CLIENT SATISFACTION SURVEY OF IN-HOME FAMILY THERAPY

BY

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Abstract

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A pilot test of a client satisfaction survey was conducted in a private agency providing in-home family therapy in west central Wisconsin. The family's names of the clients were obtained from the agency's closed client files. Of the 60 surveys, mailed 17 were returned marked undeliverable, and 4 surveys were returned completed. Of the 17 undeliverable clients, addresses were obtained for 4 clients and the survey was re-mailed to them. Participation was voluntary and anonymous. Four participants completed and returned the survey. Those who responded to the survey indicated that the service was helpful or very helpful. This was regardless of the living situation of the children both at the beginning and end of service.

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Chapter I

Introduction

In-home family therapy has become a common service, especially to those living in poor urban and rural areas. Many proponents indicate that these programs are cost effective, and prevent unnecessary out of home placements of children. Unfortunately, the empirical evidence has mixed conclusions. Currently a debate continues over the effectiveness and efficiency of this type of programming. The challenge researchers face, however, is that many of these programs are highly individualized. The programs do not operate from a single delivery system model and do not provide consistent services from program to program. Regardless of the challenges in evaluating programs, agencies providing this type of service need to develop internal mechanisms for evaluating their individual programs.

Family Solutions Associates is a for profit agency, which exclusively provided in-home family therapy. Since the agency's inception in 1997, the program has not been evaluated. The purpose of this project is to serve as a pilot for the initiation of an evaluation model of the in-home program of Family Solutions Associates, with primary reliance upon the use of a client satisfaction survey.

Statement of the Problem

The purpose of this study is to establish the beginnings of a program evaluation model for Family Solution Associates. A primary initial objective is to test a measure to determine the level of satisfaction among the past clients of the Intensive In-home program of Family Solutions Associates. Surveys were mailed to all past clients of Family Solutions Associates whose cases were closed before July of 2000. The questionnaire consisted of seven statements with the participant rating their level of agreement on a five point Likert scale. Participation was anonymous and voluntary. The statements that made up the survey addressed the issues of the participants' level of satisfaction with the services provided. The questionnaire was sent to the last known address of parent/guardian of the client with a self-addressed stamped envelope. In all of these cases, the client was identified as the child that the family was concerned with and resulted in the referral to Family Solutions Associates

Purpose of the Study

The primary objective was to initiate a review of the in-home family therapy program of Family Solutions Associates. The agency has not evaluated the program since its' inception, and in these times of fiscal responsibility there is a need to demonstrate effectiveness. Client

satisfaction was one area to evaluate in an effort to answer the question, is this program effective?

Chapter II

Literature Review

In an effort to understand the current home-based services it is important to review the history of home-based services and explore how it gained the popularity it enjoys in the current climate. Home-based programs, in their current form, have been offered since the 1970's and the effectiveness of these programs is being questioned; accentuating the need for proper program evaluation. To evaluate a program of this nature it is important to understand the concepts of program evaluation in the human service area. In Appendix A the reader will find a description of the specific in-home program being evaluated by this project.

History of In-home family

The history of home-based services begins with the development of Social Work, which began in the 1800's with wealthy women volunteering to be "friendly visitors" to the poor. The mission was to assist the poor in pulling themselves out of poverty through an increase in moral behavior. Settlement houses came from this tradition. Settlement houses were established in the poor rural areas and in poor neighborhoods of large cities. They were "an institutional response to poverty that was shaped at least in part by the needs of poor people" (Halpren, 1995). The problem

with many of these programs is that they did not hire people from the community, nor did settlement leaders usually trust neighborhood residents to determine their own needs and interests (Halpren, 1995). This lead to people from outside the neighborhood, typically wealthy philanthropic individuals, making the decisions about the services and the delivery of services offered to the poor urban families (Philpott, 1978). Settlement leaders and staff believed that it was more efficient and fair for them to make key decisions about use of resources; and they felt confident that they knew best what poor families needed (Halpren, 1995). Because of this belief, local communities' sense of ownership was also undermined by these patterns of settlement governance, financing, and staffing (Halpren, 1995). Viewing poor people as lacking the knowledge and ability to meet their needs, or define and address their situation, seemed to justify the services. This created contradictions that continue to impact services for poor people to this day (Kirchner, 1986). Many would argue that these efforts to help the poor actually undermined their communities and sense of competence in helping themselves.

In the early 1900's, Social Work began to change as the society moved towards the belief in the hard sciences. In this new culture "helping its' self could not be so easily rationalized and proceduralized. What was desired was an approach that was scientific, but not overly proceduralized and rationalistic" (Halpren, 1995 p. 22). The emergence of clinical social work

during the 1920s, with its strong psychoanalytic orientation, met this need. With the professionalization of Social Work "the assumption that poor people, at the time mostly immigrants, did not have the ability to recognize, define, and formulate solutions to their own problems contributed an important (if inadvertent) rationale to the emerging human services" (Halpren, 1995,p 22). This rationale contributed to the decline and near demise of community based programs. This attitude was not the intent of the original settlement houses, but they were not able to withstand the strong pressures towards institutionalization (Weissman, 1993).

Psychoanalytic theory strengthened social work's claim to being a true profession with a scientific foundation (a claim first made by Mary Richmond in *Social Diagnosis* in 1917). It also accelerated the ongoing shift in Social Workers' attention from community to individual "maladjustment"(Halpren,1995). With this shift, services became more centralized and less neighborhood focused. Clients found accessing services more challenging and frustrating as the bureaucracy of the helping profession "detached" from neighborhoods. Poor families seeking assistance frequently found themselves confronted with a maze of paperwork and procedures, or wandered from office to office looking for the correct place to get the services they desired. As agencies became more centralized and clinically oriented, their staff spent less time in poor

neighborhoods, causing both individual providers and whole agencies to lose their feel for the context of families' lives (Krishner, 1986).

The centralization of services into offices outside neighborhoods continues today with the vast majority of services being offered through one central office. The tide began to change slowly in the 1960's, with the advent of welfare programs like Aid to Families with Children. Unfortunately, by the end of the 1950's, the infrastructure and private monetary support of neighborhood social service programs was near collapse.

In the 1960's, the War on Poverty created a resurgence in neighborhood social service programs. The Federal government increased funding to create and re-create neighborhood support programs. With this new resurgence in community-based social services, and having learned from the past, agencies began to provide services with input from the neighborhood residents. This included efforts to employ nonprofessional community members and keep the focus on what the neighborhood leaders felt they wanted/needed for the community. The focus on the neighborhood continues to grow along with efforts to decentralize services.

In the 1970's, society became concerned with the number of children removed from their home, and languishing in foster care. Out of this concern came the concept of permanency planning, and a greater

emphasis on preventing children from being removed from their families (Lamb, 1992). This shift created the opportunity to increase neighborhood and community-based services, and Family Preservation Services were born. Many of the families targeted for these new programs were the urban poor who recently immigrated and whose cases were extremely complicated (Kirchner, 1986). In 1993, the Federal government passed the Family Preservation Act, which put more pressure on social service agencies to do more to keep families together. This intensified the need for more innovative services. As indicated before, many of the former helping agencies had disappeared, and the responsibility for responding to this crisis came to rest with the government. A few inadequately staffed and funded neighborhood programs re-established community services. Today the funding struggle continues, and the need to prove the effectiveness and efficiency of these programs is becoming stronger.

Program Evaluation

Program evaluations are becoming increasingly important because of concerns about cost, accountability, and effectiveness. In the past mental health services had considerable funding with little emphasis on accountability. As funding decreased in the 1980's, questions began to arise about the effectiveness and quality of mental health services (Plants, 1995). Agencies providing human services needed to demonstrate their

effectiveness. This pressure came from various sources including insurance companies and legislative bodies (Plants, 1995). With this pressure came, a call for and a demand to set standards of care and policies indicating what constitutes quality of care (Plants, 1995). This created a need to develop ways to evaluate and measure the outcomes for mental health services. Family based services were no exception.

Evaluations of family based services were conducted many ways. The challenge, especially for family based in-home services, is determining what is successful treatment (Fraser, 1997). Mary Jones (1980) suggests that there are three areas, which are appropriate to measure when addressing the effectiveness of family preservation services. The three areas include: case events, which usually are based on entry into the alternative care system, or substantiation of abuse or neglect. The second area is family and individual change. This would involve pre-testing and post-testing individuals and families to determine the direction of and magnitude of change. The third area is assessing client satisfaction (1980).

Although nearly a thousand articles have been published focusing on family based or family preservation Services, there are only 46 published program evaluations. Of the 46 evaluations only 10 studies measured outcomes or client change (White, 2001). Most family based services, when evaluated, continue to use case events as the criteria for

success. Many of the programs initially boasted of a near 100% success rate. Like many past program evaluations these measures used placement avoidance as criteria for success. Gelles argues against using placement avoidance as the main indicator of a successful program because placement may constitute a viable treatment option (White, 2001).

Rossi (1992) indicated there are several additional reasons for not using placement as the sole criterion for success. The first being that placement is outside the control of the family preservation program, and is made by Child Protective Service agencies and the court system (Rossi, 1992). This also implies all entry into alternative care is bad, and does not take into account the positive changes a family may have made, but the child still needed to be removed from the home (Moses, 1980). In addition, placement avoidance or case events are not an appropriate measure because of the impact of the placement moratorium on the family's current crisis. The crisis, which led to the risk of placement, may have passed, and can be difficult to determine cause and effect (Gelles, 1992). Many of the referrals to these programs were based on the concept of imminent risk of placement. This concept can vary greatly from person to person, and it is difficult to standardize. This standard is totally dependent upon the attitudes of the protective service workers.

The second area of evaluation is family and individual change. Measuring change in these families is also complicated and highly individualized. It is frequently a struggle to use this type of evaluation because of the complicated nature of the families involved in the services. The lack of clarity in establishing agreed upon goals and intended measures of success for clients also hinder this process. These programs are often under the scrutiny of policy makers who are looking for quick and easily understandable results, which are not readily available when dealing with families in crisis (Lamb, 1992). Frequently programs were judged without agencies developing a clearer understanding of what they intended to accomplish and what "success" means when evaluating the effectiveness of a program. Even after a program establishes a clear understanding of what is success, it is a challenge to locate and develop the appropriate measure to evaluate the outcome of each case.

This leads to the third area of evaluation, which is client satisfaction. The human service community is beginning to see the value in asking the client's their opinion on services, and is striving to become more consumer friendly. The human service field has recognized that clients need to participate in treatment choices and are valuing the perspective of the client. Client satisfaction, however, is considered a "soft measure." This means there is little evidence that client satisfaction is related to

measurable changes in behaviors or hard outcomes. Another concern with client satisfaction is that they are frequently skewed in a positive direction, and may not give a clear picture of the effectiveness of a service (Mullen, 1997). Client satisfaction, however, continues to be regarded as an important component in an overall program evaluation.

Chapter III

Methodology

Subjects

The subjects were selected from the closed client files of Family Solutions Associates. The clients whose cases closed between 1997, the agencies year of inception, and June 30, 2000, were the only ones selected for the survey. The client population was 60 families.

Family Solutions Associates is a for profit agency located in LaCrosse, WI, and they provide services to the seven Wisconsin rural counties surrounding this city. Three master level, primary therapists, and six bachelor level secondaries, staff the agency. A team consisting of a primary and a secondary therapist serves the clients. The secondary therapist meets with the client twice a week and the primary therapist joins one of these sessions. Therapists are assigned cases by geographic location, and the therapist personal preference. All of the therapists are self-employed and work for the agency as a contracted person.

Instrument

The purpose of the instrument was to determine the degree of satisfaction the client experienced with the services received from Family Solutions Associates. The questionnaire was based on other client satisfaction surveys from two mental health clinics, one providing on site

services, and the other providing a similar In-home service. Epstein and Taipodi (1997) suggest constructing a questionnaire with five steps in mind. The first is to understand the purpose of the survey. In this situation, the purpose was to determine the level of client satisfaction.

The second step is to gather the information desired in the shortest possible way, not to exceed a ½ hour of the participant's time. The questions asked in this survey were based on Mullen and Magnabasco's (1997) suggestion that a good client satisfaction questionnaire contains the following:

> "Dimensions of measurement 1) Interpersonal manner of the provider, 2) technical quality, 3) accessibility and convenience, 4) finances, 5) efficacy and outcomes, 6) continuity of care, and 7) overall satisfaction on (1997,p 155).

The questionnaire developed for this study incorporated all of these characteristics with the exception of the financial elements because the Wisconsin Medical Assistance Program covered the cost of the program. The final questionnaire appeared to meet these criteria.

The third step establishes a format. The format was a self-administered questionnaire, with closed questions indicating the client's degree of agreement. A cover letter accompanied the questionnaire explaining the purpose of the study, and assuring anonymity.

The fourth step was writing the questions. The questions were clear, short, and easily read. Setting up a pretest is the fifth and final step suggested by Epstein and Taipodi in developing a questionnaire. This study was the pilot study pretest for this questionnaire. It was the opinion of the researcher and others who reviewed the questionnaire that it appeared to have construct and content validity. A Copy of the final instrument employed in this study can be seen in Appendix B

Procedure

The names and addresses obtained from Family Solutions Associates client files were placed in a computer database for easy printing of envelopes. The questionnaire was mailed on July 14, 2001, with self-addressed stamped envelopes and a request for a five-day response time. Of the 60 letters sent out 17 were returned undeliverable due to address changes. A people search was conducted on the Internet. Addresses were obtained for four of these "returned mail" clients, and the questionnaire was re-mailed on July 25, 2001. One person contacted the researcher because he did not recall receiving services. No follow up mailing occurred in this study. Four questionnaires were completed and returned.

Chapter IV

Presentation of finding

Findings

The questionnaire consisted of three demographic questions concerning the placement of the child at the time of referral, and at the end of services, and the referral source.

The placement of the identified child at the time of referral varied. Two participants indicated the identified child was placed in foster/group care, another was in a relative placement, and the fourth was placed in the home. When services ended, one child moved from foster/group care to home, and the other three maintained their placement status. All of the respondents indicated they were referred by the county human/social service agency.

The first question inquired as to how helpful the participant thought the therapist was ranging from 5, meaning very helpful, to 1, meaning not helpful at all. Three participants rated the therapist as a 5 and the other rated the therapist as a 4.

Question 2 inquired about the convenience of appointment ranging from 5, very convenient, to 1, not convenient. Three of the participants rated the service as a 5 and one rated it as a 4.

Question 3 inquired as to how well the client felt the therapist understood the situation ranging from 5, all of the time, to 1, not at all.

Two participants rated the therapist as a 5 and two rated the therapist at a 4.

Question 4 asked how reliable the therapist was ranging form a 5, all of the time, and 1, not at all. One participant rated the therapist as a 4 and the other three rated the therapist at a 5.

Question 5 inquired about the degree of improvement in the situation that brought them to therapy ranging from 5, much improved, to 1, much worse. Two participants rated the therapist as a 5. One rated the therapist at a 4, and another rated the therapist at a 3.

Question 6 asked, "Because of services, I understand the problems well enough to manage them in the future" with 5 meaning strongly agree, and 1, meaning strongly disagree. One participant rated 5 and the other three responded to this item with a 4.

The final question asked whether the participant would refer a friend or family member with a similar problem. All four participants indicated they would recommend this service to a friend.

Limitations

There was a very low response rate to the survey, and there are many possible explanations for this. The family served by Family Solutions Associates are what Harry Aponte (1994) would call under-organized families. Meaning they frequently lack the ability to organize themselves

to accomplish daily tasks. The clients may not have taken the time to read the cover letter explaining the importance of the survey. The participants may not have recognized the name Family Solutions because they do not go to a clinic. The letter may not have had enough information like the child's name or the Therapist name to trigger the participant's memory of the service. A follow up mailing may have captured those who misplaced the first survey or did not take the time to look at the initial mailing.

Many of these families move frequently, and several families could not be located. The time between services ending and the questionnaire was up to three years. This may have been too long of a period for the clients to have the desire to give a response. The letter may have been too long and complicated for the clients to take the time to read and understand, and they may have put it off and then subsequently lost the papers.

Another explanation for the low response rate was that the participants did not find the service helpful and did not want to return a survey with negative comments.

Other then the low response rate this study had several other limitations. One limitation is the fact that the researcher was one of the providers. In an ideal situation, the provider should not be the researcher

because this may result in a skewed survey either in the positive or negative direction.

The population is also a limitation because of the small number of families and the small geographical area served. Social Workers selected the clients who participated in the program. The researcher had no control over client selection. The clients were also required to have Wisconsin Medical Assistance, which is a program for people near the poverty line and children in substitute care. This excluded many clients served by social services, who may have benefited or wanted the in-home program. Because of these issues, the population is not a representative sample of the area or of the clients social services serve.

Chapter V

Summary, Conclusions and Findings

Summary

The concept of working with the disadvantaged has been with social service agencies for over a century. What has changed is how the "helpers" interact with these families and communities (Halpren, 1995). Since the 1970's, in-home programs have proliferated. In-home programs along with other mental health services, expanded greatly until the 1980's, when questions about effectiveness and efficacy began to take center stage. With these questions, providers were asked to demonstrate, using solid scientific methodology, that in-home programs were effective and efficient. The use of client satisfaction surveys is a strong component of evaluating a program.

This study was a pilot test of a client satisfaction survey for Family Solution Associates, and it was mailed to 60 past clients. Of these surveys, 17 were returned undeliverable due to the clients moving, but addresses were located on four of the returned clients and then re-mailed. Four surveys were completed and returned in the self addressed stamped envelop provided.

Conclusions

Because so few participants responded, the results of the survey cannot be generalized to other clients. The surveys, which were returned, indicated the services were very helpful, and the level of satisfaction was high. The level of satisfaction appeared to be independent of the placement of the children before services and at the end of services. All of the participants indicated they would recommend the service to family or friends.

Findings

Statistical analysis was not completed on this project due to the small number of surveys sent out, and the low response rate. Twenty eight percent of the surveys were returned due to incorrect address. Of the surveys not returned less then one percent were completed and returned to the researcher.

Recommendation

1. Future survey should include identifying information like the name of the therapist and the name of the identified client. This is to assist the client's in recalling the services. Because clients are not seen in an office, the name of the agency may not be highly recognizable, as would the name of the therapist.

2. In the future questionnaires should be sent to all the persons in the family who are mature enough to complete the survey. This would obtain the whole family's opinion and not just the opinion of the person filling out the form. Because families are not homogeneous, responses may vary from individual to individual.
3. The survey may generate more responses if sent out to clients within three months of the end of services. Many of the clients serviced by the agency receive multiple services from many sources. A timelier mailing may help ensure the clients remembering the service they received.
4. Family Solutions Associates should explore the agency's goals for case outcomes, and assess how the goals determine a successful case. The agency may want to implement assessments which determine the level of functioning before services and then again after services. The FACES III, which is a current assessment tool used by the family, may be a tool to gain the client's perception of change and family functioning. Currently, the agency uses placement avoidance as a measure of success, and this, according to the literature, is not necessarily the best method of measuring success.
5. In the future, the agency may want to survey the referring agency to determine their level of satisfaction, and ascertain the referral

sources opinion about the success of the case. This would then promote an analysis of two customer groups, client and referral sources, to services provided by Family Solutions Associates.

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Appendix A

Family Solutions Associates

Donna Juleff
715/495-8396
1707 Main St., Suite 236
LaCrosse, WI 54601

Dear Participant:

Family Solutions Associates is conducting a client satisfaction survey of all our past clients. The intent of the survey is to understand your thoughts and opinions in regards to the services that you received from our agency.

This is a research project, and I advise you of the following:

I understand that by returning this questionnaire, I am giving my consent as a participating volunteer in this study. I am aware that the information is being sought in a specific manner that no identifiers are needed and so that confidentiality is guaranteed. I realize that I have the right to refuse to participate and that my right to withdraw from the participation at any time during the study will be respected with no coercion or prejudice.

Please complete the enclosed survey within five days and return it in the self-addressed, stamped envelope provided. Thank your for your attention in this matter.

Sincerely,

Donna Juleff

Note: Questions or concerns about participation in the research or subsequent complaints should be addressed first to Donna Juleff or Dr. Chuck Barnard (research advisor) and second to Dr. Ted Knous, Chair, UW-Stout Institutional Review Board for the protection of Human Subjects in Research, 11 HH, UW-Stout, Menomonie, WI, 54751, Phone (715) 232-1126.

Family Solutions Associates
1707 Main St., Suite 236
LaCrosse, WI 54601

CLIENT SATISFACTION SURVEY

Demographic: Please mark the category which best describes you situation.

1. Who referred your family to our agency?
   _____ Human/Social Services _____ School System
   ____Court System ____ Other

2. The placement of your child at the time of the referral was:
   _____ In the home _____Foster/group care _____Relative care
   _____Other (describe)

3. The placement of your child at the end of services?
   _____In the home _____ Foster/Group care _____ Relative care
   _____ Other (describe)

Evaluation

Please circle the response that most accurately reflects your experience.

1. The Family Solutions Associates Therapist who came to my home was.

   5. very helpful
   4. mostly helpful
   3. somewhat helpful
   2. not very helpful
   1. not helpful at all

2. The therapist scheduled appointments that were.

   5. very convenient
   4. mostly convenient
   3. somewhat convenient
   2. not very convenient
   1. not convenient at all

3. The therapist listened to and understood my situation.

5. all of the time
4. most of the time
3. some of the time
2. not very often
1. not at all

4. I could depend or rely on the therapist when I needed him/her.

5. all of the time
4. most of the time
3. some of the time
2. not very often
1. not at all

5. The problems, feelings or situation that brought me to the therapist are:

5. much improved

4. improved

3. some of the time

2. worse

1. much worse

6. Because of the services, I understand the problems well enough to manage them in the future.

5. strongly agree
4. agree
3. not certain
2. disagree
1. strongly agree

7. Would you recommend this service to someone in a similar situation or to someone who had the same problem?

_____ Yes I would recommend _____No, I would not recommend

If no, why not?

Appendix B

Family Solutions Associates

In-Home Counseling Program Description

There are times when outpatient therapy is inappropriate or insufficient to meet the needs of families in crisis. In-home counseling serves the entire family in the home setting to work on difficult issues that they face. Counseling is tailored to fit the needs of the individual as well as the needs of the family. Therapy is provided for a wide range of issues. These issues include: abuse, domestic violence, self-esteem, blended families, assertiveness, behavior management, stress reduction, depression, anxiety, anger management, communication, delinquent behavior, and personal relationship counseling. In-home counseling allows the convenience to deliver services to families that may not receive services due to a lack of transportation or other conditions that make outpatient therapy difficult for families to maintain.

In-home Counseling can aid in preventing an out of home placement for a child at risk. Advantages of this approach include: the ability to observe interaction as it naturally occurs, provide guidance and modeling of appropriate behaviors, and lends a comfortable, supportive environment that allows clients to take risks and receive feedback.

In-home counseling is an effective service when reunifying previously placed children back into the family home. A common concern of county agencies is the difficulty of maintaining improvements in a child after a successful placement. Children often return home to parents and families ill equipped to provide nurturing yet structured environment. Families also often have issues that have not been addressed adequately. In-Home Counseling can help families work on strengthening their communication, address areas of concern and help families make healthy choices for themselves.

During the first two weeks of intervention, information is gathered concerning pertinent family and individual history, previous interventions, support systems, and family interaction. The family is asked to participate in several exercises to aid in gaining an understanding of the family's strengths and needs. The referring agency receives a copy of the report including the results of the Circumplex assessment, family Genogram and treatment plan.

A treatment plan is developed using the information gathered during the assessment phase. It is devised with goals and indicators of success with input from the family, social worker and counselor. The treatment plan is updated every 90 days with documentation of any progress and any additional goals that are necessary to resolve issues the family may be experiencing.

On-going communication, both written and oral, is maintained between the in-

home counselor and the referring social worker. Social workers can expect copies of all reports in a specific time frame based upon the length of involvement with the family. Social workers can also expect to have oral reports from the counselor every two weeks to update them on progress the family is making. The referring worker will also be informed of any concerns or crisis that the family may be experiencing within 24 hours of receiving the information. Meetings with the family and social worker are conducted every three months to help reassess future needs for continued services.

As Family Solutions Associates is a certified clinic, reimbursement will be available through Medical Assistance, insurance, County funding and private pay.

Services are delivered by either a Master's or Bachelor's degreed counselor, or both, in cases involving families receiving Medical Assistance. Although individual family needs vary, treatment duration averages 2-6 hours per week for approximately 6-8 months. Services for Medical Assistance cases are limited to a maximum of one year.