



Foster Family-based Treatment Association

User's Guide to Measuring Consumer Satisfaction in Treatment Foster Care

Produced for the Foster Family-based Treatment Association (FFTA)

by Martha Morrison Dore, Ph.D. | January, 2010

EXECUTIVE SUMMARY

Agencies that provide Treatment Foster Care (TFC) often need to meet demands from funders or accrediting bodies to collect consumer satisfaction information. Other agencies may be motivated to collect such information for a Board or management. Or, they may want to monitor and improve service quality or staff and treatment family performance. Some treatment foster care agencies may use these data to inform strategic planning or for external marketing purposes. Others may want information about consumer satisfaction to help interpret client outcomes.

Learning how to collect consumer satisfaction information or how to assess methods already in place are often concerns for treatment foster care agencies. Questions about the term “consumer satisfaction” and the various ways it can be measured may be raised. Concerns about the pros and cons of selecting a particular data collection method, or what resources are required to support such an effort, may be expressed. The methods that other FFTA members use to measure this construct may be of interest to other TFC agencies contemplating such an undertaking.

This *User's Guide to Measuring Consumer Satisfaction in Treatment Foster Care* has been developed to address these and other frequently voiced questions and concerns. It was produced by Martha Morrison Dore, Ph.D., for the Foster Family-based Treatment Association (FFTA). This Guide was developed with the support, direction, and oversight of members of the FFTA Consumer Satisfaction Survey Ad-Hoc Committee, a subcommittee of the FFTA Research Committee. Ad-Hoc Committee members were:

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In addition to the *User's Guide*, an accompanying reference list is available for those who want to do further reading on a particular topic or about a specific instrument. Links are also provided to examples of “home-grown” instruments that have been used by FFTA member agencies to collect consumer satisfaction information. A decision tree is also provided that outlines factors to consider when measuring consumer satisfaction.

User's Guide to Measuring Consumer Satisfaction in Treatment Foster Care

I. What Do We Mean By “Consumer Satisfaction” And Why Measure It?

Consumer or client satisfaction are terms that came into widespread prominence in the late 1960s and early 1970s with the growth of the consumer movement in health and mental health care. As federal funding for community mental health services increased during this period, there was a corresponding belief that the recipients of these services should help to assess their effectiveness. In one early study of the use of consumer satisfaction measures in community mental health centers, McPhee, Zusman and Joss (1975) found that in 1973, 35% of federally funded centers measured consumer satisfaction. By the end of that decade it was found that nearly half of such centers were measuring this aspect of service delivery (Sorensen, Kantor, Margolis, & Galano, 1979).

As the effort to measure the satisfaction of consumers with health and mental health services became more widespread, questions were raised about the quality of such measurement. What did the term “consumer satisfaction” really mean? And, did the instruments that were being used to measure satisfaction with services accurately capture this concept? Jay Lebow (1983b), who conducted one of the first extensive reviews of the research on consumer satisfaction, defined the term as “the extent to which services gratify the client’s wants, wishes or desires for treatment” (p. 212). Others have defined consumer satisfaction as reflecting the degree to which the client’s experience in treatment matches his or her expectations, or the difference between what was received and what was expected (Locker & Dunt, 1978; Williams, 1994).

The implications of various definitions for measuring consumer satisfaction are significant with various populations. For example, if consumer satisfaction reflects the measure of treatment experience against expectations, what are the implications for measuring this outcome in children and youth who may have few or no expectations regarding treatment prior to the experience? This is just one of the concerns about measuring youngsters’ satisfaction with treatment; others will be addressed later in this guide.

Other client populations such as individuals from different cultures who have little knowledge or understanding of western health care, and especially mental health care, may have expectations that are vastly different from expected care in this country. In one early examination of how cultural and ethnic differences affect consumer satisfaction, Ellmer and Olbrisch (1983) suggest that a culturally-determined world view may significantly influence how mental health treatment is understood, utilized, and evaluated by consumers. For example, cultures differ significantly in their expectations regarding family involvement in the treatment of a child. The focus of the mental health system on treating the child separate from the family, or the common practice of relating primarily to the child’s mother as the primary caregiver, may conflict with cultural family roles and the primacy of the male head of household in making treatment decisions.

II. How Is Consumer Satisfaction Measured?

A. Unitary measures of consumer satisfaction

Efforts to measure consumer satisfaction with human services, particularly mental health services, began in earnest in the late 1960s and early 1970s with the community mental health movement. Researchers and community providers developed a variety of instruments to measure this construct, but none has been more widely used than the Consumer Satisfaction Questionnaire (CSQ), developed by mental

health researchers led by Clifford Attkisson and Daniel Larsen at the University of California at San Francisco (Larsen, Attkisson, Hargreaves, & Nguyen, 1979). This instrument is composed of a series of brief questions (“Did you get the kind of service you wanted?” “If a friend were in need of similar help, would you recommend our program to him or her?”). Each question is answered using a 4-point Likert scale. The instrument began as an 18-item questionnaire (Attkisson & Zwick, 1982), but was shortened to eight questions, to create the CSQ-8. The cumulative responses of the CSQ-8 provide a single or unitary client satisfaction score. Possible scores range from 8 points, indicating high dissatisfaction, to 32 points, indicating high satisfaction. The CSQ-8 has been repeatedly validated for its reliability and validity as a measure of consumer satisfaction with mental health services. It is commonly used in human service agencies because of its ease in administration and scoring. In addition, it has been shown to correlate with client-reported symptom reduction and has been used across cultures with no differences (Attkisson & Zwick, 1982; Druss, Rosenheck, & Stolar, 1999).

Despite the ease of using a brief unitary measure of client satisfaction, like the CSQ-8, such a measure fails to elicit information that can help providers better understand specific sources of satisfaction and dissatisfaction with their services. In addition, overall scores on unitary measures of consumer satisfaction are commonly quite high (negatively skewed), suggesting something else may influence clients’ responses, such as the need for social approval (Gaston & Sabourin, 1992; Ross, Steward, & Sinacore, 1995).

Indicating that a need for social approval might be evident in the high rates of consumer satisfaction found on unitary measures, one study found that oral administration of consumer satisfaction instruments increase satisfaction scores by 10% (Lebow, 1983a). Another study found that clients were more likely to express dissatisfaction with mental health services when the questionnaire was administered by a fellow consumer than by a member of the clinic staff (Clark, Scott, Boydell, & Goering, 1999). This suggests there may be some hesitancy on the part of consumers to express their dissatisfaction with services directly to the service provider, particularly if the client feels it is likely that services may be needed again in the future.

Another study, this one of adolescent group home services in Alameda County, California, used former group home residents as interviewers with similar results (Green & Ellis, 2008). Residents’ comments to interviewers reflected significantly less satisfaction with group home performance than that reported by staff. This suggests that the respondent’s perspective is also a factor in consumer satisfaction, a particularly important consideration in children’s services where parents and others are often the primary reporters.

Despite these concerns, unitary measures, like the CSQ-8, are frequently used to measure consumer satisfaction for human services with both adults and adolescents. Those who use such a brief, quantitative measure often supplement it with open-ended questions such as, “What did you like most about the services you received in XYZ program?” and, “What did you like least about this program?” Such questions allow consumers the opportunity to comment more fully on their experience if they choose. Often, despite indicating a high level of satisfaction with services overall, given the opportunity, consumers will indicate some area of service delivery with which they were dissatisfied. This provides an additional level of detail that can help service providers identify specific aspects of their programs that require examination.

B. Multidimensional measures of consumer satisfaction

Concerns regarding the utility of using a unitary measure of consumer satisfaction, like the CSQ-8, have led to research on various factors in the provision of mental health services that appear to predict consumer satisfaction (Garland, Saltzman, & Aarons, 2000). These efforts aim to develop more comprehensive

measures of client satisfaction. Factors explored in these multidimensional measures may be grouped into three general categories: structure, process, and outcome. Factors related to the structure of services include frequency, consistency, and duration of care; access to and convenience of services; and training, experience, and continuity of staff, among others. Process factors involve the type and content of treatment, as well as aspects of the therapeutic relationship. Outcome factors are related to client change, usually symptom reduction or psychosocial functioning, in one or more life domains. Outcome factors and their relation to consumer satisfaction will be discussed more fully in the following section.

Factors relating to the structure of mental health services that have been found to correlate highly with consumer satisfaction include: the ease of access to and the convenience of location to outpatient services (Brannan, Sonnichsen, & Heflinger, 1996); the fit between available services and client needs (Edlund, Young, Kung, Sherbourne, & Wells, 2003); the level of family involvement in children's care (Greenley & Robitschek, 1991; Hawley & Weisz, 2005; Hubner, Jones, Miller, Custer, & Critchfield, 2006); the focus on problem resolution as opposed to personality change (Lebow, 1982); the service quality as reflected in qualifications and training of clinical staff (Druss et al., 1999); and the provision of information about treatment (Stallard, 1996).

Recently, the most widely researched factor in consumer satisfaction has become the therapeutic process, including the helping relationship or alliance between client and clinician. Multiple studies have examined the correlation between the helping relationship and consumer satisfaction, including several studies in children's services (Brannan et al., 1996; Green & Ellis, 2007; Hawley & Weisz, 2005; Shapiro, Welker, & Jacobson, 1997). Most have found a high correlation between satisfaction with the helping relationship and consumer satisfaction with services overall.

Multidimensional measures of consumer satisfaction have drawn on this research to construct instruments that capture satisfaction with specific elements of service delivery in an effort to better inform service provision. For example, Garland and her colleagues created a multidimensional scale of adolescents' satisfaction with mental health services, entitled the Multidimensional Adolescent Satisfaction Scale (MASS) (Garland et al., 2000). Based on qualitative interviews with 41 adolescents, as well as a review of the literature on measuring client satisfaction, the authors of the MASS created and tested a 39-item questionnaire containing eight domains of client satisfaction: (1) accessibility/convenience; (2) meeting needs; (3) staff competence; (4) interpersonal relationship with staff; (5) effectiveness; (6) cultural/developmental appropriateness of services; (7) costs and paperwork; and (8) family involvement. Convergent and discriminant validity of the instrument were examined through simultaneous administration of the CSQ-8, which has been used with adolescents and adults, and among a variety of cultures.

Factor analysis of test results on the MASS revealed that the eight original domains could be collapsed into four: (1) counselor qualities; (2) meeting needs; (3) effectiveness; and (4) counselor conflict. In addition, the total number of questions on the instrument could be decreased from 39 to 21. Respondents to the revised instrument expressed the highest level of satisfaction with the "counselor qualities" domain, which reflects the skills of the clinician and the respondent's perceived relationship with the service provider, the process, and the dimension of care. Satisfaction was lower with regard to the effectiveness and structure ("meeting needs") of service delivery. Few respondents expressed dissatisfaction with services on the domain titled "counselor conflict," which consisted of questions reflecting negative perceptions of a clinician's behavior ("Counselor always thinks s/he is right," "Counselor too nosey"). The authors contend that the MASS responds to many criticisms of unitary measures of consumer satisfaction. Findings from this instrument do indicate that measurement of the perceived skill of, and quality of the relationship with, the provider of therapeutic services is an essential component of any measure of client satisfaction with adolescents.

Similarly, Shapiro and colleagues (1997) developed the Youth Client Satisfaction Questionnaire (YCSQ), a 14-item instrument with two subscales or dimensions: relationship with the therapist (process dimension) and benefits of treatment (outcome dimension). Scores on this instrument were found to positively correlate with both youth and parent reports of improvement in youth functioning. The YCSQ was administered by telephone and was structured to be understood by youth 11 years of age and older with low average intelligence. In this study, youth satisfaction was not related to youth-reported changes in mental health symptoms. Satisfaction with services was highest in younger respondents and those who had more treatment sessions.

Efforts to measure youth and parent satisfaction in the Ft. Bragg study of a system of care in children's mental health services identified four dimensions to this measurement, reflecting the three categories of factors identified earlier. The Ft. Bragg study dimensions were (1) access and convenience (structure); (2) child's treatment process (process); (3) parent and family services (structure); and (4) global satisfaction (outcome) (Brannan et al., 1996; Heflinger, Sonnichsen, & Brannan, 1996). Data were collected on 984 families whose children, ages 5 to 18, had received behavioral health services.

III. Treatment Outcomes And Their Relationship To Consumer Satisfaction In Children's Mental Health Services

The relationship of consumer satisfaction with symptom reduction and/or improved behavioral functioning post-treatment has long been a focus of research interest (Lunnen, Ogles, & Pappas, 2008; Pekarik & Wolff, 1996). In children's services, the strength of this relationship appears to depend primarily on the respondent's perspective (Godley, Fiedler, & Funk, 1998; Lambert, Salzer, & Bickman, 1998; Rey, Plapp, & Simpson, 1999). Overall, youth self-reported symptom improvement or positive change in behavior is more likely to be correlated with consumer satisfaction than is the case with parents or clinicians (Garland, Aarons, Hawley, & Hough, 2003). But even then, most studies have found this relationship to be relatively weak where it exists (Kaplan, Busner, Chibnall, & Kang, 2001; Shapiro et al., 1997).

Rather than a direct relationship between consumer satisfaction and treatment outcomes, it appears likely that this relationship is mediated by an intervening variable: the therapeutic relationship. Research on consumer satisfaction, in general and in children's services, shows process variables, including the therapeutic relationship, to be highly correlated with treatment outcomes including symptom reduction and improved psychosocial functioning (Hawley & Weisz, 2005).

IV. Special Considerations In Measuring Consumer Satisfaction With Children's Mental Health Services

An obvious question that arises in measuring consumer satisfaction with children's mental health services is "who is the consumer? Is it the child, the child's parents or other caregivers, or the referring agency that is purchasing the services?" This question arises because a child under 18 years of age is not traditionally considered to be a consumer of mental health services. With a child, unlike the case for most adults except those who are significantly impaired, services are customarily chosen for him or her by others (Young, Nicholson, & Davis, 1995). The child, depending on age, level of cognitive development, and life experience, may even have little recognition that his or her psychosocial functioning is problematic (Schwab & Stone, 1983; Shapiro, Welker, & Jacobson, 1997). Children of preschool or early latency age typically see the source of their difficulties as residing outside themselves. Other people do things to them

that cause them to react in particular ways. Children who have been psychologically damaged by abuse and/or neglect in their early years may continue to demonstrate this projective understanding into their teens and continue to blame others for their difficulties.

In a more normal developmental trajectory, children of school age begin to differentiate internally-driven states and reactions from those originating outside themselves. They may understand expected behavior in specific situations but feel unable to conform to such expectations because of their own internal deficits or shortcomings. Earlier they may have felt that they were at the mercy of external processes. Now they may feel at the mercy of internal processes that seem unrelenting and uncontrollable. For children of all ages, emotional state affects cognitive processing, judgment, and memory, such that mood may be a primary factor in a youth's evaluation of services (Mah, Tough, Fung, Douglas-England, & Verhoef, 2006).

Emotional and behavioral difficulties in children are most often defined by others, such as parents and teachers, and treatment is sought for them by others. As a result, treatment may be perceived by the child as punishment rather than an effort to help (Schwab & Stone, 1983). As mentioned previously, one of the most accepted definitions of consumer satisfaction is the relationship between expectations of treatment and the actual experience (Sitzia & Wood, 1997). For a child whose understanding and expectations of treatment are limited or, more likely, non-existent, measuring the consumer satisfaction construct becomes problematic. Further, if a child's difficulties are more painful to others than they are to him, how can a child be expected to recognize the success of treatment as measured in symptom reduction or enhanced psychosocial functioning, which are the usual outcome factors considered in consumer satisfaction?

As a result of these challenges, children's services most often take a multi-perspective approach, measuring parents' and other caregivers' satisfaction with services, as well as that of referral and funding sources in addition to the child's (Byalin, 1993; Garland, Haine, & Boxmeyer, 2007; Godley et al., 1998; Greenley & Robitschek, 1991; Lambert et al., 1998; Rey et al., 1999; Rouse, MacCabe, & Toprac, 1994; Stallard, 1996). Studies that have measured consumer satisfaction from a variety of perspectives have found very little convergence between consumer satisfaction and treatment outcome as perceived by parents, clinicians, referents, and the youth served (Garland et al., 2003, 2007; Kaplan et al., 2001; Lambert et al., 1998; Shapiro et al., 1997). The one aspect of treatment that shows a consistent relationship with satisfaction across all reporting groups is the therapeutic process, in particular, the helping alliance (Hawley & Weisz, 2005).

V. Methods For Measuring Consumer Satisfaction In Children's Services

A. Standardized instrument versus "homegrown": Selecting and adapting a measure of consumer satisfaction

As is evident from the review of the current research on measuring consumer satisfaction, selecting an appropriate measurement instrument requires thoughtful consideration of a number of factors. The first of these considerations is, "What do we want to know and why?" The second is "Who is the audience for this information?" And, finally, "What resources do we have to spend finding this out?"

As discussed above, there are two primary types of measures for consumer satisfaction: the unitary measure and the multidimensional measure. The unitary measure is short and usually includes no more than ten brief items or questions. It is easy to administer and score. The scoring is additive so that a single number indicating level of satisfaction is obtained. If a single consumer satisfaction score is sufficient for an agency's purposes, then a unitary measure, like the CSQ-8, may be entirely satisfactory. Further, the CSQ-8 and a

few other instruments like it, have been tested extensively on a variety of populations and with many different kinds of services. It has excellent psychometric support for validity and reliability. Using a standardized instrument will also enable comparisons with national norms, as well as norms for specific populations or service types, where available. If an agency wants assurance that it is doing a good job overall and needs hard data to present to funders and other external stakeholders that suggest positive performance as viewed by service recipients, a unitary measure of consumer satisfaction may be all that is needed.

In the children's field, Stuntzner-Gibson, Koren and DeChillo (1995) have developed a five-item unitary scale, the Youth Satisfaction Questionnaire (YSQ), which was modeled after the CSQ to measure satisfaction with services in youth nine years old and older. In addition to the five questions indicating overall satisfaction with services, this instrument asks respondents to grade the specific services they received over the past six months on a scale from A to F.

Rouse and colleagues (1994) have also developed a written, self-report measure of satisfaction for children, ages six to 18, the Child and Adolescent Satisfaction Questionnaire (CASQ), along with a companion questionnaire for parents, the Family Satisfaction Questionnaire (FSQ). Each instrument is composed of 12 items using a 5-point Likert scale response, along with two additional questions, one, a checklist of barriers to service, and the other, an open-ended question asking for further comment. Cumulative scoring on the 12 items results in a total score of 12 (low satisfaction) to 60 (high satisfaction). In Rouse et al's psychometric testing of these two instruments, the mean score for parents on the FSQ was 51 while the mean score for youth on the CASQ was 50.

The downside of using a unitary measure is the limited information it gives a provider about satisfaction with specific program elements. As can be seen by the high mean scores for both parents and youth on the FSQ and CASQ described above, unitary measures of client satisfaction customarily yield very high scores, suggesting they are not sensitive enough to elicit dissatisfaction with specific aspects of service received. As with any copyrighted instrument, there may be costs involved in purchasing the rights to use a standardized instrument, as well as time and expertise required to score and analyze the results.

Another possibility is to adapt a unitary measure, like the CSQ-8, by adding additional questions that relate to the specific services provided, while keeping the original scale intact. These additional questions may be in a forced choice format like the existing items on the instrument, or they may be open-ended questions that ask the respondent to elaborate on a specific aspect of the program or service. In addition to asking the consumer to comment on what he or she liked most and least about the program, other examples of open-ended questions might be, "If you could change one thing about the program, what would that be?" or "What would you tell someone who is just entering the program about what to expect?"

Adding items to an existing standardized unitary measure changes the underlying structure of the instrument and affects the existing psychometrics to some degree. Keeping the basic instrument intact by adding items that can be analyzed separately helps to address this concern, but doesn't mitigate it entirely. Adding items that call for a qualitative response can add to the cost of analysis, as extracting themes from qualitative data, depending on the number of responses, can be a labor intensive process requiring specific expertise. However, many programs find these costs to be offset by the additional insights gained from consumers' responses to even one or two open-ended questions.

The alternative to a unitary standardized measure of consumer satisfaction is using a multidimensional measure. Such measures generally contain more items or questions than the unitary type and these items address the three domains of program structure, process and outcome. Several multidimensional instruments

have been developed to measure consumer satisfaction with children's services. These include the Youth Client Satisfaction Questionnaire (YCSQ) (Shapiro et al., 1997) discussed previously. Through psychometric testing, its developers found the YCSQ to be a reliable and valid measure of satisfaction with services for young clients. Parents in their study completed the Parent Satisfaction Questionnaire (PSQ) (Kotsopoulos, Elwood, & Oke, 1989), which measures parents' satisfaction with services received by their children.

Another multidimensional instrument is the Multidimensional Adolescent Satisfaction Scale (MASS), described previously in this guide. This instrument was developed and extensively tested by Garland and her colleagues at the Child and Adolescent Services Research Center at the University of California at San Diego (Garland et al., 2000; 2003; 2007).

An alternative to using an established multidimensional measure of consumer satisfaction is to create your own. A close reading of the work of Garland, Shapiro and others who have created such instruments can provide a foundation of knowledge regarding their construction. In addition to reviewing others' work, these and other developers of consumer satisfaction measures have used focus groups of current or former service recipients to identify items to be included in such a survey. Reviewing well-constructed instruments can help you to understand how questions are constructed, as well as how to use different types of response categories. One study of various forms of client satisfaction instruments found a four-point Likert scale to be the most efficient and effective format for item response (Ross, Steward, & Sinacore, 1995). Carrying out the necessary psychometric testing to establish the reliability and validity of a "home-grown" measure, as well as the factor analysis necessary to determine the internal structure of the instrument, is likely to be beyond the resources of many youth-serving agencies. It may be possible to enlist the assistance of researchers at a local college or university in constructing a home-grown measure.

The benefit of creating your own multidimensional measure of consumer satisfaction is the opportunity to examine responses to specific aspects of a program or service provided. This can give a provider substantive information about areas needing attention or, conversely, aspects that are working well. In one study of how providers use results from consumer satisfaction surveys, Davis and her colleagues (1995) found that 55% of providers had used such feedback to make at least one specific program change. Other providers reported using consumer satisfaction data to develop new services, inform funders, and change agency policies.

Despite what type of instrument is selected to measure consumer satisfaction, the method of administering this instrument is an important consideration. How an instrument is administered has significant implications for the rate of consumer response, as well as the reliability of the data collected.

B. The measurement process

A number of studies have looked at various methods for gathering consumer satisfaction information including in-person interviews, self-administered written questionnaires, telephone interviews, mailed surveys and electronically-administered questionnaires. These studies have also looked at who administers the questionnaire or conducts the in-person or telephone surveys to see if the identity of the interviewer makes a difference in how consumers report satisfaction with services. Studies have also differentiated among data sources by method of administration to see if it makes a difference whether the respondent is a child, a parent, an employee (such as a clinician), a foster parent, a community referent, or a funding source.

A written, self-administered questionnaire is the most widely used method of measuring consumer satisfaction (Davis et al., 1995) because of its ease in administration and low personnel cost. Such a measure can be mailed, completed by the person onsite or administered online. The second most widely used method is the in-person interview, and the third is the telephone interview.

Some of the challenges of collecting consumer satisfaction information from children and youth have been previously addressed in this guide. These challenges are more or less relevant depending on the method used for gathering information. For example, a child or youth's reading level, conceptual ability, and psychosocial functioning are significant considerations when administering a written self-administered questionnaire. An in-person or telephone interview, which can be conducted in a conversational manner, tends to work better with children and young adolescents (Godley et al., 1998; Shapiro et al., 1997). A skilled interviewer who is accustomed to working with children can also manage some of the cognitive, emotional, and attention problems that may interfere with the child or youth's ability to respond to a structured survey.

Depending on the child or youth, social desirability may be a concern, particularly in an in-person or telephone interview. One effort to address this issue is seen in a study of youth group home services in California, in which the in-person interviews of residents about to transition out of the program were conducted by other residents who were specifically trained for the task (Green & Ellis, 2007; 2008). With the current emphasis on consumer participatory research, using current or former program recipients to interview other youth can be a particularly effective method of eliciting valid and reliable data, provided the interviewers are well-trained and supervised. In the Green and Ellis study, youth who served as interviewers were brought into the study from the very beginning, helping to identify important elements of the program that should be included in the survey. There were 22 structure- and process-related items in the final survey, which were highly correlated with residents' satisfaction with the group home program.

If an in-person interview or self-administered questionnaire is used with either a youth or a parent, it is clear that this should not be carried out by the same clinician who has worked with the family or the child. A mailed questionnaire has the advantage of anonymity, which addresses social desirability concerns; however, it is clear from a wide variety of studies that the response rate to mailed questionnaires is usually very low and without a great deal of follow-up (Byalin, 1993; Huebner et al., 2006).

Studies suggest that those who are most satisfied with a program are also most likely to return a mailed questionnaire, thus providing a skewed impression of the program's impact (Lebow, 1983b). Time between the end of treatment and the administration of a consumer satisfaction measure, as well as the length of the data collection instrument itself, also influence the rate of response to mailed questionnaires. Other factors which influence higher response rates in consumer satisfaction surveys include mutual termination of treatment, longer treatment length, and more positive rating of consumer's progress in the program by the clinician (Lebow, 1983b).

The timing of the measurement of consumer satisfaction has also been found to be important. Collection of consumer satisfaction data at the point of discharge or termination of services appears to elicit the most valid and reliable data. Once consumers leave a program, other life events begin to influence how the consumer views the services he or she received in retrospect. As time from discharge increases, findings on consumer satisfaction surveys become less related to the treatment experience and more reflective of the consumer's current situation. Parents who may have been very satisfied with the treatment of their child in a program at discharge may feel differently a year later when the child is skipping school and getting into trouble with the law.

C. *Sampling strategies in consumer satisfaction surveys*

The question of how many consumers to survey is one that arises in measuring consumer satisfaction, particularly when an agency's resources are limited. Is it better to administer a mailed questionnaire that can be sent to all consumers at a fairly low cost, despite the likelihood of a low response rate, or to interview a selected number of consumers at a higher cost to ensure adequate participation? If the latter, how many consumers are sufficient to reliably reflect the true level of consumer satisfaction with a program or service? Is it necessary to obtain satisfaction data from the whole population (all of the consumers who have participated in the program or received services), or a sample (some percentage of that population) of the consumers in question? If a sample would suffice, how is the number to be surveyed or interviewed chosen?

There are several issues to think about when deciding how many consumers to survey. One is the complexity of the instrument being administered. If a well-standardized unitary measure of consumer satisfaction is to be used, such as the CSQ-8 or another instrument modeled on that format, the satisfaction score is a single number or variable value and a smaller percentage of the population is needed to represent the whole. On the other hand, if the instrument to be used is a multidimensional measure, especially one that is homegrown without assurance of its reliability and validity, then eliciting a response from as large a percentage of the eligible population as possible becomes more important. This is because multidimensional measures provide scores on several dimensions or variables. The more variables on which data are being collected, the larger the sample size necessary to insure the results adequately reflects the population as a whole.

Another consideration is the variation in the population to be surveyed or interviewed. If a population is homogeneous with regard to age, sex, race, ethnicity, and diagnosis, then fewer members of the group are needed to represent the whole. However, the more variation there is in the population, the greater the number of respondents needed to adequately reflect the group as a whole.

In general, the closer the number of respondents corresponds to the total number in the population under study, the more confident one can be that data from these respondents accurately reflect the characteristics of the population that is being studied. A rule of thumb is that a sample size for a survey should be a minimum of 60% of the population to make any claims about the reliability and validity of findings. The idea here is to ensure that the results are more accurate than what would be obtained by chance (50/50). As such, mailed questionnaires, which commonly elicit a response rate of significantly less than 50% of eligible respondents, are often not worth the time and effort that it takes to generate an adequate rate of response. If a mailed questionnaire is used, specific methods for increasing the response rate include enclosing a self-addressed, stamped envelope; enclosing a token payment, such as a dollar bill or postage stamps; and sending a reminder post card one week after the original survey is mailed. One study of methods for eliciting consumer satisfaction information found that the combination of a mailed survey and a follow-up telephone interview, for those who did not return the survey, was the most effective strategy for increasing the response rate over either method used alone (Lebow, 1983b).

When judging the validity of responses to a survey questionnaire, it is also important to compare the non respondents to those who did respond. If a questionnaire is anonymous, this is not possible. However, if questionnaires can be linked by name to consumers surveyed, then a comparison of demographic and treatment characteristics can be carried out to see if those returning the questionnaire differed in some substantial way from those who did not. As mentioned previously, studies have found that those who take time to complete a client satisfaction questionnaire are more likely to be satisfied with a program than those who

did not respond. It is helpful in making decisions about how to interpret consumer satisfaction data to know if there are other differences, such as progress in treatment or level of psychosocial functioning at discharge.

If a decision is made to sample the eligible population to assess consumer satisfaction, random selection of the sample to be interviewed or surveyed is important to avoid biasing the results. Using a Table of Random Numbers, which can be found online at <http://stattrek.com/Tables/Random.aspx> or at the end of any statistics textbook, is a good way to ensure a random selection of participants. A numbered list of eligible participants is created and the Table of Random Numbers is then consulted to determine the order of selection. For example, if the number 15 is the first number listed in the Table, the 15th participant on the list would be selected as the first consumer to be surveyed. Selection continues until the predetermined sample size is complete. Sampling with replacement is also possible, such that all eligible individuals in a population are assigned a sampling order. If a sample participant cannot be located or refuses to consent to an interview, he or she can be replaced by the next name on the list so the sample size is maintained.

VI. Measuring Consumer Satisfaction In Treatment Foster Care

A 2009 survey of agency members of the Foster Family-based Treatment Association (FFTA) found that 79% (N=72) of the 91 responding agencies collect consumer satisfaction information from at least one participant group. This information is most often collected from the children and youth served (94% of the 72 agencies that collect consumer satisfaction data; N=68), but is also collected from foster parents (N=66; 92%), community agencies and referents (N=57; 79%), and birth families (N=36; 50%).

Of those agencies that indicated using a standardized or “homegrown” instrument to measure consumer satisfaction, most used homegrown instruments. Only nine respondents indicated that they used a standardized measure to elicit consumer satisfaction information from children and youth, six used a standardized instrument with foster parents, seven with community agencies and referents, and four with birth families. Five agencies used only standardized instruments to measure consumer satisfaction with all groups measured, while four agencies used some combination of homegrown and standardized instruments, depending on the consumer group. Although it might be expected that the larger agencies in the survey would have more resources to invest in selecting and using standardized instruments to measure consumer satisfaction, in this study there appeared to be no relationship between agency size and investment in using standardized instruments to measure consumer satisfaction.

When asked to indicate at what point in the treatment experience consumer satisfaction was measured with children and youth, 60 (88%) of the 68 agencies that measure satisfaction in this group indicated that they measured it during the youth’s placement, 36 (53%) agencies measured satisfaction at discharge, and 11 (16%) at a follow-up point sometime after the child or youth has left treatment foster care. A number of respondents reported measuring youth satisfaction with treatment at several points in the treatment process, including discharge and follow-up. Just 18 agencies measured youth satisfaction during treatment only, while two measured it at discharge only, one measured it only at termination and follow-up. With one exception, all agencies who measured youth satisfaction at follow-up also measured it during treatment and at discharge. Interestingly, those agencies that indicated using a standardized instrument to measure youth satisfaction were more likely to collect these data during treatment only, not at discharge or follow-up.

Three agencies who collected youth satisfaction data at a follow-up point after discharge indicated that they did so six months after the youth’s discharge from treatment foster care; one agency did a six-week

follow-up; three agencies did a three-month follow-up; two agencies contacted discharged youth every six months for the 18 months, and two agencies contacted youth annually.

Satisfaction data are collected from treatment foster parents during a youth's placement in 55 of the 66 agencies that collect these data. Thirty-one agencies collect treatment foster parent satisfaction data when a child is discharged from the home; and, in six agencies, foster parents are surveyed at a follow-up point after the child has left placement. At least one agency reported collecting foster parent satisfaction data annually whether foster parents currently have a child in their care or not.

Similarly, satisfaction data are collected from community agencies and referents by 45 agencies during a child's placement and by 30 agencies when a child is discharged. Thirteen agencies collect these data at some follow-up point after a child has left care.

Of the 36 respondents who indicated that they collect consumer satisfaction information from birth parents or family caregivers of the youth in care, most (N=27; 75%) collect these data while the youth is in treatment foster care. Seventeen agencies indicated that they collect birth parent/caregiver satisfaction data when the child is discharged from treatment foster care, while five agencies collect such data at follow-up.

Treatment foster care agencies that report collecting consumer satisfaction data (N=72) indicated using a variety of methods for doing so. Most (N=66; 92%) report using mailed questionnaires to collect these data, while smaller numbers use in-person interviews (N=29; 40%), telephone interviews (N=23; 32%), and on-line surveys (N=14; 19%). Most agencies used a combination of data collection methods, including 23 that used both in-person interviews and mailed questionnaires and 22 that used both mailed questionnaires and telephone interviews. It is not possible to tell from these data if different methods were used with different groups of respondents; whether, for example, youth in treatment foster care participated in an in-person interview, while mailed questionnaires were sent to the child's birth parents and the referring agency. Those agencies using online surveys seemed to use them most frequently in tandem with mailed surveys, suggesting they may be seen as a more convenient alternative to a mailed questionnaire rather than as a supplement to an in-person interview as they are often used with youth in diagnostic assessments.

Most treatment foster care agencies (93%) that report collecting consumer satisfaction information indicated that they actively use these data in a variety of ways. Only five agencies that collect these data report that they don't currently use the information, perhaps because of difficulties in analyzing the data and putting it into useable form. All of the agencies who use the data they collect do so to evaluate their foster family treatment program and to assure the program's quality. Most also use the information for program and staff development purposes. A slightly smaller percent use consumer satisfaction data to evaluate the performance of program staff and treatment foster parents. Other uses to which treatment foster care agencies use data on consumer satisfaction included strategic planning and marketing, as well as understanding client outcomes.

In addition to completing the survey questionnaire, several FFTA members submitted the consumer satisfaction instruments they currently use for analysis. One large treatment foster care agency with program sites in multiple states surveys youth, foster parents, birth parents, referring agencies, and program staff. The youth, birth parent, and referent questionnaires are similar in format, with a series of 14 brief questions about the respondent's experiences with the program and outcome for the youth in care. One question relates to overall satisfaction with the experience in the program. Forced choice responses to these questions are indicated on a 3-point Likert-type scale, such as 'not at all,' 'somewhat,' and 'very much.' There is also space for comments at the end of the questionnaire.

The questionnaire for treatment foster parents is quite different from those for the other three groups of participants, perhaps reflecting the centrality of the foster parents' role in the organization. The questions relate more specifically to the structure and process of the organization. In addition to 14 forced choice items, there are write-in responses to six specific questions about the organization, including one which asks the foster parent to describe his/her satisfaction with the agency.

This agency posts the results of the youth survey on its web site and compares scores on individual items with responses from the previous year's survey, indicating its concern with quality improvement and program development.

Another series of consumer satisfaction questionnaires was submitted by a large multi-service agency providing foster care among an array of services to children and families with special needs. This agency surveys youth, birth parents, and collateral agencies. Youth and birth parents receive a similar ten item forced choice questionnaire. Questions are brief, easily understood, and require a 4-point Likert response from 'never' to 'always.' Eight of the items relate to the experience of the child or family served in treatment foster care, such as "Did the staff listen to you?" "Did the staff treat you with respect?" The ninth item asks if the service was helpful and the tenth asks if the respondent would recommend the service to someone else who needed help. There is a tenth item that asks the respondent to grade the care received on a scale of 10 (high) to 1 (low), or A to F.

The satisfaction survey for collateral organizations used by this agency is shorter than that used for youth and birth parents, with five forced choice items, the item requesting an overall rating of service received, and two open-ended questions, one asking for the names of any staff deserving special recognition and why, and the other asking the respondent to identify suggested improvements in the program.

Several treatment foster care agencies submitted questionnaires used to survey treatment foster parents annually regarding their experiences with the host agency. Generally, these instruments contain a series of questions about the foster parents' satisfaction with the process involved in placing a child in their home, with the training offered by the host agency, and with the supervision and support they receive from various agency staff members. All of these instruments also provide opportunities for foster parents to write in comments and suggestions regarding the various areas identified in the questionnaire.

Most consumer satisfaction instruments submitted for this analysis were designed as self-report questionnaires. One foster parent satisfaction measure was designed to be administered via telephone interview. This instrument is very brief, consisting of five open-ended questions and one forced choice question that asks the respondent to rate their relationship with different groups of individuals significant to the role of the treatment foster parent including birth parents, case managers, therapists, and agency administrators. According to the instructions to the interviewer, this telephone interview is designed to take ten minutes, a period of time well within the established standard for telephone surveys with known respondents, which is ten to 20 minutes.

VII. Summary

The survey of Foster Family-based Treatment Association member agencies, as well as the analysis of currently-used instruments designed to measure consumer satisfaction in treatment foster care, indicates a wide range of approaches to measuring this construct. Current research on the measurement of consumer satisfaction supports these efforts and provides direction regarding ways to make them more efficient and

effective. This guide has outlined the factors to be considered in any decision on measuring consumer satisfaction in treatment foster care. The first of these decisions must be about the purpose and intended use of such information. If a single indicator of overall consumer satisfaction is all that is required, a unitary measure that can be adapted from an existing measure for each of the participating groups to be surveyed, and that can be administered in person, by telephone, or by mail at treatment discharge, will suffice. The addition of one or two open-ended questions requesting the consumer to comment on the most and least favorable aspects of the services received can provide guidance to agencies regarding interpretation of the unitary satisfaction score derived from the forced choice questions on the instrument. These data can also be used for program and staff development and quality improvement purposes, although their contribution is more limited than information from a multidimensional questionnaire.

A multidimensional questionnaire will give the provider significant additional information about consumer satisfaction with specific program elements, including program structure, process, and outcomes. As noted previously, consumer satisfaction with process elements, such as the relationship with program staff, has been found to be associated with positive treatment outcomes. Youth in treatment foster care who express greater satisfaction with their relationships with foster parents and other direct service staff have more satisfactory outcomes as indicated by improved psychosocial functioning and symptom reduction.

Most treatment foster care agencies that use a multidimensional instrument to measure consumer satisfaction have developed their own instrument to reflect specific aspects of their program's structure, process, and outcomes. Information included in this guide about existing standardized multidimensional instruments, their construction, and their content may help these agencies to assess and improve their current measures. It may also help agencies that are considering the development of a multidimensional measure to have a clearer understanding of how to construct such an instrument and some of the advantages and pitfalls in developing and using such a measure.

Measuring consumer satisfaction in treatment foster care can make a significant contribution to program improvement, quality assurance, and staff development as seen in the research reviewed here. Consumer satisfaction data also helps support strategic planning, marketing, and appeals to potential funders. Despite often limited resources, investment in measuring consumer satisfaction can provide substantial returns to agencies that engage in this process. It is hoped that the information provided in this guide can aid in planning the most effective strategies for measuring consumer satisfaction in children's services.

ABOUT FFTA

FFTA



The Foster Family-based Treatment Association (FFTA) was established in 1988 to promote, develop, improve, and support the quality of Treatment Foster Care. Since that time, FFTA has grown to become the leader in treatment foster care. Its 400 member agencies provide treatment foster care services to over 50,000 children and youth each year and a larger array of services to over 600,000 children and youth throughout North America. In carrying out its mission to strengthen agencies that support families caring for vulnerable children, FFTA provides Program Standards, technical assistance, professional development programs and other resources to help agencies improve their programs. FFTA and its chapters advocate at the local and Federal levels for the funding that agencies and families need to create positive outcomes for children and youth in out-of-home care.

Factors to Consider When Measuring Consumer Satisfaction



REFERENCES

- Attkisson, C. C. & Zwick, R. (1982). The Client Satisfaction Questionnaire: Psychometric properties and correlations with service utilization and psychotherapy outcome. *Evaluation and Program Planning*, 5, 233-237.
- Brannan, A. M., Sonnichsen, S. E., & Heflinger, C. A. (1996). Measuring satisfaction with children's mental health services: Validity and reliability of the satisfaction scales. *Evaluation and Program Planning*, 19, 131-141.
- Byalin, K. (1993). Assessing parental satisfaction with children's mental health services: A pilot study. *Evaluation and Program Planning*, 16, 69-72,
- Clark, C. C., Scott, E. A., Boydell, K. M., & Goering, P. (1999). Effects of client interviewers on client-reported satisfaction with mental health services. *Psychiatric Services*, 50(7), 961-963.
- Davis, M., Young, S., & Nicholson, J. (1995). Use of consumer satisfaction information to promote change child/adolescent mental health settings. Paper presentation at the 9th annual conference on children's mental health research, *A System of Care for Children's Mental Health*, University of South Florida. Tampa, FL.
- Druss, B., Rosenheck, R. A., & Stolar, M. (1999). Patient satisfaction and administrative measures as indicators of the quality of mental health care. *Psychiatric Services*, 50(8), 1053-1058.
- Edlund, M. J., Young, A. S., Kung, F. Y., Sherbourne, C. D., & Wells, K. B. (2003). Does satisfaction reflect the technical quality of mental health care? *Health Services Research*, 38(2), 631-645.
- Ellmer, R. & Olbrisch, M. E. (1983). The contribution of a cultural perspective in understanding and evaluating client satisfaction. *Evaluation and Program Planning*, 6, 275-281.
- Garland, A. F., Aarons, G. A., Hawley, K. M., & Hough, R. L. (2003). Relationship of youth satisfaction with mental health services and changes in symptoms and functioning. *Psychiatric Services*, 54(11), 1544-1546.
- Garland, A. F., Haine, R. A., & Boxmeyer, C. L. (2007). Determinates of youth and parent satisfaction in usual care psychotherapy. *Evaluation and Program Planning*, 30, 45-54.
- Garland, A. F., Saltzman, M. D., & Aarons, G. A. (2000). Adolescent satisfaction with mental health services: Development of a multidimensional scale. *Evaluation and Program Planning*, 23, 165-175.
- Gaston, L., & Sabourin, S. (1992). Client satisfaction and social desirability in psychotherapy. *Evaluation and Program Planning*, 15, 227-231.
- Godley, S. H., Fiedler, E. M., & Funk, R. R. (1998). Consumer satisfaction of parents and their children with child/adolescent mental health services. *Evaluation and Program Planning*, 21, 31-45.
- Green, R. S. & Ellis, P. T. (2007). Linking structure, process, and outcome to improve group home services for foster youth in California. *Evaluation and Program Planning*, 30, 307-317.
- Green, R. S. & Ellis, P. T. (2008). Foster youth evaluate the performance of group home services in California. *Evaluation and Program Planning*, 31, 174-180.
- Greenley, J. R. & Robitschek, C. G. (1991). Evaluation of a comprehensive program for youth with severe emotional disorders: An analysis of family experiences and satisfaction. *American Journal of Orthopsychiatry*, 61(2), 291-310.
- Hawley, K. M. & Weisz, J. R. (2005). Youth versus parent working alliance in usual clinical care: Distinctive associations with retention, satisfaction, and treatment outcome. *Journal of Clinical Child and Adolescent Psychology*, 34(1), 117-128.

References continued

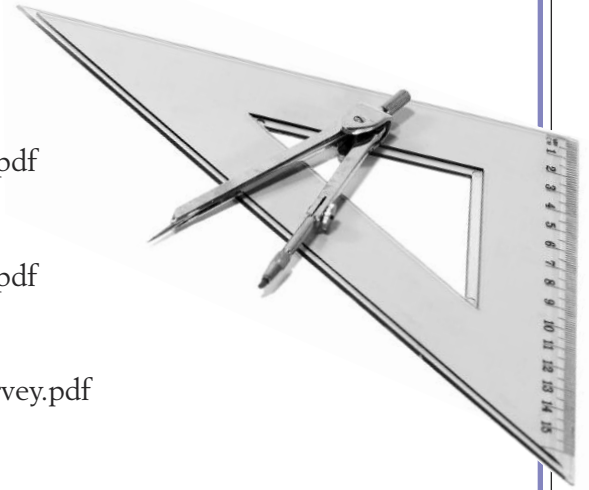
- Heflinger, C. A., Sonnichsen, S. E., & Brennan, A. M. (1996). Parent satisfaction with children's mental health services in a children's mental health managed care demonstration. *Journal of Mental Health Administration*, 23, 69-79.
- Huebner, R. A., Jones, B. L., Miller, V. P., Custer, M., & Critchfield, B. (2006). Comprehensive family services and customer satisfaction outcomes. *Child Welfare*, 85(4), 691-714.
- Kaplan, S., Busner, J., Chibnall, J., & Kang, G. (2001). Consumer satisfaction at a child and adolescent state psychiatric hospital. *Psychiatric Services*, 52(2), 202-206.
- Kotsopoulos, S., Elwood, S., & Oke, L. (1989). Parent satisfaction in a child psychiatric service. *Canadian Journal of Psychiatry*, 34, 530-533.
- Lambert, W., Salzer, M. S., & Bickman, L. (1998). Clinical outcome, consumer satisfaction, and ad hoc ratings of improvement in children's mental health. *Journal of Consulting and Clinical Psychology*, 66, 270-279.
- Larsen, D. L., Attkisson, C. C., Hargreaves, W. A., & Nguyen, T. D. (1979). Assessment of client/patient satisfaction: Development of a general scale. *Evaluation and Program Planning*, 2, 197-207.
- Lebow, J. L. (1982). Consumer satisfaction with mental health treatment. *Psychological Bulletin*, 91, 244-259.
- Lebow, J. L. (1983a). Client satisfaction with mental health treatment: Methodological considerations in assessment. *Evaluation Review*, 7, 729-752.
- Lebow, J. L. (1983b). Research assessing consumer satisfaction with mental health treatment: A review of findings. *Evaluation and Program Planning*, 6, 211-236.
- Lunnen, K. M., Ogles, B. M., & Pappas, L. N. (2008). A multiperspective comparison of satisfaction, symptomatic change, perceived change, and end-point functioning. *Professional Psychology: Research and Practice*, 39(2), 145-152.
- Locker, D. & Dunt, D. (1978). Theoretical and methodological issues in sociological studies of consumer satisfaction with medical care. *Social Science & Medicine*, 12, 283-292.
- Mah, J. K., Tough, S., Fung, T., Douglas-England, K., & Verhoef, M. (2006). Adolescent quality of life and satisfaction with care. *Journal of Adolescent Health*, 38, 607.e1-607.e7.
- McPhee, C. B., Zussman, J., & Joss, R. H. (1975). Measurement of patient satisfaction: A survey of practices in community mental health centers. *Comprehensive Psychiatry*, 16(4), 399-404.
- Pekarik, G., & Wolff, C. B. (1996). Relationship of satisfaction to symptom change, follow-up adjustment, and clinical significance. *Professional Psychology: Research and Practice*, 27(2), 202-208.
- Rey, J. M., Plapp, J. M., & Simpson, P. L. (1999). Parental satisfaction and outcome: A 4-year study in a child and adolescent mental health service. *Australian and New Zealand Journal of Psychiatry*, 33, 22-28.
- Ross, C. K., Steward, C. A., & Sinacore, J. M. (1995). A comparative study of seven measures of patient satisfaction. *Medical Care*, 33(4), 392-406.
- Rouse, L. W., MacCabe, N., & Toprac, M. G. (1994). Measuring satisfaction with community-based services for children with severe emotional disturbances: A comparison of questionnaires for children and parents. In C. Liberton, K. Kutash, & R. Friedman (Eds). *Proceedings of the 8th Annual Research Conference: A System of Care for Children's Mental Health: Expanding the Research Base* (pp. 95-96). Tampa, FL: Research and Training Center for Children's Mental Health.

References continued

- Schwab, M. E. & Stone, K. (1983). Conceptual and methodologic issues in the evaluation of children's satisfaction with their mental health care. *Evaluation and Program Planning*, 6, 283-289.
- Shapiro, J. P., Welker, C. J., & Jacobson, B. J. (1997). The Youth Client Satisfaction Questionnaire: Development, construct validation, and factor structure. *Journal of Child Clinical Psychology*, 26(1), 87-98.
- Sitzia, J. & Wood, N. (1997). Patient satisfaction: A review of issues and concepts. *Social Science and Medicine*, 45(12), 1829-1843.
- Sorensen, J., Kantor, L., Margois, R., & Galano, J. (1979). The extent, nature and utility of evaluating consumer satisfaction in community mental health centers. *American Journal of Community Psychology*, 7, 329-337.
- Stallard, P. (1996). The role and use of consumer satisfaction surveys in mental health services. *Journal of Mental Health*, 5(4), 333-349.
- Stuntzner-Gibson, D., Koren, P. E., & DeChillo, N. (1995). What kids think of services: The Youth Satisfaction Questionnaire. *Families in Society*, 76, 616-624.
- Williams, B. (1994). Patient satisfaction: A valid concept? *Social Science & Medicine*, 38(4), 509-516.
- Young, S. C., Nicholson, J., & Davis, M. (1995). An overview of issues in research on consumer satisfaction with child and adolescent mental health services. *Journal of Child and Family Studies*, 4, 219-238.

Sample “Homegrown” Consumer Satisfaction Measurement Tools Submitted by FFTA Member Agencies

- **Foster Child/Youth Satisfaction Survey-Sample 1**
http://ffta.org/members/sample_tools/foster_child_survey_1.pdf
- **Foster Child/Youth Satisfaction Survey-Sample 2**
http://ffta.org/members/sample_tools/foster_child_survey_2.pdf
- **Foster Child/Youth Satisfaction Survey-Sample 3**
http://ffta.org/members/sample_tools/Youth_Satisfaction_survey.pdf
- **Foster Parent Satisfaction Survey-Sample 1**
http://ffta.org/members/sample_tools/FP_Satisfaction_Survey.pdf
- **Foster Parent Satisfaction Survey-Sample 2**
http://www.ffta.org/members/sample_tools/sample_ssf.pdf
- **Foster Parent Support Survey**
http://ffta.org/members/sample_tools/FP_Support_Services_Survey_Instrument.pdf
- **Foster Parent Evaluation of Social Worker**
http://ffta.org/members/sample_tools/FP_EVAL_SW.pdf
- **Foster Youth’s Family’s Satisfaction Survey**
http://ffta.org/members/sample_tools/Youth_Family_Satisfaction_Survey.pdf
- **Biological Parents’ Satisfaction Survey**
http://www.ffta.org/members/sample_tools/sample_ssbp.pdf
- **Outside Professional Satisfaction Survey**
http://www.ffta.org/members/sample_tools/sample_ssop.pdf
- **Referral Source Satisfaction Survey**
http://ffta.org/members/sample_tools/Referral_Source_Satisfaction_Survey.pdf



FFTA



Foster Family-based Treatment Association