

Family Perspectives



Chapter 5

Chapter 5: Family Perspectives

Families First in Essex County: A Family Designed and Implemented System of Care

Introduction

The goal of this project has been to develop a system of services for families with children with emotional disturbance that is designed and primarily implemented by consumers. From 1993 to 1996, the project was primarily funded by a Department of Health and Human Services Center for Mental Health Services research grant received by the New York State Office of Mental Health. The researchers will be presenting the research results at a future date. This summary presents a more subjective view by the founder and director of the program.

In the past ten years, the consumer movement has changed the face of service delivery, emphasizing the need for voice, ownership, and options for people receiving services, and an end to what our program refers to as “blame and shame.” Value has been placed on families and professionals working in a partnership with the family in charge. Despite these values, even the best of systems have been primarily designed by professionals. The following are questions posed by this endeavor:

- What would a program look like that was developed in response to what *families* said they wanted and needed?
- Is it possible to develop a responsive system in an extremely rural area?

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Method

In 1991 several small grants were received to fund a planning year. In-depth, in-home interviews were held with 24 families who had children with serious emotional disturbance and tape recorded for subsequent analysis. The author asked each family the following questions:

- What was most helpful to you?
- What was not helpful to you?
- If you had a magic wand, what services would you wish for?

After the completion of the interviews, a Parent Planning Committee was formed, chaired by the project director. The committee's assignment was to make recommendations for a program based on the interview material. The committee met for eight two-hour sessions, which were videotaped. During the course of this planning year, an Essex County Child and Family Task Force was formed, which included service providers, community people, and consumers. The task force prioritized service system needs and were trained in Child and Adolescent Service System Program (CASSP) principles, with emphasis on family centered services. At each meeting, they heard a speaker who was a consumer tell the story about their experience as a service recipient.

Results

There was almost complete unanimity as to what families reported they needed and wanted. The following needs were expressed by the families interviewed: respite; information and referral; an advocate; community friend/mentor for their child; support for caregivers, siblings, and the identified child; crisis services; concrete assistance; and family center. When professionals design services for families, the services that were priori-

tized by families are usually developed years after other more traditional services, if at all.

The following is a sample of the 32 recommendations made by the Parent Planning Committee and implemented by Families First in Essex County: (a) Preference should be given to parents of children with special needs in hiring; (b) participants should be included in all trainings, as both attendees and trainers; (c) no interagency meetings should be held about families unless they are present (i.e., "Nothing About Me Without Me"); (d) there should not be any criteria for receiving services other than a family's assertion that their child has emotional/behavioral problems and they would like help; and (e) there should not be any waiting list (i.e., the program should be immediately responsive by providing support services).

More intensive services such as case management are not available to all referrals to Families First, but everyone who calls for assistance can utilize a variety of services. Families may borrow books or videotapes from the Resource Library. They may call the 800 number for support from a parent/professional, or they drop in to the Center for support. Families are provided social events to attend. They can receive the family written newsletter and notices of events. Families may request an initial home visit for planning, or even ask to be matched with another participant for support. Also, they can receive food from the Families First food shelf and concrete help through the flexible dollar fund. Families have access to both respite for child care and the respitality program for an overnight stay in a hotel. Finally, they may have an opportunity to assist another family and/or contribute in other ways to the organization.

The Parent Planning Committee felt strongly that the language that professionals use can connote either respect or blame and shame. They recommended that the following terms be used:

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- (a) “Multi-stressed” rather than “dysfunctional;”
- (b) “participant” rather than “client;” (c) “family” rather than “case;” (d) “family advocate” rather than “case manager;” and (e) “cautious” rather than “resistant.”

The following summarizes the salient learnings from this demonstration project:

- If services meet people’s needs, recognize their strengths, and are offered in a warm, hospitable and respectful environment, families will utilize the service. Even those who are usually the most difficult to engage (e.g., low socioeconomic families and mothers who are depressed), will participate.
- Traditional service providers are highly invested in maintaining the status quo and are likely to be very cautious about accepting a new paradigm of family centered service. Although significant changes were made in Essex County, such as having consumer representatives on interagency committees, it took three years before most other providers became comfortable with family centered values and procedures. Many continue to be very cautious.
- Hiring consumers is essential to a family centered service, but it presents many challenges. When staff both deliver and receive service, it requires great flexibility and sensitivity.
- Creating truly individualized, flexible services that incorporate the natural support system requires comfort with ambiguity and complexity, which can be an administrative and bookkeeping challenge.
- There is a tendency to revert to old paradigms. In order to assure that a program remains “family friendly,” providers need to always be vigilant against slippage.

Discussion

Families First in Essex County opened its doors in November, 1992. In 39 months, it has served 250 families, and the county has had fewer hospitalizations and out of home placements. An evaluation survey of consumers yielded a very high degree of satisfaction. Family members have said “Families First is my family,” and “I have been lifted out of my depression since I joined the family of Families First.” It has been clear that the agency has established a sense of community. The majority of participants assist other families, work in the office, help with social events or serve on the Board or on Advisory Committees.

The project has demonstrated that it is possible to develop a system of services that is designed and implemented by families, and that the resulting program will have services that actually please and delight recipients. It has also demonstrated that a system of family centered support services can function in a very rural area despite the challenges arising from lack of transportation, isolation, and a pool of trained professional people.

Tannen

An Examination of the Support Families Receive and Parent Perceptions of How Helpful These Supports are in Meeting the Needs of Their Children and Families

Introduction

Families with children who have emotional or behavioral disorders face complex and multiple challenges. Progress has been made to develop child-centered and family-focused systems of support to help families cope with stressful circumstances and access services from the categorical systems. However, parent input is rarely sought when planning, implementing, and evaluating these efforts.

This study examined the nature and extent of support families received from their informal social networks and from paid professionals, and how helpful these types of assistance were in meeting child and family needs. Results indicated that more support was provided by formal organizations and paid professionals than by informal organizations and unpaid individuals. Family members, however, provided the most help/support in coping with daily challenges. In addition, the greater the number of functions of service coordination received, the more successful parents were in accessing formal support and the more satisfied they were with their family's quality of life. Results indicated that receipt of service coordination may contribute to positive outcomes for families with children who have emotional or behavioral disorders. Findings imply that professionals should rely more on parent input to ensure that community support systems effectively address child and family needs.

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Method

Mail survey research methods were used to explore the nature and extent of support families received. The following areas were examined: (a) characteristics of children with emotional or behavioral disorders and their families, (b) types of informal and formal support families received, (c) relationships between child and family characteristics and support received, (d) helpfulness of support received, (e) functions of service coordination received, (f) the relationship between receipt of functions of service coordination and parent success in getting help, and (g) the relationship between receipt of functions of service coordination and child well-being and family quality of life.

Participants

Participants were parents residing in Oregon who had a child with an emotional or behavioral disorder. A sample of 250 parents was randomly selected from the Oregon Family Support Network (OFSN) database of 1000. The OFSN is a statewide, parent-run, information and family advocacy organization to support both the children and youth with emotional, behavioral, and mental disabilities and their families.

Survey packets were mailed to all selected parents. A total of 120 surveys were returned. Of these, 100 met the requirements for inclusion in the sample to be used for data analysis. The 40% return rate of useable surveys was sufficient to answer the research questions.

Instrument

A self-administered questionnaire was used for data collection. The instrument was pilot tested by meeting with three parent-run support groups. A total of 18 parents, representing (a) rural and urban settings, (b) a range of ages, incomes, and educational attainment, and (c) with children of different

ages and disability labels, attended three separate meetings. As a result of the pilot test, minor changes were made in both the terminology and instructions for completing the survey.

Reliability

The survey was divided into five parts. A test-retest reliability procedure was conducted by mailing each of the four parts of the questionnaire that included quantifiable responses to four subgroups of the 100 respondents approximately one month after receipt of the original questionnaire. Absolute agreement was calculated for Part I (family characteristics) and Part II (child characteristics). For Part I the agreement ratio was 89%, and for Part II the agreement ratio was 82%. For Part III (support families received), the percent of agreement was 77% and for Part IV (family service coordination and family outcomes), the percent of agreement was 87%. Pearson Correlation Coefficients were calculated for items with interval data in Part III and Part IV. The highest reliability coefficient was .90 for responses related to family service coordination. The lowest was .73 for the items related to helpfulness of support received. Inter-rater reliability for Part V, the one open-ended question, was calculated for 10 of the 65 parents who responded. The average agreement between raters was 85%.

Analysis

Descriptive statistics (frequencies, percentages, means, and standard deviations) and statistical analyses were conducted using the Statistical Program for the Social Sciences (SPSS). When testing statistical significance, a conservative alpha level of $p < .01$ was used to protect against experiment wise error for *t*-test results, chi-square test of association, Pearson Correlation Coefficients, and Friedman Two-Way Analysis of Variance by Ranks.

Results

Respondents represented families residing in 22 of Oregon's 36 counties, characterizing the general population of Oregon. The children and youth with emotional or behavioral disorders reflected the racial mix of the national population, with a slightly lower percentage (87%) reported as Caucasian than in the Oregon population. A wide range of child and youth disability categories were represented. The range of disability labels per child was 1 to 9, and a mean of 2.6 per child. Of the 100 children and youth represented in this study, 82 (82%) were participating in-school programs, with the largest number (72%) attending in-school programs that were not associated with day or residential treatment.

Parents were asked to report the extent to which their families received the functions of service coordination during the past year. These functions were: (a) assess the needs and strengths of the child and family; (b) develop the family service plan; (c) link the child and family with services appropriate to child and family needs; (d) monitor the delivery of services and child and family progress toward goals; (e) advocate for the child and family; (f) provide information to parents regarding where to find resources; and (g) teach self-advocacy.

Of the 100 respondents, 29 (29%) reported receiving none of the 7 functions of service coordination. The assessment function was received most frequently ($n = 59$). The least frequently received function was self-advocacy ($n = 14$). The pattern that emerged was that as the number of functions received increased, the number of families receiving those functions decreased. School personnel provided service coordination more frequently than any other discipline ($n = 29$) and schools combined with education service districts accounted for 44% of the service providers identified as delivering functions of service coordination.

Families with children ages 11 to 18 received more functions of service coordination than those ages 3 - 10 and 19 - 28; the group of 11 families with young adults ages 19 to 28 with emotional or behavioral disorders received less service coordination than the other age groups.

To examine the relationship between the extent of service coordination families received and overall parent satisfaction with family quality of life, satisfaction was measured on a scale of 1 to 4, with 1 being "not at all satisfied" and 4 being "very satisfied." The mean satisfaction rating for 91 parents was 2.19 ($SD = .9$). The Pearson Correlation Coefficient of $r = .2675$ was statistically significant at the $p < .01$ level of significance, indicating a positive relationship between parent satisfaction with family quality of life and number of functions of service coordination received. Statistical analysis of the relationship between parent success in being able to get the support their child and family needed and the receipt of functions of service revealed a significant positive relationship between these two variables ($r = .3387$; $p < .01$). In addition, a correlation of $r = .6180$ ($p < .001$) indicated a strong positive relationship between parent success in getting help and family quality of life.

The open-ended question asked parents to provide additional information about the support their child and family received. As a result of content analysis, 11 themes emerged. Of these, three were considered the most relevant to the purpose of the study: (a) parent feelings, (b) parent needs, and (c) parent recommendations. Parents' expressions of stress and difficulty in coping were described more frequently than feelings of satisfaction and hopefulness. Parent needs were categorized in 7 primary categories. These were (a) respite care, (b) transition services, (c) services for young adults (independent living: vocational, life skills, recreational), (d) service coordination, (e) financial assistance for health

services, (f) child's behavior to be more positive, and (g) support for relinquishing custody. Recommendations made by parents included increased flexibility and coordination of services across the categorical systems.

Discussion

This study explored the nature and extent of the informal and formal support families receive and how helpful these types of assistance were in meeting the needs of both children who have emotional or behavioral disorders and their families. The socioeconomic characteristics of the families reflected the general population of Oregon. Child characteristics were consistent with the literature describing the characteristics and educational placements of children and youth with emotional or behavioral disorders. However, findings may not be generalizable to the population of children, youth, and families since the sample was purposeful.

Families received support from both formal and informal sources. However, parents relied mostly on family members (informal support) when they needed someone to talk to about the daily challenges they faced. In addition, even though support received was generally perceived as helpful, parent anecdotal comments suggested that the current service system continues to be fragmented and difficult to access.

Findings from this study support continued efforts to provide service coordination within a child-centered and family-focused system of support. Statistically significant relationships were found between parent success in getting needed help and the number of functions of service coordination received. These findings suggest that family service coordination may be an effective means to ensure that families receive timely and appropriate assistance.

Results from this study support future research that examines community service delivery programs that systematically incorporate informal social networks into community-based service delivery in order to increase the amount and availability of support, and also more closely match child and family needs with the resources most appropriate to meet those needs. This concept appears more promising as local communities look for innovative ways to transform the categorical systems at a time of dwindling resources and increased demand for government accountability.

Evaluating Mental Health Services for Children: The Parent's Perspective

Introduction

Mental health services for children have been described as inaccessible, inappropriate (Saxe, Cross & Silverman, 1988), fragmented, duplicated, too restrictive, not community based, being driven by the needs of the providers or payers rather than by the needs of children and their families, and for failing to include parents as part of the treatment team (Knitzer, 1982; Young, 1990). With a history of inadequate services, the need exists to assure that appropriate treatment is available for children with mental health problems and their families.

The purpose of this study was to gain information about parents' perceptions of and satisfaction with mental health services for their children. Parents' satisfaction is an important outcome measure that serves as an objective of service delivery and a factor in improving future services. Parent's level of satisfaction was defined as the degree that the parent was pleased with parent-staff interactions.

Method

Research Questions and Data Analysis

This was a cross-sectional, descriptive study that explored relationships among variables at one point in time.

The following research questions were developed:

1. How do parents describe their situation of having a child with a mental health problem?
2. What services do parents desire?

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3. How do parents expect to be treated by staff?
4. What are parents' perceptions of staff?
5. What was parents' level of satisfaction with staff?
6. What variables are associated with parents' satisfaction?
7. What variables are associated with child's current living situation?

Descriptive statistics, frequencies, and themes were utilized for the first five questions. *T*-tests and correlations were used to analyze the association of variables with the dependent variable, parents' satisfaction. *T*-tests were also used to analyze the association of variables with the dependent variable, child's current living situation.

Subjects

The participants in this study were parents of students with mental health problems who were part of an Alternative Residential Services (ARS) program with state special education fiscal support. Students receiving ARS who were 9 years of age or older were also invited to participate in the study along with their parents. A total of 160 mailings were sent to family units. At least one response came from 47 family units (30% response rate), including 46 mothers, 24 fathers, and 25 students.

Students

Students were primarily boys (84.8%) and were between the ages of 7 and 20 years ($M = 14.4$ years). Parents reported that students had mental health or behavioral problems for 3 to 20 years ($M = 11.2$ years). Both mothers and fathers similarly rated the seriousness of the students' mental health or behavior problems as 3.9 on a five-point numeric scale with 5 being "a serious problem" and 1 being "no problem."

Children's placements for services were 42.6% at home, 36.2% in in-state residential settings, and 12.8% in out-of-state settings. Another 8.5% were in

other settings such as a nursing home and a supervised, independent living situation. The average per child expenditure of ARS funds was \$53,019.26 for the 1994-95 academic year, with a range of \$0 to \$171,232 annually.

Instrumentation

Parents described their situation with: (a) the Parent's Stressors Scale, (b) the Cause of my Child's Problem Scale (CMCP), and (c) the Burden Assessment Scale (BAS).

The Parent's Stressors Scale. Parents identified and prioritized the stressors they experienced as parents of children with mental health problems.

The Cause of My Child's Problem Scale (CMCP). The 18-item CMCP, a revision of McCauley's (1992) Causal Dimension Scale II, measured six causal dimensions including: (a) locus of causality within or external to the parent; (b) stability; (c) personal control; (d) external control; (e) locus of causality within or external to the child; and (f) pervasiveness. The coefficient alpha for the current study was .65 for mothers and .64 for fathers.

The Burden Assessment Scale (BAS). The 19 item BAS, a revision of Rinehard's BAS (1994), measured parents' perceived burden, including objective and subjective burden. The coefficient alpha in the current study was .93 for mothers and .91 for fathers.

Three other factors related to parent satisfaction were measured, including:

- *The Parent Satisfaction Scale (PSS).* The 7-item PSS measured parents' level of satisfaction with their interactions with staff (Gerkenmeyer, 1996). Coefficient alpha in the current study was .91 for mothers, .87 for fathers, and .87 for the child version.

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- *The Parent-Staff Interaction Scale (P-SIS)*. The 13-item P-SIS measured parents' perceptions of how they were treated by staff. (Gerkenmeyer, 1996). Coefficient alpha in the current study was .94 for mothers, .87 for fathers, and .87 for the child version.
- *The Expectation of Staff Interactions Scale (ESI)*. The 5-item ESI, developed by the author, measured expectations the parent or child had about staff. Coefficient alpha in the current study was .89 for mothers, .72 for fathers, and .89 for the child version.

Results

How Parents Described Their Situation

Parents' Stressors. The weighted, prioritized stressors identified by the parents included: (a) child focused stressors obtaining 406 points (32%); (b) parental role stressors obtaining 356 points (29%); (c) service system stressors obtaining 342 points (27%); and (d) family focused stressors obtaining 162 points (13%).

The Cause of My Child's Problem (CMCP). Parents did not believe they had personal responsibility for causing their child's mental health problem. The CMCP scale least endorsed by parents on the CMCP was the parents' locus of causality subscale (i.e., within you as a parent; $M = 3.8$ on a nine-point scale).

Overall, parents tended to explain their children's mental health problems as pervasive, likely to last forever, and not caused by themselves. The most highly endorsed CMCP items by mothers were *will affect all parts of your life and is inside your child* ($M = 7.1$), followed by "will last forever" ($M = 7.0$). For fathers, the most highly endorsed item was *will last forever* ($M = 7.2$), followed by *is inside your child* ($M = 6.7$).

Burden Assessment. The parents' most highly endorsed BAS item was *worried about what the future holds for your child* ($M = 3.7$ on a 4 point scale). The least endorsed burden for both mothers and fathers was *resented your child because s/he made too many demands on you* ($M = 2.0$ and 1.9 , respectively).

Parents' Desired Services

Several parents (48%) indicated that they wanted exactly what services their children were receiving. Parents also endorsed that they wanted respite services (34%), school based services (27%), in state residential services (27%), home based services (18%), out patient counseling (15%), in-state hospitalization (8%), and partial hospitalization (5%). None of the parents endorsed wanting out of state services; however, 50% (6 out of 12) of those receiving out-of-state services endorsed wanting exactly what they were receiving.

Expectations of Staff Interactions

Mothers and fathers most strongly agreed that they expected to be treated well by staff. Parents least agreed that staff treated them better than they expected.

Perceptions of Staff Interactions

In general, parents had highly positive perceptions of, and satisfaction with, their interactions with staff. The most negative perceptions were within a neutral range. Positively skewed data have been a consistent, long standing problem with consumer satisfaction and perception data (Lebow, 1982), therefore, in identifying areas to improve, the least positive responses need to be targeted, even if, as in this study, they fall in a neutral range. Mothers and fathers did not describe the staff as rude to them ($M = 2.2$ and 2.0 , respectively on a five-point scale with 1 = *strongly agreeing* and 5 = *strongly disagreeing* with positive perceptions of staff interactions). The most negatively endorsed

perceptions for mothers were that: (a) staff were (not) helpful in identifying community resources ($M = 3.0$), (b) staff had limited skills to help their children ($M = 3.0$), and (c) staff (did not) ask their opinions about what help their families needed ($M = 2.9$). The most negatively endorsed perceptions for fathers were that: (a) staff were (not) helpful in identifying community resources ($M = 2.9$), (b) staff (did not) fit services to meet the needs of their children ($M = 2.9$), and (c) staff were (not) very supportive when they were in distress ($M = 2.8$).

Level of Satisfaction

Mothers and fathers were least satisfied with how staff helped them find services their children needed ($M = 3.0$). They were most satisfied with how the staff treated them with respect ($M = 2.3$) with the lower mean representing greater satisfaction.

The Influence of Child's Current Living Situation

The child's living at home was associated with significantly higher levels of parents' total burden, subjective burden, and fathers' objective burden. Further, of the children living out of their home, those living out-of-state had significantly lower levels of parents' subjective burden, total burden, and mother's objective burden than those with in-state, residential placement (see Table 1).

Parents' Satisfaction

The more satisfied mothers were, the more (a) positive their expectations, (b) helpful they found ARS services, (c) positively staff interactions were perceived, (d) likely parents were to recommend or return to the staff for services, and (e) satisfied fathers and children were with staff interactions (see Table 2 for correlations).

The more satisfied fathers were, the more (a) positive mothers' expectations, (b) likely fathers

Table 1
Comparisons of Current Living Situation and Parents' Level of Burden

Burden	Out of Home			In Home			t	p*
	M	SD	N	M	SD	N		
Mother								
Total Burden	2.42	.74	24	2.81	.59	18	-1.93	.031
Objective Burden	2.45	.70	25	2.54	.60	19	-0.48	NS
Subjective Burden	2.34	.94	23	2.91	.80	20	-2.14	.019
Father								
Total Burden	2.28	.56	14	2.96	.51	10	-3.26	.002
Objective Burden	2.27	.50	14	2.89	.69	10	-2.42	.014
Subjective Burden	2.27	.62	14	3.00	.44	10	-3.39	.002
Burden	Out of State Residential			In State Residential			t	p*
	M	SD	N	M	SD	N		
Mother								
Total Burden	1.96	.55	6	2.65	.73	16	-2.41	.016
Objective Burden	2.07	.55	6	2.64	.68	17	-2.03	.034
Subjective Burden	1.67	.71	5	2.61	.94	16	-2.41	.020
Father								
Total Burden	1.99	.56	6	2.49	.38	8	-1.90	.047
Objective Burden	2.13	.54	6	2.38	.47	8	-0.87	NS
Subjective Burden	1.85	.67	6	2.58	.36	8	-2.41	.023

* probabilities are for one-tailed t-tests

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would recommend or return to staff for services, (c) positively parents perceived staff interactions, and (d) satisfied mothers were. Further, the more satisfied the fathers, the less pervasive mothers viewed the child's problem, the younger the child was, and the shorter length of time the child had a problem. Fathers were also more satisfied when the child was placed out-of-state and least satisfied when they lived at home.

Discussion

With a 30% response rate and small sample size, the findings must be interpreted cautiously. Nevertheless, the findings provide some information concerning the parent's perceptions of their experiences with mental health services.

Parents' satisfaction scores suggest that parents were generally satisfied with the interpersonal interactions of staff. Provision of effective case

management is indicated by parents' decreased satisfaction with the staff's ability to help them find needed services for their children and the parents' concern for their children's future.

With parents' level of burden significantly related to their child's current living situation, provision of effective support and resources is indicated in order to assure families' success and well-being when children with mental health problems are living at home. Parents' most highly endorsed desired service, respite service, was consistent with their need for support. Furthermore, services need to address fathers' needs, as fathers had significant increases in all of their burden scales when children with mental health problems lived at home.

With a significant relationship found between parents' reported intent to return or refer to staff and their level of satisfaction, parent satisfaction

may be more than an objective of care or a factor in improving services. Parents' level of satisfaction with staff interactions may also be associated with subsequent behavior (e.g., continued engagement with the service delivery system). If so, parents' satisfaction may be associated with other functional outcomes for children with mental health problems. Further research is indicated to substantiate this relationship.

Table 2
Significant Correlation of Mothers and Fathers' Level of Satisfaction with Other Variables

Variables	Mothers' Satisfaction	Fathers' Satisfaction
Mothers' Satisfaction	1.00**	.78**
Fathers' Satisfaction	.78**	1.00**
Children's Satisfaction	.62**	NS
Mothers' Perceptions	.93**	.77
Fathers' Perceptions	.73**	.92**
Recommend Staff	.89**	.84**
Return to Staff	.84**	.83**
Services Not Helpful	-.46**	NS
Mothers' Expectations	.72**	.79**
Child's Age	NS	-.56**
Length of Problem	NS	-.46*
Mothers' Pervasive View of Problem	NS	.47*

**p<.01

*p<.05

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Reliability of Parent Reports of Service Use in a Family-Focused System of Care

Introduction

Various efforts to restructure the mental health service system for children and adolescents have identified the value of a full continuum of services, coordinated by a case manager, in which families are encouraged to actively participate (Stroul & Friedman, 1986). Adequate assessments of the effectiveness of such “systems of care” require accurate information on service utilization. Very often, utilization data are obtained from a parent of the child client. This research examines whether parent reports of their child’s service use are more reliable in a family-focused delivery system than in more typical service environments that do not explicitly embrace “system of care” principles.

Methods

Sample

Data were obtained through the Fort Bragg Evaluation Project (FBEP), a longitudinal assessment of a managed care model for delivering mental health services to children and adolescents (hereafter, the “Demonstration”). The present research is based on about 600 youth who remained in the study six months after intake to the Evaluation, for whom collateral service-related data were collected.¹ About 60% of this sample received services through the family-focused Demonstration, and 40% through two traditional systems of care (hereafter, the “Comparison groups”). On average,

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the sample was about eleven years old, about 60% male. Seventy percent were white, 20% were African American; and 10% were of other or mixed races. About 80% lived in a two-parent household, with an annual income between twenty and forty thousand dollars. Over 90% of the youth had significant functional impairment (CAFAS; Hodges, 1990); over 97% obtained at least one clinical diagnosis based on parental responses to the Child Assessment Schedule (P-CAS; Hodges, Kline, Stern, Cytryn, & McKnew, 1982).²

Data Sources/Measures

Utilization data were obtained from the youth's primary caretaker (i.e., usually the biological mother) and institutional records (i.e., the management information system (MIS) at the Demonstration);³ and the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) database for the Comparison groups. The following service categories are examined: a) hospitalization (HOSP), b) residential treatment (RTC), c) outpatient therapy (OUT), and d) medical evaluations (MEDEVAL).⁴ For each category, two measures of utilization are analyzed: service use (i.e., "yes" or "no") and service dose (i.e., the number of service units received). Data are based on reports of use in the first six months after intake. Because parents may miss the distinction between hospitalization and residential treatment, or between outpatient care and medical evaluations, two general categories of use are created. "Restrictive" care includes hospitalization or RTC; "nonrestrictive" care includes outpatient care or medical evaluations.⁵

Analyses

Identical analyses of reliability were performed on the Demonstration and Comparison groups. First, the percentage of children who used each service type is reported based on each data source. Because parent and institutional reports can reveal identical rates of use without any *association* between the reports,

proportional agreements between the two sources are also provided. Kappa coefficients, which indicate whether the agreement is better than what would be expected by chance (Cohen, 1960) are shown.⁶ Agreement can arise because parents concur with institutional reports of use (i.e., "sensitivity") or nonuse (i.e., "specificity") (Kraemer, 1992). Therefore, data are also shown to indicate the nature of agreement between parent and institutional reports. Finally, correlations between collateral reports of service dose are shown.

Results

Table 1 shows that parents in the Demonstration and Comparison groups tend to report roughly equivalent rates of service use as found in their respective institutional records. Exceptions include parental overreporting of medical evaluations in the Demonstration and of RTC use among the Comparison groups.

Table 2 shows high percentages of agreement between parent and institutional reports for all service types, in both service systems. The proportional agreement on medical evaluations, though good, is the lowest observed. Most notably, Demonstration families indicate much better accuracy than the Comparison group with regard to nonrestrictive care, specifically for outpatient care. The kappas indicate that when chance agreement is eliminated, parents in both systems continue to report reliable use of restrictive care. Low kappas for nonrestrictive services are largely due to the relatively inaccurate reports of medical evaluations and the large number of youth who received outpatient care.⁷ In short, participants in the family-focused system of care provide good reports overall, better than their counterparts in traditional systems with regard to nonrestrictive services, though no better with regard to restrictive care.

Reliability of Parent Reports

Figure 1 shows that reliability depends on whether one considers the sensitivity or specificity of reports.⁸ Regarding *restrictive services*, the strong overall agreement at the Demonstration (in Table 2) is largely explained by high specificity (98%). Sensitivity of these reports is relatively low (69%), with parents at the Demonstration tending to underreport.⁹ The pattern among families in

traditional systems is similar; they also show greater specificity (94%) than sensitivity (86%). While their specificity rate is comparable to that of the Demonstration, their sensitivity rate is higher.

The findings with regard to generalized, *nonrestrictive care* show greater sensitivity than specificity in both types of systems. Outpatient care

in particular is overreported. However, this finding must be interpreted in context of the number of clients who received outpatient care. When so many receive the care, only a few cases incorrectly reporting its use would generate a high inaccuracy rate.¹⁰ The skewness of the sample's distribution is less severe in the Comparison group, where 11% did not receive outpatient care. Indeed, perhaps the most striking finding about reports of nonrestrictive services is the low specificity rate (17%) in the traditional systems. Sensitivity of reports of nonrestrictive services is comparable in both service systems. The low reliability of medical evaluation reports in both systems is largely attributable to low sensitivity (i.e., underreporting).

Table 3 shows that parent reports on doses, as with use, are more accurate for restrictive than for nonrestrictive care. In both systems, correlations between parent and

Table 1
Parent and Institutional Reports of Service Use

Service Type	Demonstration (N = 293)				Comparison (N = 318)			
	Parent		Institution		Parent		Institution	
	%	N	%	N	%	N	%	N
Hospitalization	11%	31	13%	38	29%	91	31%	97
Residential Treat.	1%	2	1%	3	8%	24	4%	11
Outpatient Therapy	95%	278	98%	288	90%	287	89%	284
Medical Evaluations	27%	80	14%	40	19%	61	18%	57
Restrictive	11%	33	13%	39	31%	98	31%	99
Non Restrictive	96%	281	98%	288	91%	289	91%	288

Note: Comparisons between Demonstration and Comparison groups on rates of service use are inappropriate. Intermediate services, available through the Demonstration only, affect the use rates of the other services presented.

Table 2
Parent and Institutional Agreement on Service Use

Service Type	Demonstration (N = 293)		Comparison (N = 318)		p (χ^2)
	% Agree (N)	Kappa	% Agree (N)	Kappa	
Hospitalization	94% (276)	.72	90% (286)	.76	.05
Residential Treat.	98% (288)	NA	95% (303)	.55	.04
Outpt. Therapy	95% (279)	NA	85% (269)	.16	<.01
Medical Eval.	72% (211)	.16	72% (228)	.06	.93
Restrictive	94% (275)	.72	92% (291)	.80	.27
Non Restrictive	96% (282)	.34	85% (269)	.08	<.01

Notes:

1. Kappas for RTC and OUT could not be computed at the Demonstration because too few cases either received (RTC) or did not receive (OUT) these services.
2. The test of significance is based on the differences in the percent agreement between the two systems of care.

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Figure 1
Sensitivity and Specificity of Parent Reports

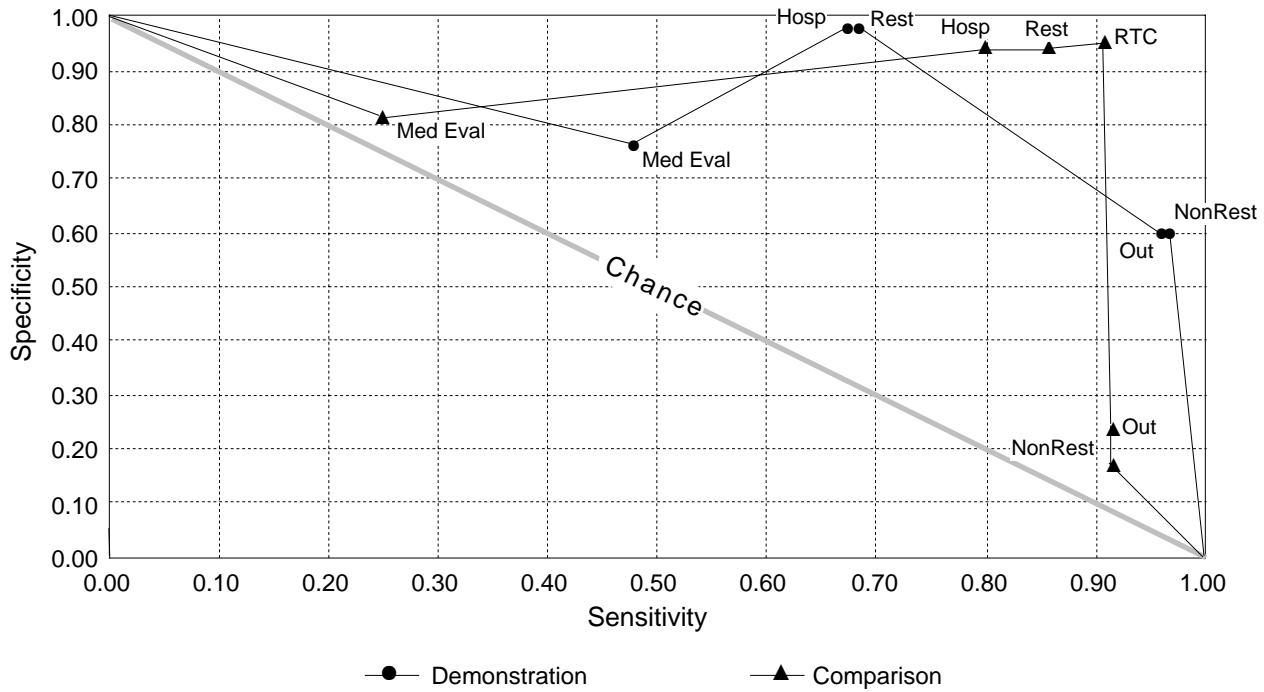


Table 3
Parent and Institutional Agreement on Dosage

	Demonstration						Comparison						CI
	Parent		Institution		r	N	Parent		Institution		r	N	
	MN	SD	MN	SD			MN	SD	MN	SD			
Hospitalization	43.4	28.7	39.2	25.5	.88 ^a	24	39.5	31.8	29.8	18.4	.31 ^a	78	.10 - .50
Residential Treat.	NA	-	NA	-	-	-	135.1	52.1	120.9	55.8	.89 ^a	10	NA
Outpatient Therapy	19.9	32.5	15.3	10.0	.13 ^b	260	10.5	9.2	9.6	9.4	.52 ^a	251	.42 - .61
Medical Evaluations	5.6	2.2	1.6	.9	.04	18	3.7	2.1	2.1	1.2	.34	14	-.24 - .74
Restrictive	42.3	28.6	40.3	25.5	.81 ^a	25	64.6	61.4	46.6	50.0	.75 ^a	85	.64 - .83
Non Restrictive	20.7	32.5	15.5	10.2	.14 ^b	268	11.0	9.2	9.8	9.7	.51 ^a	255	.41 - .60

Notes:

^a $p \leq .01$

^b $p \leq .05$

^c CI is the confidence interval around the Comparison group's Pearson correlation coefficient. A Demonstration's correlation coefficient falling within this interval suggests it is not significantly different from the Comparison group's r .

Reliability of Parent Reports

institutional records of generalized restrictive care are high and the difference between systems is not significant. When hospitalization is examined specifically, however, the correlation at the Demonstration ($r = .88$) is significantly higher than in the Comparison group ($r = .31$). On the other hand, correlations at the Demonstration for nonrestrictive care are low, and significantly lower than among the Comparison groups.

Table 4 summarizes the findings. A plus sign indicates the system with the stronger association between parent and institutional reports; a minus sign, the system with the weaker association. Of the seven *specific* service categories that can be compared, reports for the two service systems differed significantly on six. Of these six, four favored the Demonstration; two, the Comparison group. The *general* measures indicate that the accuracy of Demonstration families' reports of use and dose of restrictive care is about the same as observed among families in the traditional systems. For nonrestrictive services, Demonstration

families tend to be more accurate with regard to use, but less accurate on questions about the number of service units rendered.

Discussion

Efforts to provide more effective mental health services for children have embraced the value of including children's families in the treatment process. This paper explored the possibility that parent reports may be more reliable in a family-focused system than in traditional systems that do not explicitly pursue family-focused interventions. Findings suggest that participants in a family-centered system generate reliable utilization data. However, their reliability does not consistently exceed that observed in traditional environments. With regard to restrictive care, this may be due to the introduction of innovative, intermediate services the Demonstration made available. Families at the Demonstration showed a greater likelihood of underreporting restrictive care than those in the Comparison group, a phenomenon that may relate

to the greater number of additional services they received through the Demonstration.¹¹ Reports of the use of nonrestrictive care are good; however, reports of dose are not very reliable, and significantly more unreliable than among the Comparison groups.

The Demonstration represented a new and rather complex structure with which parents and professionals alike had to familiarize themselves. The lack of consistent superiority in reliability of utilization

Table 4
Summary of System Differences in
Parent Reliability of Service Use Reports

Use	Demonstration	Comparison	<i>p</i> value
Hospitalization	+	-	.05
Residential Treat.	+	-	.04
Outpatient Therapy	+	-	< .01
Medical Evaluations	same	same	.93
Restrictive	+	-	.27
Non Restrictive	+	-	< .01
Dose			
Hospitalization	+	-	≤ .05
Residential Treat.	NA	NA	NA
Outpatient Therapy	-	+	≤ .05
Medical Evaluations	-	+	≤ .05
Restrictive	+	-	NS
Non Restrictive	-	+	≤ .05

reports through the Demonstration suggests such organizational challenges may have impeded the system's intended capacity to meaningfully include parents in treatment planning. Other research (Sonnichsen & Heflinger, 1993) has also found that families at the Demonstration were not significantly more involved in restrictive services than parents at the Comparison sites (though they were more involved in nonrestrictive care). Together, these findings suggest that we may need to reorganize or redouble our efforts to include families as active, knowledgeable partners in the therapeutic process. Moreover, it may be that any *added* value of family-focused service systems for reliable parent reports may obtain only after participants in the system have time to adapt to the new organizational environment.

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Endnotes

1. The follow-up sample used for this research is more limited than in the original Fort Bragg database described elsewhere (Bickman, et al., 1995). First, about 10% of the Demonstration sample has been excluded because they “transitioned” into a different level of care at the time they entered the evaluation. These parents may have unusual difficulty in distinguishing between services received before and after transition, particularly when these services represent treatment for the same episode. Second, about 100 cases at the Demonstration, who indicated their childhood an initial pretreatment visit but did not return for treatment were excluded from analyses. Finally, a small number of parents in the Comparison group indicated that outpatient and medical evaluations were not paid by CHAMPUS. These cases were excluded because the transactions would not be included in the CHAMPUS database. Thus, the research is based on the approximately 600 cases for which service use data could be expected in both the parent and institutional database for the same six-month interval.
2. The child and family profiles of the Demonstration and Comparison groups were similar on factors that may differentially affect parent recall of services, for example—the types or degree of their child’s problems and their previous experience in the mental health system. See Bickman, et al., 1995 for more details on the sample and its representation of other youth in treatment.
3. Previous analysis compared the Demonstration’s MIS and provider data and found strong agreement between the two sources (Bickman, et al., 1995). Thus, the institutional record is considered the “gold standard” in this research, to which reliability of parent reports is assessed.
4. The Demonstration offered intermediate levels of care (e.g., day treatment) that were unavailable to the Comparison groups. Only the four service types offered through both service systems are included in this research.
5. Multiple reports of use of the same service type within the six month period are counted once. Dosages associated with multiple reports of the same service type are summed. Thus, service use and dose represent service types used and the total dose received, regardless of the number of episodes or providers associated with each service.
6. Kappa estimates of reliability decrease as the proportion of cases across categories departs from equality. In these data, a sizable majority of cases is classified similarly—for example, more than 90% who indicate use or nonuse of some services. In this situation, the likelihood of chance agreement is extremely high and the ability to improve prediction beyond chance (as indicated by kappa) is weak. Further, estimates of reliability also decrease as the number of response categories decreases. Thus, kappas will be lower for the nominal yes/no dichotomies used here to indicate service use than would be expected for ordinal measures. Given these properties of kappa and of these data, kappas should be interpreted in conjunction with other findings presented.
7. It is difficult to improve upon chance, thus obtain large kappas, when the vast majority of cases fall into the same category which is the case here with outpatient care.
8. Less sensitive reports suggest that parents underreport service use; less specific reports suggest parents overreport use. Cases (indicated by dots for the Demonstration, triangles for the Comparison groups) in the upper right quadrant of Figure 1 suggest relatively high specificity and sensitivity. Symbols that lie below or to the left of this quadrant suggest diminishing specificity and sensitivity, respectively.
9. At the Demonstration, too few cases had reports of RTC use, and a sensitivity measure was not calculable. Because both sensitivity and specificity measures are required for charting, Figure 1 does not include an indicator (“dot”) of RTC use for the Demonstration.
10. The proportion of clients who overreport is based on the total number of clients who did not receive that type of care. For the Demonstration, only 2% ($N = 5$) of families did not receive outpatient care. Thus, just two clients incorrectly reported use yielding a 40% inaccuracy rate.
11. Summerfelt, Foster, & Saunders, (1966) report greater service use among children at the Demonstration than at the Comparison sites. Further, auxiliary analyses were conducted on Demonstration clients to ascertain whether their underreporting of restrictive services was associated with overreporting of other service types. Findings showed that underreporters tended to report a greater number of other services than parents who accurately reported services, particularly, intermediate residential services—those that parents may be most likely to confuse with traditional restrictive settings. And, official data corroborated the parents’ reports—underreporters did in fact receive a somewhat greater number of other services than accurate reporters (3.0 vs. 1.5). This suggests that the basis for underreporting may be due to confusion that understandably may result when multiple services are provided. However, confidence in these findings is dampened by the small number of clients at the Demonstration who received intermediate services.

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Congruence Between Parent-Professional Ratings of Level of Functioning: Relationships to Collaboration and Satisfaction

Introduction

Parents of children with emotional and behavioral disorders often feel that they are not treated as equal partners in their children's services (Collins & Collins, 1990). Often, they are not consulted by professionals regarding the needs of the children (Evans, Armstrong, Thompson, & Lee, 1994). Parental participation in children's treatment decisions, however, has begun to be a mental health system goal that is embraced by both family members and mental health professionals (DeChillo, Koren, & Schultze, 1994; Evans et al., 1994; Friesen & Korloff, 1990). Indeed, parent-professional collaboration is being recognized as a component of professional service delivery (Friesen & Schultze, 1992; Edelman, Greenland, & Mills, 1992).

There has been a lack of research into the relationship of collaboration to other service goals such as satisfaction and parent-professional agreement about child treatment priorities. The present study sought to (a) replicate and expand upon findings of DeChillo et al. (1994) that suggest a relationship of parent-professional collaboration to parents' satisfaction with their children's mental health services; (b) explore the relationship of parent-professional congruence on ratings of level of functioning (LOF) to degree of collaboration; and (c) examine the relationship of parent-professional congruence on ratings of LOF to parent satisfaction with services.

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Method

Participants

Parents ($N = 76$) of youths receiving mental health services at six rural and urban community mental health centers (CMHCs) in Washington state participated in this study as part of a longitudinal study on regulatory reform. Mental health professionals completed surveys on a total of 41 youths. The sample of youths was 71% male, 8% ethnic minority, and ranged in age from 4 to 18 years old. The most common DSM-IV diagnoses were adjustment disorder (44%), attention deficit disorder (22%), and oppositional defiant disorder (14%). Ninety-three percent of the sample was Medicaid-eligible.

Instruments

Parent Survey

The Client Satisfaction Questionnaire (CSQ-8; Attkinson & Zwick, 1982), an 8-item parent report of service satisfaction, originally developed by Hargreaves and Attkinson in 1978, is rated on a 4-point scale. This widely used scale has demonstrated adequate internal consistency ($\alpha = .93$).

The PSU Family/Professional Collaboration Scale, a 20-item questionnaire, was constructed by DeChillo et al. (1994). This scale asks parents to rate their child's mental health professional's responsiveness toward them on a 4-point scale. There are five factors which are considered in this scale (i.e., supportive understanding, accessing services, sharing information, utilizing feedback, and overall collaboration).

Parent and Professional Survey

The Ecology Rating Scale (ERS) was developed by quality assurance staff at a local CMHC with input from family members of consumers and mental health providers. The 7-item questionnaire, rated on a 5-point scale, measures behavioral/emotional impairments in the following life domains: (a) family, (b) school, (c) emotional, (d) legal, (e) recreational, (f) health, and (g) social. This scale has demonstrated adequate internal consistency (Srebnik, 1996; $\alpha = .70$ for parent raters; $\alpha = .69$ for professional raters).

Results

Examining the relationship of parent-professional collaboration to parental satisfaction with their children's mental health services, a significant correlation was found between the CSQ total score and the total score on the Family/Professional Collaboration Scale ($r = .76, p < .001$; see Table 1).

The relationship of parent-professional congruence on ratings of LOF to degree of collaboration was also explored. As a first step, differences between parent and professional ratings of LOF, using the ERS, were calculated using t-test comparisons. Parent and professional ratings were

Table 1
Relationships Among Key Study Variables

	Parent-Professional Congruence	Parent Satisfaction
Parent-Professional Collaboration	-.154	.76
Parent-Professional Congruence	---	.161
Parent Satisfaction	---	---

Parent-Professional Collaboration

significantly different in the following domains: (a) family, (b) legal, (c) health, and (d) social (see Table 2).

The total ERS discrepancy score was then calculated (i.e., the difference between parent and professional ratings in each life domain of the Ecology Rating Scale). This discrepancy score was not significantly correlated with the total score on the Family/Professional Collaboration Scale, ($r = -.154, p < ns$; see Table 1).

The relationship of parent-professional congruence on ratings of child LOF to parent satisfaction with services was also explored. However, there was no significant correlation found between the total ERS discrepancy score and the CSQ total score ($r = .161, p < ns$; see Table 1).

Discussion

The results of this study reaffirm the findings of DeChillo et al. (1994) that parent satisfaction seems to be related to parent-professional collaboration. Parents and professionals in this study, however, seemed to differ in their perceptions of children's level of functioning in several areas. Professionals

perceived family and social domains as areas of greater child impairment; parents perceived legal and health domains as areas of greater child impairment. One explanation for these differences may be professional emphasis—given training in family systems approaches and negative peer group influences—on family and social impairments. Parents, embedded in the family, may also be less likely to perceive the family domain as a child's main problem area. Both of these divergent perspectives on child functioning may be valid; parents and professional should continue to form partnerships where the open exchange of ideas and information is encouraged.

Parent-professional collaboration does not seem to be associated with congruence of parent-professional LOF ratings. One explanation for this finding may be that parents perceive the interpersonal and supportive aspects of the collaborative relationship as more important than a shared view of their child's functioning. This interpretation is supported in part by the relationship found between parent satisfaction with services and perceptions of collaboration.

Satisfaction does not seem to be related to congruence of parent-professional LOF ratings. Again, parent satisfaction may depend on a number of factors (e.g. service availability and treatment outcomes), and divergent perspectives on child LOF may not play a major role in parent evaluation of services. Furthermore, a global satisfaction rating, such as the CSQ, may be less useful than a measure of satisfaction with individual service providers to investigate parent-professional agreement. It could also be that the relationship of satisfaction to congruence in LOF ratings is mediated by the degree to which services are actually provided to meet identified areas of functioning. A next step to further this line of inquiry would be to test the relationships of LOF rating congruence, the extent to which services were provided to meet identified need and service satisfaction.

Table 2
Differences between Parent and Professional
Ratings of Child Level of Functioning

ERS Domain	<i>df</i>	<i>t</i>	<i>S</i>	<i>p</i>
Family	38	-3.26	1.53	<.002
School	37	.27	1.18	ns
Emotional	38	-.31	1.53	ns
Legal	36	2.28	1.01	<.029
Health	37	2.53	1.16	<.016
Recreational	38	-.87	1.30	ns
Social	38	-2.05	1.25	<.047

Overall, this study suggest that global service satisfaction is more related to characteristics of the parent-professional relationship (i.e. collaboration) than the degree of agreement in how they view the severity of the child's difficulties. However, in order to provide specific and appropriate services, the differences in the "lenses" through which parents and professionals view a child's problems should be addressed.

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The Access Vermont Initiative: Evaluating Family Empowerment

Introduction

Within the field of mental health, there is an increasing sentiment that services for families should be designed to promote *empowerment*. Empowerment has been conceptualized as both a temporary state of being and an ongoing process involving change within the individual. Although no single definition of empowerment has been proposed that captures both conceptualizations, a growing consensus has come to see it as a process through which individuals gain control of their lives through exerting influence over their interpersonal and social environments. Within the context of human service delivery systems, the process of empowerment is thought to occur when families are provided with opportunities to access the knowledge, skills, and resources that foster control over their lives and improve its quality (Singh et al.1995).

A current model specifically designed to describe empowerment for families who have children with serious emotional disabilities was introduced by Koren, DeChillo, and Friesen (1992). This conceptual framework proposed two dimensions for empowerment—*level* and *expression*. The levels of empowerment were further defined as Family, Service System, and Community/Political. The second dimension, expression of empowerment, consists of Attitudes (what the parents feel and believe); Knowledge (what they know and have the ability to do); and Behavior (the actions of parents).

In light of this model, Koren, DeChillo, and Friesen (1992) suggested that empowerment might be a developmental process where

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parents' focus moves from immediate family concerns, to securing information and services they need to address their child's need, and finally to action to assist other families and address the needs of all children. In order to examine this model, they created the Family Empowerment Scale (FES) which is a measure of empowerment within families with children having serious emotional disabilities. Initially tested with a sample of 440 parents, factor analysis of the FES results supported their empowerment model. To further test this conceptual framework, Singh, Curtis, Ellis, Nicholson, Villani, and Weschler conducted a study and factor analysis resulting in a factor structure similar to the FES (1995).

The FES was selected as a measure of family empowerment for the evaluation of the Access Vermont Project, a multilevel crisis intervention jointly funded by a Community Mental Health Services grant and Vermont's Family Preservation Initiative. The FES, however, was previously tested with populations whose demographics were quite different from those of families served by the Family Preservation Initiative; the current study population was poorer, comprised of more single parents, and fewer parents who participated in support groups. This summary describes assessment of the FES for use with a population more typical of crisis services-oriented family preservation programs, and includes comparison of our evaluation's factor results to the factor structures and conceptual framework derived by Koren, DeChillo, and Friesen (1992).

Method

Subjects

Evaluation participants included the primary caregivers of the first 100 eligible children and adolescents to complete the intake procedures during the evaluation period of the Access Vermont Project. To be eligible for inclusion in the evaluation, the child or adolescent had to be

referred for crisis services, and determined to require a treatment team and services from two or more community agencies.

As stated before, the demographics of these families differed from those participating in previous studies utilizing the FES. For example, in the Koren et al. (1992) study, 21% of the families had annual incomes over \$50,000 and only 14% earned less than \$10,000 a year. Similarly, in Singh et al. (1995), 19% of families had incomes over \$50,000, with 17% reporting incomes of \$10,000 or less. In contrast, 86% of participants in this study reported annual incomes of less than \$25,000; no families reported incomes of over \$50,000. Consequently, these families were more likely to turn to the public service system for help rather than private therapists. Additionally, in both Koren and Singh, many families reported that they were members of support groups or organizations for families with children with serious emotional disabilities. The families in the Access Vermont sample came to the program in crisis, and none reported participating in a support group prior to receiving these services.

The previous studies had a male population of over 70%, whereas males in the current study represent 49% of the sample. Another significant difference is in the percentage of children living in single parent homes. In Koren, et al. (1992), only 28% of the children lived in single parent families; in our study, the percentage was 43%. The strongest similarity between our population and those participating in previous studies was in race; over 75% of the subjects of all three studies discussed here were Caucasian.

Clinically, we found that over 50% of the children participating in the evaluation of the Family Preservation Initiative scored in the clinical range for aggressive and delinquent behaviors. Further, 43% of the children exhibited attention problems and 36% had problems related to thought disorders.

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After receiving informed consent from the participants, demographic information, a Child Behavior Checklist (Achenbach & Edelbrock, 1991), and other measures were collected by the intake worker from the child or adolescent's primary caregiver. Within two weeks of the intake an evaluation team member telephoned the primary caregiver and collected information which included the FES and Family Satisfaction Questionnaire.

The FES consists of 34 items rated on a 5-point Likert-type scale from 1 = *not true at all* to 5 = *very true*, designed to measure two dimensions of a family's empowerment, empowerment related to various system levels and the manner in which a family expresses empowerment.

Results and Discussion

Though the demographic characteristics of our population were very different from the previous populations examined (Koren, DeChillo, & Friesen, 1992; Singh et al., 1995), the factors derived were very similar; three factors were derived which were almost identical to the four factors derived by Singh et al. (1995; see Table 1). The major difference was that the present solution has three factors while their solution had four factors, and the items in the factor they labeled knowledge were distributed over the self-efficacy, system advocacy, and competence factors for our results. Since only one item (i.e., other than those contained in the knowledge factor) moved to another factor, we used the same factor labels as Singh et al. (1995). Factor 1, self-efficacy, reflects the primary caregiver's perception of her/his ability to obtain needed services from the children's mental health system for her/his child. Factor 2, system advocacy, represents the primary caregiver's opinion on how effectively she/he can be an agent for change in the children's mental health system, and Factor 3, Competence, refers to the primary caregiver's feelings of competence as a parent. The items that moved from the knowledge

factor seem to have moved to related factors (e.g., the items that relate to knowledge about system advocacy seem to have moved to the system advocacy factor).

Based on our results, the three factor solution was the most suitable, because it was most conceptually meaningful and the statistical properties were sound. The solution explained 42% of the total variance and the alpha coefficients for the factors indicate substantial internal consistency. However, the Pearson product-moment correlations among the three factors are moderately high with all the correlations being significant at the $p < .001$ level. This moderately high correlation of all the derived factors indicates that the factors are not independent (see Figure 1).

The FES has been characterized as being a useful tool for longitudinally evaluating programs intended to assist family development related to the acquisition of knowledge, skills, services, and resources from the mental health system for children (Singh et al., 1995). We view this assertion very cautiously for two of the derived factors. An examination of Figure 2 demonstrates that the self-efficacy and competence factors are highly skewed to the upper end of the scale for this baseline measure. This indicates for our evaluation that it will be extremely difficult to measure increases in these dimensions of empowerment should they occur; also, a regression to the mean may even be expected. The system advocacy factor, however, is more evenly distributed, and it may be much more useful for measuring change over time.

Finally, we examined the relationship of perceived family empowerment to various demographic, behavioral, satisfaction, and risk variables (see Figure 3). Significant differences were found between the highest scoring and lowest scoring primary caregivers on the FES for three variables. Belief in the proposition that the family and

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Table 1
Family Empowerment Scale
Factor Loading for the Three-Factor Solution

Scale items	Factors			Koren et al. (1992)	Singh et al. (1995)
	1	2	3	Factor number	Factor number
1. Self-efficacy					
13. I make sure I stay in regular contact with professionals who are providing services to my child.	.82			2	4
12. I am able to work with agencies and professionals to decide what services my child needs.	.69			2	2
28. When necessary, I take the initiative in looking for services for my child and family.	.65			? ^a	4
27. I make efforts to learn new ways to help my child grow and develop.	.60			4	3
6. I make sure that professionals understand my opinions about what services my child needs.	.53	.48		2	2
18. My opinion is just as important as professionals' opinions in deciding what services my child needs.	.50			4	4
11. I am able to make good decisions about what services my child needs.	.49	.45	.46	2	2
5. I know the steps to take when I am concerned my child is receiving poor services.	.49			2	2
1. I feel that I have a right to approve all services my child receives.	.49			? ^a	4
19. I tell professionals what I think about services being provided to my child.	.47			4	4
26. When I need help with problems in my family, I am able to ask for help from others.	.45			1	4
30. I have a good understanding of the service system that my child is involved in.	.43			2	2
2. System Advocacy					
15. I help other families get the services they need.		.71		1	1
17. I believe that other parents and I can have an influence on services for children.	.42	.68		1	1
24. I know what the rights of parents and children are under the special education laws.		.63		2	2
22. I know how to get agency administrators or legislators to listen to me.		.62		1	1
14. I have ideas about the ideal service system for children.		.61		1	1
3. I feel I can have a part in improving services for children in my community.		.55		1	1
25. I feel that my knowledge and experience as a parent can be used to improve services for children and families.		.54		1	1
23. I know what services my child needs.		.53		2	2
8. I get in touch with my legislators when important bills or issues concerning children are pending.		.49		1	1
20. I tell people in agencies and government how services for children can be improved.		.46		1	1
10. I understand how the service system for children is organized.		.46		2	2
3. Competence					
4. I feel confident in my ability to help my child grow and develop.			.81	3	3
21. I believe I can solve problems with my child when they happen.			.72	3	3
9. I feel my family life is under control.			.67	3	2
2. When problems arise with my child, I handle them pretty well.			.62	3	3
7. I know what to do when problems arise with my child.	.42		.59	3	2
34. I am a good parent.			.58	3	3
29. When dealing with my child, I focus on the good things as well as the problems.			.53	3	3
31. When faced with a problem involving my child, I decide what to do and then do it.			.49	3	3
16. I am able to get information to help me better understand my child.			.44	1	2

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child will be unconditionally supported in services and satisfaction with services were related to higher perceived self-efficacy and ability to advocate for improved children's mental health services. High levels of perceived child behavior problems were highly associated with feelings of lack of competence in child rearing. If we assume that these associated variables are situational and subject to change in either a positive or negative direction, then it is also possible that the aspects of family empowerment measured by the FES are also situational and not developmental. We will be examining this possibility as we track this evaluation group over the next two years.

Figure 1
Factor Characteristics

Factor	Variance Explained	Reliability
Self-efficacy	27.6%	0.83
System Advocacy	7.5%	0.83
Competence	6.9%	0.84

This analysis is based on a sample of 100 parents. The three factor solution explains 42% of the variance in the FES scale items.

Correlations

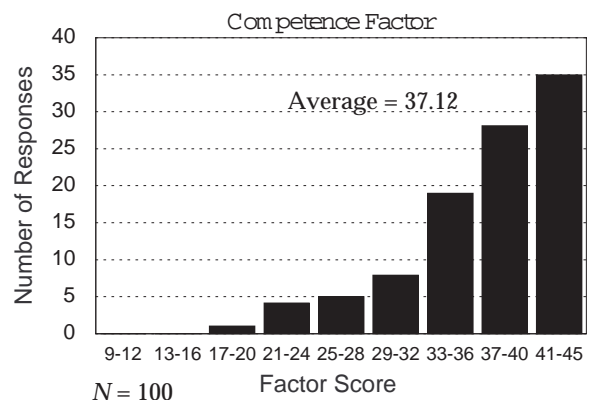
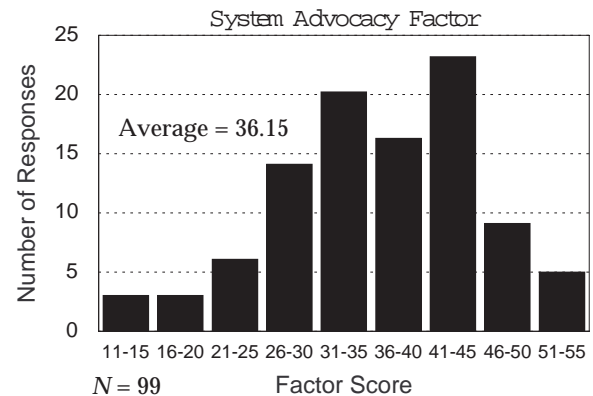
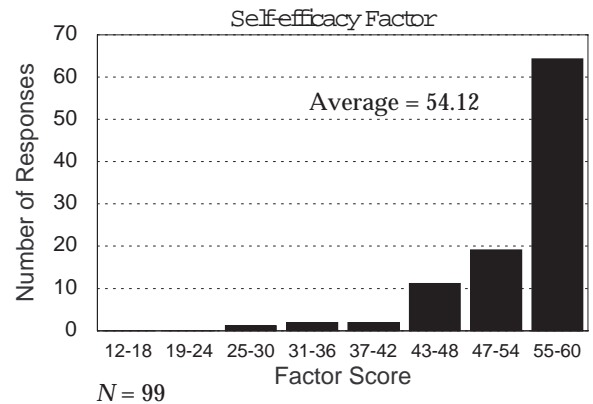
Factor	Self-efficacy	System Advocacy
Self-efficacy		
System Advocacy	.5383*	
Competence	.5827*	.4843*

N = 98

* $p < .001$

The FES, as with all the measures described in this study, measure the primary caregiver's perspective. There have been no independent observations made. However, in discussions with therapists who provide direct services, they have noted that their impressions of the empowerment of the primary

Figure 2
Factor Scores



caregiver, especially as it relates to competence as a parent, may be very different from the perspective of the primary caregiver. This is an indication that independent observation of primary caregivers will be necessary to measure their levels of empowerment and changes in actual behavior.

The data presented here is from the interviews that were completed within two weeks after intake and are based on only the first 100 families evaluated. Therefore, the results are preliminary and the data will be reanalyzed when there is a larger sample to draw from which will provide a more stable factor solution. These families will be interviewed again at 6 months, one year, and two years from the time of intake to determine if they are experiencing any developmental changes in their reports of empowerment.

References

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Figure 3
Differences Between High/Low Scoring Parents

Related Variables	Factors		
	Self-efficacy	System Advocacy	Competence
Unconditional Support	$t(40) = 3.51,$ $p < .001$	$t(33) = 3.43,$ $p < .002$	
Satisfaction with Service	$t(39) = 3.85,$ $p < .000$	$t(30) = 3.09,$ $p < .004$	
Child Behavior Problems			$t(52) = 3.40,$ $p < .001$

Empowerment groups for the tests were made of the highest and lowest scoring parents on the FES with at least 25 parents included in each group. Bonferroni Correction applied at alpha value .1 for 24 tests ($p = .004$). The other variables tested were satisfaction with provider, family risk, family income, child risk and child functioning.