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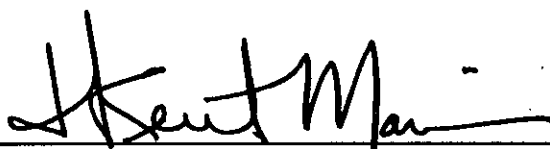
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DOCTOR OF PHILOSOPHY DISSERTATION

OF

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WALDEN UNIVERSITY
1996

ABSTRACT

PARENT SATISFACTION WITH STAFF INTERACTIONS
AT A COMMUNITY BASED MENTAL HEALTH CENTER

A DISSERTATION SUBMITTED TO
THE FACULTY OF WALDEN UNIVERSITY
IN PARTIAL FULFILLMENT OF THE REQUIREMENTS
FOR THE DEGREE OF
DOCTOR OF PHILOSOPHY

HUMAN SERVICES / COUNSELING PSYCHOLOGY SPECIALIZATION

BY
CHRISANNE MARIE CHRISTENSEN

MAY, 1996

ABSTRACT

This study investigates an important issue in mental health service provision, the level of parental satisfaction with staff interactions at a community based mental health center. A small target population, which included all families who had received services within a one year time frame, were surveyed via mail to determine levels of satisfaction. Parents responded to a questionnaire and data were collected to determine overall satisfaction, areas of service in need of improvement and areas of interaction which were most unsatisfactory. Additionally, data were compared to past study material to determine either an increase or decrease in parent satisfaction within a two year period.

The results suggested that little change existed within the two year time frame. However, a marginal decline in satisfaction was found among the parents. Results indicated a need to evaluate the parents' perception of staff helpfulness and the staff's need to educate the parents in appropriate ways to live with their severely emotionally disturbed child. Additional recommendations included other important research areas within a community based mental health system, the application of individual interview procedures and improvements to instrumentation.

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CHAPTER 1

Introduction

This study investigated an area of concern in the field of human services and counseling psychology. It identified levels of parent / consumer satisfaction from a parents' perception. This research study focused on a specific population of children and adolescents within Tri-County Mental Health (TCMH) often labeled as severely emotionally disturbed by their community and school. The primary benefactors of this study were child and adolescent mental health service consumers and their service providers at Tri-County Mental Health (TCMH). Approximately 150 parent/consumers of child and adolescent mental health services at TCMH were surveyed. The results of this proposed study were used to improve service accessibility and to develop new community based programs. Additionally, this study has explored the need for improvement in child and adolescent mental health services and made recommendations for future research.

The study of human service programs incorporates a wide range of methods representing multiple interests and perspectives (Attkisson, Hargraves, Horowitz & Sorensen, 1978). However, until recently, the service consumer's viewpoint has often been ignored or under-represented. For example, while many investigations of the outcome of effectiveness of services include investigations of satisfaction, they do not measure an increase or decrease in satisfaction (Larsen, Attkisson, Hargreaves & Nguyen, 1979).

Background of the Problem

In recent years there has been a significant shift toward broadening the scope of client participation in the study of human service programs, particularly in the area of severely emotionally disturbed children and their families. A notable example of this trend is the increase of publication and research in the area of client and parent satisfaction. The distinguishing feature of this research is the focus on feedback from recipients who are asked to evaluate the services provided to them. These families are uniquely qualified to provide suggestions and information about the services they receive. Satisfaction measures supply information about the acceptability of different psychological interventions and thus provide quality assurance and social validity data (Wolf, 1978). Client and consumer satisfaction has with some exceptions (Zamostny, Corrigan, & Eggat, 1981) proven to be a good predictor of the client's compliance with treatment, premature termination, and future help-seeking behavior (Kokotovic & Tracey, 1987; McNeill, May, & Lee, 1987; Sanbourin, Gendreau, & Frenette, 1987; Ware & Davis, 1983). For the purpose of this study, quality assurance was defined as an increase or decrease in satisfaction, and social validity was used to describe current existing programs and their level of helpfulness for the family.

Research examining children's mental health systems has generally failed to incorporate input from families as a whole. The publication of Kitzner's (1982) book, *Unclaimed Children*, was a declaration to all service agencies to incorporate input from parents of disturbed children and address the issue of parent satisfaction. Additionally, recent publications emphasize the need for

collaboration between families and service providers (Friesen & Koroloff, 1990; Collins & Collins, 1990; DeChillo et al., in press; Duchnowski, Berg, & Kutash, in press).

Attention in literature to child and adolescent mental health services (C/AMHS) has approached the problem of assessing consumer satisfaction. Much of the energy for investigating this area has been generated by the Child and Adolescent Service System Program (CASSP). CASSP was initiated by the National Institutes of Mental Health (NIMH) largely in response to Kitzner's landmark survey of children's mental health services (1982). Kitzner and her colleagues found C/AMHS to be woefully inadequate, many children were not being served, and those being served were not being served effectively and efficiently.

Stroul and Friedman (1986) summarized CASSP's basic principles in a document that was a cornerstone of the philosophies and values driving children's services. Today, one of the pivotal aspects of the CASSP philosophy is the inclusion of parents as an integral part of the treatment plan with this involvement occurring in all aspects of service - planning, implementation, and evaluation. This emphasis on family involvement in evaluation and treatment planning has provided the motivation for consumer and parent satisfaction studies. When parents are seen as participants in the treatment process, it naturally follows that their perspectives on the effectiveness of treatment and the adequacy of the system of care should be sought and incorporated into improved

methods of service delivery. The importance of the CASSP-inspired values, in combination with managed care and a greater emphasis on quality control, has resulted in a directive for the investigation into consumer satisfaction with Child and Adolescent Mental Health Services (C/AMHS).

Statement of the Problem

Parents of children and adolescents receiving services at Tri-County Mental Health Mental Retardation during fiscal year 1995 are only the second group of individuals to access services from the new Texas Children's Mental Health Plan (TCMHP), which funds the child and adolescent program. These parents were encouraged to participate in the treatment and planning process and were also surveyed for suggestions, complaints and concerns about the services they received. It is therefore, very important to ascertain the degree of satisfaction held by the parents with the treatment received by their offspring at this agency. Research in the area of current consumer satisfaction of mental health services, is an important evaluative tool to improve services to the community, future consumers and, their families. This new program has utilized such studies to improve accessibility, quality and, diversify services throughout its inception with the concept of parental satisfaction as a driving force. Lourie and Katz-Leavy (1986) noted that parents are the most important resource for the child and must be given the necessary support to fulfill that role.

Therefore, the questions to which this dissertation was directed were : (a) What is the general level of parent satisfaction, while interacting with Tri-County Child

and Adolescent staff? (b) What areas of interaction seem to be the most satisfactory in the eyes of the parents? (c) What areas of interaction seem to be the most unsatisfactory ? (d) What areas need more improvement? (e) Is the level of satisfaction among parents higher or lower compared to 1994?

Purpose of the study

This study had several purposes :

- Obtained data to determine levels of satisfaction among parents.
- Measured parental satisfaction by the completion of a valid satisfaction survey instrument.
- Compared previous results from budgetary 1994's Parent Satisfaction survey to budgetary year 1995's survey to determine an increase or decrease in satisfaction.
- Incorporated suggestions and critiques into currently existing child and adolescent programming.
- Provided TCMH service professionals with outcome data and recommendations for change and future study.

Significance of the study

In the past, client / parent satisfaction with mental health services was given low status as a research variable (Margolis, Sorenson & Galano, 1977). However, interest in assessing patient satisfaction with psychiatric services has increased substantially after the passage of the Community Mental Health Center

Amendments of 1975 (Tanner & Stacy, 1985), which emphasized measures of client satisfaction in order to stay in touch with the population it serves, and to continually improve services. This study particularly focused on the topic of parental satisfaction and the comparison of satisfaction levels of budgetary years 1994 and 1995.

The investigation of consumer satisfaction was particularly interesting for several reasons. To begin with, these measures supply information about the acceptability of different psychosocial interventions and thus provide much wanted quality assurance and social validity (Wolf, 1978). Secondly, satisfaction is moderately related to the client's view of treatment outcome (Lebow, 1983). Thirdly, parents of severely emotionally disturbed children rarely have the opportunity to participate in policy-making decisions that affect their children's welfare. Parents are uniquely qualified to describe their family's and child's needs, kinds of services sought, and the barriers to service delivery that might be overlooked by provider-experts.

Similar to other systems of care providers, Tri-County Child and Adolescent Services was shaped around family preservation and involvement. The agency's mission is a focus on maximization of the strengths of families and creation of opportunities for change by utilizing support, skill building, and clinical intervention designed to facilitate empowerment in families (Proposal for the Texas Children's Mental Health Plan, 1991). The Texas proposal also recognized that children and families are best served in their own communities. Thus, the

community becomes the therapeutic system of collaborative service providers that supports families in need.

This study made a significant contribution toward the improvement of services, accessibility and innovation for families in need. It was an example of the program's overall philosophy of the incorporation of feedback from children and parents, in an effort to gauge success or failure. The data from this survey were analyzed by this researcher in order to make recommendations to improve professional services and to determine effectiveness of treatment. Accordingly, this study provided important tangible information and insight into the needs and concerns of individuals and families in need while providing suggestions of application of services and knowledge.

Research Questions

The research questions for this study were: (a) What is the general level of parent satisfaction, while interacting with Tri-County Child and Adolescent staff ? (b) What areas of interaction seem to be the most satisfactory in the eyes of the parents ? (c) What areas seem to be the most unsatisfactory ? (d) What areas need more improvement ? (e) Is the level of satisfaction among parents higher or lower compared to 1994 ?

Definition of terms

The following terms were used in the study. They are particular to the community counseling field or used by the researcher to allow a common

understanding of the text.

Satisfaction - the word satisfaction is a broad term and various definitions of this concept have been proposed. Pascoe (1983), acknowledging the different conceptualizations of client satisfaction, defined it as “ the recipient’s reaction to the context, process and result of service experience” (p. 189).

Consumer Satisfaction - Lebow (1983) provided a narrow definition of consumer satisfaction, that is, “the extent to which services gratify the client’s wants, wishes and desires for treatment” (p. 212).

Quality Assurance - refers to the increase or decrease of satisfaction among parents during budgetary year 1994 compared to budgetary year 1995.

Social Validity Data - refers to the current programs in existence and to the helpfulness to families or to the possibility of causing families more stress.

Severely Emotionally Disturbed (SED) - those children or adolescents who are diagnosed both by the school and staff of Child and Adolescent Services as meeting the criteria in Diagnostic Statistical Manual - IV (DSM). Additionally, they must have a Global Assessment of Functioning (GAF) of 50 or below.

Target Population - individuals and families that reside in the designated Tri-County area, and students in special education programs or diagnosed as SED, who have a GAF of 50 or below or are at risk for out of home placement. Age limit of services 6-17 years.

Staff Interactions- any conversation or communication; by phone, in person or mail with the consumers’ family or the child or adolescent consumer. Staff may include any person working within Child and Adolescent Services.

Child and Adolescent Services - a special section of a community mental health mental retardation authority that works with children and adolescents age 6-17 years. This section is funded by the Texas Children's Mental Health Plan and therefore operates much like a separate entity.

Home-based Services - a team of professionals within child and adolescent services that provides counseling support and crisis intervention to consumers in their homes.

School-based Services - a team of professionals with child and adolescent services that provides services within distinct school settings. Some services are also coordinated with family members.

Case Management - a team of professionals with child and adolescent services that provides support for the therapeutic staff and is concerned with the general welfare of the client and family.

Family Preservation - a philosophical understanding of the importance and power of the family to attend to children and adolescents in need. Incorporated into this philosophy is the belief that children and adolescents should live within the family structure thus alleviating any needs for out of home placements.

Family - a individual or grouping of individuals who maintain everyday, continuing care of a child receiving services. This term may also incorporate multiple generations or foster caregivers.

Assumptions and Limitations

- People responded candidly to the survey/questionnaire.
- This study was limited by size and agency restrictions therefore limiting

generalizability greatly.

- This study was limited to a specific age population in the southwestern part of the United States.

This research project was limited to the study of satisfaction among parents of children or adolescents who were, consumers of services during budgetary year 1995. Themes surrounding satisfaction were limited to parental satisfaction with staff interactions. This study utilized a nonexperimental, cross-sectional survey design with active decision making. Although a small convenience sample of 150 families limited generalizability, this number represented the total population of families using services. Survey respondents were contacted using a computer-generated address list of all consumers of child and adolescent mental health services for fiscal year 1995.

needs and has been provided by a wide range of professionals and paraprofessionals (Glendinning, 1986; Halpern, 1986; Miller, 1987; Weiss, 1989).

The history of home visiting in Europe and the United States has recently been described by Waisk, Bryant, and Lyons (1990). They observed that although the history of formal support to families in their own homes cannot be precisely dated, by the Elizabethan era in England, health services were provided to paupers in their homes. Florence Nightingale had a strong influence on the development of home visiting services during the last half of the 19th century, and by the end of the 19th century, home visiting was a prevalent practice in Europe (Buhler-Wilkerson, 1985; Monteiro, 1985).

One of the most comprehensive home visiting programs of any country was developed in Denmark in the 1930s to address concerns about the mistreatment of illegitimate, abandoned, or orphaned children placed in private families (Wagner & Wagner, 1976). Home visiting in Europe continued to expand, and today most European countries offer home visiting services (Miller, 1987).

In the United States, home visiting services were strongly influenced by the settlement house workers in the late 1800s and early 1900s who were addressing the needs of immigrants and the urban poor. These individuals often focused on home-school relationships and used their knowledge of individual families to help the family and school work together (Levine & Levine, 1970). Some settlement house workers came to be known as school visitors or visiting teachers and

“took on the special assignment of calling on the families of children who presented special problems of an educational, social, or medical nature” (Levine & Levine, 1970, p. 128). Such work also contributed to the social work profession (Holbrook, 1983).

By the 1920s, a shift began to occur in the type of service provided to families, with the emphasis shifting from the family to the individual (Waisk et al., 1990). This shift paralleled developments in psychology during the same period, when the dominant mode of therapy was based on psychoanalytic theory with an emphasis on individual traits in personality, in contrast to an emphasis on environmental effects on personality and behavior. As with any shift in emphasis, one could still find continuing interest in the less dominant theory and approach, and such was true of home visiting (Roberts, Wasik, Castro, & Ramey, 1991). In 1935, financial assistance from the federal government for the care of children in their own homes began with the passage of the Social Security Act. This act not only provided for maternal and child health services but services for crippled children, and child welfare services. Later the Public Welfare Amendment of 1962 specifically described the option of strengthening the child’s family as an option for child welfare services (Datta & Wasik, 1988).

In the 1960s another shift in philosophy began to influence the provision of home visiting services (Wasik et al, 1991). Professionals began to view the role of parents in the rearing of handicapped children in a more positive manner, rather than blaming them for their child’s problems. These views were influenced by

such writers as Bell (1971, 1974), who questioned that the direction of influence between parent and child. He discussed his observations of other directions of behavior, specifically the children actively influencing their parent's behavior. Parents subsequently came to be seen as appropriate caregivers for their handicapped children, prompting a move toward home care and away from institutionalization for many children.

Home visiting for families has been guided by several assumptions (Wasik et al., 1990). First, it is assumed that parents are the most consistent and caring people in the lives of their children. Second, it is assumed that if parents are provided with knowledge, skills and support, they can respond more positively and effectively to their children. The third assumption is that parents' own emotional and physical needs must be met if they are to respond positively and effectively to their children. These assumptions incorporate the baseline for the family preservation movement, the need to strengthen the relationship between parent and child and, the belief that in many circumstances the family is the best environment for the child.

Modern contributions

Family preservation has emerged as a galvanizing concept cutting across diverse social welfare sectors and related helping professions (Mannes, 1992). There are numerous perspectives on what family preservation means, and a wealth of opinions on what it has come to represent. According to Nelson, Landsman, and Deutelbaum (1990) it reflects an area of rapid growth in child

welfare services. For Geismar and Wood (1986) family preservation represents an underutilized way of involving the entire family when working with juvenile delinquents. In the human services literature, “home-based services”; “family-based family centered treatment”; and “family-based services” are additional phrases often used to describe family preservation programs (Precora et al., 1987). Some academics and professionals choose to see the concept limited to short term intensive service programs that strive to prevent out-of-home placement of children, while others adopt a more expansive family support orientation (Kammerman, 1990). In the broadest sense, family preservation espouses a philosophy that most children’s needs are best met by their natural families, contends that by helping parents to more effectively function as caregivers and childrearsers, family and community life can be enhanced, and exhorts various levels of government to initiate and implement policies and programs to strengthen and support the well-being of families.

The application of sociological theory is one of the best methods for interpreting and understanding the evolution of family preservation. From the collective professional behavior the family preservation perspective presents a professional reform movement philosophy. This philosophy seeks changes in policies, programs, and practices primarily in the social welfare arenas of child welfare, juvenile and youth services, and mental health. Whittaker (1991) sees family preservation prompting “fundamental changes in thinking in the family service and child welfare fields” (p. 294). Tavantzis et al., (1985) point out how home-based services for juvenile delinquents necessitates shifting one’s focus

from how problems arose to how they are perpetuated. For those involved in the movement, family preservation represents a novel means of shaping the interactions between clients and the service system particularly in terms of agency and worker responses to clients and their families.

Although historical documentation traces the origins of family involvement and social services, recent attention to the American family in general and on families being served by the welfare state are the primary focus of this study. Politically a host of initiatives included under the mantle of parent empowerment served to demonstrate that the policy and program needs of middle-class parents, and their expression in the form of family support services, were really not that different from the needs of socio-economically disadvantaged parents (Stehno, 1986). This concept helped establish the relevance and merit of broad-based family support services for the poor, an idea central to family preservation. The family preservation movement emerged in response to the strain on the social welfare delivery system, the failure to address the needs of vulnerable families, and the resultant emphasis on out-of-home placements in foster care, residential facilities, group homes, etc., for children from those families (Mannes, 1991). It is not a movement that ponders the negative aspects of family life, but seeks to improve the quality of life for the entire family, thus improving dramatically the individuals under care.

Professional response to family preservation

There has been an increasing awareness of the empowered family in the helping

professions. These professions accept the concept of family as systems and utilize a more widespread employment of specific family centered services, therapies, and counseling techniques. In the social service sphere, the famous St. Paul Family-Centered Project responded to the collective needs of multiproblem families from 1948-1968 (Horesji, 1981). Pavenstedt (1967) reinforced the importance of working with multi-problem families. During the 1970s and early 1980s, a small number of primarily private providers transferred these principles in the course of working with families deemed at risk in order to avoid placement of children in substitute care (Hutchinson & Nelson, 1985). For professionals working in child welfare the concept of "permanency planning" suggested a means of overcoming the problems associated with placing children in foster care (Maluccio et al., 1980). Bryce and Lloyd (1981) compiled a composite portrait of how to conduct family centered practice in the homes of families to prevent placements.

The belief in family preservation, as it has coalesced, is predicated upon a growing professional consensus that every child should grow up in a permanent family, and proposes that the best way to accomplish permanency is by working with all family members in order to preserve families and prevent the placement of children outside the home (Mannes, 1991). Family preservation accepts the fact that there will be instances where substitute care is needed, but this option should only be exercised after all other viable alternatives have been exhausted. Yet, even if placement is necessary, every effort should be made to reunify the family as quickly as possible.

Whittaker (1991) articulates the tenets of the family preservation doctrine and distinguishes it from the traditional approach in the field of child welfare. Family preservation calls for shifting from a child rescue to a family support philosophy. Treatment ideologies under family preservation help families meet their essential needs in more natural settings, such as the home, by way of imparting life skills and linking them with environmental supports as opposed to employing “personalistic psychologies” designed to assess and resolve the pathologies of individual members (Mannes, 1991).

A set of values directly tied to the philosophy have evolved to guide family preservation practice. According to Maluccio (1991), the principles held in esteem are ; (a) people can change; (b) clients should be regarded as colleagues or partners; (c) the worker is responsible for instilling hope; (d) families need to become empowered, and (e) the worker needs system support. With a core set of values and a powerful philosophy, the shared generalized beliefs of the family preservation movement have gradually gelled.

Evaluations of family preservation programs

Recent evaluations of the family preservation philosophy and programs have been largely positive. Investigation into the success of family preservation has focused upon a number of outcome variables, including prevention of out-of-home placement, cost effectiveness, and family functioning (Florida Department of Health and Rehabilitative Services, 1982; Kinney et al., 1988). Additional

evaluation of the family preservation model can be found in a dissertation by Sullivan (1994), who articulates a study of parent perception of an intensive family preservation program and evaluates the effectiveness of the services. The study gives the parents the primary role of guiding the research and defining the effectiveness of a family preservation agency. Practitioners and referral agencies provided a secondary source of information. The primary findings relate to the context of service delivery, the type of service, and recommendations to improve services. Results of this study include positive outcomes from family members, specifically, the powerful impact that resulted from the assessment process and service delivery taking place in the home and community.

Bath's 1992 dissertation documents the many reported positive outcomes of family preservation in terms of the prevention of out-of-home placement, but some results have been mixed. Bath (1992) found that; (a) proportionally more abusive than neglectful families were referred for services, when comparisons were made with national and state reporting agencies; (b) neglectful families, in contrast to abusive ones, were poorer, more reliant on public income, had more children at risk of placement, more likely to be headed by a single parent, and were more likely to have medical, mental health, and substance abuse problems; (c) although the majority of all children avoided placement, children from neglectful families were almost twice as likely to be placed than children from abusive ones. Bath (1992) suggests further research in appropriateness of referrals for service under the family preservation model and in the areas of characteristics of those families receiving services.

Throughout the literature, the importance of the professional worker and philosophy of working with clients and their families is viewed as an important variable. Nugent, Carpenter, & Parks (1993) discuss the importance of the social worker or other professional and the approach to the family; the worker should approach each family as a unique entity and tailor services to meet its unique set of needs and difficulties. Service plans involving a wide range of services (multisystemic therapies) beyond counseling and therapy should be included among the services provided. The workers characteristics of service provision provide the highest probabilities of successful family preservation and reunification efforts.

Alternately, other studies have mixed results about the success of family preservation service models. Family Preservation Service (FPS) models of mental health service delivery emphasize services that are home-based, intensive, goal-oriented and time-limited (Knitzer & Cole, 1989). The primary goal of the FPS model has been to prevent recidivism (e.g., re-occurrence of child abuse, re-arrest) and consequent out-of-home placement (Knitzer, 1982; Knitzer & Cole, 1989). Although program evaluations often suggest that FPS is effective at termination of services (Biegel & Wells, 1991), little evidence supports the longterm efficacy of FPS. Most evaluations of FPS have not supported its capacity to attain favorable long term outcomes. Most of these studies combined child welfare, mental health, and juvenile justice cases, and findings were not reported separately for different types of cases. For example, AuClaire and Schwartz

(1986) randomly assigned “multiproblem families” of adolescents recommended for placement to either four-week intensive home-based treatment or traditional community services. Significant between-groups differences were found with respect to type of placement ; temporary or shelter versus long term - and proportion of service days used, but not in average number of placements. Although juvenile offenders comprised roughly 38% of the entire sample, placement results were not reported separately for offenders (Henggeler et al., 1993). Similarly, Feldman (1991) randomly assigned families to FPS and standard community services, and included delinquents with “out-of-control” cases which comprised 59% of the sample. Findings suggested that FPS achieved better placement results than standard services at 3, 6, and 9 months after treatment, but by 12 months after treatment these effects had dissipated.

Henggeler (1993) suggests that multisystemic family preservation and family preservation models in general, hold some promise with respect to disruption of antisocial behaviors. Secondly, although efforts to reduce out-of-home placement and re-arrest of juvenile offenders are positive, additional attention must be paid to projects currently under way and enhancing the effectiveness of treatment. Suggestions for this are the use of volunteer adjuncts in treatment and follow-up as well as identifying the elements of multisystemic family preservation that are the most critical to effecting and maintaining change.

Child and Adolescent Service System Program (CASSP) and the Texas Childrens' Mental Health Plan

The Texas Children's Mental Health Plan (TCMHP) represents a milestone in the delivery of mental health services to children in Texas. Its significance lies in the fact that it is the first statewide, state-funded interagency initiative developed to provide a range of core services to children with emotional disturbance and their families. As conventional service delivery strategies have become less and less effective in responding to problems of vulnerable children and families, communities nationwide have begun exploring ways to encourage collaboration among agencies to better integrate services (Ellmer, Lein, & Hormuth, 1995). The TCMHP represents one such effort and incorporates the aforementioned family preservation ideals.

A major impetus for the establishment of the TCMHP was a report, *Do Kids Count? How Texas Serves Children and Adolescents With Severe Emotional Disturbance*, published in 1990 by the Mental Health Association of Texas. The report documented that the largest amount of public dollars for mental health services were being spent on expensive inpatient psychiatric care and residential treatment and that children often were receiving services out of their home communities. Very few publicly provided intervention and prevention services were available in many communities (Ellmer, Lein, & Hormuth, 1995).

The same problem in service delivery for children with severe emotional

disturbance in Texas have also been recognized nationally. The Joint Commission on the Mental Health of Children found that millions of children and youth were not receiving needed mental health services. The President's Commission on Mental Health also found that few communities provided the volume or continuum of programs necessary to meet children's mental health needs. Both commissions recommended that an integrated network of services be developed in communities to meet the needs of children and youth with severe emotional disturbance. It is important to note that the TCMHP is family-focused, meeting the family preservation model specifically and designed to address the services necessary for the child to safely remain in his/her home or school therefore facilitating an integration of service delivery.

The planning stages of the TCMHP included policy persons from various agencies appointed by the commissioners of the Mental Health Association to build a structure for the planning and development of the needed mental health services. This group became known as the state management team (SMT). It was comprised of members of 10 human service agencies including Texas MHMR. A key element in the planning process was the joint development and management involving all participating human service agencies. Communities were required to develop community management teams (CMTs), composed of local representatives of child-serving agencies. Thus, in structure the local CMTs mirrored the SMT, with the local project directors assuming a role similar to that of the project director at the state level (Ellmer et al., 1995). (For a detailed structure of the Texas Children's Mental Health Plan see appendices.) Planning and

implementation of programming and services were determined on the local level through a team of local representatives from all the major state agencies serving children. TCMHP is distinctive in that its funds can only be expended with the approval of a local interagency management team.

Despite the success the TCMHP has had providing services to Texas children and adolescents, there are still a tremendous number of unserved youth in need of publicly funded mental health services. Texas ranks 48th nationally in funding for mental health services, most of which is spent on services for adults.

The U.S. Congress, Office of Technology Assessment (OTA, 1986), in an important monograph on children's mental health, indicated that, at a minimum, 12% of the children in the United States, or 7.5 million children, required mental health intervention. Accordingly, the Texas Children's Mental Health Plan (TCMHP) identifies a target population in this study to be over 800 children and adolescents who are not receiving needed mental health services. Youth (ages 0-17) number 99,540 and represent 29% of the total population in the tri-county area examined in this study. While the TCMHP served 26,412 children in fiscal year 1993, the Texas Department of Mental Health and Mental Retardation (TXMHMR) estimates that there are another 105,000 children in Texas in need of publicly-funded mental health services. The OTA monograph further describes additional children, such as those living in poverty, those with alcoholic parents, and those who are abused and neglected, remaining vulnerable to mental health problems. Of these children in need, between 70% and 80% were not receiving

appropriate mental health care (OTA, 1986).

These OTA findings are consistent with other reports over the last decade that children in need of mental health services are disadvantaged (Knitzer, 1982, 1984, 1985). Accordingly, the TCMHP identifies a majority of the population as having limited financial resources and therefore unable to purchase services. A 1991 analysis reflecting the gross family income for children served by Tri-County MHMR found 43% of consumers with an estimated income level of below \$4,000 (TCMHP, 1991). Additionally, 82% of the children served were from households which earned less than the average household income of \$17,699.

The Child and Adolescent Service System Program

The most recent federal initiative to address this problem is the Child and Adolescent Service System Program (CASSP) initiated by the National Institute of Mental Health (NIMH). The U.S. has an 8-decade history of recommendations by various sanctioned bodies for improving the care of emotionally disturbed children, beginning with the 1909 White House Conference on Children (Day & Roberts, 1991). The CASSP was created when Congress appropriated \$1.5 million in 1983 for administration by NIMH and awards grants to state mental health agencies to develop and/or improve their mental health service delivery system for seriously emotionally disturbed children (Day & Roberts, 1991). Tri - County MHMR is one of the agencies that received CASSP funds and later other funds through continued efforts in family preservation.

The initial goals of CASSP grant applicants are precisely similar to those of Tri-County Mental Health and the Texas Children's Mental Health Plan. The primary goal statement of CASSP that affects and is the guiding principle for this study, is the development of a mechanism for including family input in the planning and development of service systems, treatment options and individual service planning. Tri-County MHMR views this goal as directly related to parent satisfaction and the development of a multi-systemic therapeutic approach to working with children and their families. The NIMH and CASSP further expresses a strong desire for mental health services that were community -based rather than institutional (residential). Within a community-based continuum of care model, the child and family's needs rather than conventions related to service sectors should be the basis for intervention (Stroul & Friedman, 1986). This principle is evident in "wraparound services" wherein service dollars flow across funding categories (Horner & Ray, 1993).

The first 10 state CASSP programs were funded during the summer of 1984. Since then CASSP staff, many of whom are social workers, have promoted philosophical and strategic changes in the systems that serve emotionally disturbed children and adolescents. Under NIMH auspices, an independent ten state qualitative evaluation of the first 5 years of CASSP demonstration projects was conducted in 1989. Incorporating retrospective qualitative evidence (including interviews of key staff), the investigative team concluded that state level developments were in the direction of CASSP goals (Schlenger, Ethridge, Hansen, & Fairbank, 1990). As of 1992 every state had received at least one

CASSP grant (for 3-5 years), and all states have developed a vision of a system of care that guides their system development. The concept of a “system of care” suggests a comprehensive spectrum of mental health and other services; children and youth, education, and juvenile justice that is organized into a network to meet these children’s multiple needs.

CASSP standards for mental health continue with the concept of protection and support for children with the incorporation of effective case managers and advocates. The Child and Adolescent Service System Program (CASSP) standards for mental health service delivery are based on the core value that children should have access to a system of care that is child-centered and community based. Specifically, children’s services should be comprehensive, individualized, and provided in the least restrictive environment that will be clinically effective. Families should be involved in both decision making processes and service delivery. A guiding principle of CASSP is that families of emotionally disturbed children should be “full participants in all aspects of the planning and delivery of services” (Stroul & Friedman, 1986, p. vii). Services should be integrated through links between agencies. Problems should be identified early and responded to promptly. Finally, emotionally disturbed children should receive services without regard to their race, national origin, religion, gender, or physical disabilities (Stroul & Friedman, 1986).

An Overview of Issues in Research on Consumer Satisfaction with Child and Adolescent Mental Health Services

Increasing interest in consumer satisfaction measures of mental health systems and services signals a recognition that these mental health systems must be aware of and responsive to their clients. Borrowing heavily from market research, initial consumer satisfaction measures focused on adult mental health systems and on the growing awareness that appropriate mental health treatment must be client centered (Berger, 1983; Essex, Fox, & Groom, 1981; Fawcett, Seekins, Wang, Muiu, & Suarez de Balcazar, 1982). Moreover, in the early 1980s, Kitzner's research showed that among children and adolescents with severe emotional disturbance, 2 out of 3 were not receiving adequate services (Knitzer, 1982)

Central to the CASSP initiative, Stroul & Friedman (1986) articulated two core values which emphasized the need for the system of care to be child-centered and community-based. While these two core values are recognized as the ideal, the fact remains that children and their families often are excluded from planning and implementing appropriate treatment strategies (Friesen & Koroloff, 1990). However, as families come to play a more important role in developing a system of care for their children, child serving agencies will need to understand and evaluate their consumer's needs and satisfaction. Although consumer satisfaction surveys are not designed to be measures of outcomes and are not standardized to national norms, they do provide, within the community, some baseline measures from which to evaluate parent's concerns and needs for their children and

themselves (Moynihan, Forward, & Stolbach, 1993).

It has been conservatively estimated that 12% or 7.5 million of the nation's children suffer from mental health problems (National Institutes of Medicine, 1989; U.S. Department of Health and Human Services, 1990). Approximately 2 million of these children have received treatment, and about half of those receiving treatment have been inappropriately treated (Saxe, Cross & Silverman, 1988). Services for these children have been described as fragmented, duplicated, and too restrictive (Knitzer, 1982; Young, 1990). Services have also been criticized for not being community based, for being driven by the needs of the provider or payers rather than the needs of the children and their families, and for failing to include parents as part of the treatment (Gerkenmeyer, 1995). The need exists to assure that appropriate treatment is available to children with mental health problems and their families. An important part of this assurance is obtaining parent satisfaction information (Hargreaves, Attkisson, 1978).

The challenges of measuring satisfaction

Many evaluators and researchers have advocated the inclusion of client satisfaction ratings as one component of human service program evaluation (e.g., Hargreaves, Attkisson, 1978; Margolis, Sorenson & Galano, 1977; McPhee, Zusman & Joss, 1972; Zusman & Slawson, 1972). These writers have advanced several compelling reasons for assessing client satisfaction and, more generally, for involving the client in the evaluation process.

First, when the client's perspective is not taken into account, the evaluation of services is incomplete and biased toward the provider's or the evaluator's perspective. Second, in many human service fields, there are legislative mandates to include clients in the evaluative process. In mental health, for example, the Community Mental Health Center Amendments of 1975 (Title III of Public Law 94-63) require a broad-based evaluation of programs in order to receive continued funding. One provision of PL 94-63 pertains to measuring the acceptability of services, which necessitates some form of client or patient participation in program evaluation.

Most C/AMHS researchers have assumed that the definition of satisfaction is commonly understood and have not provided a formal definition in their writings. Few have attempted to elaborate satisfaction conceptually or to place the concept within any larger psychological theory. This situation was noted by Brannan and Helfinger (1993, 1994), who responded by advancing the only theoretical formulation of satisfaction currently available. Citing research that consumer expectations play an important role in satisfaction, these authors constructed a model in which parental satisfaction was determined by the interconnections between family resources, their child's mental status, prior expectations, and actual experiences with the service program (Young, Nicholson and Davis, 1995).

In the area of C/AMHS, satisfaction has emerged as a factor in several related measures, including parental collaboration (DeChillo, Koren, & Schuktze, in press)

and family burden (Koren, DeChillo, & Friesen, 1992). An attempt to factor analyze data from a scale measuring satisfaction has been made by Rouse, MacCabe, and Toprac (1994). Their results support the notion that a number of closely-related components comprise satisfaction.

Unfortunately, most research examining children's mental health systems and satisfaction has failed to incorporate input from parents of disturbed children, even though the parents have information that cannot be obtained by professionals. Early researchers comparing parents and teachers as expert informants (Rutter, Tizard, & Whitmore, 1970) suggested that parents and teachers focus on different aspects of adjustment, making both of their perspectives essential to the task of identifying children "at-risk." Research funded largely by CASSP has influenced progress toward incorporating parental involvement.

One of the cornerstones of the CASSP philosophy is that parents should be an integral part of the treatment of their children. This involvement should occur in all aspects of service provision planning, implementation and evaluation. Emphasis on family involvement in evaluation has provided the catalyst for consumer satisfaction studies. The announcement of these CASSP-inspired values, in combination with the advent of managed care and a greater emphasis on quality control, has resulted in a directive for the investigation of consumer satisfaction with C/AMHS receiving particular attention.

Parent -Professional Relationships in the Treatment of Seriously Emotionally Disturbed Children and Adolescents

In response to growing documentation of the failure of social service systems to adequately meet the needs of SED children and adolescents, the National Institutes of Mental Health (NIMH) initiated the Children and Adolescent Service System Program (CASSP). The first 10 CASSP programs were funded during the summer of 1984. Since then, CASSP staff, many of whom are social workers, have promoted philosophical and strategic changes in the systems that serve emotionally disturbed children and adolescents. The goal of CASSP is to develop multiagency, coordinated, community-based systems of care for children and adolescents with serious mental health needs (Stroul & Friedman, 1986). The concept of “system of care” suggests a comprehensive spectrum of mental health and other services; children and youth, education, and juvenile justice, that is organized into a network to meet these children’s multiple needs. A guiding principal of CASSP is that families of emotionally disturbed children should be “full participants in all aspects of the planning and delivery of services” (Stroul & Friedman, 1986, p. vii). A recent proposal to federally funded comprehensive community-based services for children also listed as a guiding principle the inclusion of families as full participants (Child Mental Health Service Initiative, 1989).

A review of the literature on the parent-professional relationship reveals little

research on how parents and professionals actually interact. Research that does examine parent-professional relationships has focused primarily on parent's views of their interactions with professionals. This research, coupled with considerable parental testimony, attests to significant parental dissatisfaction with interactions with professionals regarding their children's emotional problems (Francell, Conn, & Gray, 1988; Parents Involved Network, 1984-1989; Spaniol, Zipple, & Fitzgeralds, 1984 ; Tarico, Low, Trupin, & Forsyth-Stephens, 1989).

Any analysis of parent involvement in the provision of services to emotionally disturbed children must first acknowledge that much of the impetus for a changed parent-professional relationship has come from parents, not professionals. Historically, most children's psychiatric programs, especially inpatient and day treatment programs, rarely involved parents as important participants. If parents were involved, the dominant view toward working with them seemed to be that the professional had to assess and deal with both a disturbed child and disturbed and difficult parents (Critchley & Berlin, 1981). The theoretical bias of most professionals, a belief accepted by many families, was that mental illness is caused largely by family factors (Lusthaus, Lusthaus, & Gibbs, 1981; Palazzoli, 1986; Smets, 1982; Terkelsen, 1983). Thus, the professional defined the family's role as either informant or client.

Families repeatedly have reported that they are tired of being blamed for their child's problems and the tendency of many professionals to focus on parental inadequacies rather than strengths. Tarico et.al., (1989) concluded that parents

were consistently alienated by criticism and blame directed toward them. Even when family problems had contributed to the child's problems, "the parents' experience of being blamed inhibited rather than facilitated the treatment process"(p. 319).

This limited notion of the role of the parent has been increasingly rejected by parents. Parent advocacy groups have challenged experts who tend to blame parents for their children's mental illnesses. These groups have urged professionals to recognize and accept families as primary care givers who must be fully involved in decision-making processes concerning their children's mental health treatment. Parents also identified major systemic obstacles to family involvement and improved care such as lack of supportive family services and numerous problematic policies, regulations, and practices (McManus & Friesen, 1986; Vandecreek & Robertson, 1987). From parent's viewpoints, both systemic responses and professional attitudes and behaviors need to change.

The term "full parental involvement" has been coined by members of the Federation of Families for Children's Mental Health. This term describes parents' assertions that they should be accepted as members of a full-fledged multidisciplinary team. As a corollary of this concern, parents assert that all relevant information, including test findings and written reports on which planning and decision making is based, should be shared with them in the same manner as with other team members. Second a definition of full parental involvement includes the need for two-way communications free of professional

jargon. Third, treatment planning should focus on the children's and family's assets and strengths as well as their needs for assistance. Finally, parental involvement includes joint decision making by parents and professionals and clients themselves. (Francell et al., 1988; Spanol et al., 1984; Tarico et al. 1989).

Previous studies on parent-professional perceptions (Cone, Delawyer, & Wolfe, 1985), found that staff believed that families had little knowledge or understanding of and only marginal interest in their children's situations. They believed parents were happy with their roles as outsiders and glad to place the problems in someone else's hands. Critchley and Berlin (1981) found that as staff members developed therapeutic relationships with patients, especially as advocates on behalf of those children, they had a decreased tendency to view parental involvement as helpful. Staff bias for the children and against the parents lessened only when staff had sustained interactions with parents.

The tendency of professionals to blame parents is reflected in theoretical constructs ranging from the no longer popular "schizophrenogenic mother" theory (Fromm - Reichman, 1948), which explains how mothers cause their children's mental illness, to the more recently popularized "expressed emotion" theory (Koenigsberg & Handley, 1986) which identifies ways families may increase disturbed member's risk of relapse. Developmental theory that emphasizes the early attachment of infants to their mothers as the pivotal precursor to a host of personality effects is often used as a framework to interpret children's behavioral and emotional disorders (Mahler, Pine, & Bergman, 1975).

It is reasonable to believe that parent's problems and parent's relationships with their children may affect their childrens' or adolescents emotional well-being. However, it is evident that pervasive mother-blaming assumptions lead to overgeneralizations and distortions. The outcome for the mother is an additional source of stress rather than support.

Concepts of treatment

An interrelated issue, which contributes to the problems parents identify in the parent-professional relationship, is the concept of treatment. Traditionally, mental health professionals have orientated treatment toward pathology and the weaknesses of parents. The professional client relationship has been conceptualized in ways that emphasize the power and expertise of the professionals over that of the client or family. The resultant hierarchial relationship, as reflected in professional attitude and language, is then coupled with the professional focus on parents' deficiencies (Collins & Collins, 1990).

The lack of emphasis on support for families whose children have emotional problems is not accidental, but is related at least in part to deep-seated beliefs about the nature and cause of emotional disorders in children. Until very recently, many professionals, parents, and members of the public at large shared a belief that children's mental and emotional disorders were always a result of inadequate, inappropriate, or malignant parenting (Capla, & Hall-McCorquodale, 1985; Wahl, 1989).

These ideas are rooted in psychoanalytic theory which, beginning in the 1920s, had a profound impact on mental health practice and popular thought. Not only did psychoanalytic theory hold parents responsible for the problems of their children, practitioners were counseled against involving families of the mentally ill in any way (Friesen & Koroloff, 1990). Sigmund Freud (1952) warned against “any attempts to gain the confidence or support of parents or relatives by educating them about psychiatric treatment” (p. 83). According to Donner (1986), Freud believed that attempts to educate the relatives of the mentally ill usually led them to interfere with treatment. Similarly, Anna Freud warned against educating parents and accused them of the primary responsibility for the disturbance.

This focus continued through the 1940s, with the development of additional group modalities and other treatment innovations for individuals (Friesen & Koroloff, 1990). In the late 1940s, Frieda Fromm Reichmann (1948) published her concept of the “schizophrenic mother” which continued to perpetuate the concept of mother-blame and parental responsibility for mental illness.

During the 1950s and 1960s, new ideas and research about the genesis of mental and emotional problems led practitioners to focus on the family as the unit of treatment. Based on a systems view of family interaction and process (Bateson, 1972), children’s symptoms were seen as expressions of family conflict or as important to maintaining balance or maintaining homeostasis in the family.

Parents were now involved in treatment through family therapy, which sought to realign, reorganize, or otherwise change dysfunctional family interactions that scapegoated members or put them in a double bind. Woesner (1983) points out that this research was invaluable in bringing professionals back into communication with families, but that misapplication of the ideas engendered guilt and alienation of families from professionals.

Several important studies published in the early 1970s demonstrated the limitations of theories that held parents directly responsible for creating their children's emotional disorders (Hingten & Bryson, 1972; Waxler & Mishler, 1972; Arieti, 1974). Arieti (1974) for example, studied the interactions between persons with schizophrenia and their mothers to examine the validity of the concept "schizophrenogenic mother." He found that no more than 25% of schizophrenics demonstrated such negative maternal relationships. Hingten & Bryson (1972) reviewed the research literature on childhood psychosis and concluded that "Studies of family characteristics tend to rule out parental psychopathology as a causative factor" (p. 65).

Contemporary knowledge and thought about the etiology of childhood emotional disorders acknowledges that many factors, biological, social and psychological, may contribute to a child's disorder. In addition, an interactive rather than linear concept of the development of a child's problem is an important part of current approaches to treatment (Friesen & Koroloff, 1990).

A summary report from Northwest Regional Families as Allies Conference (McManus & Friesen, 1986) suggested that professionals can define the role of parents as patients with some problem or disorder that the professional must “treat” or as “allies, or partners, who can contribute information, energy, and perspective to a co-operative effort with professionals on behalf of children” (p. 77). The report’s authors assert that “the relationship between parents and professionals is most likely to experience the greatest improvement when parents are viewed as allies”(McManus & Friesen, 1986, p.77).

During the last few years some important changes in thought and practice have begun to converge so that state-of-the-art conceptions of an ideal system of care are more family centered and ecologically based (Weiss & Jacobs, 1988; Stroul & Friedman, 1988; Youngman & Brazelton, 1986). In addition to therapeutic strategies, there is a need to incorporate educational approaches, supportive strategies, concrete services, and self-help approaches as options in the system of care. Family roles and related services can be conceptualized in Table 1 adapted from Friesen & Koroloff (1990).

Table 1
Family Roles and Related Services

Parent's Role	Therapeutic Strategies	Educational Approaches	Supportive Strategies	Concrete Services	Self-Help Approaches
Target for change "Patient"	Individual, family or couple's therapy.	Parenting education Psychoeducational approaches			
Recipient of support and other services "Client"	Supportive psychotherapy	Professionally organized and led educational groups	Professionally organized and led support groups	Financial assistance, respite care, transportation, homemaker services, etc.	
Partner in treatment, education and development of the child "Ally"		Parent groups (self-education)	Support groups for parent, self-help, mutual aid	Parent-organized or cooperatively organized services	Parent advocacy groups, self-help groups, parent-professional coalitions.

Note : From Family-centered services: Implications for mental health administration and research, by Friessein, B. & Koroloff, N. *Journal of Mental Health Administration*, p. 23.
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Multisystemic Therapy

The goal of satisfaction research is to investigate the progress of parental involvement and the types of influences the mental health professionals have on the family. Of significant influence is the concept of multisystemic therapy (MST) (Henggeler & Borduin, 1990). MST is an innovative treatment approach that has the potential to address the special and multiple needs of children and families and is delivered within a family preservation model of service delivery. Henggeler, Schoenwald, Pickrel, Rowland and Santos (1994) describe conceptualizations central to MST as highly consistent with those identified by Stroul and Friedman (1986) and the guiding principles for systems of care. That is, MST is child-focused, familycentered, and intensive, with treatment goals and intervention strategies tailored to the needs, strengths, and goals of youth and family.

The treatment is based on sound conceptual models of serious antisocial behavior and delinquency that have substantial empirical support (Sondheimer, Schoenwald, & Rowland, 1994). Recognizing the highly contextual nature of behavior problems, MST interventions are directed toward the many determinants of problems across the multiple systems within youth and their families are involved. For example, the consumers receiving services under the Texas Children's Mental Health Plan (TCMHP) through Tri-County MHMR are involved with numerous agencies such as local probation and county youth service agencies. The concept of MST has proved useful with youths experiencing multi-problems and has demonstrated effectiveness with serious

juvenile offenders (Borduin et al., 1994), adolescent sexual offenders (Bourdin, Henggeler, Blaske, & Stein, 1990), and delinquency (Henggeler et al., 1986). Findings attest to long term efficacy (Henggeler, Melton, & Smith, 1992 ; Henggeler, Melton, Smith, Schowenwld, & Hanley, 1993).

Although MST family preservation has not yet been tested with youth who have a serious emotional disturbance and are at risk of out of home placement, there are several reasons to expect that it would be effective for a sizeable proportion of this population. First, as noted by Melton and Pagliocca (1992), it appears that children in the juvenile justice and mental health systems have similar mental health problems. Second, because MST has been effective in changing the behavior and family functioning of youth with serious antisocial behavior, it is likely to be effective in treating the estimated 50% of youth who are removed from home for conduct problems (Kiesler, 1993; Weithorn, 1988). Third, because it appears that it is the combination of assaultive and suicidal behavior, rather than just suicidal behavior along with family pathology variables, that predicts out of home placement (Gutterman et al., 1993). It is likely that MST, which has proven effective with violent offenders and their families, would be effective with youth removed from home for dangerousness.

Concepts of multisystemic therapy vary due to environmental and community availabilities and professional training however, such a concept has proven critical to successful treatment and change for children and families in care at TCMH. Incorporating a referral and assessment process that includes information

about other agency involvement and past activity in the system of care, difficult cases or situations are designated for problem solving with a community management team approach. This management team is the hallmark of the multisystemic approach. In attendance is every agency involved with child and adolescent care and, if needed, parent advocates and adult support services. Although this approach is used only in seemingly insurmountable cases, creative solutions are established. These community management team “staffings” provide families and concerned community members with first-hand experience in a multisystem or multisystemic approach. The professionals involved, usually from several agencies and psychodynamic backgrounds, provide their expertise in a given situation and enhance the positive outcome for the family.

Research Design

The method of research that looks with intense accuracy at the phenomena of the moment and then describes precisely what the researcher sees is called the survey, the descriptive survey, or the normative survey method of research (Leedy, 1974). Characteristics of a descriptive survey incorporate a carefully chosen, clearly defined population that has been specifically limited in order to provide precise data such as the target population in this study. The target population for this survey was specifically chosen based on admission criteria of TCMH discussed in detail in Chapter Three. Weathers, Furlong & Solorano (1993) state that the essential goals of survey research are to adequately define the target population to be surveyed, to develop an unbiased sampling procedure

that selects individuals to receive the mail survey, and to develop a procedure by which contact with these individuals will result in a high response rate.

Leedy (1974) pays close attention to the opportunities for bias in descriptive design and cautions the researcher to safeguard data from the influence of bias. Mail survey is appropriate safeguard against bias. Consideration was given to May (1993) and his outline of strengths and weaknesses in mail survey research. Mail surveys have a lower cost than face-to-face interviews and meet the need for anonymity which is crucial for honest responses to questionnaires. Parents must feel free to express their satisfaction and/or dissatisfaction without the fear of reprisal from staff members. Surveys also allow families time to consider other suggestions they might wish to make. This would not have been possible with face-to-face or scheduled interviews.

Additional factors pertaining to survey research as an appropriate tool are highlighted by Weisberg, Krosnick, & Bowen (1989). They discuss the use of surveys as a practical way to measure information about the prevalence of attitudes, beliefs, and behaviors both currently and over time. Although measuring changes over time is usually of limited interest, it is one way to study past satisfaction data and focus on improvements not previously recommended. To this end, Weisberg, Krosnick & Bowen (1989) recommend repeated surveys, over time, with the same instrument.

The analytical survey method is appropriate for data that are quantitative in nature and need statistical assistance to extract their meaning (Leedy, 1974). The Parent Satisfaction with Staff Interaction questionnaire allows for statistical referencing as a measure of satisfaction, while providing measurable comparison from the previous study.

Concerns about potential disasters due to low response rates prompted investigation into mail survey research. To find empirically evaluated procedures that enhance the collection of data through mail surveys, the fields of sociology and marketing are helpful. Heberlein and Baumgartner (1978) found that two factors influenced response rates to questionnaires. They found that 51% of the variance in the final response rate was associated with factors of (a) salience of the topic to the respondent and (b) the number of follow-up contacts. Incorporating above CASSP principles and parent involvement techniques into treatment of child and adolescents provided this researcher with reasonable evidence of salience of the survey topic.

also obtained, such as the demographics and open-ended question page included as page three of the survey (Herman, Morris & Fitz-Gibbon, 1987). Comments obtained from the open-ended questions were made available to staff members and coordinators for information and considerations for improvements.

Sample

The entire population size was 150, which included, parent/consumers of child and adolescent mental health services at Tri-County Mental Health. All parent/consumers were contacted using a computer generated list from the billings services department within the agency. Surveys were mailed at approximately the same time as the 1994 study which is roughly 6 months into the 1995 fiscal year. The small sample limited generalizability and an appropriate participation and return rate was difficult to achieve due to the type of population. This type of population does not traditionally respond to surveys for a variety of reasons and, a significantly large return rate was not anticipated. Therefore, staff members encouraged parent participation by personally delivering surveys to families they were currently working with.

Population

The population must have met target population criteria and had received services from Tri-County Mental Health (TCMH) during the 1995 budget year. The criteria as outlined in the Texas Children Mental Health Plan (1992) included children and adolescents between the ages of 17 and younger who experience

serious emotional, behavioral, and mental disorders as evidenced by a DSM-III-R Axis I or Axis II diagnosis. Excluding diagnostic criteria was a single diagnosis of pervasive development disorder, substance abuse, autism, or mental retardation.

Additionally, at least one of the following must apply:

- A functional impairment as indicated by a score of 50 or less, either currently or in the past year, on the Global Assessment of Functioning Scale (GAF).
- At risk of removal from the home or preferred living situation; or
- Identified as emotionally disturbed in special education.

Within these criteria, children and adolescents are equally prioritized for services who a were;

- in conservatorship of the Department of Child Protective Services;
- on court ordered probation;
- committed to the Texas Youth Commission and on parole or living in community placements;
- released from state hospitals; or
- psychiatric emergencies from the community.

All 150 parents of these children or adolescents were asked to respond to a mail survey questionnaire using a self-addressed stamped envelope, within 2 weeks. In an attempt to increase the first response rate of 15%, an additional mailing occurred 3 weeks later. After this time, staff members encouraged those parents who have not returned surveys to participate. The target population for this study resided within a very large three county area in rural Texas and, often mail

is the sole resource for communication with a significant number of the population represented.

Instrumentation

The Parent Satisfaction with Staff Interaction Survey was obtained from Gerkenmeyer (1995) . An example of the instrument and consent to participate form mailed to each parent, is located in the appendices. This instrument was previously utilized by TCMH last fiscal year and is applicable to community mental health populations as described above.

The scale was developed incorporating current existing consumer and parent satisfaction scales. Previous testing pertaining to the delivery of mental health services to children occurred at Purdue University and Indiana University Pediatric Intensive Care Unit (Gerkenmeyer, 1995). Areas of interest were defined as staff attitudes, staff availability, informing parents, providing support, including parents and, staff helpfulness.

The items were also furnished to professional experts in children's mental health and/or consumer satisfaction research. An 80% item support criteria was set to retain an item. All items except two met this criteria, but, with recommendations for wording changes, these two items were reworded and retained. A total of 12 new items were recommended by parents and professionals and added to the scale (Gerkenmeyer, personal conversation, July 26,1995).

The development of the P-SIS was in response to the need to have parent satisfaction instruments with strong psychometric support for use in evaluating parents' satisfaction with services for their children with mental health problems. The P-SIS was drawn from a large pool of items, providing specific enough information about parents' perceptions of staff interactions to be meaningful.

The instrument has 37 close-ended questions concerning the parent's general satisfaction level while interacting with Child and Adolescent staff. The responses were: (a) strongly agree, (b) agree, (c) neutral, (d) disagree, or (e) strongly disagree. These were then converted to a Likert scale, ranking them 1 to 5, respectively. The Likert scaling technique assigns a scale value to each of the five responses. Thus, the instrument yields a total score for each respondent. A discussion of each individual item, although possible, is not necessary.

Instrument development incorporated related literature to consumer satisfaction and to mental health service delivery to children. Additional literature was reviewed in the areas of existing consumer and parent satisfaction scales to identify items for the Parent Satisfaction with Staff Interactions Survey (P-SIS). A total of 76 items were generated. Several subscales were identified including staff attitudes, staff availability, informing parents, providing support, including parents and, staff helpfulness (Gerkenmeyer, 1995).

Prior to content and face validity efforts, the 15 items in the conceptual subscale “helpfulness” were deleted as Lebow (1982) suggested to avoid using outcomes from treatment as part of a satisfaction scale. The remaining 61 items were shared with two parents of children with mental health problems who were also directors of state-wide parent networks. They were asked to rate the items on a 4-point scale from “extremely relevant” to “not relevant” to identify content areas not included, and to make recommendations about the wording of items. Neither parent completed the rating scale, but did provide face validity by making changes for additional items and wording changes (Gerkenmeyer, personal conversation, July 26, 1995).

Likert-type scales are often incorporated in survey instruments successfully. The first step in constructing a Likert-type scale is to collect a number of statements about a subject such as parent satisfaction. The correctness of the statements is not important, as long as they express opinions held by a substantial number of people (Best & Kahn, 1993). As previously outlined, Gerkenmeyer (1995) conducted several parent interviews to incorporate correct questions and Likert-type scale answers. Likert-type scales express definite favorableness or unfavorableness to a particular point of view and the number of favorable or unfavorable statements is approximately equal. The Parent Satisfaction with Staff Interaction (P-SIS) survey incorporates 5 distinctly different possible responses. Clustering of the items’ means around the mid-point of the Likert scale and broad standard deviation indicates that the scale captures variability between subjects and also does not have the usual positively skewed results seen in most

satisfaction measures (Gerkenmeyer, 1995).

Gerkenmeyer (1995) anticipated that the more positively parents perceived their experiences with staff, the more positively they would rate their satisfaction with staff interactions. With this in mind, the 19- item Parent Satisfaction Scale was developed by compiling direct questions about parent satisfaction for each of the conceptually derived P-SIS subscales along with an overall statement of satisfaction with staff, providing construct validity. Two independent items expected to be positively related to the P-SIS were also added for criterion validity including; (a) If I needed services for my child again, I would go back to this staff and (b) I would recommend this staff to friends and neighbors with similar problems.

Data Collection Procedures

This survey attempted to collect data from all 150 parent/ consumers by a self-report, group administered, mailed survey instrument. Anonymity was assured through the use of code numbers. An initial survey was mailed to all parents/ consumers using names and addresses that are most currently available resulting in a 15% first return rate. After a period of 2 weeks an additional survey was mailed to nonrespondents which increased the final return rate to 31%.

Surveys were mailed using first-class postage recommended by studies by Armstrong and Lusk (1987) to increase return rates by 9%. Each survey

contained a self-addressed envelope to increase response rates. According to the self-interest hypothesis, stamped return envelopes enable individuals to act in their own best interest by reducing the time and cost involved in completing and returning the questionnaire.

Special stamps using child centered themes were used on both survey envelopes and response envelopes. The personalization hypothesis outlines the uses of regular and commemorative stamps as methods to increase the amount of personal attention given to potential respondents and encourages them to respond (Armstrong & Lusk, 1987). Each survey was hand addressed to improve participation, incorporating the concept of personalization. Each survey included a release form and statement of confidentiality.

Responses were returned to a post office box located near the mental health center. Upon receipt, results were compiled, paying close attention to the initial return rate. After approximately two weeks, another survey was mailed to non-respondents. Current agency policy prohibited any further data collection methods beyond additional mailings of the survey with requests to respond. Staff members were asked to encourage families to participate in staff meetings, paying particular attention to the issue of bias.

Data Analysis, Procedures and Techniques

The P-SIS has 13 items measuring parents' perceptions of staff interactions including items number 2, 5, 7, 9, 12, 13, 14, 15, 16, 17, 18, 21, and 22. Items 23 to

27 make up the expectation scale. Items 28 to 35 make up an importance value scale of the various concepts measured in the P-SIS. However, these different scales (parents' perceptions of staff interaction, expectation, and importance/value) were all strongly correlated with one another. Thus, they did not appear to measure different aspects of satisfaction. For the purpose of analyses, each item was assessed individually.

P-SIS will be scored utilizing the 5-point Likert scale for each of the 37 questions. The response "strongly agree" receives a "1" and "strongly disagree" receives a "5". In the P-SIS, items 9, 13, 15, and 21 are negatively worded. This was considered when scoring.

In order to assess whether there has been a change in satisfaction from 1995 compared to 1994, the survey means from 1994 were compared to the survey means of 1995, using independent t-tests. In addition, the standard deviations from 1994 were compared to the standard deviations from 1995 using analysis of variance and sign test. This highlighted any change in the variation of responses. Data analysis was performed with the assistance of the Epistat statistical program as well as with the assistance of a statistical professional. The Epistat program was selected for the previous P-SIS study and to maintain scoring and interpretative consistency it was used for this survey as well.

The population was contacted using a computer generated list of all 150 names and addresses of parent/consumers. The names included families who had received services from TCMH during fiscal year 1995. A survey instrument was

mailed to each family which appeared on the list obtained from the billing services department within the agency.. Included with each survey was a disclosure and confidentiality statement, and a brief request for participation and information about the survey. The only criteria for exclusion from the study was returned, nondeliverable surveys.

For negatively worded items, such as question 16 “Staff were rude to me,” the situation is reversed. Larger means, which indicate disagreement, are indicative of better service. In 1994 , for item 16; for example, the mean was 4.3, while in 1995 the mean was 4.7. In this case the negative change, $4.3-4.7= -.4$, indicates a change for the better from 1994 to 1995.

Areas of improvement

None of the t-test values reported in Table 2, on page 64, were statistically significant. The statistical level is reported as 0.5 and 0.1. However, items that showed an improvement from 1994 to 1995 were; 10 , 11, 16, 24, 27, 32 and 33. Particularly interesting among these items are 11, 24 and 32. These three items relate specifically to staffs’ listening skills and the parents’ perception that staff listened to their concerns. Individually they appear as;

11. “I was satisfied with how staff listened to what I had to say.”

24. “Staff listened carefully to what I had to say.”

32. “The staff listened to my needs.”

An improvement in this area is continued evidence that the concepts of parental involvement and information sharing are important to staff members working with families. Family preservation embraces the concept that parents and family members have meaningful and often new information to share with professionals. Further within this concept is that these professionals should incorporate information and opportunities for family members to participate in their child’s care. An improvement in this area , regardless of statistical significance, illustrates

positive efforts on behalf of staff to listen to family members and parents.

Declines in satisfaction

The items that showed a decline in satisfaction from 1994 to 1995 were 1, 2, 3, 4, 20, 28, and 30. Particularly interesting in this grouping are items which focus on staff availability and the support provided to the family. Individually they appear as :

2. "The hours kept by the staff fit well with my family's schedule."

4. " I was satisfied with the availability of staff."

20. "I was satisfied with how the staff helped me."

28. " I was satisfied with the support I received from staff."

30. " I was satisfied with how the staff helped my child."

It appears that family members may have been slightly frustrated with staff availability and support. Possibilities for a small decline in this area range from the number of families making up the caseload for staff, thereby curtailing the availability of appointments or home visits, as well as the length of time spent with families. Other possibilities may include the perceptions parents had of support from staff. There may have been instances where family members requested help from staff and staff refused to intervene or accommodate the parents request. Examples of this may be in crisis situations where parents requested a staff member in their home and staff declined, choosing to allow the

parent to deal with the situation as part of the therapeutic process. It is important to note that when defining "support" there may be a significant differences in meaning between staff and families. Additionally, a clearer understanding of demands on the time of staff members may be necessary. Is staff allowed flexibility in scheduling? Are there significant demands on their time with regard to meetings, committees or paperwork and documentation? What is the average caseload? Does geographical distance play an important role in time management on behalf of the staff ? Given that the tri-county area encompasses a variety of terrains and rural areas, would dividing caseload with geographic proximity in mind benefit staff and parents?

Of some concern is the slight decline in satisfaction with regard to question 1: "Overall, I was satisfied with the staff." Although this item may have a broad intepretation, a modest decline in overall satisfaction is evident statistically and should pose some concern for coordinators and staff members alike. Questions raised by the decline of general satisfaction with staff are numerous. Did parents feel they were treated unfairly? Did parents feel that staff members were not trained sufficiently? Was there frustrations with the limitations with this new and somewhat restrictive program ? It is important to note that a definition of satisfaction may be helpful for family members.

Consistency in satisfaction

Finally, items 7, 8, and 18 showed no change from 1994 to 1995. Items 8 and 18

are concerned with opinion and opportunities parents have to express opinion freely or when requested by staff. Individually they appear as;

8. "Staff asked my opinion about what help my family needed."

18. "Staff asked me my opinion about what things worked best for my child."

These results are encouraging with regard to the positive aspects of non-judgmental approaches to families and the incorporation of parent concerns about their child. However, even a slight increase in satisfaction would have been supportive for staff members and provided tangible results of their family preservation approach. Although the current data provides positive feedback, staff may have been encouraged by a continual improvement in their efforts in this area.

Item 7: "I was satisfied with the convenience of appointments with staff" provides some minor conflictual data when compared to other results regarding staff availability and convenience. It is therefore determined as a slightly negative outcome that neither an improvement or decline was found with regard to this item. Additionally, a clearer definition of convenience is needed. Parents may view convenience as staff ability to meet after late work hours or to attend to minor problems at home or school without notice. This may otherwise inconvenience other family members and disrupt a carefully designed schedule.

Additional statistical investigation

A sign test (Siegal, 1956) was performed to see if respondents perceived improvement or decline in services from 1994 to 1995 over all 18 items. Of the 18 items, 3 of those were ties, 8 improvements, and 7 slight declines from 1994 to 1995. The probability of this happening is much greater than 5 in 100 or .05, thus it is not statistically significant. So overall, there does not seem to be much difference in the respondents' perception of service from 1994 to 1995.

After concluding that there was not a glaring difference between 1994 and 1995, 18 independent analyses of variance (ANOVAS) were computed to compare 1994 variances to 1995 variances to determine any changes in the range of satisfaction responses. Only 2 of the 18 ANOVAS were statistically significant. One such item, number 16; "Staff were rude to me.", ($F(22,45) = 2.34, p < .05$) where the standard deviation for 1994 was 1.9 compared to a standard deviation of only .81 for 1995. The other was item 33; "Staff had limited skills to help my child."; ($F(45,22) = 1.93, p < .05$) where the standard deviation for 1994 was 1.4 compared to 2.7 for 1995. Because there is not a pattern of differences in variation from 1994 to 1995, it is difficult to interpret what these two differences in items 16 and 33 indicate.

Item 33; "Staff had limited abilities to help my child" may be interpreted in several ways. The word "limited abilities" may be perceived as a limit to outside resources to obtain placement or financial help. For example, the family may need financial help from month to month and staff was not able to obtain money due

to agency policy or budget shortfalls. Another example could be agency policy essentially prohibiting out of home placement and parents opposing wish to place the child. Conversely, "limited abilities" may have been interpreted as a limit on the education or expertise of staff to work with with the child. Many of the children involved in this program have severe or unusual emotional disabilities which may not be within the staff members therapeutic repertoire. One of the difficulties when working within the family preservation system is identifying professionals with exposure to the philosophy. Additionally, identifying individuals that possess a variety of counseling and educational skills is difficult.

Item 16; "Staff were rude to me" incorporates such possibilities as cultural norms and differences in language between staff and parents. While some parents may feel staff were accommodating and incorporated a courteous and helpful attitude, others may have interpreted professionalism as aloofness and detachment. Often in rural areas, such as this study, cultural norms play an important part in family dynamics. Family members may invite staff to join them for dinner and consider this type of exchange as supportive of the family tradition. Accordingly, many staff members may feel uncomfortable with this suggestion and their decline of such an invitation may be perceived as insulting. The method of congeniality and communication differ greatly within this subculture and staff members must be aware of the distinct social norms. The negative interpretation of question 16 may provide some guidance in this area and suggests care on the part of staff to appreciate these norms.

An examination of the means of the positively worded items in Table 2 reveals that the average respondent either agreed or strongly agreed, with the exception of item 10. Item 10 was, "Staff limited my participation in my child's care." For item 10 the average response was between neutral and disagree.

Conclusion and Discussion

Overall, parents appear to be as satisfied with staff interactions in 1995 as they were in 1994. No statistically significant differences in satisfaction between 1994 and 1995 could be discerned however, it is important to note that regardless of statistical significance there is important information that may benefit parents and staff within this agency. The previous discussion of individual items, scenarios of responses and results indicate that there may be multiple reasons for statistical data as well as parental impressions. For this reason, several questions come to mind with regard to satisfaction and parental response.

Both surveys seem to portray a slight assumption on behalf of staff that families and parents should be measurably happier with satisfaction. Although there are no obvious statements that the average reader may interpret as such an assumption, the wording and selection of some items can lead the seasoned researcher to this conclusion. The expectations of staff members that there would be a noticeable increase in satisfaction bears some investigation or at minimum, questioning on the part of the researcher. Why is there an assumption that family or parent satisfaction should increase in 1995? Have staff members concluded

that simply due to their consistent involvement with a family that satisfaction would increase? Or, is there a perception on behalf of the staff that parents and families should be increasingly satisfied with the mere concept of “professional” help available to them in time of distress?

The previous collection of items focus on the reality that the only research currently conducted at this agency is the measurement of satisfaction. The results of this study are mildly positive and therefore indicate that attention must be paid to the overall concept of satisfaction. Additionally, the necessity of such specific research should be considered, given the population and other environmental concerns. Further comments and recommendations are detailed in Chapter 5.

Table 2

Statistical Comparison of Parent Satisfaction

Table 2								
1994				1995				
Survey items	Number of responses	Means	Standard Deviation	Number of responses	Means	Standard Deviation	Change	T score
item 1	23	1.5	.66	45	1.7	.80	-.2	-1.13
item 2	23	1.7	.82	46	1.8	.97	-.1	-.46
item 3	23	1.7	.82	45	2.0	1.0	-.3	-1.36
item 4	23	1.7	.82	46	1.8	.90	-.1	-.48
item 5				46	1.8	1.0		
item 6				46	1.5	.70		
item 7	23	1.8	.85	46	1.8	1.0	0	0
item 8	23	1.7	.62	46	1.7	.70	0	0
item 9				46	1.6	.77		
item 10	23	4.0	1.0	46	3.5	1.3	+.5	+1.79
item 11	23	1.7	.76	46	1.6	.75	+.1	+.55
item 12				46	1.5	.59		
item 13				46	1.7	.77		
item 14				46	1.7	.79		

item 15				46	2.0	1.0		
** item 16	23	4.3	1.9	46	4.7	.81	-.4	-1.14
item 17				46	1.6	.78		
item 18	23	1.7	.91	46	1.7	.80	0	0
**item 19	23	3.7	1.3	46	3.8	1.2	-.1	-.33
item 20	23	1.6	.77	46	1.7	.80	-.1	-.52
item 21				45	1.9	.90		
item 22				46	1.7	.71		
item 23				46	1.9	.80		
item 24	23	1.8	.83	46	1.5	.81	+.3	+1.52
item 25				46	1.9	.81		
item 26				46	1.6	.69		
** item 27	23	3.5	1.4	46	4.2	1.2	-.6	-1.91
item 28	23	1.7	.69	46	2.0	.83	-.3	-1.63
item 29				41	2.0	.96		
item 30	23	1.7	.69	42	1.9	.90	-.1	-.50
item 31				43	2.0	1.0		
item 32	23	1.9	.76	43	1.7	.63	+.2	+1.17

** item 33	23	3.5	1.4	43	4.2	2.7	-0.6	-1.13
item 34				43	2.3	1.0		
** item 35				41	4.0	1.2		
item 36				42	2.0	.80		
item 37				42	1.9	.82		

Note. 1= strongly agree; 2= agree; 3= neutral;

4= disagree; 5= strongly disagree.

** negatively worded questions.

Combined survey items relating to parent's satisfaction ratings were very high except for item 10: "Staff limited my participation in my child's care." Previous discussion provided some possible insight into why this particular question was singled out by parents.

Satisfactory Staff Interactions

Research question 2 addresses specific areas of satisfaction and positive outcome; What areas of interaction seem to be the most satisfactory in the eyes of the parents?

Survey items with the mean of 1.5 are consistent with high satisfaction among parents and the highest satisfaction scoring in this study. These items appear individually as:

6. Staff were very supportive when I was in distress.
12. I was satisfied with how staff treated me with respect.
24. Staff listened carefully to what I had to say.

It should be reassuring to staff members and coordinators that these particular items have the highest satisfaction results with a mean of 1.5. The three items listed above indicate that parents perceive staff as supportive, respectful and as good listeners. These three ingredients are key to establishing positive relationships with families in distress and incorporate many of the family preservation attributes.

Following closely behind are items with a 1.6 and 1.7 mean which also indicate a high level of satisfaction. Independently these items appear as;

8. Staff asked my opinion about what help my family needed.
9. If I needed service for my child again, I would go back to these staff personnel.
11. I was satisfied with how staff listened to what I had to say.
13. Staff tried to meet my needs.
14. I would recommend these staff to friends and neighbors with similar problems.
17. I was satisfied with how staff treated my child with respect.
19. I lacked opportunities to share information.
20. I was satisfied with how staff helped me.
22. Just talking to staff made me feel better.
32. The staff listened to my needs.

Interestingly some of these items can be placed in specific groupings. One possible grouping could be reputation of service and possible referral found in items 9 and 14. Service reputation is very important in this particular agency and a positive outcome in this area is welcomed by staff. Parents' opinion of Tri-county is an important aspect of community involvement given that staff works in both home and community situations. Positive opinions from parents facilitate better relationships with school personnel and foster agency collaboration, a significant aspect of the system of care for children and adolescents. Additionally, community support and involvement is a cornerstone to the family preservation model as well as important component for future program expansion and

continuation of grant funds.

Another possible grouping includes the importance of listening skills and opportunities to share information such as item numbers; 8, 11, 19, 22 and 32 listed above. A high satisfaction rating in this area indicates that parents feel listened to as well as helpful, with regard to information sharing and treatment planning. As discussed earlier, family preservation incorporates the concepts of family involvement and maintains that parents have special information that only they can provide.

Unsatisfactory Staff Interactions

Research question 3 addresses unsatisfactory areas related to satisfaction:

What areas of satisfaction seem to be the most unsatisfactory?

Survey results that indicated the most unsatisfactory outcome are those which scored relatively high on the traditional Likert scale in this survey, with a mean of 2.0. Although a 2.0 score may be perceived as high, such a rating indicates some dissatisfaction among parents when compared to other items and such a rating is worthy of investigation. Individually these items appear as:

3. Staff asked what I thought about my child's care.
10. Staff limited my participation in my child's care.
15. Staff were willing to admit when they didn't know something.
28. I was satisfied with the support I received from staff.
29. Staff were helpful in identifying community resources.

31. I was satisfied with how staff helped me find the services my child needed.

36. I expected to be treated very well by staff.

Particularly interesting within this grouping are items relating to staff knowledge base, both therapeutically and environmentally. Items 15, 29 and 31 focus on staffs' therapeutic knowledge and the parents perception that staff is well trained and competently able to facilitate improvement in the family. A 2.0 mean indicates that parents found staff slightly lacking in some way, perhaps they felt staff members were limited in their scope of expertise or that staff portrayed an cavalier attitude. Additionally, items 29 and 31 are directly related to staffs' ability to find and coordinate outside services. A lower rating for these items may be due to the lack of community resources which is common in rural areas or, poor training on behalf of the agency. Ordinarily, identification and coordination of community resources are the responsibility of the case workers at the agency. However, due to funding cuts many of the therapeutic staff serve as case workers in addition to other duties. This may have caused some confusion among parents who felt that their needs were sufficient to warrant an individual caseworker. Parents may have become frustrated with therapeutic staffs' lack of community knowledge. The agency may want to investigate the need for identifying outside resources as well as the system which determines the assignment of case workers.

Item 3: Staff asked what I thought about my child's care, is somewhat low.

The focus of treatment should be the incorporation of parent feedback throughout the service process. It should be of some concern that this particular

item produced lower ratings. The agency may want to discuss the need for parent feedback at all levels of the therapeutic process as well as emphasizing the unique qualities of parent information and observation. One is left to wonder if staff is hesitant to ask for parents' perceptions and why.

Item 36: I expected to be treated very well by staff, provides some confusion. It is possible that parents expectations need to be explored with a more concrete method of investigation. Additionally, a more precise definition of "treated very well" is needed. Parents past experiences with other agencies may influence their answer, either negatively or positively. Additionally, staff professionalism may have been interpreted as an attitude problem among parents.

Areas in Need of Improvement

Research question 4 focuses on the need of improvement which results suggest are, service delivery and staff concerns. Specifically question 4 appears: What areas need more improvement? To determine specific areas in need of improvement, results were surveyed and those items with a mean score of 1.9 or 2.0 were considered.

An interpretation of the results indicate that parents are somewhat frustrated with the concept of staff availability. For example, parents do not feel that staff is not always available at times that are convenient for them and are not easily accessible. Additionally, parents scored their satisfaction somewhat lower in the area of support from staff. Survey items directly relating to staff availability and

support are: 2, 4, 20, 28 and 30. These items were addressed individually in Chapter 4 however, they do not represent all the areas in need of improvement. For example the mean of 2.0 on item 3: Staff asked what I thought about my child's care suggests that parents may not feel included in the overall treatment process.

Additional areas in need of some improvement are found in responses to three items. Item 15 with a mean of 2.0: Staff were willing to admit when they didn't know something, Item 25 with a mean of 1.9: Staff were sensitive to my family's values and beliefs, all incorporate a very personal viewpoint from parents. Item 19, is negatively worded and a mean of 3.8 provides additional evidence of the need for staff to consider some improvements in the area of communication with parents. Independently item 19 appears: I lacked opportunities to share information.

These three items highlight a possible need for increased sensitivity on behalf of staff. Staff members should remember that they are strangers who have suddenly become involved with family members on a very personal level. Many family members, especially parents, may have difficulty adjusting to the sudden inclusion of a stranger. Parents may feel ashamed that they must seek outside help and are slow to feel comfortable sharing their opinions or concerns. Improvement in the process by which parents are included would enhance parent satisfaction.

An additional suggestion for improvement concerns the method of staff contact

and availability of staff to attend school meetings and other appointments with parents. Item 28 with a mean of 2.0: I was satisfied with the support I received from staff, echoes the need for flexibility and understanding on behalf of staff. Staff availability is again an issue in this area but more importantly, is the concept of support for parents and the identification of community needs.

Item 29: Staff were helpful in identifying community resources, with a mean of 2.0 relates to the need for staff to be aware of outside agencies and availability and recommendation of support networks for parents. Staff members often attend school meetings with parents but are not able to attend other meetings or appointments where parents might need help. Understandably, caseloads may play a significant role in staff ability to attend other meetings or appointments but, the need for parents to learn about other outside resources and feel supported by staff is crucial.

Level of Satisfaction in 1994 and 1995

Research question 5 appears: Is the level of satisfaction among parents higher or lower compared to 1994? Although no statistical significance comparing levels of satisfaction were found, results report a slight decline in parent satisfaction in 1995 compared to 1994.

A decline in satisfaction regardless of statistical significance should be of some concern to staff members and coordinators. It is possible that the small decline in satisfaction may be due to the variety parents who responded to this survey.

Parents who were dissatisfied with services may be more likely to respond negatively and express opinions that may produce a decline in satisfaction. Other possibilities include the numerical increase of those families seeking help and the lack of adequate staff to work with this increase. A 4-8 month waiting list is not unusual for this agency and parents may feel less satisfied when services actually begin.

Research question 5 offers opportunity to discuss the measurement of satisfaction as a whole. A community based mental health setting does not seem to be an appropriate participant in the measurement of the concept of parental satisfaction. Parents may feel that an honest response could jeopardize their child's treatment. An outside research company may help with proper measurement and allow for additional comments from parents without fear of reprisal.

Central to this opinion, is the concept that a mail survey is not an appropriate way to obtain parent's opinion. A one on one interview format would yield much more helpful information and provide parents with tangible evidence of the importance of their opinion. Such an interview would also provide staff with the opportunity to discern the appropriateness of parental responses and suggestions. Additionally, a concrete interview process would overcome a potential literacy problem.

Recommendations

Recommendations for improvement are divided into three areas; comments on the survey instrument in particular, service improvement, and suggestions for further research .

Recommendations for instrumentation

After conducting this study for a second time, it has become apparent that the continued use of the PSS-I instrument will require significant improvements. Most importantly, the survey instrument needs concretely anchored questions that would alleviate the impressionistic views. This and other improvements related to the goals and objectives of the agency, must parallel the population within which the survey will be used. For example, some of the family members may not read well or at all. For those family members that have some trouble reading or comprehending, a simpler and more precise question format may be helpful in securing completed surveys. Individual interviews would be the best solution to this problem , however interviews would require new agency regulations. Possible compromises may be focus groups or weekly discussion groups with a variety of parents and staff present.

Specifically commenting on the current instrument, the use of negatively worded questions may be helpful to researchers, but may prove confusing to a percentage of the population participating in a survey of this nature. Additional recommendations surround the appearance and methodology used in conducting a survey with this particular instrument.

It is important to evaluate potential problems such as reading comprehension, at the beginning of service and make such findings available to the researcher. Additionally, the instrument is somewhat daunting in appearance to the population targeted for research. Its' appearance is clinical in nature and presents many choices that may prove confusing and time consuming to some parents or family members. The length and number of items may be reducible to accurately determine specific problems or improvement areas. Additionally, a larger comment section could be incorporated into the instrument providing the family members an opportunity to respond anonymously.

On a larger scale, it is highly recommended that the community mental health center adopt guidelines for research that incorporate consistent plans for parent involvement and evaluation measures. The mental health center could discuss with parents the probability of their participation in a mail survey (or other follow-up or research projects), secure the parents participation at the initial point of contact and confirm proper addresses. The computer generated list obtained from the mental health center for this study did not always have the most accurate address and in some cases, addresses were not available at all. This provided some concern about the proper identification of all family members receiving services and may be due to the nature of the population or to poor record keeping. If the agency were to adopt a plan for research, a demographic sheet should appear in the chart indicating pertinent information such as current address, household income or other information. This would be beneficial for

other types of research and helpful to others working with the family. It is apparent that other important factors that may have been included in the final results of this survey were neglected due to lack of information, organization of record keeping and agency policy.

Recommendations for service improvement

The above results indicate that most parents who participated in this survey were satisfied with the current level of service. This may indicate that only minor recommendations for service improvement are necessary specifically with respect to item 10 ; Staff limited my participation in my child's care. Parental or family response to this item may indicate the need for the agency to pay attention to possible conflicts in scheduling that may hamper the family members participation in treatment and daily activities. Such conflicts can may be resolved with a more flexible schedule for both family members and professional staff. Additionally, other difficulties with transportation and communication may need improvement. Traditionally, this population has had significant problems with transportation and this may continue to hamper important gains in the areas of parental involvement. With respect to communication, many families do not have telephones and coordinating appointments or other activities may prove difficult for the professional staff.

It is recommended that coordinators at the mental health agency work to define more clearly the definition of "my child's care." As this is the only significant problem highlighted in the results, it seems important to evaluate what "care" is

understood to be. Possibilities of such a definition can vary; parents may not feel they were educated about the changes needed in daily living to care for the child, parents may feel that staff limited their ability to provide basic needs for the child due to staff training in social services and agency collaboration or, parents may have felt misplaced as the authority figure working with and disciplining their child.

It is important to note two significant contributions to the positive results found in the area of service delivery. The agency maintained an extremely low staff turnover rate. This is unusual in both the social service field and important with regard to the non-traditional way services were and are delivered at the agency. Previous and current results were obtained with virtually the same staff members at both survey times. These staff members pride themselves on their level of creativity and flexibility and have received several awards and accommodations at both the state and local levels. It is possible that if staff turnover had been an issue, results may have been different.

Another contribution to the positive results outcome is the nature and availability of services in the area. As discussed previously, services to children and adolescents were unavailable until two years ago. It is possible that parents are relieved to have any service and would rate the current offerings highly, both because of past frustrations in obtaining services and lack of alternatives or comparisons.

Recommendations for further research

A consistent and coordinated research effort is needed at this agency. Suggestions for further research can be divided into five distinct categories; functioning of children and their families, maintenance of gains made in treatment over time, impact of the ecological context on programs, and population to be served, and longitudinal follow-up studies.

Even though the intake and referral process for families at the agency are provided immediately and with a family centered focus, the current overall status of the family and its' individual members is not ascertained. Understandably, the focus of problem solving is on the particular child or adolescent. However, the overall level of family functioning is rarely investigated until later progress in treatment, if at all. Although many staff members determine the level of family functioning daily, there is no formal documentation or training. Additionally, investigation into past family history and agency involvement should be a goal for intake team members. This is not to suggest that past mental health history is indicative of current problems, but that this additional information may help to prepare staff members for potential problems and multiply efforts to support the family. This information would also be useful when investigating genetic abnormalities, family stress, coping styles, and overall dysfunction.

Additional suggestions also include determining treatment gains over time both with the entire family and the individual child or adolescent. Determining certain treatment goals is common at an agency such as the one in this study.

These goals are outlined in a treatment plan determined by staff and family members. The treatment plan incorporates major changes that need to take place within the treatment time and approximate length of time needed to attain those goals. Although this may be beneficial to the staff it is not usually incorporated in communication with parents throughout the treatment process. It may be advantageous to incorporate attained goals into everyday activities with family members and children to help them visualize their progress and plan for the eventual termination of services.

Accordingly, it is extremely important to continue to follow-up with families after discharge to ascertain the current status of the family. It is strongly recommended that staff and coordinators develop a consistent follow-up plan to determine the levels of family functioning both at discharge and at determined intervals for several years. This follow-up plan should measure the current level of family functioning at discharge and obtain information at various time intervals. This would help to determine the appropriateness of discharge, the level of educational support the family received to implement change, the possibility of out of home placement and other aspects related to environmental and social functioning. It may be possible to provide concrete solutions to problems experienced by family members if a follow up plan was implemented Alternately, this research and documentation may help to secure additional funding to expand services or provide new diverse social services.

Further attention should focus on the concepts of the environment and effect

on programming and services. A number of questions should be asked: (a) What services are needed to maintain gains made in treatment? (b) What factors impede service delivery in the community? (c) Are cultural factors and issues need attention when developing services? and (d) Is the current population receiving services indicative of the community population? Such questions are viable options to help understand the current community norms and proposed changes in the immediate environmental structure of the community. It is highly recommended that the agency begin to explore what other aspects of the community precipitate family members requests for help. It may be beneficial to evaluate the impact of gang activity or poverty on those families seeking services. The ultimate goal in this suggestion is to gain a greater understanding of the current environmental factors and possibly predict trends that may need special attention.

Throughout both the past and current study there appears to be an anticipation of increases in parent satisfaction. It is unclear why the agency and staff members feel that parents should respond to satisfaction measures and that satisfaction should increase. Understandably, the concepts of family preservation forecast an improvement in parent satisfaction with continued and consistent involvement. However, there are more important measures. The community based mental health setting is one with great potential for discovery and satisfaction research does not seem to be the most important. Specific suggestion discussed earlier should provide coordinators with a basic outline for research.

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APPENDIX A
CONSENT FORMS

Tri-County MHMR
Child & Adolescent Services

Parent Satisfaction Questionnaire

Informed Consent Statement

As part of an ongoing attempt to analyze the progress of this program, the staff wants parents to help by giving feedback through a variety of ways. The purpose is to find better ways of serving children and families who receive Tri-County services. Parents know their children the best and their input is essential in planning and providing services.

In reading and signing this sheet, I acknowledge that I have agreed to participate in this study by completing this questionnaire. My name will not be written on any of this information and it will not be shown to anyone.

Confidentiality of the data will be maintained within legal limits. I understand that my participation is voluntary and confidential. If I have any questions I will feel free to contact Cammie Free at (409) 525-2701.

Parent or Guardian

Date

APPENDIX B
PARENT SATISFACTION SURVEY INSTRUMENT

PARENT SATISFACTION WITH STAFF INTERACTIONS

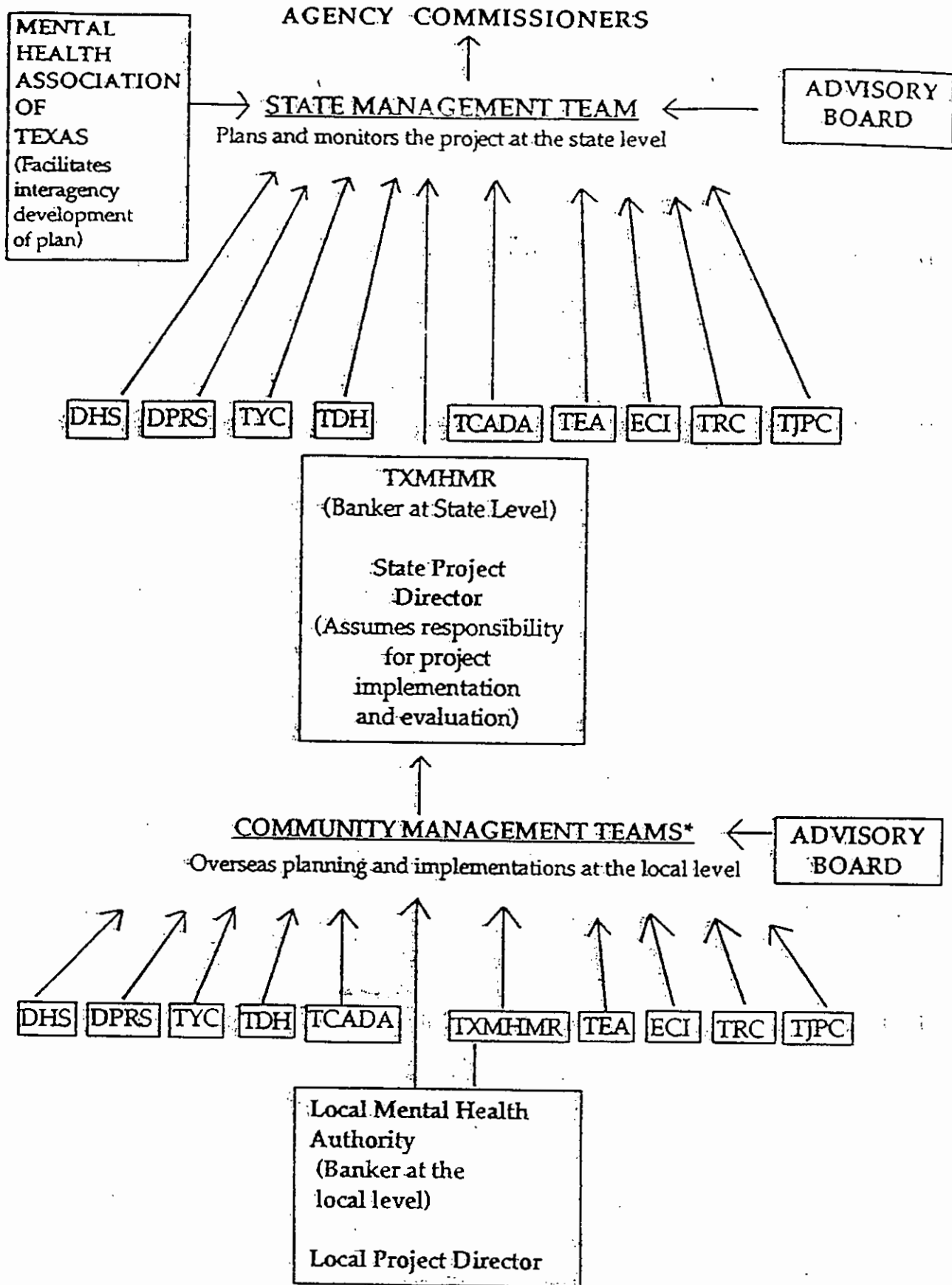
Directions: Please rate the following statements about the interactions you had with mental health professionals (Staff) who provided services to your child at Tri-County Mental Health Mental Retardation Services. CIRCLE the word that best describes your opinion.

- | | | | | | | |
|-----|---|-------------------|-------|---------|----------|----------------------|
| 1. | Overall, I was satisfied with the staff. | Strongly
Agree | Agree | Neutral | Disagree | Strongly
Disagree |
| 2. | The hours kept by the staff fit well with my family's schedule. | Strongly
Agree | Agree | Neutral | Disagree | Strongly
Disagree |
| 3. | Staff asked what I thought about my child's care. | Strongly
Agree | Agree | Neutral | Disagree | Strongly
Disagree |
| 4. | I was satisfied with the availability of staff. | Strongly
Agree | Agree | Neutral | Disagree | Strongly
Disagree |
| 5. | I was satisfied with the way the staff helped me understand my child's problem. | Strongly
Agree | Agree | Neutral | Disagree | Strongly
Disagree |
| 6. | Staff were very supportive when I was in distress. | Strongly
Agree | Agree | Neutral | Disagree | Strongly
Disagree |
| 7. | I was satisfied with the convenience of appointments with staff. | Strongly
Agree | Agree | Neutral | Disagree | Strongly
Disagree |
| 8. | Staff asked my opinion about what help my family needed. | Strongly
Agree | Agree | Neutral | Disagree | Strongly
Disagree |
| 9. | If I needed service for my child again, I would go back to these staff personnel. | Strongly
Agree | Agree | Neutral | Disagree | Strongly
Disagree |
| 10. | Staff limited my participation in my child's care. | Strongly
Agree | Agree | Neutral | Disagree | Strongly
Disagree |
| 11. | I was satisfied with how staff listened to what I had to say. | Strongly
Agree | Agree | Neutral | Disagree | Strongly
Disagree |
| 12. | I was satisfied with how staff treated me with respect. | Strongly
Agree | Agree | Neutral | Disagree | Strongly
Disagree |
| 13. | Staff tried to meet my needs. | Strongly
Agree | Agree | Neutral | Disagree | Strongly
Disagree |
| 14. | I would recommend these staff to friends and neighbors with similar problems. | Strongly
Agree | Agree | Neutral | Disagree | Strongly
Disagree |
| 15. | Staff were willing to admit when they didn't know something. | Strongly
Agree | Agree | Neutral | Disagree | Strongly
Disagree |
| 16. | Staff were rude to me. | Strongly
Agree | Agree | Neutral | Disagree | Strongly
Disagree |
| 17. | I was satisfied with how staff treated my child with respect. | Strongly
Agree | Agree | Neutral | Disagree | Strongly
Disagree |

18.	Staff asked me my opinion about what things worked best for my child.	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
19.	I lacked opportunities to share information.	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
20.	I was satisfied with how the staff helped me.	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
21.	Staff have given me useful advice about how to handle my child.	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
22.	Just talking to staff made me feel better.	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
23.	Staff helped me understand my child's problems.	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
24.	Staff listened carefully to what I had to say.	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
25.	Staff were sensitive to my family's values and beliefs.	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
26.	Staff treated my family with respect.	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
27.	Interactions with staff increased the stress in my family.	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
28.	I was satisfied with the support I received from staff.	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
29.	Staff were helpful in identifying community resources.	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
30.	I was satisfied with how the staff helped my child.	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
31.	I was satisfied with how staff helped me find the services my child needed.	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
32.	The staff listened to my needs.	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
33.	Staff had limited skills to help my child.	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
34.	Staff fit services to meet the needs of my child.	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
35.	I expected to be treated very poorly by staff.	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
36.	I expected to be treated very well by staff.	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
37.	Staff treated me the way I expected them to.	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree

APPENDIX C
STRUCTURE OF THE TEXAS CHILDREN'S
MENTAL HEALTH PLAN

Structure of the Texas Children's Mental Health Plan



* 16 funded sites; 29 systems development sites.

DHS = Department of Human Services; DPRS = Department of Protective and Regulatory Services; TYC = Texas Youth Commission; TDH = Texas Department of Health; TCADA = Texas Commission on Alcohol and Drug Abuse; TXMHMR = Texas Department of Mental Health and Mental Retardation; TEA = Texas Education Agency; ECI = Interagency Council on Early Childhood Intervention; TRC = Texas Rehabilitation Commission; TJPC = Texas Juvenile Probation Commission.

CURRICULUM VITAE

Chrisanne Christensen is currently an Associate Professor of Human Services and Psychology at Montgomery College in Texas. Her class projects and teaching style exemplify a strong belief in the potential of all individuals. Her recent experience in the field of social services and counseling includes work with severely emotionally disturbed children and their families. Miss Christensen has been active working with children and adolescents in private practice and consulting in special education. She has a strong devotion to grass roots movements in the Houston area and has been involved in development of services and fund raising.

Miss Christensen received her bachelors degree in 1984 from Hawaii Pacific University, graduating as Senior Class Vice-President. In May of 1986 she received her masters degree in Human Relations Counseling from Webster University in St. Louis, Missouri.

Miss Christensen has received numerous awards for her work in the social service field in Houston. Most recently, the 1995 Showcase Award from Texas Department of Mental Health and Mental Retardation for innovation and service. As an active professional she is committed to the education and rights of severely emotionally disturbed children.

WALDEN UNIVERSITY
DISSERTATION APPROVAL

Parent Satisfaction with Staff Interactions at a Community Based Mental Health Center

Chrisanne M. Christensen

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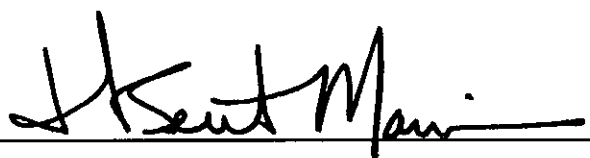
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no
UMI

DOCTOR OF PHILOSOPHY DISSERTATION
OF
CHRISANNE MARIE CHRISTENSEN

APPROVED:

A handwritten signature in black ink, appearing to read "J. Kent Morrison", is written over a horizontal line.

J. KENT MORRISON
VICE PRESIDENT FOR ACADEMIC AFFAIRS

WALDEN UNIVERSITY
1996

ABSTRACT

**PARENT SATISFACTION WITH STAFF INTERACTIONS
AT A COMMUNITY BASED MENTAL HEALTH CENTER**

**A DISSERTATION SUBMITTED TO
THE FACULTY OF WALDEN UNIVERSITY
IN PARTIAL FULFILLMENT OF THE REQUIREMENTS
FOR THE DEGREE OF
DOCTOR OF PHILOSOPHY**

HUMAN SERVICES / COUNSELING PSYCHOLOGY SPECIALIZATION

**BY
CHRISANNE MARIE CHRISTENSEN**

MAY, 1996

ABSTRACT

This study investigates an important issue in mental health service provision, the level of parental satisfaction with staff interactions at a community based mental health center. A small target population, which included all families who had received services within a one year time frame, were surveyed via mail to determine levels of satisfaction. Parents responded to a questionnaire and data were collected to determine overall satisfaction, areas of service in need of improvement and areas of interaction which were most unsatisfactory. Additionally, data were compared to past study material to determine either an increase or decrease in parent satisfaction within a two year period.

The results suggested that little change existed within the two year time frame. However, a marginal decline in satisfaction was found among the parents. Results indicated a need to evaluate the parents' perception of staff helpfulness and the staff's need to educate the parents in appropriate ways to live with their severely emotionally disturbed child. Additional recommendations included other important research areas within a community based mental health system, the application of individual interview procedures and improvements to instrumentation.