

AN EVALUATION OF CHILDREN'S SERVICES IN
COMMUNITY MENTAL HEALTH CENTERS

By

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With love to my mother

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This study investigated clinical variables in relation to the effectiveness of children's services in community mental health centers in north central Florida. These variables included parental involvement in treatment, referral source, diagnostic classification, type of treatment, and duration of treatment.

Information was obtained from 277 closed medical record charts. The charts were sampled at random from a total of 1352 cases seen during the period 1980-1983.

Using a cross-tabulation procedure, measures of the variables studied were examined according to treatment outcomes. Cases were classified as successful or unsuccessful according to therapist ratings of progress on specific treatment goals.

Analysis of data suggested that treatment success was positively related to duration of treatment ($p < .001$). There were no differences between cases rated as successful or unsuccessful with regard to referral source, diagnostic classification, or type of treatment. The results for parental involvement in its effect on treatment success were inconclusive.

It was concluded that children's services in community mental health centers were equally successful regardless of who referred the client, diagnostic classification, or the type of treatment involved. However, remaining in treatment longer than five sessions appeared to increase the chances of being rated as improved by the therapist. Implications of the study and recommendations for future research were discussed.

CHAPTER ONE INTRODUCTION

For many years, mental health services were provided through the efforts of the local communities across the United States. Quality of care was far from uniform and unavailable to many segments of the population. Many communities chose to house their mentally ill in far away institutions.

In 1963, President Kennedy called for a new approach to mental health care and Congress responded with the Community Mental Health Center Act (P.L. 88-164). This Act created community mental health centers throughout the United States. These centers were to provide alternatives to state and county mental hospitals for the prevention and treatment of mental illness (Naierman, 1978).

Community mental health centers (CMHCs) tripled in number between 1967 and 1976, increasing to a total of 528 centers (ADAMHA National Data Book, 1980). By 1983 there were 35 mental health centers in the state of Florida established with the help of federal funding. As a result of the increase in community mental health programs, care was made available to rural and poor populations as well as the urban and rich (Jones, Wagenfeld, & Robins, 1976).

The mental health center act as amended in 1965 required the centers to provide five basic services without regard to a client's ability to pay: inpatient treatment, outpatient care, partial hospitalization

services, emergency treatment and consultation, and education services (Naierman, 1978). These mental health centers were established as private, non-profit organizations with links to local, state, and federal governments. Local matching funds were required to attract federal dollars.

A center's staff usually consisted of an executive director, administrative and support personnel, and both professional and non-professional clinical staff. A board of directors from the community were responsible for policy guidelines and employment of the director. Among those professionals who were employed, there were psychiatrists (9%), psychologists (5%), social workers (9%), registered nurses (14%), and other mental health professionals (14%) (ADAMHA National Data Book, 1980).

Consequent with the establishment of a nationwide network of services came the need for large scale evaluation efforts, but mental health centers were not seen as basic research facilities. They were generally unconcerned with the discovery of new information. The primary objective of evaluation or research within centers was to determine the extent to which services were delivered. Studies to examine the results achieved were limited. The success of evaluative research depended ultimately on its usefulness to the administrator (Suchman, 1967).

In recognition of the importance of making mental health centers publicly accountable, as well as increasing their effectiveness, legislators amended the Mental Health Center Act in 1975 to include program evaluation. Centers were required to collect data which showed 1) patterns of use of services; 2) availability, accessibility, and

acceptability of services; and 3) impact of services on clientele (Fiester, 1978).

Evaluation procedures have tended to favor simple outcome measures. This is as opposed to more complex evaluation procedures which explain why a program may have had effect. Some concern was expressed that outcome research is too difficult to conduct (Keppler-Seid, Windle, & Woy, 1980), and others have cautioned that such research studies emphasize certain outcomes to the exclusion of others (Schulberg, 1981). Because of confusion, lack of knowledge and resources, and resistance, research in mental health centers has been limited. Subsequently, knowledge gaps have developed in community mental health centers, especially as to how different client types are differentially affected by services.

Relatively little was known from early evaluations as to which services were most effective for different recipients. Beginning with Eysenck's conclusion in 1952 that psychotherapy had no proven efficacy, researchers became more specific in the types of information they sought. New investigations looked at different types of treatment, demographic factors, and client personality. They also examined clinical information, therapist factors, and therapist-client interactions (Strupp & Bergin, 1969). Even so, there was insufficient research to direct the establishment of programs and implementation of services in the community mental health centers.

In 1975 it was mandated that centers provide services to children and adolescents. Yet, as with other populations, there was a question about how to provide young people these services. Both Meltzoff and

Kornreich (1970) and Levitt (1971) noted the lack of research regarding the effectiveness of mental health treatment for children. Several factors were singled out for blame: research interest in the child guidance movement by psychiatrists and social workers was not evident (Levitt, 1971); psychiatric treatment for children was less widespread than for adults (Baekeland & Lundwall, 1975); methodological problems exist in research, such as separating out changes in children and adults because they are often seen together in treatment (Levitt, 1971).

The lack of research on the treatment of children is unfortunate. Mental health centers are facing economic problems and there is a greater need to demonstrate their value. Due to less money from the federal government, centers are giving a greater part of their resources to clients who are the most seriously disturbed and who are at greater risk for institutional placement. Children and adolescents are less likely to be defined as a service priority when services are limited. This low priority and a decline in services compound the problem of research and evaluation as there is less opportunity to do research and, subsequently, less opportunity to build a documented case for more services.

Mental health centers need more help in directing their resources for the maximum benefit for clients. More information is needed about specialized client groups, such as children and elders. Supportive research is necessary in order to improve services and build a case for mental health centers.

Need for the Study

It was estimated 10 years ago that approximately 1.5 million children in the U.S. had profound emotional disturbances which precluded their living in normal family, school, and community circumstances (Smith & Hobbs, 1966). More recently it has been estimated that each year more than 6 million children, ages 5 to 19, have mental health problems severe enough to require professional treatment (Berlin, 1975). Such increasing magnitude suggests a need for specialized treatment programs which have proven efficacy.

Yet, Levitt (1971) noted that after six decades of the child guidance movement evaluative research still failed to show that child psychotherapy was effective. Outcome studies illustrating improvement rates for treatment groups summed across different categories of emotional disturbance were approximately the same as for those who did not receive treatment. Examining the issue of outcome more closely also revealed large variations in improvement rates between agencies. This suggested that investigators needed to study more specific treatment programs for different populations (Strupp & Bergin, 1969) and find where treatment was effective.

Although research efforts increased in adult psychotherapy, little research was done in child psychotherapy. Research with children when compared to adults is inadequate (Baekeland & Lundwall, 1975). Levitt pointed out that only six reviewers of psychotherapy research in the Annual Review of Psychology since its inception found it necessary to use a subheading for research with child patients (Levitt, 1971).

The child therapy researcher has several methodological problems to contend with. First, he has to consider the status of the child as a developing organism. Sometimes it is difficult to tell whether a symptom is a part of the normative growth process which will be taken care of in time or a truly deviant process in need of treatment. In a similar vein, one symptom of emotional disturbance may be replaced by another. Thus, the researcher may have to decide whether treatment for the original symptom was successful or whether the symptom remitted through the child's developmental process (Levitt, 1971).

Another difficulty involves the child's comparatively greater dependence on his environment, especially his family. Children are usually a captive audience brought to treatment by adults for problems that have been defined by adults. Thus treatment goals may be more a factor of adult rather than child expectations. This may be one reason why investigators of child psychotherapy have focused on the personality, psychopathology, and attitudes of the child's parents (Baekeland & Lundwall, 1975). Dropping out of treatment, for example, has been positively related to negative parental attitudes and behavior toward the treatment (Lake & Levinger, 1960).

To elaborate further on the special research difficulties created by the child's dependence on his environment, there is the problem that the remainder of the family is simultaneously in treatment with the child. When the child guidance movement was first started, it was common for the parents to be seen by a psychiatric social worker while their child was seen separately by a child psychiatrist. As conjoint family therapy came into vogue in the late 1960s and early 1970s, it became commonplace

to see the family together. Whether seen separately or together, it is difficult to say at the conclusion of therapy that positive results in the child were a result of his/her individual treatment. Separating out treatment effects has become a challenge to researchers.

If specific variables related to treatment success with children were established through basic research, then effective programs could be devised to meet children's mental health needs. However, it has been noted that such variables have not been isolated and that such ideal programs do not exist. An unfortunate consequence of the lack of empirical support for program interventions is the difficulty in obtaining public support.

Particularly affected are prevention programs such as mental health centers which intervene early in the development of emotional disturbance. Friedman (1983) and Kiesler (1982) have noted the preference in public policy given to institutional/residential programs over early intervention models. Such programs are often funded in response to the most immediate need while preventive services, which meet a less visible need, are neglected.

A similar lack of supportive research for children's mental health programming exists in the area of program evaluation research. Such research attempts to determine whether specific program activities attain desired results, thus establishing their usefulness in particular situations. Unfortunately, mental health center research studies have focused on the population which receives the greatest part of its resources: adults (Fortney, 1981; Kline & King, 1973; Sue, McKinney, & Allen, 1976). In a recent statewide outcome study of mental health centers, only adult

outpatient and day treatment clients were evaluated (Cox, Brown, Petersen, & Rowe, 1982). Successful outcomes with adults found in some studies do not necessarily generalize to children, however, for reasons that have been described.

One study which attempted to evaluate mental health centers' efforts to work with children has received special attention. Fiester (1978) developed an automated system to measure specific goal attainment. He was attempting to comply with federal accountability standards and also gather data on treatment effectiveness. Treatment was found to be successful in the areas of social and academic skills. The data analysis provided feedback to therapists as to their effectiveness with particular clients, making it a good example of institutional self-study.

The main problem of the Fiester study was that only outcome data were presented without the specification of process. It did not measure and partial out alternative explanations for the results, such as the effects of parent participation, referral source, or demographic status. Although Fiester used data to develop criteria for the assignment of clients to therapists, he did so only on the basis of a few limited variables, such as an individual therapist's success in a specific problem area. Without the specification of other process variables, questions about the effectiveness of centers with distinctive populations could not be answered.

The need for data-based studies of mental health centers' services is evident. They are needed to assure consumers, taxpayers, and health providers that services are valuable and warranted. In order to secure funds for programs, administrators of outpatient children's mental

health outpatient programs need more information regarding outcomes, which treatment is most successful under which conditions. The need to relate treatment success to treatment variables has also been recognized (Strupp & Bergin, 1969; Suchman, 1967).

Purpose

It was the purpose of this study to investigate mental health center outpatient services to children, adolescents, and their families and to examine successful and non-successful cases as described in official medical records on file in mental health centers. More specifically, this study examined client records to 1) identify which children's cases were classified as successful or not successful and 2) examine specific variables related to the cases. It was then possible to study these variables in terms of treatment outcomes.

Two northern Florida mental health centers provided data for the study. Approximately 275 medical charts were systematically reviewed for data, including information on initial diagnosis, referral source, type of treatment, parental involvement, and the duration of treatment. Other information on both client and treatment variables was gathered for use in secondary analyses.

General Research Questions

1. Does the presence or absence of parental involvement during treatment of children have an effect on success or reported success?

2. Are referral sources related to successful or non-successful cases?
3. Are some diagnostic categories (based on the Diagnostic and Statistical Manual III) more responsive to treatment than others?
4. Does the length of treatment have any effect on outcome?
5. Does the type of treatment have any effect on outcome?

Definition of Terms

Community Mental Health Center: A mental health agency or institution established under guidelines set by the Mental Health Act of 1963 and/or 1975.

Specialized Children's Program: A program within a mental health center designed to deliver mental health services to children (0-18 years old) and their families. Such programs were mandated in 1975 to be part of federally supported mental health centers.

Medical Record: A client's file, started when he/she seeks treatment. Also referred to as medical chart or case, it contains 1) an admission data sheet, 2) an intake summary, 3) a treatment plan, 4) a discharge summary, 5) progress notes, and 6) medication record. Other available information generally includes 7) referral source, 8) who was included in treatment, 9) clinical diagnosis, 10) treatment goals, 11) number of sessions client attended, and 12) treatment outcome rating by therapist.

Diagnostic Category: Refers to the clinical diagnosis recorded on the client's records and is based upon the Diagnostic and

Statistical Manual III for the Classification of Psychiatric Disorders (APA, 1980).

Referral Source: The primary source which directed the client/family to seek treatment at the Center.

Organization of the Study

This study is organized into five chapters. Chapter One includes the introduction, need for the study, purpose of the study, research questions, rationale, and definitions of terms. Chapter Two contains a review of the literature related to evaluative studies of mental health treatment programs for children and adolescents. A discussion of the methodology and data collection is presented in Chapter Three. Results of this study are presented in Chapter Four, including analysis of the data. A summary, conclusions, and recommendations made from the investigation are included in Chapter Five.

CHAPTER TWO REVIEW OF LITERATURE

In this chapter the community mental health movement will be traced through its historical origins beginning with the establishment of the National Institute of Mental Health and culminating in the 1980s with the revision of the Community Mental Health Act by President Reagan. Services to children will be examined, emphasizing the status of children's mental health services prior to the establishment of community mental health programs and then noting the impact of the centers on child mental health services. Types of services delivered to children in mental health centers, their appropriateness and adequacy, will be described. In separate sections, evaluative research as it applies to community mental health centers will be presented. Finally, research related to the main hypotheses will be discussed.

History of the Community Mental Health Movement

Mental health care prior to the twentieth century was largely the responsibility of the family. Large mental institutions and jails, usually far removed from the patients' communities, were the primary sources of containment and treatment of the "mentally ill." Dorothea Lynde Dix, in the mid-nineteenth century, crusaded for more humane treatment of patients in these institutions. She helped increase public

awareness of the problem in treating patients. While more mental hospitals were constructed as a result of her efforts, extreme overcrowding soon followed. Later in the 1890s the work of Sigmund Freud added an air of scientific respectability for the first time to the field of mental illness. Attitudes toward treatment of the mentally ill slowly began to change.

Mental health care before the 1940s was under the direction of state authorities. However, during World War II the large number of draft rejections for mental health problems increased public concern. This in turn led to the National Mental Health Act of 1946 which involved the federal government in the problem for the first time. At this time there were fewer than 10,000 full time mental health professionals in the United States (ADAMHA, 1980).

Several important changes in the mental health field occurred during the 1950s. Despite the fact that 75% of mental health services still occurred in inpatient facilities (National Institute of Mental Health, 1977), psychotropic medications were developed to make hospital stays shorter and enable patients to be maintained in their own communities. This kind of treatment was supplemented by an increase in the number of local outpatient psychiatric clinics (Miller, 1974). Congress established a Joint Committee on Mental Illness and Health in 1955 to study the possibility of adopting a new approach to the treatment of mental illness. Among the recommendations were the expansion of services, reduction in size of state hospitals, and increased provision of services in local communities (Joint Commission on Mental Illness and Health, 1961).

Community Mental Health Center Construction Act

The recommendations of the Joint Committee on Mental Illness and Health were used by President Kennedy to establish the Community Mental Health Center and Mental Retardation Facilities Construction Act of 1963 (P.L. 88-164). Thirty-three states acted immediately, passing legislation to authorize the construction of mental health centers (National Institute of Mental Health, 1969). The implementation of community mental health center programs was given an additional boost in 1965 with the passage of federal legislation, which provided staffing assistance to cover personnel costs (P.L. 89-105).

The primary intent of the legislation was to assist communities in developing alternatives to state and county hospitals in the treatment of mental illness (Naierman, 1978). A variety of mental health services were, for the first time, to be available to the entire population regardless of an individual's ability to pay or geographic location (Jones, Wagenfeld, & Robins, 1976).

In order to qualify for federal funds, community mental health centers had to provide a few basic services. The minimum services included inpatient and outpatient care, partial hospitalization and emergency services, and consultation and education services. Children and adolescents were not, at this time, given special services. They were instead served in programs with adults (Naierman, 1978).

The required basic services required development of new treatment techniques and a more diversified professional base. Assistance in manpower training came from the National Institute of Mental Health

and the Veteran's Administration. There was more than a thousand-fold increase in the number of mental health professionals (125,000 in 1980) in the thirty years between 1950 and 1980 (Vandenbos, 1980).

Initially, federal staffing grants to centers were awarded for a fifty-one month period. It was expected that centers would develop sufficient additional funding during this time and would become independent from federal funding. Despite varied funding from state and local governments, however, the centers had not yet gained financial independence from federal grants by 1970. Hence, federal grants were extended to eight years. Dependency on federal funds was attributed to a number of factors, including the following: 1) income to centers was reduced because payment was on a sliding fee scale based on family income and number of dependents; 2) many third party insurers did not cover community based mental health service; and 3) there was a lack of sophisticated financial management (Naierman, 1978).

By 1975 community mental health centers were well established across the country. Yet there were still problems with securing alternative funds to replace the federal staffing grants. Public Law 94-63 was established in partial response to this need (Despard, 1983). It provided a new sliding scale of federal and state funding for beginning centers, but one which declined at a faster rate than previously. This was intended to encourage centers to obtain alternative funding sooner in their development. It also supported established centers which had not succeeded in finding replacement funding.

At the same time, however, P.L. 94-63 called for an expansion of already existing services to include evaluation, screening, follow-up

and transitional services. In addition, specialized services for children, elders, alcohol and substance abusers were required. Grants were made available to finance these additional costs.

The implementation of evaluation and accountability standards had several positive effects. For the first time, mental health centers were accredited by the Joint Commission on American Hospitals. Quality of care standards were established (Joint Commission on the Accreditation of Hospitals, 1976). Better program planning and evaluation techniques were encouraged through staff development training and publications supported by the federal government (Ellsworth, 1979).

Effects of CMHC Legislation

As early as 1972 the community mental health program was being heralded as a focal point of the national effort to improve patterns of mental health care in the United States (Brown, 1975). Centers had grown in only six years (1965 to 1971) from 1 to 493 and they were in all 50 states, the District of Columbia, and Puerto Rico. It was estimated that the centers would eventually be serving areas with a combined population of 73 million (Brown, 1975).

From 1969 to 1971 the services delivered through the community mental health system nearly doubled from serving 372,000 persons to 659,000, not counting those served through consultation and education services. Public program emphasis was now based on prevention, early detection and treatment, as opposed to institutionalization. Mental health centers thus seemed to be succeeding in making mental health care available and accessible to the general public (Miller, 1974).

A survey conducted by the Joint Commission on Mental Illness and Health in 1957 investigated attitudes of the public toward mental health care as well as utilization rates (Vandenbos, 1980). Only 15% of the respondents in a poll were found to have ever used any mental health services while only 28% of this figure had received services from a trained mental health professional. When the study was repeated in 1976, by Douvan, Kulka, and Veroff (1978), the number of people using services had grown to 26%, with 47% of these having received treatment from a qualified mental health professional. In addition, 60% of those surveyed said they would use mental health services in connection with an emotional problem.

Mental health centers were especially successful in serving lower and middle income families. Over 50% of CMHC patients had incomes below \$5,000, while only 6% earned over \$16,000 per year (Brown, 1975). About one-half of all centers in 1972 were located in areas of poverty. In one Florida mental health center 60-70% of the clients (in 1982) were eligible for full reduction in fees. Only 18% of the total mental health caseloads had a family income that exceeded \$10,339 (District III Mental Health Board, 1981-1982).

In addition to serving many lower income clients, the centers also assisted persons who were formerly in public mental hospitals. Of all persons treated at mental health centers, 13% were at one time confined to public mental health hospitals as of 1972 (Brown, 1975).

Recision of Mental Health Systems Act

Mental health centers would have benefitted in 1980 from passage of the Mental Health Systems Act (H.R. 4156 and S. 1177) based on findings of the President's Commission on Mental Health (President's Commission on Mental Health, 1978). This bill would have strengthened mental health planning and resource allocations at the state level. It also sought to improve services for special groups, such as the chronically mentally ill and severely disturbed children. There was a general intention to make services accountable at the state and local level by encouraging services to high priority (most disturbed) clients, basing funding on a performance system, and emphasizing third party collections.

The proposed 1980 Mental Health Systems Act, however, was rescinded in 1980 under the Reagan administration. This left CMHCs on uncertain status. The basic federal direction at the time was the provision and monitoring of block grant funds for alcohol, drug abuse, and mental health services. Thus the states now had a much larger voice in the implementation of these services. While many of the states preserved the essential CMHC components (including the state of Florida), there is now large variation from state to state and center to center as to which services are emphasized. These differ according to varying legislative priorities.

The unofficial national mental health policy at present is deinstitutionalization with an emphasis on outpatient treatment. Actual expenditure of funds, however, disputes this premise. Kiesler (1982)

notes that medicaid expenditures in 1977 for state, county, and private institutional care for mental illness was greater than the total federal cost of the entire community mental health program (600 centers).

Recent figures suggest that something similar is occurring for children and youth in the state of Florida (Friedman, 1983). Of the total funds expended for mental health in 1983, 66.55% was allocated for residential care, while only 26.56% was designated for non-residential, including outpatient services. Prevention services received the least funding at 6.89%. It has been argued (Friedman, 1983) that more money should go to those services which intervene before residential care becomes necessary.

As first conceived, CMHCs were to deliver services to the general population in hopes of preventing institutionalization. Such preventive services were funded by the federal government on the assumption that services would eventually become financially self-sustaining through private fees and/or state or local stipends. That this has not been the case is noted by Naierman (1978). This study recommended that centers should continue to receive maintenance support from the federal government if they were to continue to provide all basic services without regard for the client's ability to pay. With the higher priority given to residential care, it is possible that preventive services will decline.

The history of community mental health reveals a pattern of increasing federal responsibility for provision of services from the early 1950s until 1980. During the past three decades scientific advances and changed social perceptions have been observed in the area

of mental illness. These new developments supported federal involvement in this area. Community mental health legislation was one important product of this involvement. In general, there was public support for a policy of early intervention and prevention in the field of mental illness in order to avoid institutionalization. This has changed, however, since 1980 with the smaller federal role in the mental health movement. Without federal monitoring and financial support, mental health centers may not be able to maintain their unique characteristics as originally mandated.

Development of Children's Mental Health Services

Prior to community mental health services including children, the Joint Commission on Mental Health of Children described mental health services to children as a national disaster. It was estimated in 1965 that there was a total of 4.6 million emotionally disturbed children between 5 and 19 years old. At the same time, children receiving services from psychiatric facilities were estimated in 1964 to be only 632,000 persons (Joint Commission on Mental Health of Children, 1973a).

There were seven White House conferences on children since 1909; however, the number of children admitted to mental hospitals in 1973 increased faster than their increase in the overall population. Admission to public mental hospitals doubled in the ten years after 1963 for patients under 25 though there was an overall reduction in the hospital population for the general population (Taschman, 1975).

Treatment at these facilities was limited to custodial care, with approximately 20 attendants to every one professional (Joint Information Services of the American Psychiatric Association and the National Association for Mental Health, 1968).

In 1973, evaluation of existing services found them often to be directed at exclusive populations while underserving specific groups such as the poor and persons living in rural areas (JCMHC, 1973a, Task Force V). These latter groups were often those most "at risk" to develop emotional disorders. When services were provided they were often inappropriate and/or uncoordinated (Gorman, 1968; Hollingshead & Redlich, 1958).

The poor were especially disenfranchised. Furman, Sweat, and Crocetti (1965) found public clinics tended to curtail their assistance to the poor when faced with an overdemand for their services. This compounded the problem from the fact that the poor were less likely in the first place to seek care prior to a mental health crisis (Myers, Bean, & Pepper, 1965).

It is the lower socio-economic status (SES) child who is most at risk to develop mental illness. Poverty is characterized by adverse physical circumstances, disorganized and often chaotic family structures, and inappropriate child rearing practices, described as authoritarian, fatalistic, and lacking positive stimulation. There is an absence of child centeredness in parental attitudes (Beiser, 1965; Malone, 1966).

Delinquents, especially prevalent among the poor, were another group that appeared to receive inadequate services. Few juvenile courts (17%) had any regular access to psychological assistance. Placements

were frequently made to training schools or reformatories, even adult prisons. High recidivism rates have proven such placements to be ineffective (U.S. Senate Subcommittee on Employment, Manpower, and Poverty, 1967).

Services to rural children were also inadequate. Rosen, Kramer, and Reddick (1968) noted that only one-tenth of the outpatient clinics opened in 1965 were in rural areas and these served only 8% of the total clinic cases. These figures were highly discrepant from actual needs as one-third of children under 18 lived in rural settings where outpatient psychiatric facilities were the only treatment available because of transportation problems (Rosen et al., 1968). Services were characterized by brevity and were often diagnostic and prescriptive in nature rather than treatment oriented.

In addition to problems in service availability to the underserved groups, there were also problems with adequacy and appropriateness of services. Clients who appeared to be too severely disturbed or unmotivated for traditional treatment were screened out (Hunt, 1962). Only about one-third of the clients referred to child psychiatric clinics ever received treatment (Levitt, 1971). There was an expectation for clients to come to the clinic and articulate a psychological problem. This was discrepant from the actual needs of the poor and/or minorities which tended to be for increased social and occupational skills (Gladwin, 1967).

Services were also fragmented. One source stated that this fragmentation occurred at every level: local, state, and federal (Taschman, 1975). On the national level alone at least 100 separately administered programs for children existed.

The Joint Commission on the Mental Health of Children concluded in 1973 that the mental health system a) tended to be oriented more to professional than to client priorities, b) was concerned with remedial services and crisis resolution rather than prevention, c) served only a small portion of those who needed help, d) provided services that were fragmented and uncoordinated. New technologies were needed to make service more accessible and available to those in need. There was also a need to increase the number of non-professionals who could deliver services to indigenous groups (JCMHC, 1973a).

The Committee recommended a number of changes to resolve these insufficiencies. Services should be coordinated and need-specific. They were to include educational, recreational, and vocational planning, as well as psychotherapy. Thus, mental health services should be integrated into the larger service agency network. Lower socioeconomic groups and minorities needed to have services established specifically for them and their special needs, utilizing the input of these groups to design such services. Particularly of relevance to the community mental health program were the suggestions that mental health services be community based whenever possible with close ties to residents. It was also recommended that greater use be made of parent education in mental health consultation as part of preventive services. In addition, paraprofessionals were suggested as personnel who could help provide more mental health services (JCMHC, 1973a).

The Community Mental Health Centers and Children

The period of the mid-seventies was a major turning point for mental health services to children. The U.S. Congress in 1975 mandated the addition of specialized children's services to the federally funded centers. Already children and youth comprised 23% of the total clients served by CMHCs (ADAMHA, 1980). Services to children were to be monitored separately from the adult population, encouraging planning and accountability from the point of view of this group (NIMH, 1969). Professional staff familiar with the special needs of youth were also added. Funds were made available through conversion grants contingent upon implementation of these new services (National Institute of Mental Health, 1977).

The NIMH specified a set of principles on which CMHC services for children and youth should be based. These included administrative and clinical guidelines. Administratively, services should be delivered on a confidential basis. They should also include the involvement of community youth and adults in planning. Facilities should be adequate and accessible to all segments of the community. Clinical services should be delivered in cooperation with other community agencies; be designed to insure continuity of care, and emphasize prevention, early identification, and early intervention (NIMH, 1978). Children's mental health in general is distinguished from adult services by the inclusion of the child's social environment as a primary focus (President's Commission on Mental Health, 1978). This considers the child's family, the school system, the courts, and various social agencies. As a result

of these guidelines, there are many similarities across centers for children's services including staffing and assessment, treatment and consultation procedures.

Staffing of Mental Health Centers

Mental health center staffing represents a full range of the core mental health professions. The ADAHMA (1980) gave a general description of personnel within mental health centers: psychiatrists, 5%; psychologists, 9%; psychiatric social workers, 14%; registered nurses, 9%; other mental health professionals, 14%; non-professionals involved in patient care (e.g., licensed practical nurses), 22%; administrative personnel, 26%. As noted already, there has been an increase in the number of mental health professionals in the field from the 1940s (10,500) to the 1980s (125,000) (Vandenbos, 1982).

The NIMH recommends that a children's staff include developmental specialists trained to be primary evaluators, back-up experts in such areas as pediatrics and speech therapy, specially trained mental health professionals, psycho-educational therapists, therapists, and para-professionals. Each functions in one or more of the mandatory service areas, such as emergency services or outpatient care (NIMH, 1978).

Referrals

Referrals may come from a variety of sources. The judicial system, social services, family physicians, school, and the family itself frequently refer children to mental health services. Rarely is the

child self-referred. Rather, someone else determines that a child has a problem (Baekeland & Lundwall, 1975; Levitt, 1971) and initiates the referral.

Referrals for the poor are most likely to come from the courts or schools. They also reflect the ethnic and social class bias of middle-class institutions. The lower the social class of the child, the longer referrals are delayed (McDermott, Harrison, Schrager, & Wilson, 1965).

Children referred for services fall into two categories according to Behar (1981). There are profound differences between children who are intelligent, willing, and able to talk about themselves and those who suffer from poor impulse control, environmental deprivation, and are less receptive to verbal therapies. The former group has potential to benefit from occasional services. The latter group, however, is chronically impaired. They need long-term care, more intensive treatment, and more follow-up.

Diagnostic Interview

Assessment is a multi-faceted process consisting of interviews and observations of a child with and separately from his/her family. Family interactions are noted. Interviews are structured in order to obtain such information as family, medical, educational, and personal histories (Appendix A). Another source of information may be the child's teacher.

Objectives of assessment procedures are several. In order to foster healthy psychosocial development and plan a timely intervention, it is important to make early identification of mental health problems

(NIMH, 1978). A good assessment gives the clinician a total picture of the person and his/her environment and enables treatment planning.

After obtaining relevant information the clinician files one or more diagnoses according to the DSM III (APA, 1980). The most commonly used classification for children in both inpatient and outpatient settings (60%) in 1980 was the transient stress disorder. This is a non-adaptive emotional reaction to environmental stress (ADAMHA, 1980). It may be inferred from this statistic that a diagnostic label for children and adolescents is not as useful as for adults in determining treatment planning. Such planning must be done with the child's family as well as with the presenting problem in mind. Diagnosis should be used for appropriate guidance and follow-up rather than categorization only.

While assessment may take up to three sessions and involve several professionals, typically some kind of treatment plan is agreed on at the time of the intake. The treatment plan may specify specific problems and identify goals and types of treatment that are applicable. If services at the center are not appropriate for the client's problem, a referral may be made to another agency.

Family financial information is also obtained during the early clinical interviews. Such information is required to set fees. A sliding scale balances the number of dependents against total income and helps establish fees paid by clients.

Treatment Methods

The National Institute for Mental Health specifies that outpatient services should be timely, coordinated with other social services, and should attempt to prevent institutionalization (NIMH, 1978).

A full range of approaches and modalities should exist to allow for individualization of services. The therapeutic possibilities are many, including individual, group, and family therapy, among others. The form of therapy varies to some extent based on age. For example, individual therapy for younger children may use symbolic play (Axline, 1967) while adolescents benefit from more verbal forms of therapy. Special diagnostic tools such as psychological testing and learning assessments should be available. Another important treatment component is medical consultation for purposes of assessment and prescription of psychoactive medication. Therapy sessions are held once weekly for a period of several months on the average.

Family involvement in treatment has become more popular in recent years, as evidence indicates that children's problems are related to family functioning (Minuchin, 1974; Haley, 1976). When relationships are impaired, dialogue between parent and child is supervised by the therapist in order to help clarify and resolve issues and problem situations.

Parents are also involved in treatment through parent education classes. These classes help parents to understand their child's behavior. An example of such an approach is Thomas Gordon's program, Parent Effectiveness Training (1975).

Some youngsters require more intensive services than a once a week visit because of the severity of disturbance. If unable to be maintained in a regular school or home placement on a full-time basis, day or evening treatment is an alternative. Such services often involve collaboration between CHMCs and local school systems (Behar, 1981).

These programs offer high staff-to-patient ratios and are oriented toward developing social and academic skills as well as meeting physical needs (NIMH, 1978).

Residential services may become necessary when a child is severely disturbed or the family is unable to provide for the emotional needs of the child. Such placements are typically made after less intensive services have been tried and found to be inadequate. In the state of Florida, for example, the Baker Act governing the rights of the mentally ill provides for the care of the client in the least restrictive alternative. Placements are ideally short (3 months) to intermediate term (6 months to 1 year).

Mental health programs focus on the educational, recreational, social, and physical needs of the client (NIMH, 1979). A variety of programs exist to meet the needs of different clients. These include traditional psychiatric hospitalization, placement in a therapeutic group or foster home, and wilderness camping (A. Gray, 1983).^{*} Rarely do mental health centers provide such services independently, however.

Emergency treatment should be available to deal with crisis situations 24 hours a day, 7 days a week. It should attempt to prevent further complications including hospitalization. Adolescents may present with a variety of problems including suicidal attempts or enraged states related often to family disturbances. Mental health professionals attempt to defuse a family crisis through discussion thereby avoiding hospitalization (Behar, 1981).

Centers provide services which help to prevent the development of emotional illness. Mental health education classes are aimed at special

^{*}Personal communication.

problems. Training and consultation are available to other caregivers. Content may include, for example, preparation for parenthood, sex education, or family relations (NIMH, 1979).

While consultation and education (C&E) services are required, however, they are rarely financially self-sustaining. Such services usually do not attract state dollars in replacing lost federal grants as state funding often goes to higher priorities of treatment such as chronic mental illness or crisis treatment (Naierman, 1978).

Outcomes of the Community Mental Health Movement for Children

Greater numbers of children and youth have received more services following the establishment of community mental health centers. Approximately 24% of all mental health care done in CMHCs in 1975 involved children and youth for a total of 1,627,000 clients (ADAMHA, 1980).

There was a reverse shift in proportion of inpatient to outpatient care for children between 1955 and 1975 (ADAMHA, 1980). Inpatient care consisted of approximately 77% of the total in 1955, while outpatient care consisted of 72% of the total in 1975. Hospital admissions for children had become less frequent proportionately than for adults. There was as well an overall increase in the number of outpatient treatment episodes between 1971 and 1975 of 154% (ADAMHA, 1980), with the majority of young people diagnosed as transient stress disorders.

There is evidence that lower socio-economic status (SES) and minority children were equitably served by CMHCs (Brown, 1975). Data cited in connection with the general mental health center population

indicate that lower socio-economic groups were well represented among CMHC clients. In addition, it is known that at least 17% of service recipients were non-white in 1975 (ADAMHA, 1980). Though services are not equally utilized by all minorities (Miller, 1974), the overall representation rate of minorities in the CMHC inpatient population (17%) surpassed the percent of minorities treated in private hospitals and in general hospital psychiatric units (10%) (ADAMHA, 1980).

Thus, there is some basis to conclude that mental health centers succeeded in making specialized services for children available to the general public by providing a greater volume of care to more clients. These clients were less severely disturbed (most had stress disorders) and were treated in outpatient settings in their local communities.

Evaluation and Community Mental Health Centers

Prior to the 1950s there was little research related to mental illness. The National Institute of Mental Health was founded in the late 1940s but it was not until the 1970s that funds were made available for meaningful and comprehensive program evaluation (Vandenbos, 1980).

Evaluation was mandated as an essential CMHC function through P.L. 94-63, Title 3 (1975). Centers were to spend at least two percent of their overall budget for evaluation (Congressional Record, 1975). They were to make an annual self-evaluation study of six areas: cost of operations, quality and patterns of service, accessibility and awareness of services, and availability of services to the public. Proof of effective treatment was not required.

The sum of these endeavors required centers to keep a wide variety of data. Included were client demographics and types and amounts of services provided to individual clients. This involved extensive record keeping (Keppler-Seid, Windle, & Woy, 1980). Caution was urged to avoid burdening centers with extra costs, redundant measurement systems, and useless and/or poor quality data. Government sources were warned to avoid overzealous requirements and rigid government standards which might be irrelevant to local needs.

Need for Evaluation

The 1960s had seen many social programs created by enthusiastic professionals. They failed, however, to obtain empirical support for their efforts and thus had difficulty in convincing state legislators and consumer groups of the efficacy of services (Kappler-Seid et al., 1980; Flaherty & Olson, 1982). Competition for federal dollars made demonstrated performance a critical issue for mental health centers as well. Though centers were largely successful in meeting federal monitoring requirements, there was also pressure to demonstrate successful outcomes and link these with planning and service delivery (Schulberg, 1982).

Program Evaluation Defined

Program evaluation is a process within organizational management rather than an independent research enterprise for making new scientific discoveries (Attkisson, Hargreaves, Horowitz, & Sorenson, 1978). Such

evaluation should be rigorous and based on a systematic data collection system. Suchman, for example, advocated an extended definition of program evaluation:

the study of planned programs for producing social change through social experiments. These experiments test the validity of the hypothesis that the action program has within it elements that will effect certain causal factors in the development of the desired objective. What is evaluated in the action hypothesis is that defined program activities will achieve specific desired objectives through their ability to influence those intervening processes that affect that occurrence of these objectives. (Suchman, 1967, p. 177)

Outcome Research Defined

Outcome research is one of the most highly favored kinds of program evaluation (Schulberg, 1981; Attkisson et al., 1978). It can help to determine if a change was made in connection with a program, although it does not necessarily specify that the change was caused by the program. Such concrete effects related to program goals can include such indicators as hospital recidivism rates, improvement on standardized tests, or changes in individual program areas, e.g., Goal Attainment Scaling (Kiresuk & Sherman, 1968).

Outcome research has been criticized from different points of view. Schulberg (1981) noted that instruments used to measure changes frequently lack validity and that evaluation of specific outcomes often excludes many relevant aspects of care. Keppler-Seid et al. (1982) questioned whether the types of client outcomes were too exhaustive to feasibly measure on a programmatic basis. They also questioned the variability between therapists, clients, and client-therapist

interactions. In addition, the lack of experimental studies in which control groups are used for comparison purposes has proven to be a problem in evaluating treatment effectiveness. Mental health evaluation should not be reduced to a series of simplistic criteria such as profit/loss ratios and gross measures of client improvement (Schulberg, 1981).

Process Evaluation Defined

Process evaluation is an alternative to outcome research. Describing how a program attempts to affect outcomes has been referred to as "process measurement" (Suchman, 1967). The steps involved in process measurement are a) specification of the program characteristics, b) analysis of effectiveness between target populations served, c) specification of conditions under which the program is most successful, d) control or explanation of factors that pose alternative explanations for the results, and e) generalization of results to other situations (Suchman, 1967). This approach attempts to illustrate the relationship between service processes and outcomes more specifically than would be the case in simple outcome research where only one variable is studied. If such linkages can be validated for different client groups, then for the future, measurement of program effort, i.e., number of sessions, alone will suffice.

General Considerations

One's choice evaluation approaches is determined primarily by intent whether it be evaluation of effort, performance, or process

(Suchman, 1967). Another variable is the degree of experimental control in a situation. This influences research design possibilities. Finally, there are practical issues, such as expense, to be considered. However, some general guidelines for evaluation have been recommended:

1. Evaluation procedures should be linked closely with evaluative objectives in order to avoid redundant or irrelevant data.
2. Criterion measures should be valid and reliable.
3. Support systems required to obtain basic information for the evaluation must be available.
4. The costs of the procedure should be considered and balanced against its value to the agency.
5. The impact of evaluation data on performance should be monitored and assessed (Coursey, Speçter, Munell, & Hurst, 1977).

Chronologically, one usually identifies program goals and objectives. Indicators of performance are developed. These are operationalized as a routine data collection system and then the data are used to assess program functioning. It has been suggested that an integrated evaluation program under one computerized system eases data collection and analysis (Coursey et al., 1977).

An example of such a system is Fiester's (1978) Automated Comprehensive Children's Evaluation System (ACCESS) for evaluating a children's mental health program. Evaluation procedures were designed to measure all basic areas mandated by P.L. 94-63 (availability, accessibility, patterns of utilization, quality of services, and client satisfaction). In addition, a modified version of Goal Attainment Scaling (Kiresuk & Sherman, 1968) was used to identify goal commonalities across clients

and assist in programmatic comparisons. A specific form was devised to collect demographic data at the outset of treatment. Shortly after case termination, a request for more information was made to clients.

As therapists' outcome ratings, demographic data, and follow-up interviews were completed, they were forwarded to data processing. A computer program analyzed the data. Print-outs were made available to each therapist. The system was flexible, standardized, inexpensive, and minimally intrusive to clinical staff.

Experimental Design in Program Evaluation

Program evaluation is not limited by research methodology. Depending upon the situation, descriptive, correlational, experimental, and quasi-experimental methods have their place in evaluation.

There are several considerations in choosing the best method for a given situation. Rigorous experimental procedures are sometimes impossible to implement within broadly aimed social programs (Weiss, 1970). Random assignment to different treatment conditions with the use of control groups is, for example, difficult and may not be feasible in most mental health centers. Quasi experiments (Cook & Campbell, 1979) are frequently more practical, as long as they are well-planned, carefully implemented, and cautiously evaluated. Schulberg (1981) suggested using small group samples in a manner analogous to a single-case design. If program quality is monitored through simple outcome measures then more detailed assessments may be pursued with smaller client samples.

Aside from overall considerations of experimental method in designing a method of program evaluation, there are other aspects that need to be taken into account. First, does one measure individual or ecological change? Second, is it best to assess change through standardized measures or through subjective individual goal attainment? Third, from what point of view should the assessment be made?

Crucial to the issue of what is to be assessed is what constitutes effective psychotherapy. Most current outcome studies look at such variables as the psychiatric status of the client, his/her level of social functioning, and the client's satisfaction with treatment (Schulberg, 1981). There exist a variety of well-established instruments for these purposes, such as the Global Assessment Scale (Endicott, Spitzer, Fliess, & Cohen, 1976).

On the other hand, Cyntrynbaum, Snow, Phillips, Goldblatt, and Tischler (1976) call for evaluation to take a more ecological perspective. As well as measures of individual change, it is proposed that family and community data be collected (e.g., socio-demographic information, physical health, school and peer adjustment, and family and individual perspectives). They advocated that successful treatment should involve environmental as well as individual change and, thus, should be a part of evaluation procedures.

Closely related to the issue of what to measure is how to measure it. This usually involves a decision between standardized measures and subjective goal attainment scales. Arguments favoring the use of standardized measures emphasize that CMHCs should focus on a few valid and reliable generic measures that are limited to a few areas of

personal functioning. This approach encourages comparability of treatments and results across centers. For example clients might be given an activities of daily living scale as a pre and post treatment measure. Progress would be determined on the improved levels of functioning as revealed by this instrument.

Another approach favors goal attainment measures which set idiosyncratic goals for each client (Kiresuk & Sherman, 1968). Change is not assessed by norms on a standardized instrument, but according to a client's observed functioning and compared to an initial rating. The latter approach is commended for its specificity with regard to the individual client. Individual results are less likely to get lost in group aggregate data.

Both approaches can provide useful information about programs. But it is difficult, if one does not limit the number of goals employed, to compare results between programs if one uses a goal attainment scale (Fishman, 1975).

From what point of view should the assessment take place? The clinician, the client, the family, and the independent observer all have different perspectives. There seems to be some agreement that multiple vantage points are desirable. Some points of view are more suited than others to different outcome measures. The therapist, for instance, may not be the most objective observer; however, he/she is frequently in the best position to rate clinical indicators of pathology and subsequently any progress that may be made. Such observations may not be evident to others. Again, objectivity, reliability, salience,

and cost are taken into account in answering the question of who should observe and make ratings (Rydman, 1981).

Topics of Special Concern in Evaluating Children's Issues

When children's services were added to CMHCs in 1975 it became necessary to evaluate them. In addition to the general problems concerning evaluation of mental health services previously discussed, children's services have some additional complexities. Levitt (1971) noted that a child is a developing organism and many symptoms are subject to spontaneous remission. This makes it difficult to determine if treatment or developmental factors alone contributed significantly to success. The tendency of certain symptoms to occur at particular ages, remit spontaneously, and then be replaced by new symptoms is also a consideration. This tends to make the researcher more cautious when interpreting results and concluding that the intervention truly benefited the client. Finally, when family members are in treatment concurrent with the client, treatment is compounded and variables related to change are more difficult to assess. It is thus difficult to attribute change to a particular technique or strategy when multiple treatment conditions exist.

The maturational threat to internal validity might be eliminated through use of controlled research, but Walker and Zinober (1978) noted the ethical difficulty involved in identifying children with unmet emotional needs and postponing their treatment for research purposes. They suggest, instead, the use of measures that have normative data in

order that tested results might be compared to similar groups who were part of a normed population. Yet, few, if any, instruments exist in the field of emotional development.

The question of who is the best informant to report change is especially crucial for children. Therapists are often selected to perform assessment because of training and experience. However, as was noted to be true with adults, personal involvement in the success of treatment may present an inherent bias. Problems include perceptual distortion, bias due to theoretical orientation, and awareness of administrative consequences (Kiesler, 1966). Fiester (1978) concluded that therapists' ratings of goal attainment in child clients were higher in some areas than the child and/or parent reports. This is not a general conclusion, however, as in other cases parents and children either tended to rate progress higher or about the same as did the therapist (Fiester, 1978).

Parents as informants may have many of the same problems as therapists. They observe their child's behavior and are aware of pre and post differences, but there is also an inherent lack of objectivity in making ratings. Other informants, such as teachers or relatives, may be more reliable and provide more valid information with respect to the client's functioning, but they too may be unable to give unbiased information in certain situations.

Similar complexities exist when children report data. Children may be unable or reluctant to supply information, especially about internal states. Furthermore, the self-reports of children may be seen as unreliable and irrelevant by adults who are more likely to be the judge of success.

Perhaps the best approach is to rely upon several sources of information. "The multi-informant approach assumes that each informant has access to different kinds of valid information on the patient and the effectiveness of treatment . . . combining the [different] perspectives can result in a general index of treatment effectiveness" (Walker & Zinober, 1978, p. 174).

Outcome Studies in Community Mental Health Centers

Research studies have been conducted for individual centers and statewide systems. Most often they have focused on broad issues of efficacy, such as whether or not CMHCs can keep clients out of state hospitals (Becker, 1974). Some studies have given attention to P.L. 94-63 requirements to assess accessibility and adequacy of service (Cox et al., 1982; Fiester, 1978). Others (e.g., Fortney, 1981; Kline & King, 1973; McGrogan, 1976; Sue, McKinney, & Allen, 1976) have been interested only in specific treatment outcomes.

In a review of the Community Mental Health Journal by Cox et al. (1982) few studies were found which measured treatment effectiveness. Reported research was usually descriptive rather than experimental. None of the studies reviewed were methodologically rigorous enough to establish causal relationships between dependent and independent variables.

Descriptive data relating antecedents and outcomes have been reported on some variables. These include data obtained from the clinical record (i.e., age, sex, occupation, and diagnosis); data related to

treatment (i.e., length, type, and intensity); and data from psychometric tests (e.g., the MMPI).

A study in Washington State provided one example of accountability procedures that served several different purposes (Cox et al., 1982). This study was concerned with the problem of statewide measurement of CMHC populations. Two samples of subjects were defined. One sample from current caseloads was used to give a descriptive cross-section of clients receiving services. Another sample, drawn from new admissions, was assessed prior to and after receiving treatment. Assessment included work and leisure activities, relationships with others, psychological distress level, and other areas of functioning. The study revealed gaps in service delivery patterns. For example, clients who scored high on a psychological distress scale received the fewest services. The study helped convince legislators of the importance of CMHC services.

One study (Becker, 1971) typified another kind of evaluative effort, measuring program achievement in a specific CMHC. It related admissions to a state mental hospital to service at a CMHC in Oregon. Records were used from both institutions to document either increase or decrease in admissions to the hospital following implementation of the CMHC. It was concluded that the center had little impact on admission to the state hospital. But, the center and hospital seemed to effect different populations. While the center provided services to clients who presumably needed them, such services were not equally available to all clients who came to the center, as indicated by the lack of state hospital clients in outpatient caseloads.

Another group of researchers (Fortney, 1981; Kline & King, 1973; McGrogan, 1976; Sue, McKinney, & Allen, 1976) studied outpatients and investigated length of treatment, type of treatment outcome, and/or status of termination. McGrogan (1976), for example, examined forty independent variables and their potential use as predictors. Information from clinical records was found to be the most predictive of four variables (duration of therapy, termination status, termination condition, and cost of treatment) as opposed to other information related to type of treatment or psychological testing. However, overall results were disappointing. It was concluded that a heterogeneous population used center services and that a variety of variables contributed to terminating prematurely or remaining in therapy.

Dropping out of therapy at a CMHC is a significant problem and may range between 35 and 40% (Kline & King, 1973; Sue et al., 1976). Centers were intended to provide care to a variety of patients using whatever services may be necessary to meet their needs, but possibly this expectation is unrealistic given the limited resource of most CMHCs. Sue et al. (1976) noted the value of identifying and describing patients who rejected a center's services. Who benefits? What needs are not met? Early termination is also an important consideration because seeing clients who immediately drop out postpones services to others in need.

Generalizations about early termination in CMHCs have been difficult to make because the definition of premature termination varies from study to study. Studies also vary in terms of population characteristics and the nature of the setting. For example, Sue et al. (1976) found

clinical diagnosis not to be predictive of dropping out while Kline and King (1973) found diagnosis to predict termination.

In one study, data were obtained from over 3,000 clients in 17 CMHC facilities (Sue et al., 1976). Defining premature termination as dropping out after only one session, it was concluded that ethnic minority clients with lower incomes and educational levels, who were diagnosed as psychotic and who were not assigned to individual therapy, were more likely to terminate prematurely. Such clients were more likely to be seen by paraprofessionals. They were most often assigned for diagnosis and evaluation only rather than regular treatment.

Kline and King (1972) through a cluster analysis found eight sets of variables, inclusive of 39 separate variables, to identify dropouts. Different clusters were associated with depression, danger to self, thought impairment, and danger to others. Dropouts tended to be younger or recently married. Life histories of broken homes and unresolved psychological issues pertaining to childhood also were a factor. The researchers concluded that dropping out of treatment was another adjustment failure similar to those of the past.

Significantly, however, the dropout group in Kline and King's study were not distinguished by symptoms of the chronically mentally ill. Being younger than other clients, this group presented a picture of a group at risk for development of more serious problems.

These conclusions were corroborated by Fortney (1981). He suggested that dropping out of treatment was a failure on the clients' part to fit into the psychotherapeutic system. In effect, dropping out was an indicator of the selection processes used by the center. Ten out

of sixteen demographic and treatment variables were found to be predictive of dropping out. Factor analysis isolated four elements: social stability (age, family size, income, contact with significant other); socio-cultural experience (age, race, education); therapeutic stance (presence of a treatment plan, professional therapist); severity of diagnosis (use of medication, diagnostic category). The results of the preliminary analysis were not confirmed in a sample one year later. This failure was attributed to changes within the center which created new and different factors and, subsequently, affected who stayed in therapy.

Dropping out of treatment is a complex process involving many variables. However, most studies test a great number of hypotheses. This increases the probability that conclusions could be spurious. Increasing the number of variables studied reduces the probability of finding a true effect when it is present (Levitt, 1971). Cohen and Cohen (1975) suggested that using a large number of variables, in the interest of thoroughness, is seldom justified. If a large number of variables is to be considered, multiple regression theory holds that such research is appropriate only when the research goal is predictive, the N is very large, the results are to be substantively interpreted, and if a cross-validation study is undertaken (Cohen & Cohen, 1975).

Another theoretical problem with studies that have used premature termination as an outcome criterion was cited by Luborsky, Auerbach, Chandler, Cohen, and Bachrach (1971). They observed that there is no explicit evidence that dropping out of treatment is consistently related to lack of client improvement. Although length of treatment was usually related in a

positive fashion to outcome, the conclusion that length itself was a curative factor was questioned for several reasons. Therapists may overestimate positive change in longer-term patients with whom they may be assumed to have some personal investment. Conversely, therapists may rate early dropouts negatively, assuming a minimum number of sessions are necessary before change can occur. Thus while premature termination is a frequently used indicator of outcome, it is not always clear what this variable involves.

Notably, all the aforementioned studies concerned with treatment outcome in mental health centers were concerned with adults. No data were collected on children and/or adolescents. One study (Kline & King, 1973) noted the importance of childhood experience in contributing to dropping out of treatment as an adult. In some studies (e.g., Kline & King, 1973; Sue et al., 1976), age was a variable, but only in increments over 18.

There is one significant exception. Fiester (1978) designed the Automated Comprehensive Children's Evaluation System (ACCESS) to fill a void in evaluating children's services. Based on a modification of goal attainment scaling (Kiresuk & Sherman, 1968), the therapist and client establish from one to three goals for treatment. Goals are broken down into different levels of attainment from best possible to worst possible outcome and are selected from 14 possible standardized skill areas to enable comparisons among therapists. At the end of treatment, the therapist and child or parent rate their perception of the child's level of attainment with respect to each goal.

Fiester described changes associated with the program in 12 out of 14 skill areas. His study encouraged rational planning of new children's services and the development of staff inservice training programs. It did not, however, relate either client (e.g., demographic characteristics) or treatment (e.g., duration of treatment) variables to outcome.

Thus, program evaluation attempts in CHMCs: 1) seldom separate effects for adults from those for children, 2) seldom study institutional processes beyond a single level (i.e., studying goal attainment in a specific area for a specific therapist), and 3) seldom investigate specific treatment outcomes as a function of situational as well as client related variables (where such studies exist, they are often subject to a criticism of making a large number of non-independent statistical analyses). Overall, little outcome research on program effectiveness with children exists.

Effectiveness of Evaluation

Pressures for more accountability have created several problems for centers. One was the demands for similar information from different monitoring groups. Another was that accountability efforts diverted energy and resources from service delivery. Also, evaluation criteria prescribed by external sources are not necessarily useful to local programs (Keppler-Seid et al., 1980).

Prior to the enactment of P.L. 94-63 requiring centers to maintain accountability data, Rocheleau (1974) reviewed Florida mental health centers and noted that CMHCs did not assess the impact of evaluation

upon later performance. Furthermore, evaluation efforts, although consuming significant amounts of resources and staff time, appeared to have little effect on the organizations themselves. Directors of centers undertaking evaluation expected little useful information from such efforts and results were used infrequently in decision making.

One of the desired outcomes of P.L. 94-63 was that accountability studies would not only produce data helpful to NIMH in monitoring legislative intent, but would serve as a stimulus to improve services (Flaherty & Olsen, 1982). Yet, Rossman, Hober, and Ciarlo (1979) found that program evaluation ranked eighth or ninth out of ten sources of input with respect to relevance for decision making by CMHC managers. This is in contrast to "input from immediate supervisors" which ranked first. Ellsworth (1973) found that when feedback on treatment efficacy was provided to staff in two separate programs, only one program improved its performance in response to the data. This outcome eventually subsided to the prestudy level.

An exception to these findings was Fortney's (1981) results of an evaluation study of a mental health center in Gainesville, Florida. This study sought to link client, therapist, and treatment variables to outcomes. The preliminary study noted four factors which discriminated between positive and negative outcomes. However, a cross validation study a year later did not confirm the original findings. Fortney speculated, in explaining the results, that the center had improved its practices partially in response to the initial study so that the original factors no longer applied.

There is general agreement (e.g., Bigelow, 1975; Flaherty & Olson, 1982; Rossman et al., 1979) that there are factors which determine the usefulness of evaluation efforts to the agency. They are

1. The study should result from the felt needs of the center and the desire to monitor its own performance, as opposed to requirements being imposed from the outside.
2. The focus of the study (i.e., cost, amounts of service delivered, etc.) should consider the audience addressed. For instance, in one survey (Rossman et al., 1979) studies related to cost were preferred by administrators while studies related to performance were felt to be most relevant by clinicians.
3. The dissemination of findings and their usefulness to the agency are important.
4. Program evaluation data are most likely to have an impact when management receives feedback that is directly involved with current issues facing the center and when information is presented in a simple and personal manner.

Outcome Studies Related to Specific Variables in the Current Study

There are several studies which relate client variables to therapy outcomes in different treatment situations (e.g., Baekeland & Lundwall, 1975; Levitt, 1971; Luborsky et al., 1971). However, there is little research on the type of treatment, parental involvement in therapy, duration of treatment, referral source, and severity of diagnosis, especially as they relate to children in a mental health center setting.

It is important in understanding the function of a mental health center not only to demonstrate whether changes occurred in clientele as a result of treatment, but also how different client groups are affected by treatment (Suchman, 1967). For example, are children whose parents participate in therapy more positively affected? Are children who are referred by the court less positively affected by treatment? If a center can answer such questions, then it can make institutional changes to better serve clients (Cox et al., 1982).

A review of related research influenced the choice of variables selected for study in this investigation. The decision to focus on a discrete number of variables was made on the basis of Cohen and Cohen's (1975) caution regarding the chances of spurious significance when simultaneously studying a large number of variables. The following variables received specific attention.

Parent Involvement

Many people believe that parent involvement is important if therapeutic changes are to occur in a child client. This is in accord with a systemic view of family functioning which emphasizes that a change within one family member will affect the entire system and vice versa (Haley, 1974; Minuchin, 1974). If an individual's role in a family helps maintain a particular family balance, then family members can maintain or help change a child's behavior.

Three studies reviewed by Levitt (1971) supported parental involvement in treatment. His review suggested that treatment was least effective when the focus was on the child alone and most effective when

mother, father, and child were included. Two studies (D'Angelo & Walsh, 1967; Gluck, 1964) clearly favored the addition of the father to treatment.

Parental involvement in therapy may not in itself be a curative factor, however. There are examples of treatment programs with children which have been successful without any parent involvement (Brody, 1978; Seeman, 1964). It is also possible that the child's age may act as a moderating variable on the effect of parent participation in therapy. Hartmann (1968) found that either group or individual therapy for parents separately from their children was unrelated to outcome with hospitalized adolescents. The negative implication of this finding for parental involvement is mitigated by the fact that the parents were seen separately. There is evidence in a related field that conjoint (seen together) marital therapy is more effective than concurrent (seen separately) marital therapy (Cookerly, 1974). The same effect may apply for parents and children.

Studies of specific dimensions of parent involvement generally indicate their importance in successfully treating the child. Lake and Lvinger (1960) found parental disagreement with therapists' problem assessment, poor cooperation in the initial interview, a parental tendency to locate the problem in the child rather than in the parent, and external coercion in bringing the child for treatment, to negatively affect treatment outcome. Another study concluded that in unsuccessful cases, parents were less likely to be in treatment (Ross & Lacey, 1961). Finally, it was noted by Lessing and Schilling (1966) that improvement was more likely to occur if the mother recognized and accepted her responsibility in the child's problem.

These findings are not universal however. Levitt (1957) and Williams and Pollack (1964) found no significant difference between dropouts and those who remained in treatment on the basis of different dimensions of parent involvement.

Knowing more about parent involvement in treatment could influence children's programs. If it were found to be a significant variable, therapists might require or work harder to obtain parent participation as a condition of providing services.

Type of Treatment

Type of treatment, as defined in this study, focuses upon individual and family therapy separately and in combination, couples therapy, use of parent and child groups, and use of medication. These are the different modalities of treatment frequently used with children.

Overall success rates have been established for child therapy summing across different treatment modalities (Levitt, 1971). However, there are few studies comparing the effect of different treatments. Malouf and Alexander (1976) noted that with many mental health facilities adopting non-traditional approaches, such as family therapy, it is important to answer the question: Which treatments are most effective and/or efficient?

Most comparative outcome studies consider the issue of whether family therapy is more effective than individual therapy for children and adolescents. Wellisch et al. (1976) studied a group of hospitalized adolescents and recorded a rehospitalization (return to hospital after

discharge) rate of 43% for the group that received individual therapy while none of the group receiving family therapy were rehospitalized. Minuchin (1974) described positive results achieved in working with families of diabetic, asthmatic, and anorexic youngsters. Structural family therapy was able to effect substantial improvement in 83-100% of patients and these changes endured in 91% of the cases. Alexander and Parsons (1973) found recidivism rates for juvenile offenders who received short-term behavioral family therapy to be substantially less (26.1% versus 49% to 73%) than for youngsters who received non-specific family group therapy or church sponsored eclectic therapies. One recent review of family therapy literature indicated that every comparative study showed non-behavioral family therapy either equal or superior to other programs which included such approaches as individual therapy, probation programs, parent counseling, methadone programs, or milieu therapy (Gurman & Kniskern, 1978).

Programs which attempt to teach communication, behavioral, or parenting skills have been termed "skill training" by Malouf and Alexander (1976). All studies reviewed which in some way attempted parent training in reinforcement techniques were successful. Outcomes were maintained over time.

In addition, Parent Effectiveness Training (Gordon, 1971) and Systematic Training in Effective Parenting (Dinkmeyer & MacKay, 1976) have also been shown to be effective in changing either parent attitudes or behaviors, relationships, or child behaviors. Few studies involving these approaches include comparisons between different treatments, however.

If centers were able to establish which types of therapy were most effective, they could better plan their services. For example, if parenting groups were shown to be as effective as individual therapy for children, then it would be less costly to serve clients in such groups. Similarly, if family therapy is no more effective than individual therapy, why offer it as an alternative since it is more costly to provide?

Duration of Treatment

Length of treatment may or may not be related to successful outcomes. It has been argued that there should be a positive relationship between outcome and number of treatment sessions (Levitt, 1971). Others have argued that the relationship between length of treatment and success is not a linear one (Meltzoff & Kornreich, 1970). Some clients may be helped by very brief interventions, while others do not show any appreciable gain.

Length of treatment and outcome for children is generally unrelated. Lessing and Schilling (1965) concluded that neither frequency, number of sessions, nor total time in treatment were related to outcome in a large outpatient clinic serving children and adolescents. The same conclusion was reached by Hartmann, Glasser, Greenblatt, and Solomon (1968), Phillips (1960), and Sheppard (1966), all of whom found no correlation between outcome and number of treatment hours.

For adults, however, the case may be different. Luborsky et al. (1971) found that in 20 of 22 studies of time-unlimited treatment,

length of therapy, as indicated by number of sessions, was positively correlated with outcome. The authors stopped short of concluding that the length of treatment itself was a causative factor, noting the tendency to rate long term clients positively and produce skewed therapist ratings. It has also been argued that those who stayed in treatment longer may simply have "felt" helped rather than making any objective changes.

Time-limited therapies appear to be no less effective than time-unlimited ones (Goldstein, Heller, & Sechrest, 1966). One study concluded that limiting therapy was associated with a more positive outcome (Schlein, Mosak, & Dreikeurs, 1963). Further evidence for the efficacy of short-term therapy comes from Rosenthal and Frank (1958) who discussed the possibility of positive change occurring within five sessions. Frank (1963) found that positive change could occur in the first session after the administration of a placebo. Heilbrun (1974) concluded, based on a series of investigations, that termination after the first interview could signal satisfaction. Overall, adult patients with acute situational problems derive little additional benefit from long-term treatment and may drop out after their needs have been met. Dropping out does not necessarily signify treatment failure, however.

These findings are especially pertinent for mental health clinics that have high dropout rates (Fortney, 1981; Smith & Kline, 1973; Sue et al., 1976). The fact that CMHCs possess high dropout rates which come early in treatment and have an overall low median number of sessions makes it important to document success of treatment by measures other than premature termination. It is questionable to use

dropping out of treatment as a sole measure of success or failure until an unequivocal relationship between dropping out and treatment outcome is demonstrated.

Duration of treatment, as it relates to children's programs in community mental health centers, is still an important issue. If an optimal duration of treatment can be identified, centers could more efficiently plan their services.

Severity of Diagnosis

Most research indicates a close relationship between severity of diagnosis and/or level of personality functioning and lack of treatment success. Ross and Lacey (1961) noted that the child who drops out of treatment was more likely to have had developmental difficulties, unusual behavior and/or non-specific symptoms, and to have been a school truant. The Institute of Juvenile Research (Lessing & Schilling, 1966) reported that degree of emotional disturbance was inversely related to improvement in cases where mothers and children were treated.

A review of outcome research with children (Levitt, 1971) categorized children into neurotic, psychotic, and acting-out domains ("neurotic" was defined as a child who was neither a psychotic, a behavior disorder, nor a special symptom). Neurotics improved at a rate of 67.5%, psychotics at a rate of 65.1%, while children with acting-out symptoms improved at a rate of only 55%. It therefore appeared that children with behavior disorders were the most resistant to treatment. This finding is alarming as aggressive, destructive, and anti-social behaviors

carry over into adult life with greater frequency than other emotional disorders. High proportions of these children are arrested, hospitalized, or abused, and experience alcoholism and divorce as adults (Robbins, 1966).

Research with adults corroborates findings with children with respect to severity of diagnosis. Barr (1977) concluded that psychotics averaged the longest in attendance while persons with marital problems left most quickly. One review found initial level of personality functioning to be positively related to treatment success in 14 out of 15 studies (Luborsky et al., 1971). Similar results were reported for the more severe diagnoses (e.g., psychosis), noting that these clients benefitted less from psychotherapy. It was concluded that the healthier the patient was to begin with, the better the outcome. The converse also appeared to be true.

Another review substantiated this position (Baekeland & Lundwall, 1975). It was reported that sociopathy, paranoia, alcoholism, and extreme depression were generally characterized by premature termination. Anxiety and moderate depression, on the other hand, improved the chances of remaining in therapy.

There is some research on this topic specific to mental health centers. Anxiety neurosis was found to be the strongest predictor of termination status in a multi-factor study (McGrogan, 1976). In another study adult dropouts tended to be more psychologically impaired and had a greater tendency to act out (Kline & King, 1973). Significantly, presence of childhood problems as recalled by adult clients was associated with dropping out of treatment. Such clients more often came

from broken homes and had conflicts in the areas of comfort and dependency. This group also included more suicidal persons and clients who were generally more psychologically impaired (Kline & King, 1973).

It is important to determine whether severity of diagnosis affects outcome in mental health centers. Given this information, informed decisions could be made about serving different diagnostic groups. Resources could be concentrated in areas where outpatient treatment was most successful. On the other hand, services could be improved for diagnostic groups not benefitting from current treatments. Referrals could be more justifiably made if resources were not adequate to provide successful treatment.

Referral Source

Research indicates that referral source is correlated with treatment outcome. In hospital medical settings, leaving treatment against medical advice was more likely for clients who were court referred (Altman, Brown, & Sletten, 1972). In another study in an outpatient clinic it was found that "refusers," defined as those who were accepted for treatment but did not show up, were more likely to be referred from the school systems (Williams & Pollack, 1964).

Motivation for treatment has consistently been demonstrated to affect treatment outcome. One review suggested that in 34 of 41 studies lack of motivation was the most important factor in defection from treatment (Baekeland & Lundwall, 1975). Although motivation may have been defined differently in the studies, the conclusion was a patient's

personal reasons for seeking treatment determined whether or not he or she stayed in it.

In the treatment of children it is the adult's motivation rather than the child's that is most salient. At least one study investigated outcomes as a function of parental attitudes toward treatment (Lake & Levinger, 1960). Parents of treatment dropouts were more likely to have submitted to institutional pressures suggesting that they take their children for treatment. This conclusion was challenged, however, by Mindess' finding that working with court-referred clients was as successful as with self-referred (Mindess, 1953). It may be that if the client perceives the agency as favorable to him regardless of referral source, the effects of an initial referral may be mitigated.

It is apparent that motivation for treatment on the part of the parent may be an important discriminator of treatment outcome in a community mental health center. The study of referral source as an indicator of motivation may help shed light on barriers to treatment.

Summary

A review of the professional literature indicates that program evaluation research is needed to validate mental health center services for particular client types. This study is designed to examine the attributes of treatment success or failure in relation to variables of involvement in treatment, referral source, severity of disturbance, and duration and type of treatment. These have all been shown to be relevant to treatment

outcome in other settings. The question is whether these can be connected to treatment outcome with predictive implications in the mental health centers studied. This will afford direct benefits to patients in terms of improvement of treatment as well as to agencies in terms of defining the most effective and efficient ways to utilize their resources.

CHAPTER THREE RESEARCH METHODOLOGY

The purpose of this study was to investigate variables related to the effectiveness of mental health center outpatient services to children. Using information from medical records, case data were gathered on five variables: referral source, type of treatment, severity of diagnosis, parent participation in treatment, and duration of treatment. The relationship of these variables to one another were examined by comparing cases described as successful and cases described as unsuccessful. Data on other variables believed to affect treatment outcome were also gathered.

This chapter is organized into the following sections: population, description of data source, sampling procedures, research hypotheses, research design, method of data collection, investigative procedures, analysis of data, and the limitations of the study.

Population and Sample

The population consisted of approximately 1300 children and adolescents, ages 0-17, who had received help from two northern Florida community mental health centers during the years of 1980 to 1983. The sample for the study consisted of approximately 275 randomly drawn child and adolescent cases.

The Mental Health Centers

The District III Mental Health Board, Inc., from which the sample was drawn, was located in one of the fastest growing population areas in the United States. It was mainly a rural area with all the counties served by the District Board below the state average in terms of population density. Racially, 84% of the population was white, 13.3% was black, and 1% other races, which was the approximate racial balance throughout Florida. Regarding age, 80% of the counties in District III had a higher percentage of young people (17 and under) than the state as a whole and a below average percentage of older (55 and over) citizens. Average educational attainment was below the state average, although there were several centers of higher education in the district (District III Mental Health Plan, 1979-1980).

The children's programs (District III Mental Health Plan, 1979-1980) selected for this study served a three county area in Northern Florida. Two of the programs were administered under the North Central Florida Community Mental Health Center, and served Alachua and Levy counties. Service locations were in Gainesville (the Child, Youth and Family Center) and in Bronson (the Community Counseling Center). The other children's program, administered under the North Florida Community Mental Health Center, was located in Lake City, Florida (the Columbia Counseling Center), and served Columbia County.

Originally the two centers were combined, having been established as a non-profit organization in 1972, under a federal staffing grant from the National Institute of Mental Health. The original service area

included ten rural counties in the north central part of the state. In 1980 the center split into the North Central Florida Community Mental Health Center, comprising the four southern counties of the original catchment area, and the North Florida Community Mental Health Center, comprising the six northern counties. This transition marked the end of an eight year federal staffing grant for the North Central Florida Community Mental Health Center and the beginning of a Federal grant for the North Florida Community Mental Health Center.

Both centers received funding from county, state, and federal governments, third party payors and client fees. State dollars flowed to each center through the District III Mental Health Board.

The District III Mental Health Board was a private, non-profit corporation. In addition to the disbursement of funds to the center, its responsibilities included the identification, review, and evaluation of mental health/substance abuse needs, services, and facilities. The Board monitored the centers to assure contractual compliance. It also served as the liaison between the Department of Health and Rehabilitative Services, the District's 15 county governing bodies, and providers of mental health and substance abuse services (District III Mental Health Plan, 1979-1980).

The individual centers operated under the direct control of Boards of Directors composed of residents of the service area. The executive directors for the centers were responsible for implementing District Board policy, managing center operations, and maintaining positive relationships with government agencies.

Whereas the centers received direct federal support during and prior to 1980, the federal government changed its funding pattern in 1980. Money to the centers now came through the state government in the form of block grants. The state of Florida chose to maintain mental health funding at 85-90% of the previous levels. Mental health centers were thus under the authority of the states and local communities.

As a consequence of the expiration of federal legislation (in 1980) governing community mental health centers, no national requirements for monitoring or evaluating centers existed. For the two centers in this study, monitoring was done jointly by the state Health and Rehabilitative Services department and its contractor for mental health services, the District III Mental Health Board.

Catchment Area 3A. Catchment Area 3A of District III was geographically large and included Columbia, Hamilton, Lafayette, and Suwannee counties. However, the area was sparsely populated (about 73,000) with all counties falling below the state mean of population density. It also had the slowest population growth rate of the District. About one-third of the service population was 17 years old or younger, a percentage higher than both the district and state averages. The census count by sex was consistent with the state averages. The percentage of black residents was, however, higher than either the District or state averages. The entire catchment area had been designated a poverty area in 1979-80 by the then Department of Health, Education and Welfare. Other special problems included a high rate of teenage pregnancy, substandard housing, and a low number

of school years completed (District III Mental Health Plan, 1979-1980).

In 1979-80, the child and adolescent population in need of mental health services was estimated to be 3,100 individuals. At that time, the center was meeting approximately 16% of the estimated needs.

Children's needs were considered a high priority as evidenced by the results of a mental health needs survey done in 1979-80. Child abuse was ranked second (out of five choices) as a problem in two of the counties while children with emotional difficulties requiring out-patient counseling was ranked second, fourth, or fifth, in three of the counties (District III Mental Health Plan, 1979-1980). Out-patient services to meet the need of family problems was cited in 1980 to be a "most needed" service as no private sector resources existed in the area from which to obtain private psychiatric care.

Service delivery was based on an organizational concept in which an Area Director and a team of clinical and support staff were responsible for the delivery and coordination of services within a geographic area. The four counties were served by two clinics, Columbia Counseling Center and the Suwannee River Counseling Center. The clinic of interest to this study, the Columbia Counseling Center, employed two full time mental health professionals specifically serving children during the period 1980-1983. One of these was a professional and the other a paraprofessional. The paraprofessional was replaced in the later part of 1983 by a professional.

Catchment Area 3B. Catchment Area 3B was the largest area in District II in terms of population. Approximately 190,000 residents

lived in the service area. The Gainesville urban area comprised 62% of the population while the remaining 38% resided in small, rural communities. Services were often limited in rural areas because of transportation difficulties for clients. Approximately 29% of the population was seventeen years of age or younger. Census counts by race and sex were consistent with state averages. However, the area had a low median income with over 50% of persons in poverty. There were also high rates of teenage pregnancies and students dropping out of school. In addition, Alachua County had a high mobility rate, a large population of youth, and one of the highest per capita crime rates in the nation. These factors indicated a relatively unstable community at risk for developing mental health problems.

In 1979-1980, the child and adolescent population in need of mental health services was estimated to be 4500 persons. About 16% of this group received services. Needs assessments for Alachua and Levy counties included the following priorities concerning children: child abuse, seriously emotionally disturbed children requiring outpatient counseling, the need for living facilities to prevent dependent children from becoming emotionally disturbed.

Service delivery in the 3B area was again based on an area concept of organization in which a team of clinical and support staff delivered services to children in a geographic area not necessarily consistent with county lines. Alachua County was served by the Child, Youth, and Family Center (CYFC) located in Gainesville, while Levy, Gilchrist, and Dixie Counties were served by the Community Counseling Center (CCC) located in Bronson. Additional Community Counseling Center outreach

clinics were located in Trenton and Cross City. The clinics of interest to this study possessed the following staffing patterns: During the period of the study the Child, Youth and Family Center had two MSW social workers, one Ph.D. counselor, one part-time clinical psychologist, and one paraprofessional counselor. The CCC employed six professional therapists (master's degree or above).

Closed Medical Records

A closed medical record contains information related to three phases of patient care: intake/diagnosis, treatment, and discharge. During the admissions interview with each client, demographic and clinical information are recorded, including race, sex, age, family size, income, marital status of parent, referral source, and history of prior psychological services. (See Appendix A.)

Following the initial or intake interview, a clinician writes a summary and a treatment plan. The summary includes the presenting problem, medical, psychiatric, educational, social, and family histories, and a case summation with both a diagnosis and prognosis. The clinical diagnosis follows categories of emotional illness as described in the Diagnostic and Statistical Manual III (APA, 1980). The treatment plan is intended to complement the intake summary. It contains a brief description of the client's problems, specific treatment goals, and how these goals will be achieved.

A clinician's observations or chart notes describe the middle phase of the treatment process. The notes show who was involved in the session,

the prominent events which occurred, and goals for future sessions. These notes are designed to be concise and theme oriented rather than descriptive and factual.

Finally, when a chart or medical record is closed, the clinician fills out both a discharge summary and a discharge sheet. The discharge summary contains a brief summation of the course of treatment. It includes the number of treatment sessions, who attended, and reports any progress that was made toward the desired goals. The clinician also rates the status of termination in such categories as "refused treatment or dropped out after one session" or "referred to other mental health center" on a discharge sheet. This evaluation reflects whether the termination was by mutual agreement or viewed as premature. A final rating of "much improved," "somewhat improved," "unchanged," "slightly regressed," or "significantly regressed" is given at termination to each treatment goal listed on the treatment plan.

Variables Investigated

It has been noted (Chapter Two) that a study of both treatment (type and duration of treatment and parent involvement) and client (severity of diagnosis and referral source) related variables was necessary to understand the effectiveness of a CMHC. The following variables were selected from a review of related research.

Parent Involvement

Parent involvement was defined as parent participation in a child or adolescent therapy session beyond the intake interview. A parent

or guardian must have been present during the intake and given permission for treatment. However, some parents out of fear, misunderstanding, or personal uninvolved preferred to be uninvolved and hoped that the center would assume full responsibility for treatment. Other parents wanted to be involved and willingly participated in the sessions. Most clinicians in most cases recommended parental involvement in the treatment of a child or adolescent. For various reasons, parent involvement in some cases was non-existent or limited. Did parent involvement make a positive difference? To help answer this question, it was necessary to differentiate cases according to whether or not the parents participated.

One session beyond the intake interview constituted parent participation in treatment. The mean number of therapy visits for centers was approximately 7.5 sessions per case. Thus proportionately, even one session beyond that required for the intake attended by the parents was significant.

Information concerning parent involvement was obtained from chart notes where the therapist routinely reported who was involved in any given session. If information was vague or ambiguous, the case was recorded as undetermined and not used in the analysis of data.

Referral Source

Referral source was grouped into seven categories: self, school system, Health and Rehabilitative Services (HRS) recommendation, community agency or church, physician or medical clinic, law enforcement

or court order or HRS performance agreement (see Appendix B). These categories included the primary referral sources and also differentiated voluntary, agency, and involuntary categories. Voluntary referrals were those in which there was no element of coercion. Agency referrals were those where the impetus for the referral came from an agency, but no court order prevailed. Involuntary referrals were those where a client was directed by police or court order or probation officer to receive treatment at the Center.

This information was routinely recorded during the intake interview on the admissions data sheet. If the referral source was unclear, it was recorded as undetermined. If two or more sources were involved, the most recent source was used.

Severity of Diagnosis

The diagnostic category of a client was related to the Diagnostic and Statistical Manual III (APA, 1980). Several codes may have existed for a client.

Classification of psychiatric disorders in the DSM III is made on two primary axes: Axis I includes clinical problems, i.e., conduct disorders, developmental disorders, etc., and conditions not attributable to a mental disorder that are a focus of attention or treatment, i.e., parent-child problems. Axis II includes personality disorders and specific developmental disorders. Each axis may include more than one diagnostic category. Other axes mentioned in the DSM III were not utilized in this study as they were not uniformly used by the centers.

For purposes of analysis, recorders were instructed to use only the first diagnosis listed on Axis I and the first diagnosis listed on Axis II. A case was classified as "mild" if it was a condition not attributable to a mental disorder or an adjustment disorder. Cases to be classified as moderate-severe included conduct, thought, affective, developmental, and personality disorders, or substance abuse. Cases in this category were distinguished by their longer duration and/or a specific pattern of behavior.

Type of Treatment

Type of treatment included 1) individual, 2) family/couple, 3) combination individual/family/couple, 4) group, and 5) medication. For all but medication, two or more sessions in a modality were necessary in order to qualify for the category.

Recorders identified the treatment modality(s) from the chart notes. If there was no specific mention of who was involved in the sessions the treatment category was marked undetermined. For a distinction of family/couple therapy, it is not necessary for family members to be seen conjointly with the client. The needed only to be present at the same session. Family treatment could not be separated from couple treatment because of ambiguous references in the chart notes.

Duration of Treatment

Duration of treatment was measured by counting the total number of sessions attended either by the client and/or other family members.

Recorders noted the number of sessions attended from chart notes and used the discharge summary for corroboration.

Criterion Measure

For each specific problem originally listed on the treatment plan, the therapist specified outcome goals or objectives. Progress toward these goals, at termination or other specific times, was rated on a five point scale: significant progress (+2), some progress (+1), no progress (-1), some regression (-1), severe regression (-2). To obtain an overall rating for an individual chart, the specific goal ratings were summed. Positive outcome was classified as any positive sum while a negative outcome was classified as any negative sum. Undetermined outcome resulted in cases being disqualified from the study.

Sampling Procedures

Two hundred and seventy-five closed medical records charts (cases) from three separate specialized children's programs within two separate mental health centers were randomly* drawn from the study. The three programs were 1) the Child, Youth and Family Center, Alachua County; 2) the Community Counseling Center, Levy County; and 3) the Columbia Counseling Center, Columbia County. These programs were interested in and willing to cooperate with the study.

Permission to access medical records for research purposes without the client's express consent is allowed by both state and federal laws if certain conditions are met. State statutes concerning confidentiality

*Additional unsuccessful cases (27) were sampled in order to elevate the proportion of such cases to 40% in the sample.

usually require a client's written permission to use a case record for research purposes. However, an exception is made if the client's identity can not be deduced from the data collected. Such was the case in this study.

Medical records librarians from each unit selected closed medical records from the period of January, 1980, until December, 1983. All cases available for review were numbered and then sampled according to a table of random numbers. Approximately 1300 charts were available for review in the three clinics.

Criteria for Inclusion Cases in the Study

In order for a case to be included in the study the chart had to contain a) an admission data form, b) an intake summary or intake form, c) a diagnosis according to the DSM III Manual, d) a treatment plan, e) chart notes, f) a discharge summary, and g) therapist rating of treatment goals. Records were rejected for the purpose of the study if the outcome was indeterminant, outcome not rated, the child classified as mentally retarded or over 17 years of age, or in the event that the child was not in treatment with the parent or legal guardian (e.g., foster care), or if the family had not returned for further sessions after the initial interview. However, all cases rejected for the study were counted (see Table 1).

Cases were divided between 162 (58.5%) positive outcomes and 112 (40.4%) negative outcomes. Approximately 65% of the total cases sampled were rejected. The following reasons applied: 10% were discarded in order to ensure sufficient negative outcomes for the sample; 44% had no evaluation

TABLE 1
 SAMPLING DISTRIBUTION BY CLINIC AND BY YEAR

	1980	1981	1982	1983	Total
<u>Gainesville</u>					
Cases Available	91 (13)	196 (28)	203 (20)	211 (30)	701 (51)
Cases Sampled	68 (18)	115 (31)	82 (22)	106 (29)	371 (43)
Cases Accepted	10 (10)	30 (30)	30 (30)	30 (30)	100 (36)
Cases Rejected	58 (21)	85 (31)	52 (20)	76 (28)	271 (47)
<u>Bronson</u>					
Cases Available	25 (14)	50 (28)	49 (28)	54 (30)	178 (13)
Cases Sampled	25 (14)	50 (28)	49 (28)	54 (30)	178 (21)
Cases Accepted	10 (13)	26 (34)	20 (26)	21 (27)	77 (28)
Cases Rejected	15 (14)	25 (24)	30 (29)	34 (33)	104 (18)
<u>Lake City</u>					
Cases Available	100 (21)	118 (25)	148 (31)	107 (23)	473 (35)
Cases Sampled	58 (19)	63 (21)	87 (29)	96 (31)	304 (36)
Cases Accepted	27 (27)	30 (30)	27 (27)	16 (16)	100 (36)
Cases Rejected	31 (15)	33 (16)	59 (30)	80 (39)	203 (35)
	Total Cases Available			1352	
	Cases Sampled			855	
	Cases Accepted			277	
	Cases Rejected			578	

of progress; 16% were cases where clients were older than 17; 22% were seen for only the intake interview; 4% of the cases involved the child being in foster care; 4% of the cases did not have a DSM III diagnosis or had an inappropriate diagnosis (e.g., retardation). See Table 1 for a summary of total cases available, cases sampled, cases accepted for the study, and cases rejected.

Demographic Description of Sample

Approximately equal numbers of cases came from the Gainesville and Lake City clinics while a smaller percentage (see Table 1) of cases came from the Bronson Clinic. This was due to the smaller number of cases available from this location. Frequency of cases by year (see Table 2) were approximately equal, except for a smaller frequency in 1980. This was explained by the introduction of the DSM III Diagnostic System in the middle of the year, making cases seen earlier in the year ineligible for the study. Thus, cases were distributed equitably by location and year.

Other demographic categories of interest included age of client, race, sex, and income. Clients ranged in age from 2 to 17 years old. This was divided into four categories corresponding with school status: preschool, 2 to 5; elementary school, 6 to 10; middle school, 11 to 13; high school, 14 to 17 (see Table 3). The data suggest that the younger children were served less often by the mental health centers. The racial balance evident in the sample (see Table 4) approximated the racial balance throughout Florida. Males and females were represented

equally in the sample (see Table 5). When race and sex were grouped together (see Table 6), white males were in the majority while black females were in the minority. There was a range in income from \$0 to \$32,000 a year. Income was divided into quintiles according to annual earnings. These included the following categories: lower-lower, lower-middle, middle-middle, upper-middle, and upper-upper (see Table 7). Almost one-half of cases fell in the lower-lower category. This is consistent with Brown's (1975) finding that over 50% of clients served in community mental health centers had incomes below \$5,000. As the poverty index for a family of four was \$9,862 (Beeghley, 1983) most clients served in the sample could be classified as living at, below, or slightly above the poverty level. In sum, distribution of cases for race and sex were close to population averages while distribution of cases for age and annual income was not representative.

Where family composition was concerned, almost 3/4 of the clients sampled lived with only one natural parent, while 1/4 did not (see Table 8). Approximately 2/3 of the clients came from families where divorce or separation had occurred (see Table 9). These data reflect a higher than normal distribution of cases involving divorce as the percentage of divorce involving children under the age of 13 in Alachua County (the county in which one of the clinics was located) was 33 to 40% (Arey, 1979). Of those divorced, approximately 1/3 had remarried, which was close to the 35% figure cited for all of Alachua County (Florida Public Health Statistics, 1980). The percentages for divorce and separation and remarriage (see Table 10) reflect approximately equal percentages of

TABLE 2
PERCENTAGE OF CASES ACCEPTED FOR THE STUDY BY YEAR

1980	1981	1982	1983
16.6 (46)	31.4 (87)	27.8 (77)	24.2 (67)

TABLE 3
PERCENTAGE OF CASES BY AGE

2-5	6-10	11-13	14-17
8 (24)	33 (91)	23 (63)	36 (100)

TABLE 4
PERCENTAGE OF CASES BY RACE

White	Black
83 (230)	17 (47)

TABLE 5
PERCENTAGE OF CASES BY SEX

	Male	Female
	55 (152)	45 (125)

TABLE 6
PERCENTAGE OF CASES BY RACE AND SEX

	Males	Females
White	44 (123)	39 (109)
Black	10 (28)	6 (17)

TABLE 7
PERCENTAGE OF CASES BY ANNUAL INCOME

	Upper- lower 7600- 10,800	Middle- middle 11,000- 15,000	Upper- middle 15,100- 24,800	Upper- upper 25,000- 32,000
Lower- lower 0-7500				
	48.4 (134)	19.5 (53)	16.2 (48)	11.2 (30)
				4.7 (12)

TABLE 8
PERCENTAGE OF CASES LIVING WITH ONLY ONE NATURAL PARENT

Living with one parent	Other
72.6 (201)	27.4 (76)

TABLE 9
PERCENTAGE OF CLIENTS EXPERIENCING DIVORCE OR SEPARATION

Natural parents divorced or separated	Other
65.7 (182)	34.3 (95)

TABLE 10
PERCENTAGE OF CASES BY MARITAL HISTORY

Intact families	Parents divorced and remarried	Parents divorced, single
30.3 (84)	30.7 (86)	38.3 (107)

cases from families where no divorce had occurred or remarriage had taken place. A higher percentage of cases were from single parent homes. The data suggest that children from single parent homes were the group most likely to receive help from the mental health centers.

Research Hypotheses

1. There is no significant difference between successful and unsuccessful cases regarding parent involvement in treatment.
2. There is no significant difference between successful and unsuccessful cases in terms of referral source.
3. There is no significant difference between successful and unsuccessful cases regarding severity of diagnosis.
4. There is no significant difference between successful and unsuccessful cases for type of treatment used by the therapist.
5. There is no significant difference between successful and unsuccessful cases in terms of duration of treatment.

Method of Data Collection

Chart Review Procedures

The principle investigator developed a procedure to review closed medical records charts. Data included information about the client, treatment, outcome, and the therapist. Information gathered about the client included family income, client age, client diagnosis, race, sex, family composition, parents' marital status, school performance, and

medical history. Information related to treatment included duration, type of treatment, and parent participation in treatment. Information on outcome included specific outcome ratings and whether or not the termination was premature. Information related to the therapist included the therapist's educational level (BA, MA or higher, paraprofessional) (see Appendix B).

Data were entered directly from the medical record onto a recording instrument (see Appendix B) according to the recorder's guide sheet (see Appendix C). The guide sheet listed the information to be obtained and explained how and where this information was to be found in a medical record. It also showed where the data were to be recorded on the recording instrument. The items on the recording instrument followed the natural order in which information appeared in the chart.

No identifying information was retained to identify the charts in order to protect client confidentiality. The code numbers assigned by the principal investigator and medical records librarian correlated any given case with the medical records chart number. The correlative list remained with the medical records librarian and was retained for the purposes of 1) data retrieval in the future, and 2) insurance against duplication in this or a future study.

A pilot study with 20 cases, not to be included in the study, tested the recording and data collection procedures. It provided information as to 1) average time to record a chart, 2) incidence of missing or ambiguous information, 3) estimated the number of charts that were required in a sampling in order to obtain the minimum number of successful and unsuccessful cases.

Permission from the Centers

A letter was sent to each center inviting its participation in the study. A proposed time schedule for the data review and recording to occur and instructions for the medical records librarian was included. Also included was an explanation of how the research might be expected to advise center programs and an offer to share results. Both centers gave permission to use their closed medical records for the purposes of the study.

Selection and Training of Recorders

Employees of the three mental health clinics in the study who had familiarity with the medical records of the agency were recruited to assist in the study. The purpose of using employees was to ensure confidentiality as well as take advantage of their familiarity with the medical records and agency procedures.

One employee of the North Florida Community Mental Health Center, Inc., reviewed the charts at that center (Lake City). One employee of the North Central Florida Community Mental Health Center, Inc., reviewed charts at the two locations (Gainesville and Bronson) at that center.

At a training session the general purpose of the study was presented. Recorders were not told the specific hypotheses involved. They were given the study's time schedule and compensation for their services was agreed upon. The recorders were made familiar with the recorder's guide sheet and recording instrument. They were 1) given precise definitions of each variable on which data were to be recorded,

2) shown how and where information was to be obtained from the medical record, and 3) instructed as to how each item was to be recorded on the data sheet.

Recorders practiced data gathering on the same medical records charts. An inter-judge reliability coefficient or proportion of agreement was computed to determine rater accuracy and reliability (see Appendix D). Kappas (Ks) were used as an indicator of reliability between judges for nominal level variables (Cohen, 1960). Items with lower correlation coefficients were more fully explained or revised to increase precision.

Data Collection Visits

All data were collected at the medical records library for each respective children's program during a time that minimized disruption to the center's regular operation (e.g., after hours). The investigator was available initially and thereafter at intervals to answer questions and clarify issues. He participated in the initial numbering and random selection of charts, using a table of random numbers. Recorders were able to review about 4 cases per hour. In the event that a medical record was incomplete or did not meet the criteria for inclusion in the study, another suitable chart also chosen on a random basis was substituted. In the case of the Bronson Clinic, all records available were sampled in the study.

One recorder reviewed a total of approximately 100 cases while the other reviewed approximately 177 cases. Collection of data at each site required no more than 10 weeks to complete.

Upon the submission of recording instruments, the investigator checked to be sure they were properly filled out. When the total number of cases was reviewed, data from the recording instruments were key punched onto cards.

General Procedures

1. The investigator developed recording procedures to obtain needed information from charts.
2. The investigator visited clinic sites to explore with administrators the feasibility of collecting the desired information.
3. Permission to do the research was obtained.
4. Data recorders were recruited and trained.
5. Approximately 10 cases were randomly drawn to test and refine the recording procedures and obtain measures of rater reliability. The recording instrument was changed to improve reliability.
6. A schedule was set for data collection.
7. The data were collected during a ten week period with the principal investigator consulting with recorders to resolve questions.
8. Data were key punched and analyzed.

Limitations of the Study

The major limitation of this study was that the information obtained was restricted to medical records. No corroborative information was available, though at times it was possible to check data from one section of the chart against data in another section. The accuracy of the

data was thus dependent on the preciseness, correctness, and objectivity of the clinicians especially as concerned ratings of outcome.

Another limitation of the study was the precision of measurement with some variables of interest. For example, parent involvement was measured only as present/not present.

Analysis of Data

Data were analyzed through cross tabulation on a joint frequency distribution of cases according to two or more classificatory variables. The joint frequency distributions were tested for strength of association by chi-square. Other measures of association such as phi or Cramer's V described the degree to which one variable predicted another (Nie, Hull, Jenkins, Steinbrenner, & Bent, 1975). The addition of other variables as controls allowed study of intervening or interacting influences.

CHAPTER FOUR ANALYSIS OF DATA

This study investigated variables related to the effectiveness of community mental health outpatient services to children. Specifically, case data were collected on five primary variables: parent involvement in treatment, referral source, severity of diagnosis, type of treatment, and duration of treatment. The relationship of these variables to cases defined as successful or unsuccessful was explored.

Closed medical records were randomly sampled from three clinics in two mental health centers. Information on 274 cases was collected systematically by trained recorders who followed the same written instructions (Appendices B and C).

Successful or unsuccessful outcomes for the cases were defined by therapist ratings on specific treatment goals. A total of 274 cases were reviewed. Of these, 162 (58.5%) had successful outcomes and 112 (40.4%) had unsuccessful ones. Data on other variables believed to affect the primary variables were also collected (Appendix B).

Analysis of the data was accomplished through a cross tabulation procedure using a joint frequency distribution on two variables. The strength of association was measured by chi-square (Nie, Hull, Jenkins, Steinbrenner, & Bent, 1975). This statistic enables one to determine the probability that the observed relationship between variables could have occurred by chance. First, row and column marginal totals were

used to calculate expected cell frequencies (if no relationship is present between variables). The expected cell frequencies are then compared to the actual values. As the discrepancy between expected and actual frequencies increases, the chi-square value becomes larger.

Chi-square only assists in determining whether or not variables are independent. It does not state the magnitude of this relationship. Either phi or Cramer's V indexes the degree of correlation between two variables much as does Pearson's R. These statistics also adjust for the fact that chi-square is directly proportional to the number of cases in the sample as well as the table size. Phi or Cramer's V are included in the tables of this study when the chi-square analysis was found to be significant or approaching significance for a primary variable.

The .05 level of significance was used in all tests of significance as the criterion for rejection of a hypothesis. However, significance levels equal or greater than $p < .25$ were reported. Below $p < .25$, results were described simply as nonsignificant. The results of the study will be reported in this chapter. More specifically, data were analyzed for each of five variables and related hypotheses.

Parent Involvement

Parent involvement in child therapy is often thought to be an important factor and is highly recommended (e.g., Levitt, 1971; Minuchin, 1974). The systemic view of family functioning (Haley, 1976) asserts that a symptom within one family member may serve a function for the entire family. The parents may be unknowingly

supporting a child's behavior. Thus, their involvement in the change process is assumed to be necessary.

Parent involvement in this study was defined specifically as parent participation in treatment after the intake interview. Parents present at one or more sessions after the intake interview were considered to be "involved" in the treatment of their child.

Data were available on all 274 cases. In 81 (29.5%) cases, both parents were included in at least one session following intake. In the remaining cases (70.4%) both parents were not included. Of the cases where both parents were included in post intake sessions, 75 (92.5%) of the parents attended sessions together. There were 6 cases (7.5%) where both parents participated in treatment, but did not do so together. Of parents who participated in therapy alone, without the other parent, there were 177 females (91.7%) and 10 males (9.3%). Single parents participating thus comprised 68% (187 cases) of the sample. There was a remainder of 6 cases (2%) of the sample where neither parent participated in sessions after the intake.

H₀₁. There is no significant difference between successful and unsuccessful cases regarding parent involvement in treatment.

The frequency of 6 cases in which there was no parent involvement in treatment was so small that further analysis seemed inappropriate. Chi-square assumes that for any category, sample frequencies are distributed normally about the population value. The assumption of normality is not met when expected population values are close to zero. Thus, with very small expected frequencies, the validity of χ^2 results

is questioned (Welkowitz, Ewen, & Cohen, 1971). For this reason, analysis was not pursued and the results remain inconclusive.

Examination of the data reveals that considerable numbers of parents, 193 (70.4%), participated in treatment without another adult. This is consistent with the representation of single parents in the sampling distribution as reported in Chapter Three.

Referral Source

Referral source may be a likely indicator of attitudes and motivation toward treatment (Lake & Levinger, 1960). Parents of children who drop out of treatment are more likely to have experienced institutional pressure and resisted treatment.

Information about the source of referral was first coded into seven categories. These were self, 103 cases (37.6%); school, 60 cases (21.9%); Health and Rehabilitative Services (HRS) suggestion, 63 cases (22.7%); community agency or church, 12 cases (4.3%); physician or medical clinic, 17 cases (6.1%); police or law enforcement agency, 15 cases (5.4%); judicial court, 15 cases (5.5%) (see Table 11).

These referral sources were then combined to yield three major categories used for analysis: 1) voluntary and personal referral (self, community agency or church, and medical clinic or private doctor); 2) agency referral (included school or HRS suggestion); 3) involuntary (included law enforcement and court ordered/HRS performance agreement).

Voluntary cases were those where little or no coercion could be presumed to exist. Of a total of 277 cases, 132 (47.7%) were in

TABLE 11
FREQUENCY DISTRIBUTION FOR REFERRAL SOURCES

Referral Source	Code	Absolute Freq	Relative Freq (PCT)	Adjusted Freq (PCT)	Cum Freq (PCT)
Self	1.	103	37.2	37.6	37.6
School	2.	60	21.7	21.9	59.5
HRS Suggestion	3.	63	22.7	23.0	82.5
Agency	4.	12	4.3	4.4	86.9
Medical Clinic	5.	17	6.1	6.2	93.1
Police	6.	4	1.4	1.5	94.5
Judicial	7.	15	5.4	5.5	100.0
	9.	3	1.1	Missing	100.0
	Total	277	100.0	100.0	

TABLE 12
FREQUENCY DISTRIBUTION FOR REFERRAL SOURCE RECLASSIFIED

Referral Source	Code	Absolute Freq	Relative Freq (PCT)	Adjusted Freq (PCT)	Cum Freq (PCT)
Voluntary and Personal Referral	1.	132	47.7	48.2	48.2
Agency Suggestion	2.	123	44.4	44.9	93.1
Involuntary	3.	19	6.9	6.9	100.0
	9.	3	1.1	Missing	100.0
	Total	277	100.0	100.0	

this category. Agency referral cases were those where the child's problem was presumably noticed by someone in a position of authority and it was suggested that counseling be sought. One hundred and twenty-three cases (44.4%) were in this category. Ordered cases were defined as those cases where substantial coercion was employed. There were 19 such cases (6.9%) (see Table 12).

H₀₂. There is no significant difference between successful and unsuccessful cases in terms of referral source.

Analysis for the three categories of referral source by type of outcome is presented in Table 13. Cases where data were either missing or the outcome was undetermined were excluded from the analysis. A total of 271 cases were included in the analysis.

Of the voluntary cases, 77 (59.7%) were considered successful while 52 (40.3%) were seen as unsuccessful. These were the same percentages for successful and unsuccessful cases as in the sample as a whole. Similar frequencies and percentages were evident for agency referral cases as well indicating no difference from sample values. There were smaller numbers of cases in the ordered category (19); 57.9% of these cases were successful while 42.1% were unsuccessful. Again, this was similar to sample values. Observed and expected frequencies were approximately equal. The chi-square statistic was .0224 with 2 degrees of freedom. This was not significant. Thus, the null hypothesis for referral source was accepted.

Severity of Diagnosis

Severity of diagnosis is associated with lack of treatment success (Lessing & Schilling, 1966; Ross & Lacy, 1961). This variable was

defined by using the DSM-III (APA, 1980) diagnostic categories listed for the children.

Cases classified as "mild" included those which were given diagnoses involving adjustment problems (e.g., maladaptive reactions to stress and/or conditions not attributable to a mental disorder; parent-child disagreements). One hundred and sixty cases, or 49.3% of the sample, fell into this category. A total of 110 cases were classified as "moderate/severe," or 40.7% of the distribution. Cases classified in this category included substance abuse, attention deficit disorder with hyperactivity, and conduct disorders, among others. Only one case was labeled psychotic and the child was diagnosed as schizophrenic.

H₀₃. There is no significant difference between successful and unsuccessful cases regarding severity of diagnosis.

A cross tabulation procedure using a joint frequency distribution for severity of diagnosis and type of outcome (successful or unsuccessful) was used for analysis. The chi-square value was .68 with 1 degree of freedom. This value was not significant. Of cases classified as mild, 98 cases (61.3%) had successful outcomes while 62 cases (38.8%) had unsuccessful outcomes. Of cases in the moderate/severe classification, 55.5% or 61 cases had successful outcomes while 44.5% had negative outcomes. Percentages of successful and unsuccessful cases for each category closely resembled sample values (58.9% successful, 41.4% unsuccessful). Since observed values were thus very close to expected values from the overall sample, the null hypothesis was accepted (see Table 14).

TABLE 13

CHI SQUARE ANALYSIS FOR TYPE OF OUTCOME BY REFERRAL SOURCE

Type of Outcome	Count	Voluntary	Agency Suggestion	Involuntary	Row Total
	Row PCT Col PCT Tot PCT				
Successful	1.	77	73	11	161
		47.8	45.3	6.8	59.4
		59.7	59.3	57.9	
		28.4	26.9	4.1	
Unsuccessful	2.	52	50	8	110
		47.3	45.5	7.3	40.6
		40.3	40.7	42.1	
		19.2	18.5	3.0	
	Column Total	129	123	19	271
		47.6	45.4	7.0	100.0

Chi square = 0.0224 with 2 degrees of freedom Significance = 0.9888

TABLE 14

CHI SQUARE ANALYSIS FOR TYPE OF OUTCOME BY DIAGNOSTIC CLASSIFICATION

Type of Outcome	Count	Mild 1	Mod-Severe 2	Row Total
	Row PCT Col PCT Tot PCT			
Successful	1.	98	61	159
		61.6	38.4	58.9
		61.3	55.5	
		36.6	22.6	
Unsuccessful	2.	62	49	111
		55.9	44.1	41.1
		38.8	44.5	
		23.0	18.1	
	Column Total	160	110	270

Corrected chi square = .680 with 1 degree of freedom Significance = .4093

Type of Treatment

It has been suggested (Gurman & Kniskern, 1978) from comparative studies that family therapy is either equal or superior to other child treatment programs, such as individual or milieu therapy. Malouf and Alexander (1976) noted the importance of evaluating the use of non-traditional approaches such as family therapy for mental health facilities.

Type of treatment in this study was defined as client participation in a particular treatment modality for two or more sessions. This variable included five separate categories. The categories and the incidence with which these were reported were as follows: 1) individual treatment, 149 cases (54.5%); 2) family/couple therapy, 201 cases (73.4%); 3) combination individual and family/couple treatment, 81 cases (30.3%); 4) group therapy, 58 cases (21.2%); and 5) use of medication, 27 cases (9.9%). The data indicated that the majority of cases were seen in family or couple therapy. This is consistent with findings of a Florida survey of programs for emotionally disturbed children and adolescents (Florida Department of Health and Rehabilitative Services, Office of Evaluation, 1982) which reported that family counseling was the most frequently provided service.

HO₄. There will be no significant difference between successful and unsuccessful cases in terms of type of treatment.

Analysis for the five different types of treatment is recorded in Tables 15 through 19. Each treatment was compared separately with all other treatments according to successful and unsuccessful cases. The results are reported by type of treatment.

For individual treatment, the chi-square value was .021 with 1 degree of freedom (see Table 15). This was not significant. Of 149 cases receiving individual treatment, 87 or 58.4% were successful while 62 cases or 41.6% were unsuccessful. Of those receiving all other treatments combined, 75 or 60% had successful outcomes while 50 or 40% had unsuccessful outcomes. The observed values were very close to the sample values of 59.1% successful cases and 40.9% unsuccessful cases. Thus the null hypothesis was accepted.

Family/couple treatment approached significance with a chi-square value of 2.93 with 1 degree of freedom (see Table 16). The significance level was $p < .08$. One hundred and twenty-five cases (62.2%) involving family or couple therapy had positive outcomes while 76 (37.8%) had negative outcomes. This was compared to 37 cases (50.7%) with positive outcomes for other therapies combined and 36 cases (49.3%) involving negative outcomes for combined therapies. Hence, observed frequencies differed somewhat from expected frequencies, but not at the level set for statistical significance ($p < .05$). Thus, the null hypothesis was accepted for family/couple treatment.

Family/couple treatment combined with individual treatment and compared to success of other therapies did not approach significance with a chi-square value of .612 and one degree of freedom. Of a total of 83 cases in which both types of treatment were involved, 52 (62.7%) cases were successful and 31 (37.3%) were unsuccessful. These values differed only slightly from expected population values of 49.1% positive and 40.9% negative cases. Values for cases not receiving this type of treatment were also similar to expected values. Thus,

TABLE 15

CHI SQUARE ANALYSIS OF TYPE OF OUTCOME BY INDIVIDUAL TREATMENT

Type of Outcome	Count Row PCT Col PCT Tot PCT	Individual Treatment	Other Treatments	Row Total
Successful	1.	87	75	162 59.1
		53.7	46.3	
		58.4	60.0	
		31.8	27.4	
Unsuccessful	2.	62	50	112 40.9
		55.4	44.6	
		41.6	40.0	
		22.6	18.2	
	Column Total	149 54.5	125 45.6	274 100.0

Chi square = 0.0729 with 1 degree of freedom Significance = 0.7871
 Phi = 0.0163

TABLE 16

CHI SQUARE ANALYSIS OF TYPE OF OUTCOME BY FAMILY/COUPLE THERAPY

Type of Outcome	Count Row PCT Col PCT Tot PCT	Family/ Couple Treatment	Other Treatments	Row Total
Successful	1.	125	37	162 59.1
		77.2	22.8	
		62.2	50.7	
		45.6	13.5	
Unsuccessful	2.	76	36	112 40.9
		67.9	32.1	
		37.8	49.3	
		27.7	13.1	
	Column Total	201 73.4	73 26.6	274 100.0

Chi square = 2.9325 with 1 degree of freedom Significance = 0.0868
 Phi = 0.1034

the null hypothesis was accepted for family/couple treatment in combination with individual treatment (see Table 17).

When group treatment was contrasted with other therapies by type of outcome, results were again non-significant. The chi-square value of 2.53 with 1 degree of freedom was significant only at the $p < .11$ level. Fifty-eight cases received group treatment while 216 did not. Of those receiving group treatment, 29 cases (50%) were successful while the same number were unsuccessful. This was a less favorable outcome than sample values (59.1% successful and 40.0% unsuccessful). It was also less favorable than the values for other therapies combined. That is, of 216 cases, 133 or 61.6% were successful and 83 or 38.4% were unsuccessful. It is evident that there was a trend for observed frequencies to differ from expected frequencies, although it was not statistically significant (see Table 18).

Relatively few clients, 27 (9.9%), were prescribed medication as part of their treatment. Of these cases, 13 (48.1%) were successful and 14 (51.9%) were unsuccessful. This is contrasted to the other treatments combined of which 149 or 60.3% were successful while 98 cases (39.7%) were unsuccessful. Expected frequencies for successful and unsuccessful cases were, respectively, 59.1% and 40.0%. Thus, there was some discrepancy between observed and expected values, yielding a chi-square of 1.49 with 1 degree of freedom. This was not significant (see Table 19).

Duration of Treatment

Research does not clearly indicate how duration of treatment is related to treatment success with children (Lessing & Schilling, 1966). This study examined this variable.

TABLE 17

CHI SQUARE ANALYSIS OF TYPE OF OUTCOME BY COMBINATION FAMILY/COUPLE TREATMENT

Type of Outcome	Count Row PCT Col PCT Tot PCT	Combination Treatment	Other Treatments	Row Total
Successful	1.	52	110	162
		32.1	67.9	59.1
		62.7	57.6	
		19.0	40.1	
Unsuccessful	2.	31	81	112
		27.7	72.3	40.9
		37.3	42.4	
		11.3	29.6	
	Column Total	83 30.3	191 69.7	274 100.0

Chi square = 0.6127 with 1 degree of freedom Significance = 0.4338

TABLE 18

CHI SQUARE ANALYSIS OF TYPE OF OUTCOME BY GROUP TREATMENT

Type of Outcome	Count Row PCT Col PCT Tot PCT	Group Treatment	Other Treatments	Row Total
Successful	1.	29	133	162
		17.9	82.1	59.1
		50.0	61.6	
		10.6	48.5	
Unsuccessful	2.	29	83	112
		25.9	74.1	40.9
		50.0	38.4	
		10.6	30.3	
	Column Total	58 21.2	216 78.8	274 100.0

Chi square = 2.5343 with 1 degree of freedom Significance = 0.1114

Duration of treatment was measured by recording the number of sessions that a client attended. Sessions ranged in number from 2 to 79, with a mean of 10.23 sessions per case. For analysis, duration of treatment was divided into 5 intervals and produced the following frequencies and percentages: 2-5 sessions, 112 cases (41.2%); 6-8 cases, 51 cases (18.8%); 9-15 sessions, 67 cases (24.6%); 16-20 sessions, 14 cases (5.1%); 21-79 sessions, 28 cases (10.3%).

H₀₅. There is no significant difference between successful and unsuccessful cases in terms of duration of treatment.

Analysis for the five categories of duration of treatment is presented in Table 20. Inspection of observed cell frequencies suggests that successful outcomes are more likely to occur as the number of sessions attended increases. For example, in the range of 2-5 sessions, there were 48 (42.9%) cases with positive outcomes and 64 (57.1%) with negative outcomes. This was in contrast to expected values based on frequencies for successful (59.2%) and unsuccessful (40.8%) cases for the sample as a whole. This contrast was reversed for the intervals with greater numbers of sessions. Taking as an example the 16-20 session interval, there are observed to be 11 (78.6%) successful cases and 3 (21.4%) unsuccessful cases. Thus, cases in this interval were more successful than the expected values. The chi-square value of 22.87 with 4 degrees of freedom was significant at the .0001 level. Thus, the null hypothesis was rejected.

Other Findings

There were several other findings worthy of report. First, referral source was cross-tabulated with income to investigate the

TABLE 19

CHI SQUARE ANALYSIS OF TYPE OF TREATMENT BY USE OF MEDICATION

Type of Outcome	Count Row PCT Col PCT Tot PCT	Medication		Other Treatments	Row Total
		Successful	1.	13 8.0 48.1 4.7	149 92.0 60.3 54.4
Unsuccessful	2.	14 12.5 52.9 5.1	98 87.5 39.7 35.8	112 40.9	
	Column Total	27 9.9	247 90.1	274 100.0	

Chi-square = 1.4930 with 1 degree of freedom
Phi = 0.0738

Significance = 0.2217

TABLE 20

CHI SQUARE ANALYSIS OF TYPE OF OUTCOME BY DURATION OF TREATMENT

Type of Outcome	Count Row PCT Col PCT Tot PCT	Number of Sessions Attended					Row Total
		2-5	6-8	9-15	16-20	21-79	
Successful	1.	48 29.8 42.9 17.6	33 20.5 64.7 12.1	47 29.2 70.1 17.3	11 6.8 78.6 4.0	22 13.7 78.6 8.1	161 59.2
Unsuccessful	2.	64 57.7 57.1 23.5	18 16.2 35.3 6.6	20 18.0 29.9 7.4	3 2.7 21.4 1.1	6 5.4 21.4 2.2	111 40.8
	Column Total	112 41.2	51 18.8	67 24.6	14 5.1	28 10.3	272 100.0

Chi square = 22.8741 with 4 degrees of freedom
Cramer's V = 0.2899

Significance = 0.0001

TABLE 21

CHI SQUARE ANALYSIS OF REFERRAL SOURCE BY INCOME

Referral Source	Count Row PCT Col PCT	Income					Row Total
		Lower-Lower	Lower-Middle	Middle-Middle	Upper-Middle	Upper-Upper	
Voluntary	1.	56	28	26	13	9	132
		42.4	21.2	19.7	9.8	6.8	48.2
		41.8	51.9	59.1	41.9	81.8	
		20.4	10.2	9.5	4.7	3.3	
Agency Referral	2.	66	23	16	16	2	123
		53.7	18.7	13.0	13.0	1.6	44.9
		49.3	42.6	42.6	51.6	18.2	
		24.1	8.4	8.4	5.8	0.7	
Involuntary	3.	12	3	2	2	0	19
		63.2	15.8	10.5	10.5	0.0	6.9
		9.0	5.6	4.5	6.5	0.0	
		4.4	1.1	0.7	0.7	0.0	
Column Total		134	54	44	31	11	274
		48.9	19.7	16.1	11.3	4.0	100.0

Chi square = 10.6854 with 8 degrees of freedom
Cramer's V = 0.1396

Significance = 0.2202

TABLE 22

CHI SQUARE ANALYSIS OF REFERRAL SOURCE (TWO CATEGORIES) BY INCOME

Referral Source	Count Row PCT Col PCT Tot PCT	Income					Row Total
		Lower-Lower	Lower-Middle	Middle-Middle	Upper-Middle	Upper-Upper	
Voluntary	1.	56	28	26	13	9	132 48.2
		42.4	21.2	19.7	9.8	6.8	
		41.8	51.9	59.1	41.9	81.8	
Involuntary	2.	20.4	10.2	9.5	4.7	3.3	142 51.8
		78	26	18	18	2	
		54.9	18.3	12.7	12.7	1.4	
		58.2	48.1	40.9	58.1	18.2	
		28.5	9.5	6.6	6.6	0.7	
	Column Total	134	54	44	31	11	274
		48.9	19.7	16.1	11.3	4.0	100.0

Chi square = 10.0499 with 4 degrees of freedom
Cramer's V = 0.1915

Significance = 0.0396

TABLE 23

CHI SQUARE ANALYSIS OF RACE/SEX BY DIAGNOSTIC CLASSIFICATION

Race/Sex	Count		Mild	Mod-Severe	Row Total
	Row PCT	Col PCT			
	Tot	PCT			
White Male	1.		66	53	119
			55.5	44.5	43.6
			40.7	47.7	
			24.2	19.4	
Black Male	2.		11	18	29
			37.9	62.1	10.6
			6.8	16.2	
			4.0	6.6	
White Female	3.		73	34	107
			68.2	31.8	39.2
			45.1	30.6	
			26.7	12.5	
Black Female	4.		12	6	18
			66.7	33.3	6.6
			7.4	5.4	
			4.4	2.2	
	Column Total		162	111	273
			59.3	40.7	100.0

Chi square = 10.1515 with 3 degrees of freedom
 Cramer's V = 0.1928

Significance = 0.0170

TABLE 24

CHI SQUARE ANALYSIS OF TYPE OF OUTCOME BY AGE OF CLIENT

Type of Outcome	Count Row PCT Col PCT Tot PCT	Age of Client				Row Total
		2-5	6-10	11-13	14-17	
Successful	1.	14	58	43	47	162
		8.6	35.8	26.5	29.0	59.1
		66.7	65.2	69.4	46.1	
		5.1	21.2	15.7	17.2	
Unsuccessful	2.	7	31	19	55	112
		6.3	27.7	17.0	49.1	40.9
		33.3	34.8	30.6	53.9	
		2.6	11.3	6.9	20.1	
	Column Total	21	89	62	102	274
		7.7	32.5	22.6	37.2	100.0

Chi square = 11.7079 with 3 degrees of freedom
Cramer's V = 0.2067

Significance = 0.0085

possibility of an interaction between these variables (Table 21). A weak effect was noted with $\chi^2 = 10.68$, $p < .22$. When referral source was reclassified according to the two categories of voluntary or involuntary, the relationship between these variables became more pronounced with $\chi^2 = 10.04$, $p < .04$. Low income levels were associated with suggestion while high income levels were associated with self-referral (see Table 22).

Another significant interaction was observed between the variable of race/sex and diagnostic classification. The following frequencies occurred in the sample: 119 white males (43.4%), black males, 29 (10.6%), white females, 108 (39.4%), and black females, 18 (6.6%). Of these, black males had a higher proportion of cases in the moderate/severe versus mild category. This difference yielded a chi-square value of 10.15, significant at the $p < .017$ level (see Table 23).

Age of client was considered a possible intervening variable in the study. Table 24 presents a chi-square analysis of type of income by client age. Cell frequencies are more positive than expected for the three lower (2-5, 6-10, 11-13) age groupings. However, for the 14-17 year olds, the observed values included more unsuccessful than successful cases. Thus, looking at age and type of outcome, a statistically significant effect was noted with $\chi^2 = 11.70$, $p < .008$. This indicated that pre-school, elementary, and middle school age children were more likely to have successful outcomes than high school youth.

Premature termination as a possible outcome variable was also reviewed. A total of 183 cases were classified as terminating before treatment was concluded. Chi-square analysis of premature termination is presented in Table 25. It is apparent that cases where clients

TABLE 25
CHI SQUARE ANALYSIS OF TYPE OF OUTCOME BY PREMATURE TERMINATION

Type of Outcome	Count Row PCT Col PCT Tot PCT	Termination Before 3	Premature Termination from 3-5	Termination from 5-10	Termination After 10	Not Applicable	Row Total
Successful	1.	6	21	34	21	80	162
		3.7	13.0	21.0	13.0	49.4	59.1
		20.7	38.9	54.8	55.3	87.9	
Unsuccessful	2.	2.2	7.7	12.4	7.7	29.2	
		23	33	28	17	11	112
		20.5	29.5	25.0	15.2	9.8	40.9
		79.3	61.1	45.2	44.7	12.1	
		8.4	12.0	10.2	6.2	4.0	
Column Total		29	54	62	38	91	274
		10.6	19.7	22.6	13.9	33.2	100.0

Chi square = 58.7859 with 4 degrees of freedom Significance = 0.0000
Cramer's V = 0.4631

TABLE 26

CHI SQUARE ANALYSIS OF TYPE OF OUTCOME BY FREQUENCY OF TREATMENT

Type of Outcome	Count Row PCT Col PCT Tot PCT	1-2 Sessions per Month	3-4 Sessions per Month	Row Total
Successful	1.	102	60	162 59.1
		63.0	37.0	
		55.1	67.4	
		37.2	21.9	
Unsuccessful	2.	83	29	112 40.9
		74.1	25.9	
		44.9	32.6	
		30.3	10.6	
	Column Total	185 67.5	89 32.5	274 100.0

Chi square = 3.7498 with 1 degree of freedom

Significance = 0.0528

Phi = .1169

terminated prematurely prior to the fifth session were more likely to be classified as unsuccessful. In cases where clients did not terminate prematurely (91 or 33.2%), outcomes were more likely to be rated positively by the therapist. The chi-square value obtained of 58.78 was significant at the $p < .0000$ level.

Frequency of treatment was recorded as an average of either 1 or 2 sessions per month or 3 to 4 sessions per month. One hundred and eighty-five (67.5%) cases were seen for an average of 1-2 sessions while 89 cases (32.5%) were seen 3-4 times per month. Those cases in the 1-2 sessions per month category contained fewer positive outcomes. Those in the 3-4 sessions category contained more positive outcomes. These differences yielded a chi-square value of 3.74 and was significant, $p < .0528$ (see Table 26).

Several therapist factors recorded included therapist educational level and years of therapist experience (see Appendix B). Therapist educational level was categorized in the following manner: high school degree, 58 (21.2%) cases; BA degree, 27 (9.9%) cases; MA degree, 165 (60.2%) cases; and Ph.D. degree, 24 (8.8%) cases. Therapist years of experience was recorded as number of years of work experience in the field. These variables were compared with type of outcome and chi-square results are reported in Tables 27 and 28. Education of therapist was not significantly associated with type of outcome ($\chi^2 = 3.88$, $p < .27$); however, there appeared to be a trend for more education to be associated with successful outcomes.

Therapist years of experience when compared to type of outcome was also insignificant, $\chi^2 = 5.5$, $p < .24$. Again, however, a trend

TABLE 27

CHI SQUARE ANALYSIS OF TYPE OF OUTCOME BY THERAPIST EDUCATIONAL LEVEL

Type of Outcome	Count Row PCT Col PCT Tot PCT	Therapist Educational Level				Row Total
		HS	BA	MA	Ph.D.	
Successful	1.	33	16	103	10	162 59.1
		20.4	9.9	63.6	6.2	
		56.9	59.3	62.4	41.7	
		12.0	5.8	37.6	3.6	
Unsuccessful	2.	25	11	62	14	112 40.9
		22.3	9.8	55.4	12.5	
		43.1	40.7	37.6	58.3	
		9.1	4.0	22.6	5.1	
	Column Total	58	27	165	24	274 100.0
		21.2	9.9	60.2	8.8	

Chi square = 3.8893 with 3 degrees of freedom Significance = 0.2737

TABLE 28

CHI SQUARE ANALYSIS OF TYPE OF OUTCOME BY THERAPIST YEARS OF EXPERIENCE

Type of Outcome	Count Row PCT Col PCT Tot PCT	Years of Experience					Row Total
		0-1	1-2	3-5	6-7	8+	
Successful	1.	13	4	45	33	12	107 61.5
		12.1	3.7	42.1	30.8	11.2	
		65.0	44.4	71.4	55.9	52.2	
		7.5	2.3	25.9	19.0	6.9	
Unsuccessful	2.	7	5	18	26	11	67 38.5
		10.4	7.5	26.9	38.8	16.4	
		35.0	55.6	28.6	44.1	47.8	
		4.0	2.9	10.3	14.9	6.3	
	Column Total	20	9	63	59	23	174 100.0
		11.5	5.2	36.2	33.9	13.2	

Chi square = 5.4490 with 4 degrees of freedom Significance = 0.2442

TABLE 29

CHI SQUARE ANALYSIS OF THERAPIST YEARS OF EXPERIENCE BY
PREMATURE TERMINATION

Therapist Years of Experience	Count Row PCT Col PCT Tot PCT	Premature Termination					NA	Row Total
		Before 3	3-5	5-10	After 10			
0-1	0.	5	2	2	2	9	20	
		25.0	10.0	10.0	10.0	45.0	11.4	
		17.2	4.8	6.5	8.3	18.0		
		2.8	1.1	1.1	1.1	5.1		
1-2	1.	0	2	4	0	3	9	
		0.0	22.2	44.4	0.0	33.3	5.1	
		0.0	4.8	12.9	0.0	6.0		
		0.0	1.1	2.3	0.0	1.7		
3-5	2.	8	12	16	7	20	63	
		12.7	19.0	25.4	11.1	31.7	35.8	
		27.6	28.6	51.6	29.2	40.0		
		4.5	6.8	9.1	4.0	11.4		
6-7	3.	10	17	7	14	13	61	
		16.4	27.9	11.5	23.0	21.3	34.7	
		34.5	40.5	22.6	58.3	26.0		
		5.7	9.7	4.0	8.0	7.4		
8+	4.	6	9	2	1	5	23	
		26.1	39.1	8.7	4.3	21.7	13.1	
		20.7	21.4	6.5	4.2	10.0		
		3.4	5.1	1.1	0.6	2.8		
	Column Total	29 16.5	42 23.9	31 17.6	24 13.6	50 28.4	176 100.0	

Chi square = 28.6917 with 16 degrees of freedom
Cramer's V = .2018

Significance = 0.0261

was observed for positive outcomes to be associated with more years of work experience. When therapist years of experience was considered with premature termination, there was a trend for cases of therapists with fewer years of experience to terminate prematurely ($\chi^2 = 28.69$, $p < .02$) (see Table 29).

Race, sex, and income were also examined as possible variables which could influence the effects of mental health treatment (Appendix B). Income was weakly associated with successful or unsuccessful outcome (see Table 30). The following frequencies were evident for various income levels: lower-lower, 0 to 7500, 134 cases (48.9%); lower-middle, 7600 to 10,800, 54 cases (19.7%); middle-middle, 11,000 to 15,000, 44 cases (16.1%); upper-middle, 15,100 to 24,800, 30 cases (10.9%); upper-upper, 15,000 to 32,000, 13 cases (4.7%). Lower income categories were less likely to have positive outcomes than those with higher incomes. This trend was not statistically significant ($\chi^2 = 6.60$, $p < .16$).

There were no significant differences between successful and unsuccessful cases due to either race, sex, or race and sex combined. For race (see Table 31) the observed frequencies for positive and negative cases almost perfectly matched the expected frequencies from the sample as a whole ($\chi^2 = .0088$, $p < .92$). A similar finding was true for sex with observed frequencies for males and females for successful and unsuccessful cases closely matching expected values in the sample ($\chi^2 = .0021$, $p < .96$) (see Table 32).

In order to ensure that there was no bias in the sample due to where the client was seen (clinic) or the year treatment was received, type of outcome was considered for both variables. The frequency

TABLE 30

CHI SQUARE ANALYSIS OF TYPE OF OUTCOME BY INCOME

Type of Outcome	Count Row PCT Col PCT Tot PCT	Income					Row Total	
		Lower-Lower	Lower-Middle	Middle-Middle	Upper-Middle	Upper-Upper		
Successful	1.	72	37	23	20	10	162	
		44.4	22.8	14.2	12.3	6.2		59.1
		54.1	68.5	52.3	66.7	76.9		
		26.3	13.5	8.4	7.3	3.6		
Unsuccessful	2.	61	17	21	10	3	112	
		54.5	15.2	18.8	8.9	2.7		40.9
		45.9	31.5	47.7	33.3	23.1		
		22.3	6.2	7.7	3.6	1.1		
	Column Total	133	54	44	30	13	274	
		48.5	19.7	16.1	10.9	4.7	100.0	

Chi square = 6.6065 with 4 degrees of freedom
Cramer's V = 0.1552

Significance = 0.1582

TABLE 31

CHI SQUARE ANALYSIS OF TYPE OF OUTCOME BY RACE

Type of Outcome	Count Row PCT Col PCT Tot PCT	Race		Row Total	
		White	Black		
Successful	1.	135	27	162	
		83.3	16.7		59.1
		59.5	57.4		
		49.3	9.9		
Unsuccessful	2.	92	20	112	
		82.1	17.9		40.9
		40.5	42.6		
		33.6	7.3		
	Column Total	227	47	274	
		82.8	17.2	100.0	

Chi square = 0.0660 with 1 degree of freedom

Significance = 0.7972

TABLE 32

CHI SQUARE ANALYSIS OF TYPE OF OUTCOME BY SEX

Type of Outcome	Count Row PCT Col PCT Tot PCT	Sex		Row Total
		Male	Female	
Positive	1.	88	74	162
		54.3	45.7	59.1
		58.7	59.7	
		32.1	27.0	
Negative	2.	62	50	112
		55.4	44.6	40.9
		41.3	40.3	
		22.6	18.2	
	Column Total	150	124	274
		54.7	45.3	100.0

Chi square = 0.0287 with 1 degree of freedom
Phi = 0.0102

Significance = 0.8600

information has already been reported in Chapter Three for these variables (see Table 1). First, considering location of treatment, there were approximately equal proportions of cases in the successful and unsuccessful categories for the Gainesville and Lake City clinics. On the other hand, Bronson had a slightly higher proportion of positive cases (see Table 33) than that expected from sample values (59.1% positive cases, 40.9% unsuccessful). However, this difference was not significant ($\chi^2 = 1.78$, $p < .40$).

A similar finding was true for type of outcome considered with year the client was seen in therapy. Successful versus unsuccessful proportions of cases for each year mirrored almost exactly the sample values. The chi-square value ($\chi^2 = 3.64$) was not significant, $p < .30$ (see Table 34).

Five variables were investigated in this study: parent involvement in treatment, referral source, severity of diagnosis, type of treatment, and duration of treatment. For only one of these variables, duration of treatment, was the null hypothesis rejected.

TABLE 33

CHI SQUARE ANALYSIS OF TYPE OF OUTCOME BY LOCATION OF TREATMENT

Type of Outcome	Count Row PCT Col PCT Tot PCT	Location of Treatment			Row Total
		Gainesville	Lake City	Bronson	
Successful	1.	57	55	50	162
		35.2	34.0	30.9	59.1
		58.8	55.0	64.9	
		20.8	20.1	18.2	
Unsuccessful	2.	40	45	27	112
		35.7	40.2	24.1	40.9
		41.2	45.0	35.1	
		14.6	16.4	9.9	
	Column Total	97	100	77	274
		35.4	36.5	28.1	100.0

Chi square = 1.7848 with 2 degrees of freedom Significance = 0.4097

TABLE 34

CHI SQUARE ANALYSIS OF TYPE OF OUTCOME BY YEAR OF TREATMENT

Type of Outcome	Count Row PCT Col PCT Tot PCT	Year of Treatment				Row Total
		1980	1981	1982	1983	
Successful	1.	28	49	51	34	162
		17.3	30.2	31.5	21.0	59.1
		60.9	58.3	66.2	50.7	
		10.2	17.9	18.6	12.4	
Unsuccessful	2.	18	35	26	33	112
		16.1	31.3	23.2	29.5	40.9
		39.1	41.7	33.8	49.3	
		6.6	12.8	9.5	12.0	
	Column Total	46	84	77	67	274
		16.8	30.7	28.1	24.5	100.0

Chi square = 3.6360 with 3 degrees of freedom Significance = 0.3035

CHAPTER FIVE
SUMMARY, CONCLUSIONS, LIMITATIONS,
AND RECOMMENDATIONS

This study investigated clinical variables in relation to the effectiveness of children's services in community mental health centers. These variables were parental involvement in treatment, referral source, diagnostic classification, type of treatment, and duration of treatment. Using a cross tabulation procedure, measures of these variables were examined according to treatment outcomes. Data were collected from 277 closed medical charts and from three separate clinics.

Analyses of treatment outcomes revealed a significant difference for duration of treatment ($p < .001$). There were no significant differences between type of outcome and parental involvement in treatment, diagnostic classification, or type of treatment.

Discussion and Conclusions

Each of the variables investigated in this study will be discussed. In addition, other findings of interest will be examined.

Parental Involvement in Treatment

Almost all parents attended treatment sessions of their children, either separately or together, after the intake interview. For this

reason there was no comparison group in which parents were not involved in treatment. Consequently, the related hypothesis could not be tested. It seems that therapists who were in the three clinics of this study encourage parent involvement when treating children for emotional problems. Apparently, parents in these clinics usually participate.

When both parents were involved in therapy after the intake interview, they were likely to participate together in treatment with their child. Cookerly (1974) noted the positive results of working with couples seen together as opposed to seeing them separately.

Perhaps some other means of research, besides the examination of medical records, may be necessary to investigate this variable. Many references to parental involvement in treatment are frequently ambiguous. A therapist might, for instance, report that the child was present for the session but not mention the parents if they were seen for only a few minutes.

Approximately 40% of the sampling (N = 106) consisted of single parents participating in treatment. This suggested that single parents are more likely to receive help from centers and that these parents are willing to be involved in treatment. Based upon the high percentage of cases which involved single parents, centers might be justified in tailoring their services to meet the needs of these parents. This could include parent and child groups focusing on the needs of single parents as well as their children.

Referral Source

No significant differences were found between treatment outcome and type of referral source. It appears that the chances for successful treatment are about the same, regardless of what referral source helped them get treatment.

Perhaps the centers were generally successful because they were able to motivate the involuntary clients and meet their psychological needs. Perhaps the clients did not feel coerced or influenced by a referral source, but were simply unaware of the mental health services that were available. Some may have had some hesitation prior to their being suggested or ordered for treatment.

The majority of clients in the three centers were from low-income families and they may have had difficulty justifying the services or making the effort to seek help prior to someone suggesting or ordering that they go for treatment. This idea is given further credence in this study by the significant interaction ($p < .04$) between type of referral (voluntary or involuntary) and income. Voluntary cases were more likely to be from the upper and middle-income levels. Cases classified as involuntary were associated with lower income families.

It seems that there is some support for centers to continue delivering services to involuntary clients. Whatever special efforts are being made with involuntary clients to help them define and work on their problems should be continued. Efforts being made to inform lower-income clients of services and to make these services more available to such clients may be an important part of the intervention process.

Diagnostic Classification

Severity of diagnosis, categorized as mild or moderate/severe, did not distinguish successful from unsuccessful outcomes. This is counter to the finding in most research that a positive relationship between these factors exists (Ross & Lacey, 1961; Levitt, 1971).

One explanation for this discrepancy was the difficulty in categorizing the various diagnoses in a way that reflected homogeneity of symptoms. Levitt (1971) divided children into three different diagnostic categories: neurotic, psychotic, and acting out. Acting out was the only category that did not show overall improvement. This is relevant to the current study in that the effect of conduct disorders, similar to acting out, may have been suppressed by other diagnostic categories in the moderate/severe grouping. An attempt to refine this variable more specifically than the mild and moderate/severe classifications was deemed too unwieldy because of the number of such classifications possible. However, since no difference was found using the broad categories of mild and moderate-severe, future studies may look at more distinct categories. In order to make comparisons between separate diagnoses, it may be necessary to look at a very large sample or sample within diagnostic categories to obtain sufficient numbers of cases for analysis.

There was one significant variable interaction with diagnostic classification that was noted. This involved an interaction with the race/sex variable. The variation was in the high frequency of black males diagnosed as moderate/severe as opposed to the other race-sex

categories. This suggests that therapists may perceive black males as more disturbed than other race-sex categories or that as a group, black males have a higher incidence of emotional problems falling in the moderate/severe category. This variance may have obscured some of the potential variance due only to severity of diagnosis, but it is unlikely that removing this variance would have made results statistically significant.

These findings suggest that centers are as successful in working with clients with moderate or severe emotional problems as defined in this study as they are with milder problems. There is thus no justification based on probability of success for centers to support prevention efforts aimed at the milder categories of emotional illness in children to the exclusion of efforts to work with more severely disturbed children. This is not to say, however, that prevention is futile since it may be that milder forms of emotional disorders may progress to moderate or severe problems if treatment is not provided.

Centers should approach with caution the finding that black males are more likely to be diagnosed as more disturbed. Blacks as a group have been noted to be less likely to come to treatment articulating a psychological problem (Gladwin, 1967). If their needs, as Gladwin suggests, are for social or occupational skills, their problems may not be accurately perceived by therapists and hence they may appear to be uncooperative with treatment and thus at risk for being diagnosed as more severely disturbed. If this is the case, centers may need to extend themselves to meet special needs of minorities and take special care in making a proper diagnosis.

Type of Treatment

The null hypothesis was accepted for each type of treatment: individual, family/couple, individual and family/couple combination, group, and medication. No significant differences were found between type of treatment and successful or unsuccessful outcomes. Several trends were noted however.

Family/couple treatment approached significance ($p < .08$ level). Cases seen in this category were somewhat more likely to have successful outcomes than other types of treatment. This is congruent with the professional literature which supports family/couple treatment as the treatment of choice for children and adolescents (Gurman & Kniskern, 1978).

Group treatment, on the other hand, was somewhat less successful ($p < .11$) when compared with the success of other types of therapy. One reason may be that group therapy, as used in the three clinics, provided less opportunity for family involvement. By its nature, it tended to restrict the interaction of parents with the therapists when they were providing treatment for children. It may also be that group therapy does not provide the type of individual attention that many adolescents and children need for improvement. No attempt was made to examine the impact of group therapy in combination with other forms of treatment. Future research might investigate this type of treatment in greater detail.

Failure to reject the null hypothesis related to type of treatment may be attributed to the way the variable was defined. For example,

family/couple treatment was defined as two or more family members being seen together for at least two sessions. There are a number of possible interventions within this category. A very powerful effect due to family/couple therapy would have to be present in order to overcome this variance. Thus, a more precise means of defining and measuring type of treatment may elicit some statistically significant differences. It may be appropriate in future studies to study the type of family therapy (or individual therapy) that is the most successful.

There was about a 30% overlap between family/couple and individual treatment in the cases studied. This indicates that an eclectic approach to treatment is often used in the three clinics. Based on these data, mental health centers might continue to provide a range of therapeutic services, as no single treatment was clearly more effective than any other.

Further research with family/couple treatment is needed. Experimental designs which randomly assign clients to different treatment categories, with precisely defined parameters, is recommended.

More research could assist mental health centers in answering the question of therapy cost-effectiveness. For example, if research shows that family/couple treatment is no more effective than other treatments, then it should be reconsidered from a cost-effectiveness standpoint. It is a more costly service to provide than other types of treatment. If group treatment is less effective than other treatments, then this modality may also need to be given more attention as to when it might best be used. While clients receive such services, they may not benefit from them.

Duration of Treatment

Regarding duration of treatment, it appears that the longer a family stays in therapy the better the outcome. This finding is important because it contradicts other research (e.g., Lessing & Schilling, 1966) which found no relationship between duration of treatment and outcome for children. On the other hand, the findings from this study support research which found duration of treatment positively related to successful outcomes with adults.

Because clients seen for fewer sessions were less likely to receive positive outcome ratings, it does not appear that brief treatment of five sessions or less is as effective as longer term treatment. This is an important point for mental health centers who provide short-term services. For instance, some service centers emphasize brief therapy either because it is believed to be more effective or because it enables therapists to reach a larger number of clients. This strategy may discourage clients who are most likely to benefit from treatment while providing services to those least likely to benefit.

Other Findings

There are several variables which, although not part of the five main null hypotheses in this study, are worth presenting. They help provide an overall picture of treatment and outcomes at mental health centers. These include some demographic variables: age, sex, race, and income of clients; and treatment variables such as frequency of treatment, number of missed appointments, premature termination, and therapist education and experience.

It appears from data collected from the records sampled that younger clients, those 13 years of age and under, have more positive outcomes than do clients 14-17 years old. Why do therapists have better success with younger clients?

One explanation may be found in the developmental nature of children. Younger clients, as noted by Levitt (1971), may be more likely to improve spontaneously. Older clients may present problems that they are less likely to "grow out of." Whatever the reason, the finding that the clients younger than 14 have more reported positive outcomes could suggest that centers might devote more resources to older clients as therapy is less likely to be successful with this group as it is currently offered.

Race, sex, and income have in past studies been thought to moderate the effect of mental health treatment. These effects were recorded and examined in this study. Income was weakly associated with type of outcome ($p < .10$). Clients from lower income categories were less likely to have positive outcomes than those with higher incomes. Such clients may be less likely to seek help prior to a mental health crisis, and/or suffer from poor physical and emotional environments characteristic of poverty and perhaps be less receptive to the kinds of treatment available.

The centers generally serve poverty-level clients. For example, 48% of clients treated had incomes under \$7200 a year. There was, nevertheless, an observed tendency to be less effective with this low-income group. Centers may need to tailor their services to meet the needs of such clients, such as providing more outreach services. They

may also need to provide for skill development and treatment programs related to occupational skills.

There were no significant differences between successful and unsuccessful cases due to either race or sex. This suggests that there was little variance in the study attributable to these factors.

Finally, there was little overall variance explained by either the year the client was treated or where treatment was received. This finding lends confidence that the sample was representative of population values.

A high correlation (Cramer's $V = .46$) was noted between therapist outcome rating and premature termination. On the basis of this correlation, future analyses might examine premature termination as a separate variable. This finding supports other studies (see Chapter Two) which have used premature termination as a measure of success or failure in treatment.

The collected data regarding frequency of treatment and number of missed sessions suggested that clients do somewhat better when they are seen at more frequent intervals and on a more regular basis. Very few patients were seen more often than once a week. Intensive treatment is a treatment variable that may need more consideration and research.

The therapist factors which were reported included years of experience and educational attainment. These were not strong elements in treatment success according to this study. Whether this indicates that all therapists rate their cases similarly, regarding success of outcome, or that training and experience have little impact on success

is not immediately apparent from the data. However, viewing years of experience in relation to premature termination, it was indicated that indeed, therapist years of experience was negatively related to premature termination ($p < .03$). This supports the concept that experienced therapists seem to be able to have more ability to motivate their clients and keep them in treatment.

Limitations

1. A general limitation of this study was that there was no feasible way to check the accuracy of the data in the medical records. It was not practical to contact clients to verify information. The accuracy of the data was necessarily, therefore, limited to the perceptions and accuracy of clinicians recording the data.

2. In order to ensure reliable recording, it was necessary to define and rely upon general variables. Parental participation, for instance, was defined as "parent included in one or more sessions after the intake interview." This may not have been a precise enough definition for valid interpretation of the data. In addition, the potential variation within categories was difficult to control. For instance, there were several interventions possible under the definition of family/couple treatment.

3. The lack of research on treatment of children in mental health centers provided few leads upon which to build the study. As part of the research for this study, a review was made of the published literature, and several requests were made to the NIMH. Information was very

limited. Because of this lack of research, definition of variables was made on the basis of research results with adult populations or other limited data.

Recommendations for Further Research

1. It has been suggested (Ellsworth, 1979) that descriptive and exploratory studies are useful in suggesting hypotheses for experimental research. This study elicited significant findings or trends in areas that are worthy of follow-up. Some trends were noted which included relationships between outcome and referral source, diagnostic classification, type of treatment, and other selected client and therapist variables. Although not statistically significant, such trends could be tested further with other populations.

2. On the basis of this research, several methodological changes are indicated. First, it is recommended that corroboration of recorded results be obtained through independent sources. Follow-up studies might focus on other outcome measures (e.g., client perception of outcome).

It has been noted that the ability to precisely measure some variables of interest to this study because of data limitations has restricted this research. In the future, it will be important to refine the precision with which some variables are defined and measured. For example, parent participation as defined in this study was not sufficiently precise to capture sample differences. It may be that other means of research must be employed in order to accomplish

this goal as precision is difficult through examination of closed medical records.

Sampling procedures may need to be revised. For example, diagnostic classification in this study was limited to two categories, mild and moderate/severe, because there was an insufficient number of cases to study each diagnostic category separately. In future research, sampling could occur within diagnostic categories to obtain sufficient cases for more complex analyses.

The results from this study suggest that treatment success in children's programs in community mental health centers is not affected by referral source, diagnostic classification, or type of treatment. Results for parental participation were inconclusive. However, duration of treatment did significantly impact treatment outcome. Clients who remained in treatment longer than five sessions were more likely to be rated as successful by the therapist.

APPENDIX A
ADMISSION DATA FORM

MENTAL HEALTH SERVICES, INC.
EVALUATION AND SCREENING FORM

CSU USE

CLIENT NAME: _____

CASE # _____ KEY # _____

EXAMINER _____

TIME: In _____ Out _____

PRESENT THERAPIST: _____

I. REFERRAL SOURCE (if referred for follow up, describe original symptoms)

II. PRESENTING PROBLEMS (include major mental, physical, social, sexual, school, legal, financial problems, etc. Use both sides of form, if needed)

III. PAST MENTAL HEALTH TREATMENT AND HOSPITALIZATIONS:

IV. PAST MEDICAL HISTORY:
Allergies to medicines:

Side effects from medicines:

Serious illnesses (including epilepsy)

Operations:

V. PRESENT MEDICATIONS (Dose and schedule, psychiatric and non-psychiatric meds)

VI. PHYSICAL STATUS REVIEW:
Sleep pattern:

Energy level:

Appetite:

Libido:

Other dysfunctions:

VII. FAMILY HISTORY OF MENTAL ILLNES/ALCOHOLISM:

VIII. BACKGROUND DATA:

Relationships:

Difficulties getting along with family or others?

Present living arrangement:

Additional support system:

Marital status:

Children:

Career:

Highest skills attained:

Longest job held:

Present employment:

Financial Resources:

Education:

Highest level attained:

School problems?

Recent Alcohol or Drug Problems?

Estimated alcohol intake in 24-hour period:

Legal History: (Any pending charges)

IX. MENTAL STATUS EXAMINATION:

Intellectual Performance: (General information, memory, retention and recall, capacity to abstract, calculate, etc.)

Thought Processes: (Insight, judgement, obsessions, delusions, bizarre ideas, et

Communications: (Coherent, confused, flight of ideas, loose associations, autistic tangential, ideas of reference, etc.)

Sensory Perception: (Orientation, illusions, hallucinations, etc.)

Behavior During Interview: (Attention span, cooperation, comprehension, reliability, etc)

Appearance: (General presentation, psychomotor activity, speech, etc.)

Emotional Status: (Mood, affect, current danger to self or others, etc.)

SUMMARY

Problem List, assessment, and Recommendations:

Provisional Diagnoses:

Disposition:

Signature of Examiner

Date

NORTH CENTRAL FLORIDA COMMUNITY MENTAL HEALTH CENTER
EVALUATION AND SCREENING
ADDENDUM FOR CHILDREN'S PROGRAM

NAME: _____ CASE #: _____ KEY #: _____

A. DEVELOPMENTAL HISTORY

Pregnancy, labor and delivery (duration, any complications, APGAR score)

Neonatal Period (any complications?)

Developmental Milestones (any complications?)

B. SCHOOL REPORTS

I.Q.:

Psychological Tests:

Vision:

Hearing:

Immunizations:

Performance:

C. PSYCHOSOCIAL DATA

Parents' description of child's personality (including temperament, discipline, etc.)
Use reverse side, if needed.

APPENDIX B
RECORDING INSTRUMENT

I. Identifying Information

A1. Client number	<u>1 - 3</u>	---
A2. Year last two digits	<u>4 - 5</u>	---
A3. Center code 1. Gainesville 2. Lake City 3. Bronson	<u>6</u>	-
A4. Number of family members. 8 equals 8 or more 9. missing	<u>7</u>	-
A5. Client age in years	<u>8 - 9</u>	---
A6. DSM category (see code) 1. mild 2. moderate-severe 9. missing data	<u>1 0</u>	-
A7. Write in first DSM Axis I code in actual numbers. Substitute 9 for letter "V". If not applicable, write in 00001.	<u>1 1 - 1 5</u>	---
A8. Write in second DSM Axis I code in actual numbers. Substitute 9 for letter "V". IF NA, write 00001.	<u>1 6 - 20</u>	---
A9. Write in first Axis II DSM code in actual numbers. IF NA, 00001.	<u>2 1 - 2 5</u>	---
A10. Write in second DSM Axis II code in actual numbers. IF NA, 00001.	<u>2 6 - 3 0</u>	---
A11. Sex 1. male 2. female	<u>3 1</u>	-
A12. Race 1. white 2. black 3. Hispanic 4. other 9. missing data.	<u>3 2</u>	-
A13. Family income. Record in hundreds: 7,500=075, 12,000=120 009=missing data.	<u>3 3 - 3 5</u>	---
A14. Referral Source 1. self (neighbor, family, friend) 2. school system 3. HRS suggestion (no performance agreement) 4. community agency or church 5. physician or medical clinic 6. police/other law enforcement 7. court-ordered or HRS performance agreement (includes judges/probation) 9. missing data	<u>3 6</u>	-
A15. Family composition 1. client lives with both natural parents/legal guardians 2. client lives with one natural parent/legal guardian 3. client living with neither parent/legal guardian 9. missing data	<u>3 7</u>	-
A16. Marital history 1. child's natural parents married to each other 2. natural parents/legal guardians divorced or separated 3. natural parents/legal guardians never married 9. missing data	<u>3 8</u>	-

A17. Current marital status if natural parents are divorced. Reference to custodial parent. 1. custodial parent remarried (not to original spouse) 2. custodial parent not remarried 3. not applicable 9. missing data	<u>3</u> <u>9</u>	-
A18. Marital status, if natural parents are divorced. Reference to non-custodial parent. 1. non-custodial parent remarried (not to original spouse) 2. non-custodial parent not remarried 3. not applicable 9. missing data	<u>4</u> <u>0</u>	-
A19. Custodial parent is 1. male 2. female 3. not applicable 9. missing data	<u>4</u> <u>1</u>	-
A20. Custodial parents marital harmony (may also be natural parents) 1. evidence of marital conflict 2. no evidence of marital conflict 3. does not apply 9. missing data	<u>4</u> <u>2</u>	-
A21. Physical trauma present, accident or illness with impairment of function 1. yes 2. no 9. missing data	<u>4</u> <u>3</u>	-
A22. School status: there are reports of problems at school (see code sheet) 1. yes 2. no 3. individual 9. missing data	<u>4</u> <u>4</u>	-
II. Treatment		
B1. Duration of treatment - number of sessions (include doctors visits if meds prescribed, also include intake) 99 or more sessions = 99	<u>4</u> <u>5</u> - <u>4</u> <u>6</u>	--
B2. Frequency of treatment - average number of sessions per month. 1. 1-2 sessions per month. 2. 3-4 sessions per month. 3. 5 or more sessions per month.	<u>4</u> <u>7</u> - <u>4</u> <u>8</u>	--
B3. Therapist years of experience (use primary therapist or who opened/closed the chart)	<u>4</u> <u>9</u>	-
B4. Therapist education 1. high school or paraprofessional 2. BA or BS 3. MA or MSW or Ed.S. 4. Ph.D. 5. current student 9. missing data	<u>5</u> <u>0</u>	-

Treatment modalities		
B5. Individual treatment-child seen twice or more alone post intake. See code instructions. 1. yes 2. no 9. missing data	<u>5 1</u>	-
B6. Family or couple treatment-two or more family members seen in same session twice or more post-intake. 1. yes 2. no 9. missing data	<u>5 2</u>	-
B7. Combination individual/family - meets conditions of B5 and B6. 1. yes 2. no 9. missing data	<u>5 3</u>	-
B8. Child or adult group participation 1. yes 2. no 9. missing data	<u>5 4</u>	-
B9. Medication prescribed as part of treatment 1. yes 2. no 9. missing data	<u>5 5</u>	-
Type of parent/parent figure participation.		
B10. Both parents/parent figures included in session after intake. 1. yes 2. no 9. missing data.	<u>5 6</u>	-
B11. If yes, did they attend together? 1. yes 2. no 3. not applicable 9. missing data	<u>5 7</u>	-
B12. If only one parent/parent figure was involved was it 1. mother/femal figure 2. father/male figure 3. not applicable 9. missing data.	<u>5 8</u>	-
III. Treatment Outcomes		
-C1. Premature termination: dropping out or rejecting treatment 1. before third session (see B1) 2. third to fifth session 3. fifth to 10th session 4. after 10th session 5. does not apply 9. missing data	<u>5 9</u>	-
Outcome Ratings of Treatment Goals		
C2. Goal I (Treatment plan) 1. significant progress 2. some progress 3. no progress 4. some regression 5. significant regression 9. missing data	<u>6 0</u>	-
C3. Goal II (treatment plan) 1. Significant progress 2. some progr ss 3. no progress 4. some regression 5. significant regression 6. not applicable 9. missing data	<u>6 1</u>	-

C4.	Goal III (treatment plan) 1. significant progress 2. some progress 3. no progress 4. some regression 5. significant regression 6. not applicable 9. missing data	<u>6 2</u>	-
C5.	Goal IV (treatment plan) 1. significant progress 2. some progress 3. no progress 4. some regression 5. significant regression 6. not applicable 9. missing data	<u>6 3</u>	-
C6.	Goal V (treatment plan) 1. significant progress 2. some progress 3. no progress 4. some regression 5. significant regression 6. not applicable 9. missing data	<u>6 4</u>	-
C7.	Overall score (see code instructions) 1. positive 2. negative 3. undetermined 9. missing data	<u>6 5</u>	-
C8.	If present, therapists' overall rating of the client is 1. improved 2. unchanged 3. worse 4. undetermined 5. does not apply 9. missing data	<u>6 6</u>	-
C9.	Average Score	<u>6 7</u> - <u>6 8</u>	--
C10.	Number of cancellations, no shows and reschedules.	<u>6 9</u> - <u>7 0</u>	--

APPENDIX C
INSTRUCTIONS FOR FILLING OUT QUESTIONNAIRE

Each item on the answer sheet must be filled out. Use "9" for missing data.

For client chart to be eligible for the study, the child must be 17 or younger, in the company of legal guardian or parent or if not, being seen with the legal guardian or parent if custody has been removed. Other criteria include presence of demographic information (admission data sheet), TREATMENT PLAN including therapist rating of treatment goals at TERMINATION, a DSM III diagnosis, and a diagnosis not specifying mental retardation (retardation includes 317.0, 318.0, 318.1, 318.2). Finally, each client must have attended at least two sessions including the intake. Specific treatment goal rating overall score must be positive or negative.

If the chart was opened twice, use only information related to FIRST time chart was opened. If there is any question regarding how to rate an item, write in the problem on the answer sheet.

- A1. Enter client number
- A2. Self explanatory
- A3. Self explanatory
- A4. Actual number of those dependents living in the house.
more than 9 = 9, 0 = missing data
- A5. Self explanatory

- A6. Mild = 1 included on Axis I:
- | | | | |
|--------|--------|--------|--------|
| V62.20 | V62.82 | V62.81 | V71.09 |
| V62.89 | V16.81 | 309.00 | 309.83 |
| V71.09 | V62.89 | 309.24 | 309.90 |
| V71.02 | V61.10 | 309.28 | |
| V62.30 | V61.20 | 309.30 | |
| V62.20 | V61.80 | 309.40 | |
| | | 309.23 | |

If two or more codes in these categories are listed on Axis I, it is still rated as "mild."

2. Moderate-severe--This includes all diagnoses not listed above on Axis I. It includes any Axis II code except V71.09. If

two or more codes are present on either axis, rate as "2" if both codes are not listed above.

9. missing data
- A7. Self explanatory, i.e., 307.21 = 307.21
V71.09 = 971.00
- A8. Self-explanatory
- A9. Self-explanatory
- A10. Self-explanatory
- A11. Self-explanatory
- A12. Self-explanatory
- A13. Income: Multiply monthly income by 12; include whatever income center used in determining fee discount. Obtain from admission data form or from fee sheet.
- A14. 1. Self refers to client seen primarily at request of family.
2. School reflects impetus for referral came from school, e.g., intake summary may state that there were problems in school and that is why the child was taken to counseling. If there is doubt about whether it was a school or self referral, see if there is anything directly related to the school, i.e., the counselor suggested child be taken for counseling. If parent simply noticed there were problems in school and brought child on his/her own, then this is a "self referral."
3. This may include single intake, protective service or child welfare and is in the case where the counseling WAS NOT part of a performance agreement or court order (refer to Intake Summary), but was suggested.
4. Agencies other than HRS such as Big Brothers/Big Sisters and churches.
5. Self-explanatory
6. If it is stated that the child had some interaction with police and POLICE suggested counseling as alternative, then list "police." This follows the same logic as "school referral."
7. An actual court order need not be present in the chart if the recorder can infer from intake summary or chart notes that such an order was made; the same is true for a performance agreement or a referral from the judge or probation and parole.

- A15. Information on these items can be obtained from the admission data sheet, intake summary, or from fee information under "dependents"; also chart notes.
- A16. Marital status/history may be found on admissions data sheet, intake summary under family history, chart notes or by noting the difference between parent and child name.
- A17. Self-explanatory
- A18. Self-explanatory
- A19. Self-explanatory
- A20. This refers to the marital relationship of the couple that the child is residing with, whether they are natural parents or not. It does not apply if they are foster parents. You may use chart notes, treatment plan, or intake or discharge summary for obtaining this information. Marital disharmony may include mention of the parents fighting with one another or disagreeing over the child.
- A21. The definition of physical trauma present includes any significant accident or illness that impaired the child's functioning. Any of the following are judged to be significant impairments: birth trauma, major hospitalization due to illness, chronic disease; asthma, diabetes, etc. If you have a question specify the circumstances on the questionnaire. See intake summary under medical history. Include sexual or physical abuse in this category.
- A22. This includes any mention of school difficulties including academic or behavior problems. Data may be found in intake and discharge summaries, treatment plan, or in chart notes.
- B1. Number of sessions must be obtained from counting chart notes where the client came for an appointment or was seen in the community. Include the intake as session one. Do not include case management visits where only a phone call was made. Count reschedules and cancellations separately. You may use the therapist's list of number of sessions in discharge summary as corroboration, but your count is the final one.
- B2. Record the average number of treatment sessions per month by visual inspection of the treatment record. Include doctor's visits if medication was prescribed.
- B3. Use the primary therapist as a reference--whoever had most often seen the client. Use the therapist years of experience at the time the client was seen.
- B4. Use the highest educational level attained by the therapist.

- B5. The child was seen alone twice or more after the intake session. The therapist may have seen the parent in the same session, but there should be a reference in the notes to having seen the child alone.
- B6. Self-explanatory. Any combination of family members present at the same session, whether seen alone or together, will do.
- B7. If yes, to both B5 and B6, then B7 is also yes.
- B8. Self-explanatory: This would also include a parent education group if there is a reference to this in the chart.
- B9. Obtain from the medication record.
- B10. Reference chart notes. You may count participation of step parents or parent surrogates. The key is to describe the participation of the current family arrangement.
- B11. Self-explanatory
- B12. Self-explanatory
- C1. See discharge sheet/termination summary or chart notes for information. Use the therapist's own evaluation of whether the termination was by mutual agreement (even though all treatment goals were not achieved) or self-initiated by the client without therapist's approval.
- C2. Outcome ratings of treatment goals C2 through C6. Reference these goals to the first time the case was closed and the goal ratings done by the therapist at that point. If there is more than one set of treatment goals as may be the case where the chart was open for more than 6 months, use the goal ratings at case closing. Not applicable is used if that goal is not filled out. Do not transpose the numbers, i.e., significant progress = "1," not "5."
- C7. Assign a value of +1 to ratings 1 & 2; a negative 1 value to 3, 4, and 5. Add them together to obtain either a positive or negative sum. An overall positive score is +1 or higher. An overall negative score is -1 or lower.

For example: Goal 1 is 1 = +1
Goal 2 is 3 = -1
Goal 3 is 2 = +1

Overall sum = +1

If the overall score equals 0, the outcome is undetermined (3).

If the therapist forgot to fill out the goal rating, then use 9.

- C8. This applies in cases where you can either infer the therapist's opinion from the discharge summary (it must explicitly state that the situation was "overall improved" by counseling) or there is a space for this item on the discharge sheet (all NCFMHC's charts), as to whether the case was "overall improved" (not all charts have this overall rating).
- C9. Calculated by principal investigator. Do not fill out.
- C10. Count total number of sessions missed due to cancellation and rescheduling or simply not coming (missed) for the appointment.

APPENDIX D
PROPORTION OF AGREEMENT*

	Prior to training	After training	Kappa** Prior to training
A1. Client number	1.0		
A2. Center code	1.0		
A3. Year case seen	1.0		
A4. Family size	.90	1.0	.535
A5. Client age	1.0		
A6. DSM category	1.0		
A7. First DSM Axis I code	1.0		
A8. Second DSM Axis I code	1.0		
A9. First SDM Axis II code	1.0		
A10. Second DSM Axis II code	1.0		
A11. Sex	1.0		
A12. Race	1.0		
A13. Income	1.0		
A14. Referral source	.90	1.0	.57
A15. Family composition	1.0		
A16. Marital history	1.0		
A17. Current marital status	1.0		

	Prior to training	After training	Kappa** Prior to training
A18. <u>reference custodial parent</u> marital status reference non-custodial parent	1.0		
A19. Sex of custodial parent	1.0		
A20. Marital harmony	.90	1.0	.83
A21. Physical trauma	.80	1.0	.77
B1. Duration of treatment	.50	1.0	.37
B2. Frequency of treatment	1.0		
B3. Therapist years of experience	NA		
B4. Therapist education	NA		
B5. Individual treatment	.60	1.0	.35
B6. Family/couple treatment	.70	1.0	.44
B7. Combination	.60	1.0	.313
B8. Group treatment	.90	1.0	.81
B9. Medication used	1.0		
B10. Parents included in session post intake	.70	1.0	.45
B11. Attend together	1.0		
B12. Sex of parent attending	1.0		
C1. Premature termination	.9	1.0	.81
C2. Goal rating 1	1.0		
C3. Goal rating 2	1.0		
C4. Goal rating 3	1.0		
C5. Goal rating 4	1.0		

	Prior to training	After training	Kappa** Prior to training
C6. Goal rating 5	1.0		
C7. Overall score	1.0		
C8. Therapist's overall rating	1.0		
C9. Average score	NA		
C10. Cancellations, no shows or reschedules	.70		.47

*Proportion of agreement is cited for variables where there was 100% agreement between recorders.

**Kappa is a statistic suitable for measuring agreement between two or more raters on nominal level data (Cohen, 1960). Kappa was not recorded when proportion of agreement was 100%. Kappas were all significant at the $p < .001$ level.

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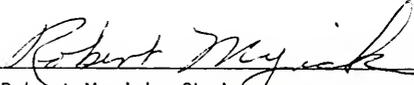
BIOGRAPHICAL SKETCH

Lewis A. Fabrick, II, is the son of Arthur and Patricia Fabrick, both University of Florida graduates. Lewis is 34 years old and is married to Finnacle Williams Fabrick who holds a doctorate from the Department of Counselor Education, University of Florida. They have two children, Elena, four, and Nathan, two.

He has resided in Gainesville, Florida, since 1959, attending high school at P.K. Yonge Laboratory School. He received his B.A. degree in psychology from Eckerd College (then Florida Presbyterian College) in 1971. After working several years at the Shands Teaching Hospital Human Development Center, he attended graduate school in social work at Florida State University.

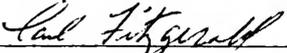
Receiving his M.S.W. degree in 1975, Lewis worked at the Child, Youth and Family Center from that time until the present. He has held positions there as a clinical social worker and as a clinical supervisor. He specializes in psychotherapy with families, couples, children, and adolescents. Currently, he is also in private practice as a state licensed clinical social worker and marriage and family therapist.

I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and in quality, as a dissertation for the degree of Doctor of Philosophy.



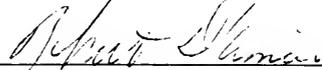
Robert Myrick, Chairperson
Professor of Counselor Education

I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and in quality, as a dissertation for the degree of Doctor of Philosophy.



Paul Fitzgerald
Professor of Counselor Education

I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and in quality, as a dissertation for the degree of Doctor of Philosophy.



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Associate Professor of Philosophy

This dissertation was submitted to the Graduate Faculty of the Department of Counselor Education in the College of Education and to the Graduate School, and was accepted as partial fulfillment of the requirements for the degree of Doctor of Philosophy.

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