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A follow-up study at the West End Creche Child and Family Clinic.

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A FOLLOW-UP STUDY AT THE WEST END CRECHE CHILD AND FAMILY CLINIC

by

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A Thesis
submitted to the Faculty of Graduate Studies
through the School of Social Work
in Partial Fulfillment of the requirements
for the Degree of Master of Social Work at
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Research Committee

Professor B. F. Monaghan	Chairman
Professor F. C. Hansen	Member
Dr. G. Booth	Member

To my parents

with love

ABSTRACT

This research project is a follow-up study of the clients' reactions to the service they received at the West End Creche Child and Family Clinic in Toronto after the termination of service. In turn, the study serves as an outcome evaluation of the programme. Programme outcome was evaluated by the clients as well as by the social workers.

The literature was reviewed in three areas: the controversy of treatment effectiveness, client and therapist perceptions of treatment outcome and variables that affect treatment outcome. Three major research questions were developed in relation to the purpose of the study: (1) Does the service provided meet the needs of the families served? (2) Are client and worker perceptions of treatment outcome similar or different? (3) What are some of the variables that relate to treatment outcome? Treatment outcome was operationally defined as the degree of problem amelioration and service satisfaction.

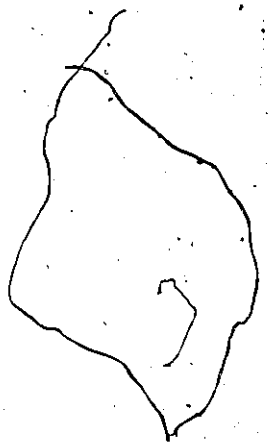
The design and instruments of the research project were derived from the Client Follow-up Study designed by Beck and Jones (1974) and from the Supplement by Beck (1977) at the Family Service Association of America. Some modifications were necessary in making the design relevant to the present setting. A sample of

fifty families was drawn from the recently closed cases at the Creche between April and September in 1979 through nonprobability sampling. Families were first contacted by mail and then by telephone for the setting up of interview appointments. An interviewing schedule was used. Social workers whose clients were included in the study were asked to fill out the worker questionnaires. Twenty-nine families (58%) were interviewed; fourteen (28%) were unable to be contacted; and seven (14%) refused to participate.

In comparison to the non-participant families, it was found that more children in the participant families were in the age group 6-10 and they usually stayed beyond the assessment period. The families were predominantly White; most parents were married with an annual family income between $15,000 and $19,999. The families usually entered treatment voluntarily. The most frequent mode of treatment was individual therapy and the duration ranged from seven months to more than two years.

The findings indicated that 90% of the families felt that they had made much or some progress in improving the problem situations and almost 90% of them were either very satisfied or satisfied with the service. It was found that there was no significant difference between client and worker perceptions of problem amelioration, but there were significant differences found in their perceptions of client satisfaction with the service. It appeared that the worker had a tendency to under-rate client satisfaction. Finally, socio-economic status of the client and client-worker relationship were found to be significantly and positively associated with change scores (calculated from problem amelioration scale).

It was concluded that, to a great extent, the Creche's services were effective in meeting the needs of the participant families. However, further research was recommended in order to generalize the results of this project and to establish causal relationships between variables. Recommendations on the Creche's programme, social work practice and research were also made.



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CHAPTER I

INTRODUCTION

Programme evaluation has been carried out in human services organization for more than a quarter of a century and has been gathering momentum in the sixties and seventies. Rieken defined programme evaluation as follows:

> Evaluation is the measurement of desirable and undesirable consequences of the action designed to achieve some objective that the actor values. Action means a conscious attempt to change individual or group behavior or psychological state in a valued direction....A program of action includes one or more treatments, which are the sets of operations and specific steps undertaken to produce the desired effects, and these effects can be called the objectives of the program. (1977, p.393)

In other words, programme evaluation is a measurement of service effectiveness.

What is the driving force behind programme evaluation research? Strupp and Hadley posed the question:

> Is the evaluation of psychotherapy an urgent necessity or merely a manifestation of well-intentioned, but hopeless naivete? (1977, p.478)

They contended that psychotherapy must and can be evaluated, even though evaluating psychotherapy is a complex task and not without its limitations. Fischer (1976), one of the advocates for evaluating effectiveness in the practice of social work, maintained a similar point of view. The measurement of service effectiveness is a necessity and has received impetus from developments within the professional field as well as within the broader social and political contexts.

With the Professional Field

The results of some research studies of treatment outcome analyzed by various psychotherapists have repeatedly failed to demonstrate the effectiveness of treatment and in fact indicated the possibility of negative effects on recipients of service. (Research on psychotherapy with adults includes: Eysenck, 1952 & 1955; Bergin, 1963; Bergin & Lambert, 1978. Research on psychotherapy with children includes: Levitt, 1957, 1963, 1967 & 1971; Barrett, Hampe & Miller, 1978.) Similarly, systematic reviews and evaluations of research concerning the outcome of social work treatment point towards the same conclusions (Segal, 1972; Fischer, 1973a, 1976 & 1979; Wood, 1978). Fischer remarked:

> It is crucial to the viability of our profession to go much further and continue to engage in the search for something better. (1976, p.xi)

Forerunners who conducted outcome research studies have spurred the awareness among professionals of possible negative effects of treatment and have called for practitioners' accountability to their clients. However, the conclusions drawn from the studies are still controversial; hence, the perpetuation of this trend of questioning treatment effectiveness in the field of treatment services is essential to bring about affirmative answers and constructive changes if necessary.

Within the Social Context

Related to the developments within the professional field to improve service quality, there is the growing awareness among service recipients of their rights to good services:

> In the broader social context, there has been a recent marked intensification of the consumer advocacy movement and an

> increase in consumer awareness of product quality. In the mental health field, this development has led many patients to scrutinize the process and outcome of their own therapy. (Strupp & Hadley, 1977, p.481)

Thomander also noted:

> With the current trend toward partial control of community service agencies (e.g. police, hospital) by members of the community who sit on review or advisory boards, mental health agencies face additional pressure to demonstrate the value of their treatment programs. (1976, p.215)

Therefore, not only is there the professional responsibility of providing good services to the clients, the consumers' movement has hastened or stimulated the helping profession to examine the effectiveness of service.

Within the Political Context

Finally, there is the hard reality that treatment facilities depend on the funding bodies to implement and maintain their programmes. In recent years there has been an increasing demand from the funding bodies of human services to demonstrate the values of such services. In the United States, the Community Mental Health Centers Amendments of 1975 required for the first time that community mental health centers establish ongoing quality assurance programs (Schulberg, 1977) after the initial Act of 1964 had been implemented for fourteen years. The Act mandated that recipients of such grants obligate at least 2% of the preceding year's operating budget for the evaluation of programme quality and effectiveness (Windle & Ochberg, 1975, cited in Schulberg, 1977, p.561).

Similarly, in Ontario, Canada, the Children's Services Division of the Ministry of Community and Social Services (1979) recognized that there has been a lack of service delivery standards and the measurement of effectiveness. The Ministry stated that there has been no comprehensive evaluation research on children's services

programmes; consequently,

> there is little information on how programs are working, who is and who is not receiving their services, what factors contribute to demand for services, how programs organize themselves with respect to delivering these services and what, if any, are the consequences of delivering services in one way compared to another. (Ministry of Community and Social Services, 1979, p.10)

In view of the situation, the Children's Service Division recognized that there is a real need to integrate the systems of planning, budgeting and funding with service delivery standards and the gathering of information to ensure that funds are spent most efficiently and effectively according to priorities. To this end, the Children's Services Division recommended that the funding approach in the 1980's should make provisions such that the Division will be able to:

> review quality of care through realistic and acceptable minimal levels of standards setting and monitoring....
> evaluate and improve organizational efficiency and effectiveness through comprehensive operational reviews of selected programs. (Ministry of Community and Social Services, 1979, p.27)

Thomander (1976) summed up the current situation of the necessity to conduct programme evaluation as follows:

> It is reasonable to conclude that there is currently considerable value placed on the public accountability of mental health professionals....Ideally, this research would not be undertaken merely to satisfy a demanding public or funding agency, but also to provide truly useful information which mental health practitioners can utilize in maximizing the quality of the services they offer. (1976, p.216)

It is important that under other pressures, the helping profession does not lose sight of the primary goal of programme evaluation which is to find ways to serve clients better.

Purpose of the Study

It is within the professional, social and political contexts

that the research project reported here was undertaken.

While the researcher was on field placement as a graduate social work student in Windsor, she began with an interest in looking at the reasons why clients terminated treatment abruptly at an outpatient children's clinic there. She was hoping to find some association between service satisfaction and premature termination. After her move to Toronto, she approached several agencies and finally came to the West End Creche Child and Family Clinic which got interested in the project. However, the Director of Social Work, Mr. Paul Dodd, felt that the project would be more valuable to the Clinic if the student researcher would study all the clients who experienced treatment at the Clinic rather than just looking at a special group. In order to benefit the Clinic with the findings of the study and to pursue the interest of the student researcher who was undertaking the project for her Master's thesis, the project then evolved into the present study. This project is a follow-up study of the clients' reactions, in retrospect, to the service they received at the West End Creche Child and Family Clinic after the termination of service. In turn, the study serves as an outcome evaluation of the programme.

Programme outcome was evaluated by the clients as well as by the social workers. It was the researcher's intention to: (1) find whether the service provided met the needs of the families served; (2) compare the client and worker perceptions of treatment outcome; and (3) search for some of the variables that may relate to treatment outcome.

Treatment outcome is defined as: (1) the extent to which problems were ameliorated; and (2) the degree of satisfaction or

dissatisfaction with the service received. The measurement of treatment outcome served to indicate whether the service provided met the needs of the clients. In addition, strengths and weaknesses of the programme were to be indicated by the identification of specific areas of problem amelioration and areas of client satisfaction and dissatisfaction.

Other variables that the researcher decided to study included client socioeconomic status, race, the duration of treatment, the frequency of contact, the degree of parental involvement, the nature of the problems, client-worker relationship and the manner of termination. These variables will be reported in relation to treatment outcome.

According to Hargreaves and Attkisson (1978), outcome evaluation can serve three purposes: (1) the continuous monitoring of programme quality; (2) the demonstration of programme effectiveness; and (3) the making of decisions about programme modifications aimed at improving effectiveness. In fact, the three purposes are interrelated. The monitoring of programme quality is done by routinely examining selected indicators of the degree to which programme objectives are being met. It serves to detect problems needing remedy or conditions requiring closer examination (Hargreaves & Attkisson, 1978). Since there had been no such activities at the West End Creche, the primary focus of the project was on achieving the first purpose stated above. No provisions were made to strictly control antecedant or intervening variables such as the severity of identified problems, previous treatment involvement at other agencies, worker characteristics, treatment modalities, etc. There was no

control group used either. In this case, there will be limitations to the interpretation of the findings. Nonetheless, this research project serves to provide a data base for the West End Creche Clinic so that further development of the programme will be made possible. This is a reasonable initial approach to evaluate programme effectiveness notwithstanding the limitations of the project within the confines of scientific research. Preliminary recommendations for programme modifications will be made.

Not only will the study be of value to the Clinic, but the findings may also shed some light on the general practice in social work as to what conditions are conducive to positive outcome, with what kind of clients. What the researcher learns from the study will add to the existing knowledge about human services and research regardless of whether the findings support previous findings or whether they raise more questions for further exploration.

The Format of the Study

The format of this research project was based primarily on the Client Follow-up Study designed by Beck and Jones (1974) and on the Supplement by Beck (1977) at the Family Service Association of America. Some modifications were made to suit the interest of the researcher and to make the design relevant to a different setting within which the study was conducted.

The Setting of the Study

This research project was conducted at the West End Creche Child and Family Clinic in Toronto, Ontario (from now on to be referred to as the Creche)).

The Creche is an outpatient psychiatric facility for the

treatment of preschool children and their families. It was founded on February 15, 1909, by a group of women who wanted to provide daycare for children of working mothers. Beginning with a staff of four and a budget of $3,152, it has developed into a multidisciplinary facility in treating disturbed preschool children and their families. One of the milestones in its development was in 1935 when the Neurological Clinic of the Hospital for Sick Children asked the Creche to cooperate with them in the treatment of a few of their clinical cases. In May, 1957, a special programme for preschool autistic children was developed.

The Creche is accredited by the Canadian Council on Hospital Accreditation and is funded primarily by the Children's Division of the Ontario Ministry of Community and Social Services. Children enrolled in the programme used to come from all parts of Metropolitan Toronto to the Central Branch located on Euclid Avenue, Toronto, some travelling long distances for daily treatment. With the increase in demand for this specialized service, a branch was opened in Scarborough in 1971 and another branch was opened in Mississauga. In 1979, a branch was opened in East York. All branches are accommodated in Junior Public Schools.

The total service is free except that parents are required to provide transportation to and from the Clinic. In the case of a child who is eligible for Junior Kindergarten, transportation is provided by local Boards of Education.

The staff now consists of social workers, child therapists who have training in child psychology, psychiatrists, psychometrists, speech pathologists, gym and dance therapists, special education

teachers, researchers, managerial staff, clerical staff and students in training from various disciplines. The social workers take on major responsibilities in working with the families and coordinating services provided by the Creche.

The Creche's major goal is:

> the treatment of appropriate preschool children and their families. The children who are appropriate for assessment and treatment at the West End Creche display symptoms which are related to delays or blocks at various stages of development. These delays or blocks can manifest themselves through: speech and language difficulties; general behavioural abnormalities; problems of attachment; problems in the development of autonomy; deficiencies in perception. These deviations may result from hereditary factors, physical illness or psychological reactions to environmental conditions. (West End Creche Child and Family Clinic, 1979)

Children who cannot be served in natural settings, such as daycare centres, day nurseries and schools, are admitted to the formal programmes of treatment. However, it is also the goal of the Creche to use the multiplier effect by using the expertise of the staff who act as consultants to daycare centres, day nurseries and schools.

The programme is available to children from infancy to seven years of age with a few pre-adolescent and adolescent children attending after school groups. Referrals to the Creche may be made directly by parents themselves, or by pediatricians, other clinical practitioners, the Children's Aid Societies, public health nurses, nursery schools, hospitals or other agencies.

The Creche offers a team approach. At the point of referral, the members of the team explore with the family their understanding of the child's difficulties and their wish to become involved in the treatment process. During the assessment, a representative of each discipline examines the child and his/her family. The team arrives

at a diagnostic statement of the problem and plans the programme for the child and family, either within the Clinic or elsewhere. If the child does not enter the treatment programme within the Clinic, the family will be assisted to find appropriate help elsewhere in the community.

A special effort is made to help a child entering treatment at the Clinic maintain his usual activities at home or nursery school. The treatment made available is designed according to the individual needs of the total family. The child may have individual therapy, group therapy, or both at the Clinic. The involvement of the parents in the total treatment is emphasized. They are expected to work with the staff and to participate in parent interviews (individual or intensive family and/or marital therapy), supportive therapy (including teaching methods for handling children who have special problems) and group meetings. The average duration of service ranges approximately from two weeks to two years.

The Creche, with its focus on preschool children, has the motives of catching problems earlier and of helping disturbed children into healthier living and education.

Summary

We can now put the research project into focus with some knowledge of the project setting, the purpose of the project and the contexts within which the project was conducted. In summary, this research project was conducted at the West End Creche Child and Family Clinic as a response to the Clinic's and the student researcher's interest in looking at treatment outcome of professional interventions. Using the basic format of the Client

Follow-up Study provided by Beck and Jones (1974) and Beck (1977), it was hoped that clients' reactions to the service provided by the Creche would give some reflections of treatment outcome and programme quality. Subsequently, recommendations could be made regarding the Clinic's programme, social work practice and research.

CHAPTER II

A REVIEW OF THE LITERATURE

The primary goal of a treatment programme is to bring about effective changes that will relieve clients of some of their problems. A survey of the literature on programme evaluation and treatment outcome brings to light the problems encountered by previous researchers in evaluating the performance of the helping professions and the direction that should be taken in order to continue with the search for ways of improving service to the clients.

The literature reviewed will be presented under three main topics: (1) the controversy of treatment effectiveness; (2) client and therapist perceptions of treatment outcome; and (3) some of the variables that affect treatment outcome.

The Controversy of Treatment Effectiveness

One of the most pressing concerns of the helping professions is the responsibility of meeting the needs of those who come to seek professional help for the amelioration of their problems. The existence of the helping professionals is justified and valued only when they are effective in meeting the needs of their clients. In recent years, concerned practitioners in various treatment programmes have begun looking at the effectiveness of treatment which for many years had been accepted without being questioned. These practitioners have come up with mixed findings; their studies have demonstrated

both positive and negative results of treatment.

Among the earlier practitioners who concerned themselves with treatment effectiveness is Eysenck (1952) who did a survey of reports on the improvement of neurotic patients after psychotherapy. He reviewed twenty-four studies reported in the literature dealing with both psychoanalytic and eclectic types of treatment and found that on the average approximately two-thirds of the patients improved after treatment. On the other hand, Eysenck also estimated from the data that some two-thirds of severe neurotics showed considerable improvement without the benefit of systematic psychotherapy. He therefore concluded that the available data failed to support the hypothesis that psychotherapy facilitates recovery from neurotic disorder. Whitehead (in Berenson and Carkhuff, 1967) summarized Eysenck's findings as follows:

> Eysenck's research and review, interpreted liberally, established that at the minimum there were no average differences in the outcome indices of persons who were treated and persons who were not treated. At the maximum, there is cause for even greater alarm: There may be justification for leaving some patients alone and relying upon the phenomenon of spontaneous remission rather than treating them in the most traditional psychoanalytic mode of practice. At the minimum, therapeutic practices have failed to establish their efficacy. At the maximum, they may be very questionable modes of intervention with highly dubious outcome. (p.22)

Later, Eysenck further asserted that:

> When it is realized that these data, poor as they are, are all the evidence available regarding a method of therapy which has been practiced for more than 50 years on hundreds of thousands patients, then it will, I think, be agreed that the failure of the data to show any degree of therapeutic effectiveness should act as a spur to ensure the initiation of the large-scale, properly planned, rigidly controlled, and thoroughly analyzed experimental studies in this important field. (Eysenck, 1955)

Following Eysenck's footsteps, Levitt (1957a) did a survey of eighteen reports of evaluations at the closing of cases and

seventeen reports at follow-up on the treatment of children. He found that about two-thirds of the patients examined at termination and about three-quarters seen at follow-up had improved. About the same percentages of improvement were found for comparable groups of untreated children, the defectors, who had been accepted for treatment but who never began treatment. Levitt therefore concluded that his evaluation of child psychotherapy failed to support the hypothesis that treatment is effective. Looking at the discrepancy between results at treatment termination and at follow-up, Levitt further suggested that time may be a factor in the improvement.

In 1963, Levitt made another attempt to evaluate psychotherapy with children. Twenty-two studies of treatment outcome were reviewed. This time the cases were grouped according to diagnostic categories. Comparing the treated group and the defector group, Levitt again contended that

> the inescapable conclusion is that available evaluation studies do not furnish a reasonable basis for the hypothesis that psychotherapy facilitates recovery from emotional illness in children. (Levitt, 1963, p.49)

The data further suggested that the improvement rate varied among psychiatric illnesses, therefore it was recommended that future comparisons should be made within diagnostic categories.

In response to the challenges of Eysenck and Levitt, Bergin (1963) addressed himself to the same question by reviewing six studies that he considered most adequately designed. He raised questions with respect to the use of an appropriate control group and took a step further to analyze the variance apparent within the experimental group, that is, the treatment group. As a result, Bergin drew three important implications from his survey:

(1) Therapist qualities affect the effectiveness of psychotherapy:

> When experimental subjects are divided according to qualities of the therapist it was found that patients of therapists who provided high therapeutic conditions (high empathy, positive regard, and congruence) improved significantly whereas patients of therapists who provided low therapeutic conditions (low empathy, positive regard, and congruence) became significantly worse. The effectiveness of one group of therapists is cancelled out by the negative effects of the other group when the two are combined into a single experimental group and compared with the controls...change does occur in psychotherapy, but in two opposite directions, the direction depending upon therapist qualities. (Bergin, 1967, p.50)

(2) The control group may not be purely a control group. Bergin contended that when people are upset, they tend to seek help from non-professionals and that the changes occurring in control groups can be attributed to this type of "help-seeking" behaviour. The so-called control subjects who improved were influenced by people who have the same personal qualities as those therapists who brought about improvement in their clients.

(3) The selection of outcome criteria is influenced by subjective value judgments, therefore the analysis of the same set of data may provide varied findings:

> There are no such phenomena as culture-free or values-free people; consequently it seems inevitable that specific attention and action is required on the part of both practitioners and researchers with regard to these facts. This involves becoming explicit about the values to which we are committed, doing all we can to specify their meaning in precise psychological terms, and finally, devoting ourselves to developing ways of achieving those ends. (Bergin, 1967, p.53)

Knowing the possible relationship between therapist qualities and the effectiveness of treatment, further studies of treatment outcome should focus on these variables. The researcher is interested in finding out in her study which qualities clients value in their therapists.

From Bergin's conclusions, researchers are cautioned to take a different approach in looking at the effectiveness of treatment. Instead of asking the global question, "Is treatment effective?", the variables that may affect treatment outcome and the selection of outcome criteria have to be taken into consideration.

Bergin has raised some hopes about the effectiveness of treatment and the outlook does not appear to be as gloomy as Eysenck and Levitt have depicted it. On the other hand, Bergin has raised a rather disturbing point with respect to the potential danger of therapy-induced deteriortation due to the poor quality of the therapist. Later in 1978, Bergin and Lambert concluded that the above average therapy often yields excellent results, and that below average therapy may even be harmful (Bergin & Lambert, 1978).

Like Levitt, Segal (1972) reviewed studies on treatment effectiveness in social work by categorizing the client population into groups according to their problem base, the social problems population and the psychologically-based problems population. In addition, differences in the types of treatment employed with each group were considered. He found that results of treatment differed between the two groups and therefore suggested that the finding was a result of the different measures used with the different populations. However, Segal also commented that, in his survey, the trends in the data with respect to the effectiveness of social work therapeutic intervention pointed strongly towards the negative direction. One implication that should be emphasized is the need to relate treatment outcome to client characteristics and types of therapeutic intervention.

Fischer (1973), one of the strong advocates for the evaluation of treatment, selected and reviewed eleven studies on the effectiveness of professional casework services. The findings were similar to previous surveys:

> Of all the controlled studies of the effectiveness of casework that could be located, nine of eleven clearly showed that professional caseworkers were unable to bring about any positive, significant, measurable changes in their clients beyond those that would have occurred without the specific intervention program or that could have been induced by nonprofessionals dealing with similar clients...thus not only has professional casework failed to demonstrate that it is effective, but lack of effectiveness appears to be the rule rather than the exception across several categories of clients, problems, situations, and types of casework. (p.13-14)

Fischer is also concerned about the deterioration effect of treatment since he found that in just under 50% of the studies, clients receiving treatment were shown to deteriorate to a greater extent than the clients in the control groups. Fischer is in agreement with Eysenck and the other researchers that definite conclusions cannot be drawn about the futility of treatment as there is no "absolute success or failure" in practice at this point. Continual research seems to be a necessity for the helping professions.

In 1976, Fischer expanded his survey to seventeen controlled studies with some overlap with his previous review. Again, he came to a similar conclusion and probably has become more convinced by his findings. He attributed this lack of casework effectiveness to the deficiencies and weaknesses in the traditional theories and methods used by caseworkers. He felt strongly that:

> The major belief system of caseworkers has impeded them both from recognizing the substantial negative evidence about the effects of their work that has been documented in this book and from searching for new knowledge and new models. (Fischer, 1976, p.159)

In other words, caseworkers adhere to the assumption that their theories and methods of practice are effective and have failed to challenge or question their assumption. Such a belief system or assumption will lead the helping professions to a dead end. In his final conclusion, Fischer suggested that caseworkers should adopt and teach methods for practice that have already had empirical evidence of effectiveness.

However, in Wood's review (1978), she differs basically from Fischer's viewpoint in that it is not the methods of practice which are at fault, but the improper application of methods by practitioners. She contended that practice methods

> need some vigorous therapy themselves if they are to survive and demonstrate their usefulness. (Wood, 1978, p.456)

The negative effects of casework treatment are not unique; Gurman and Kniskern (1978) added yet another dimension to the evaluation of treatment effectiveness in their review of studies on marital and family therapy. They paid particular attention to the negative effects in the treatment of family systems. They considered that therapist factors, patient factors or their interactions may influence the effects in the treatment. They also presented guidelines for the assessment of deterioration in the marital-family system. They asserted that the changes that occurred in the Identified Patient, the Marriage, and the Total System must be examined. In some cases, the deterioration may have reflected an intermediate stage of the therapeutic process. Two implications can be drawn from their study: (1) researchers have to specify the vantage point from which treatment outcome is evaluated; (2) repeated measurements at intervals of

time should be made in order to study the long-term effect of therapy. Some studies have recommended the need to specify who is evaluated by whom and what is the value commitment of the evaluator (Bergin, 1963; Bergin & Lambert, 1978; Strupp & Hadley, 1977; Strupp, Hadley & Gomes-Schwartz, 1977).

From the above review of the literature, it can be seen that the effectiveness of treatment is still quite controversial although evidence seems to point to the negative consequences of therapy. However, the examination of treatment effectiveness do not stop at this point. The above reviews have presented only a summary of the negative findings on treatment effectiveness, the majority of which have offered little explanations about what made treatment ineffective (Eysenck, 1952; Levitt, 1957 & 1963; Segal, 1972). For those who have offered some explanations, the analysis of the phenomenon appears to be mostly speculation on the part of the researchers and practitioners (Fischer, 1976; Wood, 1978). Hardly any of the reviews suggested that the clients should be involved in the process of evaluation. Wood (1978) did mention the importance of contracting with clients in the process of treatment in order to establish a goal for the treatment. It is by no means different in the process of research that clients should be consulted on what they consider as helpful and not helpful to them regarding their experience in treatment. The researcher feels strongly that it is time that clients be consulted in order to obtain their point of view of what has happened to them in the treatment, because they are the people that the professionals are trying to help.

Several studies that reported on clients' evaluations of

treatment outcome were cited in the survey of the literature (Feifel & Eells, 1963; Strupp, Wallach & Wogan, 1964; Siegel, 1965; Beck & Jones, 1973; Heinemann & Yudin, 1974; Blonde & Murphy, 1975; Riley, 1975; Dailey & Ives, 1978; Woodward, Santa-Barbara, Levin & Epstein, 1978; Hunter, 1979). Particularly of interest to the researcher are the studies done by Feifel and Eells (1963), Strupp et al. (1964), Riley (1975), Dailey and Ives (1978), Woodward et al. (1978), and Hunter (1979). These studies have utilized open-ended questions to elicit clients' spontaneous response to learn from them about what was helpful and not helpful to the clients in their treatment. Riley in his conclusion said:

> Much practice wisdom is being confirmed by such structured consumer feedback; some cherished professional beliefs and techniques may be shown to be of minimal value to the people social workers are trying to help. (Riley, 1975, p.250)

However, studies that depend on clients' evaluations may encounter one problem: dissatisfied clients are less likely to respond or are less willing to participate in such a study. This will result in a biased sample with the results favouring positive outcome of treatment. Strupp et al. (1964) reported an improvement rate of 95.5% of their clients, but these 95.5% represented only about 50% of the total sample. By comparing the respondents and the non-respondents, Strupp et al. found that therapists tended to rate respondents as having shown greater improvement, and as having better working relationships with their therapist. Heinemann and Yudin (1974) reported an overwhelming success rate of 97% of their clients; however, the rate of response to the follow-up effort was an extreme low of only 35% of the total sample. Riley (1975) also made reference

to the possibility that the respondents of his study might have a higher average change score (improvement score) than the non-respondents. Similarly, Dailey and Ives (1978) reported that about one-third of those who had not taken part in the study either refused out of dissatisfaction with services or out of unwillingness to participate in the study. In view of the under-representation of dissatisfied clients, the positive success rates that were reported in these studies may not be representative of their sample and there is the likelihood that the success rates may have been inflated.

The analysis of the above studies cannot be generalized to all studies that use clients' evaluations; nevertheless, the results of the analysis may account for the difference in the findings between studies of negative treatment outcome and studies of positive treatment outcome. In other words, studies that reported positive outcome of treatment may not be as successful as they claimed to be.

One way to compensate for this inflated rate of success is to obtain information on both respondents and non-respondents from agency records or from the professionals who treated the clients. A comparison of the two groups of clients will shed light on the representativeness of the final results. Feifel and Eells (1963), who reported a 90% rate of success, improved the reliability of their findings by utilizing information provided by the therapists. They found that there was no significant difference between the respondents and the non-respondents.

In the present study, the researcher planned to use clients as the evaluator of treatment outcome so that practitioners can learn from the clients' experience. At the same time, the professionals

will provide information on these clients in order to provide a balance to the results in case if there is a high non-response rate. This study, unlike some of the reviews cited earlier, will go further than looking at the effectiveness of treatment by eliciting clients' feedback on what was helpful and what was not helpful to them in their treatment experience, on areas of satisfaction and dissatisfaction, and on areas of improvement and deterioration.

Client and Therapist Perceptions of Treatment Outcome

Earlier in this chapter, the importance of specifying who is evaluating the treatment outcome was pointed out. Unless objective tests such as the MMPI are administered, subjective feelings of the evaluator are bound to influence the evaluation of the outcome. It is therefore essential to take into consideration as many outcome criteria as possible. Garfield, Prager and Bergin (1971) in their study were concerned with the relationship among eight different criteria of outcome in psychotherapy. These criteria included self-report inventories (MMPI, Q Disturbance scale) given before and after psychotherapy, global ratings of improvement completed by clients, therapists and supervisors, and before and after ratings of client disturbance provided by the therapists, the supervisors and judges. In general, there tended to be little relationship between the various criteria of change. Garfield et al. (1971) felt that the most frequent measure of outcome used has been the overall evaluation of treatment outcome by the therapist. Such evaluation is subjective and has limitations. The client as the service recipient is in a favoured position to evaluate his own changes after therapy. Nevertheless he is also liable to give a biased opinion because of his own

involvement. There may be a need to rationalize the investment of time and money (Festinger, A Theory of Cognitive Dissonance, 1957), or a need to avoid displeasing the therapist, the "hello-goodbye effect" (Hathaway, 1948). Arguments for and against the use of clients as evaluator are also presented by Margolis (1977). He considered that:

> self-report had low status in a science that increasingly emphasized hard data and observable criteria. (Margolis, 1977, p.12)

However,

> As recipients of direct services, consumers are in a unique position to report on long-term benefits that persist or generalize beyond the immediate setting. Furthermore, consumers are a good source of information about subjective considerations such as pre-therapy expectations, therapist-patient relationships, accessibility of agency services, and needs unmet by available services. (Margolis, 1977, p.14)

Thus, not only can clients' perceptions be used as a counterbalance against the bias of therapists' perceptions, but the evaluation of a programme also can become more comprehensive. Dailey and Ives (1978) concurred with the use of client perceptions of treatment so that they will give us some guidance on the quality and effectiveness of our service.

Several studies mentioned the discrepancies between staff and client evaluations of service (Feifel & Eells, 1963; Kissel, 1974; Harty & Horwitz, 1976; Dailey & Ives, 1978; Maluccio, 1979). Other studies reported consensus between them (Strupp, Wallach & Wogan, 1964; Siegel, 1965).

Harty and Horwitz (1976) studied therapeutic outcome as rated by patients, therapists and judges. They attempted to determine the extent of agreement among these three views. In addition, they

attempted to see if there was any consistent pattern in their judgment. They found that there was a tendency for therapists to overrate their success, as compared to the other two sources. Moreover, there was a tendency for therapists to overlook patients' dissatisfaction with treatment outcome. Therefore, they hypothesized that the failure to recognize and deal with the patients' negative feelings was a factor in a substantial number of unsuccessful treatments.

In contrast to Harty and Horwitz, other studies found that there is a tendency for workers to underrate success in treatment (Kissel, 1974; Dailey & Ives, 1978; Maluccio, 1979). In Kissel's study, it was found that clients' evaluations of outcome were significantly better than what would have been predicted on the basis of therapists' ratings alone. Dailey and Ives found that clients reported more than twice as much improvement than workers reported. Maluccio conducted an in-depth study of clients and social workers in a family service agency and found that there were striking differences in their perceptions, especially in regard to satisfaction with outcome and assessment of clients' functioning. There was a tendency for workers to underrate outcome; Maluccio attributed the phenomenon to workers having higher expectations than clients and the tendency to focus on pathology. He also made reference to the need for clients to justify their investment of time, energy and money.

In the study conducted by Strupp, Wallach and Wogan (1964), the data demonstrated a "substantial retrospective consensus" between patient and therapist evaluations of the outcome of the therapeutic experience. The correlation between the two evaluations of improvement was significant at the .01 level. In Siegel's review (1965),

she also found that to a great extent, there was an agreement concerning the direction of change among the respondents, the caseworkers, and the researcher.

Harty and Horwitz further suggested that:

> In fact, there is evidence that even when the overall judgments of success coincide, they may be based on very different criteria or frames of reference. (1963, p.975)

Actually, in the study of Feifel and Eells (1963), they found that there were indeed expectancy and conception disparities about therapy between patients and therapists. Their data indicate that therapists stressed changes in symptomatic relief and improvement in social relationships, whereas patients emphasized the opportunity to talk and the "human" characteristics of the therapists more than their therapeutic techniques. This further upholds Riley's contention (1975) that some professional beliefs and techniques may be of minimal value to their clients. In this case, it is important to find out the particular areas that the service recipients consider helpful.

There is really no consistency in the literature as to whether there are consenses or discrepancies between client and worker perceptions of treatment outcome. It is one of the goals of this study to examine client and worker perceptions of treatment outcome to determine if there are consenses or discrepancies in their perceptions. If there are discrepancies, it would be interesting to see if the discrepancies in perceptions have any effect on the treatment outcome.

Variables Affecting Treatment Outcome

It seems that the most frequently reported outcome criteria are the degree of problem amelioration and client satisfaction with

service. This is apparent in the foregoing literature review where rate of improvement was reported in most of the studies. It seems logical to consider that the degree of client satisfaction probably varies directly with the degree of problem amelioration. However, some studies have indicated that this may not be the case. Mcphee, Zusman and Joss (1975) seem to find low improvement rates in their review of studies even though typical high rates of satisfaction were reported. On the other hand, Woodward et al. (1978) found in their study that a low rate of service satisfaction did not necessarily reflect poor treatment outcome, that is, low rate of problem amelioration. The present study will examine client satisfaction in relation to problem amelioration.

The foregoing discussions suggested that the findings of a study of treatment outcome may vary from one evaluator to another, and from the use of one outcome criterion to another. To add to the complexity of the problem, there are many "true" variables which actually affect the outcome of treatment. Researchers and practitioners are trying very hard to isolate these variables with an ultimate goal of improving treatment outcome.

Bergin and Strupp (1972) in their feasibility study for coordinated research for psychotherapy delineated specific variables that may account for the variability of treatment outcome. Their study was an attempt to assess the feasibility of bringing together the effort of individual researchers in order to deal with a phenomenon of such extreme complexity. It is indeed overwhelming, in fact, impossible to examine all the variables in any one study.

Because of this factor, individual researchers have by necessity

> been forced to restrict their efforts to relatively narrow aspects of the larger problem. (Bergin & Strupp, 1972, p.7)

For this reason, only selected variables such as those cited below will be examined in this study.

As mentioned earlier, client characteristics (Segal, 1972), therapist qualities (Bergin, 1963), and their interactions (Gurman and Kniskern, 1978) are considered to be important factors affecting treatment outcome. In addition, service characteristics have received more and more attention from researchers.

Client characteristics such as socioeconomic status, the nature of presenting problems and the degree of client involvement have been examined by researchers in relation to treatment outcome. Dailey and Ives (1978) found that socioeconomic status is related significantly with outcome, but it is not so in Blonde and Murphy's study (1975). Neither Riley (1975) nor Hunter (1979) found "income" a significant variable. Levitt (1971) cited a few studies which showed a tendency of positive association between parental involvement and treatment outcome. Little inference can be drawn from studies that attempted to analyze the relationship between the nature of presenting problems and treatment outcome because there were too many overlaps in the problem categories to allow unambiguous interpretations (Dailey and Ives, 1975; Blonde and Murphy, 1975; Hunter, 1979).

The relationship between the client and the worker is often considered an important interactional variable affecting treatment outcome. It seems that a positive relationship between the client and the worker is related to positive outcome (Feifel & Eells, 1963;

Strupp, Wallach & Wogan, 1964; Siegel, 1965; Riley, 1975; Blonde & Murphy, 1975; Dailey & Ives, 1978; Hunter, 1979). Of course, the qualities of the worker have an important role in engaging the client in a therapy which establishes a positive relationship (Bergin, 1963).

Service characteristics such as the number of interviews and reasons for termination were also studied in relation to treatment outcome in the studies reviewed. Varying results were obtained from these studies. Worthy of note is the tendency for researchers to recommend short-term therapy (Dailey & Ives, 1978; Riley, 1975).

Findings of other researchers act as a guide for further inquiries into the relationship between some variables and treatment outcome. In many circumstances, results of one study cannot be generalized to another study with a different treatment setting, a different client population and different therapist characteristics; it is necessary to continue to study variables that were found to be significant in relation to treatment outcome. The results of the present study may support or contradict findings in the literature; nevertheless, only continual challenge to the existing knowledge will bring new knowledge to the field.

Summary

There has been considerable controversy regarding the effectiveness of treatment and the trend points toward the need for continual research with greater concerted effort and communication among practitioners and researchers. The answer to the question, "Is treatment effective in meeting the needs of the clients?" is inconclusive primarily due to the complexity of the phenomenon, the reliability of reported findings, and the differential selection of

evaluation criteria by the evaluators who hold varying attitudes and commitments towards the subject at hand. Therefore, there is a need to attend to the perceptual variations of the interested parties involved in the evaluation by eliciting both clients' and therapists' assessment of the treatment experience. Finally the variables that affect treatment outcome should also be taken into consideration. From the review of the literature, we shall now proceed to focus on the subject matter of the present study.

CHAPTER III

RESEARCH DESIGN AND METHODOLOGY

This chapter will serve as a guide to the technical approach of this study. It will explain the design of the project and the methods and procedures applied in the study in order to achieve the goals set at the beginning. The organization of this chapter is outlined as follows: the classification of the study, research questions, operational definitions, sample source and sampling method, the method and procedures of data collection, the analysis of data and the limitations of the design and methodology.

The Classification of the Study

Tripodi, Fellin and Meyer (1969) have developed a classification schema for research studies according to the major purpose of research with respect to the seeking of knowledge and in terms of the empirical methods employed to achieve such purposes. Three major categories can be differentiated, namely, experimental studies, quantitative-descriptive studies and exploratory studies. Each category is further refined and divided into several subtypes. Using Tripodi et al.'s classification schema as a guideline, the present study may be considered as a "program evaluation study" within the category of quantitative-descriptive studies. Unlike experimental studies, quantitative-descriptive studies do not use randomization in assigning subjects to experimental and control groups, nor is there the manipulation of independent variables under the experimental

conditions. However, the variables must be amenable to measurement and a systematic collection of data must be provided, thus allowing the study of their quantitative relations. Program evaluation studies are defined as:

> those quantitative-descriptive studies which are concerned with seeking the effects of a specific program or method of helping. Such programs may contain a variety of objectives pertaining to health, education, and welfare. Hypotheses may not be explicitly stated, and they frequently are derived from the objectives of the program being evaluated rather than from theory. (Tripodi et al., 1969, p.41)

It is the purpose of this study to follow up on the clients who experienced treatment at the West End Creche Child and Family Clinic in Toronto, Ontario. Feedback from the clients about their experience will shed light on the effects of the programme. The results of treatment were considered from the perspectives of both clients and workers. No specific hypotheses were explicitly stated, but inquiries were guided by a set of research questions. The research questions were formulated to examine the effectiveness of the programme in meeting the primary objective of the West End Creche, that is, to improve the functioning of disturbed children and to satisfy the needs of their families. In addition, the review of the literature helped to sharpen the focus of the research questions.

Research Questions

As mentioned in the introductory chapter, the overall goals of the present study were essentially threefold in nature: (1) Since there is predominant controversy about the effectiveness of treatment, this study was an attempt to examine retrospectively the treatment programme provided by the West End Creche as experienced by the clients. Two main outcome criteria were selected —— the degree of

problem amelioration and the degree of client satisfaction with the service; (2) knowing that perceptions of the clients and those of the workers may differ, it is important to obtain the two points of view and then compare them in terms of treatment outcome; and (3) a multitude of factors that may relate to treatment outcome are suggested in the literature. In this study, a limited number of variables were selected and their possible associations with treatment outcome were examined.

With these goals in mind, the following research questions were formulated:

A. Does the service provided meet the needs of the families served?

1. To what degree has the service provided ameliorated the clients' problems?

   a) As perceived by the family served?

   b) As perceived by the social worker?

2. What are the specific areas of improvement as reported by the families studied?

3. What is the degree of client satisfaction or dissatisfaction with the Clinic's service?

   a) As perceived by the family served?

   b) As perceived by the social worker?

4. What are the specific areas of satisfaction and dissatisfaction?

5. Is the degree of problem amelioration related to client satisfaction with the service?

B. Comparison of client and worker perceptions:

1. Is there a significant difference or similarity between client

and worker perceptions of the degree of problem amelioration?

2. Is there a significant difference or similarity between client and worker perceptions of the degree of service satisfaction?
3. When there is a significant difference or similarity in the perceptions of service satisfaction, does this associate with the client's evaluation of problem amelioration?

C. What are the variables that relate to the treatment outcome? Do client's socioeconomic status, client's race, the client-worker relationship, the duration of treatment, the frequency of contact, the degree of parental involvement, the nature of the problems and the manner of treatment termination relate to treatment outcome?

Operational Definitions

It is necessary to define some of the terms used in the research questions in order to clarify their meanings within the context of this study. These terms will be defined in the order of their appearance in the research questions.

The service provided includes any professional services rendered to the families that came to the West End Creche Child and Family Clinic. It may be any of the following or a combination of them: the assessment of the child and his/her family by the professional team (usually consisting of a social worker, a child therapist, a psychiatrist, a psychometrist and a speech pathologist); the treatment of the child by one or more professionals; the treatment of the parents or one of the parents by the social worker; the treatment of the family by the social worker; or the referrals made to other appropriate agencies after the assessment.

The needs of the families refer to any problems that are preventing the families from functioning "normally". The source of dysfunction as identified by the parents usually pertains to the functioning and behaviour of a child in the family. In addition, other related problems are also included. It is essential to note that these needs as perceived by the families may differ from the perception of their workers. The needs of those families who participated in the present study can be identified in question 8 of the Worker Questionnaire (Appendix A) and question 19 of the Interviewing Schedule for the client (Appendix B).

The term ameliorated will mean making improvements in or progress with the problems that the families presented. The degree of problem amelioration was measured by two global evaluations: one was given by the social workers in question 17 of the Worker Questionnaire and the other was given by the parents in question 26 of the Interviewing Schedule. A change score was also calculated which was based on the parent responses to questions 19, 20, 21, 23, 24, and 25 of the Interviewing Schedule. The calculations of the change score is explained in Beck (1977, pp.49-52).

The clients' problems refer to the problems presented by a child and the problems experienced by his/her parents. Clients mean both the identified child and the parents. In some cases, clients may also include other family members.

The family refers primarily to the parents of a child treated at the Clinic. Since children treated at the Clinic are usually too young to respond to the questions to be asked, the Interviewing Schedule was designed in such a way that the parents will be the

interviewees even though their children may or may not be present at the interview. Thus feedback of the treatment experience was provided by the parents.

Social workers are the only professionals on the treatment team who were involved in the study. This is because they are the coordinators of the services provided to a family and have the overall view of the family's progress. The Worker Questionnaire contains the response from a social worker.

There are a few areas of improvement examined in the study: changes in the areas that were reported as problem areas by the parents (question 19 of the Interviewing Schedule), changes in the individual members (question 23), changes in family relationships (question 24), and changes in problem coping abilities (question 25).

Client satisfaction was measured by two global evaluation scores: one was based on question 18 of the Worker Questionnaire and the other on question 18 of the Interviewing Schedule. The responses to the two questions given by the worker and the client respectively provided an overall evaluation of the degree of client satisfaction with the services.

Areas of satisfaction include the meeting of the clients' expectations, the client-worker relationship, the availability of the professionals, the degree of understanding and support from the professionals and the extent to which Clinic policies and procedures were problems to the clients. The above areas of satisfaction correspond to the responses given in questions 7, 9, 10, 11, 12, and 13 of the Interviewing Schedule.

The term client and worker perceptions is defined as the assessments given by the client and worker based on their subjective

evaluations of the treatment experience.

Significant difference or similarity in client and worker assessments of the treatment experience was determined by statistical procedures. Those procedures will be identified and explained in the next chapter.

Variables include client demographic characteristics, the client-worker relationship, the duration of the treatment, the frequency of contacts, the degree of parental involvement, the nature of the problems and the manner of treatment termination.

The treatment outcome refers specifically to the change scores.

Socioeconomic status was determined by the occupation of the father of a two-parent family or the occupation of either the father or the mother in a single-parent family. Each family will be scored on the basis of Blishen and McRoberts's socipeconomic index (1976). The socioeconomic index developed by Blishen and McRoberts in fact is a composite score made up of the relative status of an occupation and the income of that particular occupation.

The frequency of contacts refers to the number of face-to-face interviews within a specified period of time. Contacts are not restricted to one particular professional.

The degree of parental involvement refers to the amount of participation of the parents in the treatment of the child and the family. The participation could be in a parent group, or in individual sessions with a professional, or in parent-child sessions, or in marriage and family therapy at the Clinic.

The nature of the problems refers to the presenting problems that were reported by the clients.

The manner of treatment termination can be unilateral whereby the treatment was terminated either by the client or by the Clinic staff. Treatment could also be terminated mutually by both parties.

Sampling Source and Sampling Method

The population under consideration is the group of families who experienced treatment at the West End Creche Child and Family Clinic. Because of the limited time and financial resources of the researcher, a small sample of fifty families was drawn from this population.

Sampling method. Two types of nonprobability sampling were used in combination; they are accidental and purposive sampling. Accidental sampling means that "one simply reaches out and takes the cases that are at hand, continuing the process until the sample reaches a designated size" (Selltiz, Wrightsman & Cook, 1976, p.517). As for purposive sampling, the basis behind it is that:

> with good judgment and an appropriate strategy one can handpick the cases to be included in the sample and thus develop samples that are satisfactory in relation to one's needs. (Selltiz et al., 1976, p.521)

For the present study, the following criteria were used for the selection of cases: (1) only families that had terminated service at the Creche and whose files had been closed were included; (2) cases terminated either after assessment or after treatment were included; and (3) cases whose records showed an address for the client were included. The statistical information of case closures at the Creche is collected quarterly each year. Therefore, it allows the researcher to use quarterly statistics for obtaining cases. The sample was obtained by moving backward from the latest quarterly statistics until the number of cases needed had been secured. This is

to ensure that the most recently closed cases were included. The longer it is between the treatment experience and the time of the follow-up, the harder it is for the clients and the workers to recall the actual experience. This is in fact one of the disadvantages for ex post facto studies. Using the above criteria and sampling procedures, the present sample is made up of cases that were closed between April and September, 1979, inclusive which totalled to just fifty cases.

The Method and Procedures of Data Collection

The instruments of data collection. Two instruments were used for the collection of data: (1) the Worker Questionnaire (Appendix A); and (2) the Interviewing Schedule for the client (Appendix B). A record was also kept on the family members who participate in the interview (husband, wife or both) and the location of the interview.

The Worker Questionnaire. This questionnaire is for collecting information on the families from their respective workers. It is a self-administered questionnaire composed of closed-ended questions to facilitate the task of the workers who filled out the questionnaires. It contains information such as demographic characteristics of the client that were available to the worker, the stage at which the case was terminated, the presenting problems as assessed by the worker, service characteristics, the worker's assessment of the degree of parental involvement, the degree of client satisfaction and the degree of problem amelioration.

The Interviewing Schedule for the client. This schedule was adopted from the questionnaire (Form 27, Rev.) used for the Client Follow-up Study by Family Service Association of America (the 1977

Supplement, Beck, 1977, p.78; see Appendix H for permission from the publisher). Most of the questions were retained, others were slightly modified and a few more questions were added in order to make it relevant for the present study. The Interviewing Schedule is composed of open-ended and closed-ended questions. The Schedule contains information on the source of referral, the initial client motivation and parental involvement in treatment, another question on demographic characteristics to supplement what is available from the Worker Questionnaire, kinds of referral made by the Clinic staff, the degree and areas of satisfaction and dissatisfaction, the presenting problems, community characteristics that caused problems for the clients, the degree and areas of improvement, and the external forces that affect problem amelioration or deterioration.

The procedures of data collection. Each worker whose families were included in the study received a package of the Worker Questionnaire at the beginning of December, 1979 and the last package was returned by the beginning of February, 1980.

A letter of introduction from the Creche (Appendix C) was sent out to each of these families to be included in the research study in December, 1979. This was to inform them of the study, and moreover, to advise them that they would be contacted within a short time for the setting up of interview appointments if they chose to participate. Each family was then followed up by a telephone call to set up an appointment. These families were interviewed either at home or at the Creche. In some cases, only the father or the mother was interviewed; in other cases, both parents were interviewed. Some letters were returned to the Creche since no forwarding address was

available; in other cases, the clients were unable to be reached because they had no telephone or they had moved or changed their telephone numbers. For those families who did not have a telephone and those who had a new number, a covering letter (Appendix D) and the Interviewing Schedule were sent out to the address available, but no response was elicited from these families in the second mailing. During the time of data collection, some employees at Bell Canada were on strike due to labour disputes, thus new telephone numbers for relocated clients could not be obtained through the directory assistance. A total of twenty-nine families out of fifty were actually interviewed. The interviewing process began on January 21, 1980 and was completed by February 10, 1980. The whole process lasted three weeks.

The Analysis of Data

The analysis of data was assisted primarily by the use of the computer and the Statistical Package for the Social Sciences programme (Nie, Hull, Jenkins, Steinbrenner and Bent, 1975). Subprogrammes for frequencies, cross-tabulations, Pearson correlation and non-parametric correlation were used to provide descriptive statistics, two-tailed tests of significance and tests of association.

The presentation of data analysis was organized into six major sections: (1) the comparison of participants and non-participants; (2) the description of participant characteristics and service characteristics; (3) the report on problem amelioration and client satisfaction; (4) the comparison of client and worker perceptions on the treatment outcome; (5) the analysis of the relations between some selected variables and the degree of problem amelioration;

(6) the report on open-ended questions.

The comparison of participants and non-participants. As mentioned earlier, twenty-nine out of fifty families included in the sample participated in the study. Among the twenty-one non-participants, fourteen of them were unable to be contacted and seven of them chose not to participate. The response of the workers about the fifty families provided some information on all three groups. Therefore, the information collected allows the comparison of the three groups: the participants, the uncontacted group and the refusals. By comparison, it helped the researcher to see if they were different from each other and in what way they were different. Tests of significance will be applied so that some inference may be drawn with respect to the self-selection process in operation.

The description of participant characteristics and service Characteristics. This section defines the context in which interpretations of the findings will be made. Since nonprobability sampling procedures do not allow the researcher to make generalizations from the sample to the population, it is essential that the sample characteristics should be specified. This is to avoid confusing the readers and to provide clear guidance for future researchers. Weiss (1972, p.47) pointed out that it is important to specify client characteristics so that one can summarize the information on what works, what does not work, and for whom it works.

The report on problem amelioration and client satisfaction. There were two ratings for problem amelioration. The global rating of problem amelioration which was placed on a five-point Likert scale was given by both clients and workers. The other rating was the

client change score calculated from the response of the client. Client satisfaction rating was also placed on a five-point Likert scale; it was rated by both clients and workers. Areas of problem amelioration and client satisfaction will be summarized in this section.

The comparison of client and worker perceptions on the treatment outcome. The response of each participating family was matched with the response of its respective worker through the use of a code number assigned to each case (family). Thus, the differences and similarities of the two perceptions could be analyzed with respect to the research questions.

The analysis of the relations between some selected variables and the degree of problem amelioration. In this section, some selected variables will be examined in relation to client improvement. However, linkages or associations found between a particular variable and client improvement do not necessarily imply a causal relationship since no precautions were taken to minimize "spurious relationships". The term "spurious relationships" is defined as follows:

> An apparent relationship between two variables, X and Y, is said to be spurious if their concomitant variation stems, not from a connection between them but from the fact that each of them is related to some third variable or combination of variables that does not serve as a link in the process by which X leads to Y. (Selltiz et al., 1976, p.490)

Experimental or quasi-experimental studies (Campbell and Stanley, 1963) could be called for if causal relationships are to be examined. In quasi-expermental studies, a variety of research designs and methods are employed which are essentially "approximations to experimentations". Tripodi et al. considered these studies as a

transition from experimental to quantitative-descriptive studies (1969, p.24).

The report on open-ended questions. A summary of the answers to these questions will be presented in this section.

Limitations of the Research Design and Methodology

Some limitations of the above research design and methodology are apparent and should be pointed out here before the final analysis of the findings:

Related to the sample. Nonprobability sampling does not allow generalizations from the sample to the population:

> In nonprobability sampling, there is no way of estimating the probability that each element has of being included in the sample, and no assurance that every element has some chance of being included.
> Probability sampling is the only approach that makes possible representative sampling plans. It makes it possible for the investigators to estimate the extent to which the findings based on their sample are likely to differ from what they would have found by studying the population. (Selltiz et al., 1976, p.516)

The small size of the sample makes it more susceptible to introducing some bias into the data collected, thus affecting the interpretations of the findings. The presence of the nonparticipating group cuts down the number of responses tremendously. This may become another source of bias.

Related to the research design. Quantitative-descriptive studies do not provide the same kind of rigour as experimental designs which provide randomization of subjects into experimental and control groups. It has been explained earlier that without such controls, one cannot really draw inference from the analysis of data in regard to causal relationships unless approximations to experimen-

tation have been made. This means that strict controls of relevant independent variables which could influence the dependent variables under examination have been made through statistical manipulations. However, there were no such precautions done in the present study.

Related to data collection instruments. Because of the changes made in Form 27, Rev. 2 (Beck, 1977, p.78), the validity and reliability of the instrument established to date may not be applicable to the present study. In addition, some of the items in the schedule were rather complicated. The researcher found that in a few cases, especially for ethnic families whose mother tongue was not English, there were some difficulties for the interviewees to understand the questions. Thus, responses from these families may not be reliable.

Summary

This is a programme evaluation study according to Tripodi et al.'s classification schema. The research project was guided by three major research questions, each of which was operationally defined within the purpose of the study. Using nonprobability sampling, a group of families was selected for interviewing, with the help of an interviewing schedule. Their respective workers also provided information on these families for comparison through the use of self-administered questionnaires. The data collected will be analyzed in the next chapter, keeping in mind the limitations outlined above and with the design and methodology as a frame of reference.

CHAPTER IV

THE ANALYSIS OF DATA

This chapter is a report on the analysis of data and the presentation of the findings. It is divided into six sections:

(1) The comparison of participants and non-participants;

(2) The description of participant characteristics and service characteristics;

(3) The report on problem amelioration and client satisfaction;

(4) The comparison of client and worker perceptions of the treatment outcome;

(5) The report on the relationships between selected variables and the degree of problem amelioration;

(6) The report on open-ended questions.

The first section is particularly important because the results of the comparison between the participants and the non-participants will determine the interpretations of the findings in the sections that follow. From the second section on, the focus will be on the participant group.

The Comparison of Participants and Non-participants

The selected sample of fifty families was divided into three groups: the participant group, the uncontacted group and the refusal group. There were 29 families in the first group (58%), 14 in the second group (28%), and 7 in the third group (14%). Chi-square was

used to determine if the three groups were significantly different from each other. The null hypothesis of no difference would be rejected if the probability level was less than or equal to .05. The three groups were compared on ten variables: the age of the child (the identified patient), the sex of the child, the marital status of the parents, the education level of the parents, the race of the family, the stage at which the service was terminated, the worker assessment of client involvement, worker-client relationship, the degree of client satisfaction, and the degree of problem amelioration. The above information was obtained from the Worker Questionnaire (Appendix A). The results in Table 1 indicate that only two variables were found to be significant at the .05 level in differentiating the three groups, and two other variables were close to the .10 level of significance.

Table 1

Comparison of the Participant Group, the Uncontacted Group and the Refusal Group

Variables	Chi-square values	P
age	13.34667#	.01
sex	.64509	ns
marital status	12.55264	ns
race	2.90434	ns
education	8.28501	ns
stage of service at termination	8.39876#	.02
client involvement	11.56676	.07
worker-client relationship	13.17244	ns
client satisfaction	13.45955	.10
problem amelioration	10.08186	ns

#$P < .05$, $\therefore H_o$ was rejected.

Table 2

Comparison of Participant Group, Uncontacted Group and Refusal Group by Age

Sample groups	Frequencies	Age groups 1-5	Age groups 6-15	Total
participant	29	48.3%	51.7%	58%
uncontacted	14	100.0	0.0	28
refusal	7	57.1	42.9	14
Total	50	64.0%	36.0%	100%

$X^2 = 11.1299$

df = 2

$P < .01$

Age. Age is one of the differentiating variables. The majority of the children in the sample was in the age group 1-5 (Table 2). This is typical of the Creche because only a few older children are accepted for the after school programme. Age groups 6-10 and 11-15 have been collapsed into one group for analysis because only two children fell into the latter category. The uneven distribution in the uncontacted group seems to have contributed most to the variance since all the children of this group were concentrated in the youngest age group and there were none in the age groups 6-10 and 11-15. There was a slight difference between the participant group and refusal group in their distributions in the age groups. The results indicate that the participant group had a comparatively greater number of children in the age group 6-10.

Table 3

Comparison of Participant Group, Uncontacted Group and Refusal Group by Stage of Service at Termination

Sample groups	Frequencies	Stage of service at termination: assessment and treatment	assessment only	Total
participant	29	69.0%	31.0%	58%
uncontacted	13	23.1	76.9	26
refusal	7	71.4	28.6	14
Total	49	57.1%	42.9%	98

χ^2 = 8.39876, df = 2, P = .02

missing observations = 1

Table 4

Comparison of Participant Group, Uncontacted Group and Refusal Group by Worker Assessment of Client Involvement

Sample groups	Frequencies	Worker assessment of client involvement: totally	reasonably	marginally	none	Total
participant	28	25.0%	69.7%	7.1%	0.0%	57.1%
uncontacted	14	14.3	35.7	42.9	7.1	28.6
refusal	7	14.3	71.4	14.3	0.0	14.3
Total	49	20.4%	59.2%	18.4%	2.0%	100.0%

χ^2 = 11.56676, df = 6, P = .07

missing observations = 1

The stage of service at termination. The results in Table 3 indicate that the majority of the uncontacted group terminated their service after the assessment. On the other hand, the participant group and the refusal group were quite similar in their distributions; the majority of them continued their treatment after the assessment. One of the possible explanations for the difficulty in contacting those who came only for the assessment is that: there was a longer time lapse between service termination and the follow-up for those who had come only for the assessment; therefore, there was a greater chance for these clients not to be located at the time of the follow-up.

Client involvement. Although this variable was not significant in differentiating the three groups ($P = .07$), the results in Table 4 indicate that the participant group as a whole was more involved in treatment than the uncontacted group and the refusal group. More clients were rated as marginally involved in the uncontacted group than in the participant and refusal groups.

Client satisfaction with service. Even though client satisfaction with service was not found to be a significant variable in differentiating the three groups ($P = .10$), the results in Table 5 indicate that there was a high concentration of dissatisfied families in the refusal group. In the brief telephone contacts with the families who refused to participate, they voiced their dissatisfactions about their experience at the Creche (comments are provided in Appendix E). The highest degree of client satisfaction was found in the participant group. The lack of feedback from those who were dissatisfied and who refused to participate may have skewed the results

of the study; the final results may appear to be more favourable than they actually should have been.

Table 5

Comparison of Participant Group, Uncontacted Group and Refusal Group by Worker Assessment of Client Satisfaction with Service

Sample groups	Frequencies	Worker assessment of client satisfaction[a] satisfied	neutral	dissatisfied	Total
participant	29	72.4%	6.9%	20.7%	58%
uncontacted	14	35.7	35.7	28.6	28
refusal	7	28.6	14.3	57.2	14
Total	50	56.0%	16.0%	28.0%	100%

[a]The five categories have been collapsed into three; raw figures were used for the calculation of chi-square.

$\chi^2 = 13.45955$, df = 8, $\underline{P} = .10$

Table 6

Distribution of Marital Status of the Participants

Marital status	Frequencies	Percentages
single	0	0.0%
married	21	72.4
divorced	2	6.9
separated	2	6.9
common-law	3	10.3
widowed	1	3.4
Total	29	99.9%

The Description of Participant Characteristics and Service Characteristics.

Participant Characteristics

Among the 29 participant families, 48.3% of them had their children in treatment between the ages 1 and 5, 48.3% between 6 and 10, and 3.4% between 11 and 15. Among the children, 72.4% were male and 27.6% were female. The majority (72.4%) of the parents was married (Table 6). About 48.3% had finished grade eight, and 24.1% had finished grade twelve and thirteen (Table 7). The majority (82.8%) of the families was White; only 10.3% were Black and 6.9% were Oriental.

The income of the families is summarized in Table 8. The mode for family annual income was between $15,000 and $19,999. According to the latest information provided by the Consumer Income and Expenditure Division of Statistics Canada (Statistics Canada, 1979), the low income cut-offs ranged from $4,844 to $14,336 in 1978, depending on the size of the family. It was found that 72.4% of the participant families had an income above this poverty-level, 10.3% were below the poverty-level, and 17.2% did not report their income. The incidence of low income among the families studied was slightly higher than the average incidence in Ontario which was 9.6%. Blishen and McRoberts (1976) categorized families into six classes according to the socioeconomic index that they established. Participant families were categorized according to this index and their socioeconomic status is summarized in Table 9. The results of the categorization will be used as the socioeconomic status of these families for later analysis. The highest concentration of families was found in Class VI, with Class II being the second highest in concentration.

Table 7

Distribution of Education level of the Parent Participants

Education levels	Frequencies	Percentages
grade 8 & under	14	48.3%
grade 9 to 10	2	6.9
grade 12 to 13	7	24.1
university level	2	6.9
graduate level	4	13.8
Total	29	100.0%

Table 8

Distribution of Family Income of the Participants

Income	Frequencies	Percentages
$4,999 & under	1	4.2%
$5,000 - 9,999	3	12.5
$10,000 - 14,999	3	12.5
$15,000 - 19,999	8	33.3
$20,000 - 24,999	1	4.2
$25,000 - 29,999	7	29.4
$30,000 - 49,999	0	0.0
$50,000 & Over	1	4.2
Total	24	99.8%

Note. Total number of participants was 29 with 5 missing observations.

Table 9

Distribution of Socioeconomic Status of Participants

Class — Socioeconomic index		Frequencies	Percentages
I	70+	1	3.4%
II	60.00 – 69.99	7	24.1
III	50.00 – 59.99	3	10.3
IV	40.00 – 49.99	2	6.9
V	30.00 – 39.99	5	17.2
VI	below 30	9	31.0
Total		27	92.9%

Note. There were 2 families that could not be categorized; percentages were calculated with N=29.

Table 10

Client Involvement in Treatment as Assessed by Clients and Workers

Degree of involvement	Client involvement			
	worker assessment		client assessment	
	frequencies[a]	percentages	frequencies	percentages
totally	7	25.0%	14	48.3%
reasonably	19	67.9	10	34.5
marginally	2	7.1	5	17.2
not at all	0	0.0	0	0.0
Total	28	100.0%	29	100.0%

[a]There was one missing value.

Since the majority of the families using the Creche are referrals, the participants in this study were referred from a variety of facilities. The majority (86.2%) of these families did not feel that they were pressured into getting help. On a scale for rating the degree of involvement in treatment, 48.3% of the clients reported that they were totally involved; however, the results of the workers' report indicate only 25% (Table 10).

Service Characteristics

The duration and frequency of treatment. The results in Table 11 indicate that long-term treatment seems to be the mode. The duration of treatment usually lasted from 7 to 12 months, 19 to 24 months, or for more than two years. Those whose treatment lasted from 2 weeks to 2 months seem to belong to the group that came only for the assessment. Furthermore, in most cases (79.3%), clients (child and/or parent) were seen once a week or more; the remaining cases (20.7%) were seen biweekly.

The modalities of treatment. As indicated in Table 12, the client (either a child or a parent) was seen primarily on an individual basis (37.9%). The second most frequently used modes of treatment were the treatment of the couple and group treatment (children and/or parent group). The treatment of parent and child together and the use of conjoint family therapy were comparatively less frequent. However, it should be noted that each modality was not used in the exclusion of other modalities. More than one modality may have been used, but workers were asked to report only the predominant mode of treatment in each case.[1]

[1]This information was obtained from the Director of Social Work and his staff at the Creche.

Table 11

Summary of the Duration of Treatment

Duration	Frequencies	Percentages
2 weeks or less	0	0.0%
2 weeks to 2 months	7	24.1
2 - 6 months	2	6.9
7 -12 months	6	20.7
13--18 months	2	6.9
19 -24 months	6	20.7
more than 2 years	6	20.7
Total	29	100.0%

Table 12

Distribution of the Modalities of Treatment

Modalities	Frequencies	Percentages
individual	11	37.9%
couple	6	20.7
parent and child	4	13.8
group	6	20.7
conjoint family therapy	2	6.9
Total	29	100.0%

Note. Only the predominant mode of treatment in each case was accounted for; in fact, a combination of the above modalities may have been used in a case.

The manner of termination and referrals to other agencies.

There were 51.7% of the cases which were terminated by Clinic staff and 41.4% of which were terminated mutually. Only 6.9% of the cases were terminated unilaterally by the client. The most frequently reported reason for treatment termination was either that the child had reached the age limit of the treatment at the Creche (27.6%) or that treatment appeared to be appropriate in another setting (27.6%). The second most frequently reported reason was that treatment was not warranted at the Creche (20.7%). Since government cutbacks precipitated the termination of the after-school treatment group, 17.2% of the cases were terminated for this reason. The remaining 6.9% were terminated because the parents decided not to continue. At the termination of service at the Creche, some families had to continue treatment somewhere else; therefore, referrals were made to connect families up with other facilities. School placement referrals, particularly in special education, were the most frequent; they made up 27.6% of the referrals. This was followed by referrals to treatment centres for special children (24.1%). Referrals for individual treatment of the child and the counseling of the parents at other settings were the least frequent. Families that were referred to other facilities on termination at the Creche totalled to 68.9%.

The Report on Problem Amelioration and Client Satisfaction

The findings of the first major research question will be presented in this section. The question is: Does the service provided meet the needs of the families served?

Problem amelioration. The results in Figure 1 indicate that

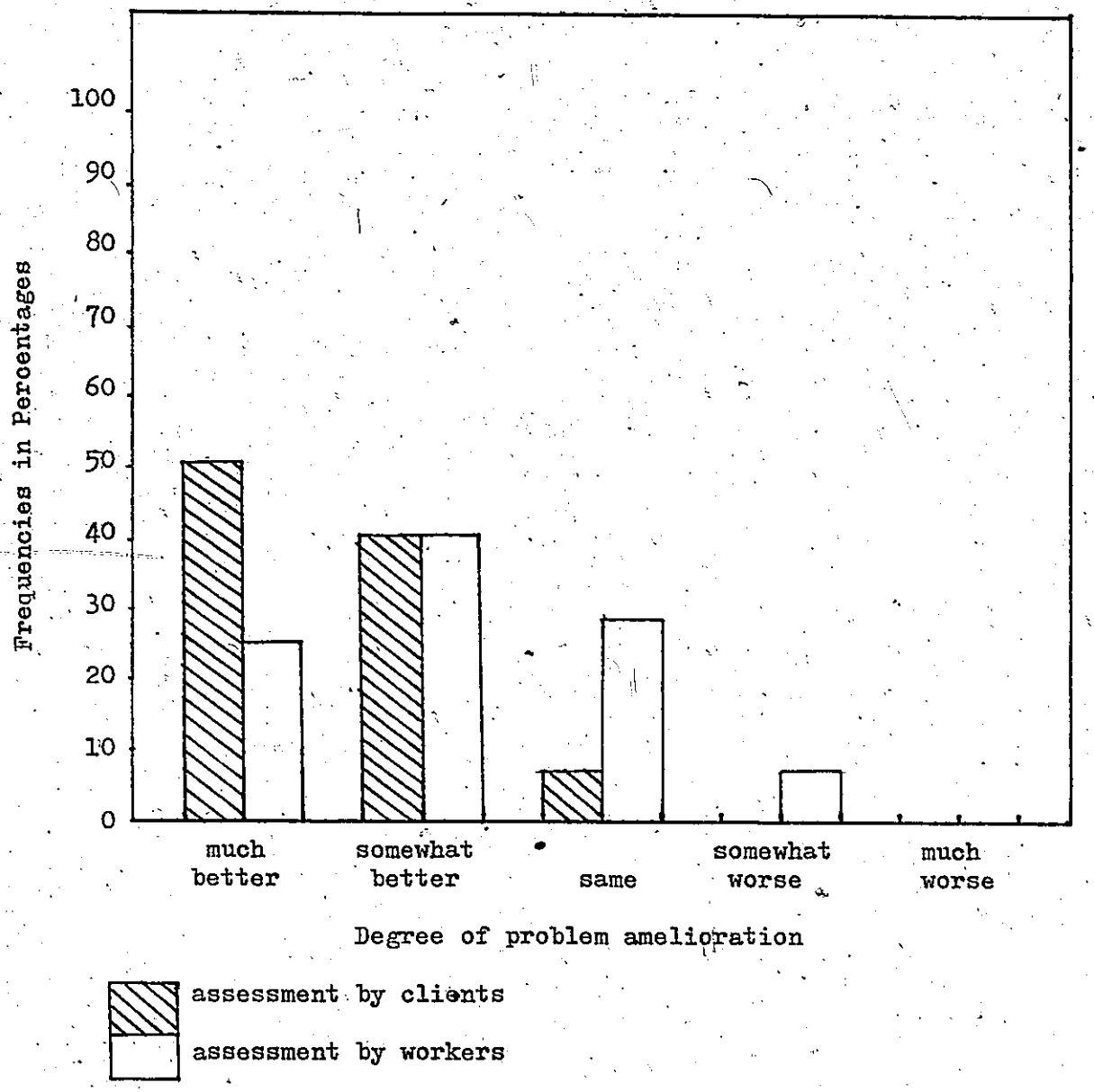

Figure 1. Problem Amelioration as Reported by Clients and Workers.

the majority of the families (93.1%) felt that they have made much or some progress, and none of them reported that their presenting problems have become worse than before they came to the Creche. The degree of problem amelioration as reported by the workers was lower: only 65.5% of the families have made much or some improvement, and the presenting problems of 6.9% of the families have actually deteriorated.

Change scores were also used to measure the degree of problem amelioration. They range from +20.0 to -20.0. Score intervals which correspond to the five degrees of amelioration are presented in Table 13. The results indicate that the change scores obtained by the families were very close to the global evaluations given by the families. About 93% of them received a score within the category of "much better" or "somewhat better". In fact, using Pearson's correlation to correlate the two variables, degree of problem amelioration and change score, Pearson's r yielded a value of .68; a moderate association between them was found to be significant at the probability level of less than .01.

Table 13

Distribution of Change Scores

Score intervals	Frequencies	Percentages
much better (+12.0 to 20.0)	9	31.0%
somewhat better (+4.0 to +11.9)	18	62.0
same (-4.0 to +3.9)	2	6.9
somewhat worse (-12.0 to -4.1)	0	0.0
much worse (-20.0 to -12.1)	0	0.0
Total	29	99.9%

Table 14

Summary of Changes in the Presenting Problems

Types of[a] problems	Frequencies[b]	Degree of problem amelioration				
		much better	somewhat better	same	somewhat worse	much worse
child-focused	81	41.9%	33.3%	23.5%	1.2%	0.0%
relationship problems	16	50.0	31.25	12.5	6.25	0.0
instrumental	3	0.0	33.3	66.6	0.0	0.0
mental and physical health of parents	2	0.0	0.0	100.0	0.0	0.0
others	2	0.0	50.0	50.0	0.0	0.0

[a]Presenting problems have been regrouped into five categories.

[b]Each category has a different N which represents the total count of presenting problems reported by parents under that category. Percentages in each row were calculated on the basis of the different N's.

Specific areas of problem amelioration. Areas of problem amelioration include: changes in the presenting problems, changes in individual family members, changes in family relationship, and changes in problem-solving abilities.

Changes in the presenting problems (Table 14). Only 19 out of the 27 presenting problems were checked off by the clients. The remaining eight items were not considered as a problem by the families. The presenting problems have been regrouped under five categories for analysis: child-focused problems (items 1 - 7 of question 19 of the Interviewing Schedule, Appendix B), relationship problems (items 8 - 10, 17 and 18 of the same question), instrumental problems (items 12, 13 and 16 of the same question), mental and physical

health problems of the parents (items 25 and 26 of the same question), and other problems (items 21 and 23 of the same question). The most common problem reported by the families was child-focused. The parents seemed to focus more on the pathology of the child than on the family as a whole. Child-focused problems and relationship problems had a much higher degree of amelioration when compared to the other categories. It may be speculated that the focus of treatment at the Creche was more on child-focused and relationship problems. On the other hand, parents might not think that it should be the Creche's role to help them with their instrumental problems and other health problems.

Changes in individual family members. There were 60 children altogether for the 29 families. As reported by their parents, 28.3% of the children have made much progress in their individual behaviour; 23.3% of them have made some progress and 48.3% have remained the same. Changes that have occurred with the husband and the wife[1] are also summarized here. Twenty-four percent (6 out of 25) of the husbands made individual changes for the better and 76% remained the same after the treatment. A comparatively higher percentage of individual improvement was found among the wives: 53.5% of them (15 out of 28) reported changes for the better. No individuals considered themselves as having deteriorated in their behaviour.

Changes in family relationship (Table 15). Again none of the families reported that their family relationship has gotten worse since they came to the Creche. As indicated in Table 15, each type of family relationship had about the same degree of improvement.

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[1] Common-law partners are also included.

Table 15

Summary of Changes in Family Relationship

Types of changes	Frequencies[a]	Degree of changes in percentages: much better	somewhat better	same	somewhat worse	much worse
talk over problems, listen to each other, share feelings	14	35.7%	35.7%	28.6%	0.0%	0.0%
handle arguments and work out differences, accept and help each other, pay attention to each other's needs	9	33.3	44.4	22.2	0.0	0.0
feel toward each other	11	45.5	36.4	18.2	0.0	0.0
get along in other ways	2	50.0	50.0	0.0	0.0	0.0

[a]Total counts within an item that was considered by parents as a problem.

Table 16

Summary of Changes in Problem Solving Abilities

Problem solving abilities	Frequencies[a]	Degree of changes in percentages: much better	somewhat better	same	somewhat worse	much worse
the way you feel about your problems	28	32.1%	35.7%	32.1%	0.0%	0.0%
the way you understand your problems	28	35.7	32.1	32.1	0.0	0.0
the kinds of ideas you have on what to do about your problems	27	59.3	33.3	7.4	0.0	0.0
the way you work with others in handling problems	7	57.1	42.9	0.0	0.0	0.0

[a]Total counts within an item that was considered by parents as a problem.

Changes in problem solving abilities are summarized in Table 16. The results indicate that families now have new options in choosing solutions to their problems and are able to use them better with other family members in handling problems. Although there was improvement in their feelings and understanding about their problems, the results indicate that the improvement was not as good as their adjustment to finding concrete solutions to their problems.

Client satisfaction with the service. As shown in Figure 2, 89.6% of the families reported that they were satisfied with the service and 3.4% of them were dissatisfied with the service. Similar to the results of problem amelioration, workers reported a lower degree of client satisfaction (72.4%) and a higher degree of client dissatisfaction (20.7%).

Specific areas of satisfaction. Areas of client satisfaction include: clients' relationship with the professionals, whether or not the service met clients' expectations, the availability of the professionals, and the understanding and support that clients had from the professionals.

Client-worker relationship. Again, as illustrated in Figure 3, clients generally reported a higher degree of satisfaction and a lower degree of dissatisfaction than workers. There were 89.6% of the families who reported that they were satisfied with the relationship in contrast to 72.4% as reported by the workers; 6.8% of the families reported dissatisfaction in contrast to 17.2% as reported by the workers.

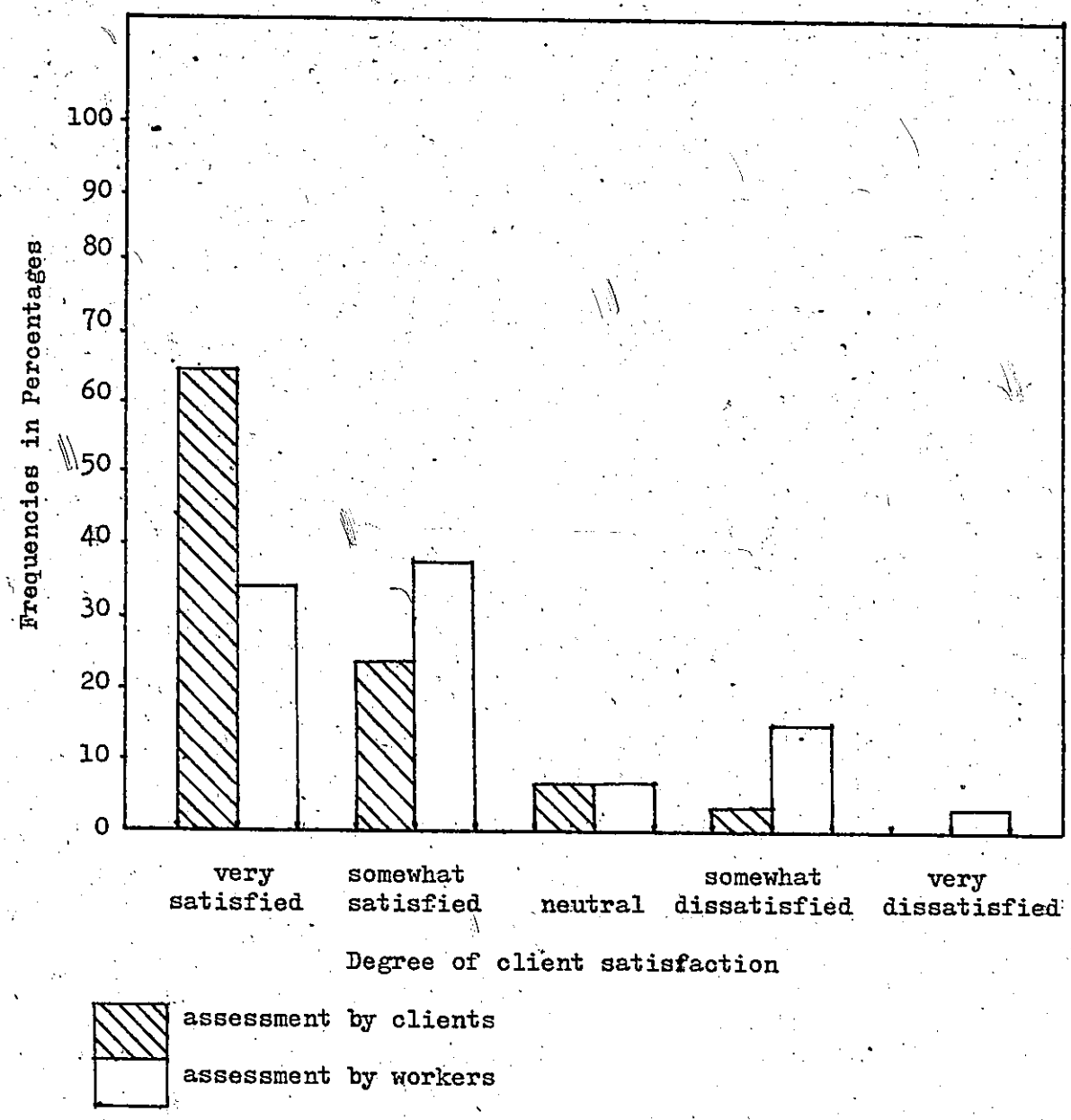

Figure 2. Client Satisfaction with Service as Reported by Clients and Workers.

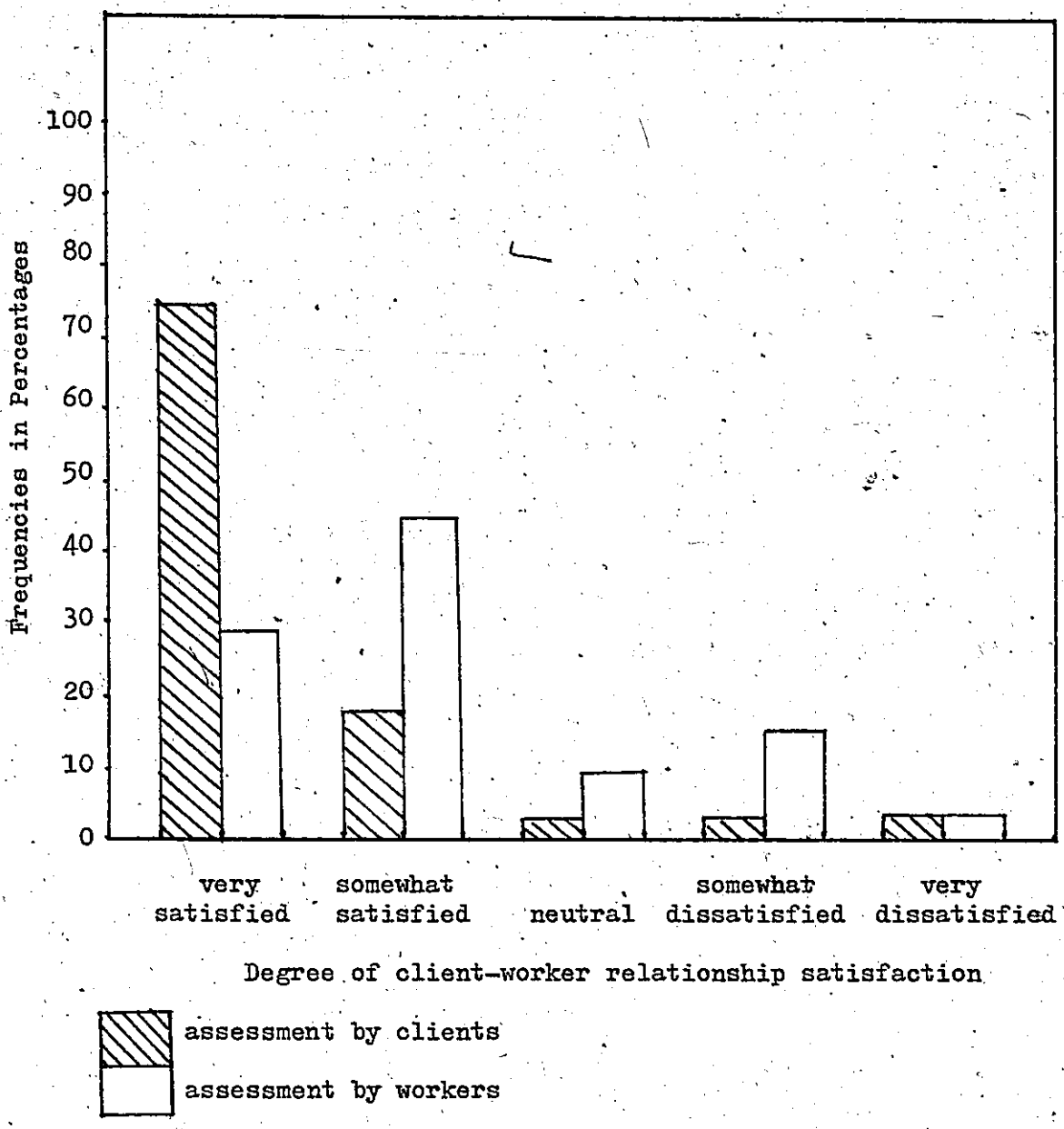

Figure 3. Satisfaction with Client-Worker Relationship as Reported by Clients and Workers.

Service expectations. About 69% of the families felt that the services they received had met their expectations in general, but 27.6% felt that this was not the case. There was one family who did not answer the question. Among those who elaborated on their disappointment, they dwelled mainly on the fact that they expected direct, straight forward answers and advice. One person said that he wanted everything to be in "black and white". On the other hand, another person felt that the staff should be listening more than giving suggestions.

The availability of the professionals. About 86.2% of the families reported that the professionals were always available to them and 6.9% reported that the professionals were available to them most of the time. There were two families who did not answer the question.

The understanding and support from the professionals. About 58.6% of the families felt that they were extremely well understood and supported, but 6.9% felt that the professionals did not show any understanding. About 17.2% felt that they were understood and supported to a great extent, and the remaining 17.2% fell into the "to some extent" category.

The relationship between problem amelioration and client satisfaction. In the literature review (McPhee, Zusman & Joss, 1975; Woodward et al., 1978), it was reported that the degree of client satisfaction did not necessarily associate with the degree of problem amelioration. However, the results in this study did not support the findings in the literature. Spearman's rank order correlation coefficient was used in analysing the data and the test of significance

Table 17

Relationship Between Problem Amelioration and Client Satisfaction
Data Provided by Clients

Degree of problem amelioration	Degree of client satisfaction: very satisfied	somewhat satisfied	neutral	somewhat dissatisfied	very dissatisfied	Total
much better	12[a]	3	0	0	0	15
better	7	3	1	1	0	12
same	0	1	1	0	0	2
worse	0	0	0	0	0	0
much worse	0	0	0	0	0	0
Total	19	7	2	1	0	29

[a]Entries in Frequencies.

ρ = .42, N = 29, P = .025, ∴ null hypothesis was rejected.

Table 18

Relationship Between Problem Amelioration and Client Satisfaction
Data Provided by Workers

Degree of problem amelioration	Degree of client satisfaction: very satisfied	somewhat satisfied	neutral	somewhat dissatisfied	very dissatisfied	Total
much better	6[a]	1	0	0	0	7
better	4	5	1	1	1	12
same	0	4	1	3	0	8
worse	0	1	0	0	1	2
much worse	0	0	0	0	0	0
Total	10	11	2	4	2	29

[a]Entries in frequencies.

ρ = .64, N = 29, P = .001, ∴ null hypothesis was rejected.

was also applied. The results in Table 17 and Table 18 indicate that the null hypothesis of no association was rejected at the probability level of .025 and .001 respectively. Client satisfaction varied directly with problem amelioration. This was true in the assessment of the clients as well as of the workers. In analysing the assessment of the clients (Table 17), it was found that a moderate degree of positive association existed between problem amelioration and client satisfaction. Similar results were found in the assessment of the workers. Therefore, it can be said that when there was a high degree of client satisfaction, there was usually a high degree of problem amelioration and vice versa.

Because of the high degree of client satisfaction and problem amelioration reported by participant families, it can be concluded that, to a great extent, the service provided by the Creche generally met the needs of the families who participated in the study. It may be misleading to generalize this statement to the original sample because there is the likelihood that dissatisfied clients were underrepresented in the participant group. Most of the families who refused to participate in the study gave some negative comments about the Creche; direct quotations are given in Appendix E. In addition, a significant difference was found in age among the three sample groups; therefore, it is more reliable to apply the findings to the older age group of 6 to 10 years old. Finally, because of the high proportion of non-participants who discontinued after the assessment, the findings should be applied only to the group who continued after the assessment.

The Comparison of Client and Worker Perceptions of the Treatment Outcome

The findings of the second major research question will be presented in this section. The purpose was to find out if client perception was different from worker perception of the treatment outcome. Comparisons were made on three variables: the degree of problem amelioration as perceived by the clients and by the workers, the degree of client satisfaction with the service, and the degree of satisfaction with client-worker relationship. The null hypothesis of no difference between the perceptions of the clients and that of the workers was tested on the three variables. A chi-square two-tailed test with the critical probability level at .05 was used.

The degree of problem amelioration. The results in Table 19 indicate that the null hypothesis was not rejected because the probability level was greater than .05. It is concluded that there was no difference in the perceptions of the clients and the workers in this respect.

The degree of client satisfaction with the service. The results in Table 20 indicate that there was a significant difference in the perceptions with respect to client satisfaction. The probability that the results occurred by chance was less than .05. Although the direction of the result cannot be indicated in a two-tailed test, looking at Table 20 carefully, there appears to be a tendency for workers to underrate client satisfaction. There were 14 cases in which workers underrated the degree of client satisfaction, but there were only two cases in which workers overrated the degree of client satisfaction. The results support the findings of Kissel (1974), Dailey and Ives (1978), and Maluccio (1979).

Table 19

Comparison of Client and Worker Perception of the Degree of Problem Amelioration

Client perception	Worker perception: much better	better	same	worse	much worse	Total
much better	6[a]	6	2	1	0	15
better	1	5	5	1	0	12
same	0	1	1	0	0	2
worse	0	0	0	0	0	0
much worse	0	0	0	0	0	0
Total	7	12	8	2	0	29

[a]Entries in frequencies.

$\chi^2 = 5.83$, df = 16, $P > .05$, ∴ null hypothesis was not rejected.

Table 20

Comparison of Client and Worker Perceptions of the Degree of Client Satisfaction

Client perception	Worker perception: very satisfied	somewhat satisfied	neutral	somewhat dissatisfied	very dissatisfied	Total
very satisfied	9[a]	7#	0	3#	0	19
somewhat satisfied	1	3	2#	0	1#	7
neutral	0	1	0	1#	0	2
somewhat dissatisfied	0	0	0	0	1	1
very dissatisfied	0	0	0	0	0	0
Total	10	11	2	4	2	29

[a]Frequencies

#Client satisfaction was underrated by workers.

$\chi^2 = 27.0$, df = 16, $P < .05$, ∴ null hypothesis was rejected.

Table 21

Comparison of Client and Worker Perceptions of Client- Worker Relationship

Client perception	Worker perception: very satisfied	somewhat satisfied	neutral	somewhat dissatisfied	very dissatisfied	Total
very satisfied	8[a]	8[#]	2[#]	3[#]	0	21
somewhat satisfied	0	4	0	1[#]	0	5
neutral	0	1	0	0	0	1
somewhat dissatisfied	0	0	1	0	0	1
very dissatisfied	0	0	0	0	1	1
Total	8	13	3	4	1	29

[a]Frequencies.

[#]Client-worker relationship was underrated by workers.

$X^2 = 47.35$, df = 16, $P < .01$, ∴ null hypothesis was rejected.

The degree of satisfaction with client-worker relationship. As shown in Table 21, a significant difference was found between client and worker perceptions and the probability that the results occurred by chance was less than .01. There also appears to be a tendency for worker to underrate satisfaction. As shown in Table 21, there were about 14 cases where workers underrated the degree of satisfaction, but there were only two cases where they overrated the degree of satisfaction.

Taking the results further, it would be interesting to find out if the difference in perceptions between clients and workers affected the degree of problem amelioration. Since client change score is a composite score of four values, it was used in the analysis by

correlating the difference in perceptions with the change scores. The difference in perceptions was obtained by taking the absolute difference between worker assessment and client assessment of service satisfaction. The results obtained were then analyzed in relation to the change scores through the use of Spearman's rank-order correlation coefficient. A two-tailed test of significance was applied. It was found that the two variables were significantly associated; the correlation coefficient rho had a value of .43 and the probability that the result occurred by chance was less than .05. Therefore, it is concluded that change score was associated with the difference in client-worker perceptions. Unfortunately, it is not possible to observe any direction that the association may take, further exploration will be necessary to make any inference.

The Report on the Relationships Between Selected Variable and the Degree of Problem Amelioration

The findings of the third major research question will be presented in this section. Client change scores were used in studying the relationships between selected variables and problem amelioration. Selected variables to be studied were socioeconomic status, race, client-worker relationship as assessed by the client, the duration of treatment, the frequency of contact, the degree of parental involvement, the nature of the presenting problems and the manner of treatment termination. Because of the extremely uneven distribution of clients among the four categories of race, and because of the small sample size, some categories were too small a group to allow meaningful analysis. Therefore, the variable "race" was deleted from the list. Similarly, since there were 27 categories

for presenting problems, but only 29 families in the participant group, the numbers in each category were too small to allow meaningful analysis; hence, this variable was also deleted from the list.

Spearman rank-order correlation coefficient was used in the analysis of the relationships between the variables and client change scores. The critical probability level of .05 was used for the two-tailed test of significance. It was found that the duration of treatment, the frequency of contact, the degree of parental involvement and the manner of termination were not significantly associated with client change scores. Only two variables were found to be significantly related to change scores; they were socioeconomic status and the client-worker relationship (Table 22).

Table 22

Relationships Between Selected Variables and Client Change Score

Selected variables by change score	N	Spearman Correlation coefficient (ρ)	P
socioeconomic status	27	.51#	.01
duration of treatment	29	.28	ns
frequency of contact	29	.08	ns
degree of parental involvement	29	.09	ns
manner of termination	29	.08	ns
client-worker relationship	29	.99#	.01

Note. The table has to be interpreted with caution since the results were obtained from a small sample where bias may have been introduced. When there was an association between two variables it did not necessarily mean that there was a causal relationship. On the other hand, significant association of other variables may not be readily apparent.

#$P < .01$, $\therefore$ null hypothesis was rejected.

Socioeconomic status. There was a positive moderate association between socioeconomic status and change scores. The correlation coefficient rho had a value of .51 and was significant at less than the .01 level. This means that clients that had a high socioeconomic status was likely to have a high change score and vice versa.

Client-worker relationship. There was a very high positive association between client-worker relationship and change score. The correlation coefficient rho had a value of .99 and was significant at much less than the .01 level. This means that clients who had a positive relationship with their worker was very likely to have a high change score.

The Report on Open-ended Questions

There were a few open-ended questions that can be summarized here: other help received from the Creche besides the most important problem, comments on client-worker relationship, policy and procedures that caused problems, main reasons for changes, Creche's influence in bringing about changes, and additional comments at the end of the interview. A vignette of some of the parents' comments is provided in Appendix F.

Other help received. Responses focused mainly around receiving help on the parents' part, getting the other spouse's involvement, marriage counseling, coordinating with the school placements, making assessment of school placements, and feeling less alone with the help of the parent group.

Comments on worker-client relationship. In general, the comments were positive. Clients reported that the professionals were dedicated, genuinely concerned, understanding and considerate. The clients felt

that the positive relationship helped them to express themselves in the interviews. However, there were two clients who decided that some of the professionals were insensitive and that they did not give enough feedback about their children's progress.

Policies and procedures that caused problems. There was the concern about confidentially. Some of the parents stated that they had demanded that they be allowed to look at their children's records, but they were turned down without getting a satisfactory explanation from the administration. A number of parents suggested that the Creche should publicize their service since it took quite a long time for some clients to finally get to the appropriate facility for treatment. Some found that the facilities were too small and they felt that the Creche should be expanded in terms of space and staff-size. Although the Creche does not have a waiting list throughout the year[1], two families said that they had to wait a few months after the assessment had been completed to enter the treatment programme. In addition, one group programme had to be terminated due to grant discontinuation. As a result, some parents felt that they had been left "high and dry". A number of parents felt that there was a lack of communication and interrelatedness between the children group and the parent group. Furthermore, the investment of time seems to be a common problem; some parents complained about the staff's insistence on the presence and involvement of the parents in the treatment of their children. Finally, the Creche provides services free to all families; one parent felt that they could have paid for the treatment especially when financing the programmes is a problem.

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[1]The information was obtained from the Director of Social Work.

Main reasons for changes and the Creche's influence. Some parents attributed changes to the services at the Creche which provided trained professionals who were kind and encouraging, who gave advice and helped parents understand their problems. Parents who received help for school referrals for their children felt that the Creche had found and made the connections with the right school for their children. Other parents attributed changes to other influences besides the Creche such as the help of the teacher at school, their own hard work in improving the problems, and the gradual maturation of their child.

Additional comments. Some parents felt that it was a great relief when they came to the Creche because moving on from agency to agency was frustrating and discouraging. A number of parents expressed that they wanted to know exactly what the diagnosis and prognosis was; a few of them wanted greater honesty from the Creche about the "bad news", yet two of the parents felt that the professionals were too blunt with them.

Summary

In the analysis of the data, the interpretations of the findings have to be made with reference to the children ages 6 - 10 and to those families that remained in treatment after the assessment.

The majority of the participant families felt that they have made progress and were satisfied with the service. It is therefore concluded that to a great extent the service at the Creche met the needs of those who participated in the study. Combining statistical analysis and the experience of the interviewer, it is felt that dissatisfied clients may have been under-represented.

In comparing client and worker perceptions of the treatment outcome, it was found that workers generally underrated treatment outcome, and they significantly under-estimated client satisfaction.

Finally, results indicate that only two variables were significantly, positively associated with client change scores — they were the socioeconomic status of the family and the client-worker relationship.

From the above analysis and the results of the study, recommendations with respect to the Clinic's service, to social work practice, and to further research will be made in the final chapter.

CHAPTER V

CONCLUSIONS AND RECOMMENDATIONS

The purpose of the study was to examine clients' reactions in retrospect to the service they received at the West End Creche Child and Family Clinic after the termination of service. The research project was designed to answer three major research questions in relation to the purpose of the study: (1) Does the service provided meet the needs of the families served? (2) Are client and worker perceptions of treatment outcome similar or different? (3) What are some of the variables that relate to treatment outcome? To answer these questions, a sample of fifty clients who had terminated treatment at the Creche was obtained for the follow-up. Perceptions of the treatment outcome were obtained from the clients and their respective workers through the use of the Interviewing Schedule for the clients and the Worker Questionnaire. The design of the Interviewing Schedule was based on the Family Service Association of America Client Follow-up Study (Beck and Jones, 1974; Beck, 1977). Twenty-nine out of the fifty clients agreed to be interviewed. Major research findings will be presented below and recommendations based on the findings will be made with respect to the Clinic's service (West End Creche Child and Family Clinic), social work practice and further research in the field.

Major Research Findings

1. The participant families were found to be different from the non-participant families in the age of the identified child and in the stage of service at which treatment was terminated. In comparison to the non-participant families, more children in the participant families were in the age group 6 - 10 and they usually stayed beyond the assessment period.

2. In examining the participant characteristics, it was found that 48.3% of the families had their children in treatment between the ages 1 and 5, 48.3% between 6 and 10, and 3.4% between 11 and 15. There were 72.4% of the children that were male and 27.6% female. The families were predominantly White and 72.4% of the parents were married. The mode for family annual income was between $15,000 and $19,999, about 10.3% of the families were below the poverty level of 1978 as set by the Consumer Income and Expenditure Division of Statistics Canada (Statistics Canada, 1979). The majority of these families were referred to the Creche by other facilities. The families usually entered treatment voluntarily, with about half of them feeling that they were totally involved in the treatment of their children.

3. The kinds of services received by the families were usually long-term, ranging from seven months to more than two years. Seventy-nine percent of the clients were seen once a week or more. The most frequent mode of treatment was on an individual basis, followed by treatment of the couple and group treatment for children and parents. Parent-child interviews or conjoint family therapy were least frequently used. Just over half of the cases were terminated by Clinic

staff, about two-fifths of them were terminated mutually, and only a small number was terminated unilaterally by the client. At service termination, about 69% of the families were helped in being connected with other facilities. Most referrals were school placements in special education.

4. The findings of the first major research question supported the fact that the Creche's services were effective in meeting the needs of the participant families: over 90% of the families felt that they had made much or some progress and almost 90% of them were either very satisfied or satisfied with the service. Areas of progress included positive changes in the presenting problems, individual family members, in family relationships and in their problem solving abilities. Areas of satisfaction included client's relationship with the professionals, meeting client's expectations, and the availability, support and understanding of the staff. Furthermore, it was found that the degree of client satisfaction and problem amelioration were positively associated.

5. The findings of the second major research question indicated that there was no significant difference between client and worker perceptions of problem amelioration. However, there were significant differences found in their perceptions of client satisfaction with the service and client satisfaction in their relationship with the professionals. In both cases, it appeared that the worker had a tendency to underrate client satisfaction. Furthermore, the difference in perceptions was found to be associated with change scores even though the direction of the association could not be determined.

6. For the third major research question, attempts were made to

examine the relationship between six selected variables and change scores. The variables included were socioeconomic status, client-worker relationship as assessed by the client, the duration of treatment, the frequency of contact, the degree of parental involvement, and the manner of treatment termination. Only two variables were found to be significantly associated with change scores: socio-economic status and client-worker relationship. It was concluded that clients that had a high socioeconomic status were likely to have a high change score and vice versa. Also, clients that had a good relationship with their workers were very likely to have a high change score.

7. Parents had made invaluable suggestions and comments which will not be repeated here, but will be addressed in the recommendations to be followed.

Recommendations

Relevant to the Clinic's Practice

Although emphasis on the involvement of the parents is stressed, there is a need for an increase in communication between the parents and the child by increasing parent-child sessions. The need to increase parent-child sessions was quite evident in the complaints from some of the parents about the lack of feedback on the treatment of their children and also in the workers' reports which indicated that the most frequently used modality was the individual session. By involving the parents and the child together, it may increase the interests of the parents to get involved.

Many families had gone through numerous treatment facilities before they came to the Creche as a referral. From parents' feedback,

there should be publicity of the kinds of services offered by the Creche. While the philosophy is catching problems earlier and helping children in need of treatment when they are young, the loss of time by going through inappropriate agencies is critical to the development of a child. For this reason, facilities that have direct contact with young children such as nurseries, daycare centres, schools and family physicians should be made aware of the services of the Creche. Publicity should even be extended to the general public. Increased demand for service does pose a problem to the Clinic in terms of staffing and limited funding, but it should not be the rationale for limited publicity; this leads to the next recommendation.

As pointed out at the beginning, this was an initial approach in examining the effectiveness of the programme to provide a data base for further development. Although there is on-going clinical follow-up done at the Creche, the results are known mainly to the worker who does the follow-up. There is a need for documentation of the effects of the programme. As the findings of the study indicated, there are reasons to believe that the Clinic has been of service to the clients. Although generalizations are not possible at this initial stage, on-going documentation of the quality of the service may in turn facilitate increase funding.

Finally, it appears that there are parents who are willing to and more than able to pay for the service. A fee-for-service system — according to the ability to pay — or thoughts along those lines may worth some consideration. Perhaps donations should be encouraged.

Relevant to Social Work Practice

Consistent under-estimation of client satisfaction and the

association between perceptual difference — the difference in perception between clients and workers — and change scores act as indicators of the importance of some social work practice process.

Wood (1978) in her report reviewed "six principles of 'quality practice'" which include: (1) the accurate definition of the problem which must be measurable; (2) the analysis of the problem within the contexts of the client's intrapersonal, interpersonal, and social systems; (3) the assessment of the problem's workability; (4) the negotiation of a contract with the client; (5) the planning of intervention strategies with the client; and (6) the ongoing and final evaluations in terms of the original definition of the problem and the contracted goals. Following this process of social work interventions, it reduces, if not eliminates, the possibility of over-estimation or under-estimation of the final outcome of treatment. Both the worker and the client have to know the specific explicit goals of treatment in order to achieve goals and to measure accurately the outcome of treatment.

The positive association between socioeconomic status and change scores is disturbing. Although their causal relationship could not be established from the analysis of the data, attention should be given to clients of low socioeconomic status so that they do not lose out in the process of treatment. Frank, Eisenthal and Lazare (1978) suggested that middle-class therapists enter treatment with class-linked preconceived notions about what their lower-class clients need, expect and want out of the treatment and then treat them accordingly and differently from what they would with their middle-class clients. Frank et al. contended that in order to minimize treatment biases

against lower-class patients and to maximize treatment effectiveness with middle- and upper-class patients, the therapists should be:

> freed of stereotyped notions about class-linked treatment conceptions, therapists should be more able to consider a broader range of treatment options for patients from all social classes...therapists need to be encouraged to begin where the patient is at....By encouraging the patient to voice his treatment preferences, the therapist not only promotes the patient's sense of autonomy and self-esteem, but cements the formation of a therapeutic alliance, and learns what treatment the patients will be most likely to accept. (Frank et al., 1978, p.68)

Lower-class clients have less resources than middle- and upper-class clients; thus, they have less options for treatment. A broader range of treatment options for lower-class clients in particular should be considered as a means to improve their chances of problem amelioration.

The positive association between client-worker relationship and change scores supports the importance of a positive relationship between the client and the worker. Comments from the families relating to the human touch of warmth and understanding from the workers support what clients value in treatment. Although causal relationship between the two variables could not be established in the study, reviews in the literature suggested that positive client-worker relationship is at least a facilitating factor in treatment which helps to engage clients in therapy. Fiester (1974) studied early psychotherapy termination concluded that a satisfying relationship plus successful outcome during the first session was necessary and sufficient to avoid termination (p.105). Bergin and Strupp (1972) also considered that positive client-worker relationship was an important factor in treatment; however, they suggested that a positive relationship could not be regarded as the sole factor determining therapeutic outcome. The study of causal effects between client-

worker relationship and treatment outcome is a research project by itself, therefore, it cannot be dealt with in a fair manner here. Further exploration is deemed necessary.

Continuity of service stands out as an important component of good social work practice as clients repeatedly emphasized the facilitative effect of being helped in getting connected with services in the community for re-integration.

Relevant to Further Research

The research project was an attempt to evaluate the programme of a child and family clinic. Being a one-person student project under time and financial restraints, there were many limitations to the study.

The size of the sample was extremely limited primarily due to the fact that face-to-face interview is time-consuming; without collaborative effort, a larger sample size is inconceivable. However, personal interviews furnish an in-depth understanding of the clients' experience. One has to weigh the pros and cons between the need for quality and the need for quantity in collecting information. Many invaluable comments given by clients might not have been elicited in a self-administered questionnaire where open-ended questions have a higher chance to be ignored. For on-going monitoring of the quality of a programme, it is preferable to obtain as many responses as possible with a less costly device through the use of a self-administered questionnaire. It will certainly give a general idea of the degree of client satisfaction. However, should there be a felt need that the programme be modified, personal interviews are preferable. A collaborative effort using more interviewers is warranted to give

the study a broad coverage, thus increasing the reliability and validity of the results of the study.

The lack of control in the study to minimize extraneous variables is another area that needs improvement. A no-treatment control group is difficult to obtain in human research; however, repeated measurements done at regular intervals such as before-and-after treatment and follow-up efforts can be utilized. This could best be carried out by making the study effort a built-in operation of the agency or clinic. With effective controls, one may begin looking at causal factors between variables.

One interesting point that should be raised before closing is: who is to judge the outcome of a programme? From whose point of view can one say that a person has benefitted from the programme? In the study, the outcome of the Clinic's programme was evaluated by the Clinic staff and the clients because different kind of measurements may be used to check the reliability and validity of the results. However, Strupp and Hadley (1977) raised another important point in the use of the different measurements. They suggested a "tripartite model" for the evaluation of outcome for the reason that the results of the evaluation may differ depending on who is making the evaluation. Hadley and Strupp took into consideration three major "interested parties" that should be included: (1) society (including significant persons in the patient's life); (2) the individual patient; and (3) the mental health professional (1977, p.188). For a comprehensive study of treatment outcome, Strupp and Hadley's conceptual model is a useful one for conducting future studies. At the beginning, the professional, social and political contexts of the research project was outlined; using the tripartite model, one will get close to become

answerable to those needs for research in treatment outcome.

APPENDICES

APPENDIX A

West End Creche Child and Family Clinic
A Follow-up Study of Closures

Questionnaire For the Social Workers

Study Number _____ Last worker before closing _____

Case Name _____

Circle your answers unless otherwise specified.

1. Age of identified patient _____ 2. Sex of identified patient: M/F

3. Marital status of parent/guardian:
   1. single 3. divorced 5. common-law
   2. married 4. separated 6. widowed

4. Highest school grade completed by family head:
   ("family head" must be a person living with the family and is the person generally considered to be the head of the family itself.)

   0 1 2 3 4 5 6 7 8 9 10 11 12 13 University 1 2 3 4 5

5. Occupation of the head of household:
   1. Professional and technical work
   2. Managerial and technical work
   3. Sales workers
   4. Clerical workers
   5. Craftsmen and kindred work
   6. Operatives
   7. Service workers
   8. Art and recreational
   9. Labourer
   10. Other

6. Race of family head:
   1. Caucasian
   2. Negro
   3. North American Indian
   4. Other (specify _____)

7. Did service continue after the assessment period? 1. Yes 2. No

8. What problem received the most agency attention or service? Rank order them if there is more than one. ("1" being the problem that received the most attention.)
   __ Raising children, taking care of their needs, discipline, etc.
   __ Child is a slow learner.
   __ Child has difficulties with feeding, sleeping, toilet training.
   __ Child has speech, vision, hearing or coordination problems, disturbing thoughts and dreams.
   __ Disruptive behaviour of child.
   __ Social withdrawal of child.
   __ Other health problems of child (physical illness, handicap).
   __ Problems between husband and wife (or common-law partners).
   __ Problems between parents and children (child under 18).
   __ Problems between other family members (siblings, extended family, etc. Specify _____).
   __ Taking care of house, meals - household management.
   __ Housing problems.

__ Managing money, budgeting, or credit.
__ Not enough money for basic family needs.
__ Being unemployed or in a poor job.
__ Doing poorly at work or having trouble holding a job.
__ Trouble handling emotions or behaviour (parent or child? Specify _____).
__ Problems in social contacts or use of leisure time. (parent)
__ Doing poorly or misbehaving in school (any child in the family).
__ Drinking too much (parent or child? Specify _____).
__ Taking drugs (parent or child? Specify _____).
__ Unwed parenthood (parent or child? Specify _____).
__ Legal problems (such as divorce, custody, rent, bills, etc., not involving crime).
__ Getting in trouble with the law (parent or child? Specify _____).
__ Health problems, physical illness, or handicap (excluding the children).
__ Mental illness (parent).
__ Mental retardation(parent).

9. Frequency of face-to-face contact of this case with all professionals:
   1. once a week or more
   2. twice a month
   3. once a month
   4. once every 3 months

10. Duration of contact:
   1. 2 weeks or less
   2. 2 weeks to 2 months
   3. 2-6 months
   4. 7-12 months
   5. 13-18 months
   6. 19-24 months
   7. more than 2 years

11. What was the predominant treatment modality for this family?
   1. individual
   2. treatment of the couple
   3. parent and child
   4. group
   5. conjoint family therapy (all members included)

12. Who were the Clinic professionals involved?
   1. social worker
   2. child therapist
   3. psychometrist
   4. psychiatrist
   5. speech pathologist
   6. teacher
   7. other _____

13. In your opinion, how satisfied was this family in their relationship with the professionals in the Clinic?
   1. very satisfied
   2. somewhat satisfied
   3. no particular feelings one way or the other.
   4. somewhat dissatisfied
   5. very dissatisfied

14. How involved were the parents/guardians?
   1. totally involved
   2. reasonably involved
   3. marginally involved
   4. not involved

15. Why do you think the family stopped coming to the Clinic?

_____

16. Who decided to discontinue treatment?
   1. clients 2. Clinic staff 3. Both 4. Other _____

17. Considering all members of the family and all problems you had worked with the family, what is your perception of the total outcome?
   1. much better
   2. somewhat better
   3. unchanged
   4. somewhat worse
   5. much worse

18. In your opinion, to what degree was the client satisfied with the the service provided?
    1. very satisfied
    2. somewhat satisfied
    3. no particular feelings one way or the other
    4. somewhat dissatisfied
    5. very dissatisfied

Please make sure you have answered all the questions.

THANK YOU VERY MUCH FOR YOUR PARTICIPATION IN THE STUDY.

APPENDIX B#

A Follow-up Study at the West End Creche Child and Family Clinic

Since you recently have been to our Clinic, we are eager to know whether the service you received from the Clinic was helpful or not and in what ways. Your opinions are important to us. If you have been to the Clinic before this last contact, please tell us about your most recent period of service. Check here for more than one contact ____.

1. Who referred you to the Clinic?
   1. self
   2. psychiatrist
   3. other clinical practitioner
   4. mental health facility
   5. mental retardation facility
   6. general hospital
   7. CAS or CCAS
   8. educational facility
   9. court facility
   10. public health nurse
   11. other (daycare, etc.)

   If not self-referred, did you feel pressured by the referring source to seek help from the Clinic? 1. Yes 2. No

2. Were you working at the time when you came to the Clinic? 1. Yes 2. No
   What type of work did you do? _____

3. What was the total family income, before tax, during the last full year? _____

4. a) What was the most important problem that brought you to the Clinic? _____

   b) To what degree was this problem solved?
   1. ____ Yes, completely
   2. ____ For the most part
   3. ____ Some part
   4. ____ Made no progress
   5. ____ Situation worse

5. Did the Clinic help you with any other problems?
   _____

   To what degree was this problem solved?
   1. ____ Yes, completely
   2. ____ For the most part
   3. ____ Some part
   4. ____ Made no progress
   5. ____ Situation worse

6. Did they suggest some other place where you might go for help?
   1. Yes 2. No
   If Yes, where? _____
   Did you go? 1. Yes 2. No
   Was this place helpful to you? 1. Yes 2. No 3. Don't know yet

7. Was there any kind of service or help you expected or needed from the Clinic that you didn't get? 1. Yes 2. No
   If yes, what was it? _____

8. a) In what way were you and your child seen at the Clinic?
   1. child seen alone
   2. one parent seen alone
   3. two parents seen together
   4. parents and child seen together
   5. child in group with other children
   6. parents in group with other parents
   7. child, parents and other members of the family seen together.

#Reproduced from How to Conduct a Client Follow-up Study and Supplement (1977) by Dorothy F. Beck and Mary A. Jones, with permission from Family Service Association of America, publisher. (modified)

8. b) Which of the above ways did you find most helpful in solving your problems? _____

9. In general, how satisfied were you with the way you and the professionals got along with each other?
   5. very dissatisfied
   4. somewhat dissatisfied
   3. no particular feelings one way or the other.
   2. somewhat satisfied
   1. very satisfied
   Please tell us why you felt this way.
   _____

10. Did the professionals make themselves available when you needed them?
    4. rarely
    3. sometimes
    2. most of the time
    1. always

11. To what degree did you feel understood and supported?
    4. not at all
    3. to some extent
    2. to a great extent
    1. extremely well

12. Did you feel that you understood what the Clinic was doing to help your child and you? 1. Yes 2. No

13. Was there anything about the Clinic or its programme or policies that made problems for you or your family, such as having to wait, distance to the Clinic, appointment hours, having to change to new workers, having too many professionals involved, etc.
    1. Yes 2. No If yes, what was it? _____

14. How involved were you able to be with the treatment programme?
    4. not involved
    3. marginally involved
    2. reasonably involved
    1. totally involved

15. What was your reason for discontinuing treatment?
    _____
    _____

16. Who decided to end treated?
    1. self
    2. Clinic staff
    3. both
    4. other _____

17. Would you consider going back to the Clinic again if you needed help in the future?
    1. Yes 2. No

18. In general, how did you feel about the services of the Clinic?
    5. very dissatisfied
    4. somewhat dissatisfied
    3. no particular feelings one way or the other
    2. somewhat satisfied
    1. very satisfied
    Any comment? _____

The questions following ask about problems that you and your family had when you came to the Clinic.

19. When people come to the Clinic, they may have some of the following problems. Please go through the list and tell us whether you or any other members of your family have any of the following problems when you first came to the Clinic.

TYPES OF PROBLEMS	MUCH BETTER	SOMEWHAT BETTER	SAME	SOMEWHAT WORSE	MUCH WORSE
1) __ raising children, taking care of their needs, discipline, etc.					
2) __ child is a slow learner.					
3) __ child has difficulties with feeding, sleeping, toilet training.					
4) __ child has speech, vision, hearing problems, disturbing thoughts and dreams.					
5) __ disruptive behaviour of child.					
6) __ social withdrawal of child.					
7) __ other health problems of child (physical illness or handicap).					
8) __ problems between husband and wife, or common-law partners.					
9) __ problems between parents and children.					
10) __ problems between other family members (who? _____).					
11) __ taking care of house, meals, etc.					
12) __ managing money, budgeting, or credit.					
13) __ doing poorly at work or having problem holding a job.					
14) __ being unemployed or in a poor job.					
15) __ not enough money for basic family needs.					
16) __ housing problems.					
17) __ trouble handling emotions or behaviour (parent or child).					
18) __ problems in social contacts or use of leisure time.					
19) __ doing poorly or misbehaving in school (other children).					
20) __ unwed parenthood (parent or child?).					
21) __ legal problems (such as divorce, custody, rent, bills, etc., not involving crime).					
22) __ drinking too much (parent or child).					
23) __ taking drugs (parent or child?).					
24) __ getting in trouble with the law (parent or child?).					
25) __ health problems, physical illness, or handicap (parent).					
26) __ mental illness (parent).					
27) __ mental retardation (parent).					

20. Now go back and circle the check for the most important problem you wanted help with.

21. For each problem you checked in question 19, please tell us whether the problem is now MUCH BETTER, SOMEWHAT BETTER, THE SAME, SOMEWHAT WORSE, MUCH WORSE compared when you first came to the Clinic. The change could be either in the problem itself, or in the way you handle it now, or in how easy or hard it is to live with.

22. Sometimes neighbourhood and community conditions cause problems for families. Was any of the following a problem for you or your family when you come to the Clinic. Please tell us all that were a problem.

1. poor job opportunities
2. poor or no job training opportunities
3. poor schools
4. run down neighbourhood
5. unsafe neighbourhood
6. heavy drug use in area
7. poor police protection
8. unfair credit resources
9. poor health resources
10. no day care centres for children
11. no home care services for aged or sick
12. inadequate legal help
13. discrimination (racial, ethnic, religious, etc.)
14. poor recreational opportunities
15. poor or costly transportation
16. other conditions (what? _____)

____ NO COMMUNITY SITUATIONS WERE A SERIOUS PROBLEM FOR OUR FAMILY. (skip to question 23)

Did the Clinic try to help you with any of these problems?
1. Yes 2. No If YES, how? _____

Was what they did helpful to you and your family? 1. Yes 2. No

23. List below all members of your family, including yourself, regardless of whether they were seen at the Clinic. Do not use names, but give their relationship to the head of your family and their age.

Persons 18 or over

RELATIONSHIP (husband, wife, common-law, etc.)	MUCH BETTER	SOMEWHAT BETTER	SAME	SOMEWHAT WORSE	MUCH WORSE
_____	___	___	___	___	___
_____	___	___	___	___	___
_____	___	___	___	___	___

Persons under 18

RELATIONSHIP (son, daughter, niece, etc.)					
_____	___	___	___	___	___
_____	___	___	___	___	___
_____	___	___	___	___	___

For each person you have listed, please tell us in terms of his or her behaviour, attitudes, feelings or ability to handle problems, whether they are MUCH BETTER, SOMEWHAT BETTER, THE SAME, SOMEWHAT WORSE, MUCH WORSE, since service with the Clinic began.

THE FOLLOWING QUESTIONS DEAL WITH FAMILY RELATIONSHIPS

24. People who have been to the Clinic sometimes find that, regardless of what they came for, there are changes in how the members of the family get along together. Would you say that since you started at the Clinic, there has been any change in the way members of your family —

	MUCH BETTER	SOMEWHAT BETTER	SAME	SOMEWHAT WORSE	MUCH WORSE
1) Talk over problems, listen to each other, share feelings...	___	___	___	___	___
2) Handle arguments and work out differences. Accept and help each other, pay attention to each other's needs.....	___	___	___	___	___
3) Feel toward each other (how close and comfortable, how you enjoy each other).....	___	___	___	___	___
4) Did you find that treatment at the Clinic affected your sexual relationship.....	___	___	___	___	___
5) Get along in other ways (how? _____).....	___	___	___	___	___

THE FOLLOWING QUESTIONS DEAL WITH THE WAY YOU HANDLE PROBLEMS.

25. When people work on their problems at the Clinic, they sometimes find that there is a change in how they feel about those problems and the way they handle them. If you have discussed any problems with the Clinic, would you say that you personally have noticed since then any change for the better or worse in —

	MUCH BETTER	SOMEWHAT BETTER	SAME	SOMEWHAT WORSE	MUCH WORSE
1) The way you feel about your problems (how worried, overwhelmed, angry, confused, guilty, etc.).....	___	___	___	___	___
2) The way you understand your problems (what they are, who or what contributes to them).	___	___	___	___	___
3) The kinds of ideas you have on what to do about your problems (what should or should not be tried).....	___	___	___	___	___
4) The way you work with others in handling problems (talk things over instead of fighting or avoiding, etc.).....	___	___	___	___	___

Since coming to the Clinic, have you actually —
made any decisions on what to do about your problems? 1. Yes 2. No
taken any specific action on your problems? #1. Yes 2. No

If you have taken some action, did this turn out to —
1. help greatly
2. help somewhat
3. make no difference
4. make things somewhat worse
5. make things much worse

APPENDIX D

West End Creche
Child and Family Clinic

February 7, 1980.

Dear:

Recently we sent out a letter inviting you to take part in a follow up interview on your experience with the Creche. Since our researcher, Miss Helen Wong, has not been able to reach you by telephone, we are sending you a questionnaire as an alternative to get feedbacks from you about the services that you received from the Creche.

Participation in this study is voluntary. We hope very much that you will decide to share your opinions in this way so that we may benefit from your experience with our Clinic. Your response will be kept strictly confidential and your name will in no way be attached to you answers.

Please find enclosed a stamped, self-addressed envelope and send the questionnaire in before February 16, 1980.

Your help in this study will be greatly appreciated.

Sincerely yours,

P. W. Dodd per HW

Paul W. Dodd, M.S.W., ACSW
Director of Social Work

PWD/hw
encl.

Accredited by the Canadian Council on Hospital Accreditation
A Registered Charitable Organization
Established in 1909
Licensed and Funded by the Ontario Ministry of Community and Social Services

West Branch
Burnhamthorpe School
3465 Golden Orchard Drive
Mississauga L4Y 3H7
Phone (416) 625-7517

Scarborough Branch
Fairmount Public School
31 Sloley Road
Scarborough, M1M 1C7
Phone (416) 264-4367

Central Branch
197 Euclid Avenue
Toronto M6J 2J8
Phone (416) 868-1827

APPENDIX E

Some of the clients who refused to participate in the study gave the following comments:-

"We are finished with you people."

"It was too far to go and I had to travel too frequently...I'm still looking for help."

"We had sent a letter to the Creche and to the Ministry."

"The diagnosis was a blow in the face!"

"It's just wasting your time. The book is closed as far as that is concerned."

"It's the agency most unwilling to listen to what people have to say."

APPENDIX F

QUOTATIONS OF CLIENTS' COMMENTS#

"I think the Creche made the wrong diagnosis, I don't see those signs in my child. I am worried about his records later on when he grows up."

"They were using big words that scared me. I couldn't understand them. The distance that I had to travel was a real problem."

"They talked about confidentiality. We did not get a good explanation with respect to looking at our records. There was a lack of feedback about the progress of our child."

"It was a relief not having to go anymore (regarding group meetings) I wish they were more honest about what they didn't know. Parents do not want an over-simplification of matters. They were afraid to say too much to you, afraid that you couldn't handle it."

"I don't want to believe that he doesn't belong to the programme at the Creche."

"They should have given the parents a chance to see what's going on in the children's group."

"They were doing a lot of talking, we wanted more actions. It's a waste of energy."

"I wish they had greater honesty about the bad news, something that can't be fixed. When we learned about it later on from someone else, it came as a major shock."

" I wanted to be more involved, but they seem to be backing off. They seem to be offended when I questioned their competency."

"If it weren't for the Creche, we wouldn't be able to get the right kind of treatment; they recommended the right place."

"It needs to be publicized more."

" They've got the people who are qualified, they should put an article in the paper or have someone from the T.V. network to interview them for publicity. We had never heard of the Creche until we got referred."

"It was the best thing that happened; they were very good with helping the kids."

" We were very upset before we went to the Creche. It's an excellent service. It's terrific to have programmes open to the general public. We could have paid something."

"I learned a lot from other parents, found out how they were coping. We thought we were in good hands, we were more trusting."

"They are the top, we are favourably impressed. They are experienced and competent....If any assessment has to be done, it should be carried out there."

#The above quotations may have been modified to ensure anonymity.

APPENDIX H

FAMILY SERVICE ASSOCIATION OF AMERICA
STRENGTH TO FAMILIES
44 EAST 23RD STREET
NEW YORK, NEW YORK 10010
(212) 674-6100

April 1, 1980

Ms. Helen Wai Chu Wong
278 Roywood Drive
Don Mills, Ontario
CANADA M3A 2E6

Dear Ms. Wong:

You may consider this letter permission to reproduce the following material from How to Conduct a Client Follow-Up Study and the 1977 Supplement, for a follow-up study which you are conducting.

Form 27, Rev.2, on page 78

Letter of introduction preceding client interviews, on page 38

Acknowledgment should read as follows: Reproduced from How to Conduct a Client Follow-Up Study and Supplement (1977) by Dorothy Fahs Beck and Mary Ann Jones, with permission from Family Service Association of America, publisher. Additional copying/duplicating of this material (mechanical, electronic, or duplicating) is prohibited without the written permission of the publisher.

Sincerely yours,

Jacqueline M. Atkins

(Mrs.) Jacqueline M. Atkins
Director, Publications Service

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VITA AUCTORIS

Helen Wai-Chu Wong (legal name has recently been changed to Mrs. Helen Chu) was born on March 27, 1954, in Hong Kong. She completed her elementary education at St. Clair's Primary School in 1966 and her secondary education at St. Paul's Co-educational College in 1973 in Hong Kong.

In September, 1973, Mrs. Chu immigrated to Canada and began her university education at McGill University, Montreal, Quebec. Mrs. Chu received the degree of Bachelor of Social Work in 1976.

After graduation, she worked as a social worker and project coordinator at the Montreal Chinese Community Service Centre which was funded by Ville Marie Social Services of Montreal. In 1977, Mrs. Chu moved to Toronto to work at the Catholic Children's Aid Society of Metropolitan Toronto in the Family Services Department.

In September, 1978, Mrs. Chu was accepted into the Master of Social Work programme at the University of Windsor. Her field placement was at the Regional Children's Centre of the Windsor Western Hospital Centre. She also worked as a teaching assistant for the second year B.S.W. method course.

After completing the major courses, Mrs. Chu returned to Toronto to work full time at the Catholic Children's Aid Society while being enrolled as a part-time graduate student at the University of Windsor for the completion of her thesis. Mrs. Chu will receive her degree of Master of Social Work in spring 1981.