

Referring Clients for Psychiatric Medication: Best Practices for Social Workers

Kia J. Bentley, Joseph Walsh, and Rosemary Farmer

A recent national survey of clinical social workers confirmed that referring clients for psychiatric medication is one of the two most frequently performed social work roles in clinical practice related to medication management. Yet little discussion has appeared in the literature as to what constitutes a good referral in these circumstances; that is, what social workers who strive for excellence in practice should be doing with respect to psychiatric medication referrals. This article suggests that while there have been few empirical investigations of effective referral practices, six dimensions of quality can be offered. These best practices set a high standard for a critical activity of social workers across fields of practice.

Key words: best practices; collaboration; psychiatric medication; referral practice

Introduction

A long-held belief in social work is that, as Sands puts it, “making an appropriate referral is a concerned and caring contribution” to a client’s well being (2000, p. 364). Prompt and timely referrals may even be connected to the prevention of unnecessary suffering for many clients (Ross & Hardy, 1999). With respect to social workers making referrals for psychiatric medication in particular, a recent national survey of clinical social workers confirmed that this activity is one of the most frequently performed social work roles related to medication management. Indeed, 72% of the large sample of National Association of Social Workers (NASW) members said they refer a client to a prescriber “often or very frequently” in a typical month (Bentley, Walsh, & Farmer, in press). Over 95% said this was

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quite an appropriate role for social workers and almost all (89.2%) felt competent in performing this role. Yet little discussion has appeared in the literature as to what constitutes a good referral, that is, what social workers who strive for excellence in practice should be doing with respect to psychiatric medication referrals. A first question to pose then is: Is there research, or even any agreed-upon practice wisdom, that will shed light on that question? This article suggests that while few researchers have empirically investigated effective referral practices, some tentative guidelines can be offered based on the limited existing research, knowledge transfer from related literature, and a synthesis of professional consensus. These best practices set a high standard for a critical activity of social workers across fields of practice.

The Context of Excellence in Medication Referral

The medical and psychological literature on referral practices most frequently addresses the relationship between primary care and psychiatry and/or psychology. The direction of concern in most of the literature is the referral from a general MD to a mental health specialist, most frequently a psychiatrist. The specific focus of much of the mostly international research is: reasons for, and appropriateness of, initial referral decisions (e.g., Evans et al., 2002; Ashworth, Clement, Sandhu, Farley, Ramsey & Davies, 2002; Nandy, Chalmers-Watson, Gantley & Underwood, 2001), the lack of compliance with referrals that are made (e.g. Glyngdal, Sorenson & Kistrup, 2002), attitudes of one medical discipline toward another (e.g. Adeyemi, Olonade & Amira, 2002), or the level of satisfaction with referrals versus a physician's expectations (e.g. Tanielian et al., 2000). Rushton and associates conducted a study that examined a broader range of disciplines as recipients of a mental health referral. Their study involved 206 primary care settings and 1,650 children and adolescents, which represented 16% out of the over 10,000 seen who had been referred on their initial visit to a range of practitioners for treatment of a variety of psychosocial problems (Rushton, Bruckman, & Kelleher, 2002). In order of frequency from most to least, the referral choice of primary care physicians (PCP) was psychologists, counselors, social workers, and psychiatrists. Expertise and availability were the most important reasons cited for the primary care physician choosing a particular provider. Factors associated with receiving a referral in the first place included the severity of the problem, the existence of psychosis or substance abuse, prior use of mental health services, and interestingly, when the physician visit lasted a long time. Importantly, only 61% of the referred families actually saw a mental health provider within six months of the referral, and of even greater concern is that only 30% saw someone more than once. The best follow-ups were associated with the primary care physician's office making the actual referral (not the family member), being referred to a psychiatrist (lowest follow-up was to a social worker), and having short waits for appointments. However, in this literature there is little discussion of specific issues concerning referral and psychiatric medication.

One of the few empirical studies anywhere of nonmedical clinicians' referrals to a prescriber of psychiatric medication was published just over 10 years ago in our own field of social work. Littrell and Ashford (1994) found little connection between field of practice setting and the propensity to refer for medication in cases of severe depression. That is, clinicians in family service agencies were equally likely to refer to a prescriber as those in mental health settings. However, in situations where the client presented less severe symptoms, clinicians in mental health settings were more likely to refer. The study did not address what constitutes excellence in medication referral.

In summary, the literature across disciplines gives less than adequate attention to the quality of referrals and highlights the problematic lack of client-centered emotional and practical preparation for a referral by referring clinicians. The literature also suggests that negotiating collaboration among providers can be challenging, and indeed inattention to cross-disciplinary relationships is common. These issues can contribute to poor follow through of referrals and result in less than adequate mental health care. Based on this literature, we specifically argue that a good referral for psychiatric medication requires attention to six dimensions:

1. Establishing and maintaining collaborative relationships with prescribers;
2. Sharing up-to-date information about psychiatric medications with clients and families;
3. Helping clients and families understand and manage the meaning of medication;
4. Preparing clients and families for the actual medication evaluation and anticipating issues that might emerge;
5. Following up on the results of the referral;
6. Managing legal and ethical concerns.

Best Practices in Making Referrals for Psychiatric Medication

Establishing and Maintaining Collaborative Relationships with Prescribers.

An extensive literature exists about interdisciplinary collaboration in general, and a smaller amount addresses the nonmedical practitioner's relationship with psychiatrists and physicians to whom they might refer clients and accept referrals of clients from. Similar to other authors, O'Malley (1996, p. 274) recommends the development of "referral highways," by "nurturing cross-referral opportunities" with those to whom one refers, meaning teaching prescribers about one's own psychosocial services in addition to learning about the other provider's services. Lawless and Wright (2000) lay out a more specific plan for developing such a referral base. First, they suggest developing a potential contact list through Internet discussion groups, community mental health providers, the yellow pages, state mental health lists, and licensing boards. They go on to suggest the development of a "Physician and Practice Profiles" which would contain the name,

address, hours, practice size, professional and personal interests, and publications of potential and actual prescribers. To get one's foot in the door of a prescriber's offices, they suggest offering to provide consultation or training, doing regular or introductory mailings or a brief video, developing a brochure or newsletter, inviting prescribers' clients to participate in a treatment group, or holding an open house. Recognizing the "complete flux" (p. 17) of referral sources, Lawless and Wright suggest maintaining one's own name recognition with reminders sent to prescribers about services. Clinicians should also recognize the barriers erected by hectic schedules, conflicting professional styles, differing uses of language and time, differing assumptions about human behaviors and differing outcome orientations (Shaefer, Chesshyre, & Kendal, 1999). Thus, relationship development with prescribers should be viewed as a "long-term project" (Lawless & Wright, 2000, p. 67).

To aid in relationship development, clinicians must do their part to effectively communicate issues that might influence treatment success, by providing thorough and complete assessments of the clients' chief concerns, current functioning, family history, treatment plans, and prognosis. In a recent survey of 435 psychiatrists, findings suggest that clinicians use a large range of communication devices in managing referrals including letters, phone calls, standardized forms, in-person visits, and e-mail. The highest satisfaction rates were associated with the use of the telephone and having received some information on the client (treatment history and reason for the referral) before the first visit (Tanielain et al., 2000). Browning and Browning (1996) argue that one's referral base will center on knowing what your collaborator wants in terms of types and depth of information, desired outcomes, and expected nature of follow-up. Browning and Browning state the obvious when they point out the importance of general friendliness, telephone etiquette, and effective writing skills.

Although conceptual articles that argue the merits of increased collaboration are easily found, few go beyond and offer concrete strategies for enhancing contact. An exception is Cameron and Mauksch (2002). In describing their funded project aimed at better integration of psychosocial services with regular medical services, they note that "lasting collaboration" (p. 348) must mean building a relationship between disciplines. This requires, among other things, more and different kinds of education and training, including more interactive didactic interdisciplinary sessions complete with video, role-plays, conjoint visits and case consultations, and periodic shadowing of each discipline's daily functioning. Similarly, in discussing the integration of psychology into primary health care, Talen, Fraser, and Cavley (2002) suggest trainees actually become a patient to experience the referral system personally, and using a practice familiar to most social work interns, they suggest trainees tour the neighborhoods of clients and make visits to key community agencies where clients will receive services or may be referred.

Responses to an open-ended question in the Bentley, Walsh, and Farmer (in press) survey of practicing social workers also offers ways to realize some of the

high hopes and enact some of these creative relationship enhancing strategies just described. When social workers were asked to name one change they would make in practice to improve their response to clients who take medication, literally half of the respondents who answered noted they would interact more extensively with the medical community. It is clear that a close, frequent, and ongoing relationship with accessible prescribers, who value psychosocial approaches and see them as complementary to medication, is essential to excellence in practice. Respondent ideas for improving collaboration and communication echo those above and include greater use of team approaches, creating more opportunities for formal and informal interaction, and more involvement of social workers in face-to-face client appointments with prescribers.

In response to a second open-ended question in the Bentley, Walsh, & Farmer survey (in press): What do you think is the most important thing that you do personally that contributes to a successful outcome with your clients who take medication? A large group of respondents noted engaging in productive collaborative interactions with prescribers. They connect their collaborative effectiveness to high frequency of contact, being proactive with them, visiting prescriber's offices, participating in consultations, and follow-up with them after the referral. The data, however, show that while practitioners highly value collaboration with prescribers, the demands of practice today make collateral contacts challenging to institutionalize.

Sharing Information Regarding Psychiatric Medications with Families and Clients.

The heart of social work practice, some would argue, is the problem-solving process, a step-by-step structure of identifying concerns and possible solutions, and comprehensively considering the pros and cons of actions prior to decision making. With respect to decisions to refer or to take psychiatric medication, social workers should be sharing up-to-date knowledge, including findings from current research about effectiveness (or lack thereof), and accurately and fully sharing alternative treatments. Littrell (2003) is even stronger in her argument that a full discussion of risks and benefits is demanded by informed consent laws and practices. She notes too that the political context of clinical drug research, the realities of relapse rates and the placebo effect, makes these discussions "daunting" (p. 118), with the social worker assuming "an awesome responsibility" (p. 117). In our view, social workers must avoid appearing as cheerleaders for the pharmaceutical industry, appearing manipulative or coercive by overstating the predicted benefits, or acting as if there are no choices. On the other end of the continuum, social workers should also avoid being pessimistic naysayers who discount all rigorous research as biased and are blind to the positive effects of these medications for many, if not most, who take them. The best practice mandate is to share the best available information on both effects and side effects of medications, as reflected in the empirical literature and in the social worker's practice experience.

The mandate extends to sharing what is known and what is not known about why psychiatric medications work and what the short- and long-term effects are. Agencies and clinicians can support this ideal by sponsoring or attending regular continuing education programs on medication-related topics, and purchasing good-quality paperback guides to psychiatric medication which are widely available.

The crucial nature of knowledge exchange is summarized by Bentley and Walsh (1998, p. 310), "With clients and families, social workers must be able to translate complex information into understandable, useful knowledge for living. Social workers should be able to dispel myths but provide realistic cautions and should be able to provide both concrete help and empathetic understanding concerning medication-related decisions."

Helping Clients and Families Manage the Meaning of Medication.

Bentley and Walsh (1998; 2001) noted that the fit that social work's person-in-environment perspective provides for undergirding roles in helping clients and families manage the meaning of psychiatric medications in their lives. This means paying close attention to what taking psychiatric medication symbolizes, or conveys, to people about themselves. Over the past few decades, the literature in sociology, anthropology, and philosophy have all given attention to this kind of subjective experience of people who take psychiatric medications, often drawing on qualitative, naturalistic research (for reviews see Bradley, 2003; Bentley & Walsh, 1998). This previous research, as well as published personal accounts of consumers of medication, attests to the tremendous variability of client reactions to, and interpretations of, psychiatric medication. For example, while some see medications as a god-send, a "remedy" that helps them be their true selves, others characterize it as poison and speak about the invasion to their body and personal identity (Jonsen, 1988). Insights like these help social workers better appreciate and empathize with both heartwarming and heart-wrenching client experiences. In this paper, our concern with meaning, identity, and sense of self is focused on two aspects of the referral process: 1) the impact of the initial referral for medication evaluation, and 2) the onset of actual (or anticipated) medication use with this unique type of medication.

Bradley (2003) provides the most comprehensive social work oriented discussion of the meaning of medication to date. She notes that when there is a triangular relationship between the client, the social worker, and a prescriber, meanings can be quite complex, and there is "fertile ground" for "multiple and potentially competing beliefs and attitudes" (p. 31). For example, she notes that positive transference can occur when the client perceives either the suggestion of a referral or the prescription itself as an acknowledgement of pain, a validation of suffering, a welcome token of the practitioner's empathy and nurturance, and hope for normalcy in their future. On the other hand, she also notes it could represent narcissistic assault, a threat to identity and independence, and an indication that the client must be more seriously ill than thought, or may convey a message that the clinician

is either disinterested or frustrated with the client. Gould and Busch (1998) note that especially when the social worker initiates a referral, there could be panic, anger, or depression. If the client initiates the conversation, there might be guilt, shame, or embarrassment. Clients may anticipate that medications will make them feel like zombies, morally weak, or flawed. Any of those could lead to premature termination of treatment, nonadherence, passive compliance in order to please the social worker, or a restriction of future information-sharing.

Floersch's (2003) attention has uniquely focused on meaning-making among children and adolescents, expressing specific concern about the impact of psychiatric medications on, for example, feelings of self-reliance, adequacy, body image, and the development of an "illness identity." His research shows that the needed response is to involve children and adolescents as "full partners in psychotropic treatment" by "listening and responding to how they make sense (i.e. interpret) of their own experience with medication" (p. 52). In exploring how social workers can help children and adolescents explore the meaning of medication, Bentley and Collins (in press) suggest that social workers creatively tailor interventions and use such techniques as story-telling, puppet play, drawing and painting. Bentley and Collins also suggest using existing or original contemporary music and poetry with adolescents when possible.

Rappaport and Chubinsky (2000) stress the experience of meaning for parents when their child receives medication. They may, for example, feel validated and protected from accusations of overreacting or exaggerating, or may feel a sense of loss, grief, or even guilt or shame, if they believe they are culpable in some way for causing the need for medication. Jensen (2004) encourages social workers to help families re-evaluate erroneous or problematic beliefs about medication and mental illness that may contribute to negative feelings in themselves or their children. He stresses a cognitive approach to addressing meaning among parents, specifically suggesting that social workers provide alternative (more accurate or more helpful) cognitions or new information.

Preparing the Client for the Referral and Anticipating Issues that Might Emerge.

Regrettably, the recent survey (Bentley, Walsh, & Farmer, in press) of practicing social workers suggests that while most think that preparing a client for a medication evaluation is indeed an appropriate social work role, only 38% said they do it "often or frequently" (Bentley, Walsh, & Farmer, in press). We argue that while the outcomes of the psychiatric medication assessment cannot be predicted, it is crucial for the social worker to help the client anticipate several potential scenarios. These scenarios may include receiving a prescription, not receiving a prescription, and helping the client anticipate various possible treatment responses, (good, bad, and in-between). This best practice conclusion is strongly supported by the classic meta-analysis of Videka-Sherman (1988) who noted that preparing clients for the processes involved in treatment is a key characteristic of successful mental health practice.

Thus, when a social worker refers a client to a prescriber, she/he is actually just setting up an evaluation for possible treatment with psychiatric medication. The goal of the assessment is for the prescriber to obtain the most complete, accurate, and richly detailed information possible so that confident decisions about specific medication types and dosage, if relevant, can be made. To start, clients and families need an overview of what to expect in the assessment process. A recently published book chapter by Bentley and Collins (in press) captures some key ideas along those lines. First, there is likely to be great variability in the processes and procedures of medication assessment, but a few common elements might be expected. For example, especially for children and adolescents the process may involve one or more interviews with the client and perhaps parents, or other important collateral contacts (where permission has been given.) Most providers would consider a 10 to 15 minute evaluation session by a single provider to be inadequate, although this still may happen too frequently. Clients can be prepared to expect a series of questions and probes, with providers often seeking an in-depth developmental history (parents or guardians may also provide this), details of past and current patterns of behavior, and thinking and feeling (from client or family members). Medical records, psychological tests, or brief checklists or inventories may be used. Importantly, it is likely that conclusions reached by the physician will be tentatively presented, with disclaimers about how adjustments in treatment with psychiatric medication may be made in the future. Although we know that most visits to both general practitioners and psychiatrists do indeed result in a prescription, clients should be prepared that a decision to prescribe may be postponed or rejected altogether. Practicing social workers report that one of the most important things they do is to coach clients in asking the prescriber questions, and in general, to take a more active role in their pharmacological treatment (Bentley, Walsh, & Farmer, in press). In addition to sharing information about processes and procedures, clients and families may be curious about the human aspects of the referral. They may have questions such as, Who is this prescriber? What are her credentials? What is he like? Again the key here is not to be overenthusiastic or to overstate things, but to offer an authentic, honest, and factual account of your professional knowledge about the prescriber (Sands, 2000).

A major dimension of a good referral is when the social worker helps the client anticipate a range of emotional responses to the evaluation. As alluded to when discussing the meaning of medication above, a comprehensive psychopharmacological assessment is "likely to be anxiety-producing even if it is associated with great hope for positive change in the future" (Bentley & Collins, in press). Social workers can also help clients and families anticipate emotional reactions to the actual effects of the medications. Frustration and impatience may result because of the lag time between ingestion and impact, often up to four or six weeks with antidepressants, for example. We also know that in spite of a general clinical effectiveness rate of 70% for psychiatric medications, this still leaves just under a third, often more, with less than desired or hoped for impact. Despair and disappointment may result. Longhofer, Floersch, and Jenkins (2003) discuss this interpretive

gap between a client's desired effects and actual effects of medication in some detail, noting the ambiguity, contradictions, and paradox that can be experienced by clients.

Following up on the Results of Referrals.

The idea presented in this paper is for social workers who make referrals to prescribers to assume some responsibility for the quality and results of the connection. Excellence in referral exceeds "steering," or merely giving a client a name and number of another provider or agency, with a sort of simultaneous washing of the hands. Thus, the building of collaborative relationships and the practical and emotional preparation of the client are part of the overarching goal of quality. Even if the social worker is terminating care of the client with the referral, some follow-up is in order. As is more common, if the referral is really the beginning of parallel care (split treatment) of some kind, that is the addition of another clinician in the treatment system, some timely follow-up and monitoring is in order, perhaps even within a day or two of making the referral or the appointment itself. Various methods of "cementing" have been suggested to reinforce the connection between the prescriber and the client. One bare bones way is to simply ask the client about the nature of contact with the prescriber, another is to use some agreed upon standardized form as a communication tool between the social worker and prescriber, as discussed earlier. All the literature attests to the notion that the most optimal method is to maintain *direct* contact with the prescriber. A needed component in follow-up care is a discussion with both the client and the prescriber about the parameters of confidentiality in the three-party arrangement.

Managing Legal and Ethical Concerns.

Walsh, Farmer, Taylor, and Bentley (2003) found that clinical social workers routinely experience a range of dilemmas and conflicts that seem relevant to psychiatric mediation referrals as they assume roles related to medication management. These include finding the line between encouragement and coercion with medication, feeling caught with families around information sharing, and feeling pressure to support a prescriber's decisions. The most frequently experienced ethical dilemma by clinical social workers, however, is respecting a client's decision not to take medications in the face of continuing symptoms. A number of other dilemmas seem to relate to the interface of medication and the structure of service delivery. For example, concern with long waiting lists to see prescribers, worries about the impact of managed care on decisions to medicate, and concerns about costs, coverage, and availability of medications were particularly bothersome to social workers in their study. Many also expressed worry about the quality of care offered by physicians. The second most frequently experienced dilemma concerned the over- or under-medication of clients, with 40% of respondents reporting at least "occasionally" that in a typical month they lacked confidence in a physician's ability to effectively prescribe.

Looking at referral from the other side of the desk, we see that prescribers also have some ethical concerns about working with social workers. In a rare study of psychiatric medication referral apart from primary care, Goldberg, Riba, and Tasman (1991) found many had concerns about three-party arrangements and resulting ambiguities of liability and responsibility. In situations where there is split treatment, that is parallel treatment by a prescriber and a nonmedical clinician, such as a social worker, shared responsibility and possible loss of autonomy is at the heart of the concern for all parties. However, the tradition of seeing the prescriber as both captain and treatment team leader, and as a deep pocket may increase her or his exposure to malpractice claims in situations where care is coordinated with another nonmedical provider (MacBeth, 2001). Clearly these kinds of dilemmas impact the referral process in complex ways and mandate open communication and intense efforts to nurture relationships.

The question for this paper is how the social worker manages ethical dilemmas and conflicts in referral practice, which seem to center on self-determination, confidentiality, and social justice concerns. Wesley (2002) argues we have to do better in the examination of competing values and be more mindful in their prioritization. A possible resource for this is Congress's (2000) five-step model, ETHIC, for decision making. Although not a substitute for supervision, her model suggests a systematic process of personal reflection, cognitive analysis, and consultation that is appealing. E stands for an examination of relevant values, whether those of client, the clinician, the profession, the organization, or society. T is to think about the various ethical standards in the NASW code, and relevant case law or other legal parameters. H is to hypothesize consequences of different choices and decisions. I is to identify who may be harmed and helped by each possible choice and decision, and C is a call to consult and seek the advice of colleagues and others.

Concluding Remarks

We argue that excellence in practice extends to making good referrals, in this case to prescribers of psychiatric medication. We use empirical research and professional consensus to argue that excellence is characterized by strong collaborative relationships with prescribers and full preparation of the client for the referral, which means clients understand the medication evaluation process, know the facts and fictions about the effectiveness of medications and their side effects, and have had a chance to explore emotional reactions and meanings. Finally, excellence means being mindful of likely ethical dilemmas that can and do emerge, but still taking responsibility for the results of the referral by following up and providing any additional information, referral or support when needed. Leigh's (1998) list of referral competencies also includes admonitions to maintain an up-to-date database of potential referral sources and to keep up regular contact with them. Importantly, she also stresses more inward, reflective practices that are needed by clinicians themselves in order to insure excellence in referral practice. She specifi-

cally encourages clinicians to routinely assess the appropriateness, suitability, and success of the referrals they make, to continuously pay attention to the possible impact and influence they are having on the client and the referral process, and to develop and maintain needed knowledge and skills for sensitive referral practices.

The implications of our argument for needed knowledge and skills are worth articulating here. Clearly it calls for social workers to continue to build their knowledge base around the effectiveness of medications, their side effects, and new developments on the horizon. Much greater attention is needed on the “lived” experiences of those who choose to use them. It calls for social workers to maintain their critical perspective about psychiatric medications and be aware about the controversies and differing opinions about their use today. It calls for an intimate knowledge of community resources, especially available prescribers whom they can trust and rely on. Sociability and political astuteness, and maybe even patience and perseverance, are demanded in the development and cultivation of these cross disciplinary relationships. We close with the most obvious implication of all: that social workers take referral practice as seriously as they do other aspects of service delivery, and using these best practices, set an especially high standard for excellence when referring clients for psychiatric medication.

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