CONSUMER SATISFACTION AS AN ASPECT OF CLINICAL EVALUATION: ITS APPLICATION IN A FAMILY TREATMENT PROGRAM

A PRACTICUM

PRESENTED TO THE FACULTY OF GRADUATE STUDIES

IN PARTIAL FULFILLMENT OF THE REQUIREMENTS

FOR THE DEGREE

M.S.W.

UNIVERSITY OF MANITOBA

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APRIL 1988

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ISBN 0-315-47954-X

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BY

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A practicum submitted to the Faculty of Graduate Studies of the University of Manitoba in partial fulfillment of the requirements of the degree of

MASTER OF SOCIAL WORK

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ACKNOWLEDGMENTS

I am very appreciative of the assistance and guidance provided by my advisor, Barry Trute throughout my graduate studies and in particular throughout this practicum experience. I am also grateful for the contribution of the other two members of my practicum committee, Linda Campbell and Chris Cassels. It was a tremendously valuable experience for me to work with all of you during the last year.

I also want to extend a thankyou to the therapists of the Family Therapy Department of Children's Home of Winnipeg for their interest and help with the consumer feedback survey. Thanks also go to Marge Pauls for all her work in assisting me with the sample selection and mail-out.

Finally, to all my friends, colleagues and family, and especially to my husband, Earl, I owe a special word of appreciation for their constant encouragement and support throughout my studies.

TABLE OF CONTENTS

INTRODUCTION..... 1

PART I LITERATURE REVIEW..... 4

Clinical Evaluation and Social Work Practice.... 4

Family Practice and Evaluation..... 24

Consumer Satisfaction: The Client's Viewpoint... 29

PART II THE PRACTICUM..... 59

Proposal..... 59

The Site..... 60

Procedures..... 61

PART III METHOD AND FINDINGS..... 68

Method..... 68

Findings..... 70

PART IV DISCUSSION AND RECOMMENDATIONS..... 77

PART V REFLECTIONS ON THE PRACTICUM EXPERIENCE..... 84

REFERENCES..... 87

APPENDIX A..... 99

Client Feedback Form
Brief Family Assessment Measure
Family Problem List
Cover Letter and Precontact Letter

INTRODUCTION

The increasing call for accountability of human service programs from funders and consumers of services and the recognition within the professional community of the desire to build theoretical frameworks and practice skills on more empiracally-based knowledge has underlined the need to build more systematic evaluative efforts into the practice of social work in agency settings. The demand to evaluate the effectiveness of clinical practice is a frequent theme in the literature. The manner in which this process can effectively be fashioned into agencys' systems and social workers' practices has been less well documented. Clinical evaluation requires practitioners to weave into the helping process a way of assessing outcomes and documenting process essentially in order to be able to answer the question "what kind of treatment helped what kind of people with what kind of problems according to what criteria?"

This document is an account of a social work practicum during which I was able:

a) to study the issues regarding clinical evaluation and its application in practice settings; in particular family-centered practice settings,

b) to be an observer and a participant in a process of

designing and implementing an ongoing evaluation strategy to aid in the evaluative efforts of a family therapy department of a private agency,

c) and to specifically focus my studies on the issue of consumer satisfaction and its application as one measure used in the evaluation of family treatment by implementing a study of consumer feedback for the family therapy department as part of its overall evaluative strategy.

Part I of this report will provide an overview of the current literature regarding the issues of clinical evaluation; its relevance and application to social work practice and the special considerations involved in evaluation of family practice. The primary emphasis of the literature review, however, is regarding the question of including the consumers of human services in their evaluation. Generally, consumer satisfaction surveys have been the method of choice for obtaining the viewpoint of clients about the services they received. The meaning of satisfaction, the utility of satisfaction measures, methodological considerations and the application of such measures in an ongoing way in agency settings are some of the issues reviewed. Most of the work that has been done in this area has generally been in the health care and community mental health fields. I attempted in my search

of the literature to locate work that specifically pertained to social work settings and family-centered treatment.

The remainder of the document reports on the practicum experience itself. Part II provides a description of the practicum proposal, site and procedures. Part III reviews the method and findings of the consumer feedback survey and Part IV discusses the findings and provides recommendations for future efforts in this regard. In the final part of this report, Part V, I reflect on the practicum experience in relation to my learning goals.

PART I

REVIEW OF THE LITERATURE

Clinical Evaluation and Social Work Practice

There are many who argue that an effective system for the delivery of human services needs to be supported by an equally effective system for the evaluation of those services (Selig et al, 1981). The literature concerning the evaluation of clinical practice clearly illustrates the necessity of social workers to have the ability to demonstrate the effectiveness of their work (Trute, 1985; Bloom & Fischer, 1982). Bloom and Fischer (1982) regard this as "the essence of successful practice" (p.16).

According to a standard social work practice textbook of the 1970's, "evaluation should be a continuing activity throughout the planned change process" (Pincus & Minahan, 1973; p.273). Evaluation of the helping process is understood in this context as not only a task completed at the end of the helping process, but as one element of the helping process itself. More strongly stated by Powers and his colleagues (1985), evaluation is an integral part of the helping process which should be "woven throughout the fabric of the entire process" (p.33). Trute (1985) explains that "...evaluation issues emerge from initial problem definition..." including the "...various decisions made in regard to treatment alternatives, conclusions reached in

regard to treatment outcomes and plans or directives offered for future disposition of the client system" (p.100).

Duehn (1985) compares the methods and modes of thought of social workers in approaching their clinical work to those of researchers in undertaking a study. He identifies the similarities in method to be:

a) problem identification, definition , specification
b) generation of alternatives, selection of stategies for problem solution
c) implementation of strategies
d) evaluation of implementation

He adds that "in the ongoing process, the four phases are not separate entities, but interconnected parts of a cycle which blend together." (p.20). The basis of effective practice, as Corcoran (1985) descibes is the connections between the elements of practice - assessment, intervention and evaluation. The association with research methods provides clues to the process of evaluation within these connecting elements. The essential point is that evaluation is as much a part of social work practice as assessment and intervention.

The growing call for accountability by funders in all human service endeavors underscores the ethical reasons for

systematically evaluating outcome as well as the need to advance knowledge in clinical practice (Trute, 1985). The social worker is firstly accountable to his/her client for the outcome of the planned change effort (Pincus & Minahan, 1973). It is also argued that social workers have an ethical obligation to develop empirical foundations for their interventions (Siegel, 1984). Siegel maintains that "practioners have little right to intervene in clients' lives on the basis of mere faith that good is being done... they have a moral obligation to monitor and test empirically the effects of their intervention" (p.325). The importance of evaluation is highlighted by Gurman (1983) when he cites Bergin's observation that "...it is one of the anomalies of the behavioral and psychiatric sciences that methods of intervention can still be invented, used and paid for by the public without a shred of evidence to demonstrate efficacy and absence of harmful effects" (p.229).

Pincus and Minahan (1973) contend that the better the practitioner does in documenting the results of his/her work in each case, the easier it will be to conduct needed research. Large number of cases provide the basis for making generalizations about social work interventions. It is necessary to start by measuring change in individual change efforts.

Treatment evaluation, as defined by Tripodi and Epstein (1980), focuses on evaluating the effectiveness and efficiency of a single social worker with a single client system. This is contrasted to program evaluation, which attempts to evaluate the effectiveness and efficiency of whole programs within the agency. They point out that program evaluation and clinical (treatment) evaluation coincide when the results of the work of more than one social worker and/or treatment outcomes with more than one client system are aggragated and analyzed.

Although the importance of clinical and program evaluation has been advocated, Mutschler (1984) maintains that there is very little actually known about the utilization of evaluation on the direct service level because administrative and policy decision making have traditionally been the focus of evaluation efforts. Additionally, Powers and his colleagues (1985) suggest that "...of all the functions involved in the problem-solving process, evaluation is the one most frequently disregarded by practitioners" (p.33). They contend that, in general, clinicians view evaluation with skepticism and as a necessary evil forced on them usually by external forces. Skill development historically did not focus on this aspect of practice. As well, social workers were not given the

tools to be consistent and systematic in the evaluation of their work (Fischer, 1981). Trute (1985) also points out that evaluation of clinical practice has been poorly conceptualized and not applied in any systematic way. Social work has tended to concentrate more on discovering the best methods of practice (that is, assessment and intervention skills) and has shown less concern with the products of practice (Raymond, 1985).

Thus, even though the theoretical basis of standard social work practice includes evaluation as an essential component of the helping process, it has been given less importance in the "real" world of practice settings. Systematic evaluation was viewed as a research task that was carried out by specialized personnel quite apart from ongoing social work practice. Raymond (1985) points out that, typically, practitioners use qualitative measures such as supervision to evaluate their work. Corcoran (1985) contends that they should be now adding systematization and specificity to their evaluative efforts.

In 1981, Joel Fischer wrote about what he saw as a "revolution" in social work. He descibed it as "...a revolution in the way social workers view knowledge and practice and in the way they use knowledge to conduct practice" (p.199). Duehn (1985) describes this revolution

in terms of a major paradigm shift which urges social workers to rigorously analyze their practice activities using research methods. This approach differs from conventional research, in that the primary aim is to serve client needs rather than to increase knowledge (Crane, 1978). It is also different from conventional clinical practice, in that the clinician uses methods and standards derived from research in data collection and assessment.

This paradigm has been given different names including: scientifically based practice (Fischer, 1981), informed practice (Powers et al, 1985), empirically based practice (Siegal, 1984) and the practitioner/researcher (Duehn, 1985). Within this paradigm, no matter what the title, methods borrowed from research are explicitly incorporated into clinical practice activities. "Thus the processes cease to be similar and become one, as practice activities are directed, monitored and evaluated by the standards and methods of scientific inquiry" (Duehn, 1985, p.44).

Welch (1983) details this trend in social work education in the attempt to integrate research methodologies and clinical practice. He sees three reasons for this trend: one is the growing recognition of social work educators of the importance of teaching practice approaches which have some degree of empirical validation in addition

to the need to evaluate the outcome of social work interventions; the second reason is the recognition that in the "age of accountability", there is the demand for agencies and the social workers they employ to demonstrate their effectiveness both as a professional requirement and as a necessity for funding sources thus requiring social workers to learn the skills to evaluate their practice; and the third reason has to do with the development of the technology to engage in systematic clinical evaluation (in particular, single system designs which take into account the individualized nature of social work).

The importance of the development of single system designs in the potential to integrate research into practice is illustrated by Fischer (1981). He claims that the advantages of single-system methodology for the clinical social worker are:

a) the design can be used by every practitioner with every case
b) it can be designed by the practitioner to be used for the practitioner's and individual client's benefit
c) it can provide crucial information to assist with assessment
d) it allows monitoring of progress with all cases
e) it can provide feedback about whether or not an

an intervention is working, thus allowing the practitioner to make changes in the intervention if needed

f) it focuses on the individual system so that variations in effects of interventions can be seen from individual to individual

g) it can provide a format for establishing accountability to clients, agencies and communities.

There is an apparent compatability of single system designs with the social work practice process (Zimbalist, 1983; Corcoran, 1985; Fischer, 1981; Bloom & Fischer, 1982). It is Corcoran's assertion that the core components of single system research methodology essentially delineate good social work practice. "Single system designs basically refer to the repeated collection of information on a single system over time" (Bloom & Fischer, 1982; p.8). The system can refer to an individual, a family, a group or any collectivity. Bloom and Fischer (1982) provide a summary of the basic components of single system designs: specification of the problem; measurement of the problem; the repetition of measures; the forming of a baseline measure; arrangements for collecting the data; a clear definition of the intervention; and analysis of the data. Welch (1983) considers the wide potential applicability of the designs makes them useful to practitioners of diverse

clinical orientations. Thus, the single-system design is viewed as a functional tool for social workers which should be able to routinely be incorporated into practice settings without causing undo alteration of the social worker's method of practice. To reiterate, research and practice reflect parallel methods of problem solving and include similar activities (Siegel, 1984).

In advocating for the application of this methodology in practice, Powers and his associates (1985) maintain that single system designs are easy to integrate into standard direct service treatment. They suggest that clients can benefit from their participation in the research component of treatment. Rather than interfering with treatment, they believe that the additional focus on the collection of evaluative data by the client can enhance the progress of the case. Another advantage is that single systems designs are usually preferred by practitioners over large-group designs because they are more easily understood. By illustration they point out that "while agency decision-makers want to know how all the clients are doing on the average, practitioners are more interested in knowing how each individual client is doing with the specific treatment he/she is getting" (Powers et al, 1985, p.217).

Although single system methodology is advocated to be practical and useful in clinical practice and clinical evaluation, there is very little evidence to indicate that evaluation methods are occurring in the mainstream of social work practice (Siegel,1984). As Welch (1983) observes, there appears to have been more promise than performance in the development of the "empirical clinician". Studies indicate that social workers with training in clinical evaluation methodology do not maintain the use of these designs in clinical practice in the agency setting (Welch, 1983; Kelly, 1982; Briar & Blythe, 1985). It was believed that if social workers were "sold" on the utility of systematic evaluation methodology and they learned the necessary skills for application to clinical practice, that practice evaluation would increase (Briar & Blythe, 1985). What this proposal overlooked were the multiple demands that agencies and clients place on social workers (Fuller & Lovelock, 1987; Briar & Blythe, 1985; Welch, 1983).

Ivanoff and his colleagues (1987), in their review of the debate about empirical clinical practice, note that the early literature on single case evaluation designs (1975-80) strictly focused on methodological rather than practice issues. The guidance in the literature was scant for those practitioners who wanted to apply the methodology to the

"multi-problem, complex client situation" in "hectic and harried service settings" (Ivanoff et al, 1987, p.294).

Other factors are raised by Meyer (1984) regarding the difficulty of integrating research and practice which she feels contributes to the problem. Although agreeing that social workers should be accountable to their clients, their agencies and their profession, she disagrees with what she views as an emphasis on "effectiveness" as a substitute for other measures of accountability. She argues that "the preoccupation with effective practice (and effectiveness defined in such a way that it could be counted) surely has left its mark on practitioners who have been willing to be tested by many criteria as being accountable, but who have been tentative about subjecting themselves to tests of effectiveness"(p.323). It is her thesis that effectiveness may be an unrealistic expectation for social workers who deal on a daily basis with problems which may indeed be intractable. She argues that social workers should always be accountable for what we do even though we may not always be effective.

Another issue which Meyer raises, which speaks to a possible reason for the paucity of ongoing clinical evaluation in social work settings, is the emphasis in the literature on the application of single system designs in

practice which is behavioural in focus. The methodology as generally utilized appears to require a narrow definition of problems and specification of variables which she believes only behaviourist practice can provide concretely. Meyer argues that "it is all but impossible for practitioners who work in different modes to participate in research" (1984, p.323). There is some support for Meyer's contention that the methodology may be more favorable to those clinicians with behaviourist leanings (Ivanoff et al, 1987; Corcoran, 1985).

Meyer's concern regarding the preponderance of the focus on effectiveness as a measure is an important one which really speaks to the issue of context. What is "effective"? This is a question which may have different answers depending on who you ask. Goldberg (1987) advises that it is imperative that the aims of a helping process be understood in the context of what is needed to achieve those aims and by what criteria the achievement of those aims will be assessed. As Lebow (1982c) points out "...good treatment does not necessarily produce positive outcomes" (p.1013). Outcome is of necessity a major consideration in the evaluation of services (outcome meaning a description of the ways the problem or situation is different at the end of the provision of services in relation to the

beginning of the helping process) (Pincus & Minahan, 1973). However, Tripodi and Epstein (1980) suggest the need for caution in the interpretation of outcomes. They stipulate that it is essential, no matter what the outcome, not to be purely mechanical in its interpretation. Outcome should always be considered in light of the clinician's common sense and practice experience. The interpretation of effectiveness, then, does not necessarily need to be rigidly defined "in such a way that it could be counted" as Meyer (1984) puts it (p.323). The proponents of systematic evaluation in clinical practice emphasize the documentation of client change as just one piece in the clinician's assessment of the outcome of a case (Ivanoff et al, 1987).

Related to this issue is the concern that evaluation methodology applied to the "real" world of practice is difficult to incorporate and may actually interfere with practice. Bloom and Fischer (1982) respond to this concern by advising that evaluation should be considered secondary to the practitioner's primary task of provision of service. They state that they "view the research and evaluation arena as secondary, not as a master of practice, but as a guide to practice" (p.22). According to Ivanoff and his associates (1987), there is more attention being paid in recent years to the integration of empirical techniques to

direct practice. The focus is not on adapting practice to research methodology, but rather, on adapting research methodology to direct practice. They provide illustrations of flexible design options used in practice settings which complement traditional assessment methods and are based on function rather than form. They call for social workers to be innovative in drawing what they can from single system methodology and suggest that different situations will require different approaches. Situations they refer to which require innovative approaches are settings which provide one-shot interventions in which outcome goals are not defined as client change over time or environmental interventions where the focus of change is on the ecological system of the client.

There is agreement that more work needs to be done before practitioners with a nonbehavioural focus can participate fully in empirical clinical practice (Ivanoff et al, 1987; Nelson, 1981; Corcoran, 1985). Although there are those who argue that the methodology is value free and can be applied to any practice orientation, it is also pointed out that "the application of single-case methodology to other theoretical orientations (other than behavioural interventions) lags significantly" (Ivanoff et al, 1987). The problems are related to the perceived need for the

specification of problems and goals in such a way that they are measurable in a systematic way; which is considered to be more adaptable to more behavioural kinds of practice. The special methodological issues for non-behavioural clinicians are addressed by Nelson (1981) and Corcoran (1985) who attempt to provide strategies for evaluation of non-behavioural interventions. More thoughtful consideration of measures for assessment, a multifactorial approach to assessment and flexibility of design and implementation are taken into account.

In addition to the debate about the practice issues involved in the application of systematic evaluation procedures (which may account for the difficulty with the integration of evaluation and practice), it has been suggested that agencies may not be providing the support which is required to engage in clinical evaluation (Powers et al, 1985; Briar & Blythe, 1985). Powers and his associates (1985) advocate for agencies to acknowledge and encourage the functional role of clinical evaluation and support practitioners in their efforts to be systematic. Trute (1985) has also raised the issue of the need to create a supportive agency environment. A thoughtful strategy is required to engage clinicians' committment to evaluation. As well, training is required in the acquisition of skills

and competence in systematic assessment. The importance of involving clinicians in the design and implementation of a clinical evaluation strategy is emphasized by many authors (including Trute, 1985; Briar & Blythe, 1985 and Mutschler, 1984) and would need to be recognized by agencies which are considering initiating ongoing evaluation procedures of clinical practice.

In order for agencies to facilitate case-specific evaluation, Briar and Blythe (1985) point out that it will be necessary for agencies to also consider the time element involved for practitioners to utilize outcome measures. Surveys of practitioners trained in the methodology of case-specfic evaluation suggest that a major barrier to this type of evaluation is lack of time. Time is required outside of direct contact with clients for data collection and assessment. In a study conducted by Welch (1983) it was discovered that social work graduates, who were trained in this methodology and believed in its utility, did not maintain its use because the time and effort required to do this work was not acknowledged by their agencies. It is also suggested by Briar and Blythe (1985) that agencies should consider the expansion of their management information systems to help facilitate the gathering and assessment of systematic information.

By creating the environment to facilitate the evaluation of clinical practice on a case by case basis, agencies can develop an outcome evaluation system which according to Hargeaves and Attkisson (1978) can provide ongoing program monitoring (through management information systems, global measures of client change and measures of client satisfaction) which can assist in the demonstration of program effectiveness. They propose that one way for an agency to argue for the effectiveness of a program is their ability to point out the extent to which the monitoring of client change is a regular part of program management. This suggests the tie-in between clinical evaluation by the individual social worker and overall program effectiveness evaluation.

It was mentioned earlier that there is very little in the literature to guide agencies and clinicians in the development of direct service evaluation strategies and their incorporation into practice on an ongoing basis. One study which focused on this issue, however, is one carried out by Mutschler (1984). She describes an on-the-job training project in a family service agency in which practitioners were trained to use a range of single system evaluation procedures. The procedures used were intended to be used for collecting assessment information,

for comparing client's and worker's perceptions of problems, for the planning of treatment interventions and for evaluating the outcome of treatment. Mutschler identified several factors which influenced practitioners' ability to apply evaluation procedures. The factors which she identified are illustrative of the many issues involved in attempting to establish ongoing clinical evaluation procedures in practice settings. The factors included:

a) the relevance of the measures and the design for data collection to the clinical service that was being provided and the ability to use the information collected in a way that was pertinent to the practitioner's interventive strategies. The measures needed to relate to the theoretical base of interventions employed as well as provide information in a manner to which the practitioner could ascribe clinical meaning. Multiple baseline and reversal designs were viewed as interfering with service objectives; pre-post design were considered the most applicable in a direct service setting.

b) the utility and practicality of the instruments used. Those that were found most useful by practitioners were easy to complete, did not take much time to complete, facilitated the assessment phase and were clinically useful (for example, they helped the client see the

situation and/or change in a different way). Mutschler points out that "...only evaluation procedures providing information and guidance for one or more phases of the treatment process were subsequently integrated into the day-to-day practice of the social workers" (p.355).

c) the involvement of practitioners in the design and implementation of evaluation. It was the practitioners who critically tested the applicability of the measures and selected the instruments to use. It is Mutschler's contention that initial negative or neutral attitudes toward the utility and application of evaluation procedures can be influenced through the collaboration with practitioners regarding the evaluation strategy.

d) the organizational context of the evaluation. The appropriate organizational structure for practice evaluation has to be in place in order for procedures to be effectively incorporated into clinical practice. In her study, Mutschler found that the agency made few organizational changes in order to facilitate systematic evaluation procedures for all clients. For example, although follow-up after termination was considered important, the agency provided no procedure for this and additionally, no recognition was given for the time involved for workers in evaluation efforts. Thus when

her project was finished, only those procedures requiring the minimum amount of time were continued to be used by workers. Mutschler also recognized the necessity for organizations to have computerized information systems in order to support direct service evaluation efforts.

To summarize this section, evaluation is viewed as an essential component of social work practice which is receiving more attention in recent years, in part, because of the need to be able to demonstrate the effectiveness of human service programs to the people who fund them. The profession is trying to combine research methodology and clinical practice in such a way that evaluation can be done more systematically and in a manner that has benefits not only for the organization, but for the practitioner as well in his/her efforts to assess and intervene with clients. The complexities and difficulties involved in this process were highlighted and underscore the need for an adequate organizational framework to support systematic evaluation in direct service settings. There is also the recognition that human problems can only be judged in relative terms (Powers et al, 1985) and that systematic evaluation is a tool which can help monitor the helping process and provide information about outcomes, but only within the context of many variables and in the hands of the practitioner.

Family Practice and Evaluation: A Special Challenge

The evaluation of family-centered practice does present special challenges which need to be considered. These center on the particular difficulties of assessment and measurement. Work with families requires an interactive, systems-oriented focus. Families are viewed as an open system in which exchanges of energy and information are transacted both within family boundaries and beyond these boundaries. "Total family functioning, therefore is multi-aspected and interdependent in both the number and dimension of transactions and occurs simultaneously with subsystem levels of activity" (Forman & Hagan, 1984;p.2). The assessment of family functioning from this viewpoint obviously becomes much more of a complex process than with a focus on the functioning of one individual. Concentration is given to inter-personal transactions and communication which is viewed as a means by which relationships are defined (Klein et al, 1980). Intervention is usually focused on altering family systems interactions. Evaluation of family systems practice, which must follow from this conceptualization of family functioning and family treatment, is therefore complicated by the complexity of the assessment and interventions. The systemic viewpoint pervades family assessment and concepts of change. The challenge is to capture that viewpoint in a way that is

consistent with the theoretical foundation and which can be used as a measure by which to evaluate change.

As in other areas of the human services, the bridging of research with theory and practice has generally been lacking in the family practice field (Olson et al, 1980). Ten years ago, Briar and Conte (1978) reported that most of the published material concerning family therapy consisted of basically "show and tell" essays with no empirical backup. One of the major problems impeding the evaluation process, they noted, was a serious lack of adequate outcome measures. Clinical experience and theory development was seen to have outpaced the development of appropriate assessment tools (Fisher, 1982; Rabin, 1981). Forman and Hagan (1984) add that assessment of families has typically been based on "clinical acumen and judgement" while efforts at obtaining more objective data has been confined to fragmented efforts. Reasons for the lack of appropriate assessment tools is related to the difficulty in clarifying the conceptual dimensions that are important for assessment. Appropriate assessment tools need to be able to evaluate clinically relevant concepts, be practical for use in clinical settings and adequately capture the complexities of family systems (Olson et al, 1980).

There has been a development in the design of family

inventories, in recent years, which can be used for assessment and evaluation purposes (Schumm et al 1985; Shields, 1986). Trute (1985) and Forman and Hagan (1984) provide a review of these standardized instruments, their psychometric properties and potential uses for research and practice. The Family Assessment Measure (developed in Canada by Skinner, Steinhauer and Santa-Barbara), the Family Adaptability and Cohesion Evaluation Scales (developed by Olson, Bell and Portner), and the Family Environment Scale (developed by Moos) are examples of some of the inventories which capture the family's perspective of family functioning. These measures are designed to assess the entire family system or at least those dimensions theorized to explain a significant portion of the activity of the family as a unit (Forman & Hagan, 1984).

There is considerable support in the literature for the use of multiple measures for assessment and evaluation purposes in family systems practice (Trute, 1985; Lebow, 1981; Sprenkle & Piercy, 1984; Olson et al, 1980; Crane, 1985; Jacobson, 1985). It is reasoned that multiple perspectives and multiple criteria are necessary to tap all the domains which are influenced by the treatment process. Lebow (1981) concludes in his consideration of the complexity of the evaluation task that, "just as family

systems views have transcended traditional linear views of causation in families, it seems appropriate to move at this time to a systemic view in outcome research" (p.185). In addition to the assessment of the family system from the family's perspective, Trute (1985) also discusses other measures which can be used including, problem checklists or rating scales which can provide information about the family's immediate concerns or presenting problems or goals, ratings of family functioning from the therapist's perspective, and measures of family satisfaction with treatment.

When multiple measures are used with multiple "players", the challenge becomes one of determining which measures to use as the primary criterion for the evaluation of outcome (Trute, 1985; Lebow, 1981; Kniskern, 1985). There is some debate about this in the literature. Jacobson (1985) argues that the primary outcome measure is the most direct possible measure of the presenting problem while Kniskern (1985) points to change in family patterns of interaction as the primary criterion. Trute (1985) suggests that clinical judgement be used when deciding which measures to use in the evaluation of family change and which to exclude.

The literature is generally lacking in guidance for

family practitioners and family service agencies to aid them with the incorporation of ongoing treatment strategies into their work. Although there has been several reviews of the outcome literature in family therapy (catalogued by Kniskern and Gurman, 1981), these have focused primarily on controlled research which uses experimental designs deemed impractical for use in family practice settings (Sprenkle & Piercy, 1984). Rabin (1981) points out that outside of the behavioural literature, the family therapy literature shows few examples of the use of single system evaluation designs with families.

Trute (1985) provides one of the few discussions of the issues involved and guidelines for family service settings which want to incorporate evaluation procedures into clinical practices. Regarding the selection of measures, Trute cites the directions offered by Cromwell who suggests that measures should be chosen which are: consistent with the interventive paradigm employed in the practice setting; practical in terms of ease of administration and scoring, time and impact on the clinical process; sensitive to transactional change over time; have adequate generalizability and be appropriate to the family's situation. In addition to choice of measures, Trute provides suggestions for timing of data collection and

considers the contextual issues involved in the evaluation of family therapy. As in any direct service setting which wants to monitor treatment, family practice agencies must also be cognizant of the environment they create to support the process of clinical evaluation.

In family treatment, the practitioner is thus faced with a more complex task of evaluation which encompasses numerous variables and which requires a multidimensional conceptualization of assessment and outcome. Measures of family functioning are fairly new and their use in clinical settings as assessment tools and indicators of family change is not extensive. There is thus little to guide the family practitioner in the clinical use of these and other outcome measures. Innovation and clinical wisdom will need to prevail.

Consumer Satisfaction: The Client's Viewpoint in Evaluation

The consumer of human services is thought to provide an essential perspective to the process of evaluating those services (Lebow, 1982a; 1983a). The history of the use of this data source will be explored in this section as well as the many issues involved in using the feedback of clients in the evaluation of direct service and the pragmatics of such a process. The opinion of the client

is usually sought in the form of determining their satisfaction regarding their experience of the helping process. There are a number of questions which emanate from this including: what meaning can you give to client satisfaction?; what are the determinants of satisfaction?; what is the relationship between client satisfaction and outcome - have you helped if the client does not feel helped?; are satisfied clients those that are helped the most?; what is the relationship between expectations of service and satisfaction?; how do you measure satisfaction?; for what purpose do we elicit consumer opinion? and is there a sound rationale for wanting the delivery of human services including therapy services to be responsive to consumer opinion? It is issues related to these questions which are addressed in the literature.

Rationale and Background of Consumer Feedback

Much of the work regarding "consumer satisfaction" has come from the medical field and the mental health field. According to Rehr (1983), it was in the 1960's that there was the first acknowledgement of the patient as a "consumer" of health services. It was during this period that the designation of "patient" changed to "consumer". With this connotation, the patient is perceived, not only as a recipient of care, but as one who is a purchaser of services

either directly or indirectly.

Morrison (1979) advocates that there should also be a "consumer-oriented" approach to psychotherapy. This perspective brings into sharper focus the role of the client as a consumer and evaluator of therapy. He maintains that this approach emphasizes the reciprocity in therapy between client and therapist, the client's role in the therapeutic process and as well, the rights of the client. The consumer of therapy is considered to be as much a chief actor as the professional in the interactive process between them (Rehr, 1983). The logical consequence of this perspective is to involve clients regularly and systematically in the evaluation of services of which they are a part (Morrison, 1979). Rehr (1983) notes that to recognize the client's point of view does not mean that it should stand alone as a judgement of service; it just recognizes that the recipient of services should be included along with other perspectives.

Within the field of social work, Rehr (1983) cites the plea of Alice Overton in 1960, who urged social workers to turn to their clients to learn what they had to say about what was beneficial and what was not as a means of improving services. This same plea was repeated by Anthony Maluccio (cited by Berkman and Weissman, 1983) when he states:

"Obtaining the views and insights of those we help is an essential means of critically examining our practice in refining our knowledge and skills. If we allow ourselves to learn from clients, we may well be able to enhance our own competence as well as theirs" (p. 228). In a similar vein, Pincus and Minahan (1973) make this assertion: "If social workers see clients as consumers of their services, as people who have valid opinions and points of view, they will seek out their opinions and suggestions on ways of improving the agency and its services" (p.277). Without feedback from clients, it has been suggested that an agency can lose sight of the degree to which it is meeting its goals and its actual usefulness as perceived by its consumers (Selig et al, 1981). There is thus a sound rationale for viewing clients as consumers in the field of social work practice and for seeking out their opinions.

In the fields of health and community mental health, patient satisfaction with treatment has received a fair amount of attention. Locker and Dunt (1978) see a connection between the development of an emphasis placed on consumer opinion in health care evaluation and a development of theories about interpersonal relations in the field of sociology. The practitioner-patient relationship became an area of interest for study and the patient's point of

view was sought out. At the same time (late 60's, early 70's) there was an increasing involvement of the "consumer" in many walks of life commonly referred to as the consumer movement.

In the mental health field, the emphasis on consumer opinion did not occur until the late 70's although consumer opinion studies appeared occasionally in the 60's and early 70's (Heath et al, 1984; Lebow, 1982b; Sorensen et al, 1979). As in the health care field, many authors point out that the increase in the direct involvement of consumers in the evaluation of community mental health services coincided with the rising consumer movement (Giordano, 1977; Lebow, 1982a; Levkoff & Shane, 1979; Margolis et al, 1977). In the United States there was also legislation for a time which mandated the study of the acceptability of treatment by patients which resulted in a marked increase in these types of inquiries (Lebow, 1983a; Larsen et al, 1979, Windle & Paschall, 1981).

In 1977 Peggy Giordano commented that the viewpoint of the consumer of social service agencies was rarely taken into account. There appears to be a shift in this perspective, for as Elaine Martin (1986) writes, "there is an increasing awareness of the value and importance of involving consumers in the evaluation of human services"

(p.186). Martin puts forth two primary arguments to support the seeking of clients' feedback. She first argues that the consumer is a source of essential data about the experience of a service which is important information for service providers who are concerned about the acceptability and quality of care. She points to evidence of the incongruities between service providers and service consumers in regard to expectations and perceived effects of services as reinforcement for the importance of understanding the consumer's viewpoint. She proposes that the "acknowledgement of the inevitable limitations or biases of service evaluation by its providers points to extension of evaluation activities to include those on the other side of the transaction, even if they too must bring the limitations of their own perceptions to the enterprise" (p.185). Her second argument is that consumers have rights which include the right to have their opinions and preferences sought out and heard. As Ms. Martin states: "Discusssion about consumers' involvement in the evaluation of services must be seen in the context of broader trends towards consumer participation and action in public arenas and towards legal and administrative measures to protect the rights and interests of consumers" (p. 185). Poertner (1985) adds to this argument that public services should

produce satisfied clients or the community may be less willing to continue public funding; the public should be satisfied with services provided with public funds which Lebow (1987) refers to as community acceptability. Regardless of any possible flaws in these arguments, Poertner (1985) reasons that the idea of client satisfaction is appealing to the sensibilities of social workers and he considers it to be consistent with social work values.

Although the awarness of the importance of the consumer's viewpoint may have changed in the last ten years, Martin (1986) contends that the actual role of consumers in systematic evaluation research is still generally a very limited one. Giordano (1977) and Martin (1986) present similar discussions concerning the obstacles which they see are present to involving consumers in any effective or useful way in systematic research-based evaluations. They view the consumer as essentially powerless relative to human service organizations. Martin points out that the separation of payment from receipt of services weakens the position of clients in relation to the service provider. The needs of the client must be judged as appropriate for service by the provider. The services by their nature are individualized on the basis of client need and professional judgement. Clients are therefore

highly dependent on the professional's judgement and actions, for it is the professional who possesses the specialized knowledge. The weak position of the client is reinforced by their lack of choice in many areas of service and by shortages of services in high demand. There is thus a long-standing tradition of client dependence upon the decisions of human service providers and "unquestioning respect for professional expertise" (Martin, 1986; p. 186).

There is also resistance to consumer involvement in evaluation by human service providers who fear losing status and power and who assert that the client's perspective about the organization and/or services is likely to be clouded by his/her particular problem, thus discounting their opinion (Giordano, 1977). In relation to this is the concern that those who are not consumers of a service by choice (such as in areas of child protection and corrections) or who have limited capacities (such as mental retardation) would be difficult to include.

These obstacles also underscore the need to seek out consumer opinion. Consumers who make no direct payment cannot indicate their opinion of the service by withholding payment and if there are no other options they may be in no position to "take their business elsewhere". And for those compulsory participants in human services, it is not

possible for them to withdraw from the service as an indicator of dissatisfaction (Poertner, 1985).

Following from the discussion about payment of services, Martin (1986) makes an important point about "who is the consumer?". The identity of the consumer is not necessarily defined by who is paying for the service. It may be difficult for an agency to decide whether the consumer is an individual, a family, another agency or the local community. It raises important implications for deciding which consumer's opinions to consult and which consumer's rights to protect (Martin, 1986). There may need to be a distinction drawn between direct and indirect consumers of human service programs.

The Meaning of Satisfaction

What does consumer satisfaction mean? What criteria do consumers use to judge the help they received? One of the consistent problems with seeking out the evaluations of clients is with the interpretation of what the data really means (Giordano, 1977). Locker and Dunt (1978) note that little attention has been paid towards developing a well defined social psychological theory of satisfaction. They maintain that "it is rare to find the concept of satisfaction defined and there is little clarification of what the term means either to researchers who use it or to

respondents who report it" (p. 288).

There is no consensus in the literature on the identification of factors or dimensions of client satisfaction (Poertner, 1985). However, there is discussion about what satisfaction may represent and suggestions about on what expressions of satisfaction or dissatifaction may be based. It has been suggested that the degree of satisfaction indicated by consumers can be expressed as the degree of congruence between their expectations of a service and their experience of it (Martin, 1986; Gutek, 1978). "Satisfaction is not only the product of the quality of treatment, but also of the level of aspiration of the client" (Lebow, 1983c; p. 735). Martin (1986) thinks that consumers' expectations may be influenced by their own past experience of formal or informal assistance, their prior knowledge and image of a particular service, their conceptions of what forms of help might be possible or their feelings of self-worth.

Studies from the health field suggest that consumers' judgements about medical care are made on the affective responses of providers in relation to the expectations they hold (Rehr, 1983). Rehr maintains that it is in the area of techniques and skills couched in affective or expressed behaviours that consumers have expectations about and on

which they form opinions. Thus, it is whether the expectations a client has about how the therapist should behave are realized that determines how he/she judges "good care". (Rehr 1983).

Satisfaction may also be related to the extent to which the perception of outcome met the consumer's expectations (Locker & Dunt, 1978). There is no conclusive evidence to support this notion. Ihilevich and Gleser (1982) cite conflicting opinions about the interaction of satisfaction with the service and satisfaction with the outcome. Locker and Dunt (1978) report a study by McKay which found that 80% of clients, whose expectations of a service were fulfilled, reported satisfaction with the service. However, 50% of clients, who reported that their expectations were not fulfilled, also reported satisafaction. They conclude that the relationship between expectations and satisfaction is not necessarily a direct one but it is "...reasonable to suggest that expressions of satisfaction are the end product of a process of evaluation in which expectations figure to some extent" (p. 289).

Martin (1986) reports that there is evidence in the human service field that global judgements of satisfaction with services are influenced by positive feelings about particular practitioners rather than assessment of results

achieved by the service. Rehr (1983) cites evidence from the health care field which suggests that affective behaviour related to the mode of care is a major factor in satisfaction. Characteristics of physicians which indicated interest, devotion and time to give to patients were found to be more meaningful than technical or administrative procedures, such as waiting time, in the overall evaluation of service (Ben-Sera cited by Rehr, 1983).

Giordano (1977) refers to the work of Richard Tessler who examined the distinction between relationship-centered satisfaction (the client's sense of closeness to the therapist) and problem-centered satisfaction (the therapist's ability to help) and determined that consumers are able to distinguish between their satisfaction with service and their satisfaction with treatment outcome. Levkoff and DeShane (1979), on the other hand, found that consumers in general do not view the helping encounter as a multi-dimensional phenomenon. Rather, they argue that consumers tend to base their evaluation on a single aspect of the encounter (the interpersonal qualities of the service provider). Their thesis is supported by a study which they cite by Ware and Snyder who found that hypothesized dimensions of "caring" and "curing" emerged as a single factor in patients' assessments of their physicians.

Rehr (1983) maintains that the "mode" of service delivery is particularly meaningful to consumers. She does not view mode as a simple concept, but one that requires looking at the role complimentarity achieved between the consumer and the service provider. Role complimentarity refers to "the interlocking set of expectations and behaviours in interpersonal systems" (Maluccio, cited by Rehr, 1983,p.41). This returns to the issue of expectations and the achievement of a service contract (clarification of roles) on which the judgement of service can later be made (Rehr, 1983). Dallos and Aldridge (1986) consider the concept of change in a similar light. They suggest that a principal component of change is the process of negotiating what will count as change and how change will be recognized. They maintain that " unless both therapists and family have negotiated a common set of indices, then both sides can never be satisfied" (p. 55). Ihilevich and Gleser (1982) point out that although it is reasonable to expect that the consumer's understanding of the therapist's role in the helping process influences satisfaction, it is not certain to what degree this comes into play in the assessment of a service.

It is safe to say that the characteristics which define satisfaction in the consumer's evaluation of a helping

encounter are ambiguous. Service may be assessed in terms of function and/or relationship. The relative importance of function and relationship to the consumer may vary from service to service (Levkoff & DeShane, 1979). Consumers may hold different expectations about different aspects of the helping process and the extent to which satisfaction is derived from expectations, these assessments may change over time as expectations change (Locker & Dunt, 1978). Given the number of possible dimensions involved, Martin (1986), concludes that a high rating of consumer satisfaction could "...reflect a combination of low self-esteem, low expectations, ignorance of alternatives, and the view that the practitioner was a kind person" (p.190).

What confounds the understanding of satisfaction is the tendency for yea-saying in consumer satisfaction studies which is difficult to partial out and control (Ihilevich & Gleser, 1982). Studies of consumer satisfaction show results which are essentially positive about services received. Gutek (1978) found that people in general tend to respond positively to global questions related to satisfaction. Measures of global satisfaction appear to be subject to a number of response biases including acquiescence, social desirability and affect or mood (Gutek, 1978). Baker (1983) reports that although a

variety of methods and question types have been tied in research studies, the findings consistently indicate a high level of satisfaction regardless of the treatment or setting being evaluated or the client population doing the ratings. The divergent views about the meaning of satisfaction suggest the complexity of the issue and foretells the possible difficulty with attempting to assess it.

Value of Consumer Satisfaction

Despite the controversy surrounding the meaning of client satisfaction, Locker and Dunt (1978) suggest that consumer satisfaction studies have the potential to be used as evaluations of the quality of care; as outcome variables; and as indicators of which aspects of a service need changing. However, it is pointed out that studies of consumer satisfaction are not in themselves evaluations of the quality of care. "Data which reveal that 80% of patients are satisfied with a given service, are not evaluations but observations that can only be used as an indicator of quality if some standard is available, accepted as constituting a definition of quality, with which the observation can be compared" (Locker & Dunt, 1978, p.289). The data derived from consumer satisfaction surveys are thus indicators of quality only to the extent that they are

interpreted as such by service providers according to the standards they define as quality.

The relationship of consumer satisfaction to other measures of outcome is a matter of debate (Sorensen et al, 1979). Gutek (1978) reports that the use of satisfaction as an outcome variable has a long history in the organizational psychology literature (job satisfaction being a major area of study). She warns that client satisfaction will not necessarily be strongly related to "objective" measures of agency effectiveness. Consumers and service providers are considered to have different criteria for judging successful outcome (Edwards et al, 1978; Maluccio, 1979; Levkoff & Shane, 1979; Toseland, 1987). Maluccio (1979), in a study of client and worker perception of treatment in a family service agency, found discrepancies in the perspectives of clients and workers, especially in regard to satisfaction with outcome and assessment of clients' functioning. They generally concurred about the benefit derived from the service, but the clients were usually more satisfied than the workers about the outcome. Toseland (1987) also found a similar discrepancy between workers and clients in a study of the effects of treatment discontinuance on outcome. He argues that this supports the need to obtain clients' feedback regarding treatment and the importance of

examining treatment outcomes from multiple perspectives.

Another perspective on the issue of satisfaction and outcome has to do with the relationship between the two. Does good outcome produce satisfaction or does satisfaction produce good outcome? What place does satisfaction with the process have in regard to the eventual outcome? Satisfaction is considered to play an important role in determining whether a therapeutic relationship is maintained (Ihilevich & Gleser, 1982). Greenfield (1983) notes the importance of satisfaction in forging the helping alliance. Most approaches to therapy emphasize the importance of the therapeutic relationship. Gurman (cited by Jones et al, 1986) concludes that it is the client's perception of the quality of the therapeutic relationship that mediates change. In a study conducted by Jones and his colleagues (1986), they also found that client's perceptions of the quality of the therapy relationship were closely linked to treatment outcome (when outcome was judged from the client's point of view). Pinsoff (1986) in attempting to understand the therapeutic alliance, has developed scales which assess the client's perception of the alliance (the items are very similar to items on consumer satisfaction surveys). It is his belief that the client's experience of the alliance will be a far more potent predictor of outcome than the

therapist's. The discussion of the therapeutic alliance is beyond the scope of this report, but the work that is being done in this area points to the need to understand the perception of treatment by the client regarding both process and outcome.

Lebow (1982a; 1983c) also discusses the influence of satisfaction on the treatment process and ultimately on outcome. He reasons that utilization of a service and premature termination are in part a product of satisfaction and to the extent that treatment cannot occur without the presence of the client, minimal satisfaction is a necessary requisite for treatment success. Additionally he adds that, "because minimal satisfaction is requisite in effectiveness, satisfaction remains an important intermediate goal of treatment..." (1983c; p.743).

The argument is also made that client satisfaction is an ultimate goal of treatment (Lebow, 1982a; 1983c; Windle & Paschall, 1981; Morrison, 1978; Morrison; 1979; Rocheleau & Mackesey, 1981). The question arises, were you of help to people if they did not feel helped? Woodward and her colleagues (1978) propose that ideally, agencies should help clients not only to function effectively but also to feel that they have been helped. This relates to some extent to an issue raised earlier regarding the decision about which

is the primary criterion measure of outcome in family therapy when multiple measures are used. Some authors argue that that the ultimate measure of outcome is whether the client "got what they came for" (Jacobson, 1985; p.157) which to some extent could be measured by reported levels of satisfaction.

Client feedback surveys can also serve to help uncover practical problems and help adjust service to the needs and expectations of its users (Love et al, 1979). Edwards and his associates (1978) suggest that dissatisfaction with aspects of service (for example accessibility or physical surroundings) can be viewed as one index of a need to modify or improve some aspect of treatment services. Agencies are being challenged to specify their competencies and to target their limited resources to areas of greatest potential impact. Magura and Moses (1984) argue that this necessitates greater reliance on feedback from clients, who are in a good position to know whether and how they have been helped.

The value of obtaining feedback from consumers of services is related to the extent to which their perspective can be captured regarding the way services were provided, the outcome of service and the attribution of change to service (Poertner, 1985). Regardless of its relationship

to other more objective measures of agency effectiveness, satisfaction is argued to be a worthy subject of study in its own right because "people live in a subjective world ... and one important part of agency effectiveness is clients' subjective reactions to their contacts" (Gutek, 1978; p.50). At the very least, satisfaction measures provide the consumer's unique point of view about the acceptablity of a service (Lebow, 1983c; Martin, 1986).

Methods for Assessing Consumer Satisfaction

In addition to providing an excellent comprehensive review of the research regarding consumer satisfaction with mental health treatment, Lebow (1982a; 1983a) also examines the pragmatics involved in assessing consumer satisfaction and provides guidelines for research in this regard (1982b; 1983c). The methodological problems associated with consumer satisfaction studies have been well documented by Lebow as well as by many other authors (Gutek, 1978; Hargraeves & Attkisson, 1979; Locker & Dunt, 1978; Larsen et al, 1979; Rocheleau & Mackesay, 1980; Nguyen et al, 1983; LeVois et al, 1981). These problems include concerns with the construction of measures used to assess satisfaction, data collection procedures, response bias and lack of variability in reponses (Lebow, 1983c). "A major problem is encountered in using satisfaction measures relates to the

ubiquitous finding that service recipients report high levels of satisfaction" (Larsen et al, 1979). LeVois and his associates (1981) propose that there are likely a number of social-psychological elements (which they refer to as artifacts) at play which may effect reports of satisfaction (for example, social desirability response bias, ingratiating responses, the Hawthorne effect or cognitive dissonance). Thus, distortion in satisfaction reports is a major problem. Considerable attention is being given to the psychometrics of consumer satisfaction by a group led by Attkisson (Attkisson & Zwick, 1982; Larsen et al, 1979; LeVois et al, 1981; Pascoe & Attkisson, 1983, Nguyen et al, 1983) in an attempt to address the major methodological problems in research of consumer satisfaction.

Consumer satisfaction is usually sought through the use of a survey of clients after the termination of treatment (although it can also be sought during and at the close of treatment). There are examples of several instruments in the literature which have been designed to assess client satisfaction (Love et al, 1979; Larsen et al, 1979; Nguyen et al, 1983; Pascoe & Attkisson, 1983; Essex et al, 1981; Tanner, 1982; Ihilevich & Gleser, 1982, Noll & Dubinsky, 1984, Damkot et al, 1983). The existing scales

which have undergone systematic analysis have come primarily from the mental health field. The one cited the most in other studies is the Client Satisfaction Questionnaire (CSQ) developed by Larsen, Attkisson, Hargraeves and Nguyen (1979). It is thought to be the most psychometrically sound consumer evaluation instrument available (Heath et al, 1981; Schulberg, 1981) and is considered to be sufficient for global inquiries about client satisfaction. It has three variants: an 8 item scale of general items and two 18 item scales which add more specific inquiries. A smaller scale of three of the items is also reported to function well as a global measure of satisfaction (Larsen et al, 1979). Hargraeves and Attkisson (1978) suggest that in designing a satisfaction measure for use in an agency setting, it would be reasonable to include the CSQ-8 or CSQ-3 in addition to items of local interest and an open-ended question to elicit criticisms or suggestions. Lebow (1983c) also offers guidelines for scale construction although recommends the use of a standard measure when possible.

Data collection can be done by mail, telephone or by in-person interview. Mail is considered the least expensive but also is subject to the lowest reponse (40% return rate according to Lebow, 1987) while telephone has a higher

completion rate (43%), but is considered somewhat more expensive and reactive. Lebow (1987) considers that a combination of the two methods offers the best balance of responding and reactivity. In-person interviews are considered to be subject to the most reactivity. Lebow also strongly recommends that someone other than the direct service provider be used to collect the data in an effort to minimize bias. Client feedback can be obtained by periodic sampling of consumers of a service or by continous monitoring of each service recipient (Hargaeves & Attkisson, 1978). Lebow (1987) reports that most settings which use client feedback measures have opted for surveying all recipients, although exclusion of some clients is done according to clinical judgement. However, he advises that "as consumer surveys aim for the greatest generalizability, exclusions are best limited to those who cannot respond to the survey" (p.193). In the case of family treatment, Lebow (1987) suggests surveying each family member. The timing of data collection depends on the purpose of the evaluation. Lebow (1982b) proposes that awareness of the possible effects of the choice of timing on the evaluation is more important than the timing selected. Anonymity of respondents is considered to reduce reactivity and social desirability response sets but limits the use of the data

especially when client satisfaction is only one measure being used in an overall monitoring strategy (Lebow, 1987).

Several authors (Pincus & Minahan, 1973; Powers et al, 1985; Schinke, 1985; Lebow, 1987) highlight the ethical issues involved in evaluation. Pincus and Minahan (1973) note that it is important to consider the extent to which follow-up after treatment termination reflects a violation of the client's right to privacy. As well, Lebow (1987) points out that client feedback surveys usually result in clients being contacted by someone other than the direct service provider. Informing clients about evaluation procedures at the beginning of service provision including the liklihood that they will be contacted by another staff member after termination of treatment is considered vital (Hargraeves & Attkisson, 1978; Lebow, 1987).

Martin (1986) maintains that commonly used methods of evaluation limit the influence of consumers in the assessment of services. Windle and Paschall (1981) strongly advocate for the involvement of clients, not only as respondents, but as designers of client feedback measures. They suggest that measures developed by those other than the consumers of a service may not be addressing the right questions. According to Locker and Dunt (1978), "a true study of consumer evaluations of the quality of care would

need to identify and employ criteria for standards used by consumers themselves" (p.290). Consumers are usually used as sources of data based on questions which basically take an organizational perspective; that is, the organization usually defines what is important to ask (Giordano, 1977). Involving consumers in the construction of the questionnaire is considered important because the viewpoint of the consumer is thought to be quite different from that of the service provider regarding the purpose of evaluation and the aspects of service on which it should focus (Giordano, 1977; Martin, 1986; Lebow, 1983c). Kaufmann and his associates (1979) discovered in their research differences between clients, board members and administrators regarding the issues they considered to be important in evaluation (clients were concerned with confidentiality and the program's links to other agencies, board members with consumers' reactions to location of services and administrators with the ethnic matching of client and therapist). The intent of involving consumers in scale development, according to Martin (1986) "is to ensure that the criteria and standards which are incorporated in the evaluation do not omit those that are relevant to the consumers' judgement of the service" (p. 193). She suggests that one way of engaging clients in this process is to

seek their feedback about the initially designed instrument regarding not only clarity of wording and comprehensibility of content, but also about the comprehensiveness of the criteria.

Applications and Selected Findings

As previously noted, the development and use of consumer measures has primarily happened in the health care and community mental health fields. Lebow (1982a; 1983a) provides an extensive review of the use of consumer satisfaction measures and findings from these studies which primarily pertain to mental health treatment. He found extensive use of these measures in community mental health centres which provide a wide range of services and much less use in other service settings. The trends discovered by Lebow (1983c) are summarized as follows:

a) most consumers report satisfaction (73% - 83% of responding consumers)

b) there is always a small percentage of dissatisfied consumers about whom very little is known

c) there is no consistent pattern which links degree of satisfaction to any particular client or treatment characteristics

d) there is no agreement to confirm whether satisfaction represents a unidimensional factor or multidimensional

factors (dimensions which include satisfaction with the clinician, outcome, access, confidentiality and medication were found in some studies)

e) there is a differential response to aspects of treatment where staff are considered more favourably and more pragmatic issues are targets of dissatisfaction (such as waiting time)

f) there is a high correlation between satisfaction and the consumer's global rating of outcome; there is a less consistent pattern between consumer satisfaction and other measures (such as therapist's satisfaction, therapist's rating of client satisfaction, and client change measures).

Despite the wide use of consumer satisfaction measures with "traditional" mental health populations, there has been much less documented use of client feedback measures with other populations (Heath et al, 1984). Studies found which did employ these measures included: a study of retarded and geriatric clients of a community agency (Heath et al, 1984); consumer satisfaction with a welfare department (Martin, 1986); a study of home-based services for the elderly (Levkoff & DeShane, 1979); a study of consumers of a child protection agency (Magura & Moses, 1984); a study of users of court-related marriage counselling services (Brown & Manila, 1977); a study of clients' and therapists'

perceptions in a family service agency (Maluccio, 1979); a study of a child-welfare related parent education program (Poertner, 1985); a study of consumers of university counselling services (Greenfield, 1983; Miller, 1978); a study of treatment discontinuance in a family service agency (Toseland, 1987); an evaluative study of brief family therapy (Woodward et al, 1978); and an evaluation project of family service agencies (Andrews et al 1986). As well, Bennum (1986) and Pardeck and his associates (1983) have used client satisfaction as an outcome measure in their evaluative studies of family therapy. The efforts of the social work department of a general hospital to develop a consumer assessment procedure for the psychiatric unit is documented by Selig and his colleagues (1981) and the components of a consumer feedback system incorporated into family-style residential treatment progams for adolescents is presented by Warfel and his associates (1981). A more recent study in the mental health field was found to have used client perception of treatment to analyze whether clients can perceive differences in the nature of the therapeutic relationship and in therapists' intervention techniques (Jones et al, 1986). In general the information regarding consumer satisfaction from these studies is consistent with the trends identified by Lebow (1983c).

This literature does demonstrate, however, the application and utility of consumer feedback measures in a wide variety of service settings and across various client populations.

Both Morrison (1978) and Lebow (1983b) point out that although there is documentation of numerous "one-shot" studies of consumer evaluations of service, there is little evidence that service providers are incorporating a system whereby clients can regularly and systematically assess the services they receive as part of their program evaluation efforts. There have been some instances cited in the literature of agencies who have developed ongoing consumer evaluation procedures (Warfel et al, 1981; Selig et al, 1981; Damkot et al, 1983; Greenfield, 1983; Poertner, 1985). Warfel and his associates (1981) provide three main recommendations regarding the development of an ongoing consumer feedback system: the system needs to be practical so that regular implementation is feasible; the information collected should be useful to the service providers; and there should be clarity about the purpose and management of the information collected for the benefit of both the consumer and the service provider. They also address the need to include program staff in the development of evaluation measures. Lebow (1982a) stresses the importance of coupling client satisfaction measures with other client

self-report change measures and therapist-assessed measures in order to provide a complete view of treatment.

Summary

The measurement of consumer satisfaction is seen as one part of a total clinical evaluation effort and as one perspective of the assessment of a clinical experience. There are no clear answers to the questions about the meaning one can attribute to the information provided by measures of consumer satisfaction. The standardization of measures and better methodology of research in this area may help to provide clearer answers in the future. In conjunction with the endeavour to incorporate systematic evaluation efforts into clinical practice, there is the consideration that the recipient of the service has valuable information to contribute to this process. It is not foreign to social work practice to "turn to clients" to learn from them about what was helpful and what was not helpful in order to refine knowledge and practice skills. The methodology of systematic evaluation of practice is less familiar; the complexities and difficulties of which have been highlighted. Systematic evaluation has the potential to be a valuable tool for the practitioner and useful in overall program evaluation efforts. Including the consumer's viewpoint rounds out the assessment picture.

PART II

THE PRACTICUM

Proposal

The objective of the practicum experience was to learn about the practical application of clinical evaluation theory to a family-centered treatment setting with special reference to the employment of consumer satisfaction as an aspect of program evaluation.

I proposed to conduct a study of consumer satisfaction in conjunction with the Child and Family Services Research Group, School of Social Work, University of Manitoba, under the direction of Dr. Barry Trute, who was consulted by Children's Home of Winnipeg to develop a strategy of evaluation for its Family Therapy Department. Dr. Trute's proposal for evaluation to the agency was aimed at designing and implementing an ongoing program monitoring system which would include basic multiple outcome and process measures. The ongoing evaluation of family therapy outcomes was planned as the major thrust. Consumer satisfaction was one of the measures which was to be considered in the overall evaluation strategy. The objective of the study I proposed was to pilot test a consumer feedback measure and various methods of data retrieval in order to recommend to the agency a measure and method of client follow-up to consider as part of the overall evaluation strategy. The objectives

of the monitoring system which was proposed by Dr. Trute included the ability to clinically assess on a single-case basis the impact of therapy on families, as well as the ability in the longer term to create a database across a number of cases to aid in the evaluation of program efforts.

My practicum committee included Dr. Trute, who was my principal advisor and supervisor, Ms. Linda Campbell, Co-ordinator, Child and Family Services Research Group, and Ms. Chris Cassells, Assistant Director, Children's Home of Winnipeg.

Site

The site of the practicum was the Family Therapy Department, Children's Home of Winnipeg which is a multi-faceted agency that offers a continuum of services to children and their families. The Family Therapy Department is designed to provide clinical services to a wide variety of families who present with child-related concerns. They receive referrals from a variety of external sources, including community agencies, schools, and families themselves, as well as internally from other programs within the agency. Child welfare concerns are often present and they do treat families with children in care. It is generally observed that a number of the families they serve present with "multi-problems" and often have "multi-service providers" involved with their family.

Procedures

The practicum experience ran from February 1987 to March 1988. An important element of this experience was my involvement in the collaborative process which Dr. Trute implemented with the family therapy staff. The collaborative process was designed to involve the therapists in the development of the evaluation strategy. Involving practitioners in this way is hoped to result in an evaluation strategy that best fits the realities of practice and to help increase the utility of the system to the therapists who have to incorporate measures into their practice (which hopefully will increase the likelihood that they will use it). The successful outcome of any clinical evaluation program primarily depends on the level of acceptance, support and involvement which can be achieved on the part of the clinical staff. (Selig et al, 1981).

The collaborative process which Dr. Trute initiated of which I was a part, included thirteen meetings with the family therapy staff over a course of thirteen months (February 4, 1987 was the first meeting and March 16, 1988 was the last meeting). The meetings initially began as training sessions in clinical evaluation, ongoing monitoring strategies and in the selection, application and interpretation of outcome measures for family systems

therapy. Measures were presented and experimented with in practice so that the therapists could decide on the available measures which best fit their practice setting. As the therapists were generally unfamiliar with the assessment measures presented and their application to practice situations, the process of trying to weave the measures into their practice and make "sense" of them clinically, was an extended one. Dr. Trute acted as a consultant regarding the practicalities of administration of instruments and their clinical interpretation on a case-by-case basis. There were several assessment measures introduced initially as options for the therapists to consider. The progression of the meetings took the form of ruling out certain instruments, introducing others and trying to establish a competence level with them; in essence putting together piece by piece the evaluation framework at a pace that was generally set by the therapy staff. In addition to the family assessment/outcome measures, other "pieces" of the framework which were developed with staff input were the family registration form (pertinent social demographics), the contact form (to record basic elements of practice activity) and as well a therapist rating scale (of family outcome) was initiated. In addition, I presented the concept of client satisfaction

as a measure and strategy for follow-up after termination of treatment in one of the meetings and sought the therapists' input in the construction of a client feedback questionnaire.

The theme which ran throughout the series of meetings and which guided the process was the importance of clinical judgement as a prevailing factor. Practice is the priority over evaluation and it was stressed that therapists should use their judgement in adapting evaluative measures to their work with families. Within the overall context of the anxiety of needing to demonstrate to funders the value of the program, the attempt was made to demonstrate to the staff that these measures are adaptable and useful in a clinical way as well as an evaluative way and the control of them and the information they provide is in their hands for their interpretation.

The design which was planned for the ongoing monitoring system included:

a) a family social demographics form filled out by the family prior to the first interview

b) a problem checklist filled out by each family memeber (over age twelve) prior to the first interview to be used as a pre-measure and at termination as a post-measure

c) the Family Assessment Measure (FAM III) completed early

in the therapist's contact with the family to be used as a pre-measure and at termination as a post-measure of family change

d) therapist rating scale of family functioning at termination

e) contact sheets completed throughout the treatment period to document activity in relation to the family

f) post-treatment follow-up of family to obtain feedback about their satisfaction with service and complete an outcome measure(s) to assess the stabilzation of change.

Client Feedback Form

I referred to the literature on survey research methods (Tripodi & Epstein, 1980; Powers et al, 1985; Austin & Crowell, 1985; Mindel, 1985; Mason et al, 1983) as well as to the literature specific to consumer satisfaction (in the human services) methodology (Lebow, 1982b; 1983c) for guidance regarding the construction of a client feedback form which could be used in a systematic way. I found several scales in the literature which had been developed to assess consumer satisfaction. Most of these were developed for use in community mental health centers and focused on obtaining feedback on a range of services. There was very little guidance in the literature regarding the use of satisfaction measures as a follow-up measure of

a clearly defined clinical treatment approach such as family therapy. The only study Lebow (1983a) found in his review of the research was the McMaster Family Therapy Outcome Study which used a family satisfaction questionnaire as one of its outcome measures (Woodward et al, 1978). In this study, families were interviewed at home six months after treatment termination by an independent follow-up worker. The questions asked pertained to overall satisfaction with service, access to the service, comprehensiveness and adequacy of the service, current feelings about presenting problems, attribution of change to treatment, satisfaction with family approach to treatment and whether they would return if they needed. These aspects were compared to those covered by the standardized Client Satisfaction Questionnaire (CSQ 8) (Larsen et al, 1979) and a six item client feedback form used by the Pacific Coast Family Therapy Training Association. Keeping in mind the need for brevity, clarity and ease of administration an 8 item closed-ended questionnaire was constructed following the design of the CSQ (8) and using the three measures from that instrument which were rated well as an overall global measure of client satisfaction, as well as items from the Pacific Coast form. The draft questionnaire was presented to the family therapy staff and two more items were added

pertaining to family change and therapist interaction with other helpers (an item of local interest to this program which had developed a protocol of working with families who present with multiple helpers in their network).

A pre-test of the questionnaire was accomplished by in-person interviews with eight clients chosen by the therapists and who had agreed to participate in the pre-test. All the respondents, who were considered to be the primary family informant, were mothers and were interviewed in their homes. I administered the questionnaires and then interviewed the repondents about each item regarding their interpretation, clarity of wording and appropriateness of response categories and sought suggestions for additional items. Based on the pre-test I made slight modifications to the wording and order of the items and eliminated one item (satisfaction with service was considered repetitive to satisfaction with therapist by respondents who equated the service with the therapist). However, this did eliminate one the of items from the standardized questionnaire. The nine item questionnaire (Appendix A) (which also has space for additional comments) entitled Client Feedback Form received final approval from therapy staff (and my practicum committee) and was ready to be used in a pilot study.

Preparation for the pilot study entailed the drafting of a covering letter to accompany the forms for mail distribution and a letter of precontact for families who were going to be followed-up by telephone (Appendix A). The letters which were signed by the Assistant Director, Chris Cassels, explained the rationale for the study and assured confidentiality of responses. The two outcome measures, the family problem checklist (which was a modification of a checklist originally developed at the Morrison Center for Youth and Family Service in Portland) and the Brief FAM, were reformated to impove the overall appearance for mail distribution. As well, the ambivalent response category of the problem checklist was eliminated.

The next section of the report will focus on the method followed for the pilot study and present the findings from the pilot study.

PART III

METHOD and FINDINGS

Method

The purpose of the study was to test out post-treatment follow-up with clients under four different response conditions to assess which condition provided the best response rate and to appraise the information provided by the client feedback form.

Although not initially planned, there were two trials to this study; one in December, 1987 and the other in March, 1988. The first sample was drawn from cases closed between December/86 and November/87 (closed within twelve months). Closed cases in which termination from treatment had occurred several months prior to closure were not considered for the sample and cases which were considered "one-shot" contacts were also not included. The second sample was drawn from cases closed between November/87 and March/88 (closed within three months). From each sample, cases were randomly assigned to the four response conditions. No attempt was made to match the samples in each condition.

The four response conditions were related to the method of data collection (mail or telephone retrieval) and the number of instruments included in data collection (the client feedback form alone or in combination with the two

outcome measures). The four response conditions were thus:

1. Mail retrieval of the Client Feedback Form
2. Mail retrieval of the Client Feedback Form and the Brief FAM
3. Mail retrieval of the Client Feedback Form, the Brief FAM and the Problem List
4. Telephone retrieval of the Client Feedback Form and the Brief FAM

For mail distribution the forms were accompanied by self-addressed stamped envelopes which were marked confidential and were addressed to Ms. Cassels who had signed the covering letter. For the purposes of this study, the forms were addressed to the person in the family who was considered the primary contact and thus only one reponse per family was elicited. Likewise, the letter which was mailed to inform the family of the impending telephone contact was addressed to the primary family contact person.

With each of the trials telephone follow-up was attempted with the mail distribution samples if questionnaires had not been returned. Questionnaires not retrieved after four weeks were considered not retrievable. With the telephone samples at least three attempts were tried to reach the family member at various times of the day

and evening and on different days. A second mail-out was done for those clients who indicated they would complete the form(s) if mailed out again. No attempts were made to "track down" families if they could not be reached at the address or telephone number which the agency had listed.

Findings

Table 1 presents the response rate for each of the response conditions (N = 8 for each condition) for the first sample (total N = 32). CFF stands for Client Feedback Form.

TABLE 1
Response of Mail Survey and Telephone Contact: First Trial

Response Condition (N=8)	Completed	Returned Address Changed	Unable to Contact	Contacted & Didn't Complete
MAIL:				
CFF	4	-	2	2
CFF & FAM	3	-	4	1
CFF, FAM & Prob. List	4	-	3	1
Telephone:				
CFF & FAM	4	2	2	0
TOTAL (N=32)	15 (47%)	2	11 (35%)	4

Table 1 shows that of the sample of 32, 47% responded to the survey either by mail or telephone. However, a large percentage of the sample could not be contacted. The

non-repondents included those whose letters were returned by the post office as moved with no forwarding address (6% of the sample), those who were unable to be reached for follow-up because the telephone number was no longer in service or was the wrong number or there was no reply after several trys (this was the largest percentage of non-respondents, 35% of the sample) and finally those that were able to be contacted for follow-up but did not return the forms (12% of the sample). There was thus 19 cases (or 59% of the total sample) which were able to be contacted either through their response to the mail and telephone survey or through the telephone follow-up to the mail survey. The response rate for those considered "contactable" was 15 completions out of 19 or 79%. 100% of those who were able to be contacted for the telephone survey agreed to be questioned. Of the mail response, two were sent in after a follow-up telephone call. The four who did not return the forms after a telephone reminder had indicated that they still had the forms and would send them in but did not. Of those unable to be contacted, the majority (70%) had been closed to the Family Therapy Department for at least six months. Table 1 also indicates that the response rate does not appear to be affected by the number of measures used in the mail follow-up, but that you do lose respondents

through the mail survey method. One of the possibilities for the fairly high percentage of those unable to be followed-up was the length of time between closure and follow-up. Another sample was thus drawn to see if the response rate would differ if follow-up occurred closer to closure (within three months).

Table 2 presents the response rate for each of the response conditions (N = 6 for each condition) for the second sample (total N = 24).

TABLE 2
Response of Mail Survey and Telephone Contact: Second Trial

Response Condition (N=6)	Completed	Returned Address Changed	Unable to Contact	Contacted & Didn't Complete
MAIL:				
CFF	4	1	-	1
CFF & FAM	1	1	2	2
CFF, FAM & Prob. List	4	2	-	-
TELEPHONE:				
CFF & FAM	3	1	1	1
TOTAL (N=24)	12 (50%)	5 (21%)	3	4

Table 2 indicates that the response rate of completed follow-ups was similar to the first sample (50% compared to 47%). The difference in the non-responders was that a

higher percentage of letters in the second trial (21%) were returned by the post office as not deliverable (these were cases closed within three months of the survey). A higher percentage of the total sample was able to be contacted during the second trial (n = 16 or 66%) compared to 59% during the first trial, but the response rate was somewhat lower (75% compared to 79%). Within the response conditions of the second sample, one respondent was not able to complete the telephone survey due partly to a language problem and partly to the difficulty of talking about her family situation which was not happily resolved in her eyes. Four of the respondents in the mail condition returned the forms after a telephone prompt. Again it was noted that respondents are lost by mail survey as there was a fair percentage (25%) who were able to be followed up by telephone and although agreeing to do so, did not return the questionnaires.

In the total sample of respondents (N = 27) from the two survey trials, only one respondent did not complete all the forms mailed. As well, one respondent during the telephone survey answered the Client Feedback questions but chose not to respond to the Brief FAM because her family constellation was no longer the same as it was during the time that her family was in treatment and she did not

think that the measure was appropriate to her present situation.

The percentage of respondents who gave positive ratings to the items on the Client Feedback Form are presented in Table 3. The total sample from the two trials are included together as there was very little variance in the pattern of their responses.

TABLE 3
Percentage of Respondents Giving Positive Responses to Items on the Client Feedback Form

Item Content	% Positive	N (Total N = 27)
Access to the service	74%	20
Extent family needs met	63%	17
Satisfaction with therapist	78%	21
Quality of service	81%	22
Extent of family change	66%	18
Improvement in family	70%	19
Personal Improvement	63%	17
Would return for help	81%	22

In regard to the item concerning therapist's interaction with other helping professionals, 70% (n = 19) answered that it was not applicable to them. Of those to

whom it was applicable, 88% (n = 7) reported satisfaction. 81% of respondents rated the quality of the service they received from the Family Therapy Department to be either excellent (n = 13) or good (n = 9) and would return to the department for help in the future if they needed it. There was also a similar rating of satisfaction with their therapist where 78% were either very satisfied (n = 15) or satisfied (n = 6). In answer to the question, "how easy was it for your family to get service?", 74% reported that it was easy or very easy. For those who found it difficult, the waiting period for the first appointment was considered overly long. Comments that were made during the telephone interviews indicated that once they were able to get their first appointment with a therapist they found access to the service easy regarding appointment times and ability to contact their therapist. Respondents did indicate less satisfaction with the extent to which they considered the service to have met the needs of their family. 37% felt that only a few (n = 6) or none (n = 4) of their needs were met. About the same proportion saw very little or no change in their family situation (34%) and no improvement or more of a problem in the family (30%). However, from additional comments that were made on the feedback form and from comments made during the telephone interviews, some

respondents were able to differentiate between their satisfaction with the service (or the process of the service) and their satisfaction or dissatisfaction with the outcome. Generally, extent of improvement in the family situation was followed by similar personal improvement, although, not always. Some comments were made that even though the family situation had not improved a great deal, they were feeling better about the situation personally. Over half of the respondents added comments which generally followed the theme of praising the therapist or an explanation why they thought the outcome was less than positive or to explain their dissatisfaction. From the comments that were made, dissatisfaction was related to poor relationship with therapist or disagreement with focus on family treatment rather than child-focused treatment. There was one comment which indicated dissagreement with the use of video in therapy.

There did not appear to be a difference in reported satisfaction with treatment or perceived outcome between those that responded by means of the telephone interview and those that responded through the mail. Respondents were able to express dissatisfaction with service by telephone which is considered to be a more reactive method of data collection.

PART IV

DISCUSSION AND RECOMMENDATIONS

The most striking feature of the findings found in the pilot study was the high percentage of families (37% of the total sample) who were unable to be contacted for follow-up after treatment termination. Family mobility appears to be a factor here. Of those who were able to be contacted the completion rate for data collection was fairly high (79% and 75% for each of the samples). No one contacted by telephone either for the telephone interview or as a follow-up to the mail survey verbally refused to participate and ability to contact a family did result in slightly higher response rate for the mail distribution sample. Non-response in the first sample was greatest for those closed to the Family Therapy Dept. for six months or longer. Even for those sampled within three months of closure, there was a fair proportion of families who could not be reached at the address or telephone number on the agency file. The findings indicate that if the primary contact person for the family can be reached by telephone, the data can be collected. The mail survey method results in loss of data. The response rate (48.5%) may be increased if the number of clients who could not be contacted was reduced (in the 2nd trial it is easier to identify those who were known to have received the forms from those situations in which it was

not clear whether the family had not responded because they did not receive the follow-up survey).

Within the mail distribution sample, the number of measures included in the survey did not appear to affect the response rate in any significant way and even families who report dissatisfaction with the service will take the time to complete the family outcome measures. Administering the brief FAM was considered somewhat awkward by telephone and particular attention had to be paid to helping the respondent understand the instructions and format of the inventory. Although the telephone interview only took a few minutes to complete, at the end of giving the FAM, it seemed that the respondent felt it was long enough. Another outcome measure included in the telephone interview would probably be considered "too much".

The advantage of the telephone method of data collection is the higher response rate but the disadvantage is the time involved in trying to reach the respondent. With the mail distribution there is the disadvantage of a lower completion rate but the option of including both outcome measures with the consumer feedback form is a benefit. Less time is required, as tracking someone down by telephone is necessary only for those who do not respond initially by mail. Also if the therapist wants to collect

data from more than one family member the mail method is less time-consuming. There are thus pros and cons to either method of data collection, but the higher reponse rate ability of the telephone method makes it preferable.

The satisfaction ratings reported by the the respondents were fairly consistent to those reported in the literature. In comparison to the findings of the McMaster Family Therapy Outcome Study (Woodward et al,1978), the findings of the present study are quite favorable. The McMaster study found that 64% of the families they interviewed reported general satisfaction with the service. The present study found 67% global satisfaction with the service (computed by analyzing the responses to questions 2, 3 and 8 on the Client Feedback Form). As in the McMaster study, the findings from this pilot study also showed varying degrees of satisfaction reported with different aspects of the treatment experience.

In the present study, there were differences between reported satisfaction with service and reported family and personal outcome. 81% of the respondents were favorable about the quality of service. However, only 66% considered that their family situation had changed and 70% that the family situation had improved. Generally, extent of improvement in the family situation was followed by similar

personal improvement, although not always. Some comments were made that even though the family situation had not improved a great deal, the repondent was feeling better about the situation.

Families satisfied with the quality of service they received and with their therapist do not necessarily report change or improvement in their family situation. In the present study, most of the families who reported dissatisfaction with the service also reported no change or improvement in the family, although not in all cases. In a few cases, clients reported that their needs were not met and that they were dissatisfied with their therapist, but also indicated some change or improvement in the family situation which is a finding also reported by the McMaster study. This points to the importance of obtaining the family's point of view about treatment and to understand client satisfaction separately from ratings of outcome. Satisfaction ratings can, for instance, provide an indication that the client felt that the family had received acceptable service even though the outcome was not what they had hoped for; that is not necessarily attributing poor outcome to poor service. For this reason, the literature supports the notion that client feedback cannot be used alone as an indicator of effectiveness. Client feedback can

however, contribute to the therapist's analysis of the effectiveness of treatment with a particular family and aids in overall evaluation of quality assessment.

The dissatisfied comments which were made additionally to the client feedback questions were generally related to a poor relationship with the therapist or disagreement with the focus on family treatment rather than child-focused treatment. These are similar issues to those reported in the McMaster study which found that staff-patient interaction was the aspect of greatest dissatisfaction for families who were dissatisfied with the service. They also found that for those families who made comments concerning the focus of treatment, parents would have been more satisfied with a focus on the child who was presented as the identified problem.

Although one of the items from the CSQ(3) was not included in the CHOW Client Feedback Form, if the item regarding satisfaction with the therapist was substituted in the analysis, an overall global rating of satisfaction could be computed (by adding the scores of questions 2, 3 and 8 with one being assigned to the most negative response and four to the most positive response). The standard about what would be considered high, medium or low satisfaction would have to be based on comparisons over

time by the Family Therapy Dept. Thus over a period of time, a database of satisfaction ratings can be accumulated for comparison purposes which can help set a standard of satisfaction for the department. In addition to comparisons over time, responses to the client feedback form can also be related to other client and treatment variables.

The continued use of the Client Feedback Form together with the Brief FAM in the follow-up of families post-treatment by means of telephone contact (which permits the best response rate) by a staff person other than the family's therapist is recommended. In order to maintain brevity and ease of administration, the additional use of the Problem Checklist is not suggested for telephone follow-up. The therapist should identify the primary informant for the family who is the person who would be contacted for the feedback information. A decision will need to be made regarding who within the organization will be responsible for doing the post-treatment telephone surveys.

It is recommended that procedures for the implementation of an ongoing client feedback follow-up strategy include:

a) informing clients at the beginning of treatment about the follow-up procedures of the Family Therapy Department with a reminder at termination that another staff person

will be contacting a designated family member for the purpose of seeking feedback about their thoughts about the service and to check out how the family is doing post-treatment

b) clarifying that the family address and telephone number is current

c) timing follow-up with-in a short period of time after the therapist has terminated with the family (3-4 weeks).

Consumer feedback is a useful index of the service provided by the Family Therapy Department from the client's perspective and as well provides a means to collect additional outcome data to help assess the stabilization of the change effort. The information thus provides useful information to both the therapist in his/her overall assessment of the outcome of a case and as well to the whole department in its overall program evaluation.

PART V

REFLECTIONS ON PRACTICUM EXPERIENCE

There is much to relect on over the year which this practicum stretched. The value to me has not only been in regard to the acquisition of knowledge about the theory on which clinical evaluation is based and on the place consumer feedback has in evaluation of practice but in seeing and being part of a struggle to integrate evaluation efforts into the demands and constraints of social work practice in an agency setting. I learned the importance of context which influences the reasons for evaluation and has impact on the manner in which evaluative efforts are carried out. The collaborative model, of engaging practitioners in the design of an ongoing evaluation effort which aims at assisting the practitioner's assessment and evaluation on a case-by-case basis as well as providing data for overall program evaluation of treatment efforts, has few precedents. I feel fortunate that I was able to observe this process from which I feel that I learned a great deal. I learned that the process of weaving assessment measures into clinical practice is not a simple one and is a process that requires the innovation and committment of the practitioners in order for this to be successfully accomplished. It also requires time, like any new skill to develop a level of comfort and competence. What also is required is a sense

that the effort has value or utility to their clinical work for the investment of clinician time and energy so that the process is continued. The importance of the consultant's clinical experience with assessment measures is invaluable to this process both in providing guidance regarding interpretation, but also to modeling the adaptability of measures to practice which I think carrys more credence from someone who actually has used the assessment measures. The development of an ongoing monitoring system requires attention to a lot of details and adjustments to practice which really cannot be imposed on therapists if the system is to be useful. All the details needed to be discussed and systems needed to be refined in order for practitioners to claim "ownership" of the evaluation. This process taught me that flexibility is essential in the design and implementation of a systematic evaluation stategy to the complexities of a family practice setting. Building staff support and engaging their interest and participation and at the same time deal with resistance and suspicions about the value and use of the data collected is a great challenge.

The practicum also served to help me learn about designing a survey form and all the details involved in trying to carry out a study, however small it may be. The experience of trying to develop a questionnaire relative to

consumer satisfaction of family systems practice taught me a lot about the importance of clarity of purpose and definition of variables as well as its value in the overall evaluation scheme. The experience of carrying out the pilot study enabled me to learn more about the issues of sampling and data collection. I was very cognizant throughout this process of my possible infringement on the right to privacy of families who have been consumers of a service in attempts to follow-them up. Trying to make sense of the information I did collect was also an interesting challenge. From the review of the literature and from this experience, I have become committed to the concept of involving consumers in the evaluation of the services of which they are a part.

I think that I learned a great deal about the adaption of evaluation skills to clinical social work practice. However, there was no evaluation of my efforts built into the design of this practicum experience. I can only hope that the outcome of the consumer feedback survey provides the Family Therapy Department of CHOW with useful information and guidance about the incorporation of client feedback into their overall evaluation strategy.

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APPENDIX A

CLIENT FEEDBACK FORM

BRIEF FAMILY ASSESSMENT MEASURE

FAMILY PROBLEM LIST

COVER LETTER

PRECONTACT LETTER

CHILDREN'S HOME OF WINNIPEG FAMILY THERAPY DEPARTMENT

CLIENT FEEDBACK FORM

We are interested in your honest opinions of the service your family received from the Family Therapy Department. Please read the following questions and circle the answer below each question which is closest to your feelings.

1. How easy was it for your family to get service?

   Very Easy Easy Difficult Very Difficult

2. To what extent did our service meet the needs of your family?

   Almost all of our needs were met Most of our needs were met Only a few of our needs were met None of our needs were met

3. To what extent were you satisfied with your therapist?

   Very Dissatisfied Dissatisfied Satisfied Very Satisfied

4. How would you rate the quality of service?

   Excellent Good Fair Poor

5. To what extent did your family situation change?

   A great deal A fair amount Very little No change

6. Did your family situation improve?

   Much Improvement Some Improvement No Improvement More of a Problem

7. Did things get better for you personally?

   Not at all Very little A fair amount A great deal

8. If you were to seek help again, would you use our service?

Definitely no	I don't think so	I think so	Definitely yes

9. If you or your family were involved with other helpers in addition to our service, how satisfied were you with the way your therapist worked with the other helpers?

Very Satisfied	Satisfied	Dissatisfied	Not Applicable

Please feel free to use this space to write in any additional comments or suggestions you would like to make:

In this part of the questionnaire we would like to know how you see your family now. Below is a list of statements about family life. Think about your family as you read each statement and show your agreement or disagreement with the statement about your family by circling your answer. For example, if you strongly agree that family duties are fairly shared in your family, you would circle number 4 under strongly agree.

	STRONGLY DISAGREE	DISAGREE	AGREE	STRONGLY AGREE
1. Family duties are fairly shared in my family.	1	2	3	4
2. My family expects me to do more than my share.	1	2	3	4
3. We feel loved in our family.	1	2	3	4
4. When things aren't going well, it takes too long to work them out.	1	2	3	4
5. I never know what is going on in our family.	1	2	3	4
6. We deal with our problems, even when they are serious.	1	2	3	4
7. When you do something wrong in our family, you don't know what to expect.	1	2	3	4
8. We tell each other about things that bother us.	1	2	3	4
9. It is hard to tell what the rules are in our family.	1	2	3	4
10. My family tries to run my life.	1	2	3	4
11. We take time to listen to each other.	1	2	3	4
12. Punishments are fair in our family.	1	2	3	4
13. When someone in our family is upset, we don't know if they are angry, scared or what.	1	2	3	4
14. We are free to say what we think in our family.	1	2	3	4

This part of the questionnaire also has to do with how your family is doing now. Below is a list of family concerns. Think about your family as you read them and show your satisfaction or dissatisfaction with how you think your family is doing now in each area by writing in the number of the response which best fits with your feelings. For example, if you were very satisfied with the showing of good feelings in your family you would write in number 4.

VERY DISSATISFIED	DISSATISFIED	SATISFIED	VERY SATISFIED
1	2	3	4

---

1. Showing good feelings (joy, happiness, pleasure,etc.) _____
2. Sharing feelings like anger, sadness, hurt, etc. _____
3. Sharing problems with the family _____
4. Making sensible rules _____
5. Being able to discuss what is right and wrong _____
6. Sharing of responsibilities _____
7. Handling anger and frustration _____
8. Dealing with matters concerning sex _____
9. Proper use of alcohol, drugs _____
10. Use of discipline _____
11. Use of physical force _____
12. Amount of independence you have in the family _____
13. Making contact with friends, relatives, church, etc. _____
14. Relationship between parents _____
15. Relationship between children _____
16. Relationship between parents and children _____
17. Time family members spend together _____
18. Situation at work or school _____
19. Family finances _____
20. Housing situation _____

Make this last rating for yourself:

21. Feeling good about myself _____

The Children's Home Of Winnipeg

December 10, 1987

General Office: 786-7051
400-777 Portage Avenue
R3G 3L1

Training Resources for Youth
100-777 Portage Avenue
R3G 0N3
786-8561

Learning Assistance Centre
246 Toronto Street
R3G 1S2
786-8431

Project Chance
305-777 Portage Avenue
R3G 3L1
775-0425

Resources for Adolescent Parents
246 Toronto Street
R3G 1S2
775-2466

Alternative Sentence Planning
165 Garry Street
R3C 1G7
943-9543

Project Independence
400-777 Portage Avenue
R3G 3L1
786-7051

Family Therapy
305-777 Portage Avenue
R3G 3L1
775-0425

Dear

I am writing to ask your help with a review we are doing of the Family Therapy Department. We are contacting families like yours who were seen in the Family Therapy Department in the last two years to find out from them how they feel about the service they received and how they see their family doing now. The help you received here and your feelings about it are very important to us as we try to assess our service.

You will find attached a questionnaire which asks a few questions about what you think about your experiences with the Family Therapy Department and how you see your family doing now. The information you give us will be kept confidential. Your name will not be used anywhere on any reports. In no way will your answers affect any service you might want in the future from this agency.

Your opinions are very important to us. We are trying to provide the best possible service to families such as yourselves. Your thoughts about the help you received here will be very helpful in assessing our service and improving services in the future.

I do hope that you will help by filling out the questionnaire and mailing it back to me in the attached envelope as soon as you can.

Thank you very much for your help.

Yours truly

Christina Cassels, M.S.W.
Assistant Director, Clinical Services

The Children's Home Of Winnipeg

General Office: 786-7051
400-777 Portage Avenue
R3G 3L1

Training Resources for Youth
100-777 Portage Avenue
R3G 0N3
786-8561

Learning Assistance Centre
246 Toronto Street
R3G 1S2
786-8431

Project Chance
305-777 Portage Avenue
R3G 3L1
775-0425

Resources for Adolescent Parents
246 Toronto Street
R3G 1S2
775-2466

Alternative Sentence Planning
165 Garry Street
R3C 1G7
943-9543

Project Independence
400-777 Portage Avenue
R3G 3L1
786-7051

Family Therapy
305-777 Portage Avenue
R3G 3L1
775-0425

February 29th, 1988

Dear

I am writing to ask your help with a review we are doing of the Family Therapy Department. We are contacting families like yours who were seen in the Family Therapy Department in the last two years to find out from them how they feel about the service they received and how they see their family doing now. The help you received here and your feelings about it are very important to us as we try to assess our service.

Within the next few days you will be receiving a telephone call from Beth Hussey, who will ask you a few questions about what you think about your experiences with the Family Therapy Department and how you see your family doing now. This should only take a few minutes of your time. The information you give us will be kept confidential. Your name will not be used anywhere on any reports. In no way will your answers affect any service you might want in the future from this agency.

Your opinions are very important to us. We are trying to provide the best possible service to families such as yourselves. Your thoughts about the help you received here will be very helpful in assessing our service and improving services in the future.

I do hope that you will help by taking a few minutes to talk with Beth when she calls.

Thank you very much for your help.

Yours truly

Christina Cassels, M.S.W.
Assistant Director, Clinical Services

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