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Cite this article: Frederico M, Cox A, and Hameed MA (2019). Measuring the experience of consumers: reliability and factorial structure of the Take Two stakeholder survey. *Children Australia* **44**: 154–161. https://doi.org/10.1017/cha.2019.21

Received: 25 October 2018
Revised: 12 May 2019
Accepted: 14 May 2019
First published online: 24 June 2019

Keywords:
Children; families; consumer feedback; stakeholder survey; out-of-home care

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Measuring the experience of consumers: reliability and factorial structure of the Take Two stakeholder survey

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Abstract

The service user experience of children, their families and other stakeholders in a therapeutic program should inform quality of care, practice and organisation of services. Children referred to Take Two are clients of Child Protection for whom abuse and neglect have been substantiated. This paper aims to describe the development of the Take Two Stakeholder Survey, as well as to examine the reliability and factorial structure of the survey. In addition, the experience of consumers utilising the service will be described together with recommendations for clinical practice improvements and enhanced consumer engagement.

Introduction

The measurement of consumer satisfaction with therapeutic services and perceptions of their effectiveness is a recognised priority in Australian-based child welfare organisations and child protection research (Trotter, 2008). A small number of studies have examined service satisfaction within the context of out-of-home care (Alexander, 2015; Barker & Place, 2005; Harris, Poertner, & Joe, 2000), while one study focused specifically on psychometric evaluation of the Client Satisfaction Inventory, which aims to measure general satisfaction with services among clients of human service agencies (McMurtry & Hudson, 2000). The results of that study indicated excellent internal consistency and satisfactory initial validation. Similarly, the 24-item Parents with Children in Foster Care Satisfaction Scale, designed to measure service satisfaction, was found to have good reliability and moderate evidence for validity (Harris et al., 2000). Harris et al. reported that the development of the scale had considerable input from the parents (consumers) and this maximised the "possibility that the instrument reflected clients' actual concerns instead of professionals' assumptions of what aspects of services are important to clients" (2000, p. 23). All the aforementioned studies are, however, international rather than Australian-based research studies. In Australia itself, there are relatively few well-designed scales to measure Australian consumers' experiences with therapeutic programs designed to ameliorate the adverse impacts of child abuse and neglect.

Listening to consumers, in particular to the children in out-of-home care, is a well-established priority for the Australian child welfare system. However, only a few systematic attempts have been made to obtain information about children's experience and satisfaction with care (Barber & Delfabbro, 2005; Holland, 2009). Consumer experience surveys, when designed and administered appropriately, are one means of providing robust measures of service satisfaction and experience of care quality. However, within Australia, there is a poor evidence base for various issues related to children in out-of-home care and significant research gaps in listening to consumers, in particular the children (Bromfield, Higgins, Osborn, Panozzo, & Richardson, 2005; Bromfield & Osborn, 2007; Cashmore & Ainsworth, 2004).

Although a review article encompassing 44 studies from 10 different countries (including 4 from Australia) elucidated a number of methodological and theoretical approaches to listening to children in care (Holland, 2009), the evidence is still limited. This review identified very few studies that triangulated the qualitative and quantitative designs and data collection for researching children's perspectives, views and experiences in care. In addition, there was a wide variation in research designs, data collection and methodological choices impeding comparability and generalisation of the findings. For example, within the context of Australian-based foster care research, various obstacles and barriers have been identified that impact the inclusion of children and young people in research designed to measure consumer experiences and feedback (Gilbertson & Barber, 2002). These include recruitment difficulties, high non-response rates, participants of programs not being available because their details are missing or they are transient and cannot be contacted for feedback, lack of cooperation from social and other workers, reluctance to participate, placement instability, lack of follow-up by social workers or other staff, assessments of participants as too distressed to participate in research and/or too dangerous to interview, as well as the inability of participants to keep research-related appointments

(Gilbertson & Barber, 2002). Despite an increasing emphasis on the importance of consumers' experiences of therapeutic services and programs for children affected by abuse and neglect, only a few Australian-based studies reporting on users' experiences of satisfaction and quality of out-of-home care in Australia were considered to be rigorous (Barber & Delfabbro, 2005).

This article aims to contribute to existing literature by focusing on the consumer experience of a therapeutic program, Take Two, offered by Berry Street in Victoria, Australia. The Berry Street Take Two program is a statewide service funded by the Department of Health and Human Services, conducted in partnership with La Trobe University, the Mindful Centre for Training and Research in Developmental Health, and the Victorian Aboriginal Child Care Agency (VACCA). It is a therapeutic service primarily for clients of Child Protection for whom abuse and neglect have been substantiated. In addition to facilitating direct practice, Take Two also has training and research components. Children from infancy to 17 years of age, who have been severely traumatised by abuse and neglect, are referred to Take Two by Child Protection. The median length of engagement with Take Two is 14 months. Take Two interventions usually involve direct clinical work with the referred child and their family, frequently on an outreach basis. Take Two also engages with families and relevant systems in the child's life to address the impact of the child's experiences of trauma on their everyday functioning (Jackson, Frederico, Cox, & Black, 2019).

This article integrates the quantitative and qualitative components of the Take Two Stakeholder surveys by exploring the (a) reliability and factorial structure of the survey (b) consumers' experience with the Take Two service, and (c) the research and clinical implications of the findings in terms of clinical practice improvements and enhanced consumer engagement.

Methodology development of the Take Two Stakeholder survey

The development of the Take Two Stakeholder Survey has been thoroughly described elsewhere (Frederico et al., 2005; Frederico, Jackson, & Black, 2010). In brief, the survey was developed in partnership between the research and clinical staff of La Trobe University and Take Two. The development of the survey was informed by previous surveys such as the Youth Services Survey (Brunk & Koch, 1999), Client Satisfaction Questionnaire (Larsen, Attkisson, Hargreaves, & Nguyen, 1979), Experience of Service Questionnaire (Commission for Health Improvement, 2002), and Youth Satisfaction Questionnaire (Stuntzner-Gibson, Koren, & DeChillo, 1995). The survey was developed to measure stakeholders' experience and satisfaction with the Take Two service in order to inform the work of Take Two. It included obtaining stakeholder perceptions about improvements in children's well-being and changes that occurred as a result of participation in the service. This built on the use of the survey previously to "elicit client and stakeholder perceptions of the program and of whether changes had occurred through participation [with Take Two]" (Frederico, Jackson, & Black, 2006, p. 13). The survey findings were expected to contribute to continuous improvement of the program by providing some evaluation of the intended program design.

Description of the Stakeholder Survey

The survey was developed, with minor variations to its earlier format, to cater for parents, children, carers and professional workers. The survey had four sections. Firstly, there were basic socio-demographic questions about the child client such as age, gender and Aboriginal and Torres Strait Islander status. The second section included six fixed-choice statements relating to the experience with the Take Two program, followed by five statements regarding child functional outcomes since receiving the Take Two service. These included statements such as *I liked the service given by Take Two*; *Take Two respected my culture* and *I get along better with family members*. These statements were rated on a 5-point Likert scale to determine the level of agreement (strongly agree to strongly disagree). The fourth section included a question related to the stakeholder's overall experience with Take Two using a 6-point Likert scale, and two questions which invited free text responses: "What has been the most helpful thing about the service from Take Two?" and "What could improve the Take Two service?"

The Ethics Committee at La Trobe University and the Department of Health and Human Services (DHHS) granted approval for the Take Two stakeholder surveys. The Ethics Approval number is 04-131.

Survey administration

The surveys were distributed by the Take Two clinicians and/or administrative staff at the review and closure phases of program delivery to the children referred to Take Two. Each survey was accompanied by a covering letter and Reply-Paid return envelope. These were either given to the respondent by the clinician or mailed to them. The surveys were given to members of the care team including professional workers, parents and carers, other involved professionals and the children themselves. Professional workers included those working with and for the referred child including teachers, Child Protection workers, community service organisations workers, case managers and youth and education support workers. Carers included a combination of foster carers, kinship carers and residential carers. The completion of surveys was voluntary. The surveys were returned to the Take Two research and evaluation team at La Trobe University.

Data manipulation and analysis

The survey collected both qualitative and quantitative data. Survey data were entered into an ACCESS database and filed electronically at La Trobe University. Data were exported to SPSS V. 24 for quantitative analysis. Descriptive statistics, including frequency distribution of the items, were examined in order to describe stakeholders' responses, in addition to assessing deviation from normality. The reliability of the survey was assessed using Cronbach's α (alpha) as an indicator of internal consistency. A value for α greater than 0.70 is considered to be satisfactory (Tavakol & Dennick, 2011). Further, given the exploratory nature of this study, an exploratory factor analysis (EFA) was conducted in order to explore the dataset rather than test specific hypotheses and/or theories. The purpose of EFA was to explore the underlying structure and dimensions of the Take Two stakeholder survey. Kaiser–Meyer–Olkin (KMO) and Bartlett's test of Sphericity were used to determine data suitability for EFA. Further, only factor loadings greater than 0.3 were retained. Correlational analysis was used to examine the association between perceived satisfaction with the Take Two service and perception of positive clinical outcomes for the children.

Table 1. Number of surveys returned per year by respondent type

Respondent type	Year (frequencies and percentages)										
	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	Total
• Child	26 (12.9%)	15(12.7%)	25(17.7%)	28 (14.5%)	34 (14.3%)	21 (12.8%)	13 (11.9%)	18 (13.3%)	15 (13.9%)	22 (15.9%)	217 (14.0%)
• Parents	13 (6.5%)	11 (9.3%)	7 (5.0%)	8 (4.1%)	12 (5.0%)	6 (3.7%)	9 (8.3%)	8 (5.9%)	1 (0.9%)	6 (4.3%)	81 (5.2%)
• Carers	41 (20.4%)	27(22.9%)	34(24.1%)	40 (20.7%)	50 (21.0%)	42 (25.6%)	19 (17.4%)	32 (23.7%)	27 (25.0%)	32 (23.2%)	344 (22.3%)
• Professional workers	121 (60.2%)	65(55.1%)	75(53.2%)	117(60.6%)	142 (59.7%)	95 (57.9%)	68 (62.4%)	77 (57.0%)	65 (60.2%)	78 (56.5%)	903 (58.4%)
Total	201	118	141	193	238	164	109	135	108	138	1545

No significant differences in the number of returned surveys across the years ($\chi 2$ (27) = 19.445, $p = 0.853$)

In terms of the qualitative data (open-ended questions), the responses were reviewed and coded using content and thematic analysis (Braun & Clarke, 2006; Schreier, 2014). Major headings and sub-headings were generated that described as much of the content as possible. The headings with similar content were merged into broader headings; this reduced the number of categories. The data were read and re-read, and coded again according to the emerging themes. Each coded section of the qualitative data was placed under the relevant theme/category. The categorisation process involved two main processes: (a) convergence, that is, deciding which part of data fit together under a category, and (b) divergence, that is, separating categories and themes, once they had been generated and labelled (Lutz & Hill, 2009). This process was continued until most of the data had been included under the relevant themes.

Results sample characteristics

Between January 2007 and December 2016, the Take Two program worked with 2724 children in 3513 episodes of care. During this period of time, the program received 1545 completed stakeholder surveys related to 675 children (this equates to 25% of the referred children having at least one stakeholder survey). The gender distribution of the children were males ($n = 378$, 56%) and females ($n = 297$, 44%). Ages ranged from 0 to 18 years with a mean of 8.04 years (Standard Deviation [SD] = 4.22). The overall average length of service involvement and treatment was 22.37 months (SD = 18.70). An affiliation with Aboriginal and Torres Strait Islander heritage was indicated for 19% of the children ($n = 129$). The majority of respondents ($n = 579$, 85.8%) gave consent for clinicians to see the feedback provided. These findings and sample characteristics were slightly different to the program-wide client profile (females 48.3%, average age 9.71 years, length of treatment 11.17 months).

Over the period of this study (2007–2016), the survey respondents were parents ($n = 81$,5.2%), children ($n = 217$, 14.0%), carers ($n = 344$, 22.3%) and professional workers ($n = 903$, 58.4%). There was no statistical difference in the number of returned surveys across this period by respondent type ($\chi 2$ (27) = 21.169, $p = 0.778$). Specifically, the average age of child respondents was 12.43 years (SD = 2.54 years) and ranged from 8 to 18 years of age. Further, it is to be noted that only 17.59% of all referred children during the period under consideration were living with one or both parents. Table 1 shows the number of returned surveys across the years and the percentage of returns in each stakeholder category.

Measuring consumers' overall experience

The results showed that children, parents, carers and workers reported high satisfaction with the Take Two service. Over 80% of respondents reported satisfaction with their experience of Take Two (consistent findings across the years) compared to less than 10% undecided and less than 5% who were not satisfied with the service. There was no pattern in terms of which stakeholders were more or less likely to be satisfied with the service ($\chi 2$ (6) = 9.62, $p = 0.142$). More specifically, a higher percentage of respondents strongly agreed or agreed on items related to quality service provision (*I liked the service*), understanding the client (*I found the people at Take Two understanding*), client inclusion in goal and intervention planning, access to service and respect for culture (*Take Two respected my culture*). In terms of perception of positive outcome for the child, 78% of stakeholders reported positive functional outcomes for the child (*improvement in handling daily life stressors*, *getting along better with family members*). Noticeably, significant patterns emerged in terms of children being more likely to endorse positive outcome (86%) compared to parents (80%), professional workers (77%), and carers (75%). These differences were significant ($\chi 2$ (6) = 21.86, $p = 0.001$), suggesting that workers, carers and parents were less likely to report positive changes for the child than the children themselves.

Reliability assessment and factor analysis

The Take Two stakeholder survey was found to have good internal consistency, with a Cronbach's α (alpha) coefficient of 0.86. In addition, all survey items, with one exception, had a moderate to strong corrected item-total correlation score greater than 0.5. The exception was the question about how easy it was to get to the service ($r = 0.410$). Overall, these findings indicated satisfactory item reliability, implying that the survey items were consistent and measuring coherent construct. Table 2 shows the inter-correlations of survey items. The item inter-correlations indicated that perceived satisfaction with the service was highly correlated with perceptions of positive change. Higher levels of satisfaction with Take Two correlated with higher levels of perceived positive impact (for example, a child was perceived to be better handling daily life). Further, several outcome-related statements were moderately or strongly correlated with each other. For example, the perception that the child was more able to handle daily life was strongly correlated with outcomes such as improvement in the child's interaction with family members ($r = 0.635$, $p < 0.001$). Overall, these moderate to strong positive item inter-correlations

Table 2. Inter-correlational analysis of core survey items

	Inter-correlational analyses										
	Perceived satisfaction with Take Two service						Perception of positive clinical outcomes				
Survey items	1	2	3	4	5	6	7	8	9	10	11
1. Liked	1										
2.Understanding	0.688**	1									
3. Included	0.645**	0.638**	1								
4. Easy	0.343**	0.281**	0.331**	1							
5. Understood	0.526**	0.547**	0.524**	0.381**	1						
6. Culture	0.410**	0.377**	0.403**	0.310**	0.552**	1					
7. Daily life	0.422**	0.319**	0.323**	0.268**	0.379**	0.255**	1				
8. Family	0.334**	0.230**	0.289**	0.250**	0.363**	0.272**	0.638**	1			
9. Friends	0.324**	0.223**	0.256**	0.264**	0.309**	0.212**	0.634**	0.595**	1		
10. School	0.299**	0.205**	0.253**	0.216**	0.298**	0.189**	0.604**	0.495**	0.656**	1	
11. Coping	0.344**	0.259**	0.271**	0.234**	0.301**	0.199**	0.715**	0.525**	0.600**	0.623**	1

** Correlation is significant at the 0.01 level (2-tailed); Survey Items 1 = I liked the service given by Take Two; 2 = I found the people at Take Two understanding; 3 = I felt included by Take Two; 4 = It was easy to get to the service; 5 = Take Two staff spoke with me in a way I understood; 6 = Take Two respected my culture; 7 = I am better at handling daily life; 8 = I get along better with family members; 9 = I get along better with friends; 10 = I am doing better in school/training/work; 11 = I can cope better when things go wrong.

Table 3. Factor loadings for core survey items

Survey items	1 (Clinical outcomes for child)	2 (Satisfaction with service)
• 9. Friends	0.833	
• 7. Daily life	0.830	
• 10. School	0.817	
• 11. Coping	0.812	
• 8. Family	0.746	
• 2. Understanding		0.813
• 1. Liked		0.811
• 3. Included		0.800
• 5. Understood		0.747
• 6. Culture		0.657
• 4. Easy		0.499
Percentage of variance	45.33%	17.18%

Extraction Method: Principal Component Analysis; Rotation Method: Varimax with Kaiser Normalization; Survey Items 1 = I liked the service given by Take Two; 2 = I found the people at Take Two understanding; 3 = I felt included by Take Two; 4 = It was easy to get to the service; 5 = Take Two staff spoke with me in a way I understood; 6 = Take Two respected my culture; 7 = I am better at handling daily life; 8 = I get along better with family members; 9 = I get along better with friends; 10 = I am doing better in school/training/work; 11 = I can cope better when things go wrong.

or correlation matrix (often termed Factorability of R (Tabachnick, 2013)) indicate that exploratory factor analysis (EFA) is an appropriate statistical method to use with this dataset.

In addition, prior to running the factor analysis, examination of the data indicated that not every variable was normally distributed. Given the robust nature of exploratory factor analysis, these deviations were not considered problematic. In addition, Kaiser–Meyer–Olkin (0.889) and a significant Bartlett's Test of Sphericity ($p = 0.000$) reflected data suitability for EFA.

The EFA used principal axis factoring with promax rotation. Consistent with Scree plot, the results identified two factors (with eigenvalues exceeding 1) as underlying the 11 core statements of the stakeholder survey. In total, these factors accounted for 63% of the variance in the questionnaire data. Table 3 shows that Factor 1 was categorised as 'clinical outcomes' for the child and Factor 2 labelled as 'satisfaction' with service. Overall, these findings indicate that the survey was a useful measure of service satisfaction and perceived outcomes for the child.

Qualitative analyses

Analysis of stakeholder qualitative comments revealed various themes related to the most helpful aspects of the Take Two service. These themes included the ability of Take Two staff to establish positive therapeutic relationships, commit to quality of care, provide clinical consultation and demonstrate therapeutic expertise (see Table 4).

The comments of the child clients, which are presented in Table 4, show that many respondents experienced an improvement in emotional regulation – an important step in the pathway to improvement. Table 4 shows that stakeholders responded positively to the relationship with the service. This feedback is important as Take Two depends on relationships to engage with clients and other stakeholders.

On the other hand, themes relating to what could be improved included continuity of the Take Two service, stability of the therapeutic worker relationship and early engagement with immediate and extended families of the children. These themes are presented in Table 5. Overall, the nature and quality of the relationship with the Take Two workers and clinicians appear to be critical to the reported positive experiences with the service.

Table 4. A selection of stakeholders' qualitative comments related to the most helpful thing about the Take Two service (Total word count = 21,569)

Relevant themes	A selection of stakeholders' de-identified comments (Ch= children, P= parent, Ca= carer, W= worker)
Emotional regulation	• Been able to control my anger (Ch) • Being able to understand my emotions through talking and communicating with others (Ch) Helped managing myself (Ch, Ca) • Talking about emotions (Ch, P)
Clinical and therapeutic support/relationship	• Someone to talk to (Ch) • Being able to talk to someone about the impact that our situation has taken upon my little family. And being able to get the help we need (P) • Being able to understand the cultural needs of the child and advocate in the child's interests for long-term ongoing care (W) • Empathy and understanding, good relationship with parents (W) • I believe it was good for [the child] to have some attention just for himself (W) • Maintaining connection, re-establishing connection with previous carers (W) • Flexibility to see young person at her house . . . Constant care and thinking about young person's best interests (W) • [The Take Two worker] has helped me cope with this situation, she has been a great support for both [the child] & myself (Ca) • I could ring and get advice anytime. [The Take Two worker] is always easy to talk to (Ca) • Flexibility of service involvement (W) • Child's connection to Take Two Worker was very positive (Ca) • I personally found the service very good for me. The worker was easy to talk to, very understanding and calming. It helped my mental state immensely (Ca) • Constant, focused attention and care for child's needs (W) • High quality, respectful, inclusive service. Child and carer engaged immediately (W) • Helped me feel better and feel good (Ch) • Being helped to make friends (Ch) • Helping with things that I don't understand (Ch) • Talking about the hard stuff (Ch) • Take Two provided great support to workers to help us with different strategies (Ca) • Being involved in the play therapy, watching and learning the methods used (Ca) • Ongoing support for carers to engage and support children and helping to understand trauma behaviours (W) • Getting on with life better than usual (Ch)
Included in decision making	• That I felt included in decisions made for me (Ch) • I felt included (had a voice) with regard to child's issues and progress (Ca)
Strengthen family relations	• Take Two has assisted to breakdown (or begin to) the barriers to engage with siblings. Assist to work through anxiety around family (W) • Helping me get along with family (Ch) • Getting the family doing work together and understanding each other more (W) • To help me with my home problems (Ch)
Professional expertise and clinical opinion	• Reflection, advice (W) • The therapeutic plan was extremely helpful in terms of the most appropriate techniques used to support [the child]. It is also veryuseful speaking with Take Two in regard to issues I am facing as a case manager and ways in which to address it (W) • Secondary consult advice re processes around case management and residential care (W) • In this particular case, it was the strong advocation for reunification which was successful (W) • Having someone who can give an informed opinion to assist in decision making about when and what to tell a child about their family history background (Ca) • Being able to bounce ideas off someone and to get advice to help with decisions re behavioural issues (Ca) They [Take Two] listen and they suggest things. Not told to do things (Ca)
Positive clinical outcome	• [The child] has become more open at sharing how she feels about issues at home rather than internalising her feelings (W) • The child has gained confidence in knowing that the past was not of her choices [sic] and she had no control over the situation.Getting along with others (Ca) • The biggest thing has been the way child has evolved with his ability to recognise and deal with bad or sad feelings. He has learned and used the strategies put in place by Take Two worker. He is a much more confident and happy child (Ca) • Seen great progress in my client over the past 10 months (W) • Helping my son to develop and he has grown to be a beautiful young man (P) • Take Two worker has always been willing to help out in situations needed and very understanding (P)
Assessment report and clinical feedback	• Excellent assessment reports (W) • I now better understand impact of trauma on parents and children (W, Ca)
Take Two's consultations and therapeutic input	• Consults with care team, carers, workers, parents (W) • [The Take Two worker] has attended care team meeting [sic] and been an integral part of [the child's] care team (W) • Assisting care team with trauma informed practice (W) • Support in care teams (W) • Helping child understand why he is no longer with his mother and father (Ca) • Breaking things down to a simpler form in order to understand [Child's] issues. For instance, I'm better able to focus on [Child's] needs now despite distractions from other agencies and departments. T2 gives me a sounding board, an objective board to cope with daily life shared with VACCA, DHS, kindergartens, and doctors etc. who are all involved (Ca) • They have either helped me over the phone or came to my home to help support me (Ca)

Table 5. A selection of stakeholders' qualitative comments related to what could improve Take Two service (Total word count = 10,116)

Relevant themes	A selection of stakeholders' de-identified comments (Ch= children, P= parent, Ca=carer, W=worker)
Continuity of service	• We were very happy with all aspects, continue the service (Ca) • Enrolling me into a Berry Street school this year (please) or if not could you guys help me getting a job (Ch) • Continuity following permanent care placement. I would offer permanent care to [Child] tomorrow except that he would then become ineligible for Take Two (3–6 months following issuing of Child Protection order). [Child] has made enormous strides in this program and continues to need Take Two support (Ca)
Stability of Take Two worker	• Being able to access another worker without any delays especially when our own worker goes on leave (P) • Same worker, less changes (Ch, Ca, W) • For staff when they say they are there for the long term, make sure they do, instead of empty promises. When terminating service to a client for staff to discuss with client instead of being told via phone when at a meeting with DHHS (Ca)
Communication and clinical feedback	• Better communication (Ca,W) between DHHS and all agencies • More discussion about decisions made (P) • Regular feedback (formal/informal) from Take Two workers regarding how clients are going during sessions (W) • Conversations with carers are a good support to our staff, but sometimes means our office (case manager, coordinator) are not informed on activity around client (W)
Increased clinical support	• To have 2 days a week instead of 1 (Ch) • Maybe more face-to-face contact with clients, time spent within placements (W) • Longer time, 2 years on and [the child] needs a different type of therapy now – which means new people in his life (upsetting) (Ca) • More help for self and more one-on-one time (Ca, Ch, P) • Longer time when I see [Clinical worker] (Ch)
More Take Two workers	• Lower caseloads (W) • More workers to work with our vulnerable and traumatised children (W) • Employ more staff to handle workload and quicken waiting list time (Ca) • Maybe more staff employed so the wait (I waited 11 months) is not so long to see someone (Ca)
More involvement with carers, teachers and DHHS	• More one-on-one work with the caregivers (W) • More involvement with DHHS and to provide better updates on what is being worked on and achieved (W)
More work with family and child engagement	• More work with parents about past trauma and bad experiences (Ca, W) • Engagement with young people is sadly lacking. Although this young person and his family are difficult it may have been more useful to persist rather than accept their rejection (W)

Discussion

The Take Two Stakeholder Survey was developed to measure stakeholders' experience and satisfaction with service, as well as perceptions of positive outcomes for the child. Seeking the views of children, parents and stakeholders is an element of improving service effectiveness. Moreover, an opportunity to provide feedback for service development is seen as empowering for clients (Tilbury, Osmond, & Crawford, 2010). Overall, this study found stakeholders in general, and the children in particular, were highly satisfied, and positive changes for children were reported in relation to their experience with Take Two. The quantitative survey analysis found good internal consistency (reliability) and satisfactorily identified two factors as underlying the core items of the survey, namely service satisfaction and perception of clinical change.

The findings indicated that reported satisfaction with the Take Two service was positively correlated with perceptions of positive clinical outcomes for the child. One possible explanation of this correlation is that consumers base their satisfaction rating on their perception of positive client outcomes. Further, the correlation between service satisfaction and perception of clinical change may reflect interpersonal care experiences such as consumer–clinician experiences (therapeutic relationship) which represent a unique dimension of quality of care. In fact, in this study, the overarching theme derived from the qualitative responses related to the nature and quality of the relationship with the Take Two worker, which appears to be critical to positive experience with the service. The positive responses to the specific questions in relation to outcomes provide more confidence in the interpretation of the findings of satisfaction. A measure of client satisfaction on its own is not a good measure of service effectiveness (Gain & Young 1998).

In addition to informing the work of Take Two, this preliminary study contributes to ongoing efforts to develop, implement and analyse reliable and valid measures for collecting data related to service satisfaction, and perception of positive change for children affected by abuse and neglect in general, and clients of Australian Child Protection authorities in particular. Comparison of the findings to previous research is limited, since there is a paucity of Australian-based studies with systematic attempts to obtain information regarding children's experience and satisfaction with out-of-home care related services (Barber & Delfabbro, 2005; Holland, 2009).

Nevertheless, the basic survey analysis of this study is consistent with the Care Satisfaction Scale designed to assess service satisfaction of parents who have children in out-of-home placement (foster care) (Harris et al., 2000). However, unlike Harris's study, the Take Two Stakeholder Survey was developed without substantial direct input from consumers (parents and children). Hence, replication of the scale development process may be necessary to determine if the items reflect the "clients' actual concerns instead of professionals' assumptions of what aspects of services are important to clients" (Harris et al., 2000, p. 23).

Within the context of the Take Two program, a number of approaches are used to ensure there is a focus on translating the study findings into service and program improvement. For

example, the administration of the Stakeholder Survey to members of the care team and the clients (children) ensures that stakeholders' feedback is routinely collected and used for service and practice improvement. At a program level, stakeholders' feedback is discussed at research executive meetings as well as clinical leadership group meetings. Further, individual feedback is sent out to senior clinical team leaders for discussion at team meetings and individual supervision sessions. As the survey collects data from all stakeholders (including teachers and child protection workers), it provides an opportunity for them to provide immediate feedback and for this to be reviewed by senior management and clinicians. These activities and endeavours are likely to contribute to an ongoing modification and refinement of aspects of existing practices, as well as contributing to the enhancement of methods for collecting consumer feedback. For example, a perceived limitation of the current strategy of mail, reply-paid envelope, is that it is limited in gaining more in-depth data or deeper understandings of which aspects of service satisfaction and/or clinical change matter most to consumers. In addition, from a translational point of view, further research is warranted to explore how the collected data are contributing to positive impact for the children and families.

From a review of the current processes and possible gaps between research and practice, an enhanced strategy is proposed to proactively engage consumers and gain feedback through face-to-face semi-structured interviews – facilitated by ex-clients of the Take Two program – in addition to the survey. This strategy of direct interviews is likely to elicit more in-depth data related to both positive and negative experiences of care, such as placement instability and staff changes which may impact consumers' experience regardless of the care they have received. The engagement of ex-clients to contribute to the interview schedules and undertake the interviews will bring an additional perspective to the gathering of feedback and measuring consumers' experiences.

Overall, this study, while preliminary and promising, has a number of limitations.

Respondents represent a convenience sample of self-selected stakeholders involved with Berry Street Take Two, hence the findings related to survey feedback may not generalise to other populations. Further, of critical importance, is the substantially low response rate of parents and children. This also needs to be interpreted cautiously, as only 17.59% of all children referred during study period were living with one or both parents. Further, Take Two clients are often involved with statutory services, which may significantly impact on parental and child engagement.

This leaves open the possibility that stakeholders may not have accurately reported their experiences or satisfaction with the Take Two program due to recall and/or social desirability biases. The survey was also administered by mail and/or in person, adding to the methodological limitations of quality data collection. At this stage, it is not possible to estimate the extent of each data collection method. Despite these limitations, the Take Two Stakeholder Survey appears to be a useful measure for collecting consumer feedback, experiences, service satisfaction and perception of clinical change for the child.

Consumer feedback and satisfaction with services is critical to the overall success of social welfare organisations and child-related programs (Kapp & Propp, 2002). However, Gilbertson and Barber (2002) identified various obstacles and barriers impeding the systematic collection of consumer feedback within the context of foster care research. Hence, research is urgently required to accurately identify what aids and limits the collection of feedback from care systems, organisations, programs and individuals, while attending to the ethical considerations of interviewing children affected by abuse and neglect. These considerations may inform enhanced methods and approaches for listening to stakeholders, in particular children in care. Client feedback is also important to evidence-based and evidence-informed practice (Tilbury et al., 2010). In addition, actively engaging the voices of child clients and other stakeholders through a feedback mechanism is consistent with Take Two's relational model of intervention and provides a message of empowerment to clients.

In conclusion, listening to the voices of children, their families, carers and members of the service and care system contributes to the rigorous evaluation of any program within the social and child welfare system in Australia. Asking stakeholders, parents and children, what they think of the services and activities in which they are involved is both meaningful and useful as an approach to assess the quality of care and evaluating service effectiveness and impact. Strengthening the capacity to listen carefully to the voices of children involved with the Take Two therapeutic program is a major area for further development in the research design and service delivery. Future directions for research include building upon the current Take Two Stakeholder Survey to explore additional avenues for children to voice to their opinions regarding a range of questions, such as what makes therapy easier to participate in, what they have found welcoming or distancing and what outcomes are important to them that may positively contribute to enhanced quality of life.

Role of funding source

Berry Street Take Two is funded by the Department of Health and Human Services, Victoria.

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Acknowledgements. We thank the consumers of the Take Two service for their time in providing valuable feedback and the support of Take Two clinicians in assisting with survey distribution. We also thank Jenny Bartlett for overseeing research administrative tasks related to the Take Two Stakeholder Survey.

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