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Consumer Satisfaction with Services in a Mental Health Center

Sandra M. Hare

Abstract

CONSUMER SATISFACTION WITH SERVICES

IN A MENTAL HEALTH CENTER

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An exploratory study was done with descriptive comparative components to examine the levels of consumer satisfaction at a mental health center, and there was also the intent to determine if satisfaction or dissatisfaction in one area of service affected the general satisfaction level. In addition, other variables and demographic data included in the questionnaire were examined.

Data collection was done by the use of a 23-item questionnaire that was administered to three departments of service, Outpatient, Drug Abuse, and Day-care, at North Orange County Mental Health Services. The sample group consisted of any adult in treatment who had made three or more visits to the clinic and who voluntarily filled out a questionnaire. The staff was also asked to participate in order to compare their assessment of the services with actual client ratings. Ninety-six consumers and 22 staff members returned questionnaires.

Significantly high levels of satisfaction were shown at the clinic with the combined consumer satisfaction level being 75.28%, thus validating the hypothesis of high ratings. Areas of high satisfaction were "satisfaction with therapist and abilities" and "methods of billing and payment." Possible areas of discontentment were "wait in the waiting room," "improvement since starting therapy," and "involuntary treatment."

In order to look at the individual areas of service and their effect on the general satisfaction levels, a Consumer Satisfaction Index was formed. Of the five questions compared against the index, "wait in the waiting room" and "methods of billing and payment" significantly affected the index.

Other findings were there was little interest in the relocation of the clinic; individual services were found most helpful; and although consumers found other mental health services to be useful, direct services were most important. Those consumers that filled out the questionnaires were largely white-Anglo, young, single adults with moderate income in the middle occupational status group. The clinic also serves many clients on public assistance. Those clients with the greater number of visits to the clinic perceived the greatest improvement since starting treatment. The open-ended comments and suggestions at the end of the questionnaire were largely complimentary to the services with frequent change of therapist being the most frequent complaint.

The returns from this questionnaire were mostly in line with previous studies from other Mental Health Services; however, a replication of the study with better control to assure better returns would be recommended.

LOMA LINDA UNIVERSITY

Graduate School

CONSUMER SATISFACTION WITH SERVICES IN A MENTAL HEALTH CLINIC

by

Sandra M. Hare

A Thesis in Partial Fulfillment of the
Requirements for the Degree of Master
of Science in the Field of Nursing

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Each person whose signature appears below certifies that this thesis in her opinion is adequate, in scope and quality, as a thesis for the degree of Master of Science.

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Chapter I

INTRODUCTION

THE STUDY

The topic of this study is the evaluation of Mental Health Services by the consumer of those services, the client. This is still an area of controversy, but the literature review reports that clients are being called on more and more to evaluate the services they receive. This is in direct contrast to the past in which the client himself was evaluated as a product of the system. Ishiyama (1970) raises the issue of whether patients are to be consumers or products of the system. The traditional view of mental institutions is of the clients as products of the system "turned out" for the benefit of the real consumer, the general public, who is primarily interested in containment rather than treatment. Ishiyama believes that improvement in mental health services can come more readily if the patient is defined as the consumer and allowed to negotiate the terms of care with those providing it.

Recent research findings, Salisin and Baxter (1972), Miller and Sinclair (1972), and Denner and Halprin (1974), indicate that even the most disturbed clients can assume the role of the consumer and make rational and informative statements about the quality of service. Denner and Halprin (1974, p. 143) state:

> If what we want is consumer evaluation, rather than evaluation of the consumer, then we should follow a procedure that deemphasizes the sick role and casts the person in the role of a rational person who has purchased something and is now in the position to judge its quality and effectiveness. To do this

> effectively, one must start with the assumption that people who have suffered from even the most severe forms of mental illness and deprivation can, if approached in a straightforward manner, provide a clinic with unambiguous evaluation feedback.

Background and Need for the Study

Since the passage of the Community Health Centers Act of 1964 (Beigel, 1970), citizen participation and community control have been areas of question and controversy.

In the early 1960's, the effectiveness of health and welfare services was initially questioned and the role of the recipient of those services was mentioned. The concept of "maximum feasible participation" was first born during this time (Thompson, 1973). At that time it meant inclusion and the participation of the poor in services.

As with any community agency who obtains a great deal of its revenue from the people it serves, the agency is also responsible to those people. Hence the term "accountability" appears frequently in literature concerning Mental Health Services (Bloom, 1972; Schiff, 1970; Downing et al., 1974; Ayllon and Skuban, 1973).

Goltz et al. (1973, p. 702) when referring to the evaluation of and accountability for services says, "financial sponsors, government and otherwise, soon will refuse to support programs whose value to the recipients is unknown."

Ralph Nader, who popularized the word "consumer" which will be used in this study, has been one of the leaders of the attack on Mental Health, stating, "citizens have no legitimate medical or program policies for the centers where community generally includes charity-minded

housewives, businessmen, lawyers, and professional persons whose main function is to spend money" (Thompson, 1973, p. 143).

In further justifying the existence of mental health as a service, Landsberg (1973) emphasized that consumer feedback studies were a necessary but often overlooked part of evaluation. He further emphasized that no evaluation is really complete without measuring how the consumer reacted to the service he received and that a well done study should not only point up areas of high and low satisfaction but also gaps in service. Thus, immediate feedback to staff and administration is provided for program planning and development.

Fiske and Bergin (1971) emphasized the importance of evaluating how all individualized goals for treatment are reached. The client or consumer comes into the clinic with a complaint. The complaint is subjective, and the measure of relief is therefore also subjective. One must then assume that the client is in the best position to evaluate relief from his subjective symptoms.

Purpose of the Study

The purpose of this study was to measure the levels of client satisfaction with services at an Outpatient Mental Health Clinic. There was also the intent to determine if satisfaction or dissatisfaction in one area of service affected the overall satisfaction with clinic services.

Problem Statement

What consumer value will clients attach to their time, effort, and money expended at the local mental health center? Does satisfaction or

dissatisfaction in one area of service affect consumer attitude in other areas?

THEORETICAL FRAMEWORK

Concept of Community Mental Health

In order to study consumer satisfaction with services at a Community Health Center, it became necessary to look at the concept of Community Mental Health.

McNeil et al. (1970, p. 23) defined Community Mental Health as a "service that covers everything which might become necessary to give maximum mental health to a given population."

Caplan (1964), when referring to Community Mental Health, used terms such as "public health psychiatry," "community psychiatry," "social psychiatry," and "preventative psychiatry." He emphasized the areas of preventive treatment and social rehabilitation for a given population.

The concept of Community Mental Health grew out of a report to the Joint Committee on Mental Health and Mental Illness in 1961. The report called for bold new approaches to mental illness within the framework of social responsibility. Out of this and John F. Kennedy's call for a "bold new approach" came the Community Mental Health Act of 1964 (McNeil et al., 1970). Ideologically, Community Mental Health, the newest movement in the mental health field, has been called by some, "The Third Revolution" (Gorman, 1970). Baker and Schulberg (1969) found that it is viewed by many professionals as an open and liberal ideological

perspective which is particularly concerned with such issues as primary prevention of mental illness through the eradication of harmful environmental conditions, treating patients with the goal of social rehabilitation rather than personality reorganization, comprehensive continuity of care and responsibility for the mentally ill, and total involvement of both professional and nonprofessional community helpers in caring for the mentally ill.

Concept of Consumer Satisfaction

The world consumer and citizen have been used interchangeably in recent literature. The dictionary defines consumer as "one who uses goods and so diminishes or destroys their utility" and citizen as an "inhabitant of a city or town, especially one enjoying its freedom and privileges" (Webster, 1968). Thompson (1973) described consumers as individuals as contrasted to professionals. Wells (1970, p. 2133) described the consumer as "one who does not make his living in the health service industry."

One of the central tenants of the mental health movement is that service programs should be designed to meet the needs of the people and that mental health professionals should make themselves accountable to the people whom they serve (Roman, 1973; Schiff, 1970). Attempts at measuring consumer satisfaction are still in their infancy and thus far no standardized methods of measurement have been attained to secure levels of consumer satisfaction (Salasin and Baxter, 1972). As recent literature shows (Fanning et al., 1972; Levine, 1970; Goyne, 1973), however, attempts are being made at measurement. The idea is presented

in literature (Ishiyama, 1970) as the consumer receiving the best for his money, the relationship being one of bilateral negotiations with the consumer demanding that he get the best product for his money and in a reasonably competitive field. The consumer then determines the product he receives.

Hypotheses Guiding the Study

Primary. The majority of consumers will show high levels of satisfaction with Mental Health services.

Secondary:

1. Involuntary treatment will be negatively correlated with the level of consumer satisfaction with Mental Health services.

2. The higher the client's satisfaction with charges for service the higher the level of consumer satisfaction with Mental Health services.

3. Satisfaction with billing and payment for services is positively correlated with the consumer's satisfaction with Mental Health services.

4. There is a negative correlation between length of time spent in the waiting room for services and the consumer's satisfaction with Mental Health services.

5. Client level of satisfaction with Mental Health services will be higher where the therapists are male.

Definitions

1. For the purpose of this study, the term "consumer" will denote any individual who utilized Mental Health services and will be used

interchangeably with the term "client."

2. "Levels of consumer satisfaction" refer to the quantified amount of happiness with services or goods received from the Mental Health clinic as measured by the recipient of those services on a questionnaire.

Assumptions

For the purpose of this study, the following assumptions were made:

1. A client's subjective rating of his improved or unimproved mental health is a valid criterion against which to measure the services of a Mental Health clinic.

2. A client is able to evaluate his level of subjective well-being and any client, even the most severely disturbed or disabled, is capable of evaluating and making suggestions for improvement of the Mental Health services of which he is a recipient.

3. Client's or consumer's subjective reports can be influential in the planning of Mental Health services.

Scope and Limitations

1. The study was limited to the Outpatient services of North Orange County Mental Health. The departments which constitute Outpatient services are Outpatient, Day-care, and Drug Abuse. Within those departments the types of treatment offered are individual treatment, group treatment, marriage and family counseling, chemotherapy, and alcoholic rehabilitation. A consumer may be receiving one or more of these services concurrently.

2. The study was limited to those consumers that had received services for three or more visits.

3. The study was run from approximately June 15, 1975, to July 15, 1975.

4. Participation in the study was on a voluntary basis only.

5. Total confidentiality was maintained through omission of identifying data.

6. The study was limited by each client's perception and honesty.

7. The study was limited in scope by those clients who decided not to participate.

METHOD OF STUDY

Conduction of the Study

This was an exploratory study containing descriptive-comparative components using data compiled from a 23-item questionnaire. Descriptive research consists of collection of data for the purpose of describing existing conditions, whereas a comparative survey involved the collection of data from different conditions and concludes with a comparison made of the findings (Sax, 1967; Fox, 1966).

Data was collected from June 15, 1975, to July 15, 1975, from willingly participating clients from Day-care, Drug Abuse, and Outpatient departments who had been seen for three or more visits. The 23-item, one-page questionnaire was given out at the window by the secretarial staff except toward the end of the study when questionnaires were placed in the waiting room by the collection box. Day-care clients filled out

the questionnaire in one afternoon session. The collection box was placed in the waiting room with a large sign asking for completed questionnaires.

The questionnaire was developed from the literature and in consideration of the various services offered at the clinic. Most items considered on the questionnaire were direct service questions having to do with satisfaction; however, other areas covered were mental health service to the community, location, and demographic data. There was one open-ended question asking for comments or suggestions for the Mental Health clinic.

Data Analysis

Item analysis was done on the returns from all the departments of service at the clinic, Outpatient, Day-care, and Drug Abuse, and the three groups were then combined together and an item analysis was done on the total client response. An item analysis was also done on staff levels of satisfaction in order to make comparisons against client responses. Levels of client satisfaction were measured in percentages and divided into "high satisfaction," "neutral," and "low satisfaction" categories.

A Consumer Satisfaction Index was formed from the questionnaire containing questions that tapped broad areas of service at the clinic. A one-way analysis of variance was done obtaining the Means and Standard Error of the Means to determine if the Consumer Satisfaction Index was significantly affected by individual questions measuring high or low satisfaction.

A correlation and partial correlation were done with the proportion of variability accounted for, and specific questions were measured against the Consumer Satisfaction Index to determine if they affected general satisfaction levels.

A third section included a discussion and analysis of percentages on questions of mental health services in the community, location of the clinic, and the demographic variables.

SUMMARY

This is an exploratory study with descriptive-comparative components using a 23-item questionnaire to determine levels of consumer satisfaction at a Community Mental Health Center. Clients at the center participated in the study on a voluntary basis only.

Levels of consumer satisfaction with service were measured and compared in the three departments of service, combined in a total patient count and compared to staff response in the same areas. In addition, the effect of high or low satisfaction with services in specific areas was measured against a general satisfaction index to determine if the overall satisfaction level was raised or lowered by these areas of response. A third section of the study investigated questions of attitude toward mental health services in the community, location, and demographic variables.

Chapter II

REVIEW OF THE LITERATURE

Before, during, and after the investigation of Consumer Satisfaction at a Mental Health Center, a thorough and ongoing review of the literature was conducted. Recent mental health journals are coming out quite frequently with articles concerning satisfaction with mental health services; however, research in this area necessitates ambiguity and is still difficult to tie together.

In the following review, goals, criteria of success, the value of consumer participation, and past research will be discussed.

GOALS AND CRITERIA OF SUCCESS

In considering community mental health, one of the first questions considered is what are the goals and what is generally wished to be achieved. In the beginning the community mental health movement grew so rapidly that there was greater emphasis on planning and establishment of facilities rather than upon the evaluation of their effectiveness. Shealy and Wright (1972, p. 109) called this the "zeigeist" aspect of the movement. Smith et al. (1974) pointed out that there was a danger that the value of such programs be judged on enthusiasms rather than merit. Thompson (1973, p. 148) summarized this by saying that "Community Mental Health, like moral treatment in the last century, otherwise may depend more on the charisma of current leadership than on evidence of any basic soundness or economy of its organization."

According to McNeil et al. (1970), community psychiatry, as has private psychiatry for years, suffers from not having clearly defined goals. They further commented (1970, p. 25) that its objective could be stated as "positive mental health for as many as possible" and that the concept of "positive mental health is remarkably fuzzy."

Although it has been difficult to define the goals of mental health, the thrust of the effort today seems to be to put the mentally ill into the mainstream of community life. There is no longer in California, except in the case of extreme difficulty, the enforced confinement of one segment of the population away from the ongoing community life. In a recent publication, a group of the nation's well-known psychiatrists commented on the goal of mental health in this fashion, "We are no longer content to banish the mentally ill to a world that we shun and deny. Instead, with all the unpleasantness, difficulties and trials that accompany professional role changes, we seek ways to bring the mentally ill into the life of the community" (Gorman, 1970, p. 349). Gorman goes on to suggest that mental illness is a social problem, and we have to help people change their communities if necessary.

One of the major difficulties in planning evaluative research as pointed out by Shealy and Wright (1972) is to find suitable criteria of success. Since the goals of the community mental health model are broad and varied, he suggests that the assessment criteria should also be broad and varied. Two basic types of criteria proposed are one aimed at assessment of rather nebulous effects on the community in general and the second concerned with the more easily measured casualty

rates. An example of the former is Phillips' (1967) "competence criterion." Smith and Hansell's (1967) argument for territorial epidemiologic rates is characteristic of the latter. Kiresuk and Sherman (1968) point out the difficulty of mental illness and treatment and the corresponding diversity of techniques and settings.

Mesnikoff et al. (1972, p. 406) divide the evaluation of a community mental health center into several components:

> (1) What are the demographic and psychopathological characteristics of the population being served? (2) To what extent are the mentally ill in this community actually receiving services from the community facility? (3) To what extent are the treatment programs designed to meet the needs of the population? (4) What are the long-term differential effects of various treatment modalities?

The purpose of evaluative research as emphasized by Goltz et al. (1973) should be an outcome project rather than a process one. It was recommended that a built-in evaluation system be a part of every mental health program.

Built-in evaluation is now becoming a part of the system at Orange County Mental Health so that when the client steps into the door for his initial interview, he has become part of a research project, so to speak.

ISSUES OF CONSUMER CONTROL AND PARTICIPATION

The issue of consumer participation and control which loomed large in the 1960's transformed into a movement toward community control of all community institutions--police, education, welfare, health and mental health. In the 1970's community control of mental health centers has

been an issue.

"Community involvement" (Bolman, 1972, p. 88) is used to describe desirable relationships between some type of institution and its community. "Community participation" has a very wide range of usages extending from nonspecific involvement to direct control. Another term is "consumer perspective which refers to the recognition that there has been a missing force in the provision of goods and services, whether economic, social or medical. This force is the perspective of the consumer, the person who lives with the results of other peoples' plans" (Bolman, 1972, p. 88).

Three reasons cited by Bolman for community control are (1) psychiatric services discriminate against the poor, (2) program relevance to changing needs, and (3) institutional survival.

Parker (1970) urges that the consumer be included and have a say in mental health services because continued control by professionals leads to the perpetuation of the status quo and the inability to change. He suggests that consumer control does not arise out of the population that is already involved, the population with money and influence, but the poor and minorities. Groups with new perspective are demanding a say.

Beigel (1970), Meyers et al. (1974), and Darley (1974) urge the importance of knowing consumer needs in the planning of services. Ruiz and Behrens (1973, p. 317) state the following:

> The idea that consumers can have a role in determining what is best for them has been challenged by many of the "experts," who claim that consumers are unable to understand the subtle issues involved in

> mental health care. But since the "experts" themselves seem to disagree so openly, they have lost many of their magical "witch-doctor" faculties in the eyes of the community at large.

And therefore we see that the consumer has become in the minds of top mental health authorities, contrary to the past, one of the foremost persons able to evaluate the service he receives. It appears from the literature and the mandate of the times that he is required to do it. The service givers appear to have put the populace in the driver's seat as to the type of service they receive.

RECENT STUDIES OF CONSUMER PARTICIPATION IN AND SATISFACTION WITH MENTAL HEALTH SERVICES

In recent years research dealing with the effectiveness of mental health services has turned from its emphasis on the therapist's evaluation to a more direct and less theoretical measurement of what the patient thinks. Fiske et al. (1970) emphasized the importance of evaluating how well all individualized goals for treatment are reached.

Although client or consumer evaluation of mental health services is a rather new phenomenon, more studies are beginning to appear in recent literature. Salasin and Baxter (1972) point out that attempts to determine client satisfaction are still in their infancy. There are no standardized techniques, methods of measurement, or agreed upon procedures.

To establish a science in this area, we must establish consistent relationships in repeated studies. It is important that investigators note how their findings compare with earlier ones. Fiske and Bergin

(1971, p. 315) make the following observations:

> If systematic investigation of therapy outcome is to advance our knowledge of this much used treatment, investigators must include in their batteries some standard measures, administered in a standard manner. This step will make it possible to collate studies in different institutions so that the body of early established findings will gradually grow.

Sindberg (1970) and Luborsky (1971) report that studies in which clients give their views of their experiences are seldom done. Luborsky argues that although global ratings (by patient and therapist) may show an overestimated view of improvement, the studies are justified in that the patient and therapist usually have intimate knowledge of specific areas which needed change in relation to the areas which did change. Garfield (1971) states that although single measure or global ratings clearly do have some value, they do not tell an adequate story and are limited.

Denner and Halprin (1974), Salasin and Baxter (1972), and Miller and Sinclair (1972) all indicate in their research that even the most disturbed of clients can be counted on as consumers to give a fair evaluation of the product that they receive.

Past studies (Garfield et al., 1971; Strupp et al., 1969; Schofield, 1964; Steiper and Wiener, 1965; Ullman and Krasner, 1965; Miller and Sinclair, 1972) indicated that percentages of clients satisfied with services would run between 67% and 80%.

Denner and Halprin (1974, p. 13) report from a study done at Illinois Mental Health Institute 71% satisfaction with services. This was a telephone exchange with post-clinic involvement patients.

Eleven percent reported dissatisfaction with services. The general tone of the questions asked the consumer was "how satisfied were the clients with services and did satisfaction vary as a function of sex, age, ethnicity, duration of treatment, or type of termination decisions. The researchers reported that the consumers reached in their study were quite satisfied with clinic services, reported a high degree of problem resolution, and usually attributed the positive change to clinical services. This did not vary from reports by Miller and Sinclair (1972) and Salasin and Baxter (1972). An interesting point of the study was that client satisfaction and problem resolution did not necessarily correlate. The client was more apt to be satisfied with services if he felt that the worker was responsible for the change and not himself.

Fanning (1971) did a study to evaluate the attitudes of clients regarding planning of their own care. The findings were as follows: (1) Both staff and patients agreed that care and treatment be a staff and patient joint plan, (2) both staff and patients agreed that the ideal time for involving the patient in the planning process should be at the time of admission, and (3) five demographic variables (sex, age, education, length of treatment, and type of service received) seemed to be significant indicators of patient attitude toward this concept. Females and the under-30 age group more often desired staff control. The more educated wanted patient involvement in treatment. Those patients having more direct contact with the staff for a year or more of services had an increasing desire for more staff control.

Kissell (1974) did a study of mothers and therapists evaluating

long-term and short-term child therapy. He contends that the value of any treatment can be seriously questioned if the client doesn't feel that he has benefited. The final aim of the study was to contrast the ratings of therapists and parents with regard to the effectiveness of the service. The rating was taken on an average of 4.9 years after service was discontinued and was done by telephone. Mothers found the service significantly more beneficial than would have been predicted on the basis of therapists' ratings alone, which in the past had been the primary way of measuring patient improvement.

Levine (1970) tried several ways to get consumer participation and feedback at the Community Consultation Center of the Henry Street Settlement before he was successful on the third attempt. The clients and their families were invited to attend regular staff conferences to evaluate two main areas with the staff. First, in new cases, they were asked how they felt about the reasons for which they were referred, how they viewed their problems, what their understanding was of the treatment and the agency's services, and what they thought would be most useful to them of what the agency had to offer. Second, in reviews of ongoing treatment, they were asked what they had expected of treatment, whether treatment had helped (if yes, in what ways; if not, why not), whether treatment should continue (if yes, what kind and to what purpose; if not, why not), and whether the conferences were useful to them.

Levine cites the purpose of the client-staff conferences was to demonstrate that if given an opportunity, consumers of services would

express themselves. She demonstrated a direct way for an agency to get answers about its services that could not be gotten any other way. It was hoped that the broken appointment and dropouts would be reduced. She further hoped that the value of some services to the client might become apparent to the worker, even though the worker did not include these services high on his priority list; thus unwanted services might be discontinued and other services added.

In stating her case, Levine (1970, p. 46) said:

> It is no accident that in mental health services in particular workers have always known that treatment cannot be successful unless the one treated is also engaged in all aspects of the treatment process and in evaluating its usefulness. This, however, is too often forgotten in actual agency and clinical practice. If this ingredient of consumer participation continues to be ignored, the agency can never be sure that what it provides is useful or learn what else may be useful. If the consumer can be allowed a role in planning and policy making because it is practical and makes good sense, it may be found that he cannot only be an effective evaluator, but even an innovator.

In spite of the problems inherent in trying to measure improvement in psychotherapy, there has developed a body of research on the subject from other areas not including mental health such as Baum et al., 1966; Feifel and Ells, 1963; Lorr et al., 1958; McPartland and Richart, 1966; Brandt, 1965; and Strupp et al., 1964.

The extent to which the results of the above mentioned studies can be generalized to all community mental health centers is unknown. Many of the studies have been done at outpatient clinics of university hospitals, veterans' hospitals, or urban mental health centers, and

there may be differences in the patient populations of urban and non-urban facilities. Many of the studies have assessed therapy done by psychiatrists or psychiatric residents, while the bulk of therapy in some mental health centers is done by psychologists and psychiatric social workers.

Beatty and Beatty (1970) did a study attempting to assess the outcome of psychotherapy done by psychologists and social workers in a community mental health setting. They based the study on three measurements: one, the therapist's judgment of whether the patient was improved or unimproved at the end of therapy; second, the patient's responses to a follow-up questionnaire which attempted to determine whether or not the patient felt he had changed since the last treatment; and third, comparison of the symptoms reported by the patient as having led him to treatment with the symptoms bothering him at the time of follow-up.

Beatty and Beatty reported 55% improvement for patients undergoing 1 to 11 therapy sessions compared to 81% for those undergoing 12 to 26 sessions and 61% for patients staying beyond 27 sessions. They found that 90% of the patients reported symptom reduction. "Patient responses seemed to indicate a greater emphasis on symptom reduction than on other benefits of therapy, such as personal growth and effectiveness in dealing with problems" (Beatty and Beatty, 1970, p. 46). Overall, they reported an improvement rate of 63% among 148 patients undergoing psychotherapy from psychologists and psychiatric social workers at a nonurban community mental health center.

The chaplaincy department of Northville, Michigan, State Hospital developed a scale to measure patient satisfaction with the hospital's treatment program (Eder and Kukulski, 1975). Called the Client Satisfaction Scale, it attempted to measure the quality of care as determined by the patients themselves and as perceived by the staff members. The scale was later adopted by the Michigan Department of Mental Health. Generally, "the scale was devised to provide the information needed to enable the staff to reduce the differences, wherever possible, between their own and the patients' perceptions of the quality of care" (Eder and Kukulski, 1975, p. 15). Consumers expressed 68% satisfaction with the services received.

SUMMARY

In this review of the pertinent and recent literature concerning evaluation of services and consumer satisfaction and participation in those services at a community mental health center, a sampling of the most salient studies was included.

Numerous researchers gave their opinion as to what they ascertained the goals and methods of evaluation of a community mental health center should include. Various studies in outcome in psychotherapy were included. The general view of the researchers was that it is nebulous and difficult to set goals except by behavioral principles, that methods of evaluation must of necessity be broad and varied, that studies of results in psychotherapy are difficult in the empirical framework, that research in consumer satisfaction is limited but very

vital to the functioning of a mental health clinic, and most important, if the consumer does not perceive improvement, then regardless of mode or technique, the therapy is a failure.

Chapter III

METHODOLOGY

The main purpose of this study was to obtain information about the levels of consumer satisfaction with services at a community mental health center. Additional questions were analyzed for their effect on the general levels of satisfaction at the clinic. A third section investigated the areas of client-conceived importance of mental health services to the community, location of the clinic, demographic variables of the study; and in addition, an open-ended question asked for comments and suggestions by the consumer to improve service.

This chapter will consider the setting of the study, research design and procedure, method of data collection, and mode of analysis of the data.

DESCRIPTION OF THE CATCHMENT AREA

The following description was obtained from the 1970 census. Due to the large population increases in Orange County and the State of California, the characteristics of the area may have changed considerably. North Orange County Mental Health Services covers a general population of somewhat over 200,000 which is 14.2% of the total Orange County population. The area consists of largely suburban tract living with the average income for the area being $13,263, somewhat higher than the median income of over $12,000 for all Orange County. This is the highest income of the six Orange County regions. The services

cover an area primarily of intact families with the divorce rate being one of the lowest in the county. Forty-three percent of the population have lived in the same house for a 5-year period.

In 1970 the total labor force was 80,909 with an unemployment rate of 5%, and for persons with income below the poverty level, it was 12.8%. Total percentage of workers with low occupational status (laborers, farmers, service workers) was 30.6% male and 31.5% female. Middle occupational status jobs (clerical and sales workers) was 31.5% male and 46.5% female with high occupational status jobs (professional, technical, managerial, and administrative) being 37.9% male and 21.9% female.

TREATMENT FACILITIES AND STAFF

The Mental Health center itself is located in downtown Fullerton, California, on one of the busiest streets. The need for services has fast outgrown the space facilities, and a move to a new location is planned in the next few months. The Drug Abuse program is housed in a separate building some two blocks away.

Various treatment philosophies at the clinic include behavior therapies, insight and psychodynamic approaches, transactional analysis, reality therapy, Gestalt, crisis intervention, marriage and family counseling, rational emotive, client-centered and eclectic therapy.

The staff is comprised of psychiatrists (concerned mainly with medical management), psychologists, social workers, nurses, mental health workers, and a plethora of student interns.

Adult outpatients are seen in day-care, assertion training groups, couples' group therapy, single member therapy groups, individual sessions, and marriage and family counseling. Day-treatment clients meet 3 days a week. Some clients utilize many services simultaneously; for instance, they might be receiving chemotherapy, attending day-treatment, and seeing a therapist individually. Methods of termination vary with the types of therapy and predilection of the counselor and/or the client.

RESEARCH DESIGN

A copy of the research proposal was submitted to Loma Linda University Research Advisory Committee on Human Experimentation and Orange County Mental Health Research Committee. It was approved by both committees.

This study was organized to answer these questions: (1) Are consumers currently satisfied with services at the local community mental health center? (2) In what areas do consumers see room for improvement of the mental health services? (3) How do consumers rate mental health services in importance to the community? (4) Is there agreement between consumers and service givers about the effectiveness of services received at the local community mental health center?

DATA COLLECTION

The questionnaire was designed so that hopefully the broad client population at the clinic might be able to understand the questions and

respond meaningfully about the service they received. Total number of clients being seen at the clinic were Outpatient, 267; Drug Abuse, 162; and Day-care, 25. Criteria for eligibility to respond to the questionnaire were (1) ability to read and write, (2) current treatment at the clinic in either Outpatient, Drug Abuse, or Day-care Services, and (3) three or more visits to the clinic.

It was intended in the questionnaire design that the client remain totally anonymous and that he not feel pressure to please the staff by his answers. The questionnaire was presented to the client on the third visit or thereafter as it was believed that he could not give a representative answer regarding his progress in psychotherapy before that time.

Before the survey began, a general announcement regarding the research and an appeal for support by the researcher was made in staff conference. Any questions regarding the project were answered, and therapists and other staff members were asked to fill out the questionnaire as they thought the consumers they were serving would answer. Twenty-two staff members responded. The staff was asked to complete the questionnaire in order to check their responses about how they perceived the service they gave against actual consumer returns.

The questionnaires were collected from approximately June 15, 1975, to July 15, 1975. The 23-item questionnaire was presented to the client at the window by the secretarial staff when he arrived for treatment. At that time he was instructed to place the completed product in the box in the waiting room, marked with large letters which read, "Completed questionnaires, please." A sign above the box read, "Please

place your completed questionnaires in this box." It was decided following a 2-week slow return rate to place a stack of uncompleted questionnaires by the collection box in order that the client might pick up and independently fill out a questionnaire if he had not yet received one. A large sign was then placed above the box that read, "Have you completed your Consumer Satisfaction Questionnaire? If not, please do so." No attempt was made by the staff to see that each questionnaire taken was returned to the box. It was hoped that the client might feel more free to be honest in his reply with less pressure to please the staff.

An exception to the above rule was made in Day-treatment as the clients were instructed to fill out the questionnaires in one of their afternoon sessions and did so in the presence of the Day-treatment staff. However, as much effort as possible was made to see that the client's privacy was maintained. The reason for this exception to the procedure was that many of these clients were heavily medicated, and it was felt that they might have difficulty completing the questionnaire. Comparison of the Day-treatment levels of satisfaction with other areas such as Outpatient will be done in the next chapter to ascertain any possible change in outcome effected by the presence of the therapist.

Since Drug Abuse clients were seen in another facility, a separate group of questionnaires was taken to that building. The secretary at the desk was instructed to see that each client had the opportunity to receive a Consumer Questionnaire. She was then to instruct the client to return the completed questionnaire to the desk. Comments on the

data and the returns from Drug Abuse will be made in the following chapter.

The Questionnaire

The 23 items of the questionnaire were listed front and back on a legal size sheet of paper. Instructions placed at the top of the sheet on the front side assured the client that his answers would remain confidential and that he was not to sign his name anywhere on the paper. Better service by the Mental Health Team was mentioned as the motivating factor. At the bottom on the reverse side, the client was thanked for completing the questionnaire, asked to recheck for unmarked questions, and asked to place the completed product in the box in the waiting room.

All questionnaires that were turned in were counted although some of them were incomplete. Generally, Questions 1 through 15 related directly to services received, Questions 16 and 17 referred to the location of the center itself, and Question 18 tapped the client's rating of the importance of mental health services to the community.

Demographic data and variables of the study were considered in Questions 19 through 22. Represented were questions about type of treatment, sex of the therapist, sex of the client, marital status, employment, occupation of client and/or spouse, ethnic background, age, public assistance, and length of therapy.

Question 23 was an open-ended question asking for additional comments or suggestions for the mental health staff. It was believed that the client would benefit by being able to express in narrative form any

positive or negative feelings, ideas, or suggestions about the center. The center would also benefit by this form of free-flowing commentary.

More specifically, the 15 questions which related directly to satisfaction with services at the clinic itself could be seen to tap several areas of consumer satisfaction.

Question 1 investigated whether the client had come to the clinic of his own volition or if he had been referred by some outside agency. For example, the probation department may strongly recommend treatment for some clients, and the conditions of their probation could be contingent on receiving treatment.

Questions 3 and 6 were time-lapse questions with 3 referring to time between first appointment and beginning treatment, and 6 referring to length of wait in the reception area.

Questions 4 and 5 referred to charges for services and the methods of handling the billing and payment respectively.

Questions 7, 8, and 9 asked questions as to client perception of improvement in psychotherapy. Question 14 asked the client to check the kinds of services that he had felt most helpful to him. As a comparison question, No. 10 considered how much improvement the client thought time alone would have provided if never having received treatment.

Personality, involvement, and interest of the therapist and staff were covered in Questions 2 and 11. In contrast, Question 12 asked the client to evaluate how much he thought his therapist liked him. Question 13 asked him to evaluate his confidence in his therapist's abilities. Overall satisfaction with services at the clinic was evaluated in

Question 15.

An example of the multiple choice questions using the Liekert-type scale is listed below. On the scale, number one usually represents a "low satisfaction" level and number five a "high satisfaction" level. However, in the interest of clarity and to avoid total consistency, these were reversed as were Questions 3, 4, and 10. This was taken into account when counting the weight of the data. The following is an example of a question using the scale:

"How interested in helping you do the staff members seem to be?"

Very uninterested Very interested
1 2 3 4 5

A Consumer Satisfaction Index was formed including the most significant items from the questionnaire. Mueller and Schuessler (1961, p. 186) describe the index as the "norming of a series of values on the means of the series. The index then is the ratio between a given value and the mean of the series."

Some of the questions used in this study were similar to those used in a Consumer Satisfaction Survey done at an Illinois Mental Health Center by Miller and Sinclair (1972). To give a degree of reliability and validity, replication of such studies can hopefully contribute to the body of knowledge regarding mental health and result in improvement in services to the consumer.

Many conclusions might be arrived at concerning the poor returns in the sample. These will be discussed in more detail in a later chapter. However, briefly stated, here are some possibilities. The sample was collected at a difficult time from the standpoint of the

clinic. Students who see a large percentage of the clients at the center were completing their year of internship as of July 1, resulting in a turnover and termination of caseload with the further effect of service slowdown. Since the questionnaire could not be filled out until the third visit, those who did not come back after the second visit for whatever reason were eliminated from the survey. No attempt was taken to account for the questionnaires that were missing, and one can only make the assumption that some of the clients may have misplaced them, taken them home and forgotten to return them, or perhaps lost interest.

However, considering that participation in the sample was on a voluntary basis only and that no effort was made to constrain the client to return the questionnaire, the results may reflect the free choice the patient felt.

ANALYSIS OF THE DATA

In designing the questionnaire, numerous statistical tests were being contemplated; however, the analysis for the purpose of this research is limited to the following procedures.

The Mean and Standard Deviation were obtained for each of the five groups, and the answers were then grouped according to their response to the questions and compared according to the Mean Satisfaction Index.

A correlation and partial correlation were done between the answers to the variables in Questions 1, "involuntary treatment," 4, "charges for services," 5, "methods of billing and payment," and 6, "wait in the waiting room." The correlation was done on one item while

holding the other three questions fixed. This was done consecutively on Questions 1, 4, 5, and 6.

SUMMARY

This was an exploratory study with descriptive-comparative components which was done to compare client satisfaction with services at a community mental health center. Other points considered were effect of one area of service on the general satisfaction level, types of service received and preferred, questions of location, and the demographic variables. The consumer was also asked to relate in narrative form his open-ended comments about the center.

The questionnaire was offered to the adult client population in three major areas of treatment: Outpatient, Drug Abuse, and Day-treatment.

A Consumer Satisfaction Index was formulated from the questionnaire to which several individual questions were compared by a one-way analysis of variance. Means and Standard Deviations were obtained in relationship to the Consumer Satisfaction Index. Correlations and partial correlations were also done in relationship to the index.

The data was programed on computer cards. The groups were divided, combined, and analyzed with respect to answering the problem question of this study. Analysis and interpretation of the results follow in Chapter IV.

Chapter IV

ANALYSIS AND INTERPRETATION OF DATA

At the conclusion of the data collection, analysis was facilitated by the computational facilities of the biostatistics department at Loma Linda University. The results of this study including significance and interpretation of the data are presented in this chapter.

PRESENTATION OF THE DATA

The central question around which this study was organized was, "What consumer satisfaction level will the client (consumer) attach to his time, effort, and money expended at the local community mental health center?"

Additional questions analyzed in Part II of this chapter were:

1. Did involuntary treatment have significant effect on the client's general satisfaction level in other areas?

2. Did satisfaction or dissatisfaction with charges for services affect general levels of satisfaction?

3. Did satisfaction or dissatisfaction with methods of billing and payment have an effect on general satisfaction levels with other services?

4. Did length of time spent in the waiting room before treatment have a significant effect on general satisfaction levels?

5. Was the sex of the therapist significant in levels of satisfaction at the clinic?

The third section of this chapter deals with additional variables and demographic data considered in the questionnaire.

The hypothesis for this study was based on numerous previous studies that showed that consumer satisfaction with services would range between 67-80% (Garfield and Bergin, 1971).

ANALYSIS AND DISCUSSION OF THE DATA

Sample Data

Total number of consumer questionnaires returned and analyzed in the study was 96. Each of the three departments gave the following returns: Outpatient--68, Day-treatment--14, and Drug--14. The staff filled out and turned in 22 questionnaires.

Comparison of Levels of Client Satisfaction at the Clinic

First the percentage of "satisfied" and "dissatisfied" clients will be considered in Questions 1 through 15 (with the exception of Question 14). These questions were chosen because they tapped direct areas of consumer satisfaction and Question 14 did not. The percentages of satisfaction in the three areas of service--Outpatient, Drug Abuse, and Day-Care--were all tabulated separately (see Tables I, II, and III) then combined together in a total patient count (Table IV). The percentages were taken from an average of the number of questions answered. Staff-predicted averages were then compared with actual consumer averages (see Tables V and VI).

For a clear presentation of the data, Categories 1 and 2 were collapsed together representing "low satisfaction," Category 3

Table I

Outpatient Services
Percent of Satisfaction Levels of Consumers Turning in the Questionnaire

N=68

Question Number	Categories 4 & 5 High Satisfaction %T	%A	Category 3 Neutral %T	%A	Categories 1 & 2 Low Satisfaction %T	%A
1. ". .own idea. ."	67.6	67.6	8.8	8.8	23.5	23.5
2. "How interested. ."	82.4	83.6	1.5	1.5	14.7	14.9
*3. ". .wait. .treatment. ."	89.7	89.7	8.8	8.8	1.5	1.5
*4. ". .charges. ."	86.8	86.8	1.5	1.5	8.8	8.8
5. ". .billing. ."	88.2	89.5	10.3	10.4	--	--
6. ". .time. .waiting room. ."	65.1	70.1	22.4	22.4	7.3	7.5
7. ". .useful ideas. ."	69.1	71.2	19.1	19.7	8.8	9.1
8. ". .understanding. ."	67.7	69.7	14.7	15.1	14.7	15.2
9. ". .improvement. ."	64.7	65.7	13.2	13.4	20.6	20.9
*10. ". .time alone. ."	77.9	81.5	10.3	10.8	7.3	7.7
11. ". .like therapist. ."	83.8	86.4	10.3	10.3	2.9	3.0
12. ". .therapist likes you. ."	69.1	71.2	22.1	22.7	5.9	6.0
13. ". .therapist's abilities. ."	84.3	84.8	11.8	12.1	2.9	3.0
15. ". .overall satisfaction. ."	82.3	84.8	11.8	12.1	2.9	3.0

Note: %T represents the percent of the total number of questionnaires turned in per level of satisfaction for that particular question.

%A represents the percent of the total number of responses per level of satisfaction for that particular question.

*3 - On the questionnaire, the values from one to five were shown as reversed with one representing "high satisfaction" and five representing "low satisfaction." The values were exchanged in the above data to give a true representation.

*4 - On the questionnaire, choice three represented "reasonable." The values were adjusted for the above column with "reasonable" being changed to "high satisfaction," which may be represented as a more true value.

*10 - On the questionnaire, one represents "high satisfaction" and five represents "low satisfaction." For the purpose of clarity, these values have been reversed above.

Table II

Day-Care Services
Percent of Satisfaction Levels of Consumers Turning in the Questionnaire

N=14

Question Number	Categories 4 & 5 High Satisfaction %T	%A	Category 3 Neutral %T	%A	Categories 1 & 2 Low Satisfaction %T	%A
1. ". .own idea. ."	50.0	53.8	21.4	23.1	21.4	23.07
2. "How interested. ."	64.3	64.3	21.4	21.4	14.3	14.3
*3. ". .wait. .treatment. ."	71.4	71.4	28.6	28.6	--	--
*4. ". .charges. ."	78.6	91.7	7.1	8.3	--	--
5. ". .billing. ."	64.3	75.0	21.4	25.0	--	--
6. ". .time. .waiting room. ."	42.9	50.0	35.7	41.7	7.1	8.3
7. ". .useful ideas. ."	64.3	69.23	21.4	23.08	7.1	7.6
8. ". .understanding. ."	85.7	92.3	7.1	7.7	--	--
9. ". .improvement. ."	57.1	61.5	28.6	30.8	7.1	7.7
*10. ". .time alone. ."	78.6	78.6	14.3	14.3	7.1	7.1
11. ". .like therapist. ."	92.9	100.0	--	--	--	--
12. ". .therapist likes you. ."	64.3	69.2	21.4	23.1	7.1	7.7
13. ". .therapist's abilities. ."	64.3	69.2	21.4	23.1	7.1	7.7
15. ". .overall satisfaction. ."	57.1	57.1	35.7	35.7	7.1	7.1

Note: %T represents the percent of the total number of questionnaires turned in per level of satisfaction for that particular question.

%A represents the percent of the total number of responses per level of satisfaction for that particular question.

*3 - On the questionnaire, the values from one to five were shown as reversed with one representing "high satisfaction" and five representing "low satisfaction." The values were exchanged in the above data to give a true representation.

*4 - On the questionnaire, choice three represented "reasonable." The values were adjusted for the above column with "reasonable" being changed to "high satisfaction," which may be represented as a more true value.

*10 - On the questionnaire, one represents "high satisfaction" and five represents "low satisfaction." For the purpose of clarity, these values have been reversed above.

Table III

Drug Abuse Services
Percent of Satisfaction Levels of Consumers Turning in the Questionnaire

N=14

Question Number	Categories 4 & 5 High Satisfaction %T	%A	Category 3 Neutral %T	%A	Categories 1 & 2 Low Satisfaction %T	%A
1. ". .own idea. ."	28.6	28.6	7.1	7.1	64.3	64.3
2. "How interested. ."	78.6	78.6	7.1	7.1	14.3	14.3
*3. ". .wait. .treatment. ."	78.6	78.6	21.4	21.4	--	--
*4. ". .charges. ."	42.9	54.5	--	--	35.7	45.45
5. ". .billing. ."	21.43	27.27	28.6	36.4	28.6	36.4
6. ". .time. .waiting room. ."	50.0	50.0	21.4	21.4	28.6	28.6
7. ". .useful ideas. ."	64.3	75.0	21.4	25.0	--	--
8. ". .understanding. ."	42.9	46.2	28.6	30.8	21.4	23.1
9. ". .improvement. ."	35.7	35.7	42.9	42.9	21.4	21.4
*10. ". .time alone. ."	57.1	61.5	14.3	15.4	21.4	23.1
11. ". .like therapist. ."	78.6	78.6	14.3	14.3	7.1	7.1
12. ". .therapist likes you. ."	57.1	57.1	28.6	28.6	14.3	14.3
13. ". .therapist's abilities. ."	85.7	85.7	14.3	14.3	--	--
15. ". .overall satisfaction. ."	57.1	66.6	28.5	33.3	--	--

Note: %T represents the percent of the total number of questionnaires turned in per level of satisfaction for that particular question.

%A represents the percent of the total number of responses per level of satisfaction for that particular question.

*3 - On the questionnaire, the values from one to five were shown as reversed with one representing "high satisfaction" and five representing "low satisfaction." The values were exchanged in the above data to give a true representation.

*4 - On the questionnaire, choice three represented "reasonable." The values were adjusted for the above column with "reasonable" being changed to "high satisfaction," which may be represented as a more true value.

*10 - On the questionnaire, one represents "high satisfaction" and five represents "low satisfaction." For the purpose of clarity, these values have been reversed above.

Table IV

All Services
Percent of Satisfaction Levels of Consumers Turning in the Questionnaire

N=96

Question Number	Categories 4 & 5 High Satisfaction %T	%A	Category 3 Neutral %T	%A	Categories 1 & 2 Low Satisfaction %T	%A
1. ". .own idea. ."	59.4	60.0	10.42	10.5	29.17	29.48
2. "How interested. ."	79.16	80.0	5.21	5.26	14.59	14.73
*3. ". .wait. .treatment. ."	85.41	85.41	13.54	13.54	1.04	1.04
*4. ". .charges. ."	79.17	83.52	7.29	7.69	8.34	8.79
5. ". .billing. ."	73.00	80.00	14.58	15.56	4.17	4.44
6. ". .time. .waiting room. ."	62.50	64.52	23.96	24.73	10.41	10.75
7. ". .useful ideas. ."	67.71	71.42	19.79	20.88	7.30	7.70
8. ". .understanding. ."	66.67	69.57	15.62	16.30	13.55	14.13
9. ". .improvement. ."	59.37	60.64	19.79	20.21	18.75	19.15
*10. "...time alone. ."	74.99	78.26	11.46	11.96	9.38	9.78
11. ". .like therapist. ."	84.4	87.1	9.38	9.68	3.12	3.23
12. ". .therapist likes you. ."	66.67	68.82	22.92	23.66	7.29	7.53
13. ". .therapist's abilities. ."	80.21	82.8	13.54	13.98	3.13	3.23
15. ". .overall satisfaction. ."	75.0	78.26	17.71	18.48	3.13	3.26

Note: %T represents the percent of the total number of questionnaires turned in per level of satisfaction for that particular question.

%A represents the percent of the total number of responses per level of satisfaction for that particular question.

*3 - On the questionnaire, the values from one to five were shown as reversed with one representing "high satisfaction" and five representing "low satisfaction." The values were exchanged in the above data to give a true representation.

*4 - On the questionnaire, choice three represented "reasonable." The values were adjusted for the above column with "reasonable" being changed to "high satisfaction," which may be represented as a more true value.

*10 - On the questionnaire, one represents "high satisfaction" and five represents "low satisfaction." For the purpose of clarity, these values have been reversed above.

Table V

Staff Predictions
Percent of Staff-Predicted Consumer Satisfaction

N=22

Question Number	Categories 4 & 5 High Satisfaction %T	%A	Category 3 Neutral %T	%A	Categories 1 & 2 Low Satisfaction %T	%A
1. ". .own idea. ."	72.7	72.7	27.3	27.3	18.2	18.2
2. "How interested. ."	77.3	81.0	13.6	14.3	4.5	4.8
*3. ". .wait. .treatment. ."	69.6	70.0	22.7	25.0	4.5	5.0
*4. ". .charges. ."	81.8	81.8	9.1	9.1	9.1	9.1
5. ". .billing. ."	68.2	68.2	22.7	22.7	9.1	9.1
6. ". .time. .waiting room. ."	45.5	47.6	45.4	47.6	4.5	4.8
7. ". .useful ideas. ."	72.7	76.2	22.7	23.8	--	--
8. ". .understanding. ."	81.8	81.8	13.6	13.6	4.5	4.5
9. ". .improvement. ."	59.1	59.1	31.8	31.8	9.1	9.1
*10. ". .time alone. ."	63.6	63.6	36.4	36.4	--	--
11. ". .like therapist. ."	86.4	90.5	4.5	4.8	4.5	4.8
12. ". .therapist likes you. ."	86.4	90.5	9.1	9.5	4.5	4.5
13. ". .therapist's abilities. ."	72.7	76.2	22.7	23.8	--	--
15. ". .overall satisfaction. ."	72.7	72.7	18.2	18.2	--	--

Note: %T represents the percent of the total number of questionnaires turned in per level of satisfaction for that particular question.

%A represents the percent of the total number of responses per level of satisfaction for that particular question.

*3 - On the questionnaire, the values from one to five were shown as reversed with one representing "high satisfaction" and five representing "low satisfaction." The values were exchanged in the above data to give a true representation.

*4 - On the questionnaire, choice three represented "reasonable." The values were adjusted for the above column with "reasonable" being changed to "high satisfaction," which may be represented as a more true value.

*10 - On the questionnaire, one represents "high satisfaction" and five represents "low satisfaction." For the purpose of clarity, these values have been reversed above.

Table VI

Comparison of Satisfaction Levels of Consumers and Staff Predictions

Consumers N=96
Staff N=22

Question Number	Total Consumer Rating	Consumer Rating by Service			Staff Rating
		Outpatient	Day-Care	Drug Abuse	
1. ". .own idea. ."	60.0	67.6	53.8	28.6	72.0
2. "How interested. ."	80.0	83.6	64.3	78.6	81.0
3. ". .wait. .treatment. ."	85.4	89.7	71.4	78.6	70.0
4. ". .charges. ."	83.5	86.8	91.7	54.5	81.8
5. ". .billing. ."	80.0	89.5	75.0	27.3	68.2
6. ". .time. .waiting room. ."	64.5	70.1	50.0	50.0	47.6
7. ". .useful ideas. ."	71.4	71.2	69.2	75.0	76.2
8. ". .understanding. ."	69.6	69.7	92.3	46.2	81.8
9. ". .improvement. ."	60.6	65.7	61.5	35.7	59.1
10. ". .time alone. ."	78.3	81.5	78.6	61.5	63.6
11. ". .like therapist. ."	87.1	86.4	100.0	78.6	90.5
12. ". .therapist likes you. ."	68.8	71.2	69.2	57.1	90.5
13. ". .therapist's abilities. ."	82.8	84.8	69.2	85.7	76.2
15. ". .overall satisfaction. ."	78.3	84.8	57.1	66.0	72.7

Satisfaction levels represent totals of % of questions answered.

represented "neutral," and Categories 4 and 5 were collapsed together to represent "high satisfaction." The combined consumer count (Table IV) supports the hypothesis that there would be generally high levels of satisfaction reported by the clients. Question 15, the general satisfaction question, showed a satisfaction level of 78.26. The combined consumer average showed a general satisfaction level of 75.28 with all client areas measured together. Both of these figures fall well in the predicted range of 67-80% satisfaction with services (Miller and Sinclair, 1972).

Overall Consumer Ratings

Concentrating on areas of highest satisfaction, 82.8% were highly confident in their therapist's abilities, 87% liked their therapist, 83.5% thought the charges were reasonable, and 85% were satisfied that they did not have to wait too long for service after their initial contact with the clinic.

Eighty percent thought that the personnel at the clinic were highly interested in their problem. Seventy-eight percent did not think that their problem would have corrected itself with time alone. Approximately 71% found that they had gotten many useful ideas from their therapist, and 69% now understood themselves better as a result of therapy. It is relevant to note that only 60% felt highly satisfied with improvement since beginning treatment. Another area of lower satisfaction was length of time in waiting room with a 64.5% satisfaction rate. Although 87% were highly satisfied with their therapist, only 69% thought their therapist had such high regard for them in return. A

possible explanation may be low self-esteem from which many clients are assumed to suffer.

A source of possible dissatisfaction is Question 1, "How much was coming here your own idea?" Only 60% of the clients reported a high satisfaction rate; however, a great deal of interpretative caution must be exercised because an outside referral to the clinic may not necessarily mean dissatisfaction with other services. See Section II of the study.

Summary Statement

In general, overall global consumer ratings reached as high as 87% on Question 11 which represented satisfaction with the therapist. Other areas of contentment were period of waiting between time of first appointment and receiving service, charges, and the therapists' abilities. Specific areas of lower satisfaction appear to be lack of improvement since starting therapy, long waiting in the waiting room, and in inferred unhappiness at being referred by others rather than treatment being the client's own idea.

Looking at each of the specific treatment areas may give some clues as to the general satisfaction scores.

Outpatient Scores

The Outpatient department consumers (Table I) showed an overall high level of satisfaction and accounted for a large part of the combined high satisfaction rate in general. Highest levels of satisfaction were in areas of "waiting for first appointment," 89.7%, "methods of

billing and payment," 89.5%, and "liking of the therapist," 86.4%. Again it may be noted that although the clients liked their therapist, only 71.2% felt that the therapist had such high regard for them in return. Question 15 which rated general overall satisfaction was rated at 85%. Lowest satisfaction rates were recorded in the areas of "how much was coming here your own idea," 67.6%, and "would time alone bring improvement," 65.7%. Since a large percentage of outpatients (see Figure 6) reported receiving individual therapy, one might conclude that consumers tend to be highly satisfied with this mode of treatment. Item analysis (Table VII) shows Outpatient percentage of satisfaction to be weighted toward Category 5 with a fairly low amount of missing data.

Day-Care Client Scores

Day-care clients (Table II) showed as high as 100% satisfaction on Question 11, "liking therapist." The item analysis (Table VIII) of Day-care returns shows that one person did not answer this question. How much of the high rating is accounted for by the therapist being in the room at the time that the questionnaire was filled out is a matter of conjecture. Other possible explanations for this high level of return might be that Day-care clients tend to be highly medicated and to have longer contact with their therapist during the day than other departments, thus developing a deeper level of dependency. Again, as reported in other areas, the clients did not feel that their therapist liked them as much as they liked their therapist.

Table VII

Outpatient Item Analysis

N=96 M=Missing Data %A=% of Total Questions Answered

Questions	Col. 1 Ct.	Col. 1 %A	Col. 2 Ct.	Col. 2 %A	Col. 3 Ct.	Col. 3 %A	Col. 4 Ct.	Col. 4 %A	Col. 5 Ct.	Col. 5 %A	M
1. ". .own idea. ."	9	13.2	7	10.3	6	8.8	11	16.2	35	51.5	-
2. "How interested. ."	6	9.0	4	6.0	1	1.5	9	13.4	47	70.2	1
*3. ". .wait. .treatment. ."	52	76.5	9	13.2	6	8.8	1	1.4	--	--	-
*4. ". .charges. ."	1	1.5	5	7.35	59	86.8	2	2.9	1	5	-
5. ". .billing. ."	--	--	--	--	7	10.5	1	1.5	59	88.1	1
6. ". .time. .waiting room. ."	1	1.5	4	6.0	15	22.4	22	32.8	25	37.3	1
7. ". .useful ideas. ."	4	6.1	2	3.0	13	19.7	14	21.2	33	50.0	2
8. ". .understanding. ."	2	3.0	8	12.1	10	15.2	14	21.2	32	48.5	2
9. ". .improvement. ."	4	6.0	10	15.0	9	13.4	4	20.9	30	44.8	1
*10. ". .time alone. ."	42	64.6	11	16.9	7	10.8	2	3.1	3	4.6	3
11. ". .like therapist. ."	1	1.5	1	1.5	7	10.6	10	15.2	47	71.2	1
12. ". .therapist likes you. ."	2	3.0	2	3.0	15	22.7	18	27.2	29	44.0	2
13. ". .therapist's abilities. ."	--	--	2	3.0	8	12.0	15	22.7	41	62.1	2
15. ". .overall satisfaction. ."	--	--	2	3.0	8	12.0	16	24.2	40	60.6	2

*3 - For the purpose of the questionnaire, "low" and "high" values were reversed.

*4 - The middle column, three, which read "reasonable" on the questionnaire represents "high satisfaction."

*10 - For the purpose of the questionnaire, "low" and "high" values were reversed.

Note: Column 1 usually indicates "low satisfaction," and Column 5 represents "high satisfaction" except in cases noted above.

Table VIII

Day-Care Item Analysis

N=14 M=Missing Data %A=% of Total Questions Answered

Questions	Col. 1 Ct.	Col. 1 %A	Col. 2 Ct.	Col. 2 %A	Col. 3 Ct.	Col. 3 %A	Col. 4 Ct.	Col. 4 %A	Col. 5 Ct.	Col. 5 %A	M
1. ". .own idea. ."	2	15.4	1	7.7	3	23.1	1	7.7	6	46.2	1
2. "How interested. ."	1	7.1	1	7.1	3	21.4	2	14.3	7	50.0	-
*3. ". .wait. .treatment. ."	4	28.6	6	42.9	4	28.6	--	--	--	--	-
*4. ". .charges. ."	--	--	1	8.3	11	91.7	--	--	--	--	2
5. ". .billing. ."	--	--	--	--	3	25.0	1	8.3	8	67.0	2
6. ". .time. .waiting room. ."	1	8.3	--	--	5	41.7	6	50.0	--	--	2
7. ". .useful ideas. ."	--	--	1	7.7	3	23.1	3	23.1	6	46.2	1
8. ". .understanding. ."	--	--	--	--	1	7.7	7	54.0	5	38.5	1
9. ". .improvement. ."	--	--	1	7.7	4	30.8	3	23.1	5	38.5	1
*10. ". .time alone. ."	9	64.3	2	14.3	2	14.3	--	--	1	7.1	-
11. ". .like therapist. ."	--	--	--	--	--	--	3	23.1	10	77.0	1
12. ". .therapist likes you. ."	--	--	1	7.7	3	23.1	2	15.4	7	54.0	1
13. ". .therapist's abilities. ."	--	--	1	7.7	3	23.1	2	15.4	7	54.0	1
15. ". .overall satisfaction. ."	--	--	1	7.1	5	35.7	3	21.4	5	35.0	7

*3 - For the purpose of the questionnaire, "low" and "high" values were reversed.

*4 - The middle column, three, which read "reasonable" on the questionnaire represents "high satisfaction."

*10 - For the purpose of the questionnaire, "low" and "high" values were reversed.

Note: Column 1 usually indicates "low satisfaction," and Column 5 represents "high satisfaction" except in cases noted above.

Table IX

Drug Abuse Item Analysis

N=14 M=Missing Data %A=% of Total Questions Answered

	Questions	Col. 1 Ct.	Col. 1 %A	Col. 2 Ct.	Col. 2 %A	Col. 3 Ct.	Col. 3 %A	Col. 4 Ct.	Col. 4 %A	Col. 5 Ct.	Col. 5 %A	M
1.	". .own idea. ."	7	50.0	2	14.3	1	7.1	4	28.6	--	--	-
2.	"How interested. ."	2	14.3	--	--	1	7.1	4	28.6	7	50.0	-
*3.	". .wait. .treatment. ."	7	50.0	4	28.6	3	21.4	--	--	--	--	-
*4.	". .charges. ."	--	--	--	--	6	55.0	3	27.3	2	18.2	3
5.	". .billing. ."	1	9.1	3	27.3	4	36.4	--	--	3	27.3	3
6.	". .time. .waiting room. ."	--	--	4	28.6	3	21.4	4	28.6	3	21.4	-
7.	". .useful ideas. ."	--	--	--	--	3	25.0	6	50.0	3	25.0	2
8.	". .understanding. ."	1	7.7	2	15.4	4	30.7	3	23.1	3	23.1	1
9.	". .improvement. ."	3	21.4	--	--	6	42.9	2	14.3	3	21.4	-
*10.	". .time alone. ."	6	46.2	2	15.4	2	15.4	2	15.4	1	7.7	1
11.	". .like therapist. ."	1	7.1	--	--	2	14.3	4	28.6	7	50.0	0
12.	". .therapist likes you. ."	--	--	2	14.3	4	28.6	2	14.3	6	42.9	-
13.	". .therapist's abilities. ."	--	--	--	--	2	14.3	5	35.7	7	50.0	-
15.	". .overall satisfaction. ."	--	--	--	--	4	33.3	4	33.3	4	33.3	2

*3 - For the purpose of the questionnaire, "low" and "high" values were reversed.

*4 - The middle column, three, which read "reasonable" on the questionnaire represents "high satisfaction."

*10 - For the purpose of the questionnaire, "low" and "high" values were reversed.

Note: Column 1 usually indicates "low satisfaction," and Column 5 represents "high satisfaction" except in cases noted above.

Table X

Staff Predictions Item Analysis

N=22 M=Missing Data %A=% of Total Questions Answered

	Questions	Col. 1 Ct.	Col. 1 %A	Col. 2 Ct.	Col. 2 %A	Col. 3 Ct.	Col. 3 %A	Col. 4 Ct.	Col. 4 %A	Col. 5 Ct.	Col. 5 %A	M
1.	". .own idea. ."	2	9.1	2	9.1	6	27.3	8	36.4	4	18.2	-
2.	"How interested. ."	1	4.8	--	--	3	14.3	12	57.1	5	23.8	1
*3.	". .wait. .treatment. ."	4	20.0	10	50.0	5	25.0	--	--	1	5.0	2
*4.	". .charges. ."	--	--	2	9.0	18	81.8	2	9.1	--	--	-
5.	". .billing. ."	1	4.6	1	4.6	5	22.8	9	41.0	6	27.3	-
6.	". .time. .waiting room. ."	--	--	1	4.8	10	48.0	7	33.3	3	14.3	1
7.	". .useful ideas. ."	--	--	--	--	5	23.8	13	62.0	3	14.3	1
8.	". .understanding. ."	--	--	1	4.5	3	13.7	13	59.1	5	23.0	-
9.	". .improvement. ."	--	--	2	9.1	7	31.8	11	50.0	2	9.1	-
*10.	". .time alone. ."	6	27.3	8	36.4	8	36.4	--	--	--	--	-
11.	". .like therapist. ."	1	4.8	--	--	1	4.8	14	66.7	5	23.8	1
12.	". .therapist likes you. ."	--	--	--	--	2	9.5	15	71.4	4	19.0	1
13.	". .therapist's abilities. ."	--	--	--	--	5	24.0	14	66.7	2	9.5	1
15.	". .overall satisfaction. ."	--	--	--	--	4	18.2	16	72.7	2	9.0	-

*3 - For the purpose of the questionnaire, "low" and "high" values were reversed.

*4 - The middle column, three, which read "reasonable" on the questionnaire represents "high satisfaction."

*10 - For the purpose of the questionnaire, "low" and "high" values were reversed.

Note: Column 1 usually indicates "low satisfaction," and Column 5 represents "high satisfaction" except in cases noted above.

Table XI

Combined Groups
Outpatient, Day-Care, Drug Abuse
Item Analysis

N=96 M=Missing Data %A=% of Total Questions Answered

Questions	Col. 1 Ct.	Col. 1 %A	Col. 2 Ct.	Col. 2 %A	Col. 3 Ct.	Col. 3 %A	Col. 4 Ct.	Col. 4 %A	Col. 5 Ct.	Col. 5 %A	M
1. ". .own idea. ."	18	19.0	10	10.5	10	10.5	16	17.0	41	43.2	1
2. "How interested. ."	9	9.5	5	5.3	5	5.3	15	15.8	61	64.2	1
*3. ". .wait. .treatment. ."	63	65.6	19	19.8	13	13.5	1	1.0	--	--	-
*4. ". .charges. ."	1	1.1	6	6.6	76	83.5	5	5.5	3	3.3	5
5. ". .billing. ."	1	1.1	3	3.3	14	15.6	2	2.2	70	77.8	1
6. ". .time. .waiting room. ."	2	2.2	8	8.6	23	24.7	32	34.4	28	30.0	3
7. ". .useful ideas. ."	4	4.4	3	3.3	19	20.8	23	25.3	42	46.0	5
8. ". .understanding. ."	3	3.3	10	10.9	15	16.3	24	26.0	40	43.5	4
9. ". .improvement. ."	7	7.5	11	11.7	19	20.0	19	20.2	38	40.4	1
*10. ". .time alone. ."	57	62.0	15	16.3	11	12.0	4	43.5	5	5.4	1
11. ". .like therapist. ."	2	2.2	1	1.1	9	9.7	4	17.8	5	68.8	3
12. ". .therapist likes you. ."	2	2.2	5	5.4	22	23.7	22	24.7	42	45.2	3
13. ". .therapist's abilities. ."	--	--	3	3.2	13	14.0	22	23.7	55	59.1	3
15. ". .overall satisfaction. ."	--	--	3	3.3	17	18.5	23	25.0	49	53.3	4

*3 - For the purpose of the questionnaire, "low" and "high" values were reversed.

*4 - The middle column, three, which read "reasonable" on the questionnaire represents "high satisfaction."

*10 - For the purpose of the questionnaire, "low" and "high" values were reversed.

Note: Column 1 usually indicates "low satisfaction," and Column 5 represents "high satisfaction" except in cases noted above.

The next highest areas of satisfaction were in the area of charges for services with 91.7% satisfaction and also in the area of self-knowledge with 92.3% feeling that they understood themselves better because of the sessions. As a comparison, in Outpatient services, only 69.7% felt that they understood themselves better as a result of the sessions.

Areas of dissatisfaction were "wait in the waiting room" with only 50% reporting satisfaction and "treatment not being client's own choice," with a satisfaction rate of 53.8%. General satisfaction level as measured in Question 15 was 57.1%. It is noteworthy that one-half of the Day-care clients failed to respond to this question. A possible explanation of this may be that Question 15 follows 14 which asks the client to check several choices. Many of the Day-treatment clients tend to be more disoriented, confused, or under heavy medication than in other areas of service so they may have overlooked the question, seeing it as part of the previous more difficult question.

Drug Abuse Client Scores

Drug Abuse clients (Table III) in answer to Question 1, "how much was coming here your own idea," showed that only 28.6% felt that it was their own idea. It is noteworthy that while all other areas were highly satisfied with methods of billing and payment, Drug Abuse showed only a 27.2% satisfaction level. Only 35.7% felt any improvement in problems since starting therapy. Areas of greater contentment were "interest of the staff members in the client," 78%, "like for the therapist by the client," 78.6%, and "confidence in the abilities

of the therapist," 85.7%. The general satisfaction question, No. 15, showed a 66.6% confidence level which was higher than the Day-care response of 50% to this question.

Staff Predictions

Staff predictions overall measured somewhat close to client reports. There were some areas, however, where there was a considerable range of difference from the consumer response. Areas where the staff predicted a higher response level than the clients were Questions 1, 8, and 12. Areas where staff predicted a considerably lower response were Questions 3, 5, 6, and 10. (Refer to Tables V and VI.)

AREAS OF HIGHER PREDICTION BY STAFF THAN ACTUAL CLIENT RESPONSE

#	Question	Client	Staff Predictions
1.	"own idea"	60.0%	72.7%
8.	"understand self better"	69.7%	81.8%
9.	"therapist likes you"	68.8%	90.5%

AREAS OF LOWER PREDICTION BY STAFF THAN CLIENT

#	Question	Client	Staff Predictions
3.	"wait for first appt."	85.4%	70.0%
5.	"methods of billing and payment:	80.0%	68.2%
6.	"wait in waiting room"	64.5%	47.6%
10.	"time alone help"	78.3%	63.6%

From the above figures, it appears that the staff felt that more of the clients came for service from their own choice than the study would actually indicate that they did. However, as the staff filled

out a questionnaire that was representative of all their clients, they may have chosen to represent those that came of their own volition. It also appears that the therapist thought that the client would feel liked well beyond what was actually apparent. An explanation for this could be that the therapist was not in contact with the client's own subjective level of self-esteem or perhaps he thought that he was communicating a caring level beyond what was actually the case.

The staff seemed to take more seriously than the client the "wait in the waiting room" and "time before first appointment." Staff also felt there would be more dissatisfaction with "methods of billing and payment" than in actuality. The consumer had much more confidence that "time alone" would not heal the problem than did the therapist. Possibly the therapist was expressing some question as to his abilities or modestly not wanting to overrate them.

Generally speaking, this study validates and supports the hypothesis gleaned from previous studies that there would be high levels of consumer satisfaction with services at the mental health center.

When the ratings, both individual department, and combined, were measured on a scale from one to five, with one being low satisfaction and five being high satisfaction, the results were as follows from the patient count on Question 15.

GROUP	LEVEL OF SATISFACTION
Outpatient	4.29
Day-treatment	3.86
Drug Abuse	3.43

Consumer Average 3.86

Staff Prediction 3.91

Up to this point, the data have dealt with the research question, "what consumer value will the client attach to his time, effort, and money spent at the Mental Health Center." The foregoing discussion and tables have presented a basic picture that shows high levels of satisfaction at North Orange County Mental Health.

II.

The second area of investigation in the study has to do with five questions compared and analyzed against a Consumer Satisfaction Index. Comparisons made against the index were questions of "involuntary treatment," "charges for services,""methods of billing and payment," "time spent in the waiting room," and "sex or gender of the therapist."

Consumer Satisfaction Index

In order to get a baseline against which to compare the effect of these questions on the overall outcome of the questionnaire, a Consumer Satisfaction Index was constructed. The questions comprising the index and their values are listed below. The values represented are percentages of Consumer Satisfaction taken from Table IV with Columns 1 and 2 (low satisfaction) and Columns 4 and 5 (high satisfaction) collapsed together.

CONSUMER SATISFACTION INDEX QUESTIONS (Questions are numbered as they appear on the Questionnaire.)	Value Percentage of Consumers Satisfied
2. How interested in helping you do the staff members seem to be?	80.0
3. How long did you have to wait between time of your first appointment and beginning treatment?	85.41
4. How do you feel about charges for services?	83.52
5. Are our methods of billing and payment satisfactory?	80.0
6. How long do you wait in the waiting room to see your therapist now?	64.52
7. How many useful ideas or suggestions have you gotten from your therapist?	71.42
8. Do you feel your sessions help you understand yourself better?	69.57
9. How much improvement have you felt in the problems that concerned you when you first came here?	60.64
11. How much do you like your therapist?	87.1
13. How confident are you in the abilities of your therapist?	82.8
15. How satisfied overall are you with the service you receive here?	78.26
The combined Consumer Satisfaction Value considering only those questions in the Index above is:	76.66

The combined Consumer Satisfaction Index value of 76.66 falls well within and toward the higher end of the predicted range of 67 to 80% as found in other consumer studies (Miller and Sinclair, 1972) showing a high level of satisfaction with services at North Orange County Mental Health.

The above questions were included in the index because they directly approached the client's satisfaction with services. Other questions that were considered to have a more indirect approach to satisfaction levels such as "location," "kinds of service utilized," and the "importance of the Mental Health Center to the community," were not included because they did not directly tap the client's personal satisfaction level. These questions including a discussion of the demographic data and open-ended comments will be discussed in Section III of this chapter.

Involuntary Treatment and its Effect on the Consumer's Satisfaction Index

A one-way analysis of variance was done to compare the Means according to the five groups measuring from "low satisfaction" to "high satisfaction." No significant difference in response to the Consumer Satisfaction Index was found in the five groups ($P > .05$) pointing out that involuntary treatment did not significantly affect the client's satisfaction with services at the clinic. The Means and Standard Error of Means are compared in Figure 1.

Figure 1

DATA GROUP		MEANS	SE
1.	"low satisfaction"	42.19	±1.70
2.		41.10	±2.50
3.		41.70	±1.90
4.		39.33	±1.60
5.	"high satisfaction"	41.90	± .89

Analysis of the above data comparing the Means of the five groups would indicate that involuntary treatment at the clinic did not affect satisfaction with services in other areas and thus the hypothesis that involuntary treatment would be negatively correlated was invalidated.

The question of "involuntary treatment" was included in the questionnaire because the literature indicated (Miller and Sinclair, 1972) that involuntary use of clinic services might color the consumer's acceptance of those services. Lorr et al. (1958) stated that those clients forcibly referred by agencies stay only for brief visits. Clients who are referred from probationary agencies may also be regarded by some service givers as being resistant to authority figures.

The indications seem to be, however, at this clinic that even though a client may not come to the center because of his own choosing, he does not necessarily see this as a deterrent from gaining help from the services. It appears as though the clients at North County Services separate Mental Health services from the penal services from which they may have been referred. (Table IV indicates that 29.48% of the clients

answering the questionnaire came for treatment without it being their own choice.)

The results may also indicate that Mental Health Services in this region may not be seen in the coercive role as other traditional type agencies.

Charges for Services and the Effect on Consumer's Satisfaction Index

The Consumer Satisfaction Index was adjusted by removing the response to the question about charges for services and a one-way analysis of variance was done comparing the adjusted Means and the Standard Error in the groups. Groups 1 and 2 were collapsed together because of the small amount of data thus making four instead of five groupings. No significant difference in response to the Consumer Satisfaction Index was found in the groups ($P < .05$) pointing out that charges for services did not significantly affect the client's satisfaction at the clinic. The adjusted Means and Standard Error of Means are compared in Figure 2.

Figure 2

DATA GROUP	MEANS	SE
1&2. "low satisfaction"	40.04	±3.01
3.	42.86	± .68
4.	34.83	±3.97
5. "high satisfaction"	36.00	±1.53

Since there was a high satisfaction rate with "charges for

services," 83.5%, there seemed to be the possibility that it would have affected the Consumer Satisfaction Index. With a lower satisfaction with "charges for services," a disgruntled client populace may have chosen to show its displeasure in other areas of the index. However, as noted in Figure 2, no significant difference was found. Those that showed "high satisfaction" with service were less satisfied with "charges for service." Perhaps the clients who felt the pinch of paying for the services received also felt more subjective benefit from those services. Albee (1969) indicated 25% of clients receiving free treatment stopped within five sessions.

Methods of Billing and Payment and Effect on the Consumer Satisfaction Index

Before a one-way analysis of variance was done obtaining the Mean and the Standard Error of the Mean, consumer value for "methods of billing and payment" was removed from the Consumer Satisfaction Index. Because of the small amount of data in some groups, satisfaction levels 1 and 2 and 3 and 4 were collapsed together making three groupings. Analysis shows the Mean Satisfaction Index for the three groups to be significantly different ($P < .01$). See Figure 3. "Methods of billing and payment" was seen as having a significant effect on the Consumer Satisfaction Index.

Figure 3

DATA GROUP	MEANS	SE
1&2. "low satisfaction"	31.00	±3.19
3&4. "neutral"	39.33	±1.27
5. "high satisfaction"	41.05	± .74

Table IV shows that there was 80% satisfaction with "methods of billing and payment." From interpreting the data then, one might cautiously assume that this "high satisfaction" level was reflected in the overall Consumer Satisfaction Index.

Sex of the Therapist and Its Effect on the Consumer Satisfaction Index

Obtaining the Mean and the Standard Error of the Mean, Figure 4 below demonstrates that the clients that filled out the consumer questionnaire did not see the sex of the therapist as significant in their satisfaction with services at the clinic. Of the 89 clients answering the question, "are you male or female," 35 males and 54 females responded. Forty had male therapists and 44 had female therapists.

Figure 4

DATA GROUP	MEANS	SE
Male	44	±1.10
Female	45	± .96

The question of "sex of the therapist" was included to ascertain if clients at North County Services preferred one gender of therapist

over another. Chessler (1971) documented that both male and female clients requested male therapists when given a choice. She felt this was true because both sexes view males as more powerful and therefore more able to help. Schwartz (1974) in analyzing the sex of the social worker and client, where there was no choice, found that the issue was largely ignored and the sex of the therapist rarely mentioned. Perhaps when the client comes to the clinic, is initially seen by a female therapist and is assigned to her, he begins to relate to her whereas, if he were initially given a choice, he would have asked for a male therapist.

Until recently, the field of psychotherapy has been dominated by men. Now, however, many more women appear to be coming into the field, perhaps through the influence of women's liberation and many other women's movements. The above statistics seem to indicate that the expertise of women therapists is well accepted at North County Services and the belief that clients prefer male over female therapists may be erroneous at least in this setting.

Correlation and Partial Correlation

A correlation and partial correlation were done between Questions 1, "client's coming of own choice;" Question 4, "charges for services;" Question 5, "methods of billing and payment;" and Question 6, "wait in the waiting room," and the Consumer Satisfaction Index. The proportion of the variability in the Satisfaction Index was accounted for as seen in Column 3, Table XII.

Table XII

Correlations and Partial Correlations Between Questions 1, 4, 5, and 6 and the Consumer Satisfaction Index and the Proportion of Variability in CSI Accounted For

Questions	Correlation	Partial Correlation	Proportion of Variability in CSI Accounted For
1. ". . own idea. ."	.25	.18	.06
4. ". .charges. ."	-.35	-.11	-.12
5. ". .billing. ."	.40	.30	.16
6. ". .time. .waiting room. ."	.44	.45	.20
	.61		.37

Question 6, "wait in the waiting room," with a satisfaction level of 64.52% showed the greatest variance of .20 and had the largest effect on the index. See Table IV.

The client's "wait in the waiting room" with a lower satisfaction rate of 62.5% (Table IV) may have tended to lower the satisfaction level of the Consumer Satisfaction Index. The unhappy client sitting in the waiting room may have tended to let his unhappiness cloud his acceptance of other levels of service. Inversely, the "longer the client waits in the waiting room," the less general satisfaction he shows with services at the Mental Health Clinic. Miller and Sinclair (1972) found "waiting in the waiting room" to be a "low satisfaction" question.

Thus, a one-way analysis of variance on Questions 1, 3, 4, 5, and a comparison of the sex of the therapist with the satisfaction levels of the index showed that the only question measured that significantly affected the client's satisfaction with services was Question 5 having to do with methods of billing and payment. A correlation and partial correlation of Questions 1, 4, 5, and 6 showed that Question 6, "waiting in the waiting room," had the largest effect on the Satisfaction Index.

From analyzing the above data, one might make the cautious statement that the questions in the index are independent and satisfaction with one area of service does not necessarily predict levels of satisfaction with other areas of service at the clinic.

III

Since all the content of the questionnaire did not relate directly to the research question or to the additional comparative questions, the third section of this chapter will deal with questions of "location," "kinds of service found helpful," "services utilized," "importance of Mental Health Services to the community," and the "open-ended comments." The demographic variables of the data which represent the last section of the questionnaire will also be discussed. Demographic data included in the discussion are (1) gender of the client, gender of the therapist, (2) marital status, (3) age, (4) ethnic background, (5) occupation, (6) income level, and (7) number of visits to the clinic.

Location of Clinic

Location of the clinic was considered in Questions 16 and 17. In Question 16, "do you feel the team could serve you much better if it had more offices close to where you and people you know live," 20 answered "yes," 35 answered "no," and 38 answered "no opinion."

Thirty-one responded to Question 17 which read, "If you said yes, where would you put the office?" Five options were listed representing the five cities that the team serves. The cities are listed in alphabetical order with the responses as follows:

Figure 5

City	Number of Responses	Percentage of Number Answering
Brea	4	12.9%
Fullerton	16	51.6%
La Habra	4	12.9%
Placentia	5	16.1%
Yorba Linda	2	6.4%

The response by clients already being served at the clinic seems to indicate that there is little interest or need felt for a new location or locations of clinic services. A possible supposition might be, however, that those living in the outlying reaches of the region do not receive services because of lack of transportation or it is inconvenient to come such a great distance. Naturally, if these people do exist, they did not vote where to locate a new clinic.

Services Received and Services Found Helpful

Question 14, "services found helpful," and Question 19, "services received," will be considered together so that a comparison may be made. See Figure 6.

Figure 6 N=96

	Type of Treatment Found Most Helpful	Type of Treatment Receiving
Individual	70	71
Group	20	28
Day Treatment	14	18
Drug Abuse	4	9
Alcoholism	2	3

The 70 clients who responded to the questionnaire found individual sessions most helpful, while 71 checked that they were receiving individual treatment. This shows a high level of satisfaction with individual treatment and would also seem to relate to Question 12, "How much do you like your therapist?" (See Table IV.) Many of the clients may have checked that they found individual treatment most helpful because they have not experienced any other type of therapy.

Twenty of the 28 customers that indicated that they were being seen in group checked that they found the service helpful. This indicates a somewhat less satisfied number than in individual therapy. Day-treatment clients demonstrated that they thought the days spent in Day-treatment were worthwhile as 18 checked receiving treatment while 14 checked that they found it most helpful. It is relevant to note that while nine clients checked that they were receiving Drug Abuse service, only four checked that they found the services helpful. Fourteen questionnaires were turned in by Drug Abuse indicating that not all clients responded to these questions. Alcoholism service was a new service represented on the team and as a result may have shown poorer

returns because it was not in full operation.

Consumer Response to Community Services

These series of Community Service questions were included on the questionnaire to ascertain how the consumers actually being served by the Center would rate direct services which they received as well as some of the other services that the Community Mental Health Center performs in the community.

In Question 18, the consumer was asked to rate the importance of Mental Health services to the community. The following includes a discussion of seven questions as they were rated on the rating scale from 0, denoting "no opinion," to 5, "probably the most important of all." Both consumer and staff ratings will be compared and discussed.

Question 1

"Providing counseling, therapy, and medication in the office of the Mental Health Center."

This question was given the largest rating by both consumers and staff of all the questions, showing that both staff and consumers see direct service as the most important service offered by Community Mental Health. See Tables XIII, XIV, and XV. Most of the answers were in Column 4 with a very important rating with consumers giving a 40.4% rating and staff giving a 45.4% rating. When collapsing together Columns 4 and 5, however, consumers rated the question 76% importance and staff rated it 86.3%.

Table XIII

Comparison of Consumer and Staff Responses--Importance of Mental Health to the Community

Question No.	% Consumer Response	% Staff Response
1	76.0	86.3
2	55.2	68.2
3	51.0	72.7
4	70.6	68.1
5	45.8	50.0
6	62.8	59.0
7	42.4	50.0

The above percentages represent Columns 4 (very important) and 5 (most important) collapsed together to show level of importance.

Table XIV

Consumer Response to Question 18, Importance of Mental Health to the Community

	0		1		2		3		4		5		Missing Data	
Q	#	%A	#	%A	#	%A	#	%A	#	%A	#	%A	#	%A
1	5	5.6	1	1.1	3	3.4	12	13.5	36	40.4	32	36.0	7	7.3
2	11	12.6	1	1.1	10	11.5	17	19.5	33	38.0	15	17.2	9	9.4
3	10	11.8	1	1.2	8	9.4	23	27.1	32	38.0	11	13.0	11	11.5
4	7	8.2	1	1.2	3	3.5	14	16.5	38	44.7	22	25.9	11	11.5
5	7	8.2	-	-	16	18.8	23	27.1	27	31.7	12	14.1	11	11.6
6	3	3.5	1	1.7	5	5.8	23	26.7	32	37.21	22	25.6	10	10.4
7	8	9.41	4	4.7	18	21.2	19	22.3	26	30.6	10	11.8	11	11.5

Question Number: Read down.

Response Number: Read across.

Possible Responses:

0 - No opinion.

1 - Not at all important.

2 - Useful, but not as important as other things.

3 - Pretty important.

4 - Very important.

5 - Probably the most important of all.

Table XV

Staff Response to Consumer Question 18, Importance of Mental Health to the Community

	0		1		2		3		4		5		Missing Data	
Q	#	%A	#	%A	#	%A	#	%A	#	%A	#	%A	#	%A
1	-	-	-	-	-	-	3	13.6	10	45.4	9	40.9	-	-
2	-	-	-	-	1	4.5	6	27.3	13	59.1	2	9.1	-	-
3	-	-	-	-	1	4.5	5	22.7	15	68.2	1	4.5	-	-
4	-	-	-	-	2	9.1	5	22.7	10	45.4	5	22.7	-	-
5	-	-	1	4.5	3	13.6	7	31.8	10	45.4	1	4.5	-	-
6	-	-	1	4.5	1	4.5	7	31.8	10	45.4	3	13.6	-	-
7	1	4.5	1	4.5	4	18.8	5	22.7	8	36.4	3	13.6	-	-

Question Number: Read down.

Response Number: Read across.

Possible Responses:

0 - No opinion.

1 - Not at all important.

2 - Useful, but not as important as other things.

3 - Pretty important.

4 - Very important.

5 - Probably the most important of all.

Question 2

"Providing consultation and help to police, clergy, teachers, and others who frequently come in contact with people who have mental health problems."

The largest number of answers was again in the fourth column for both staff and consumers. When both Columns 4 and 5 were considered together, consumers gave a 55.2% response while the staff response was 68.2%. This seems to show that staff give more importance to consultation types of service than do direct consumers. This question seems to point out that the consumer, perhaps because he doesn't feel the direct benefit of consultation services, does not see them as important to the community.

Question 3

"Providing consultation to county and other public agencies to help them work together in serving people with mental health problems."

In the combined consumer rating, only 51% (Table XIII) of the consumers thought that this service was very important or most important. 72.7% on the staff felt it to be important. This may point out the lack of knowledge about indirect services at the community level.

Question 4

"In crisis situations, going to the home of a severely disturbed or upset person to do an evaluation or provide assistance to the family."

The combined consumer response was 70.6% which was higher than

staff response of 68.1% (Table XIII). Consumers seem to feel that going to the home in a time of crisis is a very important function of Mental Health. Again, this is a direct service where the consumer can see what is being done and may denote some of his feelings of helplessness in such a situation. It is noteworthy that most of the consumers did not appear to be afraid of such an action on the part of Mental Health and seemed to see it as a help and not a threat.

Question 5

"Taking time to help people who need just information about mental health problems."

This was one of the lowest staff responses, with 50% believing it to be "very important" or "most important." Consumers rated it even of less value than staff, 45.8%. Both consumers and staff seemed to see this as one of the less vital functions of Mental Health.

Question 6

"Informing the public of services available."

The combined consumer rating (see Table XIII) was 62.8% as compared with the staff rating of 59%. Both consumers and staff seemed to see a need and attach some importance to knowledge about services. Perhaps the consumers had been unable to find services before they came in contact with Mental Health and realized the importance of knowing of its existence.

Question 7

"Spending time and effort seeking community feedback about how to

change and improve services."

This question received the lowest rating on the consumer scale of importance, 42.4%. It also received one of the lowest staff ratings, 50%, demonstrating that this did not seem to be a high priority question.

SUMMARY

Results from the above data seem to point out rather clearly that consumers regard direct services as the most important function of the Community Health Team. Staff also rated these functions high, giving priority to this area of service. Staff gave higher ratings to the consultation questions while consumers did not see these as such important services. Staff had no missing data on these questions while consumers had a considerable amount of data missing.

VARIABLES OF THE CONSUMER RETURNS

Number Being Seen at the Clinic

The total number of individuals being seen from the three departments of service was 454 with each receiving on an average approximately two visits per person. The three departments were divided as follows: Outpatient, 267; Drug Abuse, 162; and Day-care, 25. Actual numbers turning in questionnaires were: Outpatient, 68; Drug Abuse, 14; and Day-care, 25. From the above returns it appears that Day-care returns were good, Outpatient fair, and Drug Abuse returns very poor. It is not known how many of that population were eligible to fill out a questionnaire by being on the third visit or thereafter. Also it

appears from the above figures that the average all-over consumer returns would have been much higher if the Drug Abuse response would not have been so low. It is not known, but a question for future study, the sex, age range, ethnic group, marital status, income level, or occupational level of those not responding to the questionnaire.

Returns on the questionnaires showed that 35 males and 54 females returned questionnaires. The gender or sex of the therapist was almost equally divided among this group with 40 reporting seeing a male therapist and 44 reporting seeing a female therapist.

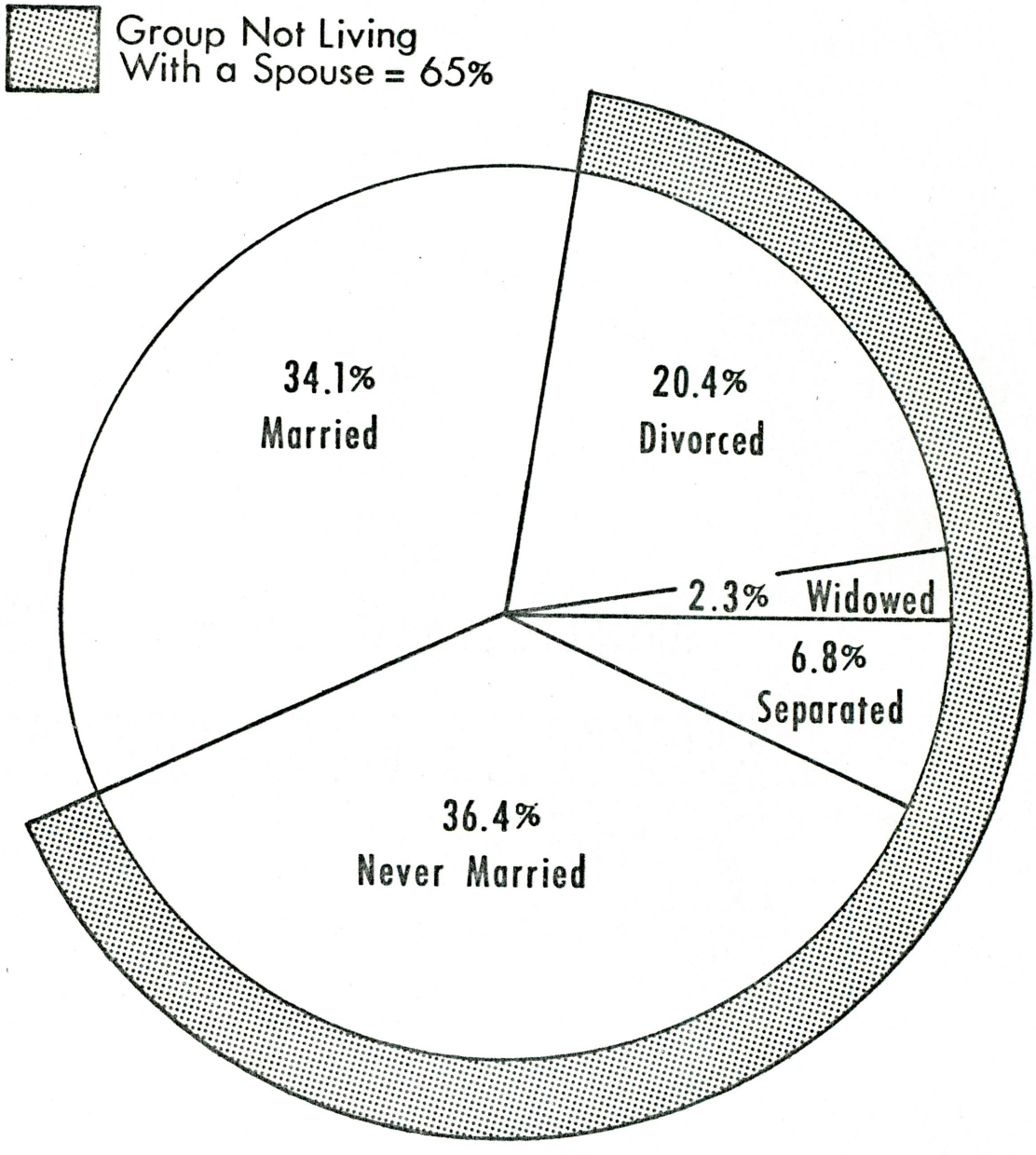
Marital Status

In reply to the question about marital status, 32 consumers checked that they had never been married; 30, married; 18, divorced; 6, separated; and 2, widowed. (See Table XVI showing percentages representing the 88 respondents.)

From the above returns, it might be postulated that for this agency single people seek help for their problems more than married people. A high proportion, 65%, of those returning questionnaires represented some form of singleness. The 1970 census reports showed 14% of the male population had never married and 15% of the female population had never married with a total never-married population of 25%. Thirty-four percent of the population being seen at the clinic have never been married.

Looking at the above data, it might be assumed that single people in North Orange County have more problems than married people, or perhaps they are more open about their problems. It might also be

TABLE XVI



Marital Status of Clients Returning Questionnaire to North County Services

assumed, however, that married people may have more money and prefer to take their problems to the private sector for counseling. The fact that 29.5% of the clients at the clinic represent the divorced, separated, or widowed may indicate that consumers are having difficulty dealing with past marriages. With the high divorce rate and ensuing loneliness, many people may see their therapist as surrogate friend.

Age

Age range in the clinic population as represented by returned questionnaires lies heavily in the 19 to 35 age group with the largest number, 35, checking the 26 to 35 age bracket. Thirty-two checked 19 to 25 years, 21 checked the 36 to 64 group. The lowest represented groups were the 0 to 18 year age group with two respondents and the over 65 age group with one respondent. See Table XVII. The low number of child's cases can be explained by the fact that child cases are seen only at the Child Guidance Clinic. Only those children involved in Family Therapy would be seen at the clinic.

It is difficult to be as certain as to why the older population is not well represented at the clinic. One reason may be that they may be transitioned to the Activities Center where they may work on crafts. Another reason may be the therapists' prejudice against working with the older population whom they see as unable to change. Also, many churches in the area sponsor activities which may provide some therapeutic substance for older people. Older people have more difficulty with transportation and may not live within walking distance of the clinic. This age group may not see psychotherapy as a possible alternative to meet

Age Range of Persons Returning Questionnaire to North County Services

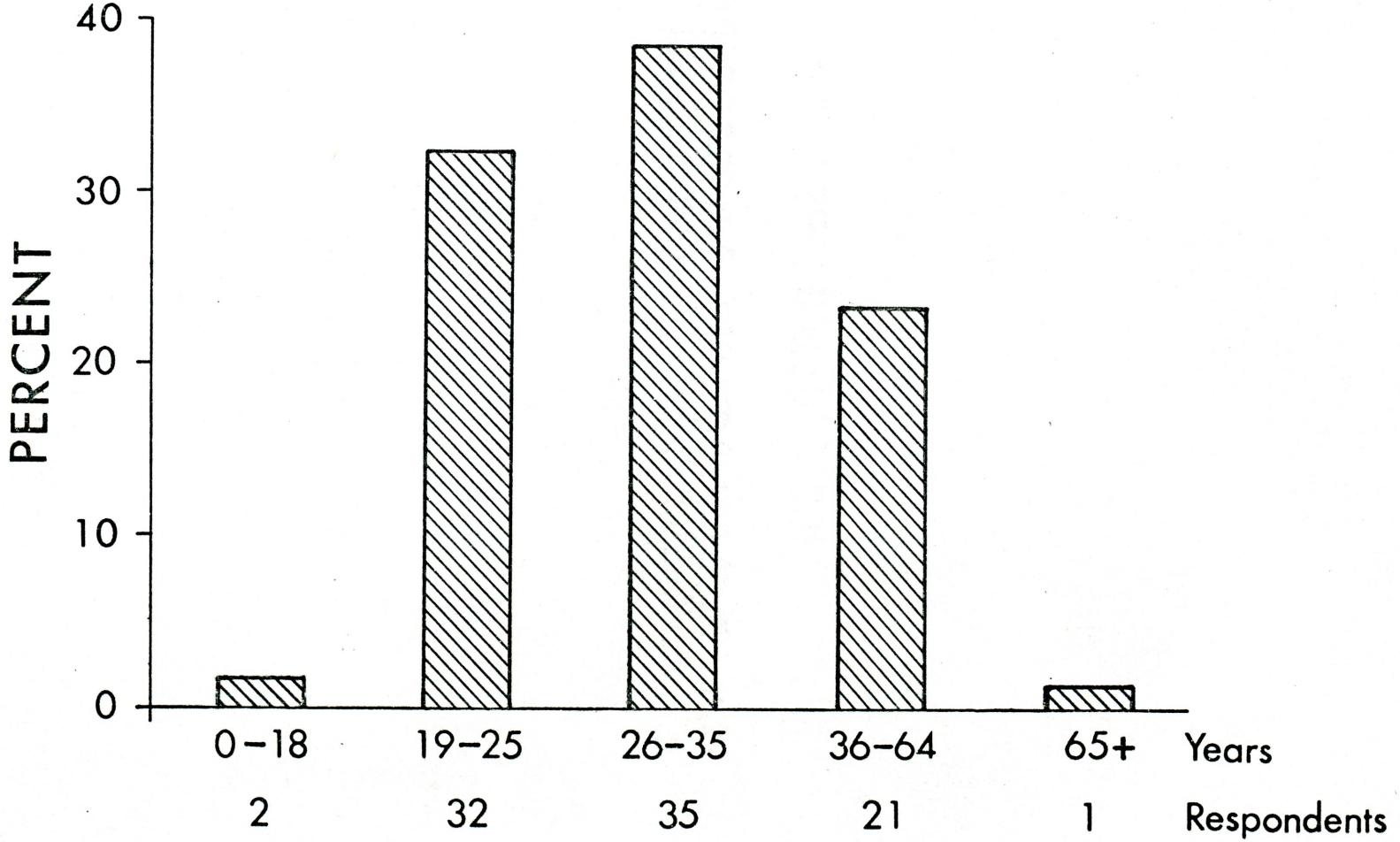


TABLE XVII

their many problems as do younger people. Perhaps they have made some resolution of their problems.

The 19 to 35 age group which represents 73.7% of the clinic population appears to consider therapy as a viable mechanism to meet their problems. This age group also seems to have less hesitancy using a tax-supported agency to meet their needs and seeing a therapist may be acceptable, even desirable as a prestigious status symbol. Another possible explanation may be that the younger population is more mobile and thus able to take advantages of the services offered. Lack of funds by the younger set, especially the 19 to 25 age group, may have driven them to seek Mental Health Center services as an alternative to no help at all. Generally, therapists may think that the younger population has more capacity to change and may slant their caseload in that direction. Many probation referrals are also in this age group. Large numbers of the therapists themselves were in this age range and may have tended to understand those problems better than those of the older population. Fullerton is a college town with two large universities that may have attracted young people who preferred the influence of an academic environment without actually being enrolled in school. The young persons may have been on welfare or in low-paying jobs. Also, despite the fact that most of the universities provided their own counseling services, many of the consumers were students. The picture of treatment at North Orange County Mental Health then seems to be that of young, single people seeking counseling.

Ethnic Background

The population that filled out the questionnaires at the clinic was almost completely white-Anglo, 70 respondents, with Mexican-Americans, 10 respondents, being the next largest ethnic group reporting. No blacks or Asian-Americans checked the questionnaires while two American Indians, two other nonwhites, and one unknown were represented. The 1970 census description lists the total nonwhite ethnic population at 15.7% with Mexican-Americans representing a large proportion of that population. Compared with the 5% ethnic population that filled out the questionnaires, it appears that 10% of the nonwhite ethnic population was not represented at the clinic. Since the questionnaires were filled out on a voluntary basis, however, one may not assume that this is true. Some possible reasons that some members of nonwhite ethnic groups might choose not to fill out the questionnaire would be difficulty with the language, distrust of a white-Anglo system, and passive resistance against what might appear representative of that system. Other ethnic groups may not see therapy as an alternative to dealing with their problems, as the traditionally conceived picture of the typical psychotherapy client is the white, upper-class suburbanite. At the time that this questionnaire was distributed, there were two Chicano therapists on the Outpatient staff and Drug Abuse had at least one black therapist.

Occupational Status

The questions regarding occupation, "what is your occupation," and "if married, your spouse's occupation," received a total of 70

responses. Eleven had reported that they were housewives while 59 said that they were unemployed. This question, a fill-in-the-blank type question, was not answered by a great many of the respondents.

A comparison was made of the occupational status of those responding to the question at the clinic and the occupational status of North Orange County as reported in the 1970 census (Table XVIII).

Looking at the table, fewer clients reported low occupational status jobs than were actually reported in the region. In the region, 30.6% of the males reported low occupational status positions as compared with 22% at the clinic. Women in the region represented 31.5% in low-status jobs while those women attending the clinic reported only 6.9% low-status positions. Perhaps this discrepancy might be accounted for by the fact that many of the consumers at the clinic reported being unemployed, even though they may have previously held a lower status position such as laborer. Members in this group may not have wanted to give their job position for fear of being identified or shame.

Middle occupational status jobs such as clerical, salesworkers, craftsmen, and students occupied the largest group at the clinic. Men represented 46.3% of those turning in questionnaires, comparing with 31.5% in the region. Women showed a much larger percentage of middle-status positions with 61.1% of those reporting at the clinic claiming such positions as compared with 46.5% in the region.

High occupational status positions such as professional, technical, managerial, and administrative were checked by 31.7% of the men or their spouses while 37.9% of the men in the region occupy these positions. Thirty-one percent of the women at the clinic checked high

Table XVIII

Comparison of Occupational Status of Consumers and Population of North Orange County as Reported in the 1970 Census

Occupation Status	Clinic Population N=70 M=41, W=29	Region II Employed Population N=80,909
Low Occupational Status:		
Laborers, farmers, service workers	Men - 22.0% (9) Women - 6.9% (2)	Men - 30.6% 16,146 Women - 31.5% 8,909
Middle Occupational Status:		
Clerical, salesworkers, craftsmen, students	Men - 46.3% (19) Women - 62.1% (18)	Men - 31.5% 16,617 Women - 46.5% 12,906
High Occupational Status:		
Professional, technical, managerial, administrative	Men - 31.7% (13) Women - 31.0% (9)	Men - 37.9% 19,978 Women - 21.9% 6,093

occupational status positions while only 21.9% of the women in the county were represented by these positions.

It appears that much fewer men and women at the clinic claim low occupational status positions than are reported in the county. Perhaps a reason for this may be that people holding those positions are of a minority ethnic group or perhaps aliens who are afraid to seek community services. The greatest number of job positions at the clinic seems to be in the middle range with women being very predominant in that area. A large number of women receiving services at the clinic claimed high occupational status positions as compared with those in the region. From the above data, it would appear that the clinic predominately serves the middle income range. Perhaps this occupational group is better informed about the services while the lower status group is suspicious of mental health, and the high-status group prefers to go to the private sector for treatment.

Income Level of Consumers

Eighty of the 96 respondents to the questionnaire answered the question of "gross yearly income for your family." The income levels were divided into five sections which the consumer could check. The largest number of consumers, 31.25% of the clinic population, checked the 0-$4,000 income bracket, 22.5% checked the $4,000-$7,999 income range, 26.25% checked the $8,000-$14,999 range, 12.5% checked $15,000-$19,000, and 7.5% checked that they earned over $20,000. See Figure 7. From assessing the data in Figure 7, it appears that the largest percentage (48.75%) of the clinic population answering the questionnaire

is in the income groups between $4,000 and $15,000. Twenty percent of the consumer population reported income over $15,000.

Figure 7

N=80

Number of Responses	Income	Percentage of Total Respondents
25	$0-$3,999	31.25
18	$4,000-$7,999	22.50
21	$8,000-$14,999	26.25
10	$15,000-$19,999	12.50
6	$20,000+	7.50

When asked on the questionnaire, "are you currently employed," 31 replied yes while 59 replied no. Thirty-four reported that they received public assistance while 49 reported that they did not receive assistance. Eleven who reported being housewives account for some of the unemployed.

Although the clinic seemed to serve a high percentage of the low income group, the middle income group also appeared to utilize services. Looking at the above data, there is also the possibility that some consumers report their income incorrectly, possibly for fear of having to pay more for the services. Perhaps the above data indicates that the general population as a whole is taking advantage of the service rather than just the poorer lower classes.

Number of Consumer Visits

Eighty-six consumers responded to the question, "Approximately

how many times have you utilized the services on Commonwealth or Whiting?" There were four items representing the number of visits that the consumer might check. The number of visits, the number of respondents, and percentage of total are shown in Figure 8 below.

Figure 8

N-86

Number of Visits	Number of Responses	Percentage of Total
3-5 times	21	24.4
6-10 times	21	24.4
11-15 times	8	9.3
16 or more times	36	42.0

From Figure 8, it can be seen that the largest number of clients being seen at the clinic, 42.0, had been seen 16 or more times. The next largest number of clients checked response 1 and 2, with 24.4% checking 3-5 times and 6-10 times consecutively.

In order to get an idea of how the clients felt about their perceived improvement since starting therapy, Question 9 was compared with the number of visits to the clinic. Figure 9 demonstrates the comparison between number of visits and improvement perceived at the clinic. The figure shows that the number of clients with 16 or more visits to the clinic had the highest rating of perceived improvement at the clinic. The lowest rating of perceived improvement was among the clients that had visited the clinic only 3-5 times. Of those visiting the clinic 16 or more times, 72.5% perceived high levels of improvement.

Of those who had visited the clinic 3-5 times, only 31.8% perceived high levels of improvement since starting treatment. Those attending 6-10 times showed a 61.1% satisfaction rate. The rate of satisfaction slipped to 57.1% among those visiting the clinic 11-15 times.

Figure 9

Perceived Client Improvement (Question 9) (Highly Satisfied) Compared with Number of Visits

Number of Visits	Percentage of High Satisfaction
3-5 times	31.8
6-10 times	61.1
11-15 times	51.1
16 or more times	72.5

In general, the above figures seem to support previous research (Luborsky et al., 1971; Garfield and Bergin, 1971) that the longer a client stays in treatment the better the outcome. Twenty out of twenty-two studies reviewed by Luborsky et al. (1971) supported this finding.

Possible explanations for the higher satisfaction rate after 16 or more visits to the clinic might range from greater dependency on the therapist to a longer time for insight and awareness to take place. Those visits where the major reason for beginning treatment was of a crisis nature, the crisis may have already resolved itself. A possible reason for the decline in satisfaction in the 11-15 visits group might be that therapy is moving from a resolution of the crisis into more long-term, character-reorganization type therapy. Perhaps a question

for the service givers at the clinic to consider is, "what are they doing to foster dependency needs in the client" beyond the short-term, goal-oriented therapy which is supposedly the predominant type of therapy to be given in a Public Mental Health setting. Perhaps the predominant therapeutic modality of this clinic was long-term oriented. It appears that those receiving longer term therapy were the most pleased and thus were the ones filling out consumer questionnaires.

COMMENTS AND SUGGESTIONS

Question 23 was included as an open-ended question asking for comments or suggestions for the Community Mental Health Center. This open-ended question was included so that the consumer might ventilate his feelings in a free-flowing, less-limited fashion than the Liekert-type scale questions. The consumer was asked to express in his own words his intimate thoughts, feelings, ideas, and suggestions about the clinic.

Out of a possible 96 responses, there were 38 essay-type comments. One client listed himself as both an Outpatient and Day-treatment client and will be counted in both responses. Outpatient had the highest number of responses with 38; Day-treatment was next with 11 responses. Drug Abuse clients made no response and staff made three comments. In percentages, 56% of the Outpatient respondents took the extra time to make comments. Day-treatment response to the question was much higher with 78.6% response to the open-ended question. As noted, there was no response from Drug Abuse clients. In order to look at the comments from the clients, several representative comments will be considered from the three groups. The groups will be divided into those making positive statements, those making negative statements,

and those making suggestions or neutral comments. The comments will be divided among the various departments. Outpatient, which showed returns of 15 positive statements, 4 negative statements, and 8 neutral or strictly suggestion statements, will be considered first.

Outpatient Services

Positive Statements:

1. In my experience more effective than the private mental health sector.

2. My entire life has been changed and made better by the help that I have received here.

3. Thank you for being here, if not I would be dead and now I want to live. Thank you, _____, I love all of you for your help.

Most of the other positive statements from the Outpatient Department had to do with comments such as "keep up the good work" and "thanks for being here."

Negative Statements:

1. People should be hired on a long-term basis. I think it is upsetting to have one's therapist leave in the middle of healing, so to speak. (This was one of three similar comments regarding the changeover of therapists during treatment.)

2. Not being able to smoke in the waiting room is a bad and uncomfortable situation for people who are very nervous and are smokers.

3. Become more interested, make more definite suggestions.

Suggestions and Neutral Statements:

1. If possible, some way to contact therapists on weekends or

evenings if problems arise that you feel you can't cope with or need help with immediately.

2. More information be made available to the public concerning mental health problems and treatment.

3. I would like to see help in referring people to county agencies which will help when a person doesn't know where to turn.

Beyond praise for the staff and services, the most frequently heard comment was objection to the frequent change in therapists. Since students were responsible for a great deal of therapy at the clinic and a great deal of the changeover was due to their going and coming, the clients were probably responding to this upheaval.

Day-Treatment (Day-treatment had five positive comments, three negative, and two neutral comments.)

Positive Comment (which is representative of the others):

1. I think we have a wonderful staff and they are doing a good job considering the time and space available.

Negative Comments: (All the negative comments are mentioned because they vary in content.)

1. More personal attention to giving medication.

2. More personal contact, understanding, if this is possible.

3. Let the patient choose his primary therapist and don't put him or her in confrontation unless they ask for it.

Neutral or Helpful Suggestions:

1. I think a typewriter in occupational therapy would be therapeutic and educational.

Staff (Staff's comments as a rule were quite different from the consumers and leaned toward inservice problems, consultation questions, and meeting the staff's needs for giving better service. All three comments are included.)

1. Better or more communication between regional teams to improve service.

2. More community consultation.

3. Need more Day-treatment outings/outdoor activities center/informal. Activities (time structure).

Most of the clients' comments were complimentary to the services, and it appears that they saw this as an opportunity to give "hurrahs" to the staff. The most frequent appearing negative comments appeared around the frequent changing of therapists. Community awareness type comments came from the staff.

Chapter V

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

This chapter contains the summary and a discussion of the conclusions and recommendations that were derived from this exploratory study with descriptive-comparative components examining levels of consumer satisfaction at North Orange County Mental Health. Additional questions were compared against a Consumer Satisfaction Index. The importance of the consumer's conception of Mental Health Services to the community, the question of location of services, types of services received, and demographic variables of the study were examined.

SUMMARY

The central purpose of this study was to examine levels of Consumer Satisfaction at North Orange County Mental Health. In addition, a Consumer Satisfaction Index was formed, and comparisons were made and examined against the index. Comparisons made and examined were questions of "involuntary treatment," "charges for services," "methods of billing and payment," "time spent in the waiting room," and "sex or gender of the therapist." A third section included in the analysis of the data contained consumer attitudes toward Mental Health Services in the community, questions of location, services available and received, and variables of the study such as age, ethnic group, marital status, income level, occupational status, and number of visits to the center.

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A review of the literature indicated that between two-thirds and three-fourths of the clients would be satisfied with the services. It has not been well documented whether the questions of "involuntary treatment," "charges for services," "methods of billing and payment," "time spent in the waiting room," and "sex of the therapist" affect client satisfaction with services in a mental health setting.

The 23-item questionnaire was given out at North Orange County Mental Health Services on the third visit or thereafter on a voluntary basis. Data collection occurred between June 15, 1975, and July 15, 1975, with total anonymity being maintained.

Statistical analysis indicated high levels of satisfaction at the clinic. Individual analysis was done on the separate departments of service--Outpatient, Day-care, and Drug Abuse--and these were combined into the total consumer count. Staff predictions of the ratings were collected and compared with client ratings. A Consumer Satisfaction Index was formed and of those questions compared against it, "methods of billing and payment" and "waiting in the waiting room" had the largest effect. "Involuntary treatment," "charges for services," and "sex of the therapist" were nonsignificant when compared against the index.

CONCLUSIONS

1. The combined patient count at Orange County Mental Health showed high levels of consumer satisfaction with services, the level of satisfaction being 75%. Question 15, the "general satisfaction" question,

showed a satisfaction level of 75.3%, and the Consumer Satisfaction Index level was 76.66. Thus, this study was in line with previous studies and validated the hypothesis which predicted high levels of consumer satisfaction with Mental Health.

2. Highest levels of satisfaction were shown in areas of "liking for the therapist," "confidence in the therapist's abilities," "charges for services," and "length of time between first visit and beginning service."

3. Pockets of "lower satisfaction" and some possible discontent were in the areas of "voluntary treatment," "wait in the waiting room," and "improvement since starting therapy." It is noteworthy, however, that none of these areas fell below 60% satisfaction.

4. Of the three departments analyzed, Outpatient showed the highest satisfaction with service, Drug Abuse the lowest, with Day-care falling in between. Staff predictions were in line with consumer ratings of service.

5. "Methods of billing and payment" and "length of time spent in the waiting room" both showed significant effect on the Consumer Satisfaction Index. "Involuntary treatment," "charges for services," and "gender or sex of the therapist" did not have a significant effect on the satisfaction levels in other areas.

6. In terms of importance to the community, Mental Health consumers gave direct service the highest rating. Lowest rating was given to the question of seeking community feedback about how to change and improve services.

7. Consumers responding to the questionnaire were generally satisfied with the location of the clinic and saw no need for a new location.

8. Individual therapy was the largest service rendered at the clinic and the service found most helpful by those attending. Drug Abuse clients appeared to express some dissatisfaction with service.

9. The variables included in the study showed that the clinic treated a young, mostly single, white-Anglo population, largely of middle occupational status, although a large number are not working and reported receiving public assistance. Of those responding to the questionnaire, a large group was in the low income range below $4,000; however, the largest group by far was in the low to middle income range ($4,000-$15,000). The number of visits seemed to be associated with satisfaction with service with those having 16 or more visits being the more highly satisfied group.

10. Comments and suggestions were generally favorable with the greatest criticism being the large turnover in therapists.

RECOMMENDATIONS

The following recommendations for further study are presented after considering the results of this study:

1. Data be collected in a more controlled fashion so that questionnaires are recorded and better returns assured. Perhaps a method of coding the data could be found so that it becomes apparent which segment of the clinic population is filling out the questionnaires. A substudy

be made of those clients failing to fill out questionnaires so as to determine if they are among the disgruntled who are expressing dissatisfaction with the center by nonparticipation.

2. A study of the dropout clientele who never get to the third visit and who possibly register their distaste with clinic services by not continuing.

3. A replication of a consumer satisfaction study, building into it the variables of experience and therapeutic modality of the therapist, comparing them with the client's general satisfaction level with service.

4. A study to determine if the dropout rate is higher in the lower socioeconomic group at the clinic.

5. A study to determine what happens to the older population at the clinic. Do they come into the clinic for treatment and are they referred to some other service such as Activities Center? Are they the victims of the therapist's prejudicial treatment and rendered not suitable for treatment, or do they never make an initial visit to the clinic and choose to handle their problems some other way rather than Mental Health Services?

6. A more closely supervised analysis of why there was such a poor response from Drug Abuse, and are Drug Abuse clients using this method to register protest against therapy, against the system, or is this part of their characterological makeup?

7. Data collection at different times of the year, as when this data was collected, the present student interns were preparing to leave

and the new ones were coming so as to produce a shift in clinic population and possible poor returns.

8. A questionnaire designed to find out if the clients filling out the questionnaire were clients that utilized the system over and over.

9. A study comparing the levels of satisfaction between those receiving short-term goal-oriented therapy and those receiving long-term personality structure reorganizing therapy.

10. A followup study matching consumer response while in treatment with his response 6 months to a year post-treatment.

11. A study of community knowledge of the center. This is already a part of a larger community study.

Implications for North Orange County Mental Health

In addition to the above recommendations, the consumers at the clinic seemed to be saying that five areas were very important to them. They were as follows:

1. The constant changeover in therapists which the consumers appeared to believe to be disrupting to their treatment and could possibly result in their leaving treatment altogether. Perhaps when assessing the expected length of treatment for the client, the Intake Officer could see that longer term cases are referred to regular team members or longer term students and that shorter term or time-limited clients are referred to less experienced, short-term students.

2. "Waiting in the waiting room" might be a subject for a study, looking to the various reasons as to why clients are left waiting for

periods of time. Some reasons might be the previous session went overtime, the previous session started late, the client was late, the therapist was interrupted, the therapist has the habit of always being late, or the therapist wants the client to think he or she is an important person so keeps the client waiting.

3. A weekend crisis line so that the client can receive some assistance in an emergency.

4. Dissemination of information about the center to the community.

5. Study of the drug abuse population and its sociological implications.

Implications for Nursing

The nurse-therapist is considered a vital part of the team at the Community Mental Health Center. There are many nurses who rise to administrative positions in the Orange County Mental Health System. Nurses as well as other members of the Mental Health team need to be aware of aspects of client satisfaction and what are the variables contributing to these levels of satisfaction. The nurse as part of the Mental Health team needs to know in what areas she as other staff members need to improve their services.

Many mental health agencies were developed rapidly, and new services were instituted so quickly in the past that only now can the formulators of those services sit back and evaluate the results in satisfaction to the consumer.

The nurse-practitioner can contribute a great deal at the local Mental Health team toward her associated professionals recognizing her

as a vital member of the team and be of value to her team members because of specific expertise and knowledge. The nurse-practitioner is usually the product of a higher education, a Master's degree or more. To put her knowledge and skill to work, she must be one of the leaders on the Mental Health team, in her community, and as a skilled practitioner.

Nurse-practitioners who are pushing for licensing for nurse-therapists in California need to be aware of what is going on in the mental health field. As a nurse-therapist, the nurse can contribute to the growing body of research as regards the Mental Health Center.

Hopefully, this study will aid future nurse-practitioners in their assessment of mental health services and guide their entering into the ever-broadening field of mental health.

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APPENDIX

NORTH ORANGE COUNTY MENTAL HEALTH CONSUMER QUESTIONNAIRE

This is a questionnaire for you to help us know how our Mental Health Team is functioning and how better to serve you. Your answers will be kept confidential and will in no way affect our services to you. Please do not put your name anywhere on this paper. We appreciate your cooperation.

1. How much was coming here your own idea?

Not my idea at all				All my idea
1	2	3	4	5

2. How interested in helping you do the staff members seem to be?

Very uninterested				Very interested
1	2	3	4	5

3. How long did you have to wait between the time of your first appointment and beginning treatment?

Very little time				Much too long
1	2	3	4	5

4. How do you feel about charges for services?

Too low		Reasonable		Too high
1	2	3	4	5

5. Are our methods of billing and payment satisfactory?

Unsatisfactory				Satisfactory
1	2	3	4	5

6. How long do you wait in the waiting room to see your therapist now?

Wait much too long				Seen immediately
1	2	3	4	5

7. How many useful ideas or suggestions have you gotten from your therapist?

None				Very many
1	2	3	4	5

8. Do you feel your sessions help you understand yourself better?

Not at all				Very much better
1	2	3	4	5

9. How much improvement have you felt in the problems that concerned you when you first came here?

None				A lot
1	2	3	4	5

10. Suppose you had not been able to see the team or other professional help. How much improvement do you think time alone would have brought?

Very little				A great deal
1	2	3	4	5

11. How much do you like your therapist?

Very little				A lot
1	2	3	4	5

12. How much do you think your therapist likes you?

Very little				A lot
1	2	3	4	5

13. How confident are you in the abilities of your therapist?

Very little				A lot
1	2	3	4	5

14. What kinds of county services have you felt most helpful to you?

[1]___Individual [2]___Group [3]___Day treatment [4]___Hospital [5]___Drug abuse
[6]___Alcoholism [7]___None [8]___Other (Please specify)_____

15. How satisfied overall are you with the service you receive here?

Very dissatisfied				Very satisfied
1	2	3	4	5

16. Do you feel the team could serve you much better if it had more offices closer to where you and people you know live?

[1]___Yes [2]___No [3]___No opinion

17. If you said YES, where would you put the office?

[1]___Brea [2]___Fullerton [3]___La Habra [4]___Placentia [5]___Yorba Linda

18. The Mental Health Team can give help in several different ways. Please rate each of the following in terms of its importance to the community.

Rating Scale

0 - No opinion
1 - Not at all important
2 - Useful, but not as important as other things
3 - Pretty important
4 - Very important
5 - Probably the most important of all

___Providing counseling, therapy and medication in the office of the Mental Health Center.

___Providing consultation and help to police, clergy, teachers and others, who frequently come into contact with people who have mental health problems.

___Providing consultation to county and other public agencies to help them work together in serving people with mental health problems.

___In crisis situations, going to the home of a severely disturbed or upset person to do an evaluation or provide assistance to the family.

___Taking time to help people who need just information about mental health problems.

___Informing the public of the services available.

___Spending time and effort seeking community feedback about how to change and improve the services.

19. What type of treatment are you receiving? (Please check one or more spaces.)

[1] ___Individual treatment	[32]	[1] ___Medication	
[1] ___Group treatment	[33]	[1] ___Day treatment	
[1] ___Continuing care	[34]	[1] ___Drug abuse	
[1] ___Marriage or family counseling	[35]	[1] ___Alcoholism	

20. Is the primary therapist you most often see: [1] ___Male [2] ___Female

21. Please provide the following information to help us identify the community groups from which you come:

Are you: [1] ___Male [2] ___Female

Are you: [1] ___Never married [3] ___Widowed [5] ___Separated
[2] ___Married [4] ___Divorced

Are you currently employed? [1] ___ Yes [2] ___No

What is your occupation?_____

If married, your spouse's occupation?_____

What is your ethnic background?

[1] ___Mexican-American	[4] ___American Indian	[6] ___Other Non-White
[2] ___Black	[5] ___Asian American	[7] ___Unknown
[3] ___White Anglo		

Age: [1] ___0-18 years [3] ___26-35 years [5] ___65+ years
[2] ___19-25 years [4] ___36-64 years

Gross yearly income for your family (approximately):

[1] ___0-$3,999	[3] ___$8,000-$14,999	[5] ___$20,000+
[2] ___$4,000-$7,999	[4] ___$15,000-$19,999	

Do you receive public assistance? [1] ___Yes [2] ___No

22. Approximately how many times have you utilized the services on Commonwealth or Whiting?

[1] ___3-5 times [2] ___6-10 times [3] ___11-15 times [4] ___16 or more

23. Do you have any additional comments or suggestions for the mental health staff?__

_____

_____

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE. PLEASE RECHECK BOTH PAGES TO BE SURE YOU HAVE NOT MISSED ANY QUESTIONS.

PLEASE PLACE YOUR COMPLETED QUESTIONNAIRE IN THE BOX PROVIDED IN THE WAITING ROOM.