*American Journal of Community Psychology, Vol. 2, No. 1*

# Measuring Consumer Satisfaction in a Community Outpost

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*Sixty-six terminated clients from an inner-city, multiethnic community mental health center outpost responded to three questions in a consumer evaluation telephone interview. In general, the ex-clients were (1) satisfied with services, (2) reported high degrees of problem resolution, and (3) tended to give the credit for this change to the clinic. Client satisfaction was not correlated with problem resolution. Most clients reported getting better, but the satisfied ones saw the clinic as responsible for the change. Greater change was reported when the clinic was responsible. The three evaluation measures did not vary as a function of age, sex, ethnicity, or termination point. Clients who terminated without therapist agreement were relatively dissatisfied and inclined to attribute change to non-therapy factors.*

One of the central tenets of the community mental health movement is that service programs should be designed to meet the needs of the people and, moreover, that mental health professionals should make themselves accountable to the people whom they serve (Roman, 1973; Schiff, 1970). Yet, as Salasin and Baxter (1972) point out, attempts to determine client satisfaction are still in their infancy. There are no standardized techniques, methods of measurement, or agreed upon procedures. However, there is a growing research literature, summarized by Salasin and Baxter (1972) and Miller and Sinclair (1972), that clearly indicates that even the most disturbed clients can assume the role of "consumer" and make rational and informative statements about the quality of service.

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There is certainly an intense interest in consumer satisfaction in this country. Although the notion of consumer satisfaction is somewhat alien to the mental health establishment, the idea has captured people's attention. Unfortunately, though, consumer evaluation is often confused with the more traditional concern of evaluating the consumer. There is a large research literature consisting of aftercare and follow-up studies containing measures of the client's perception of the services offered. However, since it is the client who is being evaluated in these studies, and he knows it, the ex-client responses must be heavily determined by the impression he wants to create concerning his mental health. 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 evaluational feedback.

These are the thoughts we had when we approached a community mental health clinic to do some research in the area of consumer satisfaction. The clinic, which serves a multi-ethnic, inner-city, working-class neighborhood has been struggling for years with the problem of community accountability and control. Although the clinic is part of a comprehensive community mental health center which has a governing board consisting of some local people, this board meets occasionally and has little or no power. At the time that the research was planned, the clinic staff had formed a special committee to explore the possibility of developing a local community board. The task was felt to be a difficult one, because local people did not seem deeply invested in "their" mental health center. It was in this atmosphere that the consumer evaluation study was conducted.

It was obvious from the beginning that staff interest in measuring consumer satisfaction served to legitimate our presence. It did not however give us carte blanche to talk to clients. The staff had two reservations. First, they felt that most research is exploitative. From their viewpoint, researchers tend to use clients to collect data, publish articles, and further their careers, while they produce data that are useless. Second, they were worried that we would interfere with the therapeutic relationship. The first concern was met by limiting ourselves to questions that interested the staff, and the second was met by limiting the initial study to terminated clients.

From speculation on the types of clients most likely to be pleased or displeased with the clinic's services, independent variables were derived for this study. Since the clinic staff at the time was predominantly female, were the

working class males uncomfortable with their female workers? Also, since the staff consisted of mostly young adults, the older or very young clients might constitute a dissatisfied group. Of more significance, perhaps, is the fact that the community could be divided into two distinct groups, a Latin group of Mexican background and Spanish-speaking in part, and a non-Latin mixture of Middle-Europeans and some Black Americans. Some staff were concerned that the Latin people felt alienated from the white professional staff and perceived the clinic as unresponsive and ineffective. Lastly, we hypothesized that the more dissatisfied clients either had terminated "too early," i.e., before the fourth session, and/or had terminated without the workers' agreement.

To determine the level of client satisfaction, the obvious question was asked: In general, how satisfied were you with the services you received? Presumably, people come to this clinic for help with their problems. But some people may be satisfied with less help than others. Thus we asked the client to report on the degree to which his problem had been resolved. And since a person's problems can improve or worsen because of many extratherapeutic factors, it made sense to determine whether the change in the status of the problem was due to the clinic's services or to other factors.

## METHOD

*Setting.* The clinic is an outpost of a federally funded comprehensive community mental health center which has aftercare responsibility for clients discharged from the inpatient service of the program. In addition, it has developed outpatient and preventative programs as the number of community persons using the clinic increased. It occupied the storefront and upper floor of a building located in the main shopping street in the community. The 1970 census data revealed that the median income in this blue collar neighborhood is approximately $8,000, but since income information on outpost clients was not routinely gathered by the staff, it is not clear how many clients were on public aid. Approximately 15% of the families were below the poverty line in this community. All clinic services were free.

The clinic staff at the time consisted of one psychologist, three social workers, two nurses, and three community workers; in total, three men and six women. Individually focused, supportive, reality-oriented therapy, with emphasis on working with collaterals describes the main therapeutic modality. Treatment was not time limited and, when necessary, clients were seen over a period of months. Groups usually were activity- or interest-centered.

Clients' charts do not permit an adequate assessment of rate of prior hospitalization, nor were diagnoses or an evaluation of symptom picture pro-

vided routinely. However, the staff's impression is that 70% of the clients in the study had no previous hospitalization. Further, presenting complaints generally could be identified as neurotic ailments with interpersonal conflicts.

*Procedure.* The set of questions used in this study was adopted in a modified form from consumer evaluation studies conducted in similar community mental health centers (Salasin & Baxter, 1972). Because of the nature of the community and the number of research personnel available, it was not feasible to contact ex-clients in person. Instead the subjects were contacted by telephone. The caller first introduced himself by name and stated that he was conducting a survey for the center and that he was not a member of the treatment staff. The following points were emphasized: (1) The purpose of the call is not to evaluate the client's mental health or social situation. Rather, the purpose is to ask the client to evaluate the clinic services. (2) The ex-client was not singled out. Everyone who terminated in 1972 is being called. (3) The caller knows nothing about the client except his name and phone number. Therefore, it would be inappropriate to have a discussion about his personal problems. If the client needs help, he should call the clinic. (4) Because hundreds of people are being surveyed, the client must respond in terms of the categories presented. Nothing else he says will be recorded.

The caller, who in every case spoke the language of the ex-client, did not adopt an impersonal or official manner. Although the caller never assisted the ex-client in formulating a response, he did emphathize with the client who struggled to reduce his complex feelings to one simple response. Ex-clients who became annoyed or began to act deviantly were not treated in any special way. No attempt was made to convince people to answer the questions. If, in the caller's judgment, he was disturbing the client, he apologized and then hung up. If it seemed as if the ex-client were annoyed because he had been called at an inopportune time, he was called again. But, if it appeared that that ex-client wanted nothing to do with the clinic and the questions just served to annoy him, no attempt was made to reach him again.

People were called in their homes or at a phone where they could speak in private. They were not called at work or in other public places. If someone other than the client answered, every effort was made to maintain confidentiality. Collaterals and others were told that a survey of attitudes was under way in their community and that the ex-client (the name was given) appeared on the "call-up" list. If the ex-client was not in, the caller asked for the best time to ring him up. Sometimes the person who picked up the phone wanted to answer the questions, but he was told: "My instructions are to talk to the people whose names appear on the list." The one exception to this procedure occurred with parents. We decided that parents had a right to know the purpose of the call. In almost every case, the parents had been seen if the child had received treatment. However, in those instances where more than one family member was under treatment, only

one member was questioned. In other words, a family or a part of a family was treated as a single client unit. There were some instances where members of the same family lived apart and had different workers. These people were treated as separate individuals and hence each of them had an opportunity to answer the questions.

After the ex-client agreed to answer the three questions, the caller presented them in an invariant order. Here too, there was some amplification of the original wording, when it was found that a bare question usually evoked clarifying questions from the respondents. Question 1 was directed to an overall assessment of satisfaction. The caller said: "I'd like to ask you how satisfied you were with the services here. In general, looking back, how good a job did we do? What would be your overall feeling?" Respondents often launched into an anecdotal description at this point; the caller waited for a short period and, at an opportune time, asked: "Would you put your answer this way... Satisfied?... Dissatisfied?... or in between? What would you say?"

Confining the ex-client to these categories on the first question sufficed to teach him the type of responses desired on the remaining two questions, and fewer digressions resulted. The second question was phrased: "You came to the clinic with certain problems and wanted help. We would like to know how the problems are now. Could you tell me which of the following answers best fits what you think? ... Mostly worked out?... Partly worked out?... Not worked out?... Gotten worse?... Gotten much worse? Which would you say, in general?"

The third question elicited the former clients' perceptions of the cause of the change or lack of change: "This change or lack of change... How much is it due to us? How much was the clinic responsible? Was the change (or lack of change) due to something else that happened to you or something you did, completely separate from the clinic?" The ex-client was instructed to respond with one of the following categories: "Yes, mostly" (change mostly due to clinic); "Yes, partly;" "No, mostly due to something else" (due to nonclinic causes); and, "No, not due to the clinic at all."

These questions were not asked in rapid-fire fashion, providing the opportunity for the respondents to elaborate their responses or clarify the questions. Sometimes, amplifying phrases had to be repeated in their entirety before the caller could be sure the ex-client understood the question.

## RESULTS

Two general questions were asked: (1) Did the respondents differ from the nonrespondents, the people who were not reached or who, if contacted, were unwilling or unable to respond? That is: How representative is the sample of

Table I. Comparison of Various Subgroups of Respondent with Nonrespondent Ex-Clients — Chi-Square Analyses

| | Respondent ($N = 66$) | Nonrespondent ($N = 160$) | $\chi^2$ |
|---|---|---|---|
| Ethnicity | | | |
| Latins | 23 | 56 | 0 |
| Non-Latins | 43 | 104 | ns |
| Age | | | |
| Youth & Older | 30 | 83 | .76 |
| Middle | 36 | 77 | ns |
| Sex | | | |
| Male | 19 | 63 | 2.22 |
| Female | 47 | 97 | ns |
| Type of termination | | | |
| Client-initiated | 32 | 103 | 4.87 |
| Mutual-agreement | 34 | 57 | $p = < .05$ |
| Termination point | | | |
| Early (3 sessions or less) | 17 | 61 | 3.19 |
| Average (> 3) | 49 | 99 | ns |

respondents? (2) In general, 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?

Only 29% of the total number of people formally terminated in 1972 ($N = 66$) were contacted and responded appropriately. Of the remainder ($N = 160$), most were not reached because their telephone number was no longer listed in the city directory. Some had never had a telephone, and a smaller group had given a number from work or a public phone. Only four people refused to cooperate. A breakdown and comparison of the respondents with the nonrespondents reveals the following (see Table I): The proportion of males and females is approximately the same in both groups. The same is true for the percentage of Latins and non-Latins, for the various age groups, and for early terminators (those who had three sessions or less) versus average terminators (more than three sessions). With regard to the type of termination decision variable, however, the client-initiated termination group was clearly underrepresented in the respondent sample ($\chi^2 = 4.87, p < .05$).

The central question of this study concerning overall consumer satisfaction was explored by comparing the distribution of answers to each of the questions by the respondent groups as a whole (see Table II). First, it is apparent that the majority of people who use this clinic are satisfied with the services (71%) and only a small percentage (11%) are dissatisfied. An overwhelming majority of the people report high or moderate levels of improvement (83%), and only a very small percentage report getting worse (5%). A majority of the people attribute the change to the clinic's efforts (66%), but a considerable number (33%) indicate that other events were more relevant to change or lack of change.

**Table II.** Responses to Evaluation Questions — Number of Ex-Clients Who Responded In Each Category

| | | | | | |
|---|---|---|---|---|---|
| Question 1: Satisfaction | 1 = Satisfied<br>47 (71%) | 2 = In between<br>12 (18%) | 3 = Dissatisfied<br>7 (11%) | | |
| Question 2: Change | 1 = Mostly worked out<br>33 (50%) | 2 = Partly worked out<br>22 (33%) | 3 = Same<br>8 (12%) | 4 = Gotten worse<br>2 (3%) | 5 = Much worse<br>1 (2%) |
| Question 3: Cause of Change | 1 = Mostly clinic<br>26 (39%) | 2 = Partly clinic<br>18 (27%) | 3 = Partly something else<br>10 (15%) | 4 = Mostly something else<br>12 (18%) | |

Do satisfied clients report more improvement than relatively dissatisfied ones? They do not. Kendall rank correlation coefficients computed between questions 1 and 2 for the overall sample and the various subgroups do not reach statistical significance (see Table III). However, in general, the more satisfied clients are more likely to see the clinic as responsible for change ($r = .22, p < .01$; see Table III). Within the various subgroups, this relationship holds only for the

**Table III.** Kendall Rank Correlation Coefficients between the Questions for Overall Sample and Various Sub-Groups

| | | Questions 1 & 2 | Questions 1 & 3 | Questions 2 & 3 |
|---|---|---|---|---|
| Overall | $r$ = | .08 | .22 | .32 |
| | $p$ = | ns | <.01 | <.01 |
| Ethnicity | | | | |
| Latin | $r$ = | .12 | .17 | .18 |
| | $p$ = | ns | ns | ns |
| Non-Latin | $r$ = | .01 | .21 | .15 |
| | $p$ = | ns | ns | ns |
| Age | | | | |
| Youngest + Oldest | $r$ = | .11 | .19 | .35 |
| | $p$ = | ns | ns | .01 |
| Middle Adult | $r$ = | .04 | .33 | .17 |
| | $p$ = | ns | <.01 | ns |
| Sex | | | | |
| Males | $r$ = | −.07 | .15 | .32 |
| | $p$ = | ns | ns | <.05 |
| Females | $r$ = | .12 | .44 | .20 |
| | $p$ = | ns | .01 | ns |
| Type of Termination | | | | |
| Client-Initiated | $r$ = | .16 | .33 | .16 |
| | $p$ = | ns | .01 | ns |
| Mutual-Agreement | $r$ = | −.05 | .14 | .32 |
| | $p$ = | ns | ns | .01 |
| Termination Point | | | | |
| Early (3 or less) | $r$ = | .21 | .28 | .27 |
| | $p$ = | ns | ns | ns |
| Average (more than 3) | $r$ = | .04 | .25 | .19 |
| | $p$ = | ns | ns | ns |

Note: Question 1 covers satisfaction; Question 2 covers degree of change; Question 3 covers the cause of the change.

**Table IV.** Comparison of Various Subgroups On Questions 1, 2, & 3 — Chi-Square Analyses

| | Question 1 Satisfaction | Question 2 Change | Question 3 Responsibility |
|---|---|---|---|
| Ethnicity | 2.39 | .70 | .14 |
| | ns | ns | ns |
| Age | .95 | 0 | 2.84 |
| | ns | ns | ns |
| Sex | .74 | .34 | .17 |
| | ns | ns | ns |
| Type of termination | 4.20 | .22 | 7.68 |
| | $p<.05$ | ns | $p<.01$ |
| Termination point | .32 | 2.77 | .93 |
| | ns | ns | ns |

Note: In the analysis of question 1, the In-between and Satisfied categories were combined; in question 3 categories 1 and 2, change due to the clinic, were collapsed together while categories 3 and 4 were collapsed, change due to other events, in order to meet the requirements for a Chi-Square analysis.

client-initiated termination group ($r = .33$, $p < .01$); for the middle-adult group 20-39 years of age ($r = .33$, $p < .01$); and for the females ($r = .44$, $p < .01$). Lastly, in general, ex-clients who report the most improvement tend to give the credit to the clinic ($r = .32$, $p < .01$; see Table III). Within the various subgroups this holds only for the "youngest + oldest" group, those 19 years of age or younger plus those 40 years old or more ($r = .35$, $p < .01$; for the males ($r = .32$, $p < .05$); and for the mutual-agreement-terminated group ($r = .32$, $p < .01$).

Does any subgroup say it is more satisfied, report more problem resolution, or give more credit to the clinic? The differences between males and females, Latins and non-Latins, early terminators and average terminators, as well as the difference between the age groups did not reach 5% significance level for any of the questions (see Table IV). The most dramatic differences appear between the client-initiated termination and mutually-agreed-upon-termination groups, on questions 1 and 3, although they report approximately the same amount of improvement on question 2. Of the mutual agreement group, 82% were satisfied, as compared with 59% of the client-initiated-termination group ($\chi^2 = 4.20$, $p < .05$). Further, 82% of the mutual-agreement group attributes change to the clinic's efforts, while 50% of the client-initiated group attributes change to the clinic, the other 50% assigning the cause of change to other factors ($\chi^2 = 7.68$, $p < .01$).

## DISCUSSION

It is clear that the people reached for this study were quite satisfied with the clinic services, tended to report a high degree of problem resolution, and

were inclined to atrribute this positive change to the clinical services. In this regard, they do not differ from most ex-clients who are asked to evaluate long-term or short-term therapy (Miller & Sinclair, 1972; Salasin & Baxter, 1972).

How useful are these results? Generalization from the sample to the whole population of clients should be done with caution. Although our respondents did not differ significantly from the noncontacted 1972-terminated clients in age, sex, ethnicity, or in incidence of early termination, they did differ in the number of people who initiated termination on their own. The proportion of people who initiated termination on their own without the agreement of the therapist was far higher among the noncontacted group; among the contacted group the number of client-initiated terminations and mutually-agreed-upon terminations was approximately equal. Thus, client-initiated termination types, those very people who proved to be least satisfied with the services, were significantly underrepresented in the sample contacted. If we add to this the fact that the unreachables, the transient and those who are too poor or too unstable to own a phone, are potentially the most unhappy clients, it is likely that the overall satisfaction rating and credit given to the clinic is inflated.

Of particular interest is that client satisfaction is not merely a function of problem resolution. Responses to question 1, satisfaction level, were not correlated with responses to question 2, problem resolution. Both relatively satisfied and dissatisfied ex-clients report approximately the same amount of improvement. But satisfied clients differ from dissatisfied ones in that the former are more likely to give the credit to the clinic. Apparently, these clients discriminate between a situation where the clinic worker makes the critical contribution and where other factors are more significant. If he feels that the worker is responsible for the change, the client is likely to be satisfied with the services. However, if he feels that he has helped himself on his own or that other people or other events are responsible for bringing about change, then he is less likely to be satisfied. It seems that these clients expect the clinic worker to have the most influence over their lives, overshadowing what they themselves or other people do. They will be relatively dissatisfied with anything less.

All in all this clinic is doing well. Problem resolution was positively correlated with attribution of responsibility to the clinic. That is, people report that improvement may be due to all sorts of things but the greatest gains are reported by those who perceive the worker as having made the real difference.

Further, clients from the various ethnic groups, of all age groups and both sexes are equally satisfied with the services, reported the same amount of improvement, and were equally inclined to give the clinic the credit. Whatever problems are associated with the mismatch between clients and therapists with regard to ethnicity, social class, etc., apparently have been surmounted in this setting. However, this staff must take note of those clients, who, for whatever reason, initiate termination without therapist agreement. They stand out as the most dissatisfied. These people do not necessarily terminate earlier than the others, nor do they report less improvement. What goes awry? It looks to us as if

at some point in the therapy process some clients, even if they are making gains, come to see the worker as irrelevant. Perhaps this judgment is sound, perhaps not. To explore this question, we plan to study client expectations for therapist involvement.

This research, conducted in the spirit of consumer evaluation, represents one legitimate area of concern for community mental health programs. This is not to suggest that other evaluative criteria, e.g., cost factors, hospitalization rates, indices of community development, are to be ignored, or that staff should be concerned only with pleasing its clients. However, to the extent that it wishes to increase consumer satisfaction, these findings suggest that the staff should examine two factors, namely, (1) the rate of client-initiated termination without therapist agreement, and (2) the client's awareness of the clinic's role in the change process.

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