

# Evaluation of a Child and Family Centre

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*This study set out to evaluate the treatment of 52 consecutive referrals to a Child and Family Centre. Mothers of referred children were interviewed before treatment and again 3 to 4 months later. The interview investigated the children's behaviour problems, their mothers' mental health and life quality, their attitudes and expectations of treatment, and their satisfaction with the treatment. Significant improvements were observed in children's behaviour problems, mothers' mental health, and some areas of the mothers' life quality. A significant correlation between the children's behaviour problems and their mothers' mental health was observed.*

Keywords: Client satisfaction; evaluation; behaviour problems; Ireland

## **Introduction**

Although interest in service evaluation and consumer satisfaction with psychiatric services has increased substantially over the past 20 years, there is still a need for the evaluation of parental satisfaction with the mental health services for children (Byalin, 1993) in terms of justifying and improving these services (Subotsky & Berelowitz, 1990). When consumer satisfaction is assessed, some studies include assessments of outcome and service utilisation while other studies settle only for reports from clients (Deane, 1993).

Studies that have related consumer satisfaction to treatment outcome have done so in a number of ways. Research on the effectiveness of psychotherapy in children and adolescents range from controlled experimental studies to studies of clinic-based and community-based interventions. The main criticism of controlled experimental studies is that the experimental conditions are different from the real-life clinical settings. In investigating the effectiveness of treatment in children and adolescents, Weisz and Weiss (1993) reviewed over 250 controlled experimental studies ( $N > 13,000$ ). In their review, Weisz and Weiss noted that 'most of these studies appear to have involved children, interventions, and/or treatment conditions that may not be very representative of conventional clinical practice' (p. 70). So it appears that the procedures and conditions associated with clinic-based therapy for children are rather different from those typically found in outcome research. Thus it is difficult to judge the extent to which the findings of outcome research can be generalised to the clinic-based interventions that

are provided to disturbed children in local communities. However, despite these difficulties there is a need for systematic research to be conducted within child and family clinics both in relation to parents' expectations and satisfaction with treatment and the overall effectiveness of treatment. In Ireland there has been very little work carried out in this area.

This study evaluates the effectiveness of the clinical service provided by a Child and Family Centre in the urban Dublin area. Effectiveness is measured along a number of dimensions. These include the adjustment of children themselves, and the mental health and life quality of their mothers. The attitudes of the mothers, and satisfaction with the clinic's services, are also examined.

## **Method**

### *Setting*

The Child and Family Centre has a policy of giving appointments to any parent who asks for one. There are four sources of referrals for an appointment at the Centre: the biggest group are general practitioners, who account for 46% of all referrals (24 families), followed by 31% (16 families) of self-referrals, 19% of school referrals (10 families), and 4% of court-related cases (2 cases). The staff involved included: one consultant child psychiatrist, two non-consultant hospital doctors, two social workers, and one speech therapist. In some cases more than one member of staff was involved. In the treatment of clients there was no inclination towards any particular form of therapy or school of thought but rather an eclectic approach aiming at 'enhancing communication among

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family members' (consultant child psychiatrist at this clinic). The Child and Family Centre is situated in a disadvantaged urban area with high unemployment rates, serving a population of approximately 78,000. A high percentage of the clients were in local authority housing in an area of high housing density.

#### Sample

The study focuses on 52 consecutive referrals who had no previous contact with the Child and Family Centre for at least 2 years prior to this study. As more than half of the mothers of the referred children were single mothers, the study focused only on the mothers as a source of information on the referred children. Out of the 52 referred children the number of boys referred (35 = 67%) was slightly more than double the number of girls referred (17 = 33%). The average age of children was 9 years ( $SD = 3.13$ ), with ages ranging from 3 to 16 years of age. The average age of the mothers was 36 years ( $SD = 6.09$ ), with ages ranging from 25 to 49 years of age.

#### Procedure

The mothers were interviewed in their own homes about 3 to 7 days prior to their first appointment, and interviewed again 3 to 4 months later, irrespective of whether they had attended the Centre, were still attending the Centre, or had finished treatment. Interviews ranged between an hour and an hour-and-a-half in length.

At the time of the second interview the number of cases still attending the service (22 cases = 42%) equalled the number of cases that had been discharged from the clinic. The average number of attendances over the 3–4 month period was 2.3 visits ( $SD = 2.50$ ), ranging from 1 appointment to 11 appointments (only 1 case attended 11 times).

#### Design

##### Measures

*Child Behavior Checklist (Achenbach, 1991).* As well as producing an overall score of behavioural problems, the 118 items in the Child Behavior Checklist (CBCL) are used to construct a profile of 8 behaviour problems. These are: Withdrawn Behaviour, Somatic Complaints, Anxious/Depressed, Social Problems, Thought Problems, Attention Problems, Delinquent Behaviour, and Aggressive Behaviour. Internalising and externalising scales are also employed. Furthermore, normal, borderline, and clinical ranges are also designated for the scores.

*The General Health Questionnaire (Goldberg, 1978).* In studying the mothers' mental health the General Health Questionnaire (GHQ-28; Goldberg, 1978) was employed. The GHQ focuses on the psychological components of ill-health and deals with distressing phenomena in normal everyday functioning. Besides reflecting an overall mental health state the GHQ has four subscales: Somatic Symptoms, Anxiety and Insomnia, Social Dysfunction, and Severe Depression. Normal and clinical ranges are

also designated for the overall scores. The split-half reliability of the questionnaire is reported at .95 in The General Health Questionnaire Manual (Goldberg, 1978). The questionnaire was scored using the suggested method of 0-0-1-1 using a threshold of 4/5 to obtain optimum discrimination (Goldberg, 1978).

*Quality of Life (Lehman, 1983).* The mothers' quality of life was investigated by administering a structured self-report interview that assesses current life experiences across a number of life areas. This interview was adapted from Lehman's Quality of Life Interview (QoLI; Lehman, 1983), which is probably the most widely used scale in the area of mental health service evaluation. While Lehman's scale was originally developed for use with a chronic psychiatric population, the overall structure of the scale and the measures are based on indicators used to assess the quality of life of the American public in studies by Andrews and Withey (1976) and Campbell, Converse, and Rogers (1976). The adapted objective life domain measures include: family contact, social contact, number of leisure activities, and health. The subjective life domain measures include: living situation, family relations, social relations, leisure, religion, finance, and health. The first global well-being section relates to the mothers' feelings about life in general (measure A), and the other section (measure B) relates to the mothers' feelings about specific aspects of their life such as boredom, hopefulness, and finding life rewarding. Internal consistency reliability coefficients (Cronbach's alpha) were computed for each of the global well-being, subjective, and objective life domain scores. Cronbach's alpha was above .75 for all measures except the first general well-being measure, which was .67.

*First Interview Questionnaire (Fitzgerald & Keenan, 1991).* In investigating a family's suitability/readiness to receive treatment a First Interview Questionnaire (Fitzgerald & Keenan, 1991) was administered. This questionnaire was developed by the authors for use within this clinic, and explores such areas as: information received from the referrer; expectations and fears about attending the Child and Family Centre; type and length of treatment expected; expectations of family versus individual assessment; stigma of attending the Child and Family Centre. Areas relating to treatment are thoroughly investigated, allowing the identification of aspects in treatment that need to be improved upon.

*Health Visitor Questionnaire (Nicol et al., 1986).* The Health Visitor Questionnaire (Nicol et al., 1986) was used to explore various aspects of treatment such as: overall usefulness of the treatment; the mother's coping with her child, her family, and herself; satisfaction with the type and amount of advice received; the mother's handling of the therapy sessions; satisfaction with the frequency of visits. For this questionnaire statements about treatment were read out to the mothers and they responded 'Yes', 'Possibly', 'No', or 'Not applicable (N/A)'. Although some questions were straightforward in that one would not expect a 'Not applicable' response, in some cases the

mothers felt that their children were referred for a 'report' rather than for treatment.

## Results

### Attendance outcome

The attendance outcome was as follows: 6 cases (12%) did not attend any of their appointments, 2 cases (4%) dropped out of treatment, 22 cases (42%) were discharged within 3–4 months after their first appointment, and 22 cases (42%) were still attending the centre 3–4 months after their first appointment. The number of cases that dropped out or never attended the centre was too small to carry out a repeated measure analysis or a factorial analysis on the data of the CBCL, the GHQ, and the QoLI. However, statistical analysis was carried out for the 22 cases who completed the treatment and the 22 cases who were still attending at the time of the second interview.

### Clients' expectations

The interviewer paid home visits to mothers of 52 consecutive referrals to the Child and Family Centre. The response rate for the First Interview Questionnaire was 100%. Of the group, 66% of the mothers received no information about the Child and Family Centre, while 31% said they were briefed about the clinic. Also, 77% of the mothers had neutral views about the clinic; 14% had a positive view, 11% had negative views, and 74% of the mothers had a realistic understanding of the treatment process and what it entailed. Of the group, 69% had no ideas about the probable length of treatment, 14% of the mothers thought the treatment would take 1 month, 14% thought it would take about 3 months or more. When the mothers were asked what they expected from the clinic regarding the child's problem, 4% answered 'Assessment', 8% answered 'I don't know', and 87% had general positive remarks ('help the child', 'sort him/her out', etc.).

When asked how long the mothers expected to wait at the clinic before they were seen, 42% said that they would be seen immediately, 35% said 'I don't know', and 22% thought that they would wait from 1–3 hours. In this Centre clients are seen immediately, with rare exceptions. Of the group, 59% of the mothers said that they had

received an appointment within 10 days of requesting an appointment, while the remainder of the sample received an appointment between 10 days and a month later.

### Children's behaviour

In classifying the children's behavioural problems into 'clinical', 'borderline', and 'nonclinical', Achenbach's recommended thresholds were used; Achenbach (1991) reports that 2% of children score above the clinical threshold and 7% of children score above the borderline threshold.

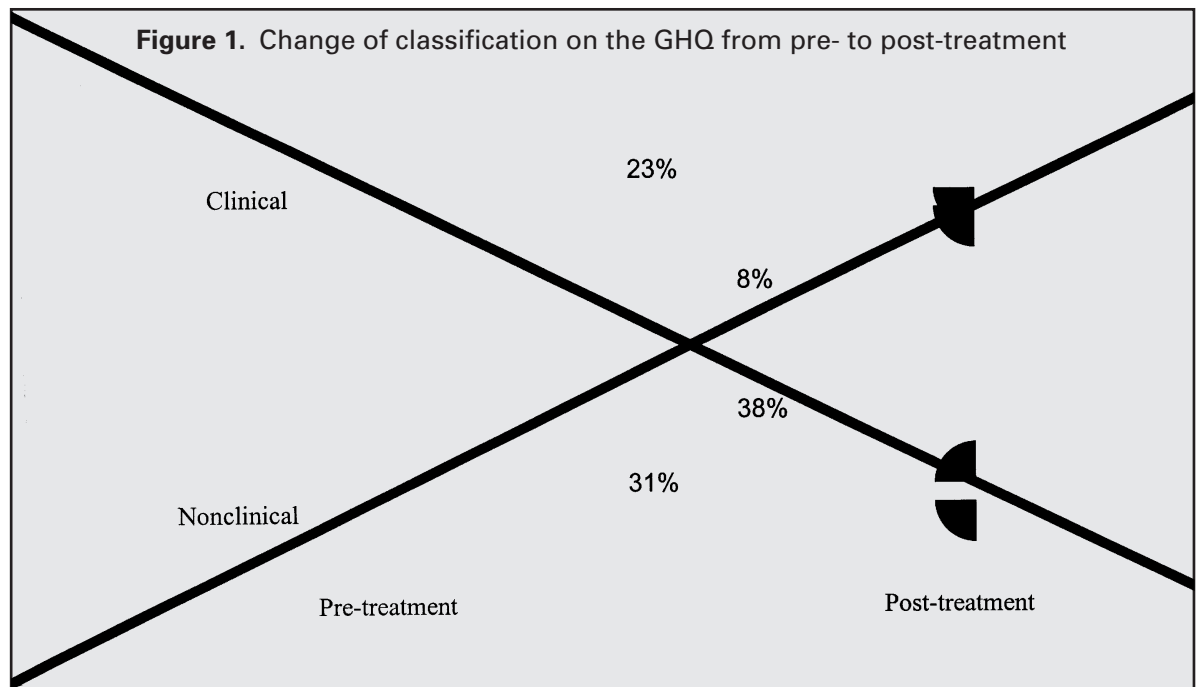
At pre-treatment, 49 cases were within the ages of 4–16 years. Of the 49 children, 25 children were classified 'Clinical', 3 children were classified 'Borderline', and 21 children were classified 'Nonclinical'. At post-treatment, results for 44 cases were available. Of this sample, 6 children were classified 'Clinical', 2 children were classified 'Borderline', and 36 children were classified 'Nonclinical'. Therefore, in terms of change in clinical categories between pre-treatment results and post-treatment results for the 44 children, 20 children (45%) were considered 'Improved cases' i.e., their classifications had shifted from 'Clinical' to 'Borderline' or to 'Nonclinical'. Cases were also considered 'Improved' if their classification had shifted from 'Borderline' to 'Nonclinical'. On the Total Behaviour category, 6 children (13%) were considered as 'No improvement' cases in that they had not shifted categories towards 'Nonclinical'. Eighteen children (41%) remained within their 'Nonclinical' category. There were no reported cases of children shifting categories towards 'Clinical'.

In investigating whether the significant changes on the scales of the CBCL were statistically significant, paired *t*-tests (two-tailed) were administered on the overall scales and also on the subscales. Significant decreases in scores ( $p < .01$ ) on all the CBCL scales except for the Internalising scale were observed. Table 1 shows the means and standard deviations for both the pre-treatment and post-treatment sets, and also the results of the *t*-tests administered on the various scales.

**Table 1.** Means, standard deviations, and *t*-tests on the scales of the Child Behavior Checklist

	Pre-treatment mean (SD)	Post-treatment mean (SD)	<i>t</i> -value
Internalising scale	54.27 (10.51)	51.71 (11.08)	1.88
Externalising scale	56.41 (11.98)	48.61 (11.34)	8.59**
Total score	60.18 (11.52)	50.14 (12.01)	9.91**

\*\* $p < 0.001$ .



**Table 2.** Means, standard deviations, and *t*-tests for the pre-treatment and post-treatment GHQ scales

	Pre-treatment mean ( <i>SD</i> )	Post-treatment mean ( <i>SD</i> )	<i>t</i> -value
Total scale	26.25 (13.65)	20.22 (12.22)	3.58**
Somatic complaints	7.40 (4.47)	5.50 (4.33)	2.90*
Anxiety & insomnia	7.71 (5.32)	5.58 (4.16)	2.86*
Social dysfunction	8.25 (2.50)	7.31 (1.86)	2.95**
Severe depression	2.89 (4.44)	1.83 (3.77)	1.80*

\**p* < .01; \*\**p* < .0001.

*Mothers' mental health and quality of life*

Using the recommended threshold of 5 (5 and above is 'Clinical') in scoring the GHQ data, the following results emerged: at pre-treatment, 30 mothers were classified as 'Clinical', and 20 mothers were classified 'Nonclinical'. At post-treatment, data were available for 48 mothers, 14 of whom were classified 'Clinical', and 34 of whom were classified 'Nonclinical'.

Of the group, 38% of the mothers were identified as 'improved' cases in that their classification shifted from 'Clinical' at pre-treatment to 'Nonclinical' at post-treatment. Fifteen mothers (31%) stayed within their 'Nonclinical' classification, 11 mothers (23%) stayed within their 'Clinical' classification (didn't improve), and 4 mothers (8%) shifted from a 'Nonclinical' classification to a 'Clinical' classification. Figure 1 shows the mothers'

change of classification from pre-treatment to post-treatment.

In investigating whether there were significant overall changes on the GHQ scales across the 3–4 month period, a two-tailed paired *t*-test was carried out on the scales of the GHQ. Significant decreases in scores (*p* < .01) on the overall scale and on all the subscales of the GHQ were observed. Table 2 shows the means and standard deviations for both the pre-treatment and post-treatment GHQ scales and also the values of the *t*-tests for the various scales.

The data collected by the QoLI provided a description of the mothers' satisfaction across several life domains as well as a frequency of social and familial contact. Of the group, 44% of the mothers were 'Satisfied' with their lives

**Table 3.** Means, standard deviations, and *t*-tests for Quality of Life pre-treatment and post-treatment measures

Global well-being measures	Pre-treatment mean (SD)	Post-treatment mean (SD)	<i>t</i> -value
Measure A	4.56 (1.37)	4.97 (1.12)	-2.12*
Measure B	4.84 (0.98)	5.11 (1.23)	-1.96

\**p* < .05.

as a whole, and more than 70% of the mothers were generally satisfied about their living situation, family relations, social relations, religion in their lives, and their health state. Also, 54% of the mothers were satisfied with their leisure activities and their personal safety. When asked about their family and social contact, the responses were as follows: 53% of the mothers were in contact with their families at least once a week, and 77% of the mothers were in contact with their friends at least once a week.

Changes on the QoLI scales were investigated by administering two-tailed paired *t*-tests. Significant improvements (*p* < .05) were observed on the Global Well-being measure A (mother's feelings about life in general) and the Social Contacts measure (Objective measure). Table 3 shows the means and standard deviations for QoLI pre-treatment and post-treatment measures with *t*-test results.

#### *Interrelationship of outcome measures*

This section is concerned with investigating relationships between outcomes for the children and their mothers. In investigating whether children's behaviour problems are correlated with their mothers' mental health, the overall scores of the CBCL were correlated with the overall scores of the GHQ. Significant positive relationships were observed both at pre-treatment ( $r = .432$ ,  $df = 48$ ,  $p < .01$ ) and at post-treatment ( $r = .482$ ,  $df = 43$ ,  $p < .0001$ ).

In studying the association between the children's behaviour problems on their mothers' mental health, the results of the GHQ were placed into two groups according to their children's 'clinical' or 'nonclinical' classification (the number of 'borderline' cases were too small to be included in the analysis). In investigating whether the mothers of 'clinical' children had significantly different scores on the GHQ scales, unpaired *t*-tests were administered for both the pre-treatment and post-treatment sets. In the pre-treatment set the results were as follows: mothers of 'clinical' children had significantly higher scores on the GHQ overall score than mothers of 'nonclinical' children ( $t = 2.65$ ,  $df = 45$ ,  $p < .05$ ; means = 30.56 vs. 20.3), on the Anxiety and Insomnia scale ( $t = 2.30$ ,  $df = 45$ ,  $p < .05$ ; means = 9.12 vs. 5.57), and on the Severe Depression scale ( $t = 2.97$ ,  $df = 45$ ,  $p < .01$ ; means = 4.6 vs. 0.91).

#### *Client satisfaction with the service*

The overall satisfaction of the service was quite positive, with 77% of the mothers finding the visits 'helpful on the whole', and 70% of the mothers reporting that 'it helped to have someone to talk to'. However, fewer than 58% of the mothers reported that they had benefited in better understanding of their children, and only 29% reported that it had helped them better understand their own reactions to things. It was the clinicians' impressions that, in many cases, the mothers saw the presenting problems as belonging mainly to their children rather than reflecting any facets of their parenting skills (43% of the mothers reported not wanting to have been told more about handling their children). Table 4 shows the responses to the Health Visitor's Questionnaire.

## **Discussion**

#### *Main findings and their implications*

On the whole, significant improvements were observed in both the children and their mothers. Although we cannot take the mothers' satisfaction with the service as a measurement of the clinic's effectiveness, it should be noted that a high percentage of the mothers were satisfied with the overall service and also with various aspects of the treatment provided by the staff of the clinic. The clinic also had very low drop-out rates (4% of all attenders dropped out of treatment), and also a short waiting list (2-3 weeks) in comparison to other Child and Family Centres. Considering a recent audit of 7000 successive child and adolescent psychiatric referrals in Scotland (Hoare et al., 1996), which reported an average non-attendance of 28%, we would have expected a higher nonattendance rate at this clinic.

The findings of this study point to a strong relationship between the children's behaviour problems and their mothers' mental health. Moreover, the administered questionnaires point to a higher percentage of improvement in the children than in the mothers. Although this difference may be more a function of the diagnostic categories of each test, nevertheless these findings point to the fact that the mothers may also be in need of help.

Considering the very long waiting lists of other child and family centres (6 months in some centres), it should be

<b>Table 4.</b> Satisfaction with the service (Health Visitor Questionnaire): A selection of results				
<b>Item</b>	<b>No</b>	<b>Possibly</b>	<b>Yes</b>	<b>N/A</b>
<i>Improved coping with child</i> It helped me to think of ways to cope with my child.	27%	4%	57%	11%
<i>Improved coping with family</i> It helped me to understand things about the whole family. The meetings were useful to us as a family group.	18% 14%	2% 4%	21% 9%	59% 73%
<i>Benefit by mother</i> It helped me to understand myself more than before. It helped me to understand my own reactions to things better.	14% 32%	4% 7%	25% 29%	57% 32%
<i>Treatment efficacy</i> It was just talk and not really useful. It helped me to have someone to talk to. Discussions like that are just a waste of time. The meetings were useful to me in seeing that other people may have similar difficulties to me.	66% 20% 77% 25%	11% 5% 9% 11%	21% 70% 12% 48%	2% 5% 2% 16%
<i>Overall benefit</i> I found it helpful on the whole.	14%	9%	77%	0%
<i>Satisfaction with the therapy process</i> Too many questions were asked. It was difficult to see the point of some of the things brought up. Other family members should have had a chance to join in the discussions. It was very easy to talk to the worker (social worker or health visitor).	75% 70% 34% 7%	5% 7% 2% 7%	16% 16% 10% 84%	4% 7% 54% 2%
<i>Wanting more advice</i> I would have liked more advice.	50%	2%	41%	7%
<i>Handling therapy</i> I sometimes felt upset after the discussions. I worried over what had been discussed.	77% 73%	4% 5%	18% 20%	0% 2%
<i>Frequency of visits</i> There were not enough visits to be really useful. Fewer visits would have been better. The visits would have been more useful if they had been more frequent.	52% 89% 55%	14% 2% 13%	25% 5% 25%	9% 4% 7%
<i>Convenience of visits</i> I found the visits inconvenient.	84%	5%	9%	2%

welcome news that this Centre has such a short waiting list. It may well be that a short waiting list reflects the staff's organisational skills but it could also be related to

the fact that many of the community members whom this Centre was designed to serve may not even be aware of the clinic's existence.

*Concerning preparation for treatment*

The results of the first interview are similar to those of Fitzgerald and Keenan (1991), who administered the same questionnaire to 46 consecutive referrals to the same Child and Family Centre. The two samples are similar with regard to: the amount of information received from the referrer, children's feelings about attending the clinic, length of time between referral and attendance at the Child and Family Centre, and expectations of family versus individual assessment. One difference worth mentioning is that 87% of the mothers in this study were willing to tell their family or friends that they had attended a Child and Family Centre in comparison to 61% of the mothers in Fitzgerald and Keenan's study. At this point, it is difficult to know whether this difference is a reflection of a genuine decrease in stigma in the community where the Centre is situated.

About half of the mothers were doctor-referred. Of these cases 80% claimed that they have received no information on the service they were about to receive. Although it would be difficult to confirm the validity of the mothers' responses, Ley and Spelman (1967) have shown that patients remember relatively little of their interview with a doctor, and it is possible that reports merely reflect a failure in retention of information. However, other research does not favour such explanations; Skuse (1975) suggested that general practitioners do not sufficiently prepare their patients for the psychiatric appointment they are arranging.

Overall, more than 70% of the mothers had no information on the service and did not know what to expect with regard to several aspects of the treatment, such as type or length of treatment. This number is very high considering the research that relates parents' expectations and attitudes towards the therapeutic process to treatment outcome. However, considering the low nonattendance rate of this clinic, pre-treatment preparation of clients may not be cost-effective since clients are briefed about their treatment when they attend their first appointment at the clinic.

*Methodological issues*

This study focused on a Child and Family Centre that employs a broad therapeutic approach. It does not evaluate a specific treatment as the staff involved with the referred cases employ different approaches. Kazdin (1988) identified 230 different forms of therapy that are in use with children. Most child therapists surveyed by Kazdin, Siegel, and Bass (1990) described themselves as eclectic. The point here is that in a nonspecialised clinic setting, it is the presenting problem that dictates the type of treatment to be received. Therefore, as much as it would be useful to evaluate the effectiveness of a specific approach, it would not give us a picture of the overall functions of a clinic that deals with a wide array of problems.

One shortcoming of this research is the lack of a control group. Although significant improvements were observed in both the children's behaviour problems and the mothers' mental health, the design does not control for the possibility of change caused by factors other than the intervention (e.g. natural remission of problems due to maturation). However, Weisz and Weiss (1993) note that 'children who drop out of treatment may be an acceptable (though not ideal) naturally occurring control group for outcome research' (p. 75). Considering the low drop-out rates of this clinic it would take 4 years for a group of 50 drop-outs to form. However, since it is difficult to assign no-treatment control groups in community settings, treatment outcome research with uncontrolled groups is quite common. This is even more the case with children and adolescent treatment outcome research, where research in general is scarce.

Other methodological shortcomings in this research are in the limitations of the questionnaires employed. An important limitation relates to the measurement of improvement in children, which was noted by investigating overall scores and categories. Both approaches suffer from an important drawback: they only detect improvement in children with a high number of behaviour problems. The improvement of children with one major behaviour problem, such as firesetting or enuresis, is not detected. Such cases may not be classified as 'clinical' or have a high score on the CBCL. Perhaps the main limitation of all the questionnaires employed, however, is that they are strongly subject to parental attitudes and rely almost exclusively on self-report. Studies employing questionnaires that rely on the clients' impressions would benefit from semistructured interviews and/or direct observation in order to overcome biasing factors.

*Suggestions for future research*

The efficacy of the clinic in actually dealing with children's behaviour problems could be better assessed with a more sophisticated design (i.e. larger sample, nonintervention control group, more frequent interviews, larger study period). Interviewing both the staff and clients would provide multiple perspectives, which could help identify areas that require further attention. The measures employed should also have a greater sensitivity to important changes in individual cases by allowing greater input from the person completing them. In investigating factors related to attrition, it would be more practical to select a Child and Family Centre with substantially higher rates of nonattendance and drop-out than the 12% and 4% (respectively) of the studied centre.

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