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Relating Parent Satisfaction to Interpersonal Experiences: Development of a Therapeutic Assessment Based Parent Questionnaire

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Relating Parent Satisfaction to Interpersonal Experiences: Development of a Therapeutic Assessment Based Parent Questionnaire

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Abstract

Relating Parent Satisfaction to Interpersonal Experiences: Development of a Therapeutic Assessment Based Parent Questionnaire

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The research study proposed in this report reviews and integrates the literature on client/parent satisfaction with Therapeutic Assessment. Specifically, the importance of parent collaboration and the intervention potential of child assessment are highlighted. The result is the development of a parent self-report measure that could be utilized in multiple settings to assess the interpersonal and collaborative experiences of parents. It is these experiences of parents which have been shown to be more highly related to general satisfaction than outcomes or demographics. The methodology includes Confirmatory Factor Analysis to revise the scale and MANCOVA to compare traditional assessment with collaborative/therapeutic assessment practices in multiple settings.

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Chapter One: Introduction

For the last 30 years, Client Satisfaction measures have become a routine part of consumer feedback collected by Community Mental Health Centers (CMHC)(Essex, Fox, & Groom, 1981; Harrington Godley, Fiedler, & Funk, 1998; Lebow, 1982). The movement has been the result of increased pressure on CMHC's to provide accountability in an increasingly consumer-oriented society (Essex, et al., 1981; Lebow, 1982; Plante, Couchman, & Hoffman, 1998). Despite their widespread use, reviews of client satisfaction literature have consistently found a lack of standardization, psyschometric validation, and resolution of methodological issues (Lebow, 1982; Young, Nicholson, & Davis, 1995). Many satisfaction surveys are created in house by the mental health centers without the background knowledge or financial resources to develop comprehensive outcome/satisfaction or program evaluation measures.(Plante et al., 1998).

More recently, the importance of parent satisfaction has received research attention and is increasingly being recognized as a critical part of child/adolescent mental health services (Gerkensmeyer & Austin, 2005; Riley, Stromberg, & Clark, 2005). A report by the Surgeon General's Conference on Children's Mental Health (2000) indicated that 12 to 20% of children have mental health problems meriting treatment, yet less than a third are receiving services and about half of those are receiving inappropriate services. Unmet needs for children and their families are reported to be as high now as they were 20 years ago (Gerkensmeyer, Austin, & Miller, 2006). Thus, the development of theoretically based and methodologically sound measures of parent satisfaction that can be used to inform clinical practice are an essential part of ensuring that children with

mental health problems and their families are receiving appropriate services (Gerkensmeyer, Austin, & Miller, 2006; Harrington Godley, Fiedler, & Funk, 1998).

A common critique in the parent satisfaction literature is that self-report measures are made from the prospective of the professionals, rather than seeking input from client perspectives (Youn et al., 1995). "From the point of view of parents, consumer particpation is met with a great deal of resistance by professionals" which is often "hidden or ignored in much of the current satisfaction literature" (Young et al., 1995, p. 234). Measelle, Weinstein, & Martinez (1998) report that "historically, families and caregivers have been treated as the primary cause of children's psychopathology by human service professionals" (p. 452). Yet it is the relationship between parents and clinician that may be most influential as "research findings have consistently shown that the most important factor contributing to satisfaction in the healthcare context has been interpersonal relationships between staff and consumers" (Gerkensmeyer & Austin, 2005, p. 62) It appears that rather than outcome variables such as symptom reduction, it is the experience of support and respect parents have when receiving services for their child which is of primary importance.

Parallel to the advances in client and parent satisfaction with mental health services is the development of Therapeutic Assessment (TA), created by Finn and colleagues (Finn, 1996, 1997, 2003; Finn & Kamphuis, 2006; Finn & Tonsager, 1997, 2002). The principles of TA have the assessor facilitate a highly collaborative 'holding environment' where clients can ask questions, explore assessment results, and create shifts in their 'story' of self. This type of assessment is an intervention designed to

provide clients with a positive change experience, and often the motivation to continue with recommendations and services. More recently, TA is being explored with children and their families via the Therapeutic Assessment Project (TAP). TAP provides parents the support they need become 'unstuck' in their perceptions of their child, which can lead to new understanding and interactions between family members. TA is already putting into practice principles that parent satisfaction is beginning to investigate, such as parental collaboration and the relationship between parents and clinician. Thus, techniques of child TA could be utilized in other assessment settings and child services to promote parental involvement and general satisfaction.

The present study proposes the creation a theoretically based and methodologically sound self-report measure for parents which will investigate the interpersonal relationships and experiences of parents during their child's assessment that are hypothesized to be highly related to general parental satisfaction. The measure will then be used in various child assessment settings to compare traditional modes of assessment to assessments incorporating elements of TA. The result should be a measure that can be used with various child services to help distinguish salient parent experiences that may be more or less common in different settings (i.e. community mental health centers, private practice, state hospitals, etc). It is hypothesized that the highest levels of parent satisfaction will be correlated with the most collaborative experiences for parents. The developed measure will allow for a more quantitative method of measuring TA constructs, and allow parent feedback to move beyond just 'satisfaction' in child/adolescent mental health services.

Chapter Two: Integrative Analysis

The following integrative analysis presents an overview of the literature related to parent satisfaction with child mental health services and how more recent developments intersect with Therapeutic Assessment. Parent satisfaction is a piece of the client satisfaction literature spanning the last 30 years, and the client satisfaction literature is able to support some general conclusions, while a number of questions across settings and service types remain. The analysis will review the most prevalent methodological issues throughout the client satisfaction literature including questionnaire development, psychometric properties, and sampling methods. The development of Therapeutic Assessment and its success with both adult and child participants through a collaborative environment is described, along with the types of parental interactions in a successful child assessment. The assessor-parent relationship developed over the course of the child assessment is conceptualized as the catalyst to increases in parental openness to new information, re-investment in the child, greater awareness of family involvement, and increased follow through on recommendations. These goals are related to the parent satisfaction literature and hence the need for research that can compare parental experiences across types of assessments, settings, and eventually, different service types.

Client Satisfaction

Background and General Findings

The early progress of the client satisfaction movement is adeptly summarized in reviews by Lebow (1982) and Larsen, Attkisson, Hargreaves, & Nguyen (1979) which discuss the state of client satisfaction literature once consumer feedback (most often via

surveys) had become "a standard part of the practice of many mental health facilities" (Lebow, p. 244). Initially, the inclusion of client feedback as a valid perspective had to be supported by developing research in a more consumer oriented society, with increased financing of services (Lebow, 1982), in light of legislative mandates [CMCHA's 1975 "acceptability of practices to client/patient" (Larsen et al., 1979)], and increased emphasis on accountability in Community Health Centers (Essex, Fox, & Groom, 1981). Larsen et al. argued that "when the client's perspective is not taken into account, the evaluation of services is incomplete and biased towards the provider's or evaluator's perspective" (1979, p. 197). Many of the conclusions of Lebow (1982) and Larsen et al. (1979) are still supported today, namely that demographics have not been found to be good predictors of satisfaction (Essex, et al., 1981; Harrington Godley, Fiedler, & Funk, 1998; Lebow, 1982; Measelle, Weinstein, & Martinez, 1998; Young, Nicholson, & Davis, 1995), that satisfaction ratings are generally high, between 70-80%, (Riley, Stromberg, & Clark, 2005) or "uniformly positive" (Essex et al., 1981, p. 227), and that other outcome measures, including therapist satisfaction, therapist ratings of client satisfaction, and client rated outcome measures lack consistent results (Larsen et al., 1979; Lebow, 1982).

Although the Client Satisfaction Questionnaire as developed by Larsen et al. (1979) (see below) found support for a single dimension of client perspective of services, other researchers have investigated beyond 'overall' satisfaction. Essex et al. (1981) developed a questionnaire via factor analysis with four dimensions: Satisfaction with Services, Acceptability of Clinician, Impact of Services, and Dignified Treatment. Thus, overall satisfaction in and of itself did not include the client perceptions of effectiveness

of the service (agreement on goals, right type of service, recommend to others), acceptability of the clinician (age, race, sex) and client treatment (dignity, respect, confidentiality, promptness, agreement on termination). Essex et al. (1981) suggested that their findings supported earlier work that satisfaction does not directly equal success (or symptom reduction) and hence client perceptions of various dimensions are necessary to gain a full picture of a client's experience with services.

Client Satisfaction Questionnaire

A major issue with early and continuing client satisfaction research is that it is often locally generated and consumed (Larsen et al., 1979; Lebow, 1982) resulting in surveys and studies that are not standardized or easily compared across settings and services (Plante, Couchman, & Hoffman, 1998; Riley et al. 2005). Attkisson and Zwick (1982) recognized that "researchers have struggled to construct a psychometrically adequate scale with demonstrated validity, brevity, low cost, and ease of administration" (p. 233) which led to the development of the Client Satisfaction Questionnaire (CSQ), first introduced by Larsen et al. (1979). The CSQ is now the most widely used measure for general satisfaction, and the only well standardized adult measure (Attkisson & Zwick, 1982; Larsen et al., 1979) now being used for parent satisfaction (Byalin, 1993; Gerkensmeyer & Austin, 2005; Harrington Godley et al., 1998; Plante et al., 1998). The original CSQ was developed via a literature search for items/concepts, 32 judge rankings of how well items tapped dimensions, analysis of the initial 248 response sample via principal components analysis, which resulted in a single dimension with a coefficient alpha of .93. The CSQ-8 (8 item general scale) uses a 4-point Likert scale and has been

found to be the shortest and most robust version for measuring general satisfaction (Attkisson & Zwick, 1982) with other researchers reporting coefficient alphas between .93 and .96 (Byalin, 1993; Gerkensmeyer & Austin, 2005; Plante et al., 1998). Initial concerns about using a measure standardized on adult clients with the parents of children receiving mental health services (Young et al., 1995) have been addressed with the findings that parent responses are often similar to those of adult clients (Essex et al., 1981) and the high coefficient alphas found with parent populations (Byalin, 1993; Gerkensmeyer & Austin, 2005). Thus it appears that the CSQ-8 is a measure of general satisfaction that is well standardized via repeated use for both adult client and parent responses.

Parent Satisfaction

The shift in research to parent satisfaction with child mental health services became more prominent in the 1990s and has followed the same development of the original client satisfaction literature, including standard problems with methodology (see below). Not only should clients be able to provide feedback about services, but parents should also "be an integral part of the treatment of their children" (Young et al., 1995, p. 220) in all areas, including evaluation, planning, and implementation. Recent research has shown that child and adolescent mental health is best treated by meeting family needs (Riley et al., 2005) and evaluating the 'bundled' services (psychotherapy, group therapy, case management, parent support groups, social skills, etc) which have become more common service modalities (Harrington Godley et al., 1998).

Just as the validity of including client perspectives in evaluation had to be established in the client satisfaction literature (Larsen et al., 1979; Lebow, 1982), parent perspectives were not welcomed unquestionably into the program evaluation literature on child and adolescent services. Perhaps even more so than adult clients, parents have historically been blamed for their child's problems (Measelle et al., 1998; Young et al., 1995) which is often overlooked in parent satisfaction literature (Young et al., 1995). Thus, parents may be skeptical of service providers and inclined to under-utilize services, or reject services when dissatisfied (Measelle et al., 1998). Similar to adult client satisfaction research, dissatisfaction with the patient-physician relationship can predict poor treatment, under utilization of services, and premature termination (Attkisson & Zwick, 1982; Measelle et al., 1998). Parent satisfaction research also parallels the client satisfaction area with the findings that demographics (child gender, child age, child race, child grade, length of treatment, parent's age, parent's gender, parent education, employment status, parent income, marital status, parent race) are not significantly related to parent satisfaction (Gerkensmeyer & Austin, 2005; Harrington Godley et al., 1998; Measelle et al., 1998; Young et al., 1995). Rather, only severity of child illness and differential settings (child living at home vs. not, state vs. community settings, public vs. alternative school) have been found to predict parent satisfaction (Gerkensmeyer & Austin, 2005; Harrington Godley et al., 1998). These findings appear to be related, in that children with more severe problems are more likely to be in a restricted setting, such as alternative school or state hospital. Thus, lower levels of satisfaction are associated with families who face more severe child problems that will be harder to successfully treat.

Combining the severity findings above with the findings of Plante et al. (1998) that parents report high levels of satisfaction, despite a lack of symptom reduction from treatment, indicates that "care" (child and parent support) is more important than "cure" (p. 54). Riley et al. (2005) took parent responses for five factors and found the percent of respondents with an average score greater than 3.5 on a Likert scale from 1 to 5. For the factors of Cultural Sensitivity, Access to Services, Parent Participation, and Appropriateness 70-82% of parents had an average factor score above 3.5, whereas only 47% of parents had average ratings above 3.5 for the Outcome factor. Thus, the Outcome factor had the lowest ratings and was the least associated with parent satisfaction. Just as with some medical conditions, such as diabetes, most childhood mental health issues (ADHD, bipolar disorder, depression, anxiety, Autism) will not disappear with treatment; rather, the goal of child and family services is to manage the symptoms successfully and try to minimize the social, emotional, and developmental side effects over time (co-morbid disorders, delinquency, gang membership, etc). The need for family support when dealing with child mental illness may help explain why parental satisfaction is not highly correlated with outcome measures and why it is essential for professionals to make a more formal and conscientious effort to include parents in child treatment.

More recent research is recognizing that although the child may need services, the parent is a critical component in "engagement and continuation of treatment" (Martin 2003; Riley et al., 2005, p. 88) as children are dependent upon adults and do not seek services themselves (Young et al., 1995). Gerkensmeyer & Austin (2005) succinctly summarized the major role of parents who: a) obtain services for the child, b) are a key to

child success via parent participation, c) are the best source of information about the effects of caring for a child with mental health problems, and d) are the primary caregivers of children after the completion of services (p. 61). The shift to including parent perspectives in treatment evaluation, and also including parents in planning and implementation of child services requires that researchers establish the process variables associated with child treatment that are most related to parent satisfaction and a positive overall parent experience.

As mentioned previously, demographic variables and other client characteristics have not been found to predict parent satisfaction. Rather, various studies have found that it is how parents experience their child's treatment which is associated with parent satisfaction. Sheppard (1993) first emphasized the importance of interpersonal skills for practitioners in the client satisfaction research by citing the need for a "dialogue of communication, empathy, the openness of the clinician, and client participation in planning/intervention" (p. 257). In their review of parent satisfaction, Young et al. (1995) reported that parents of children with SED emphasized the importance of "professional interpersonal skills and a coherent system of care" and that parent satisfaction was significantly correlated with perceived parent collaboration. Parents who reported dissatisfaction indicated the need for better communication with parents and a greater degree of parental involvement (Young et al., 1995).

In the development of the Family Satisfaction Survey (FSS), Measelle et al. (1998) worked with a parent focus group that revealed four major areas of parent concern including professionalism, job-related competencies, commitment to partnership with

parent, and respectful, non-blaming view of parents. The resulting two factor survey for case management services included Interpersonal qualities/partnership practices which accounted for 82% of the variance and Job Related Competencies which accounted for only 6.2 % of the variance. Measelle et al. (1998) found that increased contact with parents was significantly correlated with parent satisfaction, whereas length of service or caseload of the caseworkers was not related. In the work of Riley et al. (2005) on the Youth Services Survey for Families, the highest level of responses (90%) were from staff being respectful and speaking to parents in a way that they understood. Harrington Godley et al. (1998) found that satisfaction scores were most highly correlated with individual counseling than any other service (group, social skills, etc).

These studies point to the importance of the parent relationship with the clinician/service providers, the interpersonal skills of practitioners, and the need for respectful collaboration with parents. "Research findings have consistently shown that the most important factor contributing to satisfaction in the healthcare context has been interpersonal relationships between staff and consumers" (Gerkensmeyer & Austin, p. 62, 2005). Shifting the focus of parent satisfaction research from 'services' to the actual service providers (staff, case managers, clinicians) "personalizes research and highlights the individual professionals who are generally considered to be the most important elements in service provision" (Young et al., 1995, p. 227). By investigating the experience and support parents perceive when seeking mental health services for their children, researchers can begin to give service providers meaningful program feedback

about respectfully collaborating with parents to help ensure better support for both the child and family struggling with child/adolescent mental illness.

Methodological Issues

In order to understand the development of the client/parent satisfaction literature, it is essential to understand the methodological challenges in this area. Most of the issues revolve around sampling, data collection, and the psychometrics inherent in self-report questionnaires. Thus, the issues for both the client and parent satisfaction areas are similar and are combined in this section.

Sampling and Data Collection

The largest issue in the satisfaction literature appears to be the high levels, or 'ceiling effect' of satisfaction reported by clients/parents (Attkisson & Zwick, 1982; Essex et al., 1981; Harrington Godley et al., 1998; Larsen et al., 1979; Lebow, 1982; Riley et al., 2005; Young et al., 1995). This issue with the validity of reported satisfaction has been explained by the halo effect, social desirability bias, and lack of variance due to sampling bias (Harrington Godley et al., 1998; Larsen et al., 1979; Lebow, 1982; Riley et al., 2005; Young et al., 1995). The social desirability bias may contribute to high satisfaction scores because "parents may be eager to appear grateful, and could be nervous about offending mental health professionals" (Young et al., 1995, p. 225). Lebow (1982) pointed out the 'reactivity' associated with survey methods and that specific steps, such as having non-practitioners administer the surveys, should be used to lessen the reactive problem. However, even the high levels of reported satisfaction could

be compared to a baseline, but such norms across settings and services have yet to be developed (Harrington Godley et al., 1998; Larsen et al., 1979; Lebow, 1982).

The satisfaction literature has struggled with sampling bias and the fact that those least satisfied with services are more likely to terminate early and not respond to inquiries about satisfaction (Larsen et al., 1979; Lebow, 1982). More recently, researchers have been using client information files to compare basic demographics (race, sex, education, etc) to check for significant differences between 'responder' and 'nonresponder' sample groups (Measelle et al., 1998; Riley et al., 2005). Although this comparison helps ensure that the self-selected sample groups are not significantly different, demographics are not good predictors of satisfaction. Thus, although the groups may be demographically similar, that does not mean they would be similar in terms of satisfaction. Research has found that 'mutual termination' is more highly correlated with satisfaction than length of treatment (Lebow, 1982) so it would be important for researchers to try and gather data at the termination of all clients (mutual or not) and gain insight into the different experiences of those who terminate early. Although the demographic check should become a standard part in comparing survey results, it is only the first step in a more standard survey analysis procedure.

The effect of early termination is most apparent when data are collected via cross sectional time periods. Studies have varied the length of time from two weeks to months, but regardless, the sample then includes clients who have just started treatment, those in the middle, and those post treatment, and excludes those who have terminated early. Thus, the more satisfied clients are most likely over represented in cross sectional data

(Byalin, 1993). Suggested remedies have included more costly time series and longitudinal collection methods (Larsen et al., 1979; Young et al., 1995). One of the main reasons for using cross sectional data collection is the lowered time and cost when paired with the typical format of a mailed questionnaire. Unfortunately, mailed questionnaire data have a low response rate ranging from 19% (Essex et al., 1981), 28% (Byalin, 1993), 33% (Young et al., 1995), 37% (Riley et al., 2005) to 52% (Gerkensmeyer et al., 2006), with an average of 46% (Lebow, 1982). The cross-sectional and mailed survey data collection methods reflect the limited resources most community health centers and researchers have to collect data. Phone interviews have been used, but mostly as a follow up or when seeking child or adolescent data, where reading ability is even more of a concern than for adults (Shapiro, Welker, & Jacobson, 1997; Young et al., 1995). Besides the low time and cost of mailed questionnaires, the format ensures that actual service providers are not giving the surveys, which should help decrease social desirability bias. Although cross sectional data may provide more variance, in that those at the beginning of treatment may have lower satisfaction scores than those towards the middle or end, studies have not differentiated how ratings may progress from the beginning to end of treatment. Do those who remain in treatment have high satisfaction scores throughout? And are there different experiences for those who terminate after one session versus those who may terminate midway through treatment? To understand the effects of early termination and sampling bias in cross-sectional data collection, researchers must focus on the experiences parents and other clients have with practitioners (collaboration, alliance, respect) that most likely affects satisfaction and hence, service utilization.

Fortunately, researchers have made progress in terms of generating larger samples across varied settings and services. Harrington Godley et al. (1998) modeled a study using standardized measures and procedures across 22 publicly funded agencies within a state measuring 12 services (case management, crisis intervention, social skills, etc) and then compared agency vs. region *z*-scores so that agencies could clearly see if they were above or below the average satisfaction response in eight different categories. Using Medicaid youth, Riley et al. (2005) were able to sample 14 different community health centers within a state with a total of 534 surveys returned, and Gerkensmeyer & Austin (2005) used 5 very different sites including a wrap-around community site, state operated inpatient program for children, a non-profit hospital, home based intervention, and a state inpatient hospital for boys. The results differentiated among the settings, with the two community programs reporting higher levels of parent satisfaction, decision making, and informing parents. Gerkensmeyer & Austin (2005) also found that satisfaction was significantly lower for parents whose children were not living at home, which may reflect higher levels of severity and different experiences for parents working with inpatient programs versus community health centers. It is important that researchers continue to look at satisfaction across different types of services and settings (Harrington Godley et al., 1998; Lebow, 1982; Young et al., 1995) as clients may have different experiences that could help improve programs at various levels of mental health services. The majority of research has taken place at Community Mental Health Centers, a potential problem because those at a public facility have "little choice of facility, type of treatment, or practitioner" (Lebow, 1982, p. 284), which may also help explain high levels of

reported satisfaction: clients may not be aware of alternatives or hold low standards for treatment.

Psychometric and Scale Development

Beyond difficulties with the sampling methods for satisfaction are the problems of reliability and construct validity of satisfaction measures. The typically high rate of 70-90% satisfaction is often attributed not only to sampling and response bias, but also to scale design rather than true perception (Kaufman & Phillips, 2000; Riley et al., 2005). Almost all studies cite the lack of high level analysis for the scales developed or unknown psychometric properties – some do not even report reliability, and give only means and standard deviations (Attkisson & Zwick, 1982; Harrington Godley et al., 1998; Lebow, 1982; Riley et al., 2005; Young et al., 1995). Kaufman & Phillip (2000) found that sample sizes are often too small to meet the requirements for factor analysis, only 11% of satisfaction surveys tested inter-item reliability and only 5% used factor analysis. Principal Components Analysis is reported the most often by those who use factor analysis for satisfaction scale development. Only Essex et al., used Principal Axis extraction and no scale has been further analyzed with Confirmatory Factor Analysis. A review by Gerkensmeyer & Austin (2005) found 28 different scales used in 34 studies; no scale tapping different dimensions contributing to satisfaction achieved the level of replication as the CSQ-8 for general satisfaction (Young et al., 1995).

Another shortcoming in satisfaction scale development includes not actively seeking the client perspective for satisfaction – thus the developed questionnaires may lack face and construct validity without client input (Measelle et al., 1998; Young et al.,

1995). Researchers have suggested using focus groups with clients/parents to gain the perspective beyond that of the researcher's literature review (Measelle et al., 1998; Young et al., 1995). In the development of the Family Satisfaction Survey by Measelle et al. (1998) for case management, a parent support group gave four main areas (professionalism, competency, commitment to parent partnership, and respectful/non-blaming attitude towards parents) that indicate satisfaction is linked to how the parents feel treated by mental health professionals more than professional skill and competency. The inclusion of client perspectives may help researchers identify what actually contributes to variations in satisfaction and positive experiences since demographics and outcome measures have been unsuccessful predictors.

Lastly, researchers must also be aware of the response format and how this may influence self-report responses. Most self-report surveys use a 4 or 5 point Likert scale with positively stated items (Gerkensmeyer & Austin, 2005; Measelle et al., 1998; Riley et al., 2005; Young et al., 1995). The current literature review found only one scale with a reverse scored item (Riley et al., 2005) and a lack of items with different levels of difficulty that could check for extreme response patterns. It appears that in the interest of brevity, satisfaction questionnaires have consistently tried to reduce the number of items to the fewest possible, so that those reviewed were between 8 and 15 questions long with Riley et al. (2005) having the most items at 26 questions. However, the simplicity of the satisfaction questionnaires excludes components of better developed self-reports, such as extreme response detection (all positive, all negative) or social desirability bias subscales included on the Parent and Teacher response forms for the BASC for child symptoms of

mental illness. Items describing different levels of satisfaction could result in increased variability among response with some representing a basic level of 'satisfaction' whereas others could correspond to exceeded expectations that could be informative about parent experiences. Harrington Godley et al. (1998) noted the importance of including a comment block as self-report measures may not cover every aspect of service that clients would like to comment. Many of the comments by parents mirrored other research findings that the parent and child relationship with the assessor and the support provided by the services (Harrington Godley et al., 1998). Besides logistical concerns (more time slots, convenience to home) parents suggested more time with the clinicians and being treated equally/respectfully as areas needing improvement. Thus, although the Likert format itself is widely used and supported, satisfaction surveys would do well to build in features that can prevent and detect response bias, as well as give clients the chance to comment on aspects not covered by the questionnaire. Also, instead of ignoring the negative feelings parents might have during their child's treatment (guilt, frustration, confusion) or that may be induced by how the parent experiences services (not listened to, disrespected) questionnaires should investigate these responses with the goal of reducing parent negativity experienced with child treatment.

Theory

One of the earliest, yet only more recently addressed, problems with the satisfaction literature is the lack of theory surrounding 'satisfaction'. Lebow (1982) pointed out that "to some, satisfaction means a minimum state of acceptability of services, whereas for others it means near perfection" (p. 247). This lack of clarity in

what 'satisfaction' means has led to other constructs being measured. For instance, outcomes are often included as part of a satisfaction measure, but as mentioned previously, clients/parents can be satisfied without significant outcomes (Gerkensmeyer et al., 2006; Lebow, 1982; Plante et al., 1998). In a review by Gerkensmeyer (2005) of 34 parent satisfaction studies, none had a conceptual framework and only 2 presented conceptual definitions of parent satisfaction. A review by Young et al (1995) describes satisfaction as a multidimensional concept as advocated by Brannan and Heflinger (1993, 1994) related to consumer expectations. "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 et al., 1995, p. 221).

The most current work on developing and testing a framework for parent satisfaction has been by Gerkensmeyer & Austin(2005)/Gerkensmeyer et al. (2006) by adapting Oberst's (1984) discrepancy model. Satisfaction was defined as "the difference between perceived services and consumers' desired and expected services" (Gerkensmeyer et al., 2006, p. 66). The researchers presented a model measuring consumer characteristics, consumer definition of situation, desired services, and expectations that when combined with actual service should influence level of met desires, met expectations, and thus, client satisfaction. Structural Equation Modeling (SEM) was used to test the hypotheses between the various observed and latent variables in the model as depicted in Figure 1. The revised model indicated that neither consumer characteristics (child age/grade) nor parent definition of situation (stress, child difficulty, child worry) significantly predicted expectations. Rather, both consumer characteristics

and definition of situation (DOS) contributed to desired care. Thus, parents related their situation to what services they desired, but it is unclear where parents gain their expectations. It may be parents have low expectations due to their lack of control when deciding on services or being unaware of other options (Lebow, 1982). However, as predicted, met expectations and met desires significantly predicted parent satisfaction, with factor loadings of .61 (p<. 01) on met expectations and .31 (p<. 01) for met desires (Gerkensmeyer et al. 2006).

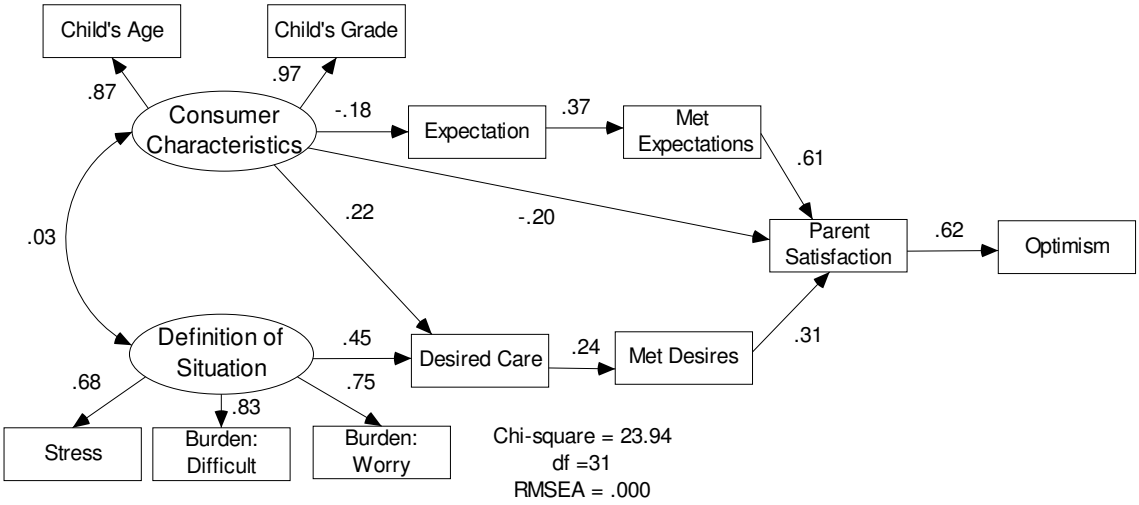


Figure 1. Revised structural equation model for parent satisfaction. (Gerkensmeyer, et al., 2006)

The most interesting addition to the model was a parental optimism variable that was significantly predicted by parent satisfaction (Gerkensmeyer et al., 2006). The authors conceptualized that parent satisfaction can be both an ultimate outcome relating to service evaluation and an instrumental outcome influencing "engagement with the therapeutic regime, clinical outcomes, and quality of life outcomes" (Gerkensmeyer et

al., 2006, p. 74). It may be that increased parent satisfaction, and hence increased optimism are two of the enabling variables related to further utilization of services/recommendations.

Finally, by focusing on general client/parent satisfaction, the feedback generated by research has been of little applicable use for program revision (Gerkensmeyer & Austin, 2005; Gerkensmeyer et al., 2006; Young et al., 1995). By shifting to the interpersonal aspect of child mental health services, researchers and evaluators can focus on the experiences parents have with child mental health services and improve specific areas, including friendliness of staff, warmth/bedside manner of clinician, and ways to collaborate and involve parents in decision making. The growing importance of parental collaboration in the satisfaction literature is cited by Young et al. (1995) with the philosophy that "collaboration empowers parents and allows them to serve as more effective agents for assuring the quality of services their children receive. Satisfaction research is one dimension of the effort towards collaboration and signifies the willingness of concerned parents to advocate for their children and of providers to hear parental concerns" (p. 223). Fortunately, this collaborative spirit already exists in Therapeutic Assessment (TA) with children and TA can further anchor theory about what underlying mechanisms create positive experiences for parents that lead to greater parental engagement and optimism.

Therapeutic Assessment

Overview

Therapeutic Assessment (TA) is a form of collaborative assessment that is individualized based on client questions and designed to be a positive intervention. TA has been developed by Finn and colleagues (Finn, 1996, 1997, 2003; Finn & Kamphuis, 2006; Finn & Tonsager, 1992, 1997, 2002) and has been reciprocally influenced by the development of collaborative assessment (Fischer 1985/1994; Handler 1996, 2007). As summarized by Finn and Tonsager (1997), TA has its roots in the humanistic movement by advancing the idea of sharing test results with clients, which allows for a greater therapeutic alliance, specific goals, and increased client self-esteem, motivation, and feelings of hope while reducing symptomology and feelings of isolation. TA can be contrasted with the more typical 'information gathering' model of assessment where the assessor is an objective observer gathering data. In TA, the assessor actively enlists the help of the client to question, explore, and test assessment information. This allows the client to learn new ways of thinking about self and others in a supportive environment that can lead to lasting changes in the client's story of self (Finn & Tonsager, 1997, Tharinger, Finn, Wilkinson, & Schaber, 2007).

The principles of TA allow the assessor to go beyond standard test scores by using test responses and experiences to "get in the shoes" of clients for empathic understanding. The assessor's own reactions, affect, and counter transference are also important pieces of information used to reveal case dynamics and potential sources of bias (Tharinger, et al., 2007). One of the main techniques used in TA is 'collaborative

empiricism' as found in cognitive behavioral therapy (Tharinger et al., 2007) where the assessor and client co-investigate various experiments about the client's questions and expected results. By engaging the client in the conceptualization and interpretation of these experiments, the assessor can help guide the client through the assimilation of new information and experiences (Finn & Tonsager, 1997, 2002; Tharinger et al., 2007).

Research with TA has shown positive treatment effects for adults, including increased likelihood of completing recommended treatment, decreased symptomology, greater self esteem, and increased hopefulness (Finn & Tonsager 1992, 1997; Tharinger et al., 2007). Case studies, including work with adults and children/adolescents, have shown the clinical utility of TA and the effects on parents (Hamilton et al., in press; Tharinger et al., in press-d). Parents have reported gaining a better understanding of their child's problems, and feeling more confident in their parenting and in seeking additional services, whereas children have shown decreased behavior problems and improved social/mood functioning (Tharinger et al., 2007). Parents have also shown increased positive affect and decreased negative affect relating to their child's challenges and future outlook (Tharinger et al., in press-d).

Therapeutic Assessment with Children

The Therapeutic Assessment Project (TAP) is a systematic research study investigating TA with preadolescent children and their families (Tharinger et al., under review-b). When working with children and their families, TA becomes a short family systems intervention whose goal is to help families to become 'unstuck' concerning the identified child (Tharinger et al., 2007). Parents are key collaborators in the assessment

process who are guided to more empathic understanding of their child and who learn ways to shift family interactions toward more positive outcomes. Through the 12 case studies completed by TAP, researchers have attempted to extrapolate the underlying mechanisms and processes that make TA with children a success. Tharinger et al. (2007) outline the general structure of the assessment process including type and order of the typical 8-10 sessions with a detailed case example. The following are some of the unique aspects of TA with children that highlight the collaborative process and help parents make shifts in their understanding of their child and in their own role in helping their child and family cope with mental health and behavioral struggles.

The first step in TA is to solicit client questions about the purpose of the assessment and help the client formulate questions that can be investigated via the different techniques available for TA (Finn, 2007). In a child TA, the parents meet with the assessors to give initial questions and background, and in the subsequent session the assessor helps the parents share a developmentally appropriate question with the child. Children are then asked to contribute their own questions, both with the parents present and in the following one on one activity with the assessor (Tharinger et al., 2007). The question-gathering process provides the structure for the ensuing assessment sessions and allows the assessors to choose the most relevant testing methods such as interview, observation, psychoeducational tests, neuropsychological tests, self reports, behavior rating scales, and performance based measures (drawings, sentence completions, TAT, Rorschach). An advantage of the methodology of TA with both adults and children is that standardized test scores can be collected to provide a nomolithic perspective (Finn &

Tonsager, 1992; Tharinger et al., 2007). However, extended inquiry, testing of the limits, and processing of the assessment experience allow for an individualized assessment that may better address the concerns and questions the parents/child bring to the assessment. The questions can be revised throughout the assessment and serve as the anchor for the discussion feedback sessions at the end (see below). It takes a conscious and purposeful effort by the assessor to engage the clients in question making, without falling into the typical expert role or accepting vague or unrealistic questions. This process sets the stage for the development of the parent-assessor and child-assessor relationships that will develop over the course of the assessment and are vital to successful collaboration.

One of the most revolutionary aspects of TA with children is that parents are allowed to watch their child's assessment (either in the room or through a one way mirror) (Tharinger et al., 2007; Hamilton, et al., under review). This 'behind the mirror' technique allows one member of the assessment team to help inform parents about general testing procedures, encourage questions and reactions to the child's performance/behavior/affect, and guide parents to gaining a new perspective of their child. The child is aware of the parents behind the mirror, and often uses this instrument to communicate with parents. In follow-up interviews of a child TA, parents often cite the 'behind the mirror' to be one of the major benefits to seeing their child in a new way and watching her interact with different people (Hamilton, et al., under review). Current research on TAP is focusing on the collaboration behind the mirror between the parents and assessment team to further highlight how this process enhances change in parent perceptions and learning.

The family session (or family intervention session) is an opportunity for the parents to be directly involved in the child assessment. After gathering assessment data, the assessment team devises an activity for family members to engage in ranging from simply playing a game, to a consensus Rorschach, to re-enacting a family argument. The family session has multiple goals including bringing the assessment findings to life, testing more systemic hypothesis of the child's problems, and allowing the family to have a positive experience to generate new ways of interacting (Tharinger, et al., under review-a). The family session can often serve as a major 'ah ha!' moment where parents can see how their reactions influence their child and gain new skills. The variety of techniques available (play therapy, empathic listening, psychodrama, consensus TAT, etc) allows the assessment team to craft an individualized family experience designed to meet the family at their current level of understanding and then hopefully create the catalyst for further assimilation of the assessment results (Tharinger, et al., under review-a). The family session is a prime example of not only having parents highly involved in a child assessment/service, but also parents being actual participants just as they would need to participate in successful treatment or therapy strategies.

One of the earliest findings of research in TA was that feedback about testing is more readily assimilated and understood if ordered according to client's preconceived perceptions (Finn 1996, Finn & Tonsager 1997). This has led to the recommendation of presenting client feedback from the most congruent to increasingly more discrepant order of client understanding. In TA with children, there are unique aspects when considering how to give developmentally appropriate child feedback and how to order feedback to be

of the most use for parents (Tharinger et al., in press-a). When providing feedback to parents in TA, feedback is divided into three levels, with the assessment team judging by the parents' reactions how to proceed to increasingly more difficult information. However, the case studies on TAP have found that since parents are continuously receiving feedback and incorporating new perspectives as an ongoing process, by the end of the assessment parents are able to hear more systemic pieces of feedback at the higher levels (Hamilton, et al., under review; Tharinger et al., in press-a). This assimilation is also aided by the feedback information being organized around the parent and child assessment questions, thus anchoring the results around areas already significant to the clients.

In continuing with the collaborative nature of the assessment, parents are invited to make sure the results 'fit' with their experience and to add suggestions or their own interpretations of the assessment experience. The child feedback is often presented as a fable crafted by the assessment team (and approved by the parents) that speaks metaphorically to the most salient struggles the child is facing and how the parents will be able to help the child cope (Tharinger et al., in press-a; Tharinger, et al., in press-b). By organizing and presenting feedback using the collaborative techniques (levels, fable writing, letter writing, parent discussion session) cited in the TAP articles, TA with children is demonstrating how assessors and professionals can talk in a way parents understand and keep them involved in the entire process. Currently, studies are under way to investigate how pieces of TA with children (question gathering, feedback levels)

can be transferred to the school assessment environment, further demonstrating the utility of TA concepts in various settings.

Overall, adult and child assessment using the principles and techniques of TA appear to meet the goal of using the assessment as a positive intervention. Until now, the effects of TA have been measured via quantitative analysis, pre/post interviews with parents and child, various weekly session self reports (alliance with assessment team, family alliance, positive/negative affect), pre and post BASC completion, and 6 month follow up measures (Tharinger, et al., under review-b). Although the self-report questionnaires used measure aspects considered related to TA, there is not currently a self-report designed to measure the interpersonal aspects present during TA. It is these interpersonal experiences (parent-assessor relationship, collaboration, child-assessor relationship, etc) that are conceptualized as the necessary catalysts for a successful TA. It is the high level of client/parent involvement that seperates TA from traditional assessment, and thus a measure designed to track these experiences should distinguish TA from other assessment types/settings. For instance, a parent self report (and eventually, a child self report) measure could show a significant difference between a traditional information gathering assessment with low levels of parent collaboration as compared to a child TA with high levels of parent input. Because TA with children is conceptualized as a family intervention, it is important to gather more data on exactly which aspects of the TA experience are most salient to parents.

Integration

The literature presented in this review indicates that TA with children can provide the theoretical structure and high levels of collaboration/parent involvement currently being sought by the parent satisfaction research. A self-report measure based on the interprersonal experiences facilitated by TA could be used to compare various assessment settings and eventually the interpersonal aspects of other child psychological services. By expanding beyond parent satisfaction to parent experience, researchers may be able to identify which interpersonal experiences are most valued by parents and are essential for child mental health service providers to focus on in program delivery and evaluation. The recognition that parent 'satisfaction' is not just an end in itself, but also a possible means to greater service utilization, follow through, and care for a child with mental illness makes the search to understand how parents experience child services even more important. "Parent satisfaction is a very important factor to measure because it is likely to be highly related to parents' being active partners in therapeutic efforts to address their child's health needs" (Gerkensmeyer, Austin, & Miller, 2006). As TA continues to demonstrate, in order to help children, the clinician must also assist the parents by providing the opportunity for new conceptualizations, attributions, and experiences. By creating a parent measure that explores the interpersonal experiences of parents during a child assessment, researchers will be able to simultaneously provide more verification of the collaborative techniques of TA, facilitate the incorporation of these techniques in other assessment settings, and investigate the interpersonal experiences most related to parent satisfaction.

Chapter Three: Proposed Research Study

Statement of Problem

Current research on parent satisfaction with child /adolescent mental health services has not found any traditional demographic variables to help predict parent satisfaction; nor has research created measures that are psychometrically sound and useful for program revision. All self-report satisfaction measures tend to have high ratings (social desirability bias, sample bias), yet parents are often only minimally involved in the service decisions and evaluations for their children. Recent research is recognizing the important role that parents play in seeking and maintaining services for their child, and that parent satisfaction may influence how parents follow through on recommendations and treatment plans. It has also been found that parent satisfaction may be more related to interpersonal relationships with staff (collaboration, respect, feeling heard) rather than child outcomes; parents may value the idea of good 'care' instead of 'cure'. However, general satisfaction does not tell researchers and program evaluators what interpersonal experiences parents are having and what experiences (new information, collaboration, child-assessor relationship, etc) are most salient for overall parent satisfaction.

Statement of Purpose

The purpose of this study is to design a parent questionnaire that measures the different experiences parents may have with an assessor, based on the Therapeutic Assessment model. Therapeutic Assessment can be a positive intervention in and of itself for both adult clients and for children and families. The principles of TA encourage high

levels of parent involvement, questioning, and interpretation, which can provide a positive change experience and a renewal of hope for parents leading to greater follow through on recommendations and parenting strategies for the child. It is hypothesized that these principles lead to higher levels of parent satisfaction and could be utilized in other assessment or service settings. Thus, this study will provide clarity about the aspects of child TA which makes it a positive experience for parents and relate these parental experiences to overall satisfaction to be compared across different assessment settings.

Research Questions and Hypotheses

Research question 1

How do various aspects of interpersonal relationships with a clinician relate to overall parent satisfaction? There are a total of six subscales currently measured by the Parent Experience of Assessment Scale (see below for scale development) that represent different areas of interpersonal experiences. The six variables discussed in the following hypotheses include Learned New Things, Parent-Assessor Relationship, Collaboration, Assessor-Child Relationship, Family Involvement, and Negative Feelings about the assessment.

Hypothesis 1a. General parent satisfaction will be most highly related to the parent-assessor relationship, level of collaboration, and the parent's perception of the child-assessor relationship.

Rationale. Previous research in the parent satisfaction literature has already shown that overall parent satisfaction is more related to interpersonal experiences, including higher levels of collaboration with parents and parents feeling respected and

heard by professionals (Gerkensmeyer & Austin, 2005; Measelle et al., 1998; Riley et al., 2005; Young et al, 1995). When reporting areas needed for improvement, parents cite better communication and a greater degree of parental involvement (Young et al., 1995).

'Collaboration' as conceptualized and practiced in Therapeutic Assessment (and hence the PEAS-1 subscale) includes the parents helping set the scope of the assessment, being informed about each step in the assessment process, contributing ideas about the validity of the test results, and working as a team with the assessor to help their child. Items similar to the Collaboration subscale can be found in the Participation in Treatment factor of the Youth Services Survey for Families (YSSF; Riley et al., 2005) and individual items (kept me informed, find the right services, included me in decision making) on the Parent Satisfaction Scale (PSS; Gerkensmeyer & Austin, 2005). The inclusion of collaboration items on the most recent parent satisfaction scales simultaneously shows the growing importance of this variable, its neglect in older satisfaction measures, and the need to further establish its importance.

'Parent-Assessor Relationship' as measured by the PEAS-I includes feeling respected, liked, and listened to by the assessor, as well as a reciprocal relationship of the parent feeling close to the assessor, liking the assessor, trusting the assessor, and feeling the assessor was genuinely interested in helping. These items are similar to the Dignified Treatment factor from the Client Satisfaction Survey (CSS) by Essex et al. (1981), items from the PSS (treated with respect, listened to what I had to say, support), and the Cultural Sensitivity factor of the YSSF, which also included respect for religious/spiritual beliefs and cultural/ethnic background (Riley et al., 2005). However, the Parent-Assessor

Relationship items on the PEAS-I includes reverse scored items and, rather than only rating how the assessor treated the parents, it also allows the parents to rate how they felt about the assessor, thus providing information about the reciprocal nature of the relationship.

Most often in parent satisfaction surveys, questions regarding the child focus on treatment outcomes (getting along better with others, better at school, daily coping, helped parent deal with child's problems, symptom reduction). However, parents still report being satisfied, despite nonsignificant outcome findings (Plante et al., 1998). Thus it seems it is the support that parents and children receive from treatment services that should also be measured. On the Youth Client Satisfaction Questionnaire (YCSQ) two factors emerged for the child – Relationship with Therapist and Benefits of Therapy, which were highly interrelated (interfactor correlation .61, $p<.0001$; Shapiro, Welker, & Jacobson, 1997). Parallel to the parent satisfaction data, child reported relationship with therapist was significantly higher than child reported benefits of therapy (Shapiro et al., 1997). Thus, parents are aware of their own relationship with the assessor, and they also have important perceptions about their child's relationship with the assessor which need to be measured. The 'Child-Assessor' subscale on the PEAS-I asks the parents how comfortable the child felt with the assessor, how well the assessor worked with the child, if the assessor and child both appeared to like each other, and if the assessor seemed to understand the child.

Based on the principles of TA and the importance of interpersonal relationships for parent satisfaction, it is hypothesized that these three interpersonal aspects will be the most highly associated with overall parent satisfaction.

Hypothesis 1b. Lower feelings of negativity associated with the assessment should be correlated with higher general satisfaction.

Rationale. The parent satisfaction literature has thus far phrased questions on parent surveys in a positive and neutral frame (Were you satisfied with….) and only qualitative comments allowed clients to express negative feelings or suggestions (Essex et al., 1981). As Gerkensmeyer & Austin (2005) pointed out, by assuming any negativity equals dissatisfaction, researchers have shown a lack of clear theoretical conceptualization. It is possible parents could be satisfied without significant change in outcome variables and may have suggestions for program improvement (Gerkensmeyer & Austin, 2005). Rather than ignore negative affect that may accompany a child's assessment, the Negative Feelings about the assessment subscale asks parents about feelings of guilt, lack of parenting efficacy, feeling blamed, ashamed, or overwhelmed. As mentioned previously, the satisfaction literature has tended to ignore the fact that parents often feel blamed by service providers (Measelle et al., 1998; Young et al, 1995). By including this subscale, the PEAS-I will allow practitioners to gain an understanding of what 'normal' or baseline level of negative affect is generally associated with needing an assessment for one's child. This will also provide valuable feedback for program revision so that parents who feel blamed or anxious can receive more support in the future. Although some negative affect is expected regardless of how well the assessment

process unfolds, it is hypothesized that lower levels of negative feelings toward the assessment should be associated with higher overall parent satisfaction.

Research question 2

How do parent experiences and general satisfaction vary by assessment type and assessment setting?

Hypothesis 2. It is expected that general parent satisfaction and the PEAS-I subscale scores will be significantly higher for therapeutic assessments than traditional child assessments. Specifically, the Learned New Things and Family Involvement subscales are most likely specific aspects of a Therapeutic Assessment that should contribute to Therapeutic Assessment receiving the highest overall parent satisfaction scores.

Rationale. Although the goals of traditional assessment include gathering data that help to describe a client's situation accurately and informing treatment, the goals of TA go beyond making a diagnosis or explaining standardized scores to parents (Finn & Tonsager, 1997). Rather, the Learned New Things subscale on the PEAS-I questions parents about learning new ways of interacting and responding to their child, changing their perception of their child, understanding child strengths, as well as gaining new information from assessment results. This scale speaks to the intervention nature of child TA in that the parents are able to question, assimilate new information, and receive tailored feedback in a supportive environment enabled by the interpersonal relationships in Hypothesis 1a. Also, instead of focusing on child outcome, the scale more closely investigates feelings of better parenting skills and effectiveness, new ideas, and new

understanding. Although hypothesized to be related to parental satisfaction, the Learned New Things subscale is most likely not as highly correlated as parent-assessor relationship, collaboration, or child-assessor relationship to general parent satisfaction. Rather, scores on this subscale should increase with more collaborative types of assessment, such as TA versus traditional assessments.

Similarly, higher scores on the experiences in the Family Involvement subscale may be expected in TA, but not in a more traditional assessment. This subscale asks parents to recognize a more systemic understanding of the child's problems including how family struggles affect the child and that family members may also need to change in order to help the child. This is one of the intervention aspects of TA, but it may not by itself be highly related to overall parent satisfaction. Rather, it is conceptualized as a piece of TA that can contribute to significantly higher overall satisfaction ratings from the TA experience when compared to other assessment modalities.

Hypothesis 2b. It is hypothesized that not only assessment type (traditional vs. therapeutic) but also service setting will be associated with differences on overall parent satisfaction and experiences. It is expected that more prescribed settings, such as schools and hospitals, will show lower overall parent satisfaction and PEAS-I subscale scores than community and private settings. Parents are expected to report lower levels of collaboration, interpersonal relationships, knowledge gained, and higher levels of negative feelings for non-therapeutic assessment settings

Rationale. More recent research in parent satisfaction has included using multiple types of settings for evaluating child services (Gerkensmeyer & Austin, 2005;

Gerkensmeyer et al., 2006; Harrington Godley et al., 1998; Riley et al., 2005;). Measuring parent responses in different allows researchers to compare across sites (hospitals, CMHCs, private settings) and different services (residential, case management, group therapy, individual therapy, social skills training, etc). Comparing types of child assessments in various settings should provide more variance in responses and in the types of experiences parents have. For instance, in a hospital setting, the parent should show lower levels on all five positively scored subscales of the PEAS-I than parent responses from a child TA. Whereas a community mental health center may show high scores on collaboration and parent-assessor relationship, it may have lower scores on new information and family involvement as progress in these areas are hypothesized to be related to the TA experience. Although general satisfaction scores are predicted to remain at the average reported level (between 70 to 80%), it is expected that even with sites conducting both traditional and collaborative assessments, the TA site and community mental health center should show significantly higher general satisfaction and PEAS-I subscale scores.

Research question 3

What interpersonal experiences with clinicians are most predictive of parents' general satisfaction?

Hypothesis 3. The parent relationship with the assessor and level of collaboration are most likely to predict overall parental satisfaction with their child's assessment.

Rationale. Although it is hypothesized that all of the six areas of the PEAS-I are related to parent satisfaction, parent satisfaction research suggests that interpersonal

relationships between parents and clinicians are highly related to overall parent satisfaction. The most direct interpersonal relationships measured on the PEAS-I are the Parent-Assessor and Collaboration subscales. These two areas form the foundation of parent/assessor alliance that is hypothesized to lead to new understanding of the child and greater systemic perspective by the parents. Especially since some of the subscales may be less relevant for more formal settings, it is hypothesized that how the parent feels treated by practitioners and the level of involvement of the parent in the child assessment will be the strongest two predictors of overall parent satisfaction.

Scale Development

The Parent Experience of Assessment Scale (PEAS-I) was developed to provide a more quantitative way to measure the underlying mechanisms in Therapeutic Assessment and investigate how salient these aspects are to parents.

Item Generation

Initial items and categories for the PEAS-I were generated by reviewing transcribed parent interviews following the completion of a child TA through the Therapeutic Assessment Project (TAP). The interviews asked parents about the TA experience, and about their attributions for their child's problems, role of family, future outlook, skills, and information gained from the assessment. Potential items were also generated by research team members who had worked with and observed parents and children during TA. Initial categories included information about the child, new skills, new understanding of child, systemic views, feeling understood, child relationship with assessor, collaboration, parent relationship with assessor, negative feelings about the

assessment, positive feelings about the assessment, and optimism/pessimism about the future.

The items within each category were constructed with both positive and negative wordings (introducing the need for reverse scoring) and some items were designed to be more difficult than others. For example, the item "I learned a tremendous amount about my child from the assessment" differentiates between those parents who found the assessment extremely insightful versus those who found it merely helpful or routine. It is hoped that the different levels of difficulty may reduce the 'ceiling effect' so often associated with satisfaction measures and thus reflect more variance in parent experiences. Items were also designed at a fourth grade reading level and with natural language wording that avoids jargon.

The 78 items were then given to 9 expert judges to sort based on item similarity. Judges were also asked to provide names for the categories they determined and were not limited in the number of categories to create. The results were entered into co-occurrence matrices and submitted to factor analysis to determine which items were grouped consistently enough to distinguish different factors.

The results were analyzed using Principal Axis factor analysis with Direct Oblimin rotation (KMO = .929; Bartlett = 4523.450, df = 2906, $p<.000$). Solutions with 3 through 8 factors were analyzed, using a .55 cutoff for minimum loading on a factor. Most factor loadings ranged from .63 to .81. Items that did not load on a factor or were highly loaded on multiple factors were removed. Some items that loaded on two factors were revised to measure only one factor, and if a factor did not have enough items,

additional items were created. The preliminary measure consists of 64 statements divided among 6 subscales with the amount of variance accounted for by the six factors ranging from 3.99 to 10.24% of total variance The Learned New Things subscale (α = .96) highlights new information gained by parents about their child from the assessment. Assessor-Parent Relationship (α = .96) is designed to measure the interpersonal relationship between the assessor and parent which includes feeling respected, valued, and heard by the assessor. Collaboration (α = .84) is a different subscale that assesses how informed and involved the parent was during their child's assessment. Assessor Child Relationship (α = .93) investigates the parent's perception of how well their child worked with and responded to the assessor. Negative Feelings (α = .88) about the assessment include anxiety, guilt, and frustration that parents may feel regardless of how collaborative the assessment is depending on the severity of their child's symptoms, but especially high levels may reflect the 'blame' parents may often feel for their child's problems. Lastly, the Family Involvement subscale (α = .92) is designed to assess how much the parent considers the family's role in helping/maintaining the child's problems. TA is designed to encourage parents to become a positive force in helping their child and re-energize parents who have 'tried everything'. The Family Involvement subscale is designed to probe the more systemic/family aspect of children struggling with mental health problems.

Pilot Testing and Revision

Pilot testing the PEAS-I on a community sample of parents/guardians who are receiving a psychological assessment for their child is essential to further refine the

subscales and items included. The baseline sample should consist of parents whose child are receiving a therapeutic assessment as some of the scales may not be as relevant to more traditional assessment settings. However, it is exactly these differences in settings that will provide variability and discriminant profiles of 'typical' parental experiences across settings and services in further studies. Basic demographic information (sex, age, diagnosis, length of treatment, etc) will also be collected to check for any bias in the sample. Parents (or guardians) will be asked to complete the questionnaire and the 8-item CSQ (see below) as a check out procedure after the last assessment meeting. Confidentiality will be maintained by a local research assistant not involved in providing services to the families. Because assessments are often shorter than other psychological services, it is expected that the problem of early termination so often encountered in other treatment services will not be as salient an issue. Thus, it is expected that the pilot testing should have a higher than average (above 75%) return rate.

After a sample of 350 cases has been collected, which will meet the 5 cases per variable minimum for factor analysis, a nested Confirmatory Factor Analysis (see Appendix A) will be conducted to further refine factors and reduce the number of items on the scale. The nested model will essentially control for each item's loading on overall parent satisfaction and then show the factor loading to the hypothesized PEAS-I subscales. The nested CFA will demonstrate that the items on the PEAS-I are related to overall parent satisfaction as well as the specific subscales. By controlling for overall parent satisfaction, the nested CFA should reveal more accurate item to subscale loadings. Past attempts to create multidimensional parent satisfaction scales have not

controlled for overall parent satisfaction, thus the primary factor accounted for so much of the variance that the questionnaires were considered unidimensional. To be retained, an item will need to have .70 factor loading on the PEAS-I subscales. Ideally, the final scale will contain no more than 40 items. Although this number is greater than many of the current satisfaction measures, the PEAS-I is also attempting to measure six subscales instead of only one or two factors for general satisfaction. Psychometric properties including as Chronbach's alpha and corrected item-total correlations will also be re-analyzed.

Method

Participants

In order to see how the experience of parents varies across assessment type and setting, four different sites will be chosen to participate. The sites would include a local school, hospital, community health center, and private therapeutic assessment setting. This will allow for comparison across different approaches of child assessment (therapeutic/collaborative vs. traditional). As part of the site participation, the non-TA settings would agree to have a designated number of practitioners receive additional training and conduct 'collaborative' child assessments during the study period. Ideally, at least 50 assessments with completed questionnaires would be returned from each site, with 25 assessments designated as 'traditional' and 25 designated as 'collaborative'. With the baseline from the previous pilot testing, the additional settings will provide normalizing information about parent experiences in different contexts and how it relates

to general satisfaction. Study respondents would be a single parent or guardian completing the questionnaires at the conclusion of the child assessment.

Instrumentation

The Client Satisfaction Questionnaire (CSQ-8; Appendix B): The CSQ-8 (Attkisson & Zwick, 1982; Larsen, et al., 1979) is the most widely used measure for general client satisfaction. Although originally normed for adult clients, it has more recently been used in parent satisfaction studies (Byalin, 1993; Gerkensmeyer & Austin, 2005). The CSQ-8 is single factor scale with high (.93-.96) reported reliability (Attkisson & Zwick, 1982; Gerkensmeyer & Austin, 2005).

Parent Experience of Assessment Scale – I (PEAS-I; Appendix C): The revised PEAS-I will be administered in all settings at the conclusion of the child's assessment. The current scale in pilot testing consists of 6 subscales: Learned New Things, Collaboration, Parent-Assessor Relationship, Child-Assessor Relationship, Family Involvement, and Negative Feelings. Chronbach alphas for each of the streamlined scales (after item elimination and rewording based on the factor analysis) ranged from .84 to .96. The measure is based on a 5-pt Likert scoring system, with some reverse scored items. There is not a total score; rather the average rating for each subscale is calculated via an electronic scoring sheet.

Demographics Form: Parents or staff will fill out a short demographics form including child age, gender, race, diagnosis, parent/respondent's gender, relationship to child, highest level of education, length of assessment, type of assessment, number of client hours, number of assessment sessions, and assessment results (see Appendix D).

Procedure

After receiving university IRB approval and confirming the participation of assessment sites, five hours of training will be provided for the clinicians whose assessments will be designated as 'collaborative' during the study. Child assessments at the school, community mental health center, and hospital will be randomly assigned to either a 'traditional' or 'collaborative' assessment. A 'traditional' assessment will consist of the usual protocol for a child assessment at that site, including number and type of sessions, instrumentation, etc. A 'collaborative' assessment will incorporate some of the interpersonal techniques of TA, including gathering parent assessment questions, regular check in with parents about the assessment progress and preliminary findings, and a discussion session with parents using Feedback Levels to help parents assimilate and provide input into the interpretation of assessment findings. Having sites include both traditional and collaborative assessments should provide greater variation in parent responses and allow for meaningful comparisons across assessment modality, setting, and within site parent experience.

The study will take place over the course of a year as practitioners complete the child assessments. Packets including the demographics cover sheet, PEAS-I, and CSQ-8 will be distributed to the sites to be administered by a non-clinician at the conclusion of the assessment, most likely the parent feedback session. For those parents whose child does not finish the assessment, the forms will be mailed after a follow-up phone call. Completed protocols will be returned for data scoring and entry.

Analysis and Expected Results

The first step in the analysis will be to check the demographic data for any significant correlations to mean PEAS-I subscale and CSQ-8 scores. Chi-Square analysis will be used to check for over/under representation of participants (gender, age, site, responders vs. nonresponders, etc). All analyses will use a .05 significance level.

Hypothesis 1a & 1b

It is hypothesized that Parent-Assessor Relationship, Collaboration, and Child-Assessor Relationship will have higher associations with overall parent satisfaction than the other three PEAS-I subscales. Lower scores on Negative Feelings should be related to higher scores on overall satisfaction. In order to assess these hypotheses, correlations will be computed between each PEAS-I subscale and the general satisfaction score from the CSQ-8. Then, the correlations will be compared statistically to see if the interpersonal subscales are significantly more correlated with overall satisfaction than the other subscales. Negative Feelings should have a significant negative correlation with overall satisfaction.

Hypothesis 2a & 2b

It is expected that different assessment types will have significantly different levels of overall parent satisfaction and subscale scores on the PEAS-I. Assessments will be categorized as either traditional or therapeutic (including formal TA and the 'collaborative' assessments at the non-TA sites). It is also hypothesized that private and community settings will receive significantly higher general satisfaction and subscale scores than the school or hospital setting.

To test these hypotheses, a MANCOVA (controlling for child severity of illness) will be conducted with the seven parent scores from the CSQ-8 and PEAS-I measures as the dependent variables and the two independent variables of assessment type (therapeutic or traditional) and site (school, private setting, CMHC, and hospital). Because of the lack of previous studies, an priori power analysis assumed a small effect size of .10, alpha of .05, and a sample size of 200 resulting in >.80 power estimate. Follow up ANCOVAs and post hoc LSD tests will be conducted to further refine significant findings from the MANCOVA. It is anticipated that the therapeutic category of assessments will have significantly higher levels of overall parent satisfaction and interpersonal experiences based on higher mean level of outcome scores on the CSQ-8 and PEAS-I subscales. Different profiles for satisfaction should emerge from the data analysis about which experiences parents are having and which ones they expect/value the most. For example, school settings may not differ significantly from hospital settings on the Negative Feelings subscale scores, but may have significant differences on the Family Involvement subscale scores. Thus, even though overall mean level of outcome scores are expected to differ by assessment type, it is important to determine which dependent variables have are associated with significantly different experiences at the various sites.

Hypothesis 3

In order to aid program revision and service delivery, it is important to discover which interpersonal experiences are most predictive of overall parent satisfaction. To test this hypothesis, a simultaneous regression analysis will help determine the subscales of the

PEAS-I best able to predict general parent satisfaction. It is expected that the relationship between the parent and the assessor and the level of collaboration (as measured by the Parent-Assessor Relationship and Collaboration subscales) will be the best predictors of overall parent satisfaction.

Chapter Four: Discussion

Summary

Parental feedback about child/adolescent mental health services is often received via parental satisfaction surveys. Service providers increasingly recognize that parent satisfaction is not only an important outcome variable with child services, but also an intermediate variable associated with greater parental involvement, continuation of child services, and parental follow through on recommendation and treatment suggestions (Gerkensmeyer et al., 2006). However, the parent satisfaction literature has suffered from a lack of theory about the mechanisms contributing to parent satisfaction and questionnaires that are not psychometrically sound or widely used. Although client and parent satisfaction with services generally range from 70-80%, most researchers attribute the high rate to a combination of response and sampling bias. Beyond child severity of illness, few predictors of parent satisfaction have been found and replicated. Rather, more recent research and qualitative comments from parents indicate that communication, collaboration, and respectful treatment are areas that need improvement. It appears that parent satisfaction is more closely associated with the "care" that the families receive as opposed to the "cure" or symptom reduction in the child. In order to provide meaningful feedback to programs about the parent experience and how child services can be improved, new measures focusing on the interpersonal aspects of service providers need to be created and validated in various settings.

Therapeutic Assessment (TA) is a highly collaborative approach to child assessment and has developed certain practices that allow the child assessment to become

a short family intervention including greater compassion and understanding of the child on the part of the parents, a revision of the child's 'story', reduced negative affect, and increased hope and optimism. Gerkensmeyer et al. (2006) found that parent satisfaction was also associated with optimism, which is hypothesized to contribute to greater parent follow through and seeking of child services. In a child TA, the foundation of high parental collaboration is begun when the assessor asks the parents for assessment questions that can provide a tailored assessment for the child and family. Using the questions as a framework, the assessor then conducts and individualized assessment where the parents watch, comment, and process the experience with the assessment team. The safe 'holding environment' created by the positive parent-assessor relationship allows the parents to explore new understanding of their child and their own role in how to help their child. Feedback is also structured around the assessment questions, making it personally relevant, and is presented according to the readiness of parents to accommodate new perspectives. TA conceptualizes feedback in three levels, and has shown that by beginning with the least disparate findings, parents and clients are able assimilate more difficult results. TA uses the strong parent-assessor relationship, high levels of collaboration, and positive child-assessor relationship to provide the initiative for change in 'stuck' families, new understanding and ways of relating to the child, and a more systemic view of how the family influences the child's struggles.

This study proposes that the theoretical orientation and practice of TA can inform the parent satisfaction literature by providing the framework for developing a parent measure targeting the interpersonal experiences of the parent during a child assessment.

The creation of the PEAS-I was designed to overcome some of the previous issues in satisfaction measure development by using parent interviews as the basis for item generation, having both positively and negatively worded items, and creating items with different levels of difficulty (i.e. the assessment completely changed the way I see my child vs. I am more aware of my child's strengths) that may reduce the ceiling effect and produce greater variability in parent responses. The pilot testing of the PEAS-I will use a nested confirmatory factor analysis to (a) help demonstrate that the PEAS-I subscales measure aspects of overall parent satisfaction and (b) control for overall parent satisfaction, producing more accurate subscale loading of items. Although designed for initial use with child assessments, the subscales (Learned New Things, Parent-Assessor Relationship, Collaboration, Child-Assessor Relationship, Family Involvement, and Negative Feelings) focus on interpersonal experiences that could be applied to most other child/adolescent services including individual treatment, family counseling, social skills, group therapy, case management, and other wrap around services.

In order to demonstrate the effectiveness of TA principles and discover the relationship between interpersonal experiences and overall parent satisfaction, the proposed study would include administering the PEAS-I and CSQ-8 to parents at the completion of their child's assessment at four different assessment settings (school, hospital, CMHC, private TA setting). The non-TA sites would be asked to incorporate some TA practices, including parental question gathering, parent check-ins, and a discussion session using feedback levels and encouraging parental interpretation of results. By having assessment cases randomly assigned to either a 'traditional' or

'collaborative' approach within settings should increase parent response variability and show the applicability and resulting parent experiences with TA constructs in multiple settings.

The anticipated results of the study would show that overall parent satisfaction is significantly related to the six PEAS-I subscale factors, with the parent-assessor relationship and level of collaboration having the highest correlations and best predict parent satisfaction. The results would also be expected to show that the therapeutic assessments (including formal TA and the 'collaborative' site assessments) showed significantly higher general and subscale scores than the traditional assessment condition. Lastly, it is anticipated that even with two assessment conditions at three of the sites, there would be a main effect for sites relating to the different subscale scores. For instance, the Learned New Things and Family Involvement mean subscale scores should be significantly higher in the private TA setting than the hospital site, since these two constructs are hypothesized to be more unique to TA. Or, a school may score highly on Child-Assessor relationship, but lower on Collaboration since there may be a strict test battery allowing less room for parental input. Thus, the results should show different 'profiles' of relative strengths and weaknesses of the different sites, which should inform assessment practice.

Limitations

Although the proposed study sought to increase variability by including different assessment sites, the use of local sites limits the generalizability of the findings to other samples (urban vs. rural, minority representation, regional differences, etc). Replication

at multiple hospitals, schools, and CMHCs would be needed before a truly reliable baseline or average mean score for the different PEAS-I subscale could be gathered. Future studies could show the convergent validity of the PEAS-I with other parent satisfaction measures, such as the Parent Satisfaction Survey. Although the constructs for each measure are different, they should be highly correlated as both are related to general parent satisfaction.

A possible source of bias in the study would be determined by how the 'collaborative' assessors are recruited and chosen. If the sites use volunteers, than it may be that those who volunteer are more collaborative by nature, thus confounding the effect of the TA techniques. Rather, it may be that two or three of the assessors are randomly assigned from the volunteer pool to receive the additional training, thus reducing the self selection bias. The difficulty with this procedure is that if the non selected volunteers then compose the 'traditional' group, then since all the volunteers could be more collaborative in nature, one may not get a true picture of the variability in a traditional assessment. In addition, some method of supervision would be necessary to ensure that those trained in the 'collaborative' approach are implementing the techniques correctly and consistently.

The current study focuses on the role of parent satisfaction and involvement in child services and recognizing that parents are the main source of advocacy for their child. However, child satisfaction and experience of services also plays an important part, including the engagement of the child in the services and how the child interacts with the parents in continuing services. For example, a child who does not enjoy a social skills

group may throw a tantrum before the appointment, thus causing more stress for the parents, who decide that going to the meeting is not worth overcoming the child's resistance or acting out behavior. The child satisfaction literature is even smaller than the parent satisfaction literature, and child satisfaction has been largely ignored due to the cognitive development of the child, and since it is the parents who often seek services for their child, the child may not recognize the problems (Shapiro, et al., 1997; Young et al., 1995). However, the child experience of assessment is also important as it may be the first formal experience a child has with mental health services, and a particularly good or bad experience may set the stage for later service expectations. And, in TA, the assessment is conceptualized as a family intervention, including a new self 'story' for the child and changes in family interactions leading to more positive and adaptive child responses. Therefore, a future endeavor would be to construct a child and even adolescent version of the PEAS with revisions to the six subscales to developmentally appropriate constructs.

Implications

Research in the area of parent satisfaction with child/adolescent mental health services is designed to help parents communicate their needs and experiences with child services. Recent studies have recognized the important role of parent "care" via inclusion of parents in the planning, implementation, and evaluation of their child's treatment and parents feeling respected, understood, and supported by practitioners. The proposed study sought to integrate the theoretical mechanisms underlying the highly collaborative parental roles in Therapeutic Assessment into a parent questionnaire. The anticipated

results would have multiple implications for not only the practice of child assessment, but also other areas of child mental health services.

By investigating the relationship between general parent satisfaction and the experiences parents have during a child assessment, researchers and practitioners can receive meaningful feedback from parents that can assist in evaluating and increasing the accessibility of child assessment practice. With replication and validation of the PEAS-I through other researchers and future studies, eventually program evaluators may be able to determine score norms used for comparison across sites and services. For example, a school could reference the average parent score on Collaboration for a school assessment and determine if their parent results are significantly higher or lower than those of other school assessments. Moving beyond general parent satisfaction to include parental interpersonal experiences can help assessment services quantify areas of parent perceived strength and weakness.

If the anticipated results are validated by the proposed study, it would provide further evidence that the principles of Therapeutic Assessment contribute to positive parent outcomes, higher general satisfaction scores, and that the selected methods can be utilized in other assessment settings. The factors measured by the PEAS-I can be applied beyond child assessment, just as the principles and techniques of TA including high parental involvement and collaboration could also be incorporated with other child and family services.

The proposed study also has implications for satisfaction questionnaire development through its use of a nested CFA model for revising the parent measure. By

using this technique, this study was able to overcome some of the methodological issues in parent satisfaction measure development, such as not controlling for overall satisfaction when investigating multifactor models. With this technique, other client measures could be designed and evaluated with more advanced statistical procedures to help ensure higher psychometric standards and construct validity. By using a questionnaire format, the ease and low cost of administration were retained, with the benefit of measuring multiple constructs contributing to parent satisfaction. The PEAS-I could become a valuable tool for clinicians in private practice and other research studies that would like more in depth parent feedback , but do not have the time or resources for extensive follow up interviews.

In the practice of child/adolescent mental health services, it is essential that service providers and practitioners receive relevant feedback about how parents perceive child services. Although measuring general parental satisfaction is standard practice in Community Mental Health Centers, more work needs to be conducted in trying to understand what mechanisms and experiences are most related to parent satisfaction. By increasing parental involvement and collaboration with child services, parents are more likely to follow treatment recommendations and continue to seek services for their child, as well as feel supported and more optimistic about the future (Gerkensmeyer et al., 2006; Tharinger, et al., under review-b). The proposed study would contribute to both parent satisfaction and Therapeutic Assessment research by demonstrating the effectiveness of TA principles in other assessment settings and providing evidence for the relationship between interpersonal experiences and general parent satisfaction. In order to

maximize the potential of child mental health services and intervention, service providers and researchers must meet the needs of both the child and parents. Understanding how parents perceive their experience with child services will allow for more specific improvements and increased effectiveness in child mental health service delivery.

Addendum

Background and Rationale for Program Development and Evaluation

The focus of this report has been the development of the Parent Experience of Assessment Scale and its potential usefulness in investigating the differences between collaborative and traditional assessment. The PEAS-I is designed to assess the process variables that research in the client and parent satisfaction has indicated are more closely related and predictive of overall satisfaction. As noted previously, there has been a movement to increase the input of consumers of mental health services, and this is most often done through satisfaction surveys. However, what is done with the results? If, as hypothesized, the PEAS-I is able to provide more specific feedback about parents' experiences with the assessment process, how can this feedback then be incorporated into practice?

As Stallard (2001) points out, the positive scores consistently found with general satisfaction makes them an attractive option for service providers to obtain 'hard' evidence of good service quality. Bailey and Simeonsson (1988) point out "parents may report satisfaction with a program simply because they know of no better alternatives or are comparing the service to no service at all" (p. 10). Through a series of interviews with clients, Williams, Coyle, and Healy (1998) attempted to delineate how clients come to their 'evaluations' of mental health services. The researchers found that clients often had negative experiences related to services, but did not report dissatisfaction because they did not 'blame' the service provider. Duty, as defined by Williams et al., is how clients determine what a service should or should not do; it is somewhere between 'realistic' and

'idealistic' expectations. If the client does not believe the service provider was responsible for a negative experience, if it has not "failed in its duty", than the client may report being satisfied despite a negative experience.

Rather than continuing to confirm high levels of general satisfaction, some researchers are advocating the reduction of dissatisfaction as more informative. However, as previously mentioned, high satisfaction scores are not associated with service outcomes and the results of surveys, ostensibly to improve practice and involve clients in shaping services, are rarely acted upon. Thus, Stallard (2001) suggests the active seeking of dissatisfaction to facilitate quality improvement of mental health practices.

Other researchers have begun to address dissatisfaction by dividing respondents into 'highly satisfied' and 'relatively dissatisfied' groups. Kapp and Vela (2004) considered those respondents one standard deviation above the average satisfaction score as 'highly satisfied' and all other respondents were considered relatively dissatisfied. King, Cathers, King, and Rosenbaum et al. (2001) argues that satisfaction and dissatisfaction are not one continuum, as the occurrence of one does not exclude the existence of the other. They considered 'highly satisfied' those respondents with a perfect score (32) on the CSQ-8 and those with a score of 23 or less as relatively dissatisfied. This indicates that dissatisfaction scores are often considered those with a mean less than 3 on a 5 point Likert scale. King et al. found that structural elements of service, such as access, appeared to be a particular trigger for dissatisfaction, while the interpersonal processes were associated with high levels of satisfaction.

The work of Williams et al. (1998) with client interviews demonstrates that high levels of satisfaction do not mean that clients did not have negative experiences. Stallard (2001) cautions that high rates of satisfaction do not indicate that the best services have been provided. Rather than continually lamenting the high scores constantly associated with general satisfaction, it appears researchers may be able to compare relative groups of satisfaction and dissatisfaction to help facilitate program feedback and improvements.

Thus, it appears that although the first step in addressing parent satisfaction is working to recognize and measure the process and parent experiences, both positive and negative. However, without a program to incorporate parent feedback into practice the potential power of the information may be lost. Therefore, I will propose a program for soliciting, evaluating, and incorporating parent feedback that would be applicable in a community, research, or private assessment setting.

Sample Quality Assurance Program

Interestingly, of all the articles reviewed for this proposal, only one (Stallard, 2001) described a process of not only collecting parent feedback, but also then attempting to change practice and track the results. "In reality, many studies demonstrate little real commitment to the principles of user involvement. The majority are one-off events based upon individually constructed questionnaires of unproven psychometric rigour and the results are rarely acted upon" (Stallard, p. 64). There are a number of reasons for resistance or concern in implementing changes on the part of assessment practices and clinicians that need to be addressed in any program revision. First, the chronically high scores of satisfaction measures (70 to 80%) may be used as evidence that the current

practice does not need fixing. Secondly, breaking down satisfaction scores by practitioners or specific site locations may be anxiety producing for practitioners, and thus avoided. Thirdly, the areas of dissatisfaction noted may not be areas practitioners feel are within their control to address, for example, fees tied to an operating budget.

Before delving into the proposed program of parent input based revision, the quality improvement practice demonstrated by Stallard (2001) may serve as a useful outline and review. In this study, the Parent Satisfaction Questionnaire (PSQ) was given to three groups of parents, each at different timepoints (1993, 1995, and 1997). The data was collected via mailed surveys and follow up phone or home visits if necessary. Approximately 30 out of the selected 60 participants provided responses in each cohort. After data collection, the highest areas of dissatisfaction were determined and addressed at a monthly clinicians meeting. Each area was reviewed and action steps, if deemed feasible, were agreed upon. Common areas of dissatisfaction included waiting time, home visits, initial meeting, number and timing of appointments, pre-appointment information, and surroundings. Action steps included sending a pre-appointment letter to families, offering a minimum of 3 visits to new referrals, and first contact for service within 2 months of referral. One area the practitioners did not feel they had the resources to address was the request for home visits.

Results of the study, through Chi-Square analysis, showed significant improvements in satisfaction relating to the reduced waiting period, pre-appointment information, total number of appointments offered, and the length of interval between appointments. Despite no changes in the reported level of helpfulness of service or

overall outcomes, general satisfaction scores had significantly increased. Qualitative data found that by the last time period, the number of comments about each area for quality improvement had decreased.

The results of this study were generally positive and show that tracking parent satisfaction over time can lead to improvements in communication and responsiveness to parent's needs, and changes in practice can then be reflected in parent measures of general satisfaction. The study identified four areas that contributed to the success of the study: commitment, preparedness/incentives to change, ownership, and on-going monitoring (Stallard, 2001). The commitment on the part of the clinicians is one of the keys in developing this type of program, as resistance to parent feedback could cripple any efforts to make reforms. According to Stallard, the commitment was developed over the course of several meetings prior to beginning and project and he associates the small size of the clinical teams with success in this area as well. Fortunately, the clinical staff was already questioning some aspects of the practice, such as the waiting period. Therefore, instead of being threatening to the clinical staff, the study was seen as an opportunity to directly examine these concerns. In terms of ownership, the clinicians were directly involved in designing the study process and received helpful, individualized feedback from their clients and the overall study. Lastly, the established process of reviewing the results, agreeing on action steps, and then assessing the changes helped ensure that change took place. "Regular consumer satisfaction surveys became an integral part of the service with the feedback serving to both reinforce positive changes in practice as well as highlighting areas of dissatisfaction" (Stallard, p. 72).

Program Decomposition

The main criteria for this program will come from a decision-oriented or objective approach. The general goal will be to facilitate the enhancement of child assessment practice through parent feedback. When developing a quality assurance program, there are multiple stakeholders that should be taken into account: the clinicians, parents, children, and administrators can all be impacted by the successful implementation of the program. First order outcomes for the program include increased positive parent self-report scores and changes in the assessment practice based on parent feedback. These changes should then be tracked over time, which include first and second order outcomes. Finally, the overall quality of the practice should be enhanced by the program.

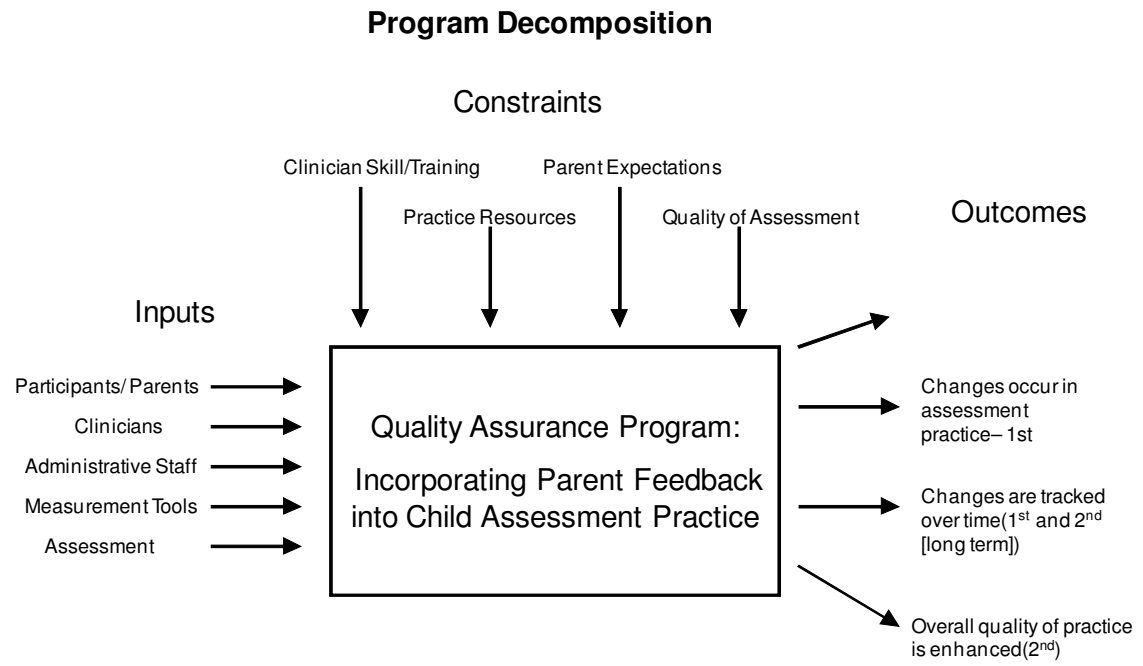


Figure 2: First Level of Program Decomposition

The overarching goal can be broken down into five transactions, as shown in Figure 3. First, the clinicians and administrators of an assessment practice must decide

that the potential benefits of the program are worth the time and effort, and should work with the evaluator to set the goals for the evaluation. Second, a plan for collecting the parent feedback must be created, and take into consideration the time, budget, and personnel constraints of the practice and evaluation. Once the plan has been developed and approved, the data collection procedures can then be implemented. Also, any issues that arise during collection should be reviewed for adjustment. After the data has been collected for the first time period, the data should be reviewed by evaluators, clinicians, and administrative staff. Action steps are then developed based on the data review.

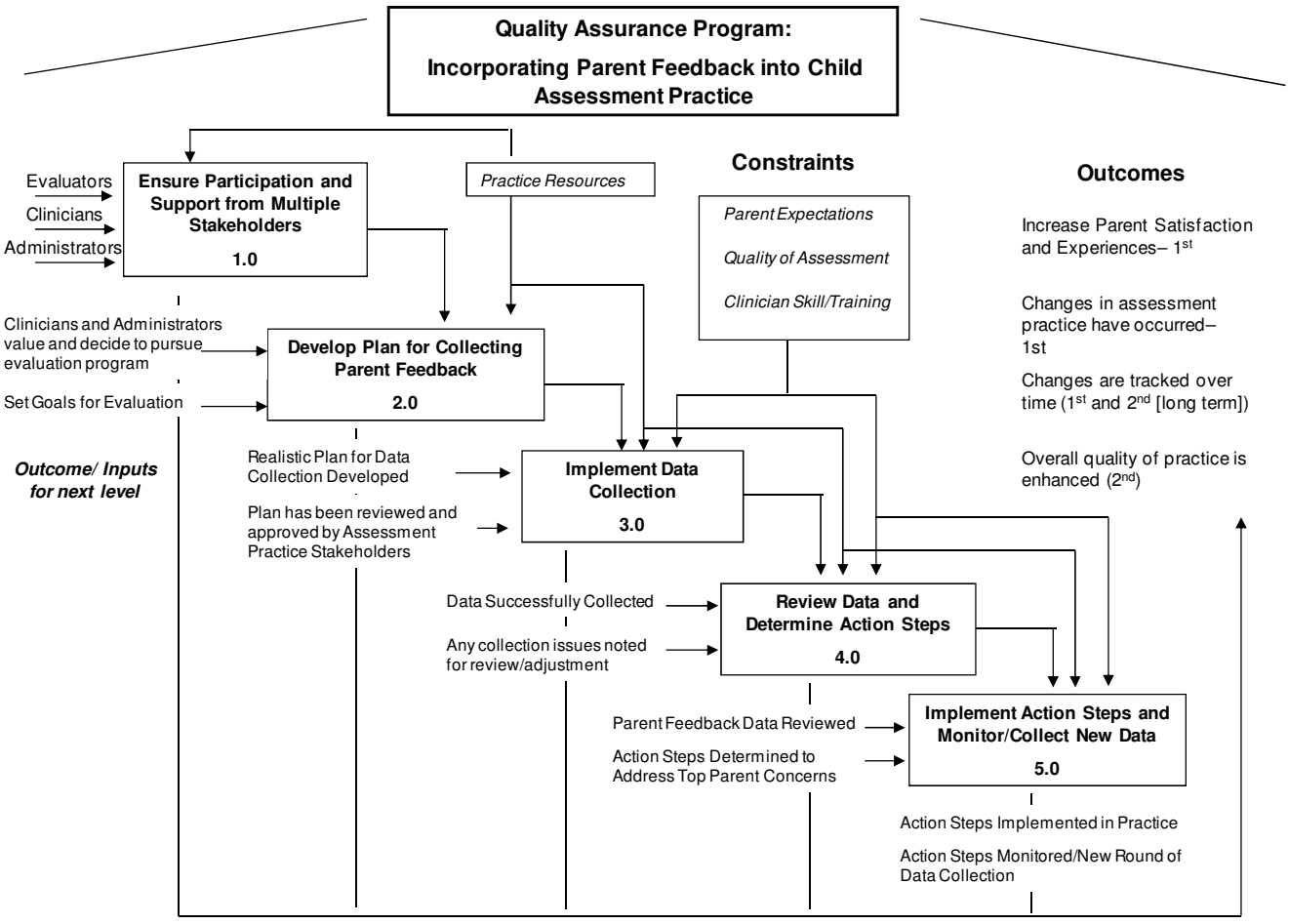


Figure 3: Second Level of Program Decomposition

Lastly, the action steps should be implemented in practice and monitored as a new round of data collection begins. After all five phases have been completed, the program can loop back to transaction 1.0 (ensure support from stakeholders) and can be continually refined over time.

Figure 4 depicts the decomposition of phase 2.0, the development of the plan for parent feedback. Once the goals have been set for the evaluation, both qualitative and quantitative methods should be considered for gaining parent feedback. Possible qualitative methods include parent focus groups, semi-structured interviews, or open

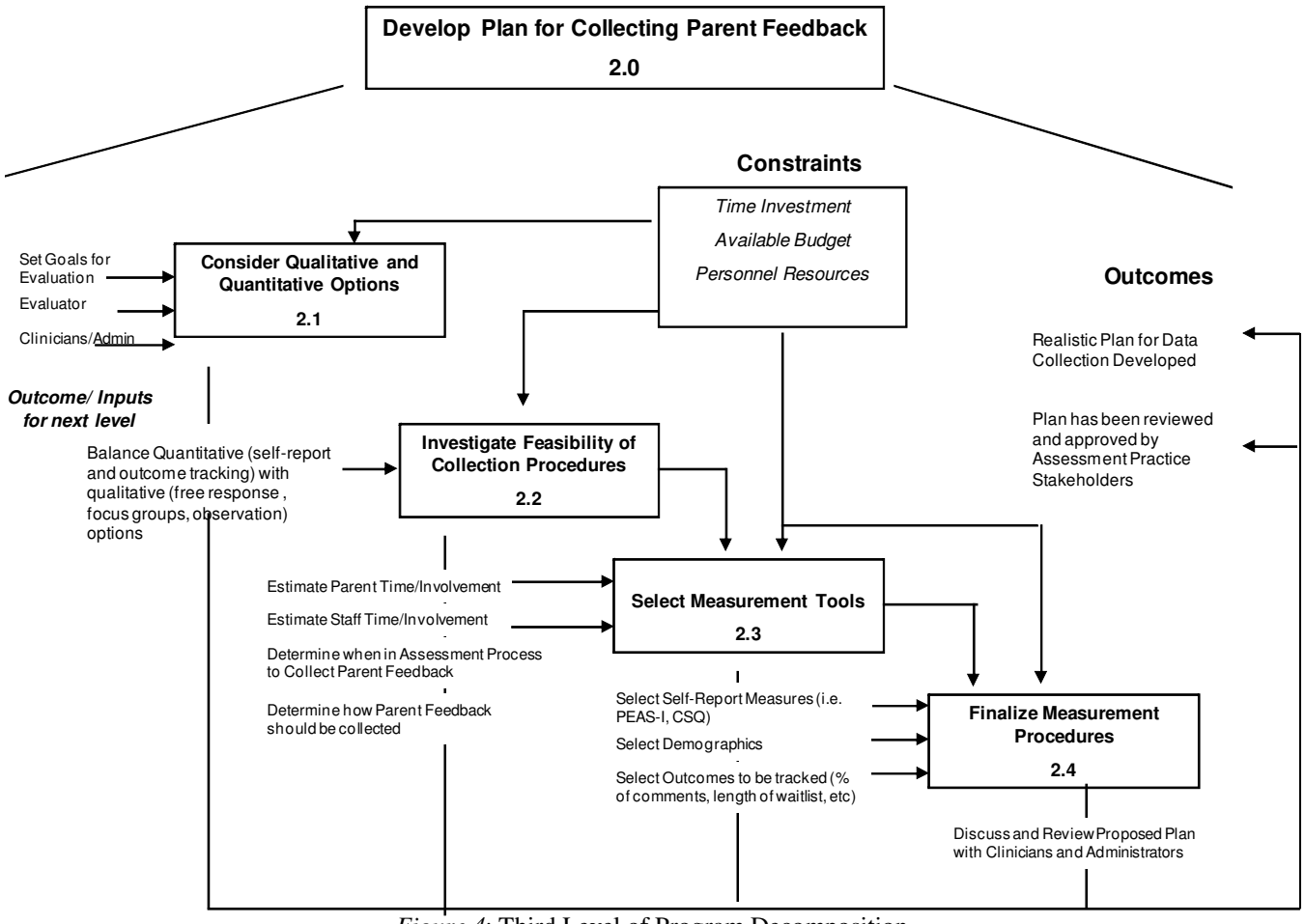


Figure 4: Third Level of Program Decomposition

ended response questions on parent self-reports. Quantitative methods include self-report measures and outcome tracking of relevance, such as demographics, the length of the wait list, number of new referrals, etc. Although observations during assessment may not be feasible, the initial interview with parents and final feedback session could be videotaped and then coded using a checklist (with 'opportunity' and 'observed' columns) for the interpersonal skills of the clinician. This could also be used for training new assessors and provide individualized feedback to clinicians. Follow-up measures should also be considered in tracking 2nd order outcomes at three and six months. Parent self-report, in addition to asking parents what services they are utilizing could help determine if treatment adherence has increased.

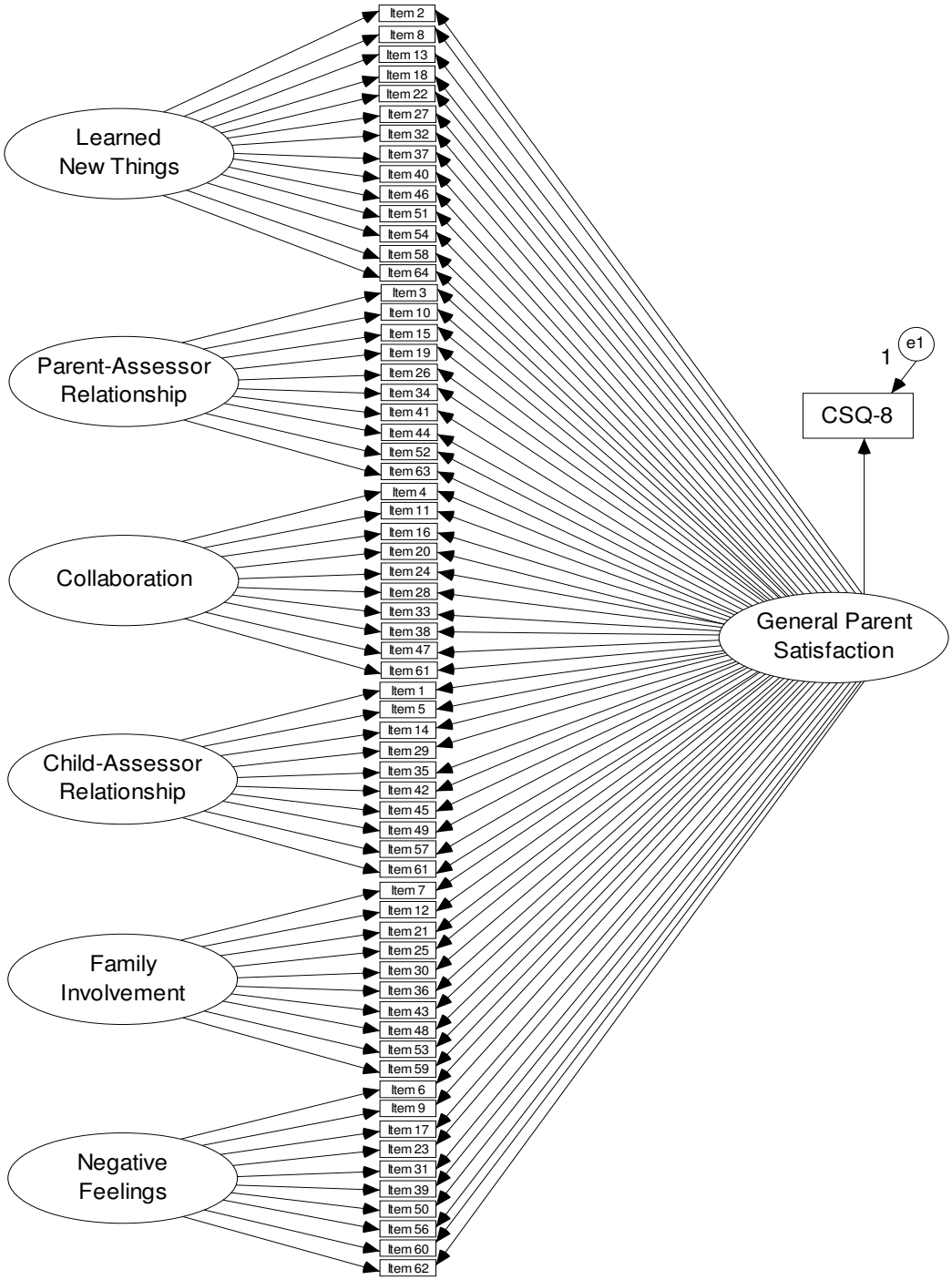
Before the third step, actually selecting the measures, the feasibility of the collection procedures must be determined, such as when and how parent feedback will be collected and by whom. In order to create an effective, yet realistic program, parent, staff, and/or evaluator time must be estimated and work within the assessment practice's resource constraints. Once both of the prior transactions have occurred, then the actual measures and procedures can be determined, such as selecting self-report measures (PEAS-I, CSQ-8, etc), developing checklists or other measures as needed, selecting demographics, selecting outcomes and pre-existing records to be tracked, and determining who will be in charge of collecting the data from parents, entering data, etc. Finally, the measurement procedure plan should be reviewed by the assessment practice clinicians and relevant administrators to ensure their continued support and that the plan appears to fit with the goals of the evaluation.

A similar breakdown would be possible for all five of the major transactions noted in Figure 3, however, the Develop the Plan (2.0) transaction was chosen due to its relevance to the PEAS-I and other measurement issues. Suggestions for the other phases include specific start and end points for data collection and clear delineation of responsibilities, how much follow-up to pursue (phone/mail) to get parent responses, and encourage the parent feedback collection process to become a permanent part of the assessment practice. The review of the data should result in concrete action steps to address the areas of dissatisfaction, but should also highlight the process/interpersonal variables that are associated with high overall satisfaction. The parent feedback could also be used to test new components of assessment, for example, adding in a child feedback session or child fable to the assessment process (Tharinger, et al., in press-b).

Overall, the proposed program seeks to take information about parent experiences during assessment, of which the PEAS-I may be just one piece of data collection, and show how research could be translated into improved practice. Researchers are increasingly advocating for the growing importance of the engagement and collaboration with parents in children mental health services. The idea that assessment itself can be a collaborative intervention and mounting evidence that it is the interpersonal experiences that are most related to parent satisfaction indicate that programs for obtaining and implementing parent feedback should be a new area of focus for mental health professionals.

Appendix A

Nested Model Confirmatory Factory Analysis for PEAS-I



Appendix B

Client Satisfaction Questionnaire (CSQ-8)

Please help us improve our program by answering some questions about the assessment your child received. We are interested in your honest opinion, whether it is positive or negative. Please answer all of the questions. Thank you very much, we really appreciate your help.

CIRCLE YOUR ANSWER

1. How would you rate the quality of service you received?

1	*2*	*3*	*4*
Poor	*Fair*	*Good*	*Excellent*

2. Did you get the kind of service you wanted?

1	*2*	*3*	*4*
Yes, definitely	*Yes, generally*	*No, not really*	*No, definitely not*

3. To what extent has our program met your needs?

1	*2*	*3*	*4*
None of my needs have been met	*Only a few of my needs have been met*	*Most of my needs have been met*	*Almost all of my needs have been met*

4. If a friend were in need of similar help, would you recommend our program to him or her?

1	*2*	*3*	*4*
Yes, definitely	*Yes, generally*	*No, not really*	*No, definitely not*

5. How satisfied are you with the amount of help you have received?

1	*2*	*3*	*4*
Very satisfied	*Mostly satisfied*	*Indifferent or mildly dissatisfied*	*Quite dissatisfied*

6. Have the services you received helped you to deal more effectively with your child's problems?

1	*2*	*3*	*4*
No, they seemed to make things worse	*No, they really didn't help*	*Yes, they helped somewhat*	*Yes, they helped a great deal*

7. In an overall, general sense, how satisfied are you with the service you have received?

1	*2*	*3*	*4*
Quite dissatisfied	*Indifferent of mildly dissatisfied*	*Mostly satisfied*	*Very satisfiend*

8. If you were to seek help again, would you come back to our program?

1	*2*	*3*	*4*
Yes, definitely	*Yes, generally*	*No, not really*	*No, definitely not*

Appendix C

PARENT EXPERIENCE OF ASSESSMENT SCALE-I (PEAS-I)

Respondent's Name	
Child's Name	
Date	

This questionnaire deals with your thoughts and feelings about your child's psychological assessment. Please read each statement carefully. Once you decide how much you agree or disagree with a statement, circle the number that best matches how the statement applies to you. Be as honest and as accurate as possible. Please do not skip any item and check only one box for each statement.

Use the following scale to rate each statement:	**Strongly Disagree**	**Disagree**	**Neutral**	**Agree**	**Strongly Agree**
1. The assessor worked well with my child.	1	2	3	4	5
2. I learned new ways of interacting with my child.	1	2	3	4	5
3. The assessor was genuinely interested in helping us.	1	2	3	4	5
4. I had a say in what the assessment focused on.	1	2	3	4	5
5. My child did not like the assessor.	1	2	3	4	5
6. The assessment process was very confusing.	1	2	3	4	5
7. I now see that our family will need to change to help my child.	1	2	3	4	5
8. I am more aware of my child's strengths.	1	2	3	4	5
9. The assessment made me feel guilty.	1	2	3	4	5
10. I liked the assessor.	1	2	3	4	5
11. The assessor helped me explain the assessment to my child.	1	2	3	4	5

12. Our family has little to do with why my child has problems.	1	2	3	4	5
13. Now I know more about why my child acts the way he/she does.	1	2	3	4	5
14. My child never really warmed up to the assessor.	1	2	3	4	5
15. The assessor liked me.	1	2	3	4	5
16. I was informed about each step of the assessment.	1	2	3	4	5
17. I am uncomfortable with how much the assessment revealed.	1	2	3	4	5
18. I didn't learn anything new about my child from the assessment.	1	2	3	4	5
19. I felt close to the assessor.	1	2	3	4	5
20. I never really understood the point of the assessment.	1	2	3	4	5
21. Many of my child's difficulties have to do with our family.	1	2	3	4	5
22. I learned a tremendous amount about my child from this assessment.	1	2	3	4	5
23. The assessment made me feel ashamed.	1	2	3	4	5
24. I felt like part of a team working to help my child.	1	2	3	4	5
25. The assessment revealed how family members play a role in my child's problems.	1	2	3	4	5
26. I felt the assessor respected me.	1	2	3	4	5
27. Now I am more confused about how to handle my child.	1	2	3	4	5
28. I helped make sense of the test results.	1	2	3	4	5
29. The assessor never really understood my child.	1	2	3	4	5

30. I don't believe our family makes my child's problems worse.	1	2	3	4	5
31. I felt blamed for my child's problems.	1	2	3	4	5
32. Now I know specific things I can do to help my child.	1	2	3	4	5
33. I understood the goals of the assessment.	1	2	3	4	5
34. I felt the assessor was cold towards me.	1	2	3	4	5
35. My child looked forward to meeting with the assessor.	1	2	3	4	5
36. My child is the only person in our family who needs to change.	1	2	3	4	5
37. I wish I had learned more concrete ways to help my child day to day.	1	2	3	4	5
38. The assessor asked me if the assessment findings seemed right to me.	1	2	3	4	5
39. The assessment was a humiliating experience.	1	2	3	4	5
40. The assessment completely changed the way I view my child.	1	2	3	4	5
41. I felt the assessor looked down on me.	1	2	3	4	5
42. My child felt comfortable with the assessor.	1	2	3	4	5
43. My child is worse with our family than with other people.	1	2	3	4	5
44. I trusted the assessor.	1	2	3	4	5
45. The assessor got my child to work really hard.	1	2	3	4	5
46. I am better able to communicate with my child.	1	2	3	4	5
47. No one ever told me what would happen during the assessment.	1	2	3	4	5

48. I now see how our family's problems affect my child.	1	2	3	4	5
49. My child and the assessor really connected well.	1	2	3	4	5
50. The assessment made me feel like a bad parent.	1	2	3	4	5
51. Now I know what to expect from my child.	1	2	3	4	5
52. I felt judged by the assessor.	1	2	3	4	5
53. My child's problems are partly caused by other struggles in our family.	1	2	3	4	5
54. The assessment has helped me have more patience with my child.	1	2	3	4	5
55. I felt that my opinion was valued.	1	2	3	4	5
56. The assessment was overwhelming.	1	2	3	4	5
57. My child dreaded almost every meeting with the assessor.	1	2	3	4	5
58. I have lots of new ideas about how to parent my child.	1	2	3	4	5
59. My child struggles more when people in our family aren't getting along.	1	2	3	4	5
60. At the end of the assessment, I was left feeling angry.	1	2	3	4	5
61. The assessor seemed to like my child.	1	2	3	4	5
62. I was anxious throughout the assessment.	1	2	3	4	5
63. The assessor really listened to me.	1	2	3	4	5
64. I understand my child so much better now.	1	2	3	4	5

Appendix D

PEAS-I Case Information Sheet

To be filled out by respondent						
Respondent's Name						
Respondent's Gender	□ male □ female					
Relationship to Child						
Highest Grade Completed						
Date Form Completed						
Child's Name						
Child's Gender	□ male □ female					
Child's Date of Birth						
Child's Race	American Indian or Alaskan Native	Asian or Pacific Islander	Black, not of Hispanic Origin	Hispanic	White, not of Hispanic Origin	Other/Unknown
(please check one)						

To be filled out by assessor				
Case ID Number				
Name of Facility				
Assessor's Name				
Type of Assessment	Psychoeducational	Personality/ Socio-Emotional	Neuropsychological	Other- Explain
(please check all that apply)				
Start Date of Assessment				
End Date of Assessment				
Number of Sessions				
Number of Hours of Client Contact				
Child Diagnosis				

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Vita

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