A study of the relationship between the strength of the consumer orientation of community mental health center policies and the degree of expressed client satisfaction.

Benjamin Franklin Lewis

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A STUDY OF THE RELATIONSHIP BETWEEN THE STRENGTH OF THE CONSUMER ORIENTATION OF COMMUNITY MENTAL HEALTH CENTER POLICIES AND THE DEGREE OF EXPRESSED CLIENT SATISFACTION

A Dissertation Presented
By
BENJAMIN F. LEWIS

Submitted to the Graduate School of the University of Massachusetts in partial fulfillment of the requirements for the degree of

DOCTOR OF EDUCATION

May 1986

School of Education
A STUDY OF THE RELATIONSHIP BETWEEN THE STRENGTH OF THE CONSUMER ORIENTATION OF COMMUNITY MENTAL HEALTH CENTER POLICIES AND THE DEGREE OF EXPRESSED CLIENT SATISFACTION

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DEDICATION

For K.

You have walked with me
on the road less traveled
by and that has made all
the difference.
ABSTRACT

A STUDY OF THE RELATIONSHIP BETWEEN THE STRENGTH OF THE CONSUMER ORIENTATION OF COMMUNITY MENTAL HEALTH CENTER POLICIES AND THE DEGREE OF EXPRESSED CLIENT SATISFACTION

MAY 1986

BENJAMIN F. LEWIS, A.B., CASE WESTERN RESERVE UNIVERSITY

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With the increasing thrust toward consumerism in the health care fields has come the recognition that the community mental health service system (CMHC) must become more consumer oriented in order for CMHCs to survive in a highly competitive marketplace. Consistent with this reality and a history of Federally mandated consumer orientation, CMHCs have allocated considerable land, labor and capital to ensure that the services they provide are "Acceptable" to their clients. This investment is reflected in CMHC policies which direct that services are to be provided in a manner that consumers perceive as "Acceptable."

Client satisfaction surveys are the accepted methodology to ascertain the degree of perceived consumer satisfaction, but they have not usually been designed,
administered or the results utilized in ways which relate to the policies and procedures that have been established to promote the client's perception of receiving Acceptable services.

This research has explored the relationship between the strength of the consumer orientation of specific CMHC policies established to direct the course and outcome of service delivery and the expressed satisfaction level of current clients with the outcome of these policies. The findings indicate that in the sample studied while overall satisfaction with services in general is high regardless of the presence or absence of consumer orientation, that a high degree of consumer orientation results in greater awareness of policies, and that increased awareness results in higher degrees of expressed client satisfaction in many areas.

This study has focused interest on the growing administrative intention in CMHCs to "serve the customer" and consumer satisfaction, and is intended to stimulate interest in an evaluative approach which will assist CMHC administrators in targeting resources more appropriately to improve the efficiency, effectiveness, and accountability of the current CMHC service delivery system.
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CHAPTER I

INTRODUCTION

Statement of the Problem

The history of the community mental health center movement has been characterized by consumer/citizen input in the areas of system design and evaluation. Over the past two decades, various interpretations and emphasis on citizen participation has led to different types of involvement of consumers/citizens in the evaluation of the Acceptability of services to the community mental health consumer.

Concurrent with this development of a participatory perspective, there has been a veritable revolution in the development of the concept of consumerism in the commercial world and in the delivery of health and mental health services.

A key concept of mental health consumerism involves tapping certain aspects of the consumers' perspective when it comes to evaluating the Acceptability of services. This has become a critical focus for CMHC administrators given an increasingly competitive marketplace for mental health services and has its parallel in the concept that attention
to the customer is a key element in the success of business enterprises. (Peters & Waterman, 1982)

The consumer's satisfaction with the manner in which services are made accessible and available and with other key aspects of the CMHC service delivery system is probably the most controllable variable in the interaction between CMHC systems and their clients. The importance of knowing the satisfactions and dissatisfactions of clients is critical to keeping and attracting a clientele.

The historical practice of involving consumers/citizens in CMHC system design and evaluation has developed into a contemporary interest in not only providing Acceptable services, but also promoting a positive perception on the part of clients as to the manner in which services are being delivered. The perception by clients and their families that services are being provided in an acceptable manner not only can affect clinical outcomes (Larsen et al., 1979), but also the marketability of services.

A series of investigations in the commercial world have suggested that there is a link between the investment that a company has in listening to its customers and treating them with respect and dignity and the success of the overall enterprise. (Peters & Waterman, 1982)

The manner in which such providers of goods and services set forth their intention to act in certain ways is
through the statement of general goals and objectives carried out through the promulgation of company policies and procedures. Policies are statements of intended action and procedures are plans to accomplish stated goals.

There have been recent indications that the same principles of consumer orientation apply to nonprofit organizations and other forms of quasi-public and public enterprise. (Peters, 1984)

Both public and private nonprofit organizations need to attract and maintain a clientele in order to survive. The increasing competition that CMHCs experience from individual and group practices of not only psychiatrists, but also licensed independent psychologists, social workers and others requires the application of strategies that will result in a positively perceived experience on the part of mental health consumers.

Similar to commercial enterprises, CMHCs also express their organizational goals through the articulation of policies and procedures. Because of a variety of regulatory and accrediting requirements, CMHCs are expected not only to have clear, written goals and objectives, but also to delineate methods of measuring their achievement. Among the policies and procedures which are considered the most critical in CMHCs are those related to the general area of Acceptability of services. These policies are the
cornerstone of CMHC standards and centers are surveyed for compliance in these areas by funding (NIMH, State Block Grant) and accrediting (JCAH) bodies. Since the orientation of most CMHC programs is clinical and often following a medical model, many CMHC policies are provider-oriented as opposed to consumer-oriented. Given that a consumer perspective is a critical variable in evaluating and marketing services, it is important to determine whether there is a positive relationship between the consumer orientation of CMHC policies and client satisfaction with the manner in which services are delivered. This dissertation concerns itself with the relationship between the strength of the consumer orientation of CMHC policies and the degree of expressed client satisfaction. The specific problem that was studied was:

Is there a positive relationship between the strength of the consumer orientation of certain community mental health center policies and procedures and the degree of expressed client satisfaction?

Significance of the Study

A significant portion of the non-personnel aspects of the budgets of CMHCs are allocated to the development and maintenance of Acceptable services. Even certain aspects
of the personnel budget relating to overtime pay for additional or non-standard hours are devoted to keeping programs staffed for hours and on days when clients are available for appointments. Staff training focusing on issues of crisis intervention, providing supportive services for waiting list clients, ensuring clients' rights and setting reasonable fees, for example, involves numerous hours and can be assigned a dollar value. Quality Assurance mechanisms are costly and not reimbursable. Involvement of advisory groups, advocacy groups and the CMHC's governing body in the development of policies and procedures requires a considerable investment of time and carries a price tag.

In addition to these administrative issues, the clinical implications of a system of services in which the clients' perception that the services he/she is receiving are Acceptable are considerable. (Gloyne & Ladout, 1973; Denner & Halprin, 1974; Edwards et al., 1979)

Lastly, in the community mental health marketplace, competition for clients has and will continue to increase, as opposed to decrease, and those programs that have satisfied clients (customers) will have a greater likelihood of survival. (NCCMHC News, 1985)

This dissertation has addressed these administrative and clinical issues. It has explored in detail the influence that the consumer orientation of the policies and
procedures which CMHCs have developed to make their services Acceptable to consumers has on the satisfaction of the consumer with the manner in which the services are received.

The implications of this is that once the factors and issues related to client satisfaction are better understood, mental health administrators will be in a more informed position to develop policies and procedures which are cost effective and which maximize positive outcomes for clients and for the system itself.

**Research Questions**

Based on research previously undertaken regarding client satisfaction, data gathered is often too program-specific to be generalizable, i.e. clients evaluating a workshop on stress management (Lewis, 1984), or so global and comprehensive as to be unmanageable. (Jass & Fowler, 1973; Larsen, 1979; Love, 1979; Daws, 1979)

This research has investigated the relationship between the consumer orientation of policies and procedures targeted at key dimensions of the delivery of CMHC services to clients and the satisfaction level of those clients. The specific research questions which will be addressed are as follows:

1. Do policies that have a stronger consumer orientation positively correlate with greater client awareness
of CMHC procedures in areas of client rights and privileges?

2. Are policies and procedures that have a stronger consumer orientation, either implicitly or explicitly, positively correlated with higher degrees of reported consumer satisfaction?

3. Are there specific policy areas where the strength of the consumer orientation is more likely to be positively correlated with higher degrees of consumer satisfaction than in other policy areas?

4. Are there additional areas that clients identify as related to the Acceptability of services that are not addressed by standard CMHC policies and procedures?

From the investigation of these questions and the results that have been obtained, a number of important inferences can be made about (1) the importance of the consumer perspective and consumer input in CMHC policy formulation, and (2) whether Acceptability as defined by providers is the same generally as that identified by consumers.

**Definition of Terms**

The following are a number of concepts that will be referred to in this dissertation:

**Acceptability**

A concept that includes the related aspects of physical Accessibility and temporal Availability and generally
refers to an attribute, attitude or characteristic of consumer satisfaction with CMHC services.

**Consumer**

One who buys goods or services for his/her own needs. In the CMHC context, this refers to the actual client receiving the service.

**Consumerism**

A contemporary definition of consumerism is one which includes the following elements:

1. A recognition on the part of producers or purveyors of a product or service that they have a responsibility to manufacture or provide the product or service at a level of safety or effectiveness which is consistent with what a reasonable person(s) (the general consuming public) would expect of the product or service;

2. That the sought after product or outcome of the service is consistent with what the product or service was provided or purchased for;

3. That the producer/provider have a set of objectives, identified standards against which they judge their product/services and which are available to the public for review; and

4. That there are policies and procedures for making the consumer aware of problems in the manufacture or provision of services that result in defects or unsafe conditions.
Client Satisfaction

A perception or belief of a mental health consumer that services are provided in a manner that is acceptable to them.

Policy

A plan for action; a statement of the intended direction of an action, often including a rationale or purpose for the action. A guide to implement strategy plans. The primary purpose of policies is to promote consistency in actions taken by organizational members and to ensure planned actions can be implemented.

Procedure

The operational steps required to translate a policy (plan) into reality (results).

Quality

That which is prized or valued; the degree of excellence that a thing possesses.

Quality Assessment

A process for determining significance or importance; evaluation in the sense of measurement, detection, analysis, and reporting.

Quality Assurance

Generally refers to acts of being or becoming confident, or receiving a guarantee of something said or done to
inspire confidence; a system or systems for maintaining desired standards of a product of performance of a service.

Background of the Problem

The Community Mental Health Centers Act of 1963 represented what was called a bold new approach to the design and delivery of mental health services. Previously, services were provided in isolated state mental hospitals where clients were labeled as "defective" and where providers literally held the key to return to the community. The 1963 legislation and subsequent regulations focused on the political, geographic, clinical and fiscal redesign of service systems and the redistribution of resources. The political and social ethic of "maximum feasible citizen participation" and the desire to overcome barriers to the delivery and utilization of services dominated the CMHC scene, with considerable attention being paid to the involvement of citizens and to the interaction of citizens with CMHC planners. The first decade of CMHC service delivery could be characterized as focusing on the issues of the redistribution of power that go along with a redistribution in the locus of mental health activity. Building partnerships dominated activity, with little attention paid to the evaluation of the quality of the service systems thus developed, the quality of the services provided and
the impact of both of these factors on the consumers of services.

The Community Mental Health Amendments of 1975 and supportive NIMH Guidelines or Standards for service delivery systems recognized this serious gap and attempted to address it through requirements for both citizen participation in governance and quality assurance evaluation to assure with a reasonable degree of confidence to (1) identified consumers, (2) other consumer systems, (3) the community-at-large, and also (4) provider personnel that:

a. commonly accepted standards of practice in all areas of services and requisite support functions are being utilized;

b. the quality of services received meets the spirit and the letter of these articulated standards; and that

c. results of evaluative activities are used to improve the quality of services being provided.

This was intended to be accomplished through the following regulations:

1. CMHCs must establish "an ongoing quality assurance program. . . ."

2. "Such CMHC will, in consultation with the residents of its catchment area, review its program of services. . . . to assure that its services are responsive to the needs of the residents of the catchment area."
3. "In each year the center shall obligate for a program of continuing evaluation of the effectiveness of its programs. . . and for a review of the quality of services provided by the center not less than 2 percent of its operating budget. . . ."

4. Grant applications shall contain assurances that the center will "provide procedures for developing, compiling, evaluating, and reporting to the Secretary (of HEW) statistics and other information relating to. . . the availability, accessibility and acceptability of its services. . . ." (NIMH, 1975)

These requirements were intended to encourage community and client self-reliance and to improve the responsiveness of CMHC services (both direct and support) to catchment area residents and their needs. While stated vaguely in the actual legislation, NIMH Guidelines define Acceptability of services as a predilection by clients, community caretakers and residents of the catchment area to continue to use a center (NIMH, 1977). Part of the concept of Acceptability are the related concepts of Availability and Accessibility. Availability of services is defined as the amount of various types of service that the center can provide at any given time, and Accessibility of services is defined as the ease of reaching a center and obtaining its services in a temporal, geographic, financial,
psychological and sociocultural sense (NIMH, 1977). These three attributes required to be assessed by NIMH overlap both conceptually and methodologically in how they can be evaluated. All really fall under the concept of Acceptability of services. For example, in surveying how Acceptable clients feel the center’s services are, it is proper and convenient to ask also about their attitudes towards the Accessibility of the center's services. Acceptability, Accessibility and Availability are conditions or characteristics of a center's program and are directly experienced by CMHC clients. The fourth area to be evaluated, Awareness, differs in that it is a characteristic of the community rather than of the CMHC and has less meaning for the client who is already receiving or has received services.

As the concept of Acceptability has been developed in the general arena of evolving consumerism, it has had a parallel development in the mental health field. Acceptability has been highly correlated with consumer satisfaction. Peters and Waterman, in their recent book, *In Search of Excellence*, state that an attribute of the best companies is the concept of "close to the customer." This attribute refers to the quality of obsession with customers (consumers) which pervades successful companies. Constant communication and contact with customers if used (1) as a process for improving quality and service, (2) to aid the
company in defining its niche in the marketplace, and (3) encouraging innovation by "listening to users" (Peters & Waterman, 1982). The same attributes can be easily applied to consumers of CMHC services in relation to the marketplace. The importance of the roles that mental health consumers can plan in the assessment and assurance of the quality of mental health services and service systems cannot be underestimated. There are few other arenas in which consumers are listened to less, have no warranties of satisfaction or legitimate ways of expressing dissatisfaction, little understanding of what they are purchasing, and little or no recourse if something goes wrong.

Almost a billion dollars a year is spent on all varieties of community mental health services. These are consumers' dollars. Public and private nonprofit CMHCs depend almost entirely on consumer funding for their survival. They have increasingly been forced to become more accountable (in the accounting sense) in recent years and also more accountable to their clientele.

Paradoxically, the CMHC movement has "spun off" its most problematic competition. As a variety of CMHC staff members became aware of the dollars to be made in community practice, they left CMHCs to set up individual, group and clinic practices. Since most CMHC clients have third party insurance coverage for the first few months of treatment up
to almost a half year, depending on coverage, and can purchase services anywhere, CMHCs are in keen competition for the insured and/or self-pay clients with other providers. This population represents the fiscal autonomy and/or survival of almost all private nonprofit CMHCs. CMHCs must also be priced appropriately since many of the competitive programs have lower overhead.

One of the desirable and unique aspects of CMHCs is that they consider sociocultural, economic and other demographic factors as a way of providing a more comprehensive service. But this alone will not assure marketing success. Clients receiving CMHC services must perceive what they are getting as sufficiently Acceptable, Accessible and Available such that they will continue to receive their services at the CMHC, that third party payers will continue to reimburse these services, that State funders will renew and develop contracts with CMHCs, and that the community, by word-of-mouth and/or other direct marketing approaches, will continue to supply clients.

With the stakes being fiscal and organizational survival, it is important for CMHCs to focus attention on the development of policies and procedures that are aimed at operationalizing the Acceptability trilogy and in techniques to measure and market the features of Acceptability.
CHAPTER II
REVIEW OF THE LITERATURE

Issues related to the historical development of the consumer perspective in community mental health, the development of Standards for assessing Acceptability and the actual participation of consumers/consumer advocates in systems of quality assurance and other forms of CMHC evaluation need to be understood fully if one is to appreciate and utilize the consumers' perspective in the design and evaluation of CMHC systems.

In addition, specific issues related to client satisfaction, including the validity of information, utilization of data, clients' involvement in the design and administration of evaluative studies, and the types of instrumentation are reflected in a review of the literature of these areas. Both the evolution of the consumer perspective as a tool in CMHC evaluation as well as the results of client satisfaction methodologies which have been surfaced in this review of the literature have led to the investigation of the concerns raised in Chapter I.

The following review of the literature in the above areas will:
1. identify the major issues and problems involved in the development of Standards, based on which CMHC policies and procedures are formulated;

2. trace the transformation of the ambiguous concept of citizen participation into the present day concept of consumerism;

3. focus on models of quality assurance evaluation that enable CMHC administrators to better determine the effectiveness of policies and procedures on outcomes; and

4. identify issues with the existing methodologies and specific instrumentation used to tap consumer data and to ascertain the consumers' perspective on the Acceptability of community mental health services.

The Standards Wasteland

Standards are statements of expected norms of behavior or condition. As such they are the basis for the promulgation of CMHC policies and procedures.

Standard setting in CMHCs is at a relatively basic stage for a variety of reasons: Each provider group—psychiatric nurses, psychiatric social workers, psychologists, occupational and recreational therapists, other mental health workers, paraprofessionals, volunteers and administrators—have developed discrete credentialing, licensing and accountability mechanisms and Codes of Ethics or
professional performance unique to their own discipline. Each have separate mechanisms for responding to malpractice or malfeasance and sanctions that can be imposed when allegations of misconduct are proven. These may include revocation or suspension of a professional license, censure, restitution, loss of referral rights, loss of vendor status as payee of third-party insurors, etc. as a sanction for noncompliance with legal or professional standards. While these consequences may offer protection from future misconduct, the situation is like closing the door after the horse has escaped.

Furthermore, the standards of professional organizations are not commonly available to the public and many professionals are not familiar with them. In order for consumers to bring an action against a professional, there would need to be not only a tremendous investment of time, but probably also the help of someone who was aware of the process involved. In the absence of uniform, widely published performance standards which can be reduced to easily understood language, the variety of consumers of mental health services have no protection or power. This is one of the factors involved in the proliferation of advocacy programs, which are desirable and necessary, but which ought to be a voice for consumer interests, not a substitute for them. (Wolfensberger, 1971)
In the United States today, there is almost a total absence of objective, uniform community mental health center standards. The National Institute of Mental Health (NIMH) promulgated standards which are exceptionally broad and flexibly applied. Given the current absence of Federal funding for most CMHC programs, these standards are no longer binding. Furthermore, NIMH has never defined what the components of a quality service mental health system are or what quality services should look like. The Community Mental Health Center Act Amendments of 1975 added a requirement that each Center must have a quality assurance program but never required any specific standards for that program above and beyond generalizations about (1) Awareness, (2) Accessibility, (3) Availability, and (4) Acceptability. With respect to the involvement of consumers in the evaluation of quality, participation is required, but NIMH has never promulgated any official guidelines for implementation of this concept of citizen/consumer participation.

What NIMH did do was to fund a number of pilot programs whose outcomes were reflected in reports to NIMH, but whose results were not broadcast to all CMHC in the form of guidelines or regulations. The one exception to this took the form of NIMH contracting with the Joint Commission on the Accreditation of Hospitals (JCAH) to develop standards that would have universal application to all CMHCs. This
effort was undertaken between 1974 and 1977 with a pilot program initiated in 1977 involving 50 centers. The JCAH Standards may be used both as an organizational development framework for constructing or restructuring mental health systems and as an evaluative and accountability tool for measuring performance and assessing certain aspects of the quality of an operating system (Erion, 1977). JCAH surveys of CMHCs include the gathering of client information about satisfaction with services, but this information is not utilized in determining the accreditation decision of a CMHC, nor is it computerized and retained as a data base for national surveys of client satisfaction. In theory, the Principles of Accreditation for Community Mental Health Centers of JCAH devotes considerable attention to the roles of a wide range of consumer groups in planning functions with the desirable goal of giving consideration to consumer priorities and ensuring the incorporation of citizens (not necessarily consumers) into the planning process. This is critical in terms of establishing the values based on which evaluation principles can be derived. Once standards are established, criteria can be developed to measure the extent of their presence in the performance of providers and provider systems. While the JCAH standards theoretically propose an amalgum of consumer, provider and other social agency perspectives and operating values, functionally, the
perspectives of those other than providers have not been fully pursued in the accreditation process. (JCAH, 1983)

Awareness and Acceptability measures are administered to clients who come on a particular day, and a sample of community agencies is surveyed with regard to their knowledge of the hours of operation, location of services provided, etc. But these are not used to determine accreditation status. There has been no attempt to correlate the consumer perspective with that of providers or other social agencies, limiting if not crippling the major thrust of such a design, namely an equal value placed on the evaluation of services and the service system by actual consumers. The imprimator of accreditation without an integrated, internal concept of quality based on adherence to standards, and without equal weighting and consideration of the consumer perspective does not meet the spirit and letter of the Balanced Service System which it purports to encourage. In addition, JCAH accreditation is totally voluntary in the community mental health center arena (as opposed to its application to hospitals). The process of external accreditation by JCAH is an expensive activity with survey costs running approximately $8,000-$10,000, and preparation costs varying from several thousand to over $20,000, depending on the state of agency readiness when the decision to apply for JCAH accreditation is made.
Citizen Participation -
The Antecedents of Consumerism

With the Community Mental Health Centers Act of 1963 came the term community responsibility which was used to characterize the role of consumers in the planning and operation of the Centers. This concept was mandated, not so much as an invitation to community control, but as a public relations measure and an accommodation of the political process to varying interests. While some saw the concept of community responsibility as an attempt to politicize mental health services in the same manner as other social movements of the era, others felt that the legitimate need for citizen involvement added to the positive self-esteem and functioning necessary to obtain and maintain good mental health and develop a mentally healthy environment. Still others identified with the notion that the community responsibility aspect of the CMHC movement was calculated to promote for patients released from State hospitals an emphasis on what many functional members of the community value, namely their control over and enhancement of the quality of their lives. (Benveniste, 1972)

Hence, given the ambiguity of language in the enabling legislation, when various approaches were attempted to exercise this "responsibility," including the equally vague concepts of citizen participation, citizen input and
citizen control, they were all without benefit of a Federal prototype—none were right, none were wrong. All were carried out in an ambiguous environment and largely took the basic form of the establishment of citizen Boards with few identified, concrete responsibilities. While it seems clear from the original language that the conceptualizers of the community mental health center legislation did not require community control, the assertion of control by many local Boards was part of the variety of developmental experiences. In addition to the ambiguity of the meaning of citizen responsibility, the citizens who had been chosen or had volunteered to serve on Boards had not always been prepared for the responsibilities they were expected to assume. In this situation of unclear roles and responsibilities consumers were often labeled as passive and noncontributing. Members were quite frustrated, caught between the desire to represent their constituencies, exercise some modicum of control over their lives, participate with others in planning and deal with demands of the bureaucracy to "review and approve," with a limited scope of decision-making for the allocation of resources. Notwithstanding this early experience, the tradition of citizen participation in community mental health has had an important impact on the development of Centers and contained elements of the promise, perspective and constraints of current CMHC
consumerism efforts. Citizen participation is an essential ingredient of American democracy but one that has been honored more in its breach. While the typical democratic notion is of direct or representative participation in the decision-making process, increasingly these activities fall into the baliwick of a power elite who have access to information and technologies which are not readily available to the ordinary citizen. The concept of "maximum feasible participation," a throwback to earlier democratic concepts of participation, became the quintessential ingredient in the thrust of the CMHC legislation. As is characteristic of many aspects of democratic process, some goals must be modified so as to accomplish others. In the case of "maximum feasible participation," what was compromised to get the "maximum" in terms of numbers and penetration was the concept of "participation." The generally vague concept of community responsibility was sufficiently ambiguous so that it created a vacuum that was filled by the actors on the early community mental health scene based on their respective interests. Those who operated hospital-oriented mental health programs, the medical and health "establishment" in the terminology of those days, saw the legislation with its focus on community participation as a threat to their institutions and to their place in the market. They also saw a new opportunity to provide additional mental
health services to discharged patients and to attract others to their services. They had their own notion of citizen participation as operationalized in the community perspective of citizens on the hospitals' Board of Directors. Such arrangements were based on the traditional utilization of volunteerism. These Boards were not community-oriented in the sense that their membership most often was comprised of the power elite and did not reflect representation of the diverse groups within the community. The general intent and promise of the community responsibility concept was compromised to accommodate to the needs and operation of these powerful hospital-based programs. Operationally, the most significant aspect of the compromise appears to have been a diminution of community control and participation in the decision-making process. (Darley, 1974; Graziano, 1969; Zinober & Dinkel, 1981)

One other critical factor influenced the path of participation from the outset and still remains a critical variable in the tensions that arise around consumer involvement in the evaluation of CMHC programs. This is the perspective and role of CMHC staff. This has been most often reflected in the need for professional expertise as an aid in decision-making. In most such situations, the tendency is for the process of self-determined decisions of citizens to be co-opted through a series of activities which
conceptualize the process as educational and/or therapeutic for the citizen participants. The process then becomes more important than the making and the ownership of the decision. (Zinober & Dinkel, 1981)

Another of the real frustrations in the area of citizen participation is the phenomenon that seems to occur when citizen representatives, selected or chosen through an appropriately democratic process ascend to power and then accede to their newly found power and the status of their new roles. Saul Alinsky suggests that co-optation can take place with newly held power in that this power can be exploited by those who would educate as a way of influencing decision-making. (Alinsky, 1961)

Notwithstanding the history of citizen participation efforts and the constraints that have been placed on them, increasingly validation of rights of consumers of mental health services has slowly evolved. An arena in which this has been reflected is the quality assurance aspect of services and service systems. To a large extent, this is the only aspect of the service system that every direct consumer comes into contact with. There is nothing vague or ambiguous about whether the consumer felt the experience was acceptable or to what extent they were aware of the services being offered or whether the services were offered at a time and place that was convenient for the consumer.
In this arena the consumer is in competition with no one for expertise. The balance of expertise is in the consumer's corner. In this arena, the consumer needs little new education. His/her experiences in the world are reasonable basic education for knowing when they are satisfied with the quality of a product or service. Involvement in the quality assurance arena also may become pivotal in the redesign of certain system components that are found to be lacking or wanting in the original planning, for example, the hours that a CMHC is open, the cost of services, parking, etc.

Increasingly, I believe a wave of consumerism in CMHCs has empowered clients with a legitimate role in quality assurance activities. This trend is reflected in expanded and continuous consumer satisfaction surveys, easily utilisable grievance/complaint procedures and by creating an environment in which the "company listens to the consumer."

A given in this construction of citizen involvement in CMHC service evaluation is that through this process citizens will become educated as to the mission, objectives and procedures of the CMHC. This approach is also in the best self-interest of the CMHC in that it can direct data gathering efforts in areas that validate its policies. For example, useful information can be gained if a satisfaction survey were to ask: "It is our goal to respond to
psychiatric emergencies—if you had a psychiatric emergency, did we respond to you in a timely, useful fashion? What would you suggest in a future situation?" In this way, the consumer is educated as to what an objective of the program is and the provider is educated as to what the perception of the consumer is. The influencing strategies that accompany consumerism need to become institutionalized into the operation of the system. This not only gives them legitimacy, but it provides reasonable security and assurance that standards will not be changed unilaterally. This approach also puts teeth into another aspect of the enabling legislation, namely that the services of the CMHC respond to local needs. When the standards for quality assurance are at a distance, such as vested in State or Federal review of a Medicare or Medicaid program, they cannot possibly relate to local needs or changes in the distribution or kind of services needed in a particular catchment area.

Models for Community Mental Health Center
Evaluation and Quality Assurance Mechanisms

Internal models

There are a number of models which provide a theoretical framework for evaluating community mental health services. No one model is best all the time and models may be
used interchangeably and in concert with each other depending on the CMHC configuration. Models involve both internal and external perspectives and each model has its unique benefits and constraints. Each model also has its own constituencies with consumers most likely preferring impact models and provider preferring care-process models. Different quality assurance mechanisms derive out of various models. What most of the models have in common is that the data looked at generally relates to (1) the quantity of services offered, (2) the productivity of staff, (3) the scope of the program, and (4) the state of facilities and cost-benefit analyses. The addition of the qualitative dimension is a relatively recent arrival on the scene and has impacted model development in terms of different factions and constituencies to be looked at. Lebow has identified five categories of models for evaluating community mental health center services:

1. The Organizational Model
2. The Care-Process Model
3. The Efficacy Model
4. The Community Impact Model, and
5. The Consumer Evaluation Model (Lebow, 1982)

The organizational model

This model focuses on overall management concerns including the scope of services, the adequacy of space and
personnel in relation to programs, and the relationship of services to community need. In this model, utilization data is looked at that relates structural aspects of the program to consumer need. The system that traditionally fund CMHCs consistently ask for this kind of data which are useful in determining efficiency and effectiveness. The type of data gathered in this model are usually relatively easy to quantify. It is also relatively easy to develop criteria related to concrete aspects of the program, such as the presence or absence of a table of organization, budget breakouts by service type, etc. While good service may in fact be correlated to good structure and management, there have not been many empirical studies in this area. Utilization data related to need may lead to identification or areas that need to be looked at more closely and changed, but such data does not look at issues of acceptability of the services to consumers. (Lebow, 1982)

The most common quality assurance mechanism related to this model of evaluation is the Utilization Review Committee. Such committees may have other names, such as Utilization of Resources Committee, but basically have functions in the area of reviewing medical records to determine whether admission for service has been appropriate and continued stays in the system can be clinically justified. Part of the function of utilization committees is also the
development and analysis of client profiles. It is from these profiles and from the criteria for diagnosis and timeframes provided by third-party payers that determinations as to appropriate admission and continued treatment are made. Variance from the review criteria could preclude continuation of services or lead to recommendations for changes in the type of treatment offered. Case selection methods involve random selection, selection on the basis of problem type, selection on the basis of deviation from established criteria, or on the basis of pattern analysis. (NIMH, 1984)

While some of the reviews involved can be performed by medical records, personnel Utilization Review Committees are usually made up of senior clinical personnel from each discipline represented on the staff. By virtue of the peer review focus of this activity, only those involved with patient care are deemed to be capable of membership. A limitation of this model is that it deals only with clinical practice and does not look at those who have not penetrated into the system. Such committees can effect change within a system in two ways: (1) they can percolate up to CMHC administrators' patterns of usage which appear problematic, and (2) they can set in motion supervision of clinicians around areas of practice that emerge as problematic. Such committees are often viewed with both apprehension and
apathy by staff and administrators. Their work is usually meticulously slow and thorough with considerable discretion used to provide wide latitude to avoid critical treatment of peers. In addition, the time it takes to percolate up through channels to the administrative level concerns about patterns of usage or of clinical practice which fall outside established norms is considerable. In such committees, consumers are not interviewed regarding their perspective on treatment and seldom, if ever, are Ombudspersons, Board members, or other outsiders involved in URC work. Increasingly, however, the notion of tapping consumer opinion to learn of the nature of the treatment experience has been experimented with. Again, such committees have a variety of vested interests in the status quo or in slow change and filtering consumer dissatisfaction through URC may be counter productive under their present construction. Since confidentiality has not proven to be problematic, as was originally feared by providers, further experimentation should be done with consumer Ombudspersons, consumer input on a case-by-case basis or by contracting URC functions out to impartial external reviewers from other mental health, health and social service agencies in the local community.

The care-process model

This model looks at the actual activity of providers and compares it with some standard of practice. Unlike the
Organizational Model, it attempts to look at the effectiveness of service delivery and therefore is somewhat more qualitative. Some of the problems associated with this model are that (1) clinicians are reluctant to have their treatment examined at the level of process recording or video tapes of sessions, (2) that developing standards against which to judge practice is a difficult task, (3) that such activities are time-consuming and may therefore not be cost effective, and (4) that the setting of overly rigid standards may stifle innovation. The quality assurance mechanism most often identified with the care-process model is peer review. Multi-disciplinary committees composed of senior clinicians review process against standards which they themselves usually set. This quality assurance mechanism seldom includes consumers/advocates in its operation. The merit of this model, in my estimation, is that it offers the possibility of involving consumers and their advocates in the development of an agency concept of quality operationalized in the criteria that are established. Consumer perspectives, gained through requesting information from them utilizing both interview and survey techniques, could easily be integrated into this mechanism.

The efficacy model

This could also be called the Outcome Model and looks at data having to do with change in clients. This model
and its concommitent quality assurance methodologies of pre-post measures administered to clients at various points in their treatment stays is one of the most commonly used quality assurance approaches. Its utility is based, in part, on the following characteristics: (1) what the therapist does is not the focus of the evaluation, rather change in the client is what is looked at, (2) pre-post measures carry with them more rigorous research than most of the other quality assurance approaches which rely on the judgement of experts, including reducing changes in behaviors to numerical values that are easier to analyze and lend themselves to easier articulation and interpretation to Advisory councils, funding bodies and consumers, and (3) most of the measures of change can be self-administered and computer analyzed thereby minimizing cost. The major problems in the utilization of this model for CMHC evaluation are: (1) the tenuous relationship between treatment and outcome, and (2) difficulties in measuring outcome based, in part, on controlling for intervening variables, spontaneous recovery, and normal growth and development. Another major problem with this mechanism has to do with administering such measures as the Global Assessment Scale or Goal Attainment Measures to so-called chronic clients. Many of these clients appropriately have individual service plans which do not set goals and objectives in the
area of improvement. They generally have goals in the area of helping these individuals maintain their current level of functioning. Notwithstanding these limitations, the quality assurance activities that emanate from this model have value in that partial ownership of the measurement instrumentation and resultant data vests with the consumer. Consumers could be educated to do considerably more with self-administered and scored instruments which would put much more control of the process in their hands.

The community impact model

This model attempts to assess to what extent the programs of the CMHC have had impact on the mental health of the community as a whole. While methodologies exist to make these determinations, they are time-consuming, depend on having large amounts of base-line data on preexisting community pathology or need and are burdened with many of the problems of the Efficacy/Outcome assessments. One of the problems for administrators and evaluators in regard to this model is that the consumers from whom they would like to gather data are not as well identified as those who cross the threshold of the CMHC requesting services. The development of these pockets of folk-support system consumers in the community will have a powerful payoff at a future date, in that public information has been disseminated, case-finding initiatives begun, and the seeds of CMHC
respect for the consumer/potential consumer perspective planted.

**The consumer-evaluation model**

This model derives in part from marketing research. The perspective that it maintains is that the services provided by the CMHC can be appropriately evaluated by the consumers of those services. These may be present clients or former clients. This model also can include assessing the satisfaction/dissatisfaction of other community agencies and providers who refer clients to the CMHC. This model is most often operationalized in the quality assurance mechanism of the client/consumer satisfactions survey. Client satisfaction measures usually look at issues of Awareness, Availability, Accessibility, and Acceptability of services based on the premise that client satisfaction is an important factor in: (1) the utilization of services, (2) a mediating goal in the treatment situation, and (3) a goal of the entire process of engagement with the CMHC experience. Consumer evaluation methods also encompass other activities which impact on quality assurance such as the use of suggestion boxes or utilization of various kinds of complaint articulation and adjudication processes. One of the benefits of quality assurance mechanisms arising out of the Consumer-Evaluation perspective is that they are direct. They do not depend on clinical analyses; they do not
contain the element of the client being judged, based on a
bias that he/she is mentally ill, but rather give the
client a forum to express an opinion, make a judgement
about the CMHC or state a dissatisfaction. Another benefit
is that such surveys are inexpensive to conduct and analyze
with results that can be interpreted in a way which most
laypersons can identify. On the other side of the ledger,
many evaluators suggest the possible distortions of clients'
responses based on positive or negative transference, poor
reality testing, and lack of knowledge about what the ele-
ments of appropriate treatment are. (Hare, Mustin, Marecek,
Kaplan, Liss & Levinson, 1979)

External models

The five evaluation models and their parallel quality
assurance mechanisms just reviewed focus on the internal
domain of the CMHC. There is one other model, The Balanced
Service System (BSS) Model (Gerhard, Dorgan & Miles, 1981)
which is reviewed here because it is an example of a type
of inter-organizational systems model which has developed
out of the recognition that it is the interaction of vari-
ous perspectives which given community mental health its
unique ability to respond to provider and consumer needs.
The BSS is a frame of reference which can be used to devel-
op a comprehensive community mental health system as well
as an evaluative, accountability and quality assurance
mechanism which can measure performance of an existing system. In this model, services are aimed at increasing the capacities of consumers (their term) to eliminate, cope with and tolerate mental disabilities. These services are provided in the "natural" environment of the consumer and are built on consumer assets, i.e., membership in social support networks. The BSS allows for indefinite membership to accommodate to the research knowledge regarding the present and continuing needs of certain populations, i.e., chronic users of mental health services. The primary thrust of service is to achieve social integration by effecting the highest consumer levels of developmental adequacy, personal independence, social interdependence, and cultural appropriateness. (Gerhard, Dorgan & Miles, 1981)

As mentioned earlier, the Joint Commission on the Accreditation of Hospitals (JCAH) was contracted by NIMH to develop Standards for the evaluation of quality in CMHCs. In turn, the JCAH chose for its evaluative model the Balanced Service System Model (BSS). While this model was not developed by JCAH, it was selected because it was the only model that was based on extensive and intensive surveys of the literature in the community mental health field, building its underlying assumptions on the available empirical evidence. This synthesis of existing knowledge led to developing a model which was not replete with new
solutions, but integrated and re-balanced the existing system. Because of the comprehensiveness of this model, as well as the fact that it has been utilized in the evaluation process of all the CMHCs accredited by JCAH since 1977, I would like to explore this model in somewhat more detail than the previously described evaluative approaches.

The BSS is derived from seven basic assumptions about the nature of human problems and the characteristics of helpful responses:

Assumption 1: The major disabilities, while almost always readily stabilized, continue with indefinite, perhaps permanent impairment to the individual.

Assumption 2: Because of the problems associated with the transfer of learning from either the general to the specific or from one specific setting to another, services should be provided in the setting that the newly acquired behavior must be applied.

Assumption 3: The types of services to be provided should be based on a continuing analysis of need and be flexibly designed to correct deficiencies in outcome.

Assumption 4: New systems seldom evolve from naturally existing and established systems.

Assumption 5: A system of service of that concentrates on cure is not consonent with our knowledge about the effectiveness of our clinical efforts.
Assumption 6: The values of the system must be stated.

Assumption 7: A service system must build on the assets of its consumers and their folk support systems. (Gerhard, Dorgan & Miles, 1981)

Secondly, in the BSS, a set of values is derived from identifying desired characteristics of the service delivery system such as "Acceptability" and "Accessibility," and refining these into "Principles" utilizing the perspectives of the three constituent groups identified by the model, namely: (1) providers, (2) consumers, and (3) other social institutions. These three groups of participants incorporate their expectations, interest and derivative principles in the formation of the mission of the system. The mission is then translated into concrete goals and objectives falling into five functional areas. These are:

1. The Service area: The goal is to reduce or eliminate mental disabilities and their adverse effects for a defined population and to encourage their social integration.

2. The Administrative area: The goal is to organize, finance, facilitate, execute, and control the delivery of mental health services.

3. The Citizen Participation area: The goal is to continually improve the system's responsiveness to consumers
and other citizens.

4. The Research and Evaluation area: The goal is to continually improve the system's level of quality and capacity to detect deviation from objectives.

5. The Staff Development area: The goal is to maximize the system's utilization of human resources.

Each of these goals is then broken out into numerous component parts and activities. The involvement of provider, consumer and other social agency groups in the articulation of the values, beliefs, assumptions, and principles of the BSS model ensures that the standards measured against include balanced constituent interest regarding quality.

The operationalized quality assurance mechanism related to the BSS conceptual model is JCAH Accreditation of community mental health centers. Since 1976, JCAH has developed, pilot tested, and validated approximately 1,600 Principles, Sub-principles, Standards, and Indicators to operationalize the BSS concept (JCAH, 1981). Assuring quality utilizing the JCAH Accreditation mechanism involves evaluating the design and performance of the CMHC system in terms of its compliance with the stated JCAH Principles. For example, Principle: Services shall be provided in a manner which effects role performance while ensuring personal privacy and dignity.
Indicators of the extent to which this is operational in the CMHC system would be based on the examination of records, documents, and survey instruments to determine:

1. The number of cases (out of 100) which reflect that problems are dealt with in a confidential manner;

2. The number of consumers giving positive answers on a questionnaire soliciting information about their perspective on whether they were treated with respect and dignity;

3. The number of consumers receiving medication who have been informed of action and side effects; and

4. The number of consumers who have requested access to their service records, etc.

There are many advantages to utilizing the BSS system approach and its concommitent quality assurance mechanisms.

1. It is comprehensive, looking not only at consumer services, but also the support functions requisite to providing quality services.

2. It looks at the inter- and intra-organizational aspects of the system.

3. It is based on the synthesized values of provider consumer and other social institution constituencies.

4. It can be utilized as an organizational development tool.

5. It is both an internal as well as external quality assurance mechanism.
6. It has been utilized nationally.

7. It has been developed and utilized for accreditation purposes by the organization with the most experience in the quality assurance arena.

This quality assurance mechanism is, however, not without its limitations and detractors. Utilization of this mechanism requires a relatively comprehensive approach to implementation. Affiliation agreements must be developed with other agencies, surveys and needs assessments administered to community constituencies and a new language learned (the JCAH manual contains 12 pages of glossary). Surveys by JCAH cost approximately $8,000-$10,000 in direct fees and often considerably more in preparation costs and costs to the system on a one-time basis for planning.

Perhaps the most difficult aspect of the JCAH approach to quality assurance is that it requires the development or redefinition of the values and mission of the system. This causes natural resistances both from providers who see their goal as service provision and consumers who have been socialized to be passive recipients of service. Finally, the BSS has lost something in its translation into the Accreditation principles. The consumer perspective is not as prominent in the performance stages as it is in the design stage. In fact, while JCAH requires that an annual client satisfaction survey be administered and information
so gathered be used to inform the judgements of the surveyors about the consumers' perspective, such information is not utilized further and does not comprise part of the data based on which the final accreditation decision is made. Consumers are not viewed as part of the survey process, nor are their stated dissatisfactions pursued.

**Issues Related to Client Satisfaction**

Issues related to client satisfaction, including validity of information, utilization of data, clients' involvement in the design and administration of evaluative studies, and types of instrumentation are reflected in a review of the literature on client satisfaction. Both the results and the methodologies of the limited research in the area of client satisfaction have varied widely based on some of the issues surfaced in this review. Some of the critical gaps that have emerged will be addressed by this research.

The most commonly utilized tool to assess consumer satisfaction in community mental health is the client satisfaction survey. Client Satisfaction Surveys (CSS) have been established as a valid method of evaluating an agency (Balch, Ireland, McWilliams & Lewis, 1977; Heinemann & Yudin, 1974; McFee, Zusman & Joss, 1975). A well planned, designed, administered, and analyzed CSS not only reveals
consumer likes and dislikes, but points up gaps in service which can only be known and experienced from the unique perspective of the consumer. Such studies also have the impact of feedback to the staff and system for purposes of program planning and development.

Technically, participation of the client in the evaluation process can increase the validity of measurement. (Windle & Paschell, 1974)

Historically, the consumer satisfaction survey approach to the assessment of consumer wants, needs, and perceived gaps in services has been problematic. The value of measuring the acceptability of mental health services and the interpretation of the information obtained in such measures are controversial issues. Although few would argue with the notion that CMHCs should provide services that benefit their clients, some professionals question whether the most commonly utilized approach to measuring acceptability, consumer satisfaction studies, provides information that is valid and/or useful for improving services. Some (Campbell, 1969) contend that evaluating acceptability is difficult because of response biases and the vague or nonspecific nature of clients' judgements; there is also the difficulty of gathering meaningful data without infringing on the rights of the clients. Furthermore, professionals sometimes feel that they, as experts,
should have the freedom to design programs which they, not the consumers, feel to be appropriate.

While these problems do exist, there are reasons for assessing Acceptability of services to clients. Probably the most important is that the process of querying consumers and other citizens puts these potential respondents in an active, responsible role and permits them to exercise some control over their own services. When properly conducted, assessments of public Acceptability can be powerful arguments for changing services. Last, such evaluations are relatively easy to implement. An additional benefit derived from querying consumers is that this process can educate them about available programs that they might utilize, as well as the role they could play in developing and improving services.

Citizen participation can provide a therapeutic benefit to clients. Although some hold the view that consumers of CMHC services have been unable to solve their own problems, there is evidence to the contrary. Studies have shown that consumers and former consumers were indeed able to make useful and relevant recommendations. Since feelings of powerlessness are sometimes at the root of mental illness, involving clients in decision-making can have the therapeutic value of fostering independent role functioning (Darley, 1978). While consumers are viewed as having a
legitimate role in the generating of potentially useful data, current consumers are not felt to be appropriate advisory group members or evaluators because they might be overly concerned about the potential impacts that their participation in evaluation activities might have on their ongoing therapy. And that while their confidentiality would be assured, they might not be willing to be critical of services while they were still dependent on them. (Zinober & Dinkel, 1981)

In service areas where the client is regarded as not simply ignorant of the professionals' knowledge but also suffering serious mental difficulties, the views of the client are likely to be regarded as of little value and possibly illegitimate. There is reason to believe that deficiencies in communication between responsible officials and program clients reinforced by social distances in education is a characteristic of many mental health programs (Beneviste, 1973). Related to the earlier discussion of the parallel development of professionalism and consumerism, staff have been quite defensive about the need for and the objectivity of consumer data. The pervasive myth has been that clients have problems expressing their feelings, dealing with anger appropriately, and may be operating inappropriately in a transference relationship with the agency.
Client criticism is regularly responded to defensively (Hare-Mustin, Marecek, Kaplan, Liss, Levison, 1979) based on the therapist's fear of inadequacy, fear of loss of the client (if the client chooses to terminate) and fear of the anger of the client directed toward the therapist.

Administrators have also shared some of this sentiment, as have Board members, reflective of the notion that clients are defective. Dissatisfactions and complaints are often viewed as petty annoyances with negligible impact on organizational functioning.

In a study investigating the attitudes and values of community mental health center Boards and management staffs towards the Federal mandate calling for increased citizen involvement in Center evaluation activities, the results were interpreted as substantiating the view that CMHC Boards and management staff reflect a provider orientation (Pinto & Fiester, 1980). Both management staff and Board members rated existing and/or potential service consumers at the bottom of the list for membership. While this study did not deal with client satisfaction per se, the authors postulate that a center's consumers are in a better position, by virtue of their participant-observer role, to evaluate CMHC services than are other members of the community (Pinto & Fiester, 1980).
Even those efforts specifically focused on the involvement of citizens/consumers in CMHC evaluation have minimized the role of consumers in the planning, design, application, analysis, and ownership of the evaluative material, with the "technical" aspects of studies falling within the professional realm and the citizens/consumers merely serving an advisory function.

Further, despite the general perception that citizen input is to be valued, the previously quoted study reported that both Board and management groups felt that citizens did not have a better understanding of the communities' mental health needs and problems than mental health professionals, and that most citizens do not know enough about CMHCs (from firsthand knowledge) to make useful suggestions (Pinto & Fiester, 1981). It is worth noting that in this and other similar studies, Board members themselves felt even more strongly than providers on these issues (Paschall, 1974; AuYong, 1973).

Another criticism of the consumer satisfaction survey and consumer complaint systems is that they are an inappropriate methodology for application in the CMHC arena. Those most vociferous in articulating this argument feel that the CSS derived out of a product orientation and cannot be applied to a service. In fact, CSS in the commercial world often deal with the same aspects of the product
or commercial service that CMHCs are required to look at, i.e., Availability, Accessibility, Awareness, and Acceptability. In addition, with all of the research effort that has existed in CMHCs, the detractors of the CSS have not been able to develop alternatives which allow for easily quantifiable consumer feedback. The proponents of CSS argue that well-designed instrumentation can be developed which captures the service quality of mental health activities and which provides accountability to funders, third-party payors, and consumers (McFee, Zusman & Joss, 1975).

The general literature on consumer satisfaction acknowledges the growing notions that "keeping the consumer satisfied" and no longer ignoring the needs and wishes of clientele are critical issues.

There appear to be a related trend in CMHCs, although the methodology is just at a beginning state. In 1972, a survey of Federally funded CMHCs reported that only 35 percent reported assessing client satisfaction in the previous two years. In most cases, this was a "one shot" survey utilizing a wide range of instrumentation (Windle & Volkman, 1973). A follow-up of the 67 centers that had reported assessing satisfaction in the 1972 survey study one year later found only 16 (24%) were still assessing patient satisfaction (McPhee, Zusman & Joss, 1975). However, a later survey of 504 Federally funded centers in
1979—four years after the CMHC Amendments of 1975—found that 48 percent of the centers responding had assessed client satisfaction in the 18 month period 1975 - 1976. (Sorenson, Kantor, Margolis & Galana, 1979)

A review of the instruments utilized in these studies indicates that there was no standardization, there were problems with validity and reliability, and that of the centers reporting, only a small percentage had assessed the satisfaction of clients in their total programs, most choosing certain aspects of the CMHC system to survey. Outpatient clinics were surveyed the most; inpatient services and emergency services the least. Most surveys were administered to discharged or former clients (Sorenson, Kantor, Margolis & Galano, 1979). There have been no further NIMH studies of the state of the client satisfaction survey since 1979.

It is somewhat understandable as to why there was the general lack of utilization of the CSS survey early on in the CMHC movement:

1. The general attitudes of provider staff toward consumers/citizens;

2. Public funding for services was readily available and growing so the assumption was made that services were appropriate and desired;

3. There was a lack of competition for clients with
other public service systems, private-nonprofit agencies and the private sector;

4. Innovation and program development were valued more than accountability;

5. The concept of quality was an internalized value, not an advertised attribute of a program or product;

6. It was either implicitly or explicitly assumed that consumer satisfaction is either unrelated to service quality or negatively related correlated with the therapeutic process.

Many of the reasons cited for failure to collect satisfaction information are unsupportable. For example, the assertion that client satisfaction data do not correlate or correlate negatively with therapeutic effectiveness or outcome is not confirmed by the CSS literature. In a review of 48 articles surfaced by Medline and Psychological abstracts data bases, 48 dealt directly with the impact of the CSS on the issues just raised. Client satisfaction studies have shown that clients who terminated from treatment are generally quite satisfied with services and that such satisfaction is largely unrelated to demographic variables such as age, sex, income, etc. (Gloyne & Ladout, 1973; Denner & Halprin, 1974; Edwards et al., 1978; Balch et al., 1977; Frank et al., 1977; Larsen et al., 1979)

Higher satisfaction and high degrees of problem
resolution and change are obtained when termination is satisfactorily mutual (Denner & Halperin, 1974), and satisfaction has been positively correlated with therapists' ratings of success (Balch, 1977), number of service contacts (Frank et al., 1977), and measures of treatment outcomes (Larsen et al., 1979).

Another criticism is that the CSS often attempts a comprehensive assessment by determining the client's attitude toward all of the aspects of the service system. This type of survey can be experienced as overwhelming in terms of time and breadth, eventuating in incomplete responses and a poor return rate (Jasso & Fowler, 1973). Other surveys have obtained the client's perspective on different issues such as effectiveness of treatment (Larsen, 1979), access to services (Atkinson, 1979), attitudes towards the agency's programs and administration (Love, 1979), and opinions about the services received (Davis, 1979).

Eliminating redundant questions on survey forms regarding satisfaction, progress in treatment (if different from satisfaction), and other issues in the environment would result in shorter, less burdensome questionnaires for the client to complete (Fox, 1980).

A further criticism of CSS is that the questions asked and the categories covered are inadequate to tell all of clients' concerns, and that there needs to be a place for
additional concerns or a "comments" block as reflected by 39 out of 52 returns in a study of the satisfaction at the Southwest CMHC which included unsolicited written comments. (Essex, Fox & Groom, 1981)

Despite the issues of comprehensiveness of surveys or the fact that they have focused on specific issues, results are often uniformly positive, making it difficult to determine when or if clients differentially respond to all of the issues contained on a lengthy survey. (Essex, 1980)

One of the arguments for not investing energy and financial resources in CSS is that they have generally noted a 70 to 90 percent level of satisfaction (Gilligan & Wilderman, 1977). These levels have been characterized as "suspiciously high" by (Love, Caid & David, 1979) and may be related to the methodology employed, the bias in the questions asked, the method of administration, and biases in the interpretation of the data. In many studies, the areas of significant dissatisfaction are identified, however, I have only found one study which retested clients after these areas had been addressed (Grob, 1978). In part, this may be accounted for by the fact that most surveys are administered to former clients, but the clear fact that dissatisfactions have not been looked at and/or correlated with client complaints, for example, is significant.
Among the problems associated with the CSS is the tendency to ask questions of clients, while maintaining the provider/organizational perspective mentioned earlier. The organization develops survey and other instrumentation based on its need to reassure itself that its mission is being carried out. This may have more to do with the organization's need to be satisfied, as opposed to learning about the real dissatisfaction level of consumers.

This universal tendency in CMHCs has implications for the frequency and scope of administration and for what happens to the findings of CSS activities. Satisfaction is assessed relatively infrequently with no clear use made of the data obtained (McPhee, Zusman & Joss, 1975). Studies of acceptability of services were reported to have been done less often to meet a CMHC's need for information than because they were required by law, regulation or funding bodies or for other reasons not related to the improvement of services, such as the evaluator's interest in public relations (Olsen, 1980).

Additional problems with the CSS involve the length of instruments—the fact that they tend to be used primarily for outpatient programs (Kirkhart, 1980); they don't tap family or support systems (Hirsh, 1980); that they ask the wrong questions or ask them in the wrong way, too abstractly or impersonally (Levine, 1980); that they don't measure
CMHC effort in the area of Acceptability, but rather
measure evaluator interest such as client/therapist match,
and that they have minimal, practically negligible consumer
input (Sorenson et al., 1979; Flaherty & Olsen, 1979).

When confronted with issues of validity, evaluators
have tended to refine instruments rather than including
clients and their perspective in the evaluative process.
(Giordano, 1977)

Finally, while I have not come across mention of it
in the literature, CSS seldom, if ever, gets at root issues
of institutionalized racism, sexism, agism, and handicapped-
pism. These phenomena are likely present in the fabric of
all CMHCs and probably have as great an impact on consumer
satisfaction with service delivery as any other Acceptable
parameter, yet a review of CSS instruments has not surfaced
any mention of these factors.

While no cost-benefit analyses have been done, it has
been noted that the costs of not doing consumer outcome
research may be too high in terms of not knowing the effec-
tiveness of services and not having consumer data to re-
pond to the legitimate concerns of those who fund CMHC
programs, third-parties, and local, State, and Federal leg-
islators and officials. (Shamblatt, 1980)

While there is much to be learned from the studies
cited in this review, one clear gap is that no study
focuses on the relationship between the policies and procedures that a CMHC develops to direct and operationalize its intentions and the perception of clients as to the manner in which services are being provided. The following chapters have been directed specifically toward this purpose.
CHAPTER III
RESEARCH DESIGN AND METHOD

This chapter describes the population of interest, the sampling method, and the sample size. It also describes the instrumentation utilized to gather information regarding CMHC policies and to assess client satisfaction. In addition, it discusses the procedures for administering the instruments and collecting the data and describes how the data will be analyzed to address each of the research questions.

Description of the Sample

The sample studied are outpatients at two CMHCs. The only individuals specifically excluded from this sample were those clients receiving an emergency service intervention at the time the questionnaire was administered. This group was by definition, in extreme crisis, and the administration of an instrument at this point would not be appropriate.

The sample was drawn from the active caseloads of two CMHCs which have not administered a client satisfaction survey within the past year. The two centers included in this study were matched along the following key dimensions
utilized by NIMH to categorize CMHCs:

1. Size of budget;
2. Type and size of staff;
3. Type of population served—percentage of acute, aftercare, etc.;
4. Number of clients served;
5. Demographic aspects of the catchment area, i.e., semi-rural, ethnic population pockets;

and found to be comparable in all of the areas.

While matched on these dimensions, the centers were polar in terms of the consumer orientation of their policies as measured by Instrument I. In constructing the study in this manner, clear statements have been made regarding the relationship between the variables studied.

The specific sampling procedure was simple random sampling. Center 1 was the Center with absent or weak consumer orientation in its policies; Center 2 was the Center with a high degree of consumer orientation in its policies. The Consumer Satisfaction Survey, found in Appendix A, was administered to 44 clients in Center 1 and 43 clients in Center 2 on May 12, 1985, an arbitrarily chosen date. Selecting the clients in this manner assured a reasonable representation of all types of clients seen in a CMHC program and is the method that the Joint Commission on the Accreditation of Hospitals (JCAH) employs to sample client
satisfaction in CMHC's applying for JCAH Accreditation.

**Hypotheses to be Tested**

The literature on client satisfaction consistently reflects high degrees of satisfaction across the board. Given that there is probably considerable variance among over 2,000 CMHCs nationally, regarding the degree of consumer orientation of their policies, the suspiciously high consumer satisfaction levels reported suggest that it would be useful to state the problem to be investigated utilizing the following null hypotheses:

**Hypothesis 1**

There is no significant relationship between client awareness of policies and procedures and the degree of expressed client satisfaction with the manner in which services are perceived as being provided.

**Hypothesis 2**

There is no significant relationship between the consumer orientation of CMHC policies and the degree to which clients are satisfied with the manner in which their confidentiality is maintained.

**Hypothesis 3**

There is no significant relationship between the consumer orientation of CMHC policies and the degree of
expressed client satisfaction with the manner in which payment for services is handled.

**Hypothesis 4**

There is no significant relationship between the consumer orientation of CMHC policies and the degree to which clients are satisfied that their rights are protected.

**Hypothesis 5**

There is no significant relationship between the consumer orientation of CMHC policies and the degree to which clients are satisfied that they have been treated in a dignified manner.

**Hypothesis 6**

There is no significant relationship between the consumer orientation of CMHC policies and the degree to which clients are satisfied with their involvement in their treatment planning.

**Hypothesis 7**

There is no significant relationship between the consumer orientation of CMHC policies and the degree to which clients are satisfied with the accessibility and availability of services.
Hypothesis 8

There is no significant relationship between the consumer orientation of CMHC policies and the overall degree of client satisfaction with the manner in which services in general are provided.

This study was designed as correlational research and as such explored the relationship between the variables identified. The strength of the study is in the size and representativeness of the sample and the correlational statistics applied.

In order to address each Hypothesis, cross tabulations of strength of each policy as rated by Instrument I with level of satisfaction of clients as ascertained by the Client Satisfaction Survey were performed. A chi-square statistic was calculated to assess the strength of this relationship. Findings were statistically significant at the level of <.05.

With respect to the research question, "Are there areas that clients identify as related to the Acceptability of services that are not addressed by CMHC policies and procedures?", an analysis was performed of the responses elicited through the open-ended questions. This involved identifying responses that were different from those solicited in the multiple choice questions, categorizing them and exploring areas of significant new concerns.
Instrumentation

In order to conduct this research, two instruments were developed and tested. Instrument I is a guideline which was used by the researcher to rate the "strength" of the consumer orientation of CMHC policies in specific areas, i.e., those dealing with Acceptability. This guideline, developed specifically for the above purpose by a consumer operated project (Colom, 1981) is objective in that it presents seven criteria for consumer-oriented policies of CMHC. If a specific criterion is present, then it is noted as present. The validity of this guideline derives out of the fact that it has met the need of CMHC administrators and policy-makers to look at the orientation of CMHC policies. The instrument was utilized in the following manner: Each policy area, i.e., Confidentiality, Rights, etc. was rated on a scale of 0-7, based on the allocation of one point for each of the criteria present. A score of zero indicated the absence of a policy in this area. The higher the score a policy received, the stronger the consumer orientation of the policy. For example, a score of five indicated that five of the seven possible criteria were present. A score of seven indicated that all seven criteria were present and that the consumer orientation of the policy was at the optimum level. Initially,
six centers along the eastern seaboard matched along the dimensions mentioned earlier had this guideline applied to their policies. From those, two were selected with the most variance in the consumer orientation of their policies utilizing this instrument.

The policy areas rated by this guideline were as follows:

1. Confidentiality
2. Clients' Rights
3. Costs/Fees
4. Dignified Treatment
5. Hours and Times of Availability
6. Involvement in Treatment Planning

These categories are the ones most often related to issues of Acceptability of services from the client's perspective.

Policies and procedures were rated as:

0  -- Not present
1 - 3 -- Weak
4 - 5 -- Average
6 - 7 -- Strong

**Instrument I**

A strong policy and procedure was one which:

1. Utilized the term "consumer";
2. Utilized the device of having the client indicate his/her understanding of the policy or procedure by signing off on it;

3. Utilized lay terms--is not written in "bureaucratsese";

4. Was informative, in that it identified those who could respond to questions by name, position, address, etc.;

5. Could be used independent of aid for others;

6. Identified an external advocate or remedy outside of the CMHC;

7. Had other features that suggest an advocative, consumer-oriented intent. (Colom, 1981)

A weak policy was one that was absent many or most of these key features and which indicated an orientation which:

1. Excluded the client from participating in deliberations regarding grievances or complaints;

2. Maintained the client in a passive and dependent role;

3. Limited the rights of clients as citizens to due process or hindered the client in pursuing any legal rights, i.e., the right to have access to one's clinical record;

4. Had other features which would suggest that the client is not considered in the application of the policy. (Colom, 1981)
Because of the manner in which CMHCs have developed and organized their policies and procedures, the rater did not have difficulty in locating and rating the policies of each center using the above criteria and scale.

Examples of both strong and weak consumer-oriented policies can be found in the Appendices. Center 2 (Appendix B) reflects many of the attributes of a strong policy and procedure. From Center 1 (Appendix C), many of the elements of a weak policy are reflected.

Based on the researcher’s review and rating of policies utilizing Instrument I, it was found that Center 1 had a score of 10 out of 42:

1. Confidentiality 2
2. Clients' Rights 1
3. Costs/Fees 4
4. Dignified Treatment 0
5. Hours and Times 2
6. Involvement in Treatment Plan 1

Center 2 had a score of:

1. Confidentiality 6
2. Clients' Rights 7
3. Costs/Fees 6
4. Dignified Treatment 7
5. Hours and Times 7
6. Involvement in Treatment Plan 6
for a total of 39 out of a possible 42.

The consumer orientation of Center 2 was clearly and demonstrably higher than Center 1.

The second instrument utilized in this research was a consumer satisfaction instrument which was administered to the 86 clients in the sample (see Appendix A).

Client satisfaction surveys have been generally found to be valid and reliable measures of the satisfaction levels of consumers of services (Balch et al., 1977; Heinemann & Yudin, 1974; McFee, Zusman & Joss, 1975). The specific questions on this instrument are ones that are generally used in client satisfaction surveys. Many of the questions have been borrowed from the CSS utilized nationally by the Joint Commission on the Accreditation of Hospitals (CMHC Division) and based on administration over a 12-year period in the accreditation of 200 CMHCs sampling over 16,000 clients. The survey questionnaire is both reliable and valid. Other questions have been developed to either further explore certain areas of satisfaction/dissatisfaction or to elicit, in an open-ended format, further information regarding satisfaction/dissatisfaction. This instrument asked clients to respond to certain questions organized by category. The questions were developed to gather data on the manner referred to earlier in which clients experience or feel about how CMHC policies and
procedures are operationalized. For example, utilizing the policies and procedures in Appendices B and C which relate to an aspect of the category, "Clients' Rights," the client would be asked the following questions:

I have read or am aware of clinic policies regarding:

Clients' Rights

--If you had a complaint, would you know who to direct it to? Yes____
No____

--If you are taking medicine prescribed by our clinic, how satisfied do you feel that the purpose for taking the medicine was explained to you? Satisfied____
Usually Satisfied____
Usually Unsatisfied____
Never Explained____
No Medicine Prescribed____

--Have the side effects of the medicine that we are prescribing for you been explained to you? Yes____
No____
No Medicine Prescribed____

--If you asked to read your record, do you think you would be allowed to? Yes____
No____
--Do you generally feel satisfied
that your rights as a client are
observed? Yes
No

In this manner, information regarding the client's perception of each key Acceptability area in this instance, Clients' Rights, was gathered.

Specific demographic information was not requested in this CSS. It has been found that there is no statistically significant relationship between the typical demographic stratifications and client satisfaction (Gloyne & Ladout, 1973; Venner & Halprin, 1975; Edwards et al., 1978; Galch et al., 1977; Frank et al., 1977; Larson et al., 1979). However, since it was speculated based on the researcher's experience that there might be a relationship between time in treatment and certain other variables, Question 24 was inserted.

The instrument was explained to the Chief Executive Officers and/or Clinical Directors of the participating CMHCs and sufficient copies provided so that each of the clients in the sample could voluntarily fill one out. The questionnaire with accompanying instructions (see Appendix A) were distributed to each client attending with instructions to fill it out in the waiting area just before his/her scheduled appointment. If the client was illiterate
or unable to give a written response, the receptionist was available to help. The survey was not filled out in the presence of the client's therapist. Completed questionnaires were placed in a box so marked and at the end of the business day placed in the pre-addressed stamped container to be returned to the researcher for preparation for statistical analysis. Clients completed the questionnaire in less than four minutes on the average.
This study has examined the relationship between the consumer orientation of key community mental health center policies and procedures and the degree of expressed client satisfaction with the manner in which services are provided.

Each of the eight hypotheses states that there is no relationship between the consumer orientation of a specific CMHC policy and procedure(s) and the degree of expressed client satisfaction. These hypotheses were tested utilizing cross tabulations of the strength of each policy as rated by Instrument I with the level of satisfaction of clients as ascertained by the Client Satisfaction Survey, Instrument II. A chi-square statistic was used to assess the strength and direction of this relationship. Based on these statistical procedures, the data generated by the survey instrument was analyzed from a number of perspectives.

The first series of relationships investigated focused on the relationship between the consumer orientation of policies and the level of awareness on the part of clients that the policies existed. This was ascertained by asking:
1. If clients were aware that the Center had policies, generally speaking; and

2. Whether they were aware of policies/procedures in the specific key areas investigated.

Frequencies were analyzed to see what phenomena surfaced in each group and then in the combined sample. This provided a sense of how client populations in the sample experienced policies and expressed their satisfactions or dissatisfactions. It also pointed to areas that might need to be further investigated as well as areas that could help to focus attention in a comparison of the two Centers.

This approach to the data analysis was helpful in that it permitted differences at various statistical and inferential levels to emerge. For example, while an analysis of combined frequencies suggests overall that satisfaction levels are consistent with those generally reported in previous studies, certain areas emerge as inconsistent with previous findings.

The data which reflects the relationship of consumer orientation of policies to client awareness of the existence of policies is found in Appendix D.

Response by Center Membership

When one looks at the Centers separately, clear differences emerge. For example, in Center 2, the Center with
a high degree of consumer orientation, significantly more clients knew that policies existed. In Center 1, the Center with low/absent consumer orientation, more clients did not know about the existence of policies and of the procedures that they need to utilize to articulate, protect and promote their rights. In Center 2, 100 percent of the sample knew that, generally speaking, policies and procedures existed. In Center 1, the Center with weak or absent consumer orientation, not everybody knew whether the Center had policies and procedures.

With respect to the six categories of specific policies, the Center with a high degree of consumer orientation had a large percentage of clients who knew of the existence of policies in the areas of Confidentiality, Clients' Rights, Fees, Grievance Procedures, Right to Read their Records, and Involvement in Treatment Planning. The Center with low or absent consumer orientation had more people who did not know about the existence of these specific policies.

**Confidentiality**

In the Center with a high degree of consumer orientation (Center 2), 100 percent of the respondents knew of the Center's policy regarding Confidentiality. In Center 1, only 71 percent of the clients knew about the existence of this policy. Additionally, the significance of this difference is magnified by the fact that the issues around
confidentiality are the "sacred cow" of the mental health field and one would expect to find 100 percent of clients in every Center aware of these policies.

Clients' rights

In Center 1, 64 percent did not know about Clients' Rights Policies. In Center 2, only 14 percent did not know about Clients' Rights Policies.

Fees

In Center 1, 36 percent of the clients sampled did not know about Fees Policies; in Center 2, only 14 percent did not know. This is a significant finding in that it is possible to infer that in the Center with low consumer orientation many clients were not aware of their right to have services provided on a sliding fee scale basis.

Client grievances

In Center 1, 82 percent of the clients surveyed did not know that the Center had a policy and procedure regarding clients lodging complaints. In the Center with high consumer orientation, only 33 percent were not aware of this policy.

Right to read one's records

In Center 1, 70 percent of the clients surveyed did not know that the Center had a policy regarding their right
to read their clinical record, if they asked to. In Center 2, only 24 percent did not know. This is an important finding in that both Centers state they have legal regulations which require that clients be informed of this right.

Involvement in treatment planning

In Center 1, 73 percent of the clients in the sample were not familiar with a policy which related to their involvement in their treatment planning. In Center 2, only 14 percent did not know.

In summary, the significance of the preceding data displays and analysis is that in every area of policy articulation, the clients of the Center that had a low or absent level of consumer orientation in its policies were significantly less aware of the existence of the types of policies asked about and by inference were significantly less knowledgeable about their rights and responsibilities vis-a-vis these areas than clients sampled in the Center where there was a high level of consumer orientation (Center 2). In Center 2, clients were significantly more aware of policies generally and specifically and consequently more aware of their legitimate rights and responsibilities as service consumers.
Responses in the Total Sample

With this information in mind, both Centers were combined in order to allow for a view of a larger sample and to see if any other differences emerged.

While (1) 84 percent of the total sample was aware of confidentiality policies, (2) 74 percent of fee scale, (3) 94 percent with availability of service hours, (4) 87 percent with time elapsed between crisis and response, (5) 86 percent thought they would be allowed to read their record, and (6) 99 percent did not experience racial, sexual, religious, or handicap discrimination, etc., only (1) 60 percent were aware of clients' rights, (2) 40 percent aware of clients' grievance procedures, (3) 44 percent were aware of the right to participate in treatment planning, (4) 52 percent of those taking medicine did not have side effects explained, (5) 45 percent did not know to whom to complain, and (6) 22 percent never had their treatment plan explained (and another 15% explained only once).

What seems to be reflected in this data is that while general satisfaction in the combined sample is high and well within the parameters of the findings of other studies (Larsen, Attkisson, Hargreaves, & Nguyen, 1979), satisfaction levels with the procedures that operationalize these policies for clients is significantly less.
In summary, the preceding presentation and analysis of data reflects that the greater the consumer orientation in the CMHC policies studied, the greater the awareness on the part of the clients in the study of policies in key areas. With this in mind, Hypothesis I was tested.

Testing Hypothesis 1: Hypothesis 1 states that there is no significant relationship between the awareness on the part of the client that policies exist in key areas and the degree of expressed client satisfaction with the manner in which services in those areas are perceived as being provided. This hypothesis was operationalized in Questions 1 and 2.

H1a. Q1. I am generally aware that the clinic policies and procedures: Yes___ No___

Q2. I have read or am specifically aware of clinic policies on:

H1b. Confidentiality ___

H1c. Clients' Rights ___

H1d. Fee Scale ___

H1e. Client Grievances ___

H1f. Right to Read My Record ___

H1g. Right to Participate in my Treatment Planning ___
Given the findings regarding clients' awareness of policies, Hypothesis 1 was tested by combining the data from both Centers and analyzing the responses of the total sample. Significant findings regarding the relationship between the awareness of the existence of policies and the degree of expressed client satisfaction are evident. Tables 11 through 18 (Appendix D) present the relevant data for the sub-hypotheses related to Hypothesis 1.

Confidentiality

Of clients in the total sample who were familiar with the Confidentiality Policy, 85 percent were "ALWAYS" satisfied that their confidentiality was never breached while of those in the sample that did not know about the policy, only 77 percent felt that their confidentiality had never been breached.

Medication purpose

Of those clients in the total sample who knew specifically of policy(ies) regarding Clients' Rights, 60 percent were generally satisfied that the purposes of the medication they were taking (if any) was explained. Of those who did not know of these policies, only 26 percent were generally satisfied.
Medication side effects

Of those in the total sample who were familiar with Clients' Rights policy(ies), 54 percent were satisfied that the side effects of the medicine they were taking were satisfactorily explained. Of those who did not know specifically of a Clients' Rights policy, 18 percent were satisfied with the explanation of side effects.

Right to read one's record

Of the clients in the total sample who were aware of a policy(ies) regarding Clients' Rights, 94 percent felt that if they asked to read their record, they would be allowed to do so. Of those in the total sample who were not aware of such a policy(ies), only 73 percent thought they would be allowed to read their record.

Of the clients in the total sample who were familiar with a specific policy that operationalized the Right to Read Client Records, 98 percent felt that if they asked, they would be allowed to. Of those who did not know of such a policy(ies), 71 percent felt they would be allowed to read their clinical record.

Client grievances

Of the clients in the total sample who had knowledge of a specific policy(ies) regarding Client Grievances, 77 percent felt they knew with whom to lodge a complaint. Of
those who were not aware of such a policy(ies), only 39 percent felt they knew to whom to complain.

Of interest is the fact that while there is a positive relationship between knowledge of the Clients' Rights policies and the specific sub-categories of Clients' Rights, i.e., right to be informed of medication side effects, read your record, etc., there is no significant relationship between knowledge of these policies and general satisfaction that the Clients' Rights are being observed. The general question seems to be answered in a more collapsed, impressionistic way than the responses to the specific component parts suggests. This finding may have implications for the structuring of survey instruments for future Client Satisfaction Surveys and help to explain the phenomenon of generally high levels of expressed satisfaction, as most surveys simply ask general questions about general satisfaction.

Fees

Of those clients in the total sample who knew specifically of policies regarding fees, 95 percent were either always or often satisfied with the manner in which fees were collected. Of those who did not know about such a policy, 88 percent were satisfied with the manner in which fees were collected.
Involvement in treatment planning

The data reflects that while not statistically significant, in the categories of "2-3 TIMES and CONTINUOUSLY," clients who knew about the policy indicated that they were involved in Treatment Planning approximately 1.5 times more than those who did not know of the policy.

Again, while not statistically significant, the data indicates that over 1.5 times more clients who knew of Treatment Involvement policies either "ALWAYS" or "OFTEN" felt in control of the services they were receiving.

Levels of significance for each of the sub-hypotheses are shown in Tables 11 through 19 (Appendix D). Sub-hypotheses in the areas of relationship between knowledge of policy and satisfaction with the manner with which policies are operationalized for Confidentiality, Clients' Rights, Fee Scale, Client Grievances, and Right to Read One's Clinical Record were rejected.

The sub-hypothesis regarding the relationship between knowledge of policies in the area of Involvement in Treatment Planning and the manner with which involvement is perceived was not rejected.

Hypothesis 1 is partially accepted.

Involvement in Treatment Planning is the one area of all those investigated which reflects the general societal attitudes toward patient-therapist relations and the
application of a variety of schools of psychiatric and psychological practice which deem the provider/practitioner to be the "expert" and the client to be a passive receptor of treatment.

In the Center with a high degree of consumer orientation, there were specific rights that clients were informed of in relation to participation in Treatment Planning, including the provision that the client "sign-off" on his/her Treatment Plans. While a relationship between this Center's consumer orientation and knowledge of this policy is significant at the .0000 level and while there seems to be a direction towards a positive relationship between knowledge of policies in this area and actual client perception, it is not statistically significant. Further investigation should be undertaken in this area.

In summary, client knowledge of policies increased satisfaction, specifically in areas involving confidence in confidentiality, knowledge of grievance procedures, knowledge of right to read one's record, and involvement in and perception of being in charge of one's treatment planning.

Testing Hypothesis 2: Hypothesis 2 states that there is no significant relationship between the consumer orientation of C.M.H.C. policies and the degree to which clients are satisfied with the manner in which confidentiality is
maintained. This hypothesis is operationalized in Questions 17, 18, and 19.

H2a. Q17. How often do you feel that the staff has given or gotten information to/from your family without receiving your permission beforehand?  

- Never___  
- Occasionally___  
- Often___  
- Always___

H2b. Q18. How often do you feel that the staff has given or gotten information from other mental health, health or social service agencies without your permission beforehand?  

- Never___  
- Occasionally___  
- Often___  
- Always___

H2c. Q19. Generally speaking, how satisfied are you that your confidentiality is respected?  

- Always___  
- Often___  
- Occasionally___  
- Never___
Tables 20 through 22 (Appendix D) display the relevant data for this hypothesis.

Of those respondents in the Center with a high degree of consumer orientation, 93 percent felt satisfied that their confidentiality with their families had never been breached. In the Center with low/absent consumer orientation, 88 percent felt that confidentiality had never been breached. While not statistically significant, it is worth noting that in the Center with low/absent consumer orientation, almost two and one-half times more respondents felt that their confidentiality vis-a-vis family was occasionally breached.

The data reflects that there is no significant relationship between the consumer orientation of CMHC policies, specifically in the area of Confidentiality policies and the general satisfaction with the manner in which confidentiality is maintained.

All sub-hypotheses related to Hypothesis 2 are accepted and Hypothesis 2 itself is accepted.

Testing Hypothesis 3: Hypothesis 3 states that there is no significant relationship between the consumer orientation of C.M.H.C. policies and the degree of client satisfaction with the manner in which payment for services is handled.
This hypothesis is operationalized in Questions 14, 15, and 16.

H3a. Q14. Do you feel that the fees you are paying are:
   Just Right____
   Too Little____
   A Little Too Much____
   Much Too Much____

H3b. Q15. How often are you satisfied with the way fees are collected from you?
   Always____
   Often____
   Occasionally____
   Never____

H3c. Q16. Do you generally feel satisfied that you are receiving value for your dollar spent on mental health services?
   Yes____
   No____

Tables 23 through 25 (Appendix D) show the relevant data for this hypothesis.

There is no significant relationship between the consumer orientation of CMHC policies and the degree of client satisfaction with the manner in which payment for services is handled.
The levels of significance for the sub-hypotheses of Hypothesis 3 are displayed in Tables 23 through 25 (Appendix D).

All the sub-hypotheses are accepted and Hypothesis 3 is accepted.

**Testing Hypothesis 4:** Hypothesis 4 states that there is no significant relationship between the consumer orientation of C.M.H.C. policies and the degree to which clients are satisfied that their rights are protected. This hypothesis is operationalized in Questions 6, 7, 8, 9, and 10.

**H4a. Q6.** If you are taking medicine prescribed by our clinic, how satisfied do you feel that the purpose for taking the medicine was explained to you?  
- Satisfied___
- Usually Satisfied___
- Usually Unsatisfied___
- Never Explained___
- No Medicine Prescribed___

**H4b. Q7.** Have the side effects of the medicine that we are prescribing for you been explained to you?  
- Yes___
- No___
H4c. Q8. If you asked to read your record, do you think you would be allowed to?

Yes  No

H4d. Q9. If you had a complaint about your treatment, would you know to whom to direct it?

Yes  No

H4e. Q10. Do you generally feel satisfied that your rights as a client are observed?

Yes  No

Tables 26 through 30 (Appendix D) show the relevant data for this hypothesis.

In the Center with high consumer orientation, 67 percent of the respondents were either always or usually satisfied, that the purposes of the medicine they were taking (if any) was satisfactorily explained to them. In the Center with low or no consumer orientation, only 27 percent were in these categories. This finding is significant at the .0015 level.

Of those taking medicine, the Center which had a strong consumer orientation in its policies had three times as many clients who indicated that the side effects of the
medicine they were taking had been explained to them as the Center with weak/absent consumer orientation.

The data reflects that with the exception of the fact that most people felt they would be permitted to read their record (H4c) if they asked to do so, that in the Center with strong consumer orientation, satisfaction was higher than in the other Center in relation to the component parts of Client Rights. However, overall high satisfaction with Rights being observed is reflected in Table 30.

The levels of significance for the sub-hypotheses related to Hypothesis 4 are shown in Tables 26 through 30.

--Sub-hypothesis 4a is rejected at the level of significance of .0015.
--Sub-hypothesis 4b is rejected at the level of significance of .0001.
--Sub-hypothesis 4c is accepted.
--Sub-hypothesis 4d is rejected at the level of significance of .0041.
--Sub-hypothesis 4e is accepted.

Hypothesis 4 is partially accepted.

Testing Hypothesis 5: Hypothesis 5 states that there is no significant relationship between the consumer orientation of C.M.H.C. policies and the degree to which clients are satisfied that they were treated in a dignified manner.
This hypothesis is operationalized utilizing Questions 5, 11, 12, and 13.

H5a. Q5. How often have you had to wait more than 15 minutes for a scheduled appointment? Never___
          Occasionally___
          Often___
          Always___

H5b. Q11. Do you feel that the clinic has discriminated against you because of any of the following? (Please check any that apply):
          Race___
          Sex___
          Religion___
          Handicap___
          Other (Specify)___

H5c. Q12. If you feel that you have been treated disrespectfully, which best describes the situation you felt disrespected in?
          (Check all that apply):
          Being Admitted___
          When Fee was Set___
          Waiting in the Waiting Room___
          Response to Initial Call for Service___
In appointments with Your Counselor

Other (Specify)

H5d. Q13. How often do you feel satisfied
that you have been treated in a
respectful and dignified manner? Always
Often
Occasionally
Never

Tables 31 through 42 (Appendix D) display the data relevant to this hypothesis.

Virtually no clients felt that they were disrespected by having to wait for appointments or were discriminated against because of race, sex, religion, or handicap at any time in their treatment.

The levels of significance for the sub-hypotheses related to Hypothesis 5 are shown in Tables 31 through 42 (Appendix D).

All sub-hypotheses are accepted and Hypothesis 5 itself is accepted.

Testing Hypothesis 6: Hypothesis 6 states that there is no significant relationship between the consumer orientation of C.M.H.C. policies and the degree to which clients are satisfied with their involvement in treatment planning.
This hypothesis is operationalized in Questions 20 and 21.

H6a. Q20. How often has your treatment plan been explained to you so that you understand it?
  Once____
  Two or Three Times____
  Continuously____
  Never____

H6b. Q21. How often do you feel in control (in charge) of the services you are receiving?
  Always____
  Often____
  Occasionally____
  Never____

Tables 42 and 43 show the relevant data for this hypothesis.

The data for this question comes very close to being statistically significant. The responses reflect that in the Center with a high level of consumer orientation, clients are involved to a considerably higher degree in the development, review, and application of their treatment. Of particular interest is that almost four times as many individuals in the Center with no/low consumer orientation
indicated that they were never involved in their treatment planning.

There is basically no difference between the responses of clients at Centers 1 and 2 regarding their perception that they were in charge of the treatment they were receiving.

Levels of significance for the sub-hypotheses related to Hypothesis 6 are shown in Tables 42 and 43 (Appendix D).

All sub-hypotheses are accepted and Hypothesis 6 itself is accepted.

Testing Hypothesis 7: Hypothesis 7 states that there is no significant relationship between the consumer orientation of C.M.H.C. policies and the degree to which clients are satisfied with the accessibility and availability of clinic services.

This hypothesis is operationalized in Questions 3 and 4.

H7a. Q3. Do you generally feel satisfied that the days and hours that the clinic is open meets your needs for appointment times?  

   Yes___  
   No___

If you checked "No," what days/hours would you like? ________________________
H7b. Q4. Do you feel that the time between your first contact with us (phone call) and your first clinic appointment was:

Too Long___

Just Right___

Tables 44 and 45 show the relevant data for this hypothesis.

Virtually all clients in both Centers were satisfied with the days and times that the Center was open.

Virtually all clients in both Centers were satisfied with the promptness of the clinic's response to their initial request for services.

Levels of significance for the sub-hypotheses related to Hypothesis 7 are shown in Tables 44 and 45 (Appendix D).

All sub-hypotheses were accepted and Hypothesis 7 itself is accepted.

Testing Hypothesis 8: Hypothesis 8 states that there is no significant relationship between the consumer orientation of C.M.H.C. policies and the overall degree of client satisfaction with the manner in which services in general are provided.

This hypothesis was tested utilizing the data gathered in Questions 22, 23, and 24 on Instrument 2, the Consumer Satisfaction Survey.
H8a. Q22. You came to the clinic with certain problems—generally speaking, how are those problems now? 

- Much Better___
- A Little Better___
- A Little Worse___
- Much Worse___

H8b. Q23. If a friend were in need of similar help, would you recommend our clinic to him/her? 

- Yes___
- No___

H8c. Q24. In an overall general sense, how satisfied are you with the services you received? 

- Very Satisfied___
- Mostly Satisfied___
- Mostly Dissatisfied___
- Very Dissatisfied___

Tables 46 and 47 show the relevant data for this hypothesis.

In the Center with a high degree of consumer orientation in its policies, 63 percent of the respondents indicated that the problems that they came to the Center with were much better. In the Center with low/no consumer orientation in its policies, only 42 percent indicated that
their problems were NEVER better. While this finding is not statistically significant, it does point to the direction of a positive association between the policy orientation of Center 2 and overall sense of improvement.

Again, while not statistically significant at the less than the .05 level, this finding suggests two directions. First, the finding is consistent with other research in the area of client satisfaction in that virtually all clients are either very satisfied or mostly satisfied. There were no clients who were mostly or very dissatisfied. Again, however, as with the response to Question 22, this data seems to point to a direction in the relationship between high degrees of consumer orientation in policies and overall satisfaction with the manner in which services are delivered. In the Center with high consumer orientation, 67 percent were very satisfied with the general manner in which services were delivered; in the Center with low/no consumer orientation, only 48 percent of the respondents indicated that they were very satisfied with the manner in which services were delivered.

Levels of significance for the sub-hypotheses related to Hypothesis 8 are shown in Tables 46 and 47 (Appendix D).

All sub-hypotheses are accepted and Hypothesis 8 itself is accepted.
Additional Hypotheses Tested

As the data was analyzed, a number of cross tabulations yielded interesting results, some of which were briefly followed up on in the study. These called for the development of additional hypotheses which relate to the extent to which a temporal variable, that is length of time in treatment may influence the degree of expressed client satisfaction. Both the literature and the experience of the researcher suggested that the longer a client was in treatment, the more he/she would perceive the manner in which services were provided as satisfactory.

Hypothesis 9 states that there is a significant and positive relationship between length of time in treatment and level of client satisfaction.

Hypothesis 10 states that there is a significant and positive relationship between length of time in treatment and the client's involvement in treatment planning.

Hypothesis 11 states that there is significant and positive relationship between length of time in treatment and client satisfaction with the manner in which clients' rights are observed.

Tables 48 through 50 present the data related to these hypotheses.

Cross tabulations were performed to test the strength of the relationship between the length of time in treatment
and the variable of Clients' Rights, Involvement in Treatment Planning, Overall Satisfaction with Services in each Center in the study and across both Centers.

The results of these cross tabulations presented in Tables 48 through 50 indicate that while there is a slight indication that degree of client satisfaction increases over time, there is no significant relationship either in the Center that had a "weak" consumer orientation in its policy, or in the Center that had a "strong" consumer orientation, or through combining both Centers between the variable of length of time in treatment and clients perceived involvement in treatment planning, perception of client rights, or overall general satisfaction with services provided. A limitation in this result is that the study did not attempt to discriminate between time in treatment over 12 months and degrees of client satisfaction.

--The level of significance for Hypothesis 9 is presented in Table 48. Hypothesis 9 is rejected.

--The level of significance for Hypothesis 10 is presented in Table 49. Hypothesis 10 is rejected.

--The level of significance for Hypothesis 11 is presented in Table 50. Hypothesis 11 is rejected.

Finally, the administration of this instrument included a section that solicited additional responses to
the questions, "Are there things that you are especially satisfied with?" Are there things that you are especially dissatisfied with?" The following responses were elicited:

**Dissatisfactions**

"intermittent billing so that it adds up to a large amount without being aware of it."

"I am concerned that the receptionist identifies the Center when she calls me at work."

"The effort used to get in touch with me concerning counselor's cancelling appointments is not great."

"I feel like I'm not getting any place."

"I would like better physical checkups. The clinic does not check for allergies which we all know can cause mental problems."

"My counselor changed without giving me more time to think about the change. She knew but didn't tell me."

"They made one attempt to put me into the hospital."

**Satisfactions**

"Very thoughtful, courteous staff who listens carefully to what you say."

"Flexibility, genuine concern."

"I enjoy being able to talk about things and getting an unbiased opinion on them which really helps."
"Convenient appointments, excellent counseling."

"I feel like my psychologist is totally involved with me when I come for visits."

"Everyone here is very pleasant and I have no complaints."

"My group is always dynamic. Counselor is always prompt in returning my calls."

"Eagerness to help."

"Anytime I have an emergency, there is always someone to talk to or get some advice from."

"I've been lucky enough to have the same therapist for a number of years."

"Diane's warm greeting, complete trust."

"Receptionist very pleasant, when appointment was cancelled, we were notified early."

"The compassion is great. The people are nice; it's a very understanding place."

"Counselors are excellent people and try to be conscientious."

"I received support in discussing incest."

"I received support with my daughter."

"I'm always explained to about everything."

"Groups have been very helpful."

"I really like __________________."

"I feel care and concern from the staff."
The following statements can be made about these responses:

1. The Center with high consumer orientation had twice as many satisfaction responses and twice as many dissatisfaction responses as the Center with low/no consumer orientation. One might speculate that clients feel freer to respond both positively and negatively in this environment.

2. The satisfactions reflect interpersonal concern and caring as opposed to skill and professional training.

3. The satisfactions reflect and enhance the manner in which clients perceive the received services.

The following statements can be made about the dissatisfactions:

1. The Center that had low/absent consumer orientation had 1.5 times more dissatisfactions than it had satisfactions.

2. Dissatisfactions reflect perception that people (receptionist, billing office, counselors) don't care enough.

3. The dissatisfactions tend to reinforce that the manner in which services are provided is not oriented enough to the consumer.
CHAPTER V
DISCUSSION

In the commercial world, companies invest tremendous resources in customer relations and similar activities with the notion in mind that a customer who is pleased with the services/produce he/she received is a walking advertisement for the company. Client satisfaction is "guaranteed." The contemporary maxim for success in the commercial and increasingly the public sector is to be obsessed with the customer.

It is of great concern then that this study concludes that client satisfaction either in general or with most specific aspects of the CMHC's services is not significantly related to an obsession with the customer. Since the study also clearly showed that increased knowledge of policies leads to increased satisfaction, the question can also be put, "Why aren't CMHCs educating their clients about their rights and responsibilities?" This is particularly important because of the history and tradition of the Community Mental Health Center movement which focused in part on enabling and empowering.

In the Center with weak or absent consumer orientation, clients in the sample had little knowledge of the
existence of policies and consequently no procedural knowledge of how to articulate, protect or promote their rights. Along with other indications such as the attrition of community education and prevention activities and the institutionalization of CMHC Boards, does this finding point to a re-professionalism of services in a way which infantalizes and disempowers clients?

Or is it that as client consumers we have settled for mediocrity when we should be demanding excellence? Have we accepted the average and systematically lowered our expectations? A recent article suggested that we have systematically lowered our expectations (of the way in which we are treated), and our lowered expectations have been fulfilled. We are inundated with products that occasionally work, people who fail to show up, and service-oriented organizations that have made service a four-letter word (Mescon & Mescon, 1984). Further research needs to be undertaken to determine if the findings of this study are generalizeable to other CMHCs and/or to private and group practices, the CMHC's competitors in the community mental health marketplace.

A second issue that is raised in this study is the finding that while general satisfaction with some policy areas is high and general satisfaction with the sum total of services is quite high, significantly lower levels of
satisfaction are observed when one looks at the procedural/operational building blocks of general policies, i.e., those that most directly effect clients. Clients in the sample are more dissatisfied with the component-operational aspects of a policy than the policy in general.

For example, respondents who felt they would not be allowed to read their records or did not know to whom to complain were generally satisfied that their rights as a client are observed. That clients in the sample do not generally speaking make the leap from dissatisfactions with specifics to dissatisfactions with the general manner in which the treatment experience is perceived is an interesting phenomenon which merits further study. However, this phenomenon may account for the universally high levels of satisfaction reported in the literature in spite of dissatisfactions experienced by clients.

This study suggests that instrumentation be refined to further assess these areas of dissatisfaction, as they represent a pull in the direction away from overall satisfaction. Increasingly, as competition for clients manifests itself in the marketplace, areas of dissatisfaction must be ameliorated in order to promote deeper and less ambivalent satisfaction.

It is troubling that while there is a slight indication that satisfaction increases over time in treatment,
that there is no significant relationship overall between time in treatment (up to 12 months) and general satisfaction.

Does this mean that clients began treatment satisfied and stay that way? I think not. If this finding suggests that clients stay in treatment regardless of how satisfied or dissatisfied they are with the manner in which services are provided, then are we dealing with a population that is characteristically compliant? Since the samples studied were not chronic, i.e., only one-half had been in treatment for more than 12 months, does the ambiguity of this situation, combined with the clear indication that satisfaction increases with knowledge of policies, suggest that policies and procedures be introduced to clients at the outset of treatment and reinforced throughout? In the Center, with strong consumer orientation, all clients got a client handbook. Why then did not all clients indicate that they were aware of all policies?

The manner in which clients become acquainted with or have knowledge of policy, i.e., read on the bulletin board, got a client handbook, etc. may also have impact on subsequent satisfaction and merits further investigation.

Finally, while the data is limited, it seems that in the Center where the consumer orientation was higher, clients sampled were able more often to offer additional
positive and negative statements regarding their satisfactions and dissatisfactions. A tentative inference may be drawn from this conclusion that orienting policies towards the consumer may, in conjunction with other factors, permit the expression of those additional variables which the consumer can uniquely articulate and which may be critical in the attainment and maintenance of an effective, accountable community mental health service system.
CHAPTER VI
CONCLUSIONS

This study has examined the relationship between the consumer orientation of key community mental health center policies and procedures and the degree of expressed client satisfaction with the manner in which services are provided.

It is suggested through a series of eight null hypotheses that there is no relationship between the inclusion of a consumer oriented perspective in the intent and language of policies and the level of satisfaction of clients with the manner in which they perceive they are receiving and experiencing certain aspects of the CMHC service delivery system.

Furthermore, this study adds to knowledge in the area of client satisfaction in community mental health programs by soliciting and gathering data on areas of satisfactions or dissatisfactions that appear to be different from or substantial variations on those often identified in the Client Satisfaction Survey literature in mental health.

This research has concluded that in the sample studied, higher degrees of consumer orientation in Center policies is positively and significantly associated with
greater awareness of the existence of policies that direct the provision of client services.

Greater awareness makes it possible for clients to have knowledge of their rights and obligations. Less awareness makes exercise of rights and responsibilities more problematic.

Greater awareness and knowledge are positively and significantly associated with higher levels of expressed satisfaction in the areas of Confidentiality, Clients' Rights, Grievance Procedures, Collection of Fees, and Right to Read One's Own Clinical Record. This is singularly not the case with Involvement in Treatment Planning.

The study has also concluded that in the sample of CMHCs and clients investigated, that there is no positive and significant relationship between the consumer orientation of a Center and the degree of client satisfaction with the manner in which confidentiality is maintained, payment for service is handled, dignified treatment is perceived, clients' involvement in treatment planning is perceived, and accessibility of services is perceived. There is no positive or significant relationship between consumer orientation and a general sense of well-being and satisfaction.

In many of the areas associated with Clients' Rights, there was a positive and significant relationship between
consumer orientation and degree of expressed satisfaction. This becomes an especially critical finding because the other parameters focused on in this study are in fact statements of client rights, albeit in discrete areas. This finding, linked with the positive and significant association of knowledge of policies with higher degrees of client satisfaction, strongly suggests that to the extent that Client Rights generally and specifically are communicated to clients is the extent to which greater satisfaction may become evident.

The study also looked at the relationship between length of time in treatment and Involvement in Treatment Planning, Satisfaction with Clients' Rights and General Satisfaction, and found no significant relationships.

The study also indicated that clients in the sample identified that personal concern on the part of staff was an important additional ingredient in satisfaction, and that negative personal contacts tended to reinforce dissatisfactions.

A final finding of significance in analysis of the overall sample is that there is a significant relationship between the client's perception that he/she has improved in treatment and the overall level of satisfaction with the manner in which services are being provided (see Table 51, Appendix D). The question is whether feeling improved in
treatment led to higher satisfaction or whether higher satisfaction led to a feeling of improvement. While causality cannot be inferred, this finding seemed to support the view that there is a link between the perception that services delivered in a manner that respects client dignity, rights and perspective, and the perception that the treatment has helped them get (feel) better. This is an area which deserves further attention and investigation.

This study has focused interest on the growing administrative intention in CMHCs to "serve the customer" and consumer satisfaction, and is intended to stimulate interest in an evaluative approach which will assist CMHC administrators in targeting resources more appropriately to improve the efficiency, effectiveness, and accountability of the current CMHC service delivery system.
APPENDIX
APPENDIX A

CONSUMER SATISFACTION SURVEY

(Sample)

Dear Client:

We want to provide you with the best quality mental health service available. In order for us to know what we're doing well and what we need to improve, we need your help.

The following questions have to do with some of the things that we feel are important for us to hear from you about.

Your answers are completely anonymous. Please be assured that we will use them to improve our services. Thank you in advance.

Sincerely,

Executive Director

Directions

On the next few pages are a series of questions that have to do with the way you feel about your experience as a client in our mental health clinic. There are no right
or wrong answers. We want to know what you think about some of the things that you have experienced here.

Please read each question carefully. In most questions you will be asked to check your answer.

Example 1. Did you hear about us from another client?
(Please check one) Yes ___
No ___

Example 2. How often are you satisfied with the services you receive?
Always ___
Often ___
Occasionally ___
Never ___

It should take less than five minutes to complete this questionnaire. When you are finished, please place this in the container marked "Completed Questionnaires."

Thank you again for your cooperation.
Consumer Survey

Please place a check next to all that apply:

1. I am generally aware that the clinic has policies and procedures. Yes___  No___

2. I have read or am specifically aware of clinic policies on:
   - Confidentiality___
   - Clients' Rights___
   - Fee Scale___
   - Client Grievances___
   - Right to Read My Record___
   - Right to Participate in My Treatment Planning___

3. Do you generally feel satisfied that the days and hours that the clinic is open meets your needs for appointment times? Yes___  No___
   If you checked "No," what days/hours would you like? __________________

4. Do you feel that the time between your first contact with us (phone call) and your first clinic appointment was: Too Long___  Just Right___
5. How often have you had to wait more than 15 minutes for a scheduled appointment? Never
    Often
    Occasionally
    Always

6. If you are taking medicine prescribed by our clinic, how satisfied do you feel that the purpose for taking the medicine was explained to you? Satisfied
    Usually Satisfied
    Usually Unsatisfied
    Never Explained
    No Medicine Prescribed

7. Have the side effects of the medicine that we are prescribing for you been explained to you? Yes
    No
    No Medicine Prescribed

8. If you asked to read your record, do you think you would be allowed to? Yes
    No

9. If you had a complaint about your treatment, would you know to whom
10. Do you generally feel satisfied that your rights as a client are observed?

Yes____

No____

11. Do you feel that the clinic has discriminated against you because of any of the following? (Please check any that apply)

Race____

Sex____

Religion____

Handicap____

________________ Other (Specify)____

12. If you feel that you have been treated disrespectfully, which best describes the situation you felt disrespected in?

(Check all that apply)

Being Admitted____

When Fee was Set____

Waiting in the Waiting Room____

In Appointments with Your Counselor____

Response to Initial Call for Service____

________________ Other (Specify)____
13. How often do you feel satisfied that you have been treated in a respectful and dignified manner?
   - Always____
   - Often____
   - Occasionally____
   - Never____

14. Do you feel that the fees you are paying are:
   - Just Right____
   - Too Little____
   - A Little Too Much____
   - Much Too Much____

15. How often are you satisfied with the way fees are collected from you?
   - Always____
   - Often____
   - Occasionally____
   - Never____

16. Do you generally feel satisfied that you are receiving value for your dollar spent on mental health services?
   - Yes____
   - No____
17. How often do you feel that the staff has given or gotten information to/from your family without receiving your permission beforehand? 
   Never___
   Occasionally___
   Often___
   Always___

18. How often do you feel that the staff has given or gotten information from other mental health, health or social service agencies without your permission beforehand? 
   Never___
   Occasionally___
   Often___
   Always___

19. Generally speaking, how satisfied are you that your confidentiality is respected? 
   Always___
   Often___
   Occasionally___
   Never___

20. How often has your treatment plan been explained to you so that you
21. How often do you feel in control (in charge) of the services you are receiving?

Once____
Two or Three Times____
Continuously____
Never____

22. You came to the clinic with certain problems—generally speaking, how are those problems now?

Always____
Often____
Occasionally____
Never____

23. If a friend were in need of similar help, would you recommend our clinic to him/her?

Yes____
No____
24. In an overall general sense, how satisfied are you with the services you received?  

   Very Satisfied___
   Mostly Satisfied___
   Mostly Dissatisfied___
   Very Dissatisfied___

25. Are there things about the services you received or the way you received them that you are especially DISSATISFIED with? (Please list)

26. Are there things about the services you receive or the way you receive them that you are especially SATISFIED with? (Please list)

27. Approximately how long have you been receiving services here?  

   Less Than Month___
   1 - 3 Months___
   3 - 6 Months___
More Than 6 Months
More Than A Year

IF YOU WOULD LIKE US TO RESPOND TO YOUR COMMENTS:

Name_______________________________________
Address_____________________________________
Phone_______________________________________

Thank you for taking the time to fill out this questionnaire. I can assure you that the results will be used to improve our services.
APPENDIX  B

CLIENT RIGHTS AND GRIEVANCE PROCEDURE

--Staff Policy--

(Center 2)

Principle: It is an essential part of the services pro-
vided by the ________________ that every consumer be
aware of their rights concerning treatment and services,
and that every effort be made to ensure those rights.

Basic Requirements

1. An explanation of consumer rights must be promi-
   nently displayed in each facility.

2. Each client upon entry into the ___ system must
   be given a written explanation of their rights as clients.
   If the person cannot read, the rights must be read to them.

3. If a client does not speak and/or read English,
   they must be either given a copy of their rights as cli-
   ents written in a language they understand or their rights
   must be explained to them by a translator.

4. Each client's file must contain a signed statement
   that they have heard or been read their rights as clients
   and understand them.
5. Every effort must be made to ensure that client rights are protected during each phase of their contact with ________.

6. Any client complaint or grievance must be dealt with quickly and responsively.

Responsibility

1. It is the responsibility of every _____ employee, volunteer, or student in placement to ensure that the rights of the consumers with whom they deal are protected.

2. Clinic personnel, Organizational Unit Directors, and supervisory personnel must constantly monitor _____ services to ensure that client rights are protected.

Procedure

1. There shall be a copy of the rights of _____ consumers prominently displayed in each facility.

2. Written explanations of consumer rights shall be available, and easily accessible, at every _____ location.

3. Clinicians/Organizational Unit Directors shall be responsible to ensure that non-English speaking consumers are effectively informed of their rights by either foreign language translations of the written policy or by translator.
4. Each client's file must contain a signed statement that the client has either read, or been made aware of, their rights as consumers.

5. _____ policy shall specify a formal mechanism for facilitating client expression of opinions, recommendations, and grievances.

6. Each sub-unit and program of _____ may promulgate a set of policies and procedures which meets the needs of their consumer constituents, if requested. The policies and procedures must be in writing, understandable, and readily accessible to consumers.

7. Each sub-unit and program shall maintain a file of consumer comments and grievances specifying what action was taken in each instance.

8. Any client feedback must be responded to formally within 30 days.

Documentation

1. Appended is the format for notification of consumer rights:

Clients' Rights (Staff Policies)

A. All clients will be given a client's rights handout or an explanation of rights at their Intake Evaluation. That this explanation has been given will be documented on the referral sheet in the client record.
B. The client's right to services cannot be denied because of race, creed, color, national origin, sex, sexual orientation, handicap, criminal record, or political orientation.

C. We cannot refuse or restrict services because of a client's inability to pay.

D. The client has a right to receive therapy in the least restrictive manner possible. With each level of penetration into the system, we must document in the client's record why it was necessary and why less absorption was unsuitable.

E. The client has a right to request a therapist of his/her choice. When we cannot fill a request, other alternatives will be offered.

F. The client has the right to refuse to participate in a particular treatment option or service (group therapy, Day Hospital, etc. . . .).

G. The client has the right to participate in the development of his/her Individual Treatment Plan and the right to refuse to agree to any part of the contract. He/she may request a representative be present in developing the plan.

H. The client has the right to change therapists.

   (1) Every effort will be made not to interrupt the usual flow of the treatment process when
a change is being made.

(2) The current therapist must suggest a few alternative therapists to the client desiring the change.

(3) The current therapist must arrange a meeting between him/herself, the client and the new therapist before the change takes place.

(4) Clients do not have the right to continually change therapists in order to avoid progress.

I. The client has a right to see his/her record, to obtain a copy of the original, and to add comments to the original.

(1) The client must make a request in writing.

(2) The client will view the record with his/her therapist or with the unit supervisor, or with the Director of Mental Health Programs.

(3) An appointment for this must be made within one week of the client's written request.

J. The client has the right to have his/her record reviewed by the Unit Manager or Director of Mental Health Programs. A consultation will be arranged with the person conducting the review once it is completed.

K. The client has the right to give any person she/he designates access to information about his/her condition. This permission must be in writing.
(1) We strongly urge clients to offer designated persons a written report and not a full view of the record.

(2) Therapists have the right to hold such permissions for 30 days when they can document that the client was unstable when giving the permission, and that it could be detrimental to the client.

L. The client has the right to refuse medication or hospitalization unless the client has been determined to be harmful to him/herself or others. In this case, the proper legal papers must be filed prior to treatment.

M. The client's right to privacy and dignity will be protected at all times.

(1) It is the agency's responsibility to protect all client records. The agency is liable for any failure of that obligation, therefore, any staff person examining cases they have no responsibility for will be dismissed immediately. Additionally, the staff is responsible for treating their case records carefully. If you do not have a permanent office, do not leave records at a temporary location.
(2) Therapists will be discreet when discussing clients in the presence of others who are not involved in the case.

(3) Therapists who are leading groups will point out to the group members that they are all responsible for private information about each other, and that a violation of another's confidence could cost them the trust of the group.

N. Clients have a right to the most complete explanation available about the biochemical effects and side effects of medications prior to taking them. This explanation is the responsibility of the prescribing psychiatrist.
YOUR RIGHTS AS A CONSUMER
OF SERVICES OFFERED BY

________________________ represents a partnership between mental health personnel and the towns of ______
________________________ to provide mental health and other human services to area citizens.

Personnel take pride in the services offered and feel strongly that every person served should actively participate in the planning and delivery of services they receive.

Part of our obligation to our clients is to appraise each consumer of their rights and to give them every opportunity to ask questions, make suggestions, or lodge complaints.

If you feel that you are being denied any or all of the rights listed, please let us know. You may do so in a number of ways. Here are a few:

1. Tell the worker with whom you have been involved, or
2. Ask to speak to the Senior Clinical Supervisor or Unit Director, or
3. Call or write to the Executive Director, ______
________________________ at:

Healthy Lane
Everytown, MA 01234
987-6543

Letters will receive prompt, personal attention.
Rights

1. You have the right to be treated with courtesy, respect, and dignity.

2. You have the right to know generally the process through which services are offered, including the general course of treatment, and with whom you will be working.

3. You have the right to ask questions and be an active participant in the planning of the services you will receive.

4. If you have questions concerning the services you are, or will be receiving, and do not feel satisfied with the response you receive, you may request to speak with the clinical supervisor of your worker or the senior clinical supervisor in the clinic or the Organizational Unit Director, or the Executive Director.

5. You have the right to know who on the Clinic and Program level is responsible for the services you are receiving and how they may be contacted.

6. If a medication is prescribed by a _____ physician, you have the right to know what the medication is, why it is being prescribed, what it is expected to change, and general side-effects which might be reasonably anticipated.

7. You have the right to refuse to serve as a research subject and the right to refuse to be examined,
observed, or treated when the primary purpose is educa-
tional or informational rather than therapeutic.

8. You have the right to see your own record and to add information you feel is relevant to your record, subject to legal restrictions under State and Federal law.

I have read and feel I understand my rights as a consumer of services of _______________________.

[Signature]

[Date]
Complaint Procedure

If the client has a complaint about the agency, the procedure for resolving that complaint will be as follows:

1. The person receiving the complaint will immediately refer the client and/or the complaint, if written, to the Director of Mental Health Programs, or in the latter's absence, the Executive Director.

2. The Director of Mental Health Programs will inform the client of his/her right to representation and of the levels of formal grievance open to him/her.

3. The Director of Mental Health Programs will document the complaint in writing and direct the client to the Unit Manager responsible for the staff person involved in the complaint.

4. The respective Unit Manager will send to the Director of Mental Health Programs a written report of the resolution of the complaint as soon as practicable from the date of first documentation.

5. The Director of Mental Health Programs will follow-up with the client to ensure resolution, and will write a summary of all action taken.

6. All complaint material will be stored in a permanent file to be maintained by the Director of Mental Health Programs.
7. Complaint material will be brought to the Board of Directors for review on a quarterly basis.

8. This procedure will be posted in all Tri-County Mental Health offices in clear view of the Client population.

9. State agencies authorized to help in protection of rights will be posted in clear view of the client population.
Grievance of Service Consumers

The term "service consumer" may be applied to any client or relative of a client receiving direct service at the Center, to individuals or agencies making referrals or receiving consultation/education services, or to any citizen-at-large who has a complaint relative to service delivery.

Complaints About Clinical Services

These should first be directed to the primary case manager. Any complainant calling the Center to register a grievance can be told who is the case manager by the office staff, except where doing so would represent a breach of confidentiality (in that case, the complainant should call the Center Director). If satisfaction is not obtained, it is recommended that the complainant contact the Associate Director for Clinical Services. If satisfaction is still not forthcoming, the Center Director should be contacted. Should the issue remain unresolved, the complainant may
then state the grievance in written form to the Center Board President, who would be obliged to either resolve the matter directly with the Center Director, or refer the matter to the Board Corporation for resolution.

Complaints About Consultation-Education Services

These should first be directed to the Center staff member responsible for the service under question. If satisfaction is not obtained, the complainant may contact the Associate Director for Community Services. If satisfaction is still not obtained, the Center Director may be contacted directly. If resolution is not obtained at that level, the complainant may contact the Center Board President.

Complaints About Clerical, Business, Billing Procedures

Complaints about clerical or business procedures should be directed to the Associate Director for Business Management. Failing satisfactory resolution, the Agency Director should be contacted. If satisfaction is still not achieved, the Board President may be contacted.
General Complaints

Any complaints not covered in the above categories may be presented directly to the Center Director. Failing satisfaction, the complainant may submit his grievance to the Board President.
APPENDIX D

DATA ANALYSIS RESULTS
TABLE 1

Relationship Between Center Membership and Awareness of Policies in General

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SIGNIFICANCE = .0403
TABLE 2

Relationship Between Center Membership
And Knowledge of Policies by Category

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### TABLE 3

Relationship Between Consumer Orientation of Policies Regarding Confidentiality and Client Satisfaction With Which Confidentiality is Maintained

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<th>% OCCASIONALLY</th>
<th>% OFTEN</th>
<th>% ALWAYS</th>
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139
TABLE 4

General Knowledge of Existence of Policies

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RAW CHI SQUARE = 4.20513 WITH 1 DEGREE OF FREEDOM.
SIGNIFICANCE = .0403
TABLE 5

Knowledge of Policies by Center Membership

--Confidentiality

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RAW CHI SQUARE = 14.61893 WITH 1 DEGREE OF FREEDOM.
SIGNIFICANCE = .0001
### TABLE 6

Knowledge of Policy by Center Membership

--Clients' Rights

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<th>TOTAL</th>
</tr>
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<td>44</td>
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<td>36.4</td>
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RAW CHI SQUARE = 21.89293 WITH 1 DEGREE OF FREEDOM

SIGNIFICANCE = .0000
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<td></td>
<td>14.3</td>
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<td>48.4</td>
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| COLUMN | 22 | 64 | 86 |
| TOTAL  | 25.6 | 74.4 | 100.0 |

RAW CHI SQUARE = 5.50192 WITH 1 DEGREE OF FREEDOM.
SIGNIFICANCE = .0190
TABLE 8

Knowledge of Policies by Center Membership

--Client Grievances

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<td>8</td>
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<td></td>
<td></td>
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<td>51.2</td>
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RAW CHI SQUARE = 20.75582 WITH 1 DEGREE OF FREEDOM.

SIGNIFICANCE = .0000
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RAW CHI SQUARE = 18.74194 WITH 1 DEGREE OF FREEDOM.
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RAW CHI SQUARE = 29.75906 WITH 1 DEGREE OF FREEDOM.
SIGNIFICANCE = .0000
TABLE 11

Relationship Between Knowledge of Policies Re: Confidentiality
and Degree of Satisfaction that Confidentiality is Respected

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<th>COUNT ROW %</th>
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<th>OCCASIONALLY</th>
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RAW CHI SQUARE = 11.60592 WITH 3 DEGREES OF FREEDOM.
SIGNIFICANCE = .0089
### Table 12: Relationship Between Knowledge of Policy Re: Client Rights and Degree of Satisfaction Regarding the Explanation of the Purposes of Medicine

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**Raw CHI Square** = 10.45948 with 3 degrees of freedom.

**Significance** = .0150


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RAW CHI SQUARE = 11.68020 WITH 2 DEGREES OF FREEDOM.
SIGNIFICANCE = .0029
TABLE 14

Relationship Between Knowledge of the Policies Regarding Clients' Rights and the Degree of Satisfaction With Being Given the Right to Read Your Record

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<td>Knew</td>
<td>47</td>
<td>3</td>
<td>50</td>
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<td></td>
<td>94.0</td>
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<td>COLUMN</td>
<td>69</td>
<td>11</td>
<td>80</td>
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<tr>
<td>TOTAL</td>
<td>86.2</td>
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RAW CHI SQUARE = 6.75274 WITH 1 DEGREE OF FREEDOM.

SIGNIFICANCE = .0094
TABLE 15

Relationship Between Knowledge of Policy of Right to Read Your Record and Perception of Being Allowed To

<table>
<thead>
<tr>
<th>COUNT ROW %</th>
<th>YES</th>
<th>NO</th>
<th>ROW TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Didn't Know</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25</td>
<td>10</td>
<td></td>
<td>33</td>
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<tr>
<td>71.4</td>
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<td></td>
<td>43.8</td>
</tr>
<tr>
<td>Knew</td>
<td></td>
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<td></td>
</tr>
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<td></td>
<td>45</td>
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<td>97.8</td>
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<td>56.3</td>
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<td>COLUMN TOTAL</td>
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</tr>
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<td>69</td>
<td>11</td>
<td></td>
<td>80</td>
</tr>
<tr>
<td>TOTAL</td>
<td>86.2</td>
<td>13.7</td>
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RAW CHI SQUARE = 11.52561 WITH 1 DEGREE OF FREEDOM.
SIGNIFICANCE = .0007
TABLE 16

Relationship Between Knowledge of Policy Regarding Client Grievances and Knowledge of Complaint Process

<table>
<thead>
<tr>
<th>COUNT ROW %</th>
<th>YES</th>
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<th>ROW TOTAL</th>
</tr>
</thead>
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<tr>
<td>Didn't Know</td>
<td>19</td>
<td>30</td>
<td>49</td>
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<tr>
<td></td>
<td>38.8</td>
<td>61.2</td>
<td>58.3</td>
</tr>
<tr>
<td>Knew</td>
<td>27</td>
<td>8</td>
<td>35</td>
</tr>
<tr>
<td></td>
<td>77.1</td>
<td>22.9</td>
<td>41.7</td>
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<td>COLUMN</td>
<td>46</td>
<td>38</td>
<td>84</td>
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<tr>
<td>TOTAL</td>
<td>54.8</td>
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RAW CHI SQUARE = 12.13181 WITH 1 DEGREE OF FREEDOM.

SIGNIFICANCE = .0005
TABLE 17

Relationship Between Knowledge of Policy Regarding Fees and the Degree of Satisfaction with the Manner in which Fees are Collected

<table>
<thead>
<tr>
<th>COUNT ROW %</th>
<th>ALWAYS</th>
<th>OFTEN</th>
<th>OCCASIONALLY</th>
<th>NEVER</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Didn't Know</td>
<td>11</td>
<td>4</td>
<td>0</td>
<td>2</td>
<td>17</td>
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<tr>
<td></td>
<td>64.7</td>
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<td>0</td>
<td>11.8</td>
<td>22.1</td>
</tr>
<tr>
<td>Knew</td>
<td>46</td>
<td>11</td>
<td>3</td>
<td>0</td>
<td>60</td>
</tr>
<tr>
<td></td>
<td>76.7</td>
<td>18.3</td>
<td>5.0</td>
<td>0</td>
<td>77.9</td>
</tr>
<tr>
<td>COLUMN</td>
<td>57</td>
<td>15</td>
<td>3</td>
<td>2</td>
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<td>74.0</td>
<td>19.5</td>
<td>3.9</td>
<td>2.6</td>
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RAW CHI SQUARE = 8.34842 WITH 3 DEGREES OF FREEDOM.

SIGNIFICANCE = .0393
TABLE 18

Relationship Between Knowledge of Policies Regarding Involvement in Treatment Planning and the Degree to which Clients Perceive That They are Involved in Treatment Planning

<table>
<thead>
<tr>
<th>COUNT ROW %</th>
<th>ONCE</th>
<th>2-3 TIMES</th>
<th>CONTINUOUSLY</th>
<th>NEVER</th>
<th>ROW TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Didn't Know</td>
<td>7</td>
<td>11</td>
<td>9</td>
<td>11</td>
<td>38</td>
</tr>
<tr>
<td></td>
<td>18.4</td>
<td>28.9</td>
<td>23.7</td>
<td>28.9</td>
<td>44.2</td>
</tr>
<tr>
<td>Knew</td>
<td>6</td>
<td>15</td>
<td>19</td>
<td>8</td>
<td>48</td>
</tr>
<tr>
<td></td>
<td>12.5</td>
<td>31.3</td>
<td>39.6</td>
<td>16.7</td>
<td>55.8</td>
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<td>13</td>
<td>26</td>
<td>28</td>
<td>19</td>
<td>86</td>
</tr>
<tr>
<td>TOTAL</td>
<td>15.1</td>
<td>30.2</td>
<td>32.6</td>
<td>22.1</td>
<td>100.0</td>
</tr>
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</table>

RAW CHI SQUARE = 3.62362 WITH 3 DEGREES OF FREEDOM.
SIGNIFICANCE = .3015
TABLE 19

Relationship Between Knowledge of Policy Regarding Involvement in Treatment Planning and How Often Clients Felt in Charge of the Services They Received

<table>
<thead>
<tr>
<th>COUNT ROW %</th>
<th>ALWAYS</th>
<th>OFTEN</th>
<th>OCCASIONALLY</th>
<th>NEVER</th>
<th>ROW TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Didn't Know</td>
<td>14</td>
<td>10</td>
<td>13</td>
<td>1</td>
<td>38</td>
</tr>
<tr>
<td></td>
<td>36.8</td>
<td>26.3</td>
<td>34.2</td>
<td>2.5</td>
<td>44.2</td>
</tr>
<tr>
<td>Knew</td>
<td>24</td>
<td>17</td>
<td>7</td>
<td>0</td>
<td>48</td>
</tr>
<tr>
<td></td>
<td>50.0</td>
<td>35.4</td>
<td>14.6</td>
<td>0</td>
<td>55.8</td>
</tr>
<tr>
<td>COLUMN</td>
<td>38</td>
<td>27</td>
<td>20</td>
<td>1</td>
<td>86</td>
</tr>
<tr>
<td>TOTAL</td>
<td>44.2</td>
<td>31.4</td>
<td>23.3</td>
<td>1.2</td>
<td>100.0</td>
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RAW CHI SQUARE = 6.16699 WITH 3 DEGREES OF FREEDOM.
SIGNIFICANCE = .1038
### TABLE 20

Cross Tabulation of Question 17 By

Degree of Client Satisfaction

<table>
<thead>
<tr>
<th>COUNT ROW %</th>
<th>NEVER</th>
<th>Occasionally</th>
<th>ALWAYS</th>
<th>ROW TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Center 1</td>
<td>37</td>
<td>5</td>
<td>0</td>
<td>42</td>
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<tr>
<td></td>
<td>88.1</td>
<td>11.9</td>
<td></td>
<td>51.2</td>
</tr>
<tr>
<td>Center 2</td>
<td>37</td>
<td>2</td>
<td>1</td>
<td>40</td>
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<tr>
<td></td>
<td>92.5</td>
<td>5.0</td>
<td>2.5</td>
<td>48.8</td>
</tr>
<tr>
<td>COLUMN</td>
<td>74</td>
<td>7</td>
<td>1</td>
<td>82</td>
</tr>
<tr>
<td>TOTAL</td>
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<td>1.2</td>
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RAW CHI SQUARE = 2.23827 WITH 2 DEGREES OF FREEDOM.

SIGNIFICANCE = .3266
## Table 21

Cross Tabulation of Question 18 By Degree of Client Satisfaction

<table>
<thead>
<tr>
<th></th>
<th>COUNT</th>
<th>ROW %</th>
<th>NEVER</th>
<th>OCCASIONALLY</th>
<th>ROW TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Center 1</td>
<td>40</td>
<td>95.2</td>
<td>2</td>
<td>51.9</td>
<td>42</td>
</tr>
<tr>
<td>Center 2</td>
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<td>89.7</td>
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<td>48.1</td>
<td>39</td>
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<td>6</td>
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RAW CHI SQUARE = .89011 WITH 1 DEGREE OF FREEDOM.
SIGNIFICANCE = .3454
# TABLE 22

Cross Tabulation of Question 19 By
Degree of Client Satisfaction

<table>
<thead>
<tr>
<th>COUNT</th>
<th>ALWAYS</th>
<th>OFTEN</th>
<th>OCCASIONALLY</th>
<th>NEVER</th>
<th>ROW TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>CENTER 1</td>
<td>36</td>
<td>6</td>
<td>1</td>
<td>1</td>
<td>44</td>
</tr>
<tr>
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<td>81.8</td>
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<td>2.3</td>
<td>2.3</td>
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<td>0</td>
<td>41</td>
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<td>14.1</td>
<td>1.2</td>
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RAW CHI SQUARE = 1.91058 WITH 3 DEGREES OF FREEDOM.
SIGNIFICANCE = .5912
**TABLE 23**

Cross Tabulation of Question 14 By

Degree of Client Satisfaction

<table>
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<tr>
<th>COUNT ROW %</th>
<th>JUST RIGHT</th>
<th>TOO LITTLE</th>
<th>A LITTLE TOO MUCH</th>
<th>ROW TOTAL</th>
</tr>
</thead>
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<tr>
<td>Center 1</td>
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<td>3</td>
<td>39</td>
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<td></td>
<td>87.2</td>
<td>5.1</td>
<td>7.7</td>
<td>49.4</td>
</tr>
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<td>Center 2</td>
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<td>4</td>
<td>40</td>
</tr>
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<td>80.0</td>
<td>10.0</td>
<td>10.0</td>
<td>50.6</td>
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<td>COLUMN</td>
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<td>6</td>
<td>7</td>
<td>79</td>
</tr>
<tr>
<td>TOTAL</td>
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<td>7.6</td>
<td>8.9</td>
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RAW CHI SQUARE = .85761 WITH 2 DEGREES OF FREEDOM.

SIGNIFICANCE = .6513
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<th>OCCASIONALLY</th>
<th>NEVER</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
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<td></td>
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<td>2</td>
<td>39</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>50.6</td>
</tr>
<tr>
<td>Center 2</td>
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<td>68.4</td>
<td>10</td>
<td>2</td>
<td>0</td>
<td></td>
<td>38</td>
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<td></td>
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<td>49.4</td>
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<td>3</td>
<td>2</td>
<td></td>
<td>77</td>
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<td>3.9</td>
<td>2.6</td>
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RAW CHI SQUARE = 4.42636 WITH 3 DEGREES OF FREEDOM.

SIGNIFICANCE = .2190
TABLE 25

Cross Tabulation of Question 16 By
Degree of Client Satisfaction

<table>
<thead>
<tr>
<th>COUNT ROW %</th>
<th>YES</th>
<th>NO</th>
<th>ROW TOTAL</th>
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</thead>
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<tr>
<td>Center 1</td>
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<td>1</td>
<td>41</td>
</tr>
<tr>
<td></td>
<td>97.6</td>
<td>2.4</td>
<td>50.6</td>
</tr>
<tr>
<td>Center 2</td>
<td>39</td>
<td>1</td>
<td>40</td>
</tr>
<tr>
<td></td>
<td>97.5</td>
<td>2.5</td>
<td>49.4</td>
</tr>
<tr>
<td>COLUMN</td>
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</tr>
<tr>
<td>TOTAL</td>
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RAW CHI SQUARE = .00031 WITH 1 DEGREE OF FREEDOM.

SIGNIFICANCE = .9859
### TABLE 26

Cross Tabulation of Question 6 With Degree of Client Satisfaction

<table>
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<tr>
<th>COUNT ROW %</th>
<th>SATISFIED</th>
<th>USUALLY SATISFIED</th>
<th>USUALLY UNSATISFIED</th>
<th>NO MEDICINES</th>
<th>ROW TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Center 1</td>
<td>9</td>
<td>3</td>
<td>0</td>
<td>32</td>
<td>44</td>
</tr>
<tr>
<td></td>
<td>20.5</td>
<td>6.8</td>
<td>0</td>
<td>72.7</td>
<td>51.2</td>
</tr>
<tr>
<td>Center 2</td>
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<td>8</td>
<td>1</td>
<td>13</td>
<td>42</td>
</tr>
<tr>
<td></td>
<td>47.6</td>
<td>19.0</td>
<td>2.4</td>
<td>31.0</td>
<td>48.8</td>
</tr>
<tr>
<td>COLUMN</td>
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<td>11</td>
<td>1</td>
<td>45</td>
<td>86</td>
</tr>
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<td>1.2</td>
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RAW CHI SQUARE = 15.42920 WITH 3 DEGREES OF FREEDOM.

SIGNIFICANCE = .0015
TABLE 27

Cross Tabulation of Question 7 With
Degree of Client Satisfaction

<table>
<thead>
<tr>
<th>COUNT ROW %</th>
<th>YES</th>
<th>NO</th>
<th>NO MEDICINES</th>
<th>ROW TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Center 1</td>
<td>8</td>
<td>6</td>
<td>30</td>
<td>44</td>
</tr>
<tr>
<td></td>
<td>18.2</td>
<td>13.6</td>
<td>68.2</td>
<td>51.2</td>
</tr>
<tr>
<td>Center 2</td>
<td>26</td>
<td>5</td>
<td>11</td>
<td>42</td>
</tr>
<tr>
<td></td>
<td>61.9</td>
<td>11.9</td>
<td>26.2</td>
<td>48.8</td>
</tr>
<tr>
<td>COLUMN</td>
<td>34</td>
<td>11</td>
<td>41</td>
<td>86</td>
</tr>
<tr>
<td>TOTAL</td>
<td>39.5</td>
<td>12.8</td>
<td>47.7</td>
<td>100.0</td>
</tr>
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</table>

RAW CHI SQUARE = 18.38863 WITH 2 DEGREES OF FREEDOM.
SIGNIFICANCE = .0001
TABLE 28

Cross Tabulation of Question 8 With Degree of Client Satisfaction

<table>
<thead>
<tr>
<th>COUNT ROW</th>
<th>YES</th>
<th>NO</th>
<th>TOTAL ROW</th>
</tr>
</thead>
<tbody>
<tr>
<td>Center 1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>32</td>
<td>8</td>
<td>40</td>
</tr>
<tr>
<td></td>
<td>80.0</td>
<td>20.0</td>
<td>50.0</td>
</tr>
<tr>
<td>Center 2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>37</td>
<td>3</td>
<td>40</td>
</tr>
<tr>
<td></td>
<td>92.5</td>
<td>7.5</td>
<td>50.0</td>
</tr>
<tr>
<td>COLUMN</td>
<td>69</td>
<td>11</td>
<td>80</td>
</tr>
<tr>
<td>TOTAL</td>
<td>86.2</td>
<td>13.7</td>
<td>100.0</td>
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RAW CHI SQUARE = 2.63505 WITH 1 DEGREE OF FREEDOM.
SIGNIFICANCE = .1045
## TABLE 29

Cross Tabulation of Question 9 With Degree of Client Satisfaction

<table>
<thead>
<tr>
<th>COUNT ROW %</th>
<th>YES</th>
<th>NO</th>
<th>ROW TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Center 1</td>
<td>17</td>
<td>26</td>
<td>43</td>
</tr>
<tr>
<td></td>
<td>39.5</td>
<td>60.5</td>
<td>51.2</td>
</tr>
<tr>
<td>Center 2</td>
<td>29</td>
<td>12</td>
<td>41</td>
</tr>
<tr>
<td></td>
<td>70.7</td>
<td>29.3</td>
<td>48.8</td>
</tr>
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<td>COLUMN</td>
<td>46</td>
<td>38</td>
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</tr>
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<td>TOTAL</td>
<td>54.8</td>
<td>45.2</td>
<td>100.0</td>
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RAW SQUARE = 8.24538 WITH 1 DEGREE OF FREEDOM.

SIGNIFICANCE = .0041
### TABLE 30

**Cross Tabulation of Question 10 With Degree of Client Satisfaction**

<table>
<thead>
<tr>
<th>COUNT ROW</th>
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<th>NO</th>
<th>ROW TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>CENTER 1</td>
<td>42</td>
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<td>43</td>
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</table>

**RAW CHI SQUARE** = \( .98837 \) **WITH 1 DEGREE OF FREEDOM.**

**SIGNIFICANCE** = \( .3201 \)
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<th>OFTEN</th>
<th>ALWAYS</th>
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<td>51.2</td>
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<td>48.8</td>
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<td>1</td>
<td>86</td>
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<td>1.2</td>
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RAW CHI SQUARE = 6.74670 WITH 3 DEGREES OF FREEDOM.
SIGNIFICANCE = .0804
### TABLE 32

Cross Tabulation of Question 11(1)

With Degree of Client Satisfaction

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<th>ROW TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
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<td></td>
<td></td>
</tr>
<tr>
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<td>97.7</td>
<td>1</td>
<td>1</td>
<td>44</td>
</tr>
<tr>
<td></td>
<td>51.2</td>
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<td></td>
<td></td>
<td></td>
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<tr>
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<td>0</td>
<td>0</td>
<td>42</td>
</tr>
<tr>
<td></td>
<td>48.8</td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>COLUMN</td>
<td>85</td>
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<td>1</td>
<td>1</td>
<td>86</td>
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<td>TOTAL</td>
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RAW CHI SQUARE = .96578 WITH 1 DEGREE OF FREEDOM.

SIGNIFICANCE = .3257
TABLE 33

Cross Tabulation of Question 11(2)

With Degree of Client Satisfaction

<table>
<thead>
<tr>
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<th>ROW TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
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<td>1</td>
<td>2.3</td>
<td>51.2</td>
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<td>97.6</td>
<td>1</td>
<td>2.4</td>
<td>48.8</td>
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<td>2.3</td>
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<td>100.0</td>
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RAW CHI SQUARE = .00111 WITH 1 DEGREE OF FREEDOM.

SIGNIFICANCE = .9734
TABLE 34

Cross Tabulation of Question 11(3)
With Degree of Client Satisfaction

<table>
<thead>
<tr>
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<th>NO</th>
<th>ROW %</th>
</tr>
</thead>
<tbody>
<tr>
<td>CENTER 1</td>
<td>44</td>
<td>100.0</td>
</tr>
<tr>
<td></td>
<td>44</td>
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<td>42</td>
<td>100.0</td>
</tr>
<tr>
<td></td>
<td>42</td>
<td>48.8</td>
</tr>
</tbody>
</table>

<p>| COLUMN | 86 |        |
| TOTAL  | 100.0 | 100.0   |</p>
<table>
<thead>
<tr>
<th>COUNT</th>
<th>NO</th>
<th>ROW TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>CENTER 1</td>
<td>44</td>
<td>44</td>
</tr>
<tr>
<td>100.0</td>
<td>51.2</td>
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<td>42</td>
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<tr>
<td>100.0</td>
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<td>86</td>
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<td>TOTAL</td>
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TABLE 36

Cross Tabulation of Question 12(1)
With Degree of Client Satisfaction

<table>
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<tr>
<th>COUNT ROW %</th>
<th>NO</th>
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<th>ROW TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Center 1</td>
<td>42</td>
<td>2</td>
<td>44</td>
</tr>
<tr>
<td></td>
<td>95.5</td>
<td>4.5</td>
<td>51.2</td>
</tr>
<tr>
<td>Center 2</td>
<td>41</td>
<td>1</td>
<td>42</td>
</tr>
<tr>
<td></td>
<td>97.6</td>
<td>2.4</td>
<td>48.8</td>
</tr>
<tr>
<td>COLUMN</td>
<td>83</td>
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</tr>
<tr>
<td>TOTAL</td>
<td>96.5</td>
<td>3.5</td>
<td>100.0</td>
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</table>

RAW CHI SQUARE = .29903 WITH 1 DEGREE OF FREEDOM.

SIGNIFICANCE = .5845
TABLE 37

Cross Tabulation of Question 12(2) With Degree of Client Satisfaction

<table>
<thead>
<tr>
<th>COUNT</th>
<th>NO</th>
<th>YES</th>
<th>ROW TOTAL</th>
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</thead>
<tbody>
<tr>
<td>Center 1</td>
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<td>44</td>
</tr>
<tr>
<td></td>
<td>100.0</td>
<td>0</td>
<td>51.2</td>
</tr>
<tr>
<td>Center 2</td>
<td>41</td>
<td>1</td>
<td>42</td>
</tr>
<tr>
<td></td>
<td>97.6</td>
<td>2.4</td>
<td>48.8</td>
</tr>
<tr>
<td>COLUMN</td>
<td>85</td>
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</tr>
<tr>
<td>TOTAL</td>
<td>98.8</td>
<td>1.2</td>
<td>100.0</td>
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</table>

RAW CHI SQUARE = 1.05994 WITH 1 DEGREE OF FREEDOM.

SIGNIFICANCE = .3032
TABLE 38

Cross Tabulation of Question 12(3) with Degree of Client Satisfaction

<table>
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<th>ROW TOTAL</th>
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</thead>
<tbody>
<tr>
<td>Center 1</td>
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<td>44</td>
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<tr>
<td></td>
<td>100.0</td>
<td>0</td>
<td>51.2</td>
</tr>
<tr>
<td>Center 2</td>
<td>41</td>
<td>1</td>
<td>42</td>
</tr>
<tr>
<td></td>
<td>97.6</td>
<td>2.4</td>
<td>48.8</td>
</tr>
<tr>
<td>COLUMN</td>
<td>85</td>
<td>1</td>
<td>86</td>
</tr>
<tr>
<td>TOTAL</td>
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<td>1.2</td>
<td>100.0</td>
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RAW CHI SQUARE = 1.05994 WITH 1 DEGREE OF FREEDOM.
SIGNIFICANCE = .3032
TABLE 39

Cross Tabulation of Question 12(4) With Degree of Client Satisfaction

<table>
<thead>
<tr>
<th>COUNT ROW %</th>
<th>NO</th>
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<th>ROW TOTAL</th>
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<tr>
<td>Center 1</td>
<td>42</td>
<td>2</td>
<td>44</td>
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<tr>
<td></td>
<td>95.5</td>
<td>51.2</td>
<td></td>
</tr>
<tr>
<td>Center 2</td>
<td>41</td>
<td>1</td>
<td>42</td>
</tr>
<tr>
<td></td>
<td>97.6</td>
<td>2.4</td>
<td></td>
</tr>
<tr>
<td>COLUMN</td>
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<td>86</td>
</tr>
<tr>
<td>TOTAL</td>
<td>96.5</td>
<td>3.5</td>
<td>100.0</td>
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RAW CHI SQUARE = .23903 WITH 1 DEGREE OF FREEDOM.

SIGNIFICANCE = .5845
TABLE 40

Cross Tabulation of Question 12(5)
With Degree of Client Satisfaction

<table>
<thead>
<tr>
<th>CENTER 1</th>
<th>NO</th>
<th>ROW %</th>
<th>CENTER 2</th>
<th>NO</th>
<th>ROW %</th>
<th>COLUMN</th>
<th>TOTAL</th>
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</thead>
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<tr>
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<td>42</td>
<td>42</td>
<td>100.0</td>
<td>86</td>
<td>86</td>
</tr>
<tr>
<td></td>
<td></td>
<td>51.2</td>
<td></td>
<td></td>
<td>48.8</td>
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</table>
TABLE 41
Cross Tabulation of Question 13 With Degree of Client Satisfaction

<table>
<thead>
<tr>
<th></th>
<th>COUNT</th>
<th>ROW %</th>
<th>ALWAYs</th>
<th>OFTEN</th>
<th>ROW TOTAL</th>
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<tbody>
<tr>
<td>Center 1</td>
<td>34</td>
<td>77.3</td>
<td>10</td>
<td>22.7</td>
<td>51.2</td>
</tr>
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<td>Center 2</td>
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<td>88.1</td>
<td>5</td>
<td>11.9</td>
<td>48.8</td>
</tr>
<tr>
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<td>71</td>
<td>82.6</td>
<td>15</td>
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RAW CHI SQUARE = 1.74786 WITH 1 DEGREE OF FREEDOM.
SIGNIFICANCE = .1861
### TABLE 42

Cross Tabulation of Question 20 With Degree of Client Satisfaction

<table>
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<tr>
<th>COUNT ROW %</th>
<th>ONCE</th>
<th>2-3 TIMES</th>
<th>CONTINUOUSLY</th>
<th>NEVER</th>
<th>ROW TOTAL</th>
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<tbody>
<tr>
<td>Center 1</td>
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<td>11</td>
<td>12</td>
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<tr>
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<td>25.0</td>
<td>27.3</td>
<td>34.1</td>
<td>51.2</td>
</tr>
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<td>Center 2</td>
<td>7</td>
<td>15</td>
<td>16</td>
<td>4</td>
<td>42</td>
</tr>
<tr>
<td></td>
<td>16.7</td>
<td>35.7</td>
<td>38.1</td>
<td>9.5</td>
<td>48.8</td>
</tr>
<tr>
<td>COLUMN</td>
<td>13</td>
<td>26</td>
<td>28</td>
<td>19</td>
<td>86</td>
</tr>
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<td>30.2</td>
<td>32.6</td>
<td>22.1</td>
<td>100.0</td>
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</table>

RAW CHI SQUARE = 7.58975 WITH 3 DEGREES OF FREEDOM.

SIGNIFICANCE = .0553
### TABLE 43

Cross Tabulation of Question 21 With

Degree of Client Satisfaction

<table>
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<tr>
<th>COUNT ROW %</th>
<th>ALWAYS</th>
<th>OFTEN</th>
<th>OCCASIONALLY</th>
<th>NEVER</th>
<th>ROW TOTAL</th>
</tr>
</thead>
<tbody>
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<td>12</td>
<td>1</td>
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<tr>
<td></td>
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<td>22.7</td>
<td>27.3</td>
<td>2.3</td>
<td>51.2</td>
</tr>
<tr>
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<td>8</td>
<td>0</td>
<td>42</td>
</tr>
<tr>
<td></td>
<td>40.5</td>
<td>40.5</td>
<td>19.0</td>
<td>0</td>
<td>48.8</td>
</tr>
<tr>
<td>COLUMN</td>
<td>38</td>
<td>27</td>
<td>20</td>
<td>1</td>
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<td>44.2</td>
<td>31.4</td>
<td>23.3</td>
<td>1.2</td>
<td>100.0</td>
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RAW CHI SQUARE = 3.99151 WITH 3 DEGREES OF FREEDOM.

SIGNIFICANCE = .2624
TABLE 44

Cross Tabulation of Question 3
With Client Satisfaction

<table>
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<tr>
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<th>ROW TOTAL</th>
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</thead>
<tbody>
<tr>
<td>CENTER 1</td>
<td>43</td>
<td>1</td>
<td>44</td>
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<tr>
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<td>97.7</td>
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<td>52.4</td>
</tr>
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<td>4</td>
<td>40</td>
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<td>10.0</td>
<td>47.6</td>
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<td>94.0</td>
<td>6.0</td>
<td>100.0</td>
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RAW CHI SQUARE = 2.23484 WITH 1 DEGREE OF FREEDOM.
SIGNIFICANCE = .1349
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<th>JUST RIGHT</th>
<th>ROW TOTAL</th>
</tr>
</thead>
<tbody>
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<td>12.2</td>
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<td>50.6</td>
</tr>
<tr>
<td>CENTER 2</td>
<td>2.5</td>
<td>97.5</td>
<td>49.4</td>
</tr>
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</table>

RAW CHI SQUARE = 2.77474 WITH 1 DEGREE OF FREEDOM.
SIGNIFICANCE = .0958
TABLE 46

Cross Tabulation of Question 22 With Degree of Client Satisfaction

<table>
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<tr>
<th>COUNT ROW %</th>
<th>MUCH BETTER</th>
<th>A LITTLE BETTER</th>
<th>A LITTLE WORSE</th>
<th>ROW TOTAL</th>
</tr>
</thead>
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<td>2</td>
<td>41</td>
</tr>
<tr>
<td></td>
<td>41.5</td>
<td>53.7</td>
<td>4.9</td>
<td>50.6</td>
</tr>
<tr>
<td>Center 2</td>
<td>25</td>
<td>14</td>
<td>1</td>
<td>40</td>
</tr>
<tr>
<td></td>
<td>62.5</td>
<td>35.0</td>
<td>2.5</td>
<td>49.4</td>
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<td>COLUMN</td>
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<td>3</td>
<td>81</td>
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<td>44.4</td>
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RAW CHI SQUARE = 3.62313 WITH 2 DEGREES OF FREEDOM.
SIGNIFICANCE = .1634
### TABLE 47

Cross Tabulation of Question 23

With Degree of Client Satisfaction

<table>
<thead>
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<th>YES</th>
<th>NO</th>
<th>ROW TOTAL</th>
</tr>
</thead>
<tbody>
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<td>Center 1</td>
<td>41</td>
<td>1</td>
<td>42</td>
</tr>
<tr>
<td></td>
<td>97.6</td>
<td>2.4</td>
<td>50.0</td>
</tr>
<tr>
<td>Center 2</td>
<td>41</td>
<td>1</td>
<td>42</td>
</tr>
<tr>
<td></td>
<td>97.6</td>
<td>2.4</td>
<td>50.0</td>
</tr>
<tr>
<td>COLUMN</td>
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</tr>
<tr>
<td>TOTAL</td>
<td>97.6</td>
<td>2.4</td>
<td>100.0</td>
</tr>
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</table>

**RAW CHI SQUARE = .00000 WITH 1 DEGREE OF FREEDOM.**

**SIGNIFICANCE = 1.0000**
<table>
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<tbody>
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<td>5.9</td>
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<td>3-6 Months</td>
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<td>6</td>
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<tr>
<td>More Than 12 Months</td>
<td>100.0</td>
<td>44</td>
<td>0</td>
<td>51.8</td>
</tr>
</tbody>
</table>

COLUMN TOTAL: 84 98.8 1 100.0

RAW CHI SQUARE = 4.04762 WITH 4 DEGREES OF FREEDOM.

SIGNIFICANCE = .3996
TABLE 49

Cross Tabulation of Length of Time in Treatment With Degree of Involvement in Treatment Plan

<table>
<thead>
<tr>
<th>COUNT ROW</th>
<th>ONCE</th>
<th>2-3 TIMES</th>
<th>CONTINUOUSLY</th>
<th>NEVER</th>
<th>ROW TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less Than 1 Month</td>
<td>1</td>
<td>40.0</td>
<td>20.0</td>
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<tr>
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<td>20.0</td>
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<td>5.8</td>
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<tr>
<td>1-3 Months</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>5</td>
<td>13</td>
</tr>
<tr>
<td></td>
<td>15.4</td>
<td>23.1</td>
<td>23.1</td>
<td>38.5</td>
<td>15.1</td>
</tr>
<tr>
<td>3-6 Months</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>16.7</td>
<td>33.3</td>
<td>33.3</td>
<td>16.7</td>
<td>7.0</td>
</tr>
<tr>
<td>6-12 Months</td>
<td>4</td>
<td>5</td>
<td>5</td>
<td>4</td>
<td>18</td>
</tr>
<tr>
<td></td>
<td>22.2</td>
<td>27.8</td>
<td>27.8</td>
<td>22.2</td>
<td>20.9</td>
</tr>
<tr>
<td>More Than 12 Months</td>
<td>5</td>
<td>14</td>
<td>17</td>
<td>8</td>
<td>44</td>
</tr>
<tr>
<td></td>
<td>11.4</td>
<td>31.8</td>
<td>38.6</td>
<td>18.2</td>
<td>51.2</td>
</tr>
<tr>
<td>COLUMN TOTAL</td>
<td>13</td>
<td>26</td>
<td>28</td>
<td>19</td>
<td>86</td>
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<tr>
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<td>15.1</td>
<td>30.2</td>
<td>32.6</td>
<td>22.1</td>
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</table>

RAW CHI SQUARE = 4.76881 WITH 12 DEGREES OF FREEDOM.
SIGNIFICANCE = .9653
TABLE 50

Cross Tabulation of Length of Time
In Treatment With General Satisfaction

<table>
<thead>
<tr>
<th>COUNT ROW %</th>
<th>VERY SATISFIED</th>
<th>MOSTLY SATISFIED</th>
<th>ROW TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less Than 1 Month</td>
<td>3 (60.0)</td>
<td>2 (40.0)</td>
<td>5 (5.8)</td>
</tr>
<tr>
<td>1-3 Months</td>
<td>5 (38.5)</td>
<td>8 (61.5)</td>
<td>13 (15.1)</td>
</tr>
<tr>
<td>3-6 Months</td>
<td>5 (83.3)</td>
<td>1 (16.7)</td>
<td>6 (7.0)</td>
</tr>
<tr>
<td>6-12 Months</td>
<td>10 (55.6)</td>
<td>8 (44.4)</td>
<td>18 (20.9)</td>
</tr>
<tr>
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<td>26 (59.1)</td>
<td>18 (40.9)</td>
<td>44 (51.2)</td>
</tr>
<tr>
<td>COLUMN TOTAL</td>
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<td>37</td>
<td>86</td>
</tr>
<tr>
<td>TOTAL</td>
<td>57.0</td>
<td>43.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>

RAW CHI SQUARE = 3.63204 WITH 4 DEGREES OF FREEDOM.

SIGNIFICANCE = .4581
<table>
<thead>
<tr>
<th>COUNT ROW %</th>
<th>VERY SATISFIED</th>
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<th>ROW TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Much Better</td>
<td>31</td>
<td>11</td>
<td>42</td>
</tr>
<tr>
<td></td>
<td>73.8</td>
<td>26.2</td>
<td>51.9</td>
</tr>
<tr>
<td>A Little Better</td>
<td>16</td>
<td>20</td>
<td>36</td>
</tr>
<tr>
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<td>44.4</td>
<td>55.6</td>
<td>44.4</td>
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<tr>
<td>A Little Worse</td>
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<td>3</td>
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<td>66.7</td>
<td>3.7</td>
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<td>33</td>
<td>81</td>
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<tr>
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<td>100.0</td>
</tr>
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</table>

RAW CHI SQUARE = 7.79099 WITH 2 DEGREES OF FREEDOM.
SIGNIFICANCE = .0203


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