will be assessed by different members of staff, the secretary attached a note on the Referral Form asking the relevant staff member to complete the information on the form. She cannot separate out the copies for social services and for the epidemiologists until this is done. The referral form is an actuarial record of the Centre's involvement with the client, providing a set of standardised data. The Centre is obliged to keep their Health and Social Service paymasters and epidemiologists apprised of their work by submitting these forms on a regular basis. The secretary's' methods for the fulfilment of these formal actuarial needs therefore provides for efficiency.

In contrast, the Duty Book was a creation of Centre staff. It did not exist for any external bureaucratic or contractual reason, but was used for a number of present and hypothesised future needs. Thus the secretary used it to ensure that no referral forms were missing before the

Allocation Meeting. It acted as a marker as to whether the referral form was completed and, after allocation, was a ready reference point for finding out who was involved in the case. Moreover, as the only central and indeed chronological source of data on cases referred to the Centre, it provided an efficient device for the abstraction of data relating to the work of the Centre over any given period.

In short, the secretaries ensure that gaps in the information of both formal and informal actuaries are filled. They provide the antidote to Garfinkel's observation that mental health staff are interested in contractually necessary information and that as such the actuary is often incomplete, i.e. that there are good organisational reasons for bad clinical records, (Garfinkel, 1967). Moreover in doing all this the secretaries provide for an efficient use of collated data for others whose duty it is to work on such data, for example social service staff and epidemiologists.

In both 'facilitating contractual work' and 'fulfilling actuarial needs' the secretaries therefore provide a set of 'conditions' under which staff might most efficiently accomplish their various contractual obligations. In contrast to these two categories though, the secretaries have to provide their own organisation which will allow for these possibilities. In relation to the clerking process one of the secretaries will put aside time each Friday to chase up referral forms, and to create Data 4; She will also set aside the Monday after the Allocation Meeting to use this data to structure her work for the day, pinning it on the wall, and dealing with each case in turn. These informal methods therefore provide a system in which the secretary accomplishes her responsibilities.

The description presented in this paper has been aimed at disentangling the complex web of work relations which characterise the clerking process in a CMHC. The process is not the remit of a single individual. Through collaborative interaction staff produce a social organisation which allows for collaboration in bringing the prospective case from the point of referral to the decision for assessment or rejection. One way that staff accomplish this collaboratively is by ensuring that at any relevant point in time the data relating to any case can be read retrospectively for a prospective using. In terms of the clerking process the key points for such a reading are, barring contingencies, after the referral has been taken, and then at the Allocation Meeting. In terms of the Case History file a proper order is adhered to, so that at any time mental health staff might use the data for a relevant reading in accomplishing their contractual obligations regarding the case.

No problems arise for staff where there is an inversion of the activity which characterises the normative sequence of the Case History file, so long as the right and proper contractual duties to the client can be seen to have been met. Staff, usually secretaries, simply rehistoricise the events to achieve compliance with the normative order in the production of the file.

The production of sufficient referral form data by the Duty Officer accomplishes

his/her status as Duty Officer, and in so doing provides for the contractual obligations of other mental health staff in considering the case at the Allocation Meeting. This decision-making in turn provides relevant grounds for work by an assessment officer if the case is accepted.

Taken as purely document producing activities, the Duty Rota and Allocation Meeting work produce huge amounts of data. It is the administrative task of secretaries to collate this data in ways that provide mental health workers the means to fulfil their obligations, and further, to ensure that the non-contractual and actuarial aspects of a case's documentation are dealt with. In doing all this activity the secretaries provide the 'glue' at the nodal points of 'stages' and provide the last ingredient which makes for a 'fluidity' or 'legato' in the movement of cases through the clerking process and beyond.

1.'Exclusion' is not dealt with in this paper given the limits of space. The Centre does not only deal with 'problems', but with 'problems waiting to happen', people they term as being 'at risk' of having a mental health problem. Such people come to the Centre in an entirely different way in that staff do all that is possible ***not*** to document the person's relation with the Centre. In such cases then, no documentation exists apart from a contact name and addres.

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