Journal of Child and Family Studies, Vol. 7, No. 4, 1998, pp. 451-467

Parent Satisfaction with Case Managed Systems of Care for Children and Youth with Severe Emotional Disturbance

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Case management has emerged as an integral component of current efforts to reform the delivery of mental health services to children and youth with Severe Emotional Disturbance (SED). We examined parental satisfaction with one program's case management system for SED children. In order to validly address parental satisfaction, the program first turned to a group of its parents to develop a satisfaction measure, the Family Satisfaction Survey (FSS). Of the 51 parents who returned an FSS, 74% of the parents were generally satisfied while 26% indicated that they were dissatisfied with their families' case management services. Multivariate regression analyses were employed to examine the role played by client, service, and outcome variables in predicting parental satisfaction. After controlling for child diagnoses, severity of impairment, and levels of psychosocial stress, parent satisfaction with case management services was best predicted by the frequency of monthly contact and fewer days is a psychiatric hospital proportional to length of service. Our results suggest that parent satisfaction is based not only on what case managers do but on how this service impacts SED children's ability to remain at home and in their communities.

KEY WORDS: case management; client satisfaction; children's mental health services; service reforms; integrated services.

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1062-1024/98/1200-0451$15.00/0

There is widespread agreement that children with Severe Emotional Disturbance (SED) have been ill-served by an inadequately conceptualized and organized mental health care system. Major criticisms have been leveled at the absence of integration among public sector service agencies, the inappropriateness of care (i.e., symptom reduction and crisis-only approaches to chronic emotional problems), and the lack of monitored, long-term service planning and delivery (Knitzer, 1993; Saxe, Cross, Silverman, 1988; Tuma, 1989). In response to this crisis, major reform efforts have been launched around the country that emphasize: (a) legislated coordination among child-serving agencies in order to reduce fragmentation; (b) the creation of community-based services that deal with problems in adaptation and well-being rather than crisis management only; and (c) ongoing coordination of care so that children and youth remain linked to services that can help to maintain them in their natural environments (Stroul & Friedman, 1986). As referred to by the last of these features, case management is currently a favored tool among policy makers to reduce the use of expensive, "deep end" care (e.g., inpatient hospitalization, residential treatment) in favor of less costly home, school, and community based services (Chamberlain & Rapp, 1991).

Despite case management's role in service system reforms and its legitimization in the form of public policy (Knitzer, 1993), an absence of systematic evaluations of case management has left it unclear whether families even want this type of service in the first place. Historically, families and caregivers have been treated as the primary cause of children's psychopathology by human service professionals (Surber, 1994). As a result, families are often skeptical of service providers and inclined to under-utilize if not reject social services when dissatisfied (Greenley & Robitschek, 1991). Primary-care studies and research in the area of adult mental health have found that dissatisfaction with the patient-physician relationship often predicts poor treatment compliance, under-utilization, and premature termination (Attkisson, Roberts, & Pascoe, 1983). At present, family satisfaction with children's case management services has not been investigated systematically. Yet, given the primacy of the relationship between families and case managers as well as the possibility that client evaluations could mediate treatment outcomes (Lebow, 1983; Williams, 1994), assessments of family satisfaction with case management are vitally needed.

Although client satisfaction is seen as an important indicator of service effectiveness (Williams, 1994), a number of important conceptual and methodological issues have impeded progress in its usage. First, measures of client satisfaction are typically developed by social scientists or service providers with little attention given to the perspectives of service recipients (Greenley & Robitschek, 1991; Williams, 1994). Consequently, the opera-

tional definitions that underlie most measures of satisfaction often neglect issues of genuine concern to families in favor of professionals' untested assumptions.

A second major limitation of family satisfaction research is that most studies typically examine client satisfaction independently of objective service characteristics and other possible determinants of satisfaction such as patient demographics. Reviews of the client satisfaction literature (Lebow, 1983; Ruggeri, 1994; Williams, 1994) indicate that when service variables such as length of care, treatment setting (inpatient vs. outpatient), and provider orientation have been included in studies, there have been few consistent links between family satisfaction and service characteristics (Ruggeri, 1994). Demographic variables such as age, gender, and race have also been inconsistent or poor predictors of client satisfaction with mental health services (Lebow 1983; Ruggeri, 1994). Unlike service variables where we would hope to see positive associations between high satisfaction and indicators of actual service quality, the lack of association between satisfaction and demographic data could, in fact, indicate that services are functioning similarly for different groups. In contrast, diagnostic variables have emerged as the most consistent predictors, with satisfaction tending to be lowest among adult clients with the most severe forms and level of pathology (Lebow, 1983; Ruggeri, 1994). Given that case management services have been intentionally prescribed to children and families with the most severe forms of problems and needs, research is needed in order to determine whether this is an effective and satisfactory type of service for this group.

A third limitation pertains to the point that few studies have included objective outcome measures when assessing subjective measures of satisfaction. Given that case management services for SED children are intended to help maintain children in their own communities, measures of hospital recidivism and length of stay in residential treatment facilities might be correlates, if not important predictors of parental satisfaction. In one of the few studies of children's case management services, Evans, Banks, Huz, and McNulty (1994) found that SED children were hospitalized less and for shorter periods following enrollment into an intensive coordinated care program. Although parental satisfaction was not measured in this study, it would be reasonable to speculate that parents would be most satisfied when children were able to stay out of the hospital. On the other hand, parental satisfaction might be low if community based services were not provided in lieu of hospital treatment or if non-hospitalized children overwhelmed the coping resources of parents. In sum, inclusion of demographic, clinical, and outcome data, in addition to actual service measures, is needed if we are to understand whether children's case management services are perceived as satisfactory by parents and in the best interest of children and families.

The present study was conducted by the Family Mosaic Project of San Francisco in order to evaluate parental satisfaction with its case management services for SED children and youth. To implement this study, the Family Mosaic Project first relied on a group of its own parents to specify what they felt were the key ingredients of effective case management. The product of this process was the Family Satisfaction Survey (FSS) which served as the evaluation instrument in the present investigation. Three central questions were addressed. First, based on qualitative information derived during the FSS's development, what are the most important dimensions of case management to parents of SED children? Second, how satisfied are parents with children's case management services in one integrated care setting? Finally, which client (e.g., demographic and clinical), service, and outcome variables best predict parent satisfaction, and does the inclusion of these measures improve our understanding of which SED children and families are perceived as benefiting from case managed systems of care?

METHOD

Setting

The Family Mosaic Project, launched in 1990 with grant funds from the Robert Wood Johnson Foundation (RWJ), is a local demonstration of multiagency collaboration, family participation, and community-based service delivery within a capitated system of financing (see Cole & Poe, 1993). At the center of Family Mosaic's system of care is its interagency case management unit which provides intensive service coordination for SED children currently in or at imminent risk for out-of-home placement. Family Mosaic's case managers, with average case-loads of 10-12 families, perform a variety of functions with the overarching goal of promoting child and family adaptation through the delivery of home, school, and community-based services.

Procedures

The present evaluation study was conducted in three phases. Phase one involved the development of the Family Satisfaction Survey (FSS). During the second phase, FSS questionnaires and posted return envelopes were mailed to the primary care giver of all currently enrolled Family Mosaic clients. Questionnaires were numerically coded so that questionnaires could be linked to demographic and clinical data maintained by the agency. Each FSS was enclosed with a cover letter, signed by an agency parent and Family Mosaic's executive director, that assured families that responses would

be treated confidentially and in the aggregate. Families were also guaranteed that no one directly involved in their day-to-day care would have access to completed surveys. During the third phase, client, service, and outcome data were extracted from children's active case records and linked to the parent satisfaction data.

Family Satisfaction Survey (FSS)

The satisfaction questionnaire used in the present study was developed by a group of agency parents, with technical assistance with scale construction and item refinement provided by the first author. During the course of a year, thirteen members of a parent support group drew on personal experience to identify essential characteristics of good case management (for a more comprehensive description of the instrument's development see Measelle, 1993). Parents identified four broad aspects of case management that they felt contributed to their satisfaction and dissatisfaction. These included case managers': (a) professionalism (e.g., availability to families, responsiveness, honesty and integrity, and discretion and confidentiality); (b) job-related competencies (e.g., case monitoring practices, information and knowledge base, effective system coordination, and effective interventions during crises); (c) commitment to partnership with parents (e.g., genuine involvement and advocacy, acknowledgment of parents' decision making rights and responsibilities, active support of parental decision making, and protection parents' legal rights); and (d) respectful, non-blaming views of parents (e.g., demonstrated respect of parents and non-blaming attitudes and assumptions).

Based on the these four domains, the final version of the FSS consisted of 27 items, all of which were intended to address the following central question: "How satisfied are you with the basic services provided by your case manager?" All items were rated on a 4-point Likert-type scale ranging from 1 ('very dissatisfied') to 4 ('very satisfied'). The FSS also included two quality assurance items. First, parents were asked whether they wished to continue working with their current case manager. Second, attached to the FSS was a separate consent form which provided parents with the means to initiate mediation procedures by requesting to have either the clinical director, case management supervisor, or a "neutral" parent advocate contact them.

Case Record Information

Additional demographic, services, and outcome data were extracted from official client records. Standard in all Family Mosaic client records is

information about children's (a) age, (b) gender, (c) ethnicity, and (d) psychiatric diagnosis. Upon enrollment in Family Mosaic, all children were psychologically assessed by a licensed professional and DSM diagnoses made on all five Axes. At the time of this study, DSM-III-R (American Psychiatric Association's Diagnostic and Statistical Manual of the Mental Disorders, 1987) was the current diagnostic nosology.

For each family, the date of entry into the Family Mosaic Project was extracted from clinical records. Based on this date, the following variables were calculated: (a) length of case management services (date of entry minus date survey sent to all families); and (b) estimate of the average amount of monthly telephone *and* face-to-face contact between family members and the case manager (recorded in monthly billing reports). This mean was computed by dividing the total number of contacts since enrollment by the length of case management service variable. An estimate of (c) the case load size for each of the Family Mosaic case managers was also derived.

From agency billing statements, we extracted information about the number of days children had spent in (a) residential treatment; and/or (b) psychiatric hospitalization since entry into Family Mosaic and up to the date the FSS surveys were mailed. As with the contact variable, the absolute number of days a child spent in either treatment setting would vary depending on how long families had been with Family Mosaic. Thus, each count was divided by the length of service variable. The resulting data reflected the proportion of time since enrollment that each child had spent outside of their home in residential care and in psychiatric hospitals. For example, if a child had been hospitalized a total of 18 of his 90 Family Mosaic days, his individual score would be .20, meaning that 20% of his time since enrollment had been spent in a psychiatric hospital.

Sample

One-hundred fourteen FSS questionnaires were mailed to the parent(s) or primary care-taker(s) of every child and youth in the active case load of the agency. Demographic and clinical data are presented in Table 1 for respondents and non-respondents.

Of the 114 active families who were sent an FSS, 51 (44.7%) returned completed questionnaires. A total of 32 (63%) questionnaires were completed by mothers, 10 (19%) by grandmothers, 6 (10%) by legal female guardians (e.g., foster parent), and 4 (8%) by fathers. Of those children whose parent or primary caretaker responded to the survey, 73% were boys and 27% were girls. The mean age was 13.4 year for boys (SD= 3.0), and 12.8 years for girls (SD= 4.0). Approximately 61% of these children were

Table 1. Demographic and Diagnostic Information of Respondents and Non-respondents

	Respondents (n = 51)	Non-respondents (n = 63)
Age		
4 to 9	22.4%	13.5%
10 to 14	36.8%	38.4%
15 to 20	40.8%	48.1%
Mean	13.2 yrs.	13.4 yrs.
Gender (child)		
Male	72.9%	80.8%
Female	27.2%	19.2%
TOTAL	100.0%	100.0%
Ethnicity		
African-American	61.1%	69.2%
Asian-American	3.0%	4.0%
Caucasian	10.2%	11.5%
Latino	14.3%	11.5%
Native-American	2.1%	0.0%
Biracial	9.3%	3.8%
TOTAL	100.0%	100.0%
Axis I Diagnoses		
Affective disorders	35%	39%
Conduct disorders	27%	33%
Attention deficit disorder	14%	8%
Anxiety disorders	6%	8%
Psychotic disorders	6%	2%
Adjustment disorders	2%	6%
Other disorders	4%	4%
Developmental disorders	6%	0%
TOTAL	100%	100%
Major internalizing disorders	43%	52%
Major externalizing disorders	41%	40%
Other primary Axis I disorders	16%	8%
TOTAL	100%	100%
Axis II Diagnoses		
Deferred	43%	35%
No diagnosis	33%	35%
Personality disorders	10%	20%
Developmental disorders	14%	10%
TOTAL	100%	100%
Axis IV (Severity of Psychosocial Stressors)		
Moderate (score = 3)	21%	20%
Severe (score = 4)	65%	64%
Extreme (score = 5)	14%	16%
TOTAL	100%	100%
Axis V (Global Assessment of Functioning: GAF)		
90-71 (few if any symptoms)	0%	0%
70-61	4%	4%
60-51	22%	16%
50-41 (serious impairment)	43%	55%
40-31	27%	23%
30-21	4%	2%
20-1 (maximum danger to self)	0%	0%
TOTAL	100%	100%

African-American, 12% were Latino, 11% were Caucasian, 10% were Biracial, and 6% were of other ethnic backgrounds.

Diagnostically, mood (35%) and conduct disorders (27%) were the two most common Axis I disorders among children in the responding part of the sample. Twenty-six percent had comorbid diagnoses. Using Achenbach's and McConaughy's (1987) empirical grouping of childhood syndromes, 43% of the children in the responding sample had a major internalizing disorder (e.g., depression or anxiety), whereas 41% had a major externalizing disorder (e.g., conduct disorder or attention deficit disorder). Diagnosed developmental (14%) and personality disorders (10%) were much less prevalent. Nearly two-thirds (65%) of the children in the responding sample had been exposed to severe forms of psychosocial stress prior to entry into the project as indicated by the severity score on Axis IV of the DSM-III-R's multiaxial system (M = 3.92 for the responding sample, SD = .59). At referral, 74% of the children in the responding sample were assessed as seriously impaired or worse as indicated by the global assessment of functioning (GAF) score on Axis V (GAF M = 46.5, SD = 8.45). In summary, these demographic and clinical data confirm that Family Mosaic's clients meet criterion for the SED classification. Moreover, these data are consistent with other published data on SED children and youth who reside in San Francisco County (Barber, Rosenblatt, Harris, & Attkisson, 1992).

A series of chi-squares and one-way ANOVAs were conducted to compare the demographic and clinical characteristics of the 51 families that returned surveys with the 63 families that did not. Results reveal that respondents and non-respondents did not differ in terms of children's mean age, gender, ethnicity, or length of time under clinical case management. Similarly, children's primary diagnoses did not differentiate respondents from non-respondents, nor did levels of psychosocial stress or children's level of functioning. In sum, these data suggest the families and children who participated in the present study were demographically and clinically similar to those who chose not to participate.

RESULTS

The Structure of Parents' Satisfaction with SED Children's Case Management

We first conducted a principal components analysis (PCA) with a varimax rotation of the initial results to identify the FSS's primary dimensions. Using Cattell's scree test as a guide to factor retention, the PCA yielded a two-factor solution that reflected parent satisfaction with case managers'

interpersonal qualities and partnership practices on the one hand (13 items; 82.0% of the total variance), and parent satisfaction with case managers' job-related competencies on the other (14 items; 6.2% of the total variance). Although meaningful conceptually, extensive cross-loadings (11 items had cross-loadings of .45 or greater) and a high correlation between scale scores ($r = .78, p < .001$) suggested that the FSS was tapping one rather than multiple dimensions of parental satisfaction. As such, in the remaining analyses, we used a global measure of parent satisfaction which was the mean of all 27 items. The internal consistency of this unidimensional satisfaction score was high (Chronbach's $\alpha = .93$).

Levels of Parents' Satisfaction with Children's Case Managers

Overall, parents were quite satisfied with the agency's case managers ($M = 3.26, SD = 1.11$). A total of 38 (74.5%) parents indicated some level of satisfaction with their case manager. Of these, 29 (56.9%) parents tended to be very satisfied and 9 (17.6%) tended to be mostly satisfied with case managers. On the other hand, a sizable minority of the agency's parents reported clear dissatisfaction, with 13 (25.5%) expressing some degree of dissatisfaction. Seven (13.7%) parents tended to be very dissatisfied, while 6 (11.8%) parents tended to be mostly dissatisfied with their case manager. In order to explore the possible ramifications of differing levels of satisfaction, parents' ratings on the two quality assurance items were analyzed next.

Bivariate correlations revealed that high parental satisfaction tended to correlate significantly with the desire to retain current case managers ($r = .63, p < .001$). Examined categorically, 44 (86%) of the parents or surrogate parents reported that they wished to continue working with their current case manager, including all 39 of the very or mostly satisfied respondents. By comparison, not all dissatisfied parents wished to stop working with their case manager. Although six out of seven very dissatisfied families wished to stop working with their case manager, none of the six mostly dissatisfied respondents expressed this desire.

Parents' use of the FSS's mediation form was also examined to investigate whether the desire to continue with a current case manager, despite feelings of dissatisfaction, was related to the belief that these concerns could be addressed. As might be expected, satisfied parents tended not to use the mediation option. In all, 17 parents (33%) requested mediation, including: the 6 mostly satisfied parents who did not wish to terminate with their case manager; 6 of the 7 very dissatisfied parents who did wish to

terminate with their case manager; and 5 of the 6 mostly dissatisfied parents who did not wish to terminate with their case manager.

Predictors of Parental Satisfaction with Children's Case Management Services

The inclusion of client, service, and outcome variables in the analysis of consumer satisfaction with mental health services can help to provide a more detailed picture of how services are perceived relative to how they are actually working. As indicated in Table 2, children's age, gender, and race were unrelated to parental satisfaction with case managers. To preserve power, children's primary diagnosis at referral was examined according to Achenbach's and McConaughy's (1987) empirically based groupings of major childhood syndromes (internalizing, externalizing, and other behavioral/emotional disorders). Still, children's primary diagnosis was statistically unrelated to parental satisfaction.

In contrast, clinicians' ratings of the level of psychosocial stress in children's lives at enrollment (Axis IV of DSM-III-R's multiaxial system) was significantly associated with parent satisfaction. Children faced with less severe forms of psychosocial stress tended to have parents who were more satisfied with case managers. Similarly, children's GAF score at referral was also related to parental satisfaction. As shown in Table 2, parent satisfaction was significantly higher in families where children were less rather than more impaired.

Children and families had been receiving case management services through Family Mosaic a mean of 21 months (SD = 12.71 months, range = 2 to 41 months) at the time of this evaluation. As shown in Table 2, however, parental satisfaction was not related to length of service. Similarly, the size of the managers' case load (M = 9.5, SD = 3.30; including respondents and non-respondents) was also unrelated to parent satisfaction.

At the time of this study, Family Mosaic employed 12 case managers. All case managers had at least 2 client families return completed questionnaires, with 7 as the highest response rate for any one case manager (M = 4.3 families per case manager; SD = 2.21). Although 8 (67%) of the case managers had at least one dissatisfied family in the sample, all 12 case managers had at least one satisfied family in their case load; on average, 79% of the families in each managers' case load were satisfied. These descriptive findings suggest that the agency's entire staff contributed to the high level of parental satisfaction. Likewise, accountability for parental dissatisfaction was borne by more than two-thirds of the staff.

Table 2. Interrelations Among Parent Satisfaction, Client, Service, and Outcome Variables

		1	2	3	4	5a	5b	6	7	8	9	10	11
1.	Satisfaction	—											
Client Variables													
2.	Age	.09	—										
3.	Gender[a]	.01	.04	—									
4.	Race[b]	−.12	−.07	−.08	—								
5a.	Axis I[c]	−.13	−.10	.11	.02	—							
5b.	Axis I[d]	.06	−.38**	−.12	.05	.17	—						
6.	Axis IV	−.32*	−.05	.01	−.19	.19	.14	—					
7.	Axis V	.36**	−.02	.13	.05	−.19	.25	−.45***	—				
Services Variables													
8.	Length of Service	.03	.19	−.16	.17	.10	.11	.16	−.04	—			
9.	Case Size	.07	.16	−.04	.16	.17	.01	.08	−.30*	.29*	—		
10.	Contact	.39**	.02	−.01	−.21	.25	.12	.01	.01	.11	.24	—	
Outcome Variables													
11.	Residential	.09	.11	−.18	−.14	−.25	−.34*	−.25	.08	−.07	−.11	.05	—
12.	Hospital	−.41**	−.18	−.12	.11	−.04	.12	−.05	−.14	−.18	.06	−.13	.08

[a](Male = 0, Female 1).
[b](African-American = −1, Other Disorders = 0, Externalizing = 1).
[c](Internalizing = −1, Other Disorders = 0, Externalizing = 1).
[d](Internalizing = 0, Other Disorders = 1, Externalizing = 1).
$N = 51$. *$p < .05$; **$p < .01$; ***$p < .001$.

The third service variable examined was an estimate of the mean amount of monthly contact between families and their case managers. On average, families and case managers spoke or met with each other more than five times per month (M = 5.79, SD = 2.83). As shown in Table 2, parental satisfaction tended to increase significantly the more contact families had with their case manager each month. Examined descriptively, case managers had over twice as much contact each month with very satisfied (M = 6.32, SD = 2.82) and mostly satisfied parents (M = 6.89, SD = 2.95) than they did with very dissatisfied parents (M = 3.10, SD = 1.90) and approximately 40% more contact each month than with mostly dissatisfied parents (M = 4.82, SD = 1.58).

Examined next was the relationship between parental satisfaction and time children spent in residential treatment settings and in psychiatric hospitals (as a proportion of time since enrollment into Family Mosaic's case management system). Children's mean number of days in residential placement was 71.6 days (SD = 174.34; range = 0 to 839) and the mean number of hospital days was 7.7 days (SD = 14.46, range = 0 to 52) while receiving services through Family Mosaic. As indicated in Table 2, parental satisfaction was unrelated to the proportion of time children spent in residential placements but was significantly related to the hospitalization index. Specifically, parental satisfaction was higher the less time proportionally that children were hospitalized. In other words, parents tended to be more satisfied when children were able to be maintained at home or in their communities rather than in psychiatric settings.

Multivariate Predictors of Parental Satisfaction

Using multiple regression procedures, we next examined which of the significant or near significant client, service, and outcome variables best predicted parental satisfaction. With parents' continuous global satisfaction score serving as the dependent variable, the following variables were entered simultaneously into a regression equation: (a) two effect codes were entered to account for the contributions of children's primary diagnostic category; (b) the severity of children's psychosocial stress (Axis IV); (c) children's global assessment of functioning score at enrollment (Axis V); (d) the average monthly contact between families and case managers; and (e) the number of days children spent in the hospital proportional to their length of time with Family Mosaic.

As shown in Table 3, these five variables explained approximately 46% ($p < .001$) of the variance in parents' satisfaction with their case manager. However, the only unique, independent predictors of parental satisfaction

Table 3. Regression of Parental Satisfaction with Case Management Service on Select Client, Service, and Outcome Variables

Variable	B	SE(B)	t	R^2
Child's Axis I				
Effects Code 1	−.18	.12	−1.50	.03
Effects Code 2	.10	.13	.78	.02
Severity of Psychosocial Stress	−.26	.13	−1.93	.05
GAF Score	.13	.14	.94	.03
Average Monthly Contact	.13	.04	3.17**	.16**
Hospitalization	−.38	.12	−3.19**	.17**
Total R^2				.46***

**$p < .01$; ***$p < .001$.
$N = 51$.

were the amount of monthly contact between families and case managers and the amount of time children spent in a psychiatric hospital proportional to their time with Family Mosaic. In a final series of regression models, different interaction terms were tested. Of particular interest was whether or not parental satisfaction varied as a function of the interaction between (a) the amount of psychosocial stress in children's lives and the mean amount of monthly contact between families and case managers; or (b) the severity of children's disabilities and the mean monthly contact with case managers. Contrary to expectation, none of the interactions tested proved significant. Thus, in the present study, after controlling for differences in child and service factors, greater monthly contact between families and case managers and lower rates of child psychiatric hospitalization emerged as the best independent predictors of parent satisfaction with the agency's case management services.

DISCUSSION

This study was undertaken by the Family Mosaic Project of San Francisco, an integrated service agency, to evaluate parental satisfaction with its case managed system of care for children and youth with SED. A particularly important aspect of this evaluation lies in its utilization of a parent-developed satisfaction measure. Traditionally, the vast majority of client satisfaction measures have been developed by stake-holders other than service recipients (Lebow, 1983; Ruggeri, 1994). As a result, the validity of consumer satisfaction data has been questioned. In order to include parent perspectives, not only in the evaluation of but also in the conceptualization of quality case management services, Family Mosaic invited parents to develop a satisfaction questionnaire. Although empirical analysis

of the resulting 27-item survey only supported a single satisfaction factor, it is noteworthy that this parent-developed instrument still yielded findings that are germane to effective service delivery, whereas most professionally developed satisfaction measures have fallen short of this mark (Greenley & Robitschek, 1991).

Results from this study are encouraging as approximately 75% of the parents and primary caregivers of SED children were quite satisfied with their families' case management services. Moreover, fully three-quarters of the families in each case managers' case load expressed satisfaction with their case manager. Parental satisfaction did not differ as a function of most *client* variables, including children's age, gender, and primary clinical diagnosis; *service* variables, including length of service and case load size; or the *outcome* variable of number of days spent in residential treatment proportional to length of time with Family Mosaic. Two variables, one service and one outcome, were identified as independent predictors of parent satisfaction. After controlling for child diagnosis, severity of impairment, and levels of psychosocial stress, parent satisfaction with case management services was best predicted by (a) the frequency of monthly contact between families and their case manager; and (b) fewer days in a psychiatric hospital proportional to the length of time with Family Mosaic.

One interpretation of these findings would suggest that parents are indeed largely satisfied with case management services for SED children and youth. Families caring for SED children have service needs in multiple domains. Historically, child and family services have been dispersed throughout various human service agencies, each with their own bureaucratic entitlement procedures as well as professional cultures that maintain critical, if not harmful attitudes of families. However, in addition to drawing on managers' knowledge of the system to help SED children and families gain access to needed services, newer models of case management emphasize the crucial role that case managers play in providing families with practical *and* emotional support (Surber, 1994). These results suggest that such services are well-received by parents as assessed on dimensions identified by parents themselves.

On the other hand, given the correlational nature of these data, we cannot rule out the possibility that the positive views of some parents drive the provision of greater amounts of service and, possibly, result in case management decisions that keep children out of psychiatric hospitals. Nevertheless, several findings in this study help to counter the claim that satisfied parents are easier to work with and, thus, have children for whom case management works more effectively. First, the significant prediction of parent satisfaction by contact with case manager and psychiatric hospitalization was independent of child impairment and levels of psychosocial

stress. Second, at the bivariate level, contact between families and case managers was unrelated to the severity of children's impairment, levels of psychosocial stress, and to the number of days children spent in hospitals. As such, case managers were no more likely to interact with the parents of less impaired children or children who required less hospitalization than they were to interact with more complicated cases. Finally, recall that this sample consisted *only* of families of children with severe emotional disturbances; even the least impaired children and families in this sample had very complex psychiatric and psychosocial service needs. That satisfaction was linked at all to a service or outcome indicator is significant given that parents of SED children have historically received little in the way of effective public mental health services (Knitzer, 1993).

Despite high overall levels of parental satisfaction, a significant minority (approximately 26%) of the Family Mosaic's parents expressed some level of dissatisfaction with their case management services. Children and youth with serious emotional disturbances have historically been one of the hardest populations to serve. Not only do they require multiple services on an ongoing basis, but problems in many areas of their lives regularly undermine their adaptation. As such, we may still lack adequate and satisfactory service technologies for a number of these children and their families. In the present study, an important distinction emerged among parents at different levels of dissatisfaction: compared to all but one of the highly dissatisfied parents who wanted to terminate with their current case manager, none of the mostly dissatisfied parents wished to terminate with their case manager. The fact that all of the parents in this latter group requested mediation suggests that some may still believe that their concerns could be redressed through formal discussions with agency personnel. In general, incorporating mediation mechanisms in evaluation methods may help to promote trust among respondents and a willingness to respond more openly. More importantly, such steps may also provide service providers and recipients with the opportunity to make adjustments to children's care that could help guard against treatment failure.

Several limitations of this study bear mention. First, the small sample size obtained within one treatment setting necessitates that the study's findings be viewed with some caution; additional studies are needed before we can draw firmer conclusions about the *perceived* effectiveness of case management services for populations of SED children and youth. Second, parents' evaluation of case management services are just one of the necessary perspectives to assess. Including children's evaluations of their care is likely to improve our understanding of case management as well as to identify service barriers when discrepancies among various stake-holders are identified.

Finally, parental satisfaction may have been influenced by other setting characteristics and qualities, in particular, the fact that Family Mosaic had the resources needed to employ a select, well trained staff of case managers whose average case loads of 10 families per manager are small by social service standards (Surber, 1994). Demonstration projects often produce positive results given their financial resources, high-caliber staff, and optimal service conditions (Ruggeri, 1994; Williams, 1994). Although this idea underscores the importance of service evaluations beyond early phases of program implementation, in the present context, high levels of parental satisfaction may reflect that intensive case management can be an effective service for SED children and youth when appropriately conceptualized and funded.

Nonetheless, these results demonstrate a high level of parental satisfaction with the case management services provided by a "demonstration" project to the families of children with severe emotional disturbances. Further, these findings highlight the importance of frequent contact between families and case managers as well as case management's role in helping to keep children out of psychiatric hospitals and in their communities. The strengths of these results are two-fold: first, they were derived using a measure developed by parents and second, this study used objective measures of client characteristics, services characteristics, and child outcome indicators as objective barometers of perceived service effectiveness and parental satisfaction. Thus, these data have content and predictive validity, both so essential in monitoring the effectiveness of services delivery, as perceived by the recipients of these services.

ACKNOWLEDGMENTS

This work was supported by a Robert Wood Johnson/Family Mosaic Project pre-doctoral research fellowship to Jeffrey Measelle. We wish to acknowledge our appreciation of the substantial contributions of Dr. Karyn Dresser. Many thanks are owed to Lois Jones of Parents Helping Parents. Finally, our special thanks to the children, parents, and families who participated in this research and who receive services through the Family Mosaic Project.

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