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AN EVALUATION OF CLIENT SATISFACTION WITH THE SERVICES PROVIDED BY A COMMUNITY-BASED MENTAL HEALTH AGENCY

A Project

Presented to the

Faculty of

California State University,

San Bernardino

In Partial Fulfillment

of the Requirements for the Degree

Master of Social Work

---

by

Cheri-Lyn Kaye Fahlgren Romero

Sarah Elisabeth Hayes

June 2006

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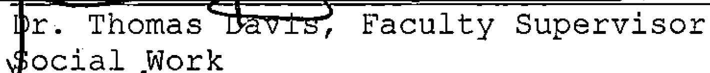
Approved by:



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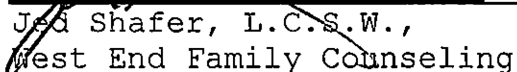

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ABSTRACT

This study will facilitate agency efforts to develop improved methods of service delivery. The strengths and weaknesses of a community-based family-counseling agency were evaluated. Recommendations for greater sustainability were then enumerated. The purpose of this study was to conduct a program evaluation of a community-based agency that provides mental health services to children. The focus of the evaluation was client satisfaction with services provided by the agency. Seventeen parents of children who have used the agency's services participated. The researchers sent out a satisfaction survey by mail to the parents for completion. Quantitative and qualitative methods were used to analyze the responses. Respondents reported a high level of satisfaction with the services provided.

DEDICATION

To my wonderful family: I could not have made it this far without your love and support. I am privileged to call you my family even with all our quirks. Thank you for being there. To my mother: There are no words that could sum up how much you mean to me and there will never be enough ways to say thank you to express my appreciation. To my husband: I could not have asked for a better best friend. I love you all!

Cheri-Lyn

Thank you to my family for their continuous emotional support and sound advice throughout this research endeavor. I could not have endured the process without your help. This is it-I have survived the program! I have complete faith that we will continue to provide each other with the strength to overcome whatever lies ahead in the future. Love you all!

Sarah

To our four-legged friend (you know who you are): thanks for providing comic relief during stressful moments! Let's party!

TABLE OF CONTENTS

ABSTRACT iii

LIST OF TABLES vii

CHAPTER ONE: INTRODUCTION

Problem Statement 1

Prevalence of the Problem 1

Stressors 3

The Role of Professionals 5

Consumer Satisfaction 6

Purpose of the Study 7

Significance of the Project for Social Work 9

CHAPTER TWO: LITERATURE REVIEW

Introduction 10

Theories Guiding Conceptualization 11

Bronfenbrenner's Ecological Theory 11

Developmental Theory 12

Applied Developmental Science 13

Prevention 14

Early Intervention 17

Early Intervention for Low-Income Families 18

Therapeutic Relationship 21

Federal Legislation 23

Existing Programs 24

Social Work in the School Setting 26

Client Satisfaction with Services 26

Summary 30

CHAPTER THREE: METHODS

Introduction 31

Study Design 31

Sampling 32

Data Collection and Instruments 33

Procedures 36

Protection of Human Subjects 37

Data Analysis 38

Summary 38

CHAPTER FOUR: RESULTS

Introduction 39

Presentation of the Findings 39

Demographics 49

Summary 54

CHAPTER FIVE: DISCUSSION

Introduction 55

Discussion 55

Limitations 69

Recommendations for Social Work Practice,
Policy and Research 69

Conclusions 70

APPENDIX A: QUESTIONNAIRE 72

APPENDIX B: FOCUS GROUP QUESTIONS 77

APPENDIX C: LETTER OF INTENT 80

APPENDIX D: INFORMED CONSENT 82

APPENDIX E: DEBRIEFING 84

APPENDIX F: INFORMED CONSENT FOCUS GROUP 86

APPENDIX G: DEBRIEFING FOCUS GROUP 88

REFERENCES 90

ASSIGNED RESPONSIBILITIES PAGE 94

LIST OF TABLES

Table 1. Overall Satisfaction with Individual Counseling 39

Table 2. Overall Satisfaction with Family Counseling 40

Table 3. Overall Satisfaction with Group Counseling 40

Table 4. Overall Satisfaction with Information and Referral 40

Table 5. Overall Satisfaction with Short-term Services Provided at the Clinic (Less than 12 Weeks) 41

Table 6. Overall Satisfaction with Long-term Services Provided at the Clinic (Less than 12 Weeks) 41

Table 7. Overall Satisfaction with Parent Education Classes 41

Table 8. Overall Satisfaction with Provision of Prescription Drug Medication 42

Table 9. Interest Level with Resource and Referral to Other Agencies in the Community that Serve Children with Emotional and Behavioral Problems 42

Table 10. Interest Level with Improved Communication with Your Child's Teacher 42

Table 11. Interest Level with Improved Communication with Other Professionals with Whom Your Child Interacts 43

Table 12. Interest Level with Increased Access to Information About Your Child's Problem, Disability or Diagnosis 43

Table 13. Interest Level with Connection to Parents with Children Who Have Similar Problems 44

Table 14. Interest Level with Health Care Coverage to Meet the Medical and Mental Health Needs of the Children 44

Table 15. Of The Services Provided by This Agency, What Services are Working Best for Your Child(ren)? 45

Table 16. What Improvements Have You Seen in Your Child Since He/She Began Receiving Services at this Agency? 46

Table 17. What Recommendations Do You Have that Would Help the Agency Meet Your Needs? 47

Table 18. How can your Child's Therapist be more Helpful to you? 48

Table 19. Gender-Demographics 49

Table 20. Age in Categories 49

Table 21. Age of Respondent (Parent/Caregiver) 50

Table 22. Ethnicity 50

Table 23. Marital Status of Respondent (Parent/Caregiver) 51

Table 24. Respondent's (Parent/Caregiver) Relationship to Child 51

Table 25. Gender of Child 52

Table 26. Age of Child 52

Table 27. Mean Age of Child 53

Table 28. Ethnicity of Child 53

Table 29. Length of Time Child Has Been Receiving Services 54

CHAPTER ONE

INTRODUCTION

This chapter will provide an overview of services for children with emotional and behavioral problems or disorders. Statistical data relevant to the study of this particular population will be discussed first. The ensuing discussion will then focus on some of the problems currently experienced by children and families in regard to seeking and receiving mental health services. In addition, this chapter will highlight some of the environmental stressors that families face when there is a child with an emotional or behavioral problem. This chapter will conclude with a discussion of how this topic is relevant to social work practice.

Problem Statement

Prevalence of the Problem

Over the last 20 years, the need for psychosocial services for children has more than doubled from 7 to 18% (American Academy of Pediatrics, 2000; Mowbray & Holter, 2002). Some reports estimate that roughly 18 to 20% of the child and adolescent population need services for mental, physical, developmental, and behavioral disorders

(Armstrong & Huz, 1992, p.35; Wyngaarden Krauss, Wells, Gulley, & Anderson, 2001). 75 to 80% of children who have emotional and behavioral problems do not receive treatment (Mowbray & Holter, 2002).

Research indicates that the mental health needs of children are not being adequately met at the present time. A study by Sturm, Ringle, and Andreyeva (2003) revealed that 80.6% of mental health service needs among school-age children in California are not met. California has the highest percentage of unmet mental health needs for school-age children out of the 13 states in the study. Although the unmet needs are partially explained by race/ethnicity, the largest factor in disparities among states is due to income variance and inequalities within the health care coverage system for each state.

Children, parents, families, and professionals are experiencing a fragmented system of services. The most commonly cited reasons for service fragmentation are lack of coordination among providers, lack of knowledge among parents and professionals, as well as poor provision of mandated available services (SAMHSA, n.d.). Every aspect of a community-based program serving the physical or mental health needs of families is equally important in

the treatment and recovery of youth (Wyngaarden Krauss, Wells, Gulley, & Anderson, 2001). Additionally, there are not enough community-based programs that provide activities and services (Armstrong & Huz, 1992, p.35).

The personal and environmental factors that families experience lead to an even more stressful situation when the professionals do not, or cannot, provide comprehensive and client-centered services. Research shows a lack of follow through for referrals, number of treatments (i.e., therapy), and services (Wyngaarden Krauss, Wells, Gulley, & Anderson, 2001). There is a lack of appropriate follow-up and analysis of services given to children once they are in the system. This prevents community-based programs from making changes to guidelines that would better serve the needs of children and families (Armstrong & Huz, 1992, p.35). Therefore, it is evident that a more comprehensive and collaborative approach to providing services to this population is needed.

<u>Stressors</u>

Families whose children have emotional and behavioral problems experience stress above and beyond that experienced by families whose children do not. This

in turn affects the family's ability to seek and receive benefits from services. An example of a needed service is community and work place support for parents who have children with emotional or behavioral disorders (Scharlach, 2001, p. 217).

Changes in family structure, as well as changes in the social and political forces that impact families are also relevant to discussion of children who have emotional or behavioral problems. One author stated that there are more women in the workforce today; while at the same time there are a greater number of elderly family members living in the family home who are in need of care. In addition, other relatives tend to live far away and therefore cannot provide direct support. This increases the amount of stress in the family and indicates a greater need for community support (Scharlach, 2001).

Another significant factor is substance abuse. When parents abuse substances, it becomes more difficult for the professionals to provide the child with services (Edlefsen & Baird, 1994). Additionally, the professionals may not have the resources or experience to work with individuals who abuse substances.

These increases in family and work stressors result in a greater amount of strain in the family. This need for increased community support includes the need for a greater amount of support from the employer (Scharlach, 2001).

The Role of Professionals

Professionals in the fields of social services, psychology, education, and among others place increasing emphasis on collaboration and multidisciplinary approaches in working with clients. For example, public schools are mandated to hold Individualized Education Program (IEP) meetings to plan services for children with special needs.

Traditionally, parents have not been encouraged to participate in the assessment and treatment planning processes for their children. Typically, parents are treated merely as informants regarding their child's behavior, or even treated as clients themselves (Soderlund, Epstein, Quinn, Cumblad, & Petersen, 1995). Involving the parent in planning and intervention not only ensures greater follow through on interventions, but also takes into account the issues that the family views as most important. Parental involvement can exist at all

levels of planning and intervention, including overall program evaluation and supervision (Soderlund, et al 1995).

Consumer Satisfaction

There is an increasing interest in assessing consumer satisfaction with social services (Martin, Petr, & Kapp, 2003). In regard to mental health services for children, it is noted that there are two primary benefits resulting from getting consumer input and feedback regarding services. One positive effect is that the family experiences a sense of validation and respect when they are included in planning and evaluation. A second positive effect is that the organization can identify strengths and weaknesses of the services they provide which can then lead to better interventions and service delivery (Martin, Petr, & Kapp, 2003).

Studies conducted in the United Kingdom concur with the current trend in the United States toward increasingly involving clients or consumers in evaluation of services. Higher levels of consumer satisfaction are correlated with positive client outcome (Stallard, 1994). Additionally, assessing consumer satisfaction with services is one way to evaluate the effectiveness of

interventions in situations where other methods of evaluation would be more difficult or impossible to measure (Stallard, 1994).

Purpose of the Study

This study will help an agency to improve service delivery for their clients. It will accomplish this by assessing the strengths and weaknesses of a community-based agency and making recommendations for greater sustainability.

The purpose of this study was to conduct a program evaluation of a community-based agency that provides mental health services to children. The focus was on client satisfaction with services. Available services were identified, clients were asked to assess the quality, and give their perspective on what could be done to improve services. Additionally, the study identified services not currently provided by the agency, from which clients think they could benefit.

A survey was used to measure client satisfaction with services. The survey method was chosen because it was the most advantageous due to time constraints as well as feasibility concerns in regard to the agency.

The agency used for this study is a non-profit, public benefit charity, and is governed by a volunteer Board of Directors. The agency provides an array of mental health and related services for clients through each of the programs offered. For this project the Department of Behavioral Health Outpatient Services program was evaluated.

The Department of Behavioral Health Outpatient Services program offers counseling services to individuals, families, and groups who have been referred from the San Bernardino County Department of Behavioral Health. The clients served in this program are from low-income families who qualify for Medi-Cal. The children served by this program experience a range of mental health issues. Some of the common diagnoses or issues are depression, Attention Deficit/Hyperactivity Disorder, Oppositional Defiant Disorder, Schizophrenia, and anxiety disorders.

The research question examined in this study: From the parents' perspective, were the services provided by a community-based mental health agency meeting the needs of families with children who had emotional and behavioral problems?

Significance of the Project for Social Work

It is hoped this information will enhance the quality of care provided to this population and make others aware of the importance of intervention and prevention early in a child's life. This study was concerned with the implementation phase of the Generalist Intervention Model. The input provided by the participants of the study offers a new perspective on service delivery. Specifically, the study may provide an opportunity for the therapists and administrators to critically assess the quality of services provided from the perspective of parents of child clients.

Furthermore, the insight gained from this study may guide future studies in similar mental health settings. It is hoped the information will encourage professionals and family members to work cooperatively to improve the quality of life for the children.

CHAPTER TWO

LITERATURE REVIEW

Introduction

There are many diverse and complex components involved in a study of this type. This literature review examines approaches to viewing and conceptualizing the population under study. Theories describing the normative processes of human development will be discussed first, followed by a discussion highlighting the importance of preventive and early intervention efforts to prevent or lessen the severity of emotional or behavioral disorders later in life.

An overview of federal legislation calling for the provision and improvement of mental health services to children provides a framework for examining current trends in treatment settings and methods. Last, the concept of client satisfaction is explored as it relates to improving services to children who have been diagnosed, or who are at-risk for emotional or behavioral disorders.

Theories Guiding Conceptualization

Bronfenbrenner's ecological theory of development was utilized in guiding this research. Closely related to Bronfenbrenner's theory was Developmental Theory. The basic principles of Prevention Science were discussed, specifically as they related to the impact low-income families.

Bronfenbrenner's Ecological Theory

Bronfenbrenner's ecological theory explaind four levels of the environment that impact and interact with the child simultaneously for his or her development. The levels included the microsystem, mesosystem, exosystem, and the macrosystem. The microsystem consisted of the child's immediate environment such as the home. The mesosystem included the interactions between two or more microsystems. The exosystem included such settings as the parent's work environment and the neighborhood. The macrosystem examined the impact of cultural and societal influences (Bronfenbrenner, 1979; Bronfenbrenner, 1989; Eamon, 2001).

Bronfenbrenner suggested that many levels of the ecological environment ("process-person-context-time model") affected the theories used to study children who

were in economic deprivation (Eamon, 2001, p. 262). The micro system of the home may have caused poor socio-emotional development for children living in poverty. There were many stressors that caused this situation. Among these stressors were the possible lack of involvement in the child's life by over-worked and exhausted parents, or parents who were living in marital conflict. Another stressor was living at or below the poverty level, which was associated with attending low-quality schools (Eamon, 2001).

<u>Developmental Theory</u>

The goal of Prevention Science was to alleviate the problems and suffering of individuals (Lerner, 2001). Prevention science could be strengthened when interventions were based on what science had discovered about human development in general. By taking normal human development into account, one could better identify risk and protective factors within the environment (Maggs & Shulenberg, 2001). The ultimate goal for implementing change using Prevention Science was to relieve or even prevent human suffering through making alterations to an individual's environment.

Applied Developmental Science

There were identifiable factors contributing to emotional and behavioral disorders. These factors were responsive to preventive intervention efforts. Borrowing from the concept of Applied Developmental Science, prevention programs often had the goal of preventing or deterring youth from "falling off the normative course of healthy development" (Lerner, 2001, p. 255). Promoting positive development was a guiding force for this study. It was important to develop programs that acted as "asset developers" to improve the client's quality of life (Domitrovich & Greenburg, 2000; Lerner, 2001, p. 255). The Applied Developmental Approach used resources from within the community to identify and strengthen the "Five C's of positive youth development: competence, confidence, character, caring and compassion, and connection" to institutions in society (Lerner, 2001, p. 255). This approach recognized youth as resources rather than deficits to society. This would assist children in succeeding and feeling empowered as they face the world ahead of them (Lerner, 2001).

There were several internal and external assets that interact to build a strong adult (Benson, 1997; Lerner,

2001). The external assets included support from family and friends, "empowerment, boundaries and expectations, and opportunities for the constructive use of time." Internal assets included "commitment to learning, positive values, social competencies, and positive identity" (Benson, 1997; Lerner, 2001, p. 255).

Prevention

Social workers and others in the helping professions found that Prevention Science was an important tool for identifying and planning interventions for children at-risk for emotional and behavioral problems. Incorporating these two concepts to be used in the context of determining how best to unify and coordinate services not only had the potential to benefit the client, but professionals as well. Although not yet fully instituted into our society, these approaches have been gaining credibility through time and experience.

Why use Prevention Science? Prevention science was a concept that proposed change based on data collected through strict scientific research methods (Weissberg & Greenberg, 1998). The Prevention Science approach tended to view social problems as stemming from psychopathological causes and therefore attempted to

identify the epidemiology of the problem or disorder (Weissberg & Greenberg, 1998).

The process commenced by identifying a specific problem or concern within a community. The next step was to identify elements that either lead to a greater prevalence (risk) or lesser prevalence (protection) of the problem or disorder (Weissberg & Greenberg, 1998). This meant that communities needed to identify factors in the child's environment, such as low socioeconomic status that put the child at-risk. Then communities could equip the youth with tools needed to overcome those negative factors. The remainder of the process involved following through with the scientific research procedures by conducting and replicating trials, implementing interventions, and determining the effectiveness of interventions.

In different forms and settings the core values and practices of Prevention Science have been used to improve the lives of children, families, and the communities in which they live. Programs such as Head Start have been established based on the idea that early intervention for at-risk youth can prevent problems later on in life.

In addition, Prevention Science research has been used to identify and prevent mental health disorders (Cunningham, 2000). The concept of identifying risk and protective factors fit well within the mental health field. Treatment of mental health disorders could include the prevention and treatment of emotional and behavioral health issues. Identifying certain populations or youth characteristics that contribute to mental health problems was an important component of prevention.

Durlak and Wells (1998) reviewed 130 programs aimed at preventing mental health disorders and other issues of maladjustment to determine if they were effective in meeting the stated objectives. The review discussed three types of prevention: primary, secondary (indicated), and tertiary. Primary prevention attempted to intervene with the general population or groups of individuals who had been identified as at-risk for later problems (Durlack & Wells, 1998). Secondary (or indicated) prevention provides intervention with individuals who had exhibited behaviors suggestive of possible disorders, but that were not yet serious enough to warrant a specific diagnosis. Tertiary prevention provided intervention after a child has been diagnosed with a disorder.

Most significant in their findings was that prevention programs do resulted in statistically positive outcomes for children. Specifically, secondary prevention was effective in preventing more severe conduct problems and other externalizing behaviors when the child presented warning signs early on in development (Durlack & Wells, 1998).

Early Intervention

Research showed that children who had parental support had a shorter recovery period from a mental illness than those who did not have parental support (Armstrong & Huz, 1992, p. 35). Early identification and intervention were critical to work with children who had emotional or behavioral problems. Screening and assessment should have been initiated as early as entry into preschool programs and should have addressed a number of issues with an emphasis on socio-emotional competence (Miller, Gouley, Shields, Dickstein, Seifer, Magee, & Fox, 2003). Social skills and the ability to regulate emotion were crucial to success in preschool and later academic endeavors. Poverty and low socioeconomic status had been shown to place children at higher risk

for social and emotional disorders due to the amount of early exposure to environmental stressors (Miller et al., 2003). Unfortunately, early screening and assessment were rare, even though these services had the potential to benefit at-risk children.

Early Intervention for Low-Income Families

Edlefsen and Baird (1994) highlighted the importance of early intervention services for economically disadvantaged children to protect against mental health problems. Three areas of risk had been identified. Disadvantaged children did not enter the education system equipped with the necessary intellectual, social, or emotional maturity. They had often already witnessed traumatic events. Also, the parents of these children could not or did not facilitate an interest in learning.

Edlefsen and Baird (1994) noted the lack of availability of mental health services for preschool age children. Research indicated that early intervention protected these children and prevented the development of serious mental health problems later in life. Parents who were experiencing economic problems were less likely to

be available to meet their child's emotional and social needs (Huebner, 2000).

Research revealed that children from low-income families or families who abused substances were often not ready for entrance into school. This resulted in poor academic performance and difficulty catching up to the other children. Families working long hours, two jobs, or who were preoccupied with substance abuse problems spent less time supporting their children or preparing them for life tasks and school, which set them up for failure (Edlefsen & Baird, 1994; Huebner, 2000). Children of a lower socio-economic status were less likely to be read to; therefore, it was important to develop programs to encourage reading in the family (Huebner, 2000). These factors could lead to future mental health problems for children (Edlefsen & Baird, 1994).

Professionals needed to consider the additional needs of a family in which substance abuse was occurring; however, they were often hesitant to work with these families. One reason is that professionals feared they did not have the capacity to provide for all the additional needs of a family who experienced substance abuse. Professionals were also hesitant for fear of

needing to report the family to Child Protective Services. Parents who struggled with substance abuse must face the fact that their children were more likely to suffer from neglect, physical, or sexual abuse. As a consequence, children may have also experienced other negative effects such as, "rejection, abandonment, anger, victimization, or sadness" (Edlefsen & Baird, 1994, p. 571; Jenks, 1990).

There was a need for supportive programs for parents in the workforce whose children were under the age of six (Scharlach, 2001). These parents experienced a great deal of stress as they struggled with their various roles such as, caregiver, wife, or husband (Scharlach, 2001). Families with young children must find adequate childcare in order to be able to continue working. A stressful job that required a great number of hours increased the level of stress in the family, which could then result in a lack of consistent care available to small children (Scharlach, 2001). The impact of these factors on the family system was even greater when there was a child who had some type of emotional or behavioral problem.

Prevention was an important component of services for children and adolescents. Potential problems for

disadvantaged or at-risk children and adolescents would often be ignored until antisocial behaviors appeared. By the time these behaviors appeared, one often found frustrated teachers, parents, and law enforcement officials giving attention to overcoming the problem. Sadly, the behavioral patterns would be set in the child by this point. Attention and direction from a well functioning, community-based program might have avoided the negative behavior before it had begun.

It was important to recognize the strengths of disadvantaged and at-risk children early in their lives, by establishing programs that taught them appropriate coping skills and provided them with the knowledge that they could be successful (Lerner, 2001).

Therapeutic Relationship

The establishment of a therapeutic working relationship was the fundamental aspect of therapy with children. Since children learn and communicate best through play, play therapy was one of the most effective methods through which to build a therapeutic relationship (Landreth, 1991). Landreth (1991) identified six core elements in establishing a therapeutic relationship with

children. The first and most crucial element was to provide a physically and emotionally safe environment for the child. This was also the time when the therapist must set limits and boundaries to guide the remainder of the therapeutic process.

Once the child felt safe, it was beneficial to allow the child to freely share their thoughts, feelings, and perspectives with the therapist. Encouraging the child to openly share validated the child's experiences and strengthened the child's sense of self. Once these physical and emotional needs were met, the child was able to explore the more cognitive aspects of him or herself. This fostered within the child a sense of self-responsibility and empowerment to make a positive contribution within his or her external environment (Landreth, 1991).

The end result of building this therapeutic relationship was that there were noticeable changes in the child's overall responses to and interactions with the social environment (beyond the therapist's office). Through the therapeutic relationship and activities of play therapy a child became more responsible and learned how to organize and be in better control of his or her

own feelings. Additionally, the child was able to identify and accept a new self-concept (Landreth, 1991).

On a cognitive level, children learned how to balance their actions with their feelings. By being able to identify and accept their feelings they were better able to physically interact with others in their social environment. This interaction involved not only possessing the ability and strength to confront problems, but also the willingness to take responsibility for one's actions (Landreth, 1991).

Federal Legislation

The federal government addressed the responsibility of ensuring that the mental health needs of adults and children were adequately met. The Alcohol, Drug Abuse, and Mental Health Administration Reorganization Act of 1992 required that community mental health centers provide inpatient screening, outpatient services, partial hospitalization, aftercare, day treatment, 24-hour emergency services, and psychosocial rehabilitation services for children, elderly, and seriously mentally disabled adults (Bentley, 1994). This legislation also required that states implement a system that allows

individuals to be aware of, and gain access to, these services (Bentley, 1994).

Existing Programs

What types of interventions were currently being implemented to help children with emotional or behavioral disorders? Fecser (2003) described a school-based mental health program in Ohio called the Positive Education Program (PEP). The PEP program emphasized structure and predictability of routines as key elements to working with this population. Behavior management techniques were applied within a positive working relationship between teacher and child. The focus of this program encompassed an ecological perspective, and the involvement of parents and other significant people in the youth's lives was a core component of the program (Fecser, 2003).

Armstrong and Huz (1992) reported that the states of Washington and New York had programs that provided support and crisis intervention for children and their families. The program involved a counselor who was assigned only two families to work with, and was on call 24 hours a day for a four-week period to help the family through their crisis (Armstrong & Huz, 1992, p. 36).

Other services that currently existed required the caseworker to be on call all the time for as many as ten families at a time. They provided intervention services to families who had children who were at-risk of placement in psychiatric hospitals (Armstrong & Huz, 1992, p. 36).

Studies showed children in family-based programs recovered more quickly when the parents were involved in mental health treatment (Armstrong & Huz, 1992, p. 35). It was beneficial to develop partnerships with various members of the family, community, and with the youth to help them achieve goals that produced well-equipped and well-rounded adults (Damon, 1997; Lerner, 2001).

Promoting Alternative Thinking Strategies (PATHS) was a program that gave second and third grade students training to understand and control their emotions. The follow-up showed that students had fewer behavioral and social problems than the control group that did not receive training (Domitrovich & Greenberg, 2000). The study examined 34 programs that were effective in the prevention of mental health and behavioral disorders in school-aged children (5-18). However, their research revealed a serious lack of information to support the

effectiveness of the program design or implementation (Domitrovich & Greenberg, 2000).

Social Work in the School Setting

An area of school social work that had received great attention in recent times is mental health. Schools had experienced a recent increase in the availability and use of mental health services in school-linked and school-based service programs (Franklin, 2001). Federal legislation mandated the provision of school-based mental health services to children. This reflected a general trend toward relying on the public education system to socialize children and provide them with practical skills for becoming self-reliant adults (Popple & Leighninger, 2002).

Client Satisfaction with Services

Although there had been a significant increase in concern about measuring client satisfaction within the medical and mental health fields, a clear, concise, universally agreed-upon definition or conceptualization of the term client satisfaction was still lacking. Definitions of the term client satisfaction were usually stated in the form of measurable or observable behaviors.

On reviewing several studies that attempted to define or conceptualize "client satisfaction," Harris and Poertner broadly defined the term as "clients' perspectives on aspects of the service transaction important to them" (1998, p. 5). The authors then proceeded to identify each of the studies that they had found, and gave examples of how to operationalize the concept of client satisfaction.

One commonly used instrument was the Client Satisfaction Questionnaire (Harris & Poertner, 1998). This questionnaire could be used by a variety of service providers because it could be modified to fit the specific purposes of the current study. Using a Likert-type scale, the questionnaire included several aspects of service delivery and outcomes including overall satisfaction as well as satisfaction with the physical setting, method of treatment, procedures, staff interactions, treatment quality, length of service, and treatment outcome (Gaston & Sabourin, 1992).

The Institute for Research on Poverty identified similar categories of client satisfaction. Although this particular study focused on client satisfaction with services in settings providing physical health care, many

of the items identified were congruent with studies assessing the quality of mental health services (Koshel, 1997). Common themes included assessing the overall quality of services, communication between the participant and the professionals, and issues of convenience (such as length of time spent in waiting room). Other dimensions of client satisfaction included client perception of the professional's competence, professionals spending enough time with the client, and personal qualities or attributes of the professional, such as courteousness, respectfulness and sensitivity (Koshel, 1997).

Harris and Poertner (1998) studied the level of satisfaction parents felt with the professionals who were providing mental health services for their children. This study measured level of satisfaction with services as well as the parents' perceptions of interactions between staff members (Harris & Poertner, 1998). The researchers also assessed client satisfaction by asking if the parent would consider working with the same staff members in the future, and if they would recommend the staff members to friends and other family members.

McComas, Kosseim, and Macintosh (1995) assessed client satisfaction with services in a clinic serving children with physical disabilities. They asked participants to assess the overall quality of the service process as well as the quality of the end product. To assess the service process they asked participants about communication, waiting and evaluation time, persons in the clinic, process choice, responsibility, and organization (McComas, Kosseim, & Macintosh, 1995).

One article reported a need for assessment of the family's experiences entering and satisfaction with the system and services (Wyngaarden Krauss, Wells, Gulley, & Anderson, 2001). Each family had a basic need that should be met to guarantee satisfaction with, as well as coordination for appropriate and competent services (Wyngaarden Krauss, Wells, Gulley, & Anderson, 2001). A framework needed to be designed that correlated community norms and studies with the extent of needs, the assessment of programs in place, and the success of those programs (Armstrong & Huz, 1992, p. 35; Mowbray & Holter, 2002; Rog, 1990).

Summary

There were several factors to take into consideration in order to assess client satisfaction with mental health services for children. Theories that addressed the normative course of development for children could be helpful tools for assessing whether or not the therapeutic interventions provided by mental health professionals are appropriate. The importance of the therapeutic relationship was also explored. It was important for social workers and other mental health professionals to offer opportunities for clients (or the parents of child clients) to become involved in the planning, implementation, and evaluation phases of treatment.

CHAPTER THREE

METHODS

Introduction

This chapter will cover the methods that were used to conduct the study. First, the researchers described the type of research and then explored the reasoning as to why the particular design was selected. Second, the specific process for collecting and evaluating the research data were explained. This section will also discuss the potential for harm to human participants, and will address how the researchers protected participants.

Study Design

The purpose of this study was to explore parent satisfaction with the services provided to their child by West End Family Counseling Services. West End Family Counseling Services was described as a community-based agency that provided outpatient mental health services to children and families. Furthermore, the study asked parents to provide suggestions for how the agency could improve its services.

This study used an exploratory research design by utilizing a survey to measure client satisfaction with

services. The survey consisted of both closed-ended and open-ended questions. The researchers then offered respondents the opportunity to participate in a focus group. Survey respondents indicated interest in focus group participation by marking a box on the informed consent form.

A strength of this study was that it elicited the parental perspective on services to children. A limitation was that this study did not directly assess the child's perspective on services. An additional limitation was that this was a non-random sample and therefore the findings of the study lacked generalizability.

The research question examined in this study: From the parents' perspective, were the services provided by a community-based mental health agency meeting the needs of families with children who had emotional and behavioral problems?

Sampling

The sample consisted of approximately 70 parents whose children used the agency's services. There were approximately 150 child client cases open in the program

at the time the study was conducted. Participants had to be a parent or legal guardian of a child receiving services at West End Family Counseling Services.

A strategic sampling method was utilized in order to eliminate potential participants who would be unable to appropriately respond to questions due to safety concerns in the individual's home environment, or who were mentally unstable. Participants were eliminated based on information gathered from the therapists before sending out the surveys. The researchers chose to survey parents because they were the most knowledgeable about the history and current circumstances affecting their child. The survey process took place over a period of several weeks.

Data Collection and Instruments

This study focused on parent satisfaction with services. The researchers identified what services were currently available and asked the parents to assess their level of satisfaction with services, and gathered their perspective on what could be done to improve services. The study asked parents to provide suggestions for how the agency could improve, what services were missing, and

what further services parents would be interested in receiving.

This was a descriptive and exploratory study with no independent or dependent variables. The instrument that was utilized was a survey with quantitative and qualitative questions (See Appendix A). A focus group was formed in order to validate the results of the survey. During the focus group process participants were given the opportunity to expand on responses to the open-ended questions (See Appendix B).

Demographics such as gender, ethnicity, participant's relationship to child, and marital status were measured at the nominal level. Age and length of services were measured at the interval level. The first section of the survey assessed overall satisfaction and was measured at the ordinal level. The second section assessed the extent to which specific services had been helpful and was measured at the ordinal level. Section three asked participants qualitative questions regarding services currently provided and asked for recommendations for improvement at the nominal level. Section four assessed needed services that were not currently provided by the agency. These responses were measured at the

ordinal and nominal levels. Descriptive statistics were used to identify frequencies and means.

The instrument was created specifically to address the programs at West End Family Counseling Services. The researchers could not find a preexisting survey to assess this agency. The agency's "parent partner" was asked to fill out the survey to conduct a pre-test of the instrument. The parent partner was an individual who worked in close proximity with the parents and had extensive knowledge of the parents' perspective.

The therapists reviewed the instrument prior to distribution to ensure that it was appropriate and applicable to the population under study. This also gave therapists the opportunity to provide suggestions for other questions or topics to explore that would potentially improve the quality of the study.

A strength of this survey was that it was agency specific and did not take much of the participant's time. A limitation in this study was that the researchers developed the survey and therefore it might not hold validity. Another possible limitation was that the participants' responses might be affected by social desirability bias. Participants might have felt

uncomfortable due to concerns about the researchers' ability to protect their anonymity.

Procedures

The researchers wrote a letter to the therapists providing them with information about the study. The researchers asked the therapists to identify potential parents who would not be able to participate due to safety concerns or who are mentally unstable. Once the pool of potential participants had been compiled the researchers mailed out the surveys in English and Spanish to all eligible clients. The survey took approximately 15 to 20 minutes to complete. A second survey was mailed out two weeks after the first mailing. An addressed stamped envelope was provided with the survey for the participant to mail back the survey to the agency. The envelope specified the researchers' name and was placed in the researchers' mailbox.

The informed consent form included a section inviting respondents to participate in a focus group. If a respondent was interested in participating they wrote their first name and provided contact information. The focus group was held in a conference room at the agency

and refreshments were provided. The researchers arranged to voice-record the content of the focus group meeting to ensure accuracy in analysis of the data gathered. The focus group was scheduled to take place for approximately two hours. This study was approved by West End Family Counseling Services (See Appendix C).

Protection of Human Subjects

Confidentiality of participants was protected by the survey being sent directly back to the researchers. The researchers kept the informed consent separate from the survey in a secure location. No foreseen physical or psychological risks were anticipated for study participants. Participants were asked to mark a letter of informed consent before completion of the survey (See Appendix D). After completing the survey, participants received a debriefing statement (See Appendix E).

For those who chose to participate in the focus group meeting, a second informed consent was marked (See Appendix F). At the conclusion of the focus group meeting a debriefing statement was provided (See Appendix G).

Data Analysis

Qualitative and quantitative procedures were utilized. This study used descriptive statistics to analyze frequencies. In the qualitative analysis the researchers were looking for common themes, similarities, differences, and program ideas.

Types of constructs likely to emerge were lack of transportation, childcare, social support, and tutoring for their child.

Summary

This chapter explored the design of the research project. Issues pertaining to the process and procedure for selecting potential participants were discussed. Practical considerations for collecting data at the agency were also explored in an attempt to ensure a quality project that might yield helpful information to improve service delivery.

CHAPTER FOUR

RESULTS

Introduction

This chapter will present the quantitative and qualitative results. The findings regarding overall satisfaction with the agency's programs will be reported. In addition, the respondents' interest in additional services, the information regarding the respondents' perceptions of services, and the demographics will be displayed.

Presentation of the Findings

Please rate your overall satisfaction with each of the services listed below.

Table 1. Overall Satisfaction with Individual Counseling

	N	Mean	Std. Deviation
a. Individual Counseling	17	4.8824	.33211

Table 2. Overall Satisfaction with Family Counseling

	N	Mean	Std. Deviation
b. Family Counseling	9	4.56	1.014

Table 3. Overall Satisfaction with Group Counseling

	N	Mean	Std. Deviation
c. Group Counseling	11	4.91	.302

Table 4. Overall Satisfaction with Information and Referral

	N	Mean	Std. Deviation
d. Information and Referral	11	4.91	.302

Table 5. Overall Satisfaction with Short-term Services Provided at the Clinic (Less than 12 Weeks)

	N	Mean	Std. Deviation
f. Short-term Services	7	4.29	1.254

Table 6. Overall Satisfaction with Long-term Services Provided at the Clinic (Less than 12 Weeks)

	N	Mean	Std. Deviation
g. Long-term Services	13	4.77	.599

Table 7. Overall Satisfaction with Parent Education Classes

	N	Mean	Std. Deviation
h. Parent Education Classes	9	4.78	.441

Table 8. Overall Satisfaction with Provision of Prescription Drug Medication

	N	Mean	Std. Deviation
i. Provision of Prescription drug meds	10	4.70	.949

Please rate your interest level with the following:

Table 9. Interest Level with Resource and Referral to Other Agencies in the Community that Serve Children with Emotional and Behavioral Problems

	N	Mean	Std. Deviation
2.a Resource and Referral	14	4.36	1.277

Table 10. Interest Level with Improved Communication with Your Child's Teacher

	N	Mean	Std. Deviation
2.b Teacher-Improved Communication	14	4.50	1.286

Table 11. Interest Level with Improved Communication with Other Professionals with Whom Your Child Interacts

	N	Mean	Std. Deviation
2.c Professionals-Improved Communication	14	4.71	.611

Table 12. Interest Level with Increased Access to Information About Your Child's Problem, Disability or Diagnosis

	N	Mean	Std. Deviation
2.d Diagnosis-Increased access to information	13	4.77	.599

Table 13. Interest Level with Connection to Parents with Children Who Have Similar Problems

	N	Mean	Std. Deviation
2.e Connection to Parents with similar problems	14	3.86	1.351

Table 14. Interest Level with Health Care Coverage to Meet the Medical and Mental Health Needs of the Children

	N	Mean	Std. Deviation
2.f Health Care coverage to meet needs	12	4.67	.651

The narrative results from the qualitative interviews are displayed below.

Table 15. Of The Services Provided by This Agency, What Services are Working Best for Your Child(ren)?

Counseling/ talking	"Talking with teacher," "Talking with people," "West End Family Counseling Services," Coping skills, Anger management training, Individual counseling, Counseling, Sessions with psychologist, Child likes services, They don't upset him
Medication	"Medication," Sessions with psychiatrist
Everything	"Everything"- all the services.
Scheduling	"Evening appointments"

Table 16. What Improvements Have You Seen in Your Child Since He/She Began Receiving Services at this Agency?

Mood	"Very slight improvement in attitude"; Child "seems to be in good spirits he's more of a happy and understanding child"; "Child has become more emotionally balanced which is enabling him to handle situations with more confidence"; "More calm"; "Depression has improved"; "not saying things use to say that use to worry me"
Education	"Learning more"; "Small increase in education"; "Doing better in school"
Behavior	"Behavior is better"; "Not getting in trouble at a school"; "Learning social skills"; "an increase in conduct"; "controls anger more"; "sometimes he gets mad, but he is better than when he didn't go"; "more organized"
Everything	"Everything"; Everything has been a total change for him as well as us"
	"Not sure yet"

Table 17. What Recommendations Do You Have that Would Help the Agency Meet Your Needs?

Increase visits	Extend the counseling as needed for the child, "To give more attention to our needs"
Education	"To share with me a little about my child, so I can help"; "To have more information publish in the window on table about how can you get help about domestic violence and what kind of insurances they take."
Education/Support groups	Parenting class for grandparents; Grandparent support group
Services in Spanish	"I would like psychiatric services to be in Spanish"
	"Make sure child has confidence in all workers"
	"Appointment call reminder day prior to appointment."
	"Nothing"/"None"

Table 18. How can your Child's Therapist be more Helpful to you?

Increase visits	More visits (See therapist more often); "See counselor more often, but parent understands that others with more need should take priority."
Education for parents	"I'd like to have material that will improve my child's conduct, and material related to school, and social skills material that will help build an equilibrium between parents and children."; Tell [caregiver] what is going on in their groups (not what he says) [but] what I can do at home to back up what is being learned… I need help in helping my grandson"; "What to do in case [child] gets too violent"; "to be advising me about his improvements, and what is causing his behavior, or his problem also. An evaluation every four or five sessions."
Education for child	Counselor help open up: He needs to open up more to his counselor, because I feel he need more help than he says; Teaching more things to him
	"More therapy in school"
	"None"; "Already is"; "Everything is well (good)."

Demographics

Parent/Guardian information:

Table 19. Gender-Demographics

		Frequency
	Male	2
	Female	13
	Total	15
Missing		2
Total		17

Table 20. Age in Categories

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	27-36	7	41.2	46.7	46.7
	40-49	4	23.5	26.7	73.3
	50-52	4	23.5	26.7	100.0
	Total	15	88.2	100.0	
Missing		2	11.8		
Total		17	100.0		

Table 21. Age of Respondent (Parent/Caregiver)

	N	Mean	Std. Deviation
Age-Demographics	15	39.2000	9.32891

Table 22. Ethnicity

	Frequency	Percent	Valid Percent	Cumulative Percent
African American	1	5.9	7.1	7.1
White, Caucasian	3	17.6	21.4	28.6
Hispanic, Mexican	6	35.3	42.9	71.4
Samoan	1	5.9	7.1	78.6
Spanish, Ispana	3	17.6	21.4	100.0
Total	14	82.4	100.0	
Missing	3	17.6		
Total	17	100.0		

Table 23. Marital Status of Respondent (Parent/Caregiver)

	Frequency	Percent	Valid Percent	Cumulative Percent
Widowed	2	11.8	11.8	11.8
Cohabitating	2	11.8	11.8	23.5
Single	3	17.6	17.6	41.2
Divorced	2	11.8	11.8	52.9
Married	8	47.1	47.1	100.0
Total	17	100.0	100.0	

Please indicate your relationship to the child:

Table 24. Respondent's (Parent/Caregiver) Relationship to Child

	Frequency	Percent	Valid Percent	Cumulative Percent
Mother	6	35.3	37.5	37.5
Father	1	5.9	6.3	43.8
Grand-mother	4	23.5	25.0	68.8
Parent	4	23.5	25.0	93.8
Legal Guardian	1	5.9	6.3	100.0
Total	16	94.1	100.0	
Missing System	1	5.9		
Total	17	100.0		

Child information:

Table 25. Gender of Child

	Frequency	Percent	Valid Percent	Cumulative Percent
Male	16	94.1	94.1	94.1
Female	1	5.9	5.9	100.0
Total	17	100.0	100.0	

Table 26. Age of Child

	Frequency	Percent	Valid Percent	Cumulative Percent
5	1	5.9	5.9	5.9
6	1	5.9	5.9	11.8
7	1	5.9	5.9	17.6
8	5	29.4	29.4	47.1
9	1	5.9	5.9	52.9
10	5	29.4	29.4	82.4
11	2	11.8	11.8	94.1
16	1	5.9	5.9	100.0
Total	17	100.0	100.0	

Table 27. Mean Age of Child

	N	Mean	Std. Deviation
Age of Child-Demographics	17	9.1176	2.44649

Table 28. Ethnicity of Child

	Frequency	Percent	Valid Percent	Cumulative Percent
African American	1	5.9	7.1	7.1
Hispanic, Mexican	6	35.3	42.9	50.0
Spanish, Ispana	3	17.6	21.4	71.4
two or more	4	23.5	28.6	100.0
Total	14	82.4	100.0	
Missing System	3	17.6		
Total	17	100.0		

Table 29. Length of Time Child Has Been Receiving Services

	Frequency	Percent	Valid Percent	Cumulative Percent
Less than a Year	7	41.2	41.2	41.2
1 Year to 2 Years	6	35.3	35.3	76.5
3 Years to 4 Years	3	17.6	17.6	94.1
None	1	5.9	5.9	100.0
Total	17	100.0	100.0	

Summary

In this chapter tables were used to visually display the quantitative and qualitative results. The data was analyzed by calculating frequencies and means. The findings regarding overall satisfaction with the agency's programs were reported. In addition, the respondents' interest in additional services, the information regarding the respondents' perceptions of services, and the demographics were displayed.

CHAPTER FIVE

DISCUSSION

Introduction

This research project endeavored to determine whether the parents of child and adolescent clients were satisfied with the services received by West End Family Counseling Services. The researchers elicited the consumer perspective on the aspects of the service transaction that were most important to them and their families. The remainder of this chapter will interpret the study findings in more detail and offer recommendations for further research.

Discussion

As a whole, consumers reported satisfaction with the services currently provided by the agency. Services offered were congruent with the stated mission to provide high quality services to the community that the agency serves. Counseling was the primary service provided by the agency. Counseling services were offered for individuals, families, and groups. Respondents reported a high level of satisfaction with all three of the main counseling services. When asked what service was working

best, most responded that it was the counseling sessions. Therefore, the agency was achieving success in providing the primary service (counseling).

The data indicated that consumers were generally "very satisfied," with some reporting to be "somewhat satisfied." West End Family Counseling possesses the necessary expertise to fulfill the mental health needs of the children and families in the community.

Over one third of the respondents indicated they had been receiving services through West End Family Counseling for more than one year. This response indicates that consumers were benefiting from the services enough to continue attending scheduled appointments consistently for a significant length of time. The respondents were primarily Caucasian, Hispanic, and Spanish. The population surveyed consisted of low-income families who receive Medi-Cal. These factors indicated a high level of dedication on the part of parents to make sure that their child made it to their appointments.

Some respondents expressed an interest in their child receiving more frequent sessions, or more sessions overall. A barrier to receiving services for a period of

more than a year could be due to the number of sessions allowed under the guidelines for Medi-cal. Further research would need to be conducted in order to determine if consumers using Medi-cal received fewer sessions than people who use private health insurance.

Of those respondents whose children received individual counseling, all but two indicated the highest level of satisfaction. The remaining two indicated the next highest level of satisfaction. Despite being very satisfied with the individual counseling process, parents indicated that some aspects of service are still lacking, or could be improved.

Parents reported interest regarding increased access to information about what happened in their child's individual or group counseling sessions (sessions in which parents/guardians did not have an active role). This was consistent with previous research regarding the role of parents in the actual counseling or service provision process. Previous research indicated that parents were typically used as consultants in the beginning stage of the process such as describing the child's problem behaviors, but then were not included in

treatment planning or implementation (Soderlund, Epstein, Quinn, Cumblad, & Petersen, 1995).

Parents and guardians reported wanting to be more involved in the treatment of their children. This interest in involvement could be fulfilled by simply informing the parent about what occurred within the individual or group counseling sessions. The therapist could also instruct parents on techniques they could implement in the home environment to support what children were learning in the counseling sessions.

Involving parents in a significant way would allow parents to feel a certain level of validation and respect as individuals, as well as within their role as parents and caregivers. Previous research supports this concept as well (Martin, Petr, & Kapp, 2003). This might indicate that more families would be interested in participating in family counseling because it would enable parents to maintain close involvement in their child's therapeutic process.

This desire of parents to become more involved clearly had implications for favorable treatment outcomes for the child (Fecser, 2003). Previous research into children's mental health services further clarified both

the positive and negative implications of parents' direct involvement in their child's treatment. One potentially negative aspect was that other factors within the family system could prevent meaningful or fulfilling involvement in the child's mental health treatment. For example, the parent's own mental and physical well-being might have a negative impact on treatment outcomes.

Low-income families experienced a myriad of problems, including difficulty in accessing services in the fragmented mental health system. Additionally, despite good intentions, parents in low-income families found it difficult to attend to their child's social and emotional needs. These difficulties might arise due to stressors such as time constraints or substance abuse (Edlefsen & Baird, 1994). When the family's primary language was Spanish, additional stressors might impact the family system. For example, a language barrier could place a strain on the relationship between the parent and the mental health professional(s). It was noted that seven of the respondents answered the questionnaire in Spanish, indicating that the agency was able to provide services in Spanish. Furthermore, this indicated that

services were being provided in a culturally sensitive manner.

In their responses to this evaluative study, parents reported a high level of satisfaction with the information and referral services provided by West End Family Counseling agency. In fact, many families had come in with needs beyond that of just counseling. West End Family Counseling was able to provide assistance in accessing resources within the community to bring the family back into a state of homeostasis. By providing information and referral services to consumers, the agency was fulfilling an antecedent need of the client system (a need that pre-existed or possibly co-occurred with the primary reason for seeking treatment).

Parents may have been more likely to seek outside help in relation to their child's identified needs, rather than their own individual or family needs. Taking the first step of seeking mental health services for their children might also be helping families to access other important services within the community. These services might address the mental health needs of the parents, or address other types of problems experienced by low-income families. Some of these services might

include child care, work place support, or referrals to substance abuse treatment programs.

Another service that respondents indicated a high level of satisfaction with was parent education classes. Similarly, parents also indicated a high level of interest in access to information about their child's problem, disability, or diagnosis. In the open-ended section of the survey, parents expressed interest in gaining more knowledge about specific techniques and tools they could use to further assist their child to thrive in their daily environments.

For social workers and other mental health professionals, this was an important consideration for clinical practice. Parents wanted to be empowered so that they in turn could empower their children to improve and be more successful in their daily interactions within the social environment. The therapeutic relationship paves the path for positive cognitive and emotional growth in the child through setting appropriate boundaries and expectations. Parents could also develop healthier relationships with their children by learning to set appropriate boundaries and expectations. Parents could also restructure their use of time to commit to helping

their child develop to his or her fullest potential (Benson, 1997; Lerner, 2001).

The respondents whose children received prescription drug medication reported a high level of overall satisfaction. This might have been due to the quality of the services that they received. Perhaps the child's quality of life had improved since taking medication. Even though many parents did not want medication for their child, some parents had found medication to be an asset.

A high number of respondents indicated being very interested in receiving resources from, and referral to other agencies in the community serving children with emotional and behavioral problems. This might be attributable to the parents' desire to seek help for their child in as many ways, and in as many settings as possible to be able to fully address the child's as well as the family's needs.

This interest in receiving services in multiple settings also related to the parents' interest in improving communication with their child's teacher and other professionals with whom their child interacted. In

general, parents wanted to seek out as much information and support as possible to help their child.

Parents and caregivers were "moderately" to "somewhat interested" in connecting to other parents with children who have similar problems. This might have been due to the fact that parents who responded might have already been receiving enough services to fulfill their needs, or might have had schedules that did not allow the time necessary to attend support groups. This was an important concern because as professionals provided referrals, they should have kept in mind that parents might be too busy to follow through on several referrals. A best practice approach to helping the family could be to ask the parent what type of services they were most interested in and then provide the corresponding referrals.

The qualitative results enabled the researchers to identify two significant domains. Two components within each domain were interpreted. The first domain was related to the respondent's perspective of services provided: what was working best, as well as improvements that had been observed in the child's behavior, mood, and attitude. The second domain explored how the therapists,

and the agency as a whole, might have been more helpful in further serving the client's needs.

Respondents reported observing several positive changes in their child. These changes included improvement in mood or attitude, education, and behavior. The children served by this program experienced a range of mental health disorders. Some of the common diagnoses were Attention Deficit/Hyperactivity Disorder, Oppositional Defiant Disorder, Schizophrenia, mood, and anxiety disorders. Parents attributed positive changes in their child to participation in the agency's services, suggesting that what the agency was doing was effective.

The data suggested that the symptoms indicative of the child's diagnosed disorder had diminished. The respondents reported improvements in behavior and attitude. Evidence of these improvements included, the "child has become more emotionally balanced which was enabling him to handle situations with more confidence," the child appears "more calm," and "[their] depression has improved." One respondent stated that sometimes their child, "gets mad, but he is better than when he didn't go," directly attributing improvements to the experience of counseling (See Table 16). These responses might be

indications that the agency was successful in providing treatment to children.

As indicated by the responses to the qualitative questions, respondents reported that their children experienced the most benefit by virtue of having someone to talk to about their problems. The most prevalent responses involved "counseling" or "talking," indicating that the communication was the most helpful or therapeutic (See Table 15). These responses were consistent with the theories presented by Landreth (1991). Just as Landreth stated, children must first establish a trusting therapeutic relationship through playing and talking with the therapist before significant change in mood and behavior could occur. Parents reported that their child benefited most from communicating with the therapist, and the child's behavior and mood had improved since seeking services. Therefore, it could be concluded that the agency was providing quality service and fostering strong therapeutic relationships.

Through this process of talking, the client was also able to learn appropriate ways to verbally and nonverbally express a variety of thoughts and feelings. For example, one respondent identified coping skills such

as anger management training as an important component of the counseling service for their child. (See Table 15). The process of the therapist communicating verbally and nonverbally with the child might help the child to feel more empowered and less stigmatized.

Children in need of counseling might have previously lacked the necessary support systems essential to emotional balance. Parents who were experiencing economic problems were less likely to be available to meet their child's emotional and social needs (Huebner, 2000). The adults in these children's lives might have been unable to give direct attention or might not have known what to do to help their child. Therapists might have been able to provide an outlet for children to express themselves in a safe, non-threatening environment in ways that may not be possible in the school, home, or other community settings. Therapists tended to interact with children in non-judgmental and empathic ways. A recommendation for this agency would be to continue providing the quality of services that they were currently providing.

The second domain explored how the therapists and the agency as a whole might have been more helpful in further serving the client's needs. Despite the fact that

most respondents reported a high overall satisfaction, some also provided suggestions for how the agency could have served their needs even better. Respondents offered a variety of recommendations in order to help the therapists and the agency to improve services.

A small portion of respondents reported that they wanted their child to have seen the therapist more often and in other settings, such as school. This might have been due to the respondents' perception of the services working well; however, they thought their child could have benefited even more from an increased number of sessions. An increased number of sessions might allow the therapist to provide more individualized attention to the child's specific needs.

It was important for professionals to interpret this information carefully. It was understandable and certainly desirable that each child receive the maximum benefit from the agency's available resources. Due to restrictions insurance companies put on services, it might have been very difficult to increase the amount of sessions the child received. While the agency might not be able to increase the number of sessions, due to restraints imposed by insurance providers, the agency

might be able to help the child if they provide referrals to increase the amount of overall assistance the child received. For example, the agency could provide referrals to after school programs or the Boys and Girls Club.

The most prevalent response was that parents would like to receive education regarding how to help their child, and interventions that could be implemented by the parent in the child's home environment. In addition, some respondents would like services specifically addressing the unique needs of grandparents raising grandchildren.

The respondents generally wanted to be included in the therapeutic process. They also expressed a desire to be educated as to how to help their child. Parents and caregivers needed to feel more empowered to effect change in their child. They were also interested in information that would enable them to continue to provide care even after services at the agency had concluded. Therefore, in the future, it might be beneficial for the agency to provide more programs or group activities that educate parents on intervention strategies.

Limitations

A limitation for this study was that it did not directly assess the child's perspective on services. The researchers acknowledge that while parents were an excellent source of information about their child, the researchers did not get first-hand information from the primary consumer-the child client.

An additional limitation was that a non-random sample was utilized, and therefore the findings of the study lack generalizability. Although some of the recommendations could be useful in assessing the basic mental health needs of low-income families with children, it might not apply to all low-income families, or all community-based mental health providers.

Materialization of the focus group did not occur due to inadequate number of participants for this phase. The absence of the focus group data was a function of the difficulty of the clients being able to attend.

Recommendations for Social Work Practice, Policy and Research

There were many positive qualities about the services provided by West End Family Counseling Services. The results of this client satisfaction survey showed

that the therapists (some of whom are licensed social workers) are providing a high quality of care. This study showed that it is important to include the consumer and their family/caregivers in planning and treatment.

A recommendation for improving services was to create more opportunities for families to feel they are involved with their child's treatment. An increased number of family sessions might help families develop and maintain a more centralized role in their child's life.

A recommendation for further studies was to include the child in the research process. Since the child was the one actually receiving and benefiting from services, it would be beneficial to have received his or her perspective on the therapy process. In order to fully explore the issue of consumer satisfaction, the parent perspective could be included in the final analysis.

Conclusions

Community-based mental health services are a vital component of social services provided to communities. In particular, there is a need for mental health services that specifically address the unique developmental aspects of children's lives: emotional, behavioral, and

cognitive. West End Family Counseling Services is meeting this need; however, the agency is not able to meet all the needs of the community alone. The community would benefit from the provision of a variety of programs that would address the diverse mental health needs of children of low-income families in a responsive, culturally sensitive manner.

APPENDIX A

QUESTIONNAIRE

Please Circle One

1. Are you receiving services at the clinic?	**Yes**	**No**
2. Do you receive short-term services (less than 12 weeks)?	**Yes**	**No**
3. Do you receive long-term services (12 weeks plus)?	**Yes**	**No**

Section 1

Please rate your overall satisfaction with each of the services listed below.

Very Satisfied 5	Somewhat Satisfied 4	Moderately Satisfied 3	A Little Satisfied 2	Not At All Satisfied 1	Not Applicable 0

a. Individual Counseling	5	4	3	2	1	0
b. Family Counseling	5	4	3	2	1	0
c. Group Counseling	5	4	3	2	1	0
d. Information and Referral	5	4	3	2	1	0
e. Parent Partner Program	5	4	3	2	1	0
f. Short-term services provided at the clinic (less than 12 weeks)	5	4	3	2	1	0
g. Long-term services provided at the clinic (less than 12 weeks)	5	4	3	2	1	0
h. Parent Education Classes	5	4	3	2	1	0
i. Provision of prescription drug medication	5	4	3	2	1	0

Section 2

Please indicate your interest level with the following:

a. Resource and referral to other agencies in the community that serve children with emotional and behavioral problems.

Very Interested 5	Somewhat Interested 4	Moderately Interested 3	A Little Interested 2	Not At All Interested 1	Not Applicable 0

b. Improved communication with your child's teacher.

Very Interested 5	Somewhat Interested 4	Moderately Interested 3	A Little Interested 2	Not At All Interested 1	Not Applicable 0

c. Improved communication with other professionals with whom your child interacts.

Very Interested 5	Somewhat Interested 4	Moderately Interested 3	A Little Interested 2	Not At All Interested 1	Not Applicable 0

d. Increased access to information about your child's problem, disability or diagnosis.

Very Interested 5	Somewhat Interested 4	Moderately Interested 3	A Little Interested 2	Not At All Interested 1	Not Applicable 0

e. Connection to parents with children who have similar problems.

Very Interested 5	Somewhat Interested 4	Moderately Interested 3	A Little Interested 2	Not At All Interested 1	Not Applicable 0

f. Health care coverage to meet the medical and mental health needs of the children.

Very Interested 5	Somewhat Interested 4	Moderately Interested 3	A Little Interested 2	Not At All Interested 1	Not Applicable 0

Section 3

1. Of the services provided by this agency, what services are working best for your child(ren)? ______________________________

____

____

2. What services would benefit you that are not currently being provided?

____

____

____

3. What would you want to change regarding the services that are provided?

____

____

____

4. What recommendations do you have that would help the agency meet your needs?

____

____

____

5. What does your child tell you about their experiences? ____________________

____

____

6. What improvements have you seen in your child since he/she began receiving services at this agency? ____

____

____

7. How can your child's therapist be more helpful to you? ____________________

____

____

8. Has your family been in previous treatment? (please circle one) **Yes** **No**

If yes, How does the previous treatment compare to your current experience?

____

____

____

____

Demographics

Parent/Guardian information:

Gender Male _____ Female _____

Age _______________

Ethnicity ______________________________

Marital Status

Married ______ Divorced ______ Single ______

Cohabitating ________ Widowed _____

Please indicate your relationship to the child (e.g., Parent, step-parent, grandparent, legal guardian): ____

Child information:

Gender Male _______ Female ________

Age _______________

Ethnicity ______________________________

How long has your child been receiving services through West End Family Counseling Services? ____

APPENDIX B

FOCUS GROUP QUESTIONS

Focus Group

1. Of the services provided by this agency, what services are working best for you?
2. What services would you like to have provided that you do not currently have?
3. What would you want to change regarding the services you have been provided?
4. What recommendations do you have for improving the services provided by the agency?
5. In what ways could this service be improved to better meet your specific needs?
6. What does your child tell you about their experiences with the services that are provided?
7. What improvements have you seen in your child since he/she began receiving services at this agency?
8. What other services may benefit you?

Demographics

Parent/Guardian information:

Gender Male______ Female_______

Age________________

Ethnicity________________________

Marital Status:

Married___ Divorced___ Single___

Cohabitating___ Widowed___

Please indicate your relationship to the child (e.g., Parent, step-parent, grandparent, legal
guardian):_______________________________

Child information:

GenderMale____ Female_____

Age________________

Ethnicity________________________

How long has your child been receiving services through West End Family Counseling Services? ____

APPENDIX C

LETTER OF INTENT

West End
Family Counseling Services

serving our communities since 1955

November 16, 2005

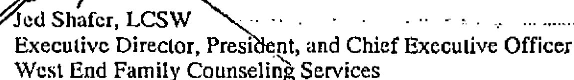
Dr. Rosemary McCaslin
Department of Social Work
California State University, San Bernardino
5500 University Parkway
San Bernardino, CA 92407

Dear Dr. McCaslin:

This letter confirms the intent of Cheri-Lyn Fahlgren Romero and Sarah Hayes to conduct a research project at West End Family Counseling Services. The project is intended to partially fulfill the requirements for a Master's degree in Social Work at California State University, San Bernardino.

West End Family Counseling Services grants permission for Ms. Fahlgren Romero and Ms. Hayes to conduct their research project at this agency. This project entails a survey to be completed by the parents and/or guardians of minor clients. The survey will gather information regarding participants' satisfaction with services provided by the agency, and will provide survey participants an opportunity to offer recommendations for services that may be of further benefit to the families this agency serves.

The students will conduct their research project under the supervision of agency professional staff. It is understood that client's participation in the study is voluntary and that the utmost care will be taken to ensure the confidentiality of all participants in this study.



Jed Shafer, LCSW
Executive Director, President, and Chief Executive Officer
West End Family Counseling Services

Ontario Headquarters
855 North Euclid Avenue
Ontario, CA 91762
(909) 983-2020 FAX (909) 983-6847

Norton-Fisher Child & Family Center
7165 Etiwanda Avenue
Rancho Cucamonga, CA 91739
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www.wefcs.org

APPENDIX D

INFORMED CONSENT

INFORMED CONSENT

This study in which you are being asked to participate is designed to investigate client satisfaction with the services provided by West End Family Counseling Services. This study is being conducted by Cheri-Lyn Fahlgren Romero and Sarah Hayes under the supervision of Dr. Tom Davis, Assistant Professor of Social Work. This study has been approved by the Department Of Social Work Sub-Committee of the Institutional Review Board, California State University, San Bernardino.

For this study, you are being asked to complete a questionnaire concerning your satisfaction with the services provided and your perspective on what services will benefit you. You are also being asked to complete a set of demographic and background questions such as your age, gender, ethnicity, and marital status. The questionnaire should take about 15 to 20 minutes to complete.

All of your responses will be held in the strictest of confidence by the researchers. Your name will not be reported with your responses. All data will be reported in group form only. Participation in this study will have no effect on the services that you receive from the agency. Additionally, the agency will not know who participated. You may receive the group results of this study on completion in September 2006 located in the reception office.

Your participation in this study is totally voluntary. You are free not to answer any questions and withdraw at any time during this study without penalty. When you have completed the questionnaire, you will receive a debriefing statement describing the study in more detail. In order to ensure validity of the study, we ask that you not discuss this study with other participants. While there are no foreseeable risks involved to you as an individual for participating in this study, the valuable information we obtain from this study will be helpful in better understanding what services will better serve you.

If you have any questions or concerns about this study, please contact Dr. Tom Davis at (909) 537-3839.

By placing a check mark in the box below, I acknowledge that I have been informed of, and that I understand, the nature and purpose of this study, and I freely consent to participate. I also acknowledge that I am at least 18 years of age.

Place a check mark here ☐ **Today's date:** ____________

If you would be willing to talk about your thoughts and feeling on this subject and provide the agency with further feedback in a group discussion, please provide your first name and phone number.

Name ____________________________ Phone Number ________________

CALIFORNIA STATE UNIVERSITY, SAN BERNARDINO
SOCIAL WORK INSTITUTIONAL REVIEW BOARD SUB-COMMITTEE
APPROVED 1/1/06 VOID AFTER 1/1/07
IRB# SW0617 CHAIR [illegible]

APPENDIX E

DEBRIEFING

Study of Client Satisfaction with Services Provided by

West End Family Counseling Services

Debriefing Statement

The study you have just completed was designed by Cheri-Lyn Fahlgren Romero and Sarah Hayes to investigate client satisfaction with the services provided by West End Family Counseling Services. In this study the researchers assessed the current level of perceived benefit from and satisfaction with services provided by the agency. Furthermore, the researchers hope to gain insight into services that are not currently provided by the agency, but from which you, the client, think you may benefit in addition to the current services.

Thank you for your participation and for not discussing the contents of this questionnaire with other clients who may participate. If you have any questions about the study, please feel free to contact Assistant Professor Tom Davis at (909) 537-3839. If you would like to obtain a copy of the group results of this study, the results will be available at the agency after September 2006.

APPENDIX F

INFORMED CONSENT FOCUS GROUP

INFORMED CONSENT

This study in which you are being asked to participate is designed to investigate client satisfaction with the services provided by West End Family Counseling Services. This study is being conducted by Cheri-Lyn Fahlgren Romero and Sarah Hayes under the supervision of Dr. Tom Davis, Assistant Professor of Social Work. This study has been approved by the Department Of Social Work Sub-Committee of the Institutional Review Board, California State University, San Bernardino.

For this study, you are being asked to take part in a group discussion concerning your satisfaction with the services provided and your perspective on what services will benefit you. You are also being asked to complete a set of demographic and background questions such as your age, gender, ethnicity, and marital status. This discussion will last approximately two hours.

All of your responses will be held in the strictest of confidence by the researchers. Your name will not be reported with your responses. All data will be reported in group form only. Participation in this study will have no effect on the services that you receive from the agency. Additionally, the agency will not know who participated. You may receive the group results of this study on completion in September 2006 located in the reception office.

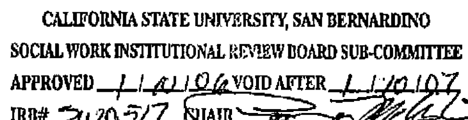
Your participation in this study is totally voluntary. You are free not to answer any questions and withdraw at any time during this study without penalty. At the end of the discussion, you will receive a debriefing statement describing the study in more detail. In order to ensure validity of the study, we ask that you not discuss this study with other participants, except with those who are here. While there are no foreseeable risks involved to you as an individual for participating in this study, the valuable information we obtain from this study will be helpful in better understanding what services will better serve you. Participants will be offered refreshments during the meeting.

If you have any questions or concerns about this study, please contact Dr. Tom Davis at (909) 537-3839.

By placing a check mark in the box below, I acknowledge that I have been informed of, and that I understand, the nature and purpose of this study, and I freely consent to participate. I also acknowledge that I am at least 18 years of age.

Place a check mark here ☐ **Today's date:** ____________

I Agree To Have My Comments Audio Taped ☐



APPENDIX G

DEBRIEFING FOCUS GROUP

Study of Client Satisfaction with Services Provided by West End Family Counseling Services

The study you have just completed was designed by Cheri-Lyn Fahlgren Romero and Sarah Hayes to investigate client satisfaction with the services provided by West End Family Counseling Services. In this study the researchers assessed the current level of perceived benefit from and satisfaction with services provided by the agency. Furthermore, the researchers hope to gain insight into services that are not currently provided by the agency, but from which you, the client, think you may benefit in addition to the current services.

If you have any questions about the study, please feel free to contact Assistant Professor Tom Davis at (909) 537-3839. If you would like to obtain a copy of the group results of this study, they will be available at the agency after September 2006.

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ASSIGNED RESPONSIBILITIES PAGE

This was a two-person project where authors collaborated throughout. However, for each phase of the project, certain authors took primary responsibility. These responsibilities were assigned in the manner listed below.

1. Data Collection:

   Team Effort: Cheri-Lyn Kaye Romero & Sarah Hayes

2. Data Entry and Analysis:

   Team Effort: Cheri-Lyn Kaye Romero & Sarah Hayes

3. Writing Report and Presentation of Findings:

   a. Introduction and Literature

      Team Effort: Cheri-Lyn Kaye Romero & Sarah Hayes

   b. Methods

      Team Effort: Cheri-Lyn Kaye Romero & Sarah Hayes

   c. Results

      Team Effort: Cheri-Lyn Kaye Romero & Sarah Hayes

   d. Discussion

      Team Effort: Cheri-Lyn Kaye Romero & Sarah Hayes