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| Authors(s) | Carr, Alan |
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AUDIT AND FAMILY SYSTEMS CONSULTATION: EVALUATION OF PRACTICE AT A CHILD AND FAMILY CENTRE

ABSTRACT

This audit of practice at a child and family centre included a 16 month case note review covering 319 cases, a postal survey of 45 families and an interview survey of 10 GPs who typically referred cases to the centre. The audit furnished information from three different perspectives on the referral process, the consultation process, and outcome for clients attending the centre. The referral rate was about one new case per day and peak referral times were the beginning of the autumn and winter school terms. Almost half the referrals came from GPs and the remainder were largely from Paediatrics, Education and Social Services. Most clients were seen within two months. Half of the families referred had serious psychosocial difficulties including multiple problem members, multiproblem children, multi-agency involvement, psycho educational difficulties, child protection problems or child placement difficulties. The majority of cases received six hours of consultation. Families where child abuse had occurred or families containing a multiproblem adolescent received a more intensive service. Between a half and three quarters of cases had positive outcomes as rated by staff and parents.

This paper was jointly written with Penny Owen and Dermot MacDonnell. Revised copies of the audit sheets are contained in Carr, A. (1995). *Positive Practice: A Step-By-Step Guide to Family Therapy*. Reading: Harwood.

The service was viewed by GPs to be highly satisfactory. On the negative side, many parents felt ill-prepared for the consultation process and most children did not enjoy the experience.

INTRODUCTION

Few audits of family therapy or systems consultation have been reported (Allman et al, 1989; Chase & Holmes, 1990; Dangan & Fish, 1991; Frude & Dowling, 1980; Thomas & Hardwick, 1989; Mashal et al, 1989, Manor, 1991). This is unfortunate because audit studies throw light on overall patterns of practice that occur in regular clinical settings. Published audit reports provide benchmarks against which other clinical teams can assess their work. The information provided by these studies complement the results of controlled treatment outcome studies. While the latter have high internal validity, audit studies have high ecological validity.

From a clinical team's view point, the results of a service audit are particularly valuable. They provide answers to questions like. How many cases are we seeing? Who refers them? What proportion of our cases are really complex and difficult? How many sessions do we see them for? Who drops out? What do our clients think of us? What do our referring agents think of us? How could we improve our service?

It was precisely a curiosity about these types of questions that spawned the audit described here. This curiosity was potentiated by a climate which was increasingly requiring clinicians in our field to provide evidence of therapeutic efficacy and quality service provision. At a National level we were being advised to develop audit systems to help us document and improve the quality of our services (Parry-Jones, 1992). At a local level a similar demand was made all the more poignant because our parent Hospital was preparing for Trust status (which it has since achieved). To place the audit in context, a description of the clinic follows.

THE CLINIC

Our Child and Family Centre provides a mental health service for a predominantly rural catchment area in the east of England. The population under 16 is 40,000. The Centre is based in a free standing building and is administratively attached to a large District General Hospital. Services are provided on site and at a satellite clinic in a small hospital 15 miles away. The satellite clinic is based in a small market town.

During the period when the audit described here was conducted, there was one senior staff member in each of the following disciplines: Psychiatry, Psychology, Occupational Therapy and Social Work. In addition there were part time junior or senior staff members in

all four disciplines along with a number of trainees on placement. The total staff compliment was never more than 9 Whole Time Equivalent clinicians. While each member of the clinical team had loyalty to a different therapeutic tradition, a family-systems orientation was the overarching framework which unified practice (e.g. Carr et al, 1989a; 1989b; 1989c; Gawlinski et al, 1988).

The questions to which we wanted answers have already been mentioned. What follows is an outline of the methods we chose to secure the data to answer them.

METHOD

Data were collected from three sources: the case notes, patients and referring agents.

Case Notes: The Thurlow Evaluation Survey Schedule (TESS) was used to abstract information from the files of all new cases referred to the clinic between September 1986 and December 1987. The TESS data are an information set which describes a cohort of new patients attending the Thurlow House Child and Family Centre over a 16 month period.

TESS was developed by clinic staff in the early months of 1986 and used routinely as a face sheet in new patients' files during these 16 months. TESS was based on an instrument used in a survey one of previously conducted (McDonnell, 1973). All TESS sheets used in this period were checked for completeness before data analysis.

Postal Survey of Clients: A Postal Survey Questionnaire was sent to a cohort of 46 families who attended the clinic between September 1986 and November 1986. Of these, 20 were returned. In addition, this questionnaire was sent to a cohort of 41 families who attended the clinic between September 1988 and November 1988. Of these 25 were returned completed. Because the two surveyed groups did not differ significantly on Postal Survey or TESS variables, data from both groups were analysed as a single data set. The non-response rate of about 50% was typical of surveys of this type (Stallard & Chadwick, 1991).

GP Interviews: Ten GPs who routinely referred cases to the clinic were interviewed using a semistructured interview schedule in the first half of 1990. The interviews were conducted by one of us (PO), a research assistant to the audit project who was not a member of the clinical team. The group of GP's interviewed provided 'consumer panel information' of the type that can best be provided by frequent users of the service. Their views were not intended to be representative of other referring agents such as social workers or GPs who referred infrequently.

DATA ANALYSIS AND RESULTS

Data from the Thurlow Evaluation Survey Schedule, the Postal Survey and the GP interview schedule were verified and analysed on an Amstrad PC 1640 using Systat software. The Chi Square test was used to test for all significant differences referred to in the results section and Spearman's rho was used for all correlation's.

THE REFERRAL PROCESS

Referral Rate. In the 16 month period between September 86 and December 87, 362 families were referred to the clinic. Of these, 319 attended their first appointment. This represents an attrition rate of only 12% and an annual first attendance rate of 239 cases per year. One third of these, that is 80 cases per year, were multiproblem families. In summary, a new family is referred to the clinic each working day of the year and a failure to attend a first appointment only occurs about once a fortnight. About seven multiproblem families are referred each month.

If it is conservatively assumed that each of the 80 multiproblem cases referred per year contained only two problem members, then the annual intake of people attending with problems is about 319.

Source of Referrals. Almost half of the cases (47%) were referred by GPs. The remainder were referred by the Paediatric Department of the District General Hospital (20%), the Local Authority's Education (12%) and Social Service (11%) Departments and a variety of hospital Consultants, Clinical Medical Officers and Health Visitors (11%).

Timing of Referrals. There were two peak referral times during the year: February/March (25%) and October/November (23%). These represent an increase in referrals occurring at the start of school terms beginning in September and January. The time lag in each instance reflect the time taken for the teacher to advise the parent to request a referral to the Clinic from the GP. The lowest rate of referrals occurred around Christmas over the months of December and January (8%). The remainder were spread relatively evenly across the year: April/May (13%), June/July (14%), August/September (17%).

Waiting Lists and Intake Procedures. The majority of cases were seen within a month (64%) and the remainder (36%) were offered an appointment within three months. A small but significant group of patients (7%) were offered immediate crisis consultations. Crisis consultations were offered for cases of self-harm, acute psychotic states, urgent child abuse assessments and atypical paediatric cases where an urgent opinion on psycho-social factors was required.

Eight out of ten intake interviews were conducted at the main

Clinic in Thurlow House. One in ten were conducted at a Satellite Clinic in Wisbech. The remainder were carried out on a ward of the District General Hospital, at the Clients home or elsewhere in the community.

Characteristics of Referrals. Cases were spread across the life cycle in the following way. About a quarter (23%) of the families referred were young couples or single parents with the identified patient being a child under 5. In 41% of cases families were established and had primary school-going children with the identified patient being in the 6-11 year old category. In 37% of cases families were dealing with the difficulties posed by having teenage children.

Although the clinic has had a policy of operating from a family-systems orientation, virtually all referrals were described in individual terms. The male/female ratio for referred children was 2:1, a common finding in survey's of attendance's at Child Mental Health Clinics (Bailey & Garralda, 1989).

At a systems level, cases were classified in terms of severity of psychosocial difficulties and the patterning of these difficulties within referred families. Only 50% of referrals presented with a single focal problem. The remainder presented with a range of severe psychosocial difficulties. The distribution of these within the cohort is described in Table 17.1. These cases are complex, difficult to manage and place heavy demands on clinic resources. What follows is a description of each of the categories contained in the table.

Multiproblem families referred to families with two or more distinct problems. For example, a referred child presented with a conduct disorder, the mother suffered from depression and the father abused alcohol. In cases where families faced a major problem which was complicated by the fact that one of the children presented with specific reading retardation or mild mental handicap the case was classified as having psycho-educational difficulties. Families where there was one child who presented with three or more distinct problems such as an emotional disorder, a history of self-harm and a multiplacement experience were described as families with multiproblem children. Multiagency involvement refers to cases where three or more agencies or professionals were involved at one time. For example, in one such case a GP, a paediatrician, a community based social worker, a health visitor, an adult psychiatrist and two probation officers were involved when the case was referred to us. Cases where child abuse was strongly suspected or had occurred were classified as child abuse cases in Table 17.1. Foster care cases in Table 17.1 are those where a child was already in foster care or where assessment for suitability for foster care was requested.

Table 17.1. Family Psychosocial Difficulties

| Family Difficulties | Frequency | % |
|--|-----------|----|
| Multiproblem family | 106 | 33 |
| Psycho-educational difficulties present in one child | 91 | 29 |
| Family contains a multiproblem child | 60 | 19 |
| Child Abuse | 58 | 18 |
| Multi-agency Involvement | 52 | 16 |
| In foster care | 32 | 10 |

Note: N = 319. Percentages sum to more than 100 because categories are not exclusive.

Cases were also classified from a traditional psychiatric perspective. Table 17. 2 describes the main ICD- 9 diagnoses shown by identified patients using the first axis of Rutter's multiaxial system (Rutter et al, 1975). Mixed disorders of emotions and conduct, adjustment reactions, conduct disorders and emotional disorders account for more than four out of five cases. The predominance of these types of cases is consistent with the epidemiology of childhood disorders (Links, 1983).

Table 17. 2. ICD-9 Diagnosis

| Diagnosis | ICD-9 Code | Frequency | % |
|--|------------|------------|------|
| Mixed Disorder of Emotions and Conduct | 312.3 | 104 | 33.0 |
| Adjustment Reaction | 309 | 74 | 23.0 |
| Conduct Disorder | 312.0 & .1 | 44 | 14.0 |
| Conduct Disorder | 313 | 38 | 12.0 |
| Psychosomatic Difficulties* | | 22 | 7.0 |
| Child Psychosis | 299.9 | 1 | 0.3 |
| Normal Developmental Variation | | 36 | 12.0 |
| Total | | 319 | |

*Includes anorexia (307.1), enuresis (307.6), encopresis (307.7), psychalgia (307.8), psychic factors associated with various physical illnesses (316), physiological malfunctioning arising from mental disorders (306).

A small but significant group of identified patients (n=22) presented with psychosomatic disorders. These included eating disorders, elimination disorders, psychogenic pain, and problems adjusting to long term illnesses like diabetes or cystic fibroses. More than one in ten cases were found to be in the normal range and were probably referred because of parental concerns about the normality of a child's development.

THE CONSULTATION PROCESS

Staffs' Perspective. The identified patient and significant family members from the child's household and/or network were invariably invited to an intake consultation. This preliminary consultation involved parents and siblings in the case of intact families. In child care cases or other complex cases with multi-agency involvement, social workers, foster parents, probation officers or other significant network members attended. We adopted this practice because failure to engage with significant network members early in the consultation process can often greatly compromise later therapeutic progress (Carr, 1990a). Following the intake consultation, a preliminary family formulation was drawn up and a plan for further involvement established, if this was required. One approach that we used in formulating family problems and some case examples are described elsewhere (Carr, 1990b)

In 11% of cases families were found to be functioning normally and their children were found to display normal developmental variation. These cases were not seen for further consultation and none were re-referred for consultation during the 16 month audit period. In 72% of cases further consultations occurred. Depending upon the formulation, these consultations occurred at one or more levels within the system including the interagency network, the family, the couple, the parents as individuals or the child. A number of such programmes have been previously described (Carr et al, 1989a; 1989c).

Our rationale for consulting to particularly complex cases involving families with adolescents and our programme for working with child protection cases have been documented elsewhere (Carr, et al, 1989b; Gawlinski et al, 1988). Both programmes provide a systemic framework for working with these complex and cases. They also outline the rationale used by our multidisciplinary team for dealing with family and professional network subsystems. In the 16 month period under review, 46 cases (14%) completed the Adolescent Programme. Four entered the programme and dropped out. Nine cases (3%) completed the Thurlow House Child Protection Programme. Here there was only one drop out.

A third of cases (34%) were active for 0-3 months; just over a

third (39%) were active for 3-9 months and the remainder (27%) were active for between 9 months and two years. Apart from complex cases assigned to the Adolescent Programme and the Child Protection Programme, each case received an average of 6 hours consultation. This is congruent with the finding that brief therapeutic contact of between 6 and 10 hours has been reported in reviews of family therapy and a variety of other child therapies (Kazdin, 1991, Carr, 1991).

Clients' Perspective. Patient's opinions based on the Postal Survey (n = 45) about the services they received are set out in Table 17.3. On the positive side, more than two thirds of the patients surveyed felt that the therapist understood and sympathised with them, was moderately fair, gave practical advice and was helpful in the intake interview.

On the negative side, only 22% of patients knew what to expect when they first attended the clinic and only 15% of children liked attending the clinic a lot. Both of these issues will be addressed later in the Discussion section.

GP's Perspective. In Table 17.4, the results of the interviews with the GPs are summarised. GP were in strong agreement in describing the type of service they required from the clinic. More than 70% expected a service that ameliorated presenting problems, improved family functioning, reduced risk associated with child care cases and improved interagency management of complex cases. After treatment, they expected that their input into referred cases would decrease. They also stressed the importance of written or oral feedback from the clinic.

The need for patients to be better prepared before attending the Child and Family Centre was endorsed by 80% of the GPs. This is in keeping with the opinions of patients and the attitudes of children outlined in the previous section.

OUTCOME

Staffs' Perspective. In the bulk of families (60%) completed assessment and/or treatment programmes. In only 15% of cases were two or more consecutive appointments missed and contact discontinued. In 25% of cases, families partially completed treatment but withdrew with the team recommending further intervention.

Key staff involved with each case rated outcome on a four point scale (Good, moderate, poor and deterioration). Because such ratings are subject to error due to clinicians either over or underestimating outcome, two precautions were taken. First, operational definitions of each category were agreed at staff meetings. Second, in a subsample of 20 cases, rated by two clinic staff, inter-rater reliability was assessed. 90% agreement was obtained.

Table 17.3. Patients' Perspectives

| Patient's Beliefs | Frequency | % |
|--|-----------|----|
| Consultation Process | | |
| We felt completely or moderately understood | 37 | 82 |
| We felt that the therapist completely or moderately sympathised with us | 36 | 80 |
| We felt that the therapist was completely or moderately fair | 35 | 78 |
| We felt that the therapist gave some or a lot of practical advice | 31 | 69 |
| After the intake interview, we saw the clinic as helpful | 31 | 69 |
| We knew what to expect when we first attended the clinic | 10 | 22 |
| Our child liked the clinic a lot | 6 | 15 |
| Outcome | | |
| After treatment there was some or much improvement in the main problem | 25 | 56 |
| The consultations were moderately or completely helpful | 30 | 67 |
| We have not sought further help since we attended the clinic | 34 | 76 |
| We would recommend the clinic to others with similar problems | 37 | 82 |
| We would definitely or probably return for treatment if the problem recurred | 33 | 73 |
| We would like to be able to refer ourselves for consultation | 22 | 49 |

Note: N = 45. Percentages do not sum to 100 since categories are not exclusive

For the cohort as a whole, staff gave 57% of cases a rating of good outcome and 18% a rating of moderate outcome. Overall, therefore staff viewed 75% of interventions as being at least moderately successful. In the remaining 25% of cases poor outcome was recorded. No case was rated as deteriorated. Deterioration referred to a reduction in psychosocial functioning between referral and discharge. Poor outcome referred to minimal improvement during the same period.

Patients' Perspectives. From Table 17.3 it may be seen that just over half the parents surveyed (using 5 point likert scales) rated the

service they received as leading to some or much improvement and about two thirds described the service as completely or moderately helpful.

These results in combination with the staff ratings of outcome suggest that the clinic offers a useful service to between a half and three quarters of its patients, a finding consistent with more tightly controlled research on family therapy outcome (e.g. Carr, 1991).

Table 17.4. GPs' Perspectives

| GP's Beliefs | % |
|--|-----|
| Consultation Process | |
| Treatment at the clinic should lead to... | |
| a reduction in the severity or intensity of the presenting problem | 90 |
| an improvement in overall family functioning | 100 |
| a reduction in risk to the child's well being in child care cases | 90 |
| an improvement in the interagency management of complex cases | 80 |
| a reduction in the number of attendance's of the patient at my surgery | 70 |
| It is very important to receive written or oral communication from the clinic about referred cases | 90 |
| Patients need better preparation before attending the clinic so that they will know what to expect | 80 |
| Outcome | |
| The clinic provides a good service to my patients | 80 |
| The formulation offered by the clinic is very helpful | 70 |
| Patients should be able to refer themselves to the clinic for treatment | 20 |

Note: N = 10. Percentages do not add to 100 because the categories are not exclusive

It is noteworthy that staff rated outcome significantly more positively than patients (Chi Square (1df) = 7.92, p<.01).

To identify aspects of the consultation process associated with good outcome selected items from both the TESS sheet and the Postal Survey Questionnaire were correlated with patient's reports of improvement in the presenting problem (rated on a 5 point scale). Five meaningful items correlated significantly (p<.01) with patient reported outcome. Feeling understood (r = .49), feeling sympathised with (r = .62), seeing the therapist as fair (r = .43) and viewing the therapist's advice as practical (r = .62) were all positively correlated with good outcome. A positive outcome was also associated with seeing the

therapist as helpful during the intake interview ($r = .58$). These results are consistent with widely obtained findings on therapist variables associated with therapeutic success in individual and family therapy, despite the diversity of rating scales used in this burgeoning literature (Carr, 1991; Keuhl et al, 1990, Kazdin, 1991).

About three quarters of patients sought no further help with their problems after discharge, would recommend the clinic to others with problems and would return if the problem recurred. This suggests that patients saw the clinic as offering a quality service.

Only about half of the patients surveyed thought that self referral was a desirable option.

GPs' Perspective. From Table 17.4, it may be seen that 8 of the 10 GPs surveyed rated the service offered by the clinic to patients as good or very good (points 4 or 5 on a 5 point scale).

7 out of 10 rated the formulation offered by the clinic as very helpful (5 on a 5 point scale).

In line with patients' views only 20% of GPs favoured the idea of patients being able to refer themselves for treatment rather than the GP making the referral. These findings are in stark contrast to those of Richards (1992). In a survey of 48 GP's in the Merton Child Guidance Clinic's catchment area, she found that 90% were in favour of self-referral. Self-referral has never occurred in our district, so patients have not experienced the benefit it first hand. In Merton, self-referral has been common practice for years and clients obviously would not want to lose this referral method.

DISCUSSION

A number of substantive and methodological issues deserve further discussion. The purpose of the audit was to systematically describe the referral and consultation processes and the outcome of consultation from the perspectives of staff, patients and referring GPs. The audit confirmed many impressions which the clinical team had formed, but also highlighted issues which otherwise would have gone unnoticed. First, we were surprised that half of the families we saw presented with multiple problems and represented a client group with serious and extensive therapeutic needs. We had not suspected that the proportion was so large. Second, we were pleased to note that despite the large proportion of our cases that fell into the multiproblem category, our successful outcome rate was in keeping with the results of controlled treatment outcome studies (e.g. Markus et al, 1990). This information along with the statistics on referral rate of one new family per day or over 1000 new people per year was useful in making a case to management about increasing staffing levels.

Third, we were disappointed that many of the families that

were referred to us felt ill-prepared for the consultation process. We have tried to rectify this situation by writing an extensive services prospectus and making this available to referring agents.

Fourth, we were also disappointed to learn that children found the consultation process unpleasant. However, it is probably inevitable that many youngsters labelled as identified patients experience the referral and consultation process as punitive. At a therapeutic level all team members remain committed to making the consultation process as benign as possible for children. A detailed account of the variety of strategies that have evolved are given elsewhere (Carr, In Press). These include making the waiting room and consultation rooms cosmetically attractive to children, correcting negative expectations in the first session, explaining the therapeutic process and systemic ideas in concrete rather than abstract terms, using dolls and drawings to help children explain their view of the family situation, teaching children turn taking and other social skills necessary for engaging in therapy, using stories and metaphors with a specific focus on helping children reframe their view of the family situation, and providing children with adjunctive play therapy and an advocacy relationship with the play therapist to support them in family therapy sessions.

The methods that were used in the audit (case note review; postal survey; interview survey) were adequate for achieving our objectives. They captured important data about the domains of interest (referral, consultation and outcome) from three key sources (staff, patients and referring GPs). The quality of the information was sufficient for making essentially managerial rather than scientific decisions about future service delivery. However, our methods for collecting data had their limitations and it is worth reviewing these.

First, the TESS sheet, the Postal Survey and the GP Interview Schedule had limited coverage. Only a small number of items was contained in each instrument. In audit, the dilemma is always to balance the comprehensiveness of the instruments used, against the likelihood that respondents will co-operate. In this audit, particularly with the TESS sheet, our decision to design a brief instrument was very successful. In the majority of cases staff completed this face and where data were missing, it was possible to extract it from case notes with limited difficulty.

Second, the reliability of the data furnished by the three instruments is largely unquantified. For the TESS data, interrater reliability information was calculated for outcome only. It is particularly important to rate this accurately, hence our decision to check reliability here. We did not calculate interrater reliability for variables like diagnosis or psychosocial difficulties because we were satisfied that the rules for giving a diagnosis or scoring a psychosocial

difficulty as present were clear enough to lead to accurate and reliable use of the categories. However, we acknowledge that this is a major weakness of the study. Ideally the inter-rater reliability of all variables needs to be assessed so that the degree of confidence which may be placed in the obtained results can be accurately specified. Also, if variables are defined in a way that yields high interrater reliability, then the scales may be used by other investigators and results from all studies using the scales compared.

The reliability of patients' and GPs' responses are unknown. We have assumed that both patients and GPs have been as accurate as possible in letting us know their views. Ideally, test-retest reliability data should have been obtained on a subsample of cases to determine the stability of respondents views over time.

Third, the validity of the data in this audit is unquantified. For example, we do not know the extent to which ratings of outcome would correlate with well established criteria like changes on psychometric scales like the Child Behaviour Checklist (Achenbach & Edelbrock, 1983) or the McMaster Family Assessment Device (Miller et al, 1985).

These reliability and validity problems are not unique to our study and they typify many audits of clinical practice in the field. Frude & Dowling (1980) have argued that self-reports from consumers are valuable in their own right, even if their reliability and validity remains unquantified. They furnish information that clinicians may usefully bring to bear on the way in which clinical services are offered.

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