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ASSESSING CONSUMER SATISFACTION IN MENTAL HEALTH TREATMENT SETTINGS: A GUIDE FOR THE ADMINISTRATOR

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ABSTRACT: This paper offers a guide for administrators of mental health facilities who seek to obtain consumer evaluation data. A number of specific choices in these studies are considered. These include the selection of: the purpose intended for the research, the inclusion of personnel, client groups, and governing boards in the generation of the research, the client sample, the instrument for assessing satisfaction, the method of data collection, the method of presentation of the survey to the consumers, and the timing of the assessment. Issues surrounding consent are also addressed, and a number of additional pragmatic suggestions are offered.

Over the last few years, there has been a great increase in interest in measures of consumer satisfaction in mental health treatment settings (Lebow 1982). The inclusion of satisfaction measures in the evaluation of mental health treatment has become relatively commonplace and the publication of these studies frequent (Lebow 1983a). A recent survey of community mental health centers indicated that approximately one-half of all federally funded centers were engaged in studying consumer satisfaction. Although the study of satisfaction in facilities other than federally funded centers is surely less frequent (in federally funded centers the study of acceptability has been mandated by law), the study of satisfaction in these settings also appears to be increasing.

However, only recently has a careful consideration of the methodology in these efforts begun to emerge (Larsen, Attkisson, Hargreaves, and Nguyen 1979; Lebow 1982, 1983b; LeVois, Nguyen, and Attkisson 1981; Marin 1980; Rocheleau and Mackesey 1980; Scheirer 1978). The majority of this work has been flawed, limiting the conclusions that can be drawn from this method of

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program evaluation. Several articles have extensively discussed the methodological problems in this research (Larsen, et al. 1979; Lebow 1982, 1983b; LeVois, et al. 1981; Marin 1980; Rocheleau and Mackesey 1980; Scheirer 1978). It is not the purpose of this paper to duplicate such a methodological discussion. Rather, this article has a practical focus in community mental health and on the pragmatics of conducting consumer evaluations.

THE IMPORTANCE OF STUDYING SATISFACTION

The first question an administrator is likely to pose about this research is why it should be done at all. A number of specific purposes can be suggested. Consumer satisfaction data can serve an important monitoring function for the facility. The level of satisfaction within programs and across facilities can be compared, suggesting the relative acceptability of programs. On a more specific level, the satisfaction of clients of specific clinicians can be assessed, aiding in quality assurance efforts. Consumer satisfaction is also of obvious importance to clients and potential clients; the very process of conducting such surveys has value for community relations and high face validity for community boards mandated to monitor services. Further, since most surveys find a high level of positive response, consumer surveys also can serve as foci in public relations and fund raising campaigns. The "scientific" potential of these measures is also considerable. These data can have an important role in the investigation of the comparative acceptability of treatments, the investigation of the relation of acceptability and outcome, and the assessment of how clients differ in their response to treatment.

Once convinced of its value, the administrator must assess how a consumer survey can further organizational goals. Methods will vary with the purposes for which the survey is designed. Consumer satisfaction surveys can focus on a global satisfaction or be specific, can focus on the activity of individual clinicians or on group data, can carefully consider interrelationships of variables or merely summarize overall trends. Obviously, differences in cost of the evaluation are associated with these different purposes; the more complex the purpose, the greater the cost. Unfortunately, the choice of purpose is one that is frequently not considered at the onset of such surveys. This results in data that do not respond to the questions of interest and/or in the collection of more data than is needed.

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A central initial choice is between accenting collecting data for decision making or public relations. Campbell (1976) has provided the classic discussion of this choice. Where data are desired for public relations alone, the specifics of method assume reduced importance; under these circumstances the positive biases that are intrinsic to consumer satisfaction methods are of little concern. A simple survey may be sloppily executed with the desired results. This use of the consumer survey may be somewhat Machiavellian, but can provide support for the funding of needed services.

Little advice will be offered here to the administrator desiring to obtain positive results. The natural propensity of clients to respond positively to such surveys combined with the consumer orientation of most mental health programs results almost always in a positive response. Instead, this paper focuses on suggestions of method for the administrator who wants to use these data in decision making and/or for scientific purposes.

SETTING UP THE RESEARCH

The single most vital recommendation that can be made about consumer satisfaction research is to include a methodologically sophisticated individual in the development of the research. Untrained individuals can design and execute surveys, but they are likely to ignore important aspects of method. Trained methodologists are not rare commodities; training in research method is frequently a component of programs in clinical psychology, and specific training programs in evaluation research are becoming commonplace. The cost of employing such a methodologist in the design of a study need not be great. Center staff may possess the requisite expertise or a methodological consultant can be obtained on a part-time basis. The costs of failing to engage an appropriately trained methodologist far outnumber the costs in doing so.

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The involvement of advisory boards and consumer groups at the onset of the effort is also advisable. In some instances, boards (Zinober and Dinkel 1979) and consumer groups (Prager and Tanaka 1980) have conducted surveys. For sake of simplicity, I believe surveys are most efficiently conducted by nonclinical staff employed by the center, but the inclusion of input from all levels of the organization and from consumer groups is suggested. Groups will be more receptive to evaluations that they have a role in developing. Administrators, staff, consumers, and boards have varying focal interests (Krause and Howard 1975), and the items chosen as important by these various groups may vary considerably (Kaufmann et al. 1979; Prager and Tanaka 1980; Windle and Pachall 1981). The more points of view that can be included initially, the more likely the result will speak to interests of the various concerned groups. Of course, someone still needs to be in charge and obtain input from a select number of consultants at different levels within and outside the organization.

THE CHOICE OF SUBJECTS

An important decision involves who is to be included in the survey. This choice is often overlooked by the inexperienced researcher. Several specific choices are involved:

a) All recipients of service may be included or a technique of representative sampling may be chosen;
b) Clients may be included regardless of level of psychopathology or the more disturbed members of the population may be excluded;
c) Clients may be included regardless of length of treatment or clients whose treatments are judged to be too brief to allow an adequate trial of treatment may be excluded;
d) Clients may be included regardless of type of program or clients from specific programs may be focused upon.

Surveys have the highest level of generalization, i.e., applicability, to the full range of mental health clients, when the broadest array of participants are included. Therefore, exclusions should not be based on length of treatment or level of psychopathology except when absolutely necessary. The only instance where exclusion of clients is truly necessary is when large numbers of patients with minimal reality contact are in the population to be sampled, as in a locked inpatient ward. In general, the gain from assuring all patients have an intact view of reality as well as significant therapy experience is far outweighed by the additional effort required to make such a division of the client sample.

The issue of treatment integrity (whether clients have received sufficient treatment to offer an accurate view of the service) is best addressed on the level of data analysis, not data collection. A separate analysis of those clients who have had sufficient treatment to allow for an adequate test of the treatment and those not felt to have treatments with integrity is warranted. For outpatient mental health treatment, a simple division at three or five sessions makes most sense. For inpatient treatment, a stay of over three days may be taken as an arbitrary division for integrity. (The reader should be cautioned that these points of division are offered only as rules of thumb; different treatments will demand different levels of participation to guarantee integrity.) In the mental health field, the separate analysis of those who terminate soon after beginning treatment and those who continue in treatment beyond this time is particularly important, since the relevant factors in treatment will likely differ across these groups. At the same time, the opinions of both groups remain important and need to be addressed. Eliminating early terminators from the assessment would bias the result toward a favorable outcome; focusing on early terminators would bias the result toward a more negative view.

Whether the assessment should focus on the whole population or on a particular subpopulation is largely a question of the purpose of the assessment. For representative sampling suggesting the satisfaction of clients at a facility, all clients should be eligible for inclusion in the sample. When the focus is on the satisfaction of a subgroup (e.g., high risk clients), then the sample can be tailored to represent the subgroup of interests. Conducting a series of focused assessments on a rotating basis may be a good compromise, allowing a view of all programs without too much data collection at any one time.

Sampling is suggested as preferable to surveying all clients. In most mental health consumer satisfaction surveys, sampling techniques are not used, providing more data than one needs (and a sample size so large that statistical significance is often obtained without clinical significance). Sampling may be from open (Pandiani et al. 1982) or closed cases and may be conducted on a subsample or on a sample representative of the whole population. A simple sampling strategy taking every nth case after some arbitrary starting point in the alphabet (changed for each assessment) to achieve a sample of 100 to 200 cases per study is suggested. (The exact number of respondents needed will also be a product of the uses intended for the data.) Sampling is not likely to be the method of choice in two instances: 1) the selection of respondents can be biased by program staff or appear biased and 2) when the consumer evaluation is utilized as a part of case review in quality assurance and a goal is detection of all problematic cases. However, in most instances, sampling is preferable.

THE CHOICE OF AN INSTRUMENT

Most evaluations of client satisfaction have developed their own instruments for assessing satisfaction, emphasizing the unique interests of the facility rather than selecting an appropriate, well-validated questionnaire or interview protocol developed elsewhere. Such instrument development has two significant drawbacks: 1) adequate psychometric contruction is more difficult than might be thought, and such quickly constructed instruments are likely to be psychometrically deficient, and 2) unique instruments do not allow for comparisons across instruments or facilities. The choice of a well-validated instrument used in multiple settings allows for better dependability in the data and comparison across settings. Choosing a well-validated measure also involves less effort than instrument construction; thus this choice will generally be preferable to instrument construction.

Several excellent instruments have been recently developed. The most carefully psychometrically developed and widely used are the scales developed by Attkisson and his colleagues (Larsen et al. 1979; LeVois et al. 1981; Pascoe and Attkisson 1983). The Client Satisfaction Scale (CSQ) has three variants—a short general scale (CSQ-8), and two longer forms (CSQ-18). The former scale is preferable for general inquiries about satisfaction, the latter two when particular interest is focused on specific aspects of satisfaction (e.g., accessibility, cost). The Evaluation Ranking Scale (Pascoe and Attkisson 1983) is a six item scale inquiring about satisfaction with general aspects of care (e.g., access, competence of provider). Its major innovation lies in the addition of a ranking of the importance of the various dimensions examined. Other excellent scales are available tailored to inpatient treatment (Distefano, Pryer, and Garrisson 1980a; 1980b), and outpatient service (Flynn et al. 1981; Love, Caid, and Davis 1979; Slater, Linn, and Harris 1982).

Items of specific interest to a facility can be added to any of these scales. Possible sources for these items include the ward environment scales (e.g., Moos 1974); various scales assessing psychotherapy (e.g., the *Therapy Session Report,* Howard and Orlinsky 1975), and questionnaires assessing open ended responses to treatment (e.g., Ahmed and Koltuv 1976). Items assessing related aspects of treatment (e.g., outcome) or variables likely to confound satisfaction responses (e.g., life satisfaction, see LeVois et al, 1981) also can be profitably added to these instruments. However, little benefit will accrue from quickly assembled new scales; further efforts should be limited to those employing a standard scale as a base or careful psychometric development of a new scale of broad interest. Investigators are also cautioned not to change specific items in standard scales since such changes prevent comparability across settings.

CHOOSING A METHOD OF DATA COLLECTION

Several alternatives are available for a method of data collection. In-facility questionnaires, in-facility interviews, phone interviews, interviews in the home, and mailed questionnaires all have merits and weaknesses. Mailed questionnaires are inexpensive, but also subject to high rates of attrition (Lebow 1982). Assessments conducted at the treatment facility yield higher rates of response but may overemphasize the service offered on the day of the assessment and contain more systematic bias due to reactivity and expectancy. Interviews in the home may be best, but also are most expensive. The highest payoff in relation to cost probably stems from combining mail and phone methods; nonrespondents can be followed up by phone. Home interviews are costly and should be reserved for more intensive examinations of treatment. The choice between phone and mail as principal methods should be made on the basis of resources available; somewhat higher levels of response can be obtained from phone methods, but trained staff are needed to conduct such interviews. The decision in part also will depend on the population under study; poor clients may not have phones.

A related issue involves intensity of the follow-up. Mental health patients are highly transient and often difficult to locate. Phone interviews and the scheduling of in-person interviews may demand several attempts at contact. A program attempting such a survey should expect to engage in multiple follow-up efforts. Given that response rates are seldom above 50% even with comprehensive follow-up and that nonrepresentative samples are likely in such surveys, significant attempts at follow-up are needed. (Experience suggests that two mailings are desirable in a mailed questionnaire, and three to five attempts at phone contact for surveys is not unusual.) The exact point of diminishing return will depend on the sample and resources available, but multiple attempts at follow-up and multiple methods of contact (e.g., mail and phone) should be included if at all possible.

PRESENTING THE SURVEY TO CLIENTS

The specific manner in which the survey is presented to clients also is quite important. Issues to consider include whether anonymity will be guaranteed, who is presented as having initiated the survey, and the reason stated for conducting the survey.

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The question of anonymity is a difficult one. From a research perspective, anonymity is preferable since it reduces the alteration of responses to be more acceptable and show the client in a better light. However, anonymity limits some possible uses of these data; for example it prevents aggregation of data by therapist or the use of responses in a case review quality assurance format. The solution to this dilemma lies in including a statement clarifying the limits of the use of these data (i.e., it will not be shared directly with the practitioner and will have no consequences for the client's further treatment) while including some mechanism for tracking the client by either name or code.

Who is presented as initiating the study and why it is presented as being conducted also require careful consideration. Of course, while these statements must be determined by who actually initiated the study and the purpose of the study, procedures should aim to decrease reactivity and bias. Orientations to the survey emphasizing the involvement of objective observers likely to follow up findings but not likely to employ severe consequences (e.g., terminating funding for the agency) are preferred to those suggesting severe consequences or a rubber stamp. The inclusion of consumer groups or governing boards in the survey development can have the additional pay-off here of providing an ideal solicitor of information. Presentations should also emphasize that the client's response (or lack thereof) will not affect the availability of further service to the client, and the uses of the data should be made clear and possible fears as to their use allayed. Denner and Halprin (1975) present an excellent example of a request for satisfaction data consistent with most of the principles enumerated above.

TIMING OF THE ASSESSMENT

There are a range of alternatives for the timing of these assessments. Assessments may be conducted early during treatment, late during treatment, at a random distribution of points during treatment, just after treatment has ended or at some distant follow-up. Any of these alternatives is acceptable. The preferred timing will depend on the purpose of the study. If early treatment is a subject of particular interest, assessing satisfaction at 15 to 30 days after the onset of treatment may be most valuable. If the satisfaction of clients during the course of treatment is of particular interest, then assessing satisfaction among active clients with varying lengths of treatment at a given point in time is likely to be best. If, as in most instances, concern is with client reaction to the whole of treatment, assessment just after the close of treatment is best. Satisfaction at some more distant follow-up may also be of interest, as this provides time for the client to place treatment in proper perspective, but the data become significantly more difficult to obtain. For a thorough assessment of satisfaction, clients should be surveyed at several points in time, but such assessments will be possible only where the resources are great.

CONSENT AND ETHICAL ISSUES

The issue of client consent to participate in research also needs to be considered in such evaluations. The legal mandate for client consent in such surveys is not clear (Pandiani et al. 1982), but ethical requirements necessitate the need for a consent procedure. In these surveys, such a consent is best obtained in a nonthreatening way; often the consent to participate in such surveys is far more disturbing than the data collection procedure. Consent is most crucial when follow-up after treatment is to be conducted; the client should not be contacted without such a consent obtained during treatment. Optimally, the client should be asked to sign a consent form at the beginning of treatment after a thorough explanation. Such a procedure has the additional benefit of increasing the response rate at follow-up.

ADDITIONAL PRAGMATIC CONSIDERATIONS

Several problems in consumer evaluation can be mitigated through careful planning. Specific suggestions include:

1) Keep careful records of client's address and phone number throughout treatment. Mental health treatment populations are typically transient; some surveys have found 40% of clients to no longer be at the original address at the time of follow-up. The overall success rate in follow-up can be markedly increased by obtaining the address of a relative or friend likely to know the location of the client; this however, increases problems of confidentiality and cost of the follow-up. Cost-benefit analysis suggests such additional measures are only appropriate given a major study of satisfaction, not for simple monitoring.

Multiple methods of data collection may prove helpful.

2) Consider the pragmatic factors that can maximize the likelihood of obtaining a response from the client. For example, phone follow-up is best conducted in the evening and on weekends. As noted earlier, multiple methods of collection can prove helpful in increasing the rate of response without greatly adding to cost.
3) In mail surveys, clearly note who is to respond. A problem may arise in that family members may feel it appropriate to respond if a mentally disturbed family member does not see fit to. There is no foolproof method for insuring completion by the appropriate person, but screening of the comments provided in the open-ended part of these instruments can help identify responses by individuals other than the client.
4) In cases of marital and family therapy, all family members over the age of 12 should be included in the sample pool. Assuming consensus on the part of the family about satisfaction with treatment is not warranted

(Lebow 1981). In order to insure that large families do not have a disproportionate impact on the satisfaction at a facility, the satisfaction rating within families should be averaged to give a family rating. However, the raw data should remain available for review to assess whether certain family members may have been highly dissatisfied.

5) The satisfaction of family members not in treatment also has particular relevance in some client populations, e.g., young schizophrenic patients dependent on their parents and child cases. The satisfaction of these individuals should be studied subject to the constraints of consent discussed above.
6) Open-ended responses should be obtained in addition to the scale items wherever possible. The meaning of client satisfaction and its specific determinants may emerge much more clearly from such responses than from ratings; further, such responses more often lead to specific suggestions. Information obtained from open-ended questions is especially important when clients are dissatisfied. Dissatisfaction is a low frequency behavior with great salience, and efforts should be directed to provide thorough descriptions of dissatisfactions.
7) Follow uniform procedures across efforts wherever possible. Regular procedure allows for comparability of data.
8) Focus on clearly formulated questions when planning the study and examining the data. State *a priori* what is to be learned from each study. Given the nature of satisfaction data (i.e., the high percentage of favorable responses), efforts comparing different types of treatments, units, and facilities in the same population should be particularly useful.
9) Develop a means for disseminating the data to client groups, staff, and governing boards. In particular, develop a system for sharing these data on an individual basis with staff that allows for anonymity for the client and feedback for the staff member. Quarterly reports to staff on the aggregated satisfaction of their clients have proved useful in this regard (Pandiani et al. 1982).
10) Where possible, these data should be integrated into a management information system with client, cost, and outcome data (e.g., Sherman and Smith 1980; Newman and Sorenson 1983; Filstead, Crandell, Altman, and Lebow 1982). This will increase cost of the evaluation but will allow for far more sophisticated analysis.

INTERPRETING FINDINGS

Findings must also be carefully interpreted. In consumer satisfaction research, it is particularly important to consider appropriate baseline data obtained utilizing these instruments in other populations. The response to most consumer surveys is positive; therefore, if not considered in juxtaposition with appropriate baseline data, all results will appear positive. The typical survey finds three of four clients clearly stating satisfaction (Lebow 1983a); data from centers should be compared with this general norm, the specific norms for each instrument, and the specific norms for satisfaction in the type of client sample under study.

There also is some evidence that clients respond to such surveys with an undifferentiated or halo response, i.e., they may not discriminate between aspects of the care system when responding to these instruments. Therefore, one also must be cautious in drawing specific conclusions since a client may be responding to a positive view of care as a whole rather than the specific item being summarized. As most response patterns are skewed, it is those aspects of treatment for which less than the normal amount of satisfaction is expressed that should receive the most attention.

The nature and representativeness of the sample studied and the reactivity of procedures must also be considered carefully when interpreting results. For example, if the rate of attrition of early treatment dropouts from the sample is high, this is likely to inflate the level of satisfaction (although dropouts typically state they terminate for reasons other than dissatisfaction). If the therapist collects the data this also would be expected to augment rates of satisfaction. Findings must also be interpreted in the light of the specific purposes for initiating the survey and hypotheses formulated before the research was initiated.

SUMMARY

Client satisfaction data have value, but care in the conduct of such studies is needed. This paper has offered a series of methodological suggestions for consumer satisfaction studies in mental health treatment settings. If these suggestions are followed, data that is useful to the management, clinical staff, clients, and governing boards of mental health facilities can emerge. If method is left to chance, the effort may be wasted. Cost/effectiveness analysis suggests the greater benefits of the more rigorous approach.

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