EVALUATION OF DIRECT SERVICES OF A COMPREHENSIVE COMMUNITY MENTAL HEALTH CENTER: A RETROSPECTIVE AND PROSPECTIVE APPROACH

A Thesis

Presented to

the Faculty of the Psychology Department

Appalachian State University

In Partial Fulfillment

of the Requirements for the Degree

Master of Arts

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by

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May 1974

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Dedication

To my wife, Laura and our daughters, Kimberly and Erin, who gave freely and sacrificed much. To my parents who footed the bill.

Acknowledgements

The author would like to acknowledge the efforts of many people without whose co-operation this study would not have been possible: Dr. Robert Maris, for his assistance and encouragement in the design and implementation of this study; Dr. Richard Levin and Dr. Henry Schneider, for their willingness to serve on the committee; Rev. Robert Foster, for his confidence, co-operation, and conviction that program evaluation should be an integral part of our operation; the staff of Foothills Mental Health Center of Caldwell County, for their co-operation in administering and collecting questionaires; and Mrs. Catherine Laws for her clerical assistance.

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ABSTRACT

A discussion of some of the issues and problems associated with program evaluation in the mental health field is presented. A fifty item Client Satisfaction Survey is administered to clients at the Foothills Mental Health Center of Caldwell County. These items are divided into five categories of improvement: symptom alleviation, interpersonal effectiveness, marriage and family adjustment, school and employment adjustment, and self-concept and self-management. Responses are recorded in percentages on Likert-type scale in addition to mean scores for the five categories of improvement. Results are presented in tabular form and are discussed. Responses indicate general satisfaction with services received and a moderate degree of perceived improvement on the part of the client. A demographical breakdown of mean scores is also presented along with termination information. A proposal for a prospective program evaluation approach is included.

REVIEW OF THE LITERATURE

Substantial funds are allocated each year for the delivery of mental health services, yet there is a marked paucity of reliable information regarding the costs and effectiveness of these services (Ellsworth, 1974). A 1969-1972 survey by the National Institute of Mental Health reports that only 2.2-2.7% of staff time was devoted to research and evaluation, which is well below the recommended 5 to 10 per cent. In addition, only 22 per cent of centers report data on outcome relative to goals, and 35 per cent of centers report information on client satisfaction (Windle and Volkman, 1973). As the issue of professional accountability to the community and funding agencies is assuming increasing priority, the demand for sound programs designed to determine effectiveness of program impact on the community, effectiveness of direct services upon recipients, and the efficiency of resource utilization continues to grow (Cooper, 1973).

There have been numerous obstacles to the successful implementtation of evaluation programs. One source of resistance typically emanates from clinical staff who might fear that their efforts may not be demonstrably effective (Ellsworth, 1974). Too often, clinicians function under the assumption that whatever transpires during a therapy session is, by definition, therapeutic (Lennard and Bernstein, 1971). This attitude may be understandable in the light of the dearth of outcome studies demonstrating the efficacy of prolonged psychotherapy. In reviewing outcome studies, Cross, (1964), Bergin (1966), and Eysenck (1952) have questioned the proven efficacy of psychotherapy.

Another source of resistance to program evaluation sometimes comes from mental health administrators, According to Ellsworth (1974), the absence of concrete evidence enhances administrators' sense of security in programs which have been promoted as certain successes. Also, even when the evaluation data is available, many administrators still elect to exercize control based upon personal conviction and tradition, rather than on data which shows which approach works best. In spite of the fact that hundreds of programs have been evaluated, program mediocrity is still perpetuated. As Mechanic (1974), points out, too often evaluation efforts turn out to be chips, with which administrators "play political poker with counterfeit currency." Many administrators respond to evaluation efforts by the approach: "Damn the data and full speed ahead." (Walker, 1972). Accordingly, if mental health professionals do not become aware of problems associated with comparative studies of different approaches, "administrative fiat" will dictate program decisions. (Walker, 1972).

Many mental health professionals place a high premium on their autonomy in determining the best treatment for their clients. This potential source of resistance can be circumvented by the tactful employment of constructive feedback to aid the practicioner in making the best possible treatment decision. From the outset, it should be made clear to clinicians that it is not their professional competency or dedication which is being evaluated, rather a specific treatment

approach. (Ellsworth, 1974). Evaluation should be considered as a process of continuing education rather than a regulatory function (Mechanic, 1974).

Once these traditional obstacles have been surmounted, the evaluation researcher faces many potential pitfalls. One major problem of evaluation of outcomes is determining what data is to be collected and from whom. Typically, data has been drawn from clients, their families and significant others, in addition to therapist' reports. However, Carr and Whittnebaugh (1969) report significant discrepancies among these sources as to treatment effectiveness. Patient testimony is obviously the best source for measuring subjectively felt discomfort or distress, but clients' reporting of behavioral or community adjustment has not been reliable (Paul, 1967). One method of obtaining valid and reliable information regarding the client's community and behavioral adjustment has been expounded by Ellsworth (1974) in his Personal Adjustment and Roles Skills Inventory (Pars). This approach involves obtaining information, on a pre and post basis, from family members, significant others, employers, and others qualified to realistically assess the client's community adjustment. However, others question the use of family testimony based on the premise that some family situations are pathogenic in nature, and reports in improvement from the familys' persective may actually mean that the client is sicker. (Lennard and Bernstein, 1971). Many researchers caution against employing behavior in a treatment setting as a criteria for

treatment effectiveness because, typically, this behavior fails to generalize to a community setting (Sinnett, et. al., 1965.) This also introduces the potential problem of the therapist introducing his own values as standards for improvement (Lennard and Bernstein, 1971).

Other common threats to valid and reliable outcome studies are enumerated by Ellsworth (1974). Regression to the mean is a phenomenon which one can generally expect when dealing with behavior which is statistically infrequent. One must also consider possible confounding from non-specific effects such as therapist variables or client variables which can have a greater influence on outcome than any particular treatment. Initial differences in adjustment as well as data loss from sample attrition must also be considered. Thus it can be seen that the problem of criteria for treatment effectiveness remains the scourge of evaluation research.

A new subjective approach to outcome evaluation has recently been advocated by Guttentag (1973). She maintains that much evaluation research has been maligned because it fails to fit within the confines of the "classical experimental straight jacket." She postulates an untenable analogy between an independent variable and a treatment program. Typically, an evaluation researcher does not formulate his own hypothesis; rather program goals generally dictate what he investigates. Too often, the evaluation researcher has little control over complex variables in a social context. (Mechanic, 1974. Futhermore, randomization is often difficult as one cannot control who enters and who leaves

treatment. Weiss (1974) concurs and states that randomization must often be sacrificed on the "altar of operational practicality."

Others have followed Guttentag in advocating the importance of subjectivity in evaluation research. Shantz (1972) maintains that outcome rearch can be benefitted by taking the individuality of clients' goals into consideration. James (1969) points out that while the clients' satisfaction with therapy cannot be considered the primary criterion of ultimate effectiveness of treatment, it can be a valid indicator of the degree of fulfillment of unmet needs which initially led the client to therapy. In line with this individualistic approach to evaluation is the Goal Attainment Scale developed by Kiresuk and Sherman (1968). In this method, client-specific goals are negotiated between the client and an intake clinician. The client is then randomly assigned to a therapist for treatment. At the end of a designated period, usually three months, a trained independent rater assesses the degree of goal attainment; drawing information from a variety of sources. The degree of goal attainment is then converted to T scores which serve as indices of treatment effectiveness.

One variation of Goal Attainment Scaling is Contract Fulfillment Analysis (Stelmachers, 1972). This appraoch differs from Goal Attainment Scaling (GAS) only in that goals are negotiated between client and therapist, and there is no random assignment of clients to therapist. This approach would have its advantages in samll, crisis-intervention oriented centers where the number of clinicians is small and philosophical orientation is not disimilar.

In summary, obstacles to program evaluation efforst originate on

many fronts: inadequate funding, resistances from clinicians and administrators, methodological difficulties, of which the criteria issue seems to be prevalent. Recently, evaluation efforts have moved away from the classical experimental design strategy to a more individualized, subjective approach.

It is the purpose of this study to assess the degree of client satisfaction with the services received at the Foothills Mental Health Center of Caldwell County. Despite the rising demand for accountability and increasing pressure from state funding agencies for program evaluation, this study represents the first step in the implementation of an evaluation program for the center. The basic strategy of this approach relies primarily on consumer feedback and subjective reporting, on the part of the client, of perceived improvement. Although this approach neither circumvents nor rectifies the methodological problems mentioned above, it will provide immediate feedback to the staff as to how the clients view services received.

METHOD

Subjects: Subjects were clients of the Foothills Mental Health Center of Caldwell County. They were divided into three different categories: (1) Those clients whose cases were closed, (2) Clients who were, at the time, involved in individual psychotherapy, and (3) Psychiatric aftercare clients. Subjects ranged in age from fourteen to sixty-nine years of age. There were twenty-six males and fifty-four females included in the sample. A wide range of psychiatric diagnoses were represented ranging from Transient-situational disturbances to Chronic-schizophrenia.

Apparatus: The apparatus consisted of a fifty item Client Satisfaction Survey (See Appendix A), an answer sheet (See Appendix B), and a letter of explanation (See Appendix C). The survey was modeled after one developed by the Mobile Mental Health Center, Mobile, Alabama. The items were selected to elicit information which could be divided into five categories of improvement. In addition, there was a category for termination information and a general reaction category. Criteria for inclusion into improvement categories were as follows:

(1) Symptom Alleviation (Items 2, 9, 21, 28, 33, 35, 46). Criteria for inclusion into this category included some of the symptoms most commonly encountered in a clinical setting (e.g. anxiety, tension, depression, somatic complaints, insomnia, loss of appetite, etc.).

(2) Interpersonal Effectiveness (Items 3, 20, 36, 38, 41, 42, 48). Criteria for inclusion into this category included skills for effective interpersonal relationships (e.g. trust, self-disclosure, risk-taking, etc.). These items deal with interactions with people other than the immediate family.

(3) Marriage or Family Adjustment (Itmes 4, 16, 23, 39, 49, 50). Criteria for inclusion into this category included abilities to deal with problems and interpersonal skills within a marital or familial situation.

(4) Employment or School Adjustment (Item 11, 19, 37, 40, 44). Criteria for inclusion into this category were factors specific to school or employment adjustment (e.g., grades, attendance, absenteeism, productivity, satisfaction with situation, etc.).

(5) Self-Concept and Self-Management (Items 5, 13, 14, 15, 25, 26, 32). Criteria for inclusion into this category consisted of feelings about self, as well as abilities to cope with daily stresses (e.g. ability to handle problems, alcohol and drug use, self-concept, hospitalization, etc.).

The following categories were designed to elicit termination information and general reaction to services:

Termination Information (Items 10, 17, 27, 43, 45). This category contained information pertinent to termination (e.g. unilateral withdrawal, mutual agreement to terminate, dissatisfaction with services, etc.).

General Reaction to Services (Items 1, 6, 7, 8, 12, 18, 22, 24, 29, 31, 34, 47, 49). This was a catch-all category designed to assess a wide range of clients' reactions to services offered (e.g. mechanics of operation, expense, subjective feelings about seeking services, reactions to therapist, general satisfaction, etc.).

There were five possible responses to the items on the survey: Strongly Agree, Agree, Disagree, Strongly Disagree, Does Not Apply. These responses were number coded on the answer sheet to facilitate tabulation (See answer sheet in Appendix).

As there was no empirical validity determined for the categories, assignment of items into categories was essentially on the basis of face validity and operational definition, with the real possibility of overlap among categories. However, as this instrument was designed for only one usuage, the author and the staff of Foothills Mental Health Center felt that the categories would yield valuable information pertinent to the needs of the center.

Procedure: Fifty terminated cases were chosen at random from the files. The Client Satisfaction Survey, answer sheet, letter of explanation, (See Appendix C) and an addressed, stamped envelope were mailed to each of these former clients. Clients under thirteen years of age were excluded from the sample. Telephone contact was attempted with those who had failed to return the survey after three weeks, and again at a six-week interval. Termination information was gathered from this source.

The survey was also administered at the center to those clients who were undergoing individual psychotherapy. The criterion for inclusion into this group was that the client must have seen a therapist for at least three sessions. If the third visit occured during the course of the study, the client was included in the sample. As younger children would have had some difficulty reading the items on the questionaire, an arbitrary cut-off age of thirteen was established. This precluded evaluation of children and youth services, but this will be done at a later date. Surveys were administered to all clients in this category during the period March 15 - April 15, 1974.

The survey was also administered to those clients being seen on an after-care basis. Clients in this category were seeing one of the two staff psychiatrists for a brief period, usually for medication review and support. Although these clients usually saw a nurse or a social worker prior to seeing the psychiatrist, they were not considered participants in psychotherapy. As with the psychotherapy clients, questionaires were administered to all after-care clients seen during the period of March 15-April 15, 1974.

Two units of measurement were employed. One was the actual percentage of clients form the three groups agreeing, disagreeing, etc. with the statements. The other was a mean score for the five categories mentioned above. This was obtained by averaging the number codes for items within a particular category. Standard deviations were also calculated. In cases where items were negatively worded, the number code was reversed before averaging. For example, a "one" was changed to a "four", a "two" to a "three", etc. A mean score of one would represent a maximum positive and favorable response; whereas a mean of "four" would indicate a maximum unfavorable or negative reaction. Intermediate reactions would be represented by means between one and four; the lower the mean, the more favorable the response. The mean score was used only for the five categories of improvement and not for termination or general reaction data.

The overall response percentages to each item on the survey for the three groups are given. (See Table 1). A vast majority of clients (75-100%) seemed to be satisfied with the mechanics of operation (e.g. expense, impressions of therapist, staff co-operation, etc.). There also seemed to be no indication that clients were embarrassed by seeking services, and most indicated that they would recommend the services to their friends who were having difficulties. The medication item (#22) revealed that 85 per cent of after-care clients state that they benefitted from medication, while 70% of psychotherapy participants said the term did not apply. For the most part, responses tended to run in a similar direction for all three groups.

Mean scores and standard deviations for the five improvement categories are given for each of the three groups. (See Table 2). All groups indicated improvement in the five areas by improvement categories. Psychotherapy participants achieved lower means on all categories, except school and employment adjustment, but the difference was very slight and could possibly be an artifact of the instrument. There is extremely little variation within groups on the five categories. Standard deviations show moderate dispersion and seem to indicate an internal consistency of responses within categories. After-care responses reflected the smallest amount of variance.

Information regarding termination is given. (See Table 3). Only one-fifth of this sample returned the questionaire (11 out of 50.) Approximately 75 per cent of clients disagreed with the statement that they stopped treatment because they felt they were making no progress.

Approximately 65 per cent agreed that termination occured with mutual consent of therapist and client. Everyone disagreed that termination occured because of unfair treatment of the client. Approximately 27 per cent agreed that termination occurred because the therapist unilaterally determined that his services were no longer needed.

Mean scores of improvement categories for all groups combined are given in a demographic arrangement according to sex, marital status, and educational level. (See Table 4). Single males with a college education seem to show substantially more improvement on all categories than do their counterparts with less education. For married males, the difference in not obvious, although those with a college education seem to show slightly more improvement. For married and single females, those with college education showed more improvement on almost all categories with only small differences between grammar and high school educated females. For divorced females, those with grammar school education showed substantially more improvement than those with high school or college education.

DISCUSSION

The results of the survey strongly indicate that a vast majority of clients favorably view the services offered by Foothills Mental Health Center of Caldwell County. A large majority of clients (75-80%) indicated a significant degree of improvement in five areas: symptom alleviation, interpersonal effectiveness, marriage and family adjustment,

school and employment adjustment, and self-concept and self-management. Whether this improvement is directly attributable to therapists' efforts or to some other factor cannot be determined with this instrument. A more tightly controlled outcome study would be required to establish a causal link between therapy and improvement. Also, clients' reporting of improvement cannot be unquestionably assumed to be valid as was mentioned in the literature review.

There are many procedural difficulties inherent in this type of approach to evaluation. Many of the terminated cases were difficult to locate and a large majority (four-fifths) failed to return the questionaire, even after two telephone contacts. This introduces many possible biases for this particular group of clients (e.g. characteristices of people who return questionaires, characteristics of those who leave an area after experiencing difficulties, characteristics of those having telephones, etc.). Therefore, the validity of improvement scores for terminated cases must remain suspect.

Although an approach of this type contains many potential weaknesses, it is the first attempt, of any sort, made to evaluate services which have been in operation for over four years. Also, in addition to the useful information obtained, this study has enabled the author to become familiar with a variety of different approaches to program evaluation and concomitant problems. From among these different approaches, the author has selected a method of program evaluation which will serve as an integral and ongoing part of the operations at Foothills Mental Health Center. The methodology of this approach is formulated in the epilogue.

EPILOGUE

A DESCRIPTION OF THE METHODOLOGY OF THE CONTRACT FULFILLMENT ANALYSIS VARIATION OF GAOL ATTAINMENT SCALING: A MODEL FOR EVALUATION OF DIRECT SERVICES OF A COMMUNITY MENTAL HEALTH CENTER

After the initial social history is obtained at intake, the client and therapist will negotiate goals for therapy. Typically, these goals are related to problem areas in the clients' life and are usually included in one of the following areas:

(1) Agression
(2) Alcohol/drug abuse
(3) Anxiety/depression
(4) Education
(5) Family/marital
(6) Interpersonal relationships and social activities
(7) Legal/financial
(8) Living arrangements
(9) Physical complaints
(10) Psychopathological symptoms
(11) Sexuality
(12) Suicide
(13) Work

Once the clients' problem areas are mutually agreed upon, they are enumerated in terms of expectations of treatment success - ranging from the most unfavorable outcome likely to the most favorable outcome likely. There are provisions on this guide for weighting the various scales as to goal priorities. The stated goals will be client-specific and should be made as precise and quantifiable as possible. A series of workshops will be conducted at the center to train staff members in the effective techniques of goal scaling. The Program Evaluation Project has made a wealth of material available for assistance in delineating reasonable and realistic expectations for clients with specific presenting problems.

Therapist will complete one of these guides for each of his/her clients. At the end of a designated time period (probably three and six months intervals), a random sample of goal expectations will be selected from each therapists' case load. For obvious reasons, the therapist will not know beforehand which goal scales will be selected. A pair of independent follow-up interviewers will be hired to conduct the follow-up interviews. Upon employment, they will be thoroughly instructed in the proper techniques of scoring goal attainment. Again, Dr. Kiresuk and his staff at the Program Evaluation Project have provided excellent programmed instructional materials to assist the follow-up interviewer in his tasks. Naturally, strict provisions are made to assure the confidentiality of the follow-up interview. In many cases, it will be necessary to elicit information from sources other than the client (e.g. employer, spouse, family members, teachers, significant others, etc.). This will not be done without the written permission of the client.

Once the Goal Attainment Follow-Up Guide has been scored, the resultant raw score is converted to a T-score designed to have a normal distribution with a mean of 50 and a standard deviation of 10. To facilitate statistical procedures, a conversion key is provided by the Program Evaluation Project. Once the Goal Attainment Scale has been calculated, it is easily converted into a percentile ranking.

The possible uses of this type of data are many. It can be used to compare the relative efficacy of different treatment approaches to different presenting problems. It will provide valuable information as to the

overall effectiveness of services offered by the center. It will provide some objective feedback to individual therapists. It will offer information as to which presenting problem or combination of problems presents the most difficulty in goal attainment. It will assist decision-makers in deciding which programs work best and which programs need emphasis. It will provide a means of comparing client variables to goal attainment.

TABLES

TABLE 1

Response Percentages for Individual Items on Survey

a=Percentages for clients undergoing psychotherapy (n=24)
b=Percentages for after-care clients (n=45)
c=Percentages for terminated cases (n=11)

ITEM	STRONGLY AGREE	AGREE	DISAGREE	STRONGLY DISAGREE	DOES NOT APPLY
1. My therapist seemed genuinely concerned and willing to help.	a=87.5% b=26.6% c=54.5%	a=12.5% b=71.1% c=45.5%	a=0 b=0 c=0	a=0 b=0 c=0	a=0 b=2.2% c=0
2. I am not as nervous since coming to the Mental Health Center.	a=20.8% b=31.1% c=27.3%	a=62.5% b=48.8% c=63.7%	a=4.2% b=15.5% c=9.1%	a=0 b=0 c=0	a=12.5% b=4.4% c=0
3. I can get along better with people since coming to the Mental Health Center.	a=25% b=17.7% c=45.5%	a=50.0% b=60.0% c=27.3%	a=0 b=13.3% c=9.1%	a=0 b=0 c=0	a=25.0% b=11.1% c=18.2%
4. I am more willing to take my share of the responsibility for family problems.	a=33.3% b=20.0% c=36.3%	a=58.3% b=53.3% c=27.3%	a=0 b=11.1% c=18.2%	a=0 b=2.2% c=0	a=8.3% b=2.2% c=18.2%
5.I can handle my problems better since coming to the Mental Health Center.	a=54.2% b=17.8% c=45.5%	a=41.7% b=62.2% c=45.5%	a=0 b=11.1% c=0	a=0 b=0 c=0	a=4.2% b=8.9% c=9.1%
6.I was not helped by coming to the Mental Health Center.	a=4.2% b=6.5% c=18.2%	a=0 b=11.1% c=9.1%	a=37.5% b=37.8% c=36.3%	a=58.3% b=35.5% c=36.3%	a=0 b=8.9% c=0

TABLE 1 (Cont.)

ITEM	STRONGLY AGREE	AGREE	DISAGREE	STRONGLY DISAGREE	DOES NOT APPLY
7. I had to wait too long before receiving help at the Mental Health Center.	a=4.2% b=8.9% c=0	a=0 b=13.3% c=0	a=33.3% b=46.6% c=54.5%	a=58.3% b=26.6% c=45.5%	a=4.2% b=4.4% c=0
8. I was embarrassed by coming to the Mental Health Center.	a=4.2% b=8.9% c=0	a=12.5% b=13.3% c=0	a=54.2% b=33.3% c=45.5%	a=29.1% b=35.5% c=45.5%	a=0 b=2.2% c=0
9.I have become worse since coming to the Mental Health Center.	a=4.2% b=4.4% c=0	a=4.2% b=8.9% c=0	a=29.1% b=44.4% c=45.5%	a=58.3% b=37.8% c=54.5%	a=4.2% b=4.4% c=0
10. I stopped coming to the Mental Health Center because I felt I was making no progress.	a=0 b=2.2% c=0	a=0 b=2.2% c=0	a=16.6% b=28.9% c=36.3%	a=37.5% b=37.8% c=36.3%	a=45.8% b=28.9% c=27.3%
11. My grades in school have improved since coming to the Mental Health Center.	a=4.2% b=2.2% c=9.1%	a=20.8% b=13.3% c=0	a=4.2% b=2.2% c=9.1%	a=4.2% b=0 c=9.1%	a=66.6% b=82.2% c=72.7%
12. Services at the Mental Health Center are too expensive.	a=4.2% b=8.9% c=0	a=4.2% b=11.1% c=9.1%	a=41.7% b=48.8% c=54.5%	a=45.8% b=26.6% c=36.4%	a=4.2% b=8.0% c=0
13. I drink less alcohol since coming to the Mental Health Center.	a=4.2% b=13.3% c=9.1%	a=4.2% b=17.7% c=18.2%	a=4.2% b=4.4% c=27.3%	a=8.3% b=0 c=18.2%	a=79.1% b=64.4% c=27.3%

TABLE 1 (Cont.)

ITEM	STRONGLY AGREE	AGREE	DISAGREE	STRONGLY DISAGREE	DOES NOT APPLY
14. I use fewer non-prescription drugs since coming to the Mental Health Center.	a=8.3% b=13.3% c=36.5%	a=16.6% b=40.0% c=9.1%	a=16.6% b=15.5% c=18.2%	a=8.4% b=2.2% c=0	a=50% b=28.9% c=36.4%
15. I have had to be hospitalized for nervous or emotional problems since coming to the Mental Health Center.	a=4.2% b=6.6% c=0	a=0 b=13.3% c=9.1%	a=12.5% b=33.3% c=27.3%	a=16.6% b=6.6% c=18.2%	a=66.6% b=22.2% c=27.3%
16. I am able to handle family problems better since coming to the Mental Health Center.	a=29.1% b=11.1% c=27.3 %	a=62.5 % b=64.4 % c=54.4 %	a=0 b=15.5 % c=9.1 %	a=0 b=0 c=9.1 %	a=8.3 % b=8.9 % c=0
17. I stopped coming to the Mental Health Center because my therapist and I agreed that I no longer needed the services.	a=8.3% b=0 % c=27.3 %	a=9.2 % b=11.1 % c=36.3 %	a=16.6 % b=31.1 % c=18.2 %	a=4.2 % b=11.1 % c=0	a=66.6 % b=48.8 % c=18.2 %
18. I would recommend the Mental Health Center to my friends who have emotional or nervous problems.	a=66.6% b=46.6 % c=63.7 %	a=25.0 % b=42.2 % c=27.3 %	a=0 b=2.0 % c=9.1 %	a=8.3 % b=8.9 % c=0	a=0 b=0 c=0
19. I get along better in my work since coming to the Mental Health Center.	a=20.0 % b=20.0 % c=45.5 %	a=45.0 % b=42.2 % c=45.5 %	a=0 b=15.5 % c=0	a=0 b=0 c=0	a=33.3 % b=22.2 % c=9.1 %
20. It is easier for me to make friends since coming to the Mental Health Center.	a=12.5 % b=17.7 % c=27.3 %	a=54.2 % b=42.2 % c=45.5 %	a=8.0 b=20.0 % c=9.1 %	a=0 b=0 c=0	a=25.5 % b=17.7 % c=18.2 %

TABLE 1 (Cont.)

ITEM	STRONGLY AGREE	AGREE	DISAGREE	STRONGLY DISAGREE	DOES NOT APPLY
21. I worry less since coming to the Mental Health Center.	a=25.0 % b=22.2 % c=27.3 %	a=50.0% b=55.5 % c=63.7 %	a=16.6 % b=13.3 % c=0	a=0 b=4.4% c=9.1%	a=8.3 % b=4.4 % c=0 %
22. The medication I received at the Mental Health Center has helped me.	a=12.5 % b=28.9 % c=18.2 %	a=12.5 % b=57.7 % c=18.2 %	a=4.2 % b=2.0 % c=9.1 %	a=0 b=2.0% c=0	a=70.8% b=8.9 % c=54.4 %
23. I feel beter about my marriage since coming to the Mental Health Center.	a=12.5 % b=8.9 % c=9.1 %	a=20.8 % b=40.0 % c=27.3 %	a=8.3 % b=4.4 % c=18.2 %	a=0 b=4.4% c=0	a=58.3 % b=40.0 % c=45.5 %
24. I felt my therapist would be available after-hours if I needed him.	a=37.5 % b=13.3 % c=45.5 %	a=41.7 % b=51.1 % c=27.3 %	a=4.2 % b=13.3 % c=9.1 %	a=4.2% b=0 c=0	a=12.5 % b=20.0 % c=18.2 %
25. It is easier for me to make decisions since coming to the Mental Health Center.	a=12.5 % b=17.7 % c=45.5 %	a=70.8 % b=51.1 % c=18.2 %	a=4.2 % b=13.3 % c=9.1 %	a=0 b=2.0% c=9.1 %	a=12.5 % b=13.3 % c=18.2 %
26. I like myself better since coming to the Mental Health Center.	a=33.3 % b=13.3 % c=45.5 %	a=50.0 % b=55.5 % c=18.2 %	a=0 b=13.3 % c=36.4 %	a=0 b=4.4 % c=0	a=16.6 % b=11.1 % c=0
27. I stopped coming to the Mental Health Center because I felt I was getting better.	a=0 b=2.0 % c=27.3 %	a=12.5 % b=8.9 % c=36.4 %	a=4.2 % b=31.1 % c=9.1 %	a=4.2 % b=8.9 % c=0	a=79.1 % b=46.6 % c=27.3 %

TABLE 1 (Cont.)

ITEM	STRONGLY AGREE	AGREE	DISAGREE	STRONGLY DISAGREE	DOES NOT APPLY
28. My appetite has improved since coming to the Mental Health Center.	a=8.3% b=22.2% c=18.2%	a=20.8% b=51.1% c=27.3%	a=4.2% b=11.1% c=18.2%	a=4.2% b=4.4% c=9.1%	a=62.5% b=8.9% c=27.3%
29. I would recommend the Mental Health Center to my friends who have an alcohol or drug problem.	a=45.0% b=40.0% c=54.4%	a=50.0% b=46.6% c=36.3%	a=0 b=2.2% c=9.1%	a=0 b=4.4% c=0	a=4.2% b=6.6% c=0
30. I am more likely to openly discuss my problems since coming to the Mental Health Center.	a=37.5% b=24.4% c=54.4%	a=41.7% b=62.2% c=18.2%	a=8.3% b=4.4% c=0	a=4.2% b=2.2% c=18.2%	a=8.3% b=4.4% c=9.1%
31. I would hesitate to return to the Mental Health Center in the future.	a=8.3% b=4.4% c=0	a=0 b=11.1% c=9.1%	a=20.8% b=48.8% c=36.3%	a=66.6% b=31.1% c=54.4%	a=4.2% b=6.4% c=0
32. I am more likely to face my problems since coming to the Mental Health Center.	a=75.0% b=15.5% c=45.5%	a=25.0% b=73.3% c=45.5%	a=0 b=4.4% c=0	a=0 b=4.4% c=0	a=0 b=4.4% c=9.1%
33. I am able to sleep better at night since coming to the Mental Health Center.	a=25.0% b=26.6% c=45.5%	a=41.7% b=55.5% c=18.2%	a=8.3% b=8.9% c=9.1%	a=0 b=2.2% c=0	a=25.0% b=4.4% c=27.3%
34. I could have solved my problems just as easily without the aid of the Mental Health Center.	a=0 b=2.2% c=0	a=0 b=6.5% c=9.1%	a=25.0% b=40.0% c=36.3%	a=70.8% b=42.2% c=54.4%	a=4.2% b=6.5% c=0

TABLE 1 (Cont.)

ITEM	STRONGLY AGREE	AGREE	DISAGREE	STRONGLY DISAGREE	DOES NOT APPLY
35. I feel better physically since coming to the Mental Health Center.	a=16.6% b=20.0% c=27.3%	a=50.0% b=57.7% c=54.4%	a=12.5% b=20.0% c=9.1%	a=0 b=0 c=0	a=20.0% b=4.4% c=9.1%
36. People seem more friendly towards me.	a=8.3% b=4.4% c=18.2%	a=41.7% b=55.5% c=36.3%	a=4.2% b=17.7% c=18.2%	a=4.2% b=2.2% c=0	a=41.7% b=11.1% c=27.3%
37. I get along better in school since coming to the Mental Health Center.	a=16.6% b=0 c=9.1%	a=8.3% b=13.3% c=9.1%	a=0 b=0 c=9.1%	a=0 b=0 c=0	a=75.0% b=84.4% c=72.8%
38. I take an active part in more activities since coming to the Mental Health Center.	a=12.5% b=13.3% c=18.2%	a=29.1% b=35.5 c=45.5%	a=16.6% b=28.9% c=36.3%	a=0 b=0 c=0	a=37.5% b=22.2% c=0
39. I understand my parents better since coming to the Mental Health Center.	a=16.6% b=11.1% c=18.2%	a=29.1% b=28.9% c=27.3%	a=16.6% b=8.9% c=9.1 %	a=0 b=0 c=0	a=37.5% b=48.8% c=45.5%
40. I am more productive in my work since coming to the Mental Health Center.	a=12.5% b=17.7% c=27.3%	a=41.7% b=42.2% c=54.4%	a=12.5% b=4.4% c=0	a=0 b=2.2% c=0	a=33.3% b=31.1% c=18.2%
41. I am more understanding of others since coming to the Mental Health Center.	a=25% b=15.5% c=36.3%	a=50% b=66.6% c=45.5%	a=12.5% b=13.3% c=9.1%	a=0 b=2.2% c=0	a=12.5% b=4.4% c=9.1%

TABLE 1 (Cont.)

ITEM	STRONGLY AGREE	AGREE	DISAGREE	STRONGLY DISAGREE	DOES NOT APPLY
42. I am more likely to express my feelings since coming to the Mental Health Center.	a=41.7% b=22.2% c=36.3%	a=45.8% b=66.6% c=45.5%	a=0 b=8.9% c=9.1%	a=4.2% b=0 c=9.1%	a=8.3% b=2.2% c=0
43. I stopped coming to the Mental Health Center because I was treated unfairly.	a=4.2% b=2.2% c=0	a=0 b=6.5% c=0	a=8.3% b=33.3% c=27.3%	a=45.8% b=15.5% c=54.4%	a=41.7% b=42.2% c=18.2%
44. I miss fewer days of work or school since coming to the Mental Health Center.	a=16.6% b=11.1% c=9.1%	a=12.5% b=22.2% c=27.3%	a=8.3% b=15.5% c=9.1%	a=8.3% b=2.2% c=9.1%	a=54.2% b=44.4% c=45.5%
46. I have more energy since coming to the Mental Health Center.	a=8.3% b=17.7% c=18.2%	a=41.7% b=51.1% c=54.4%	a=25.0% b=15.5% c=18.2%	a=0 b=4.4% c=9.1%	a=25.0% b=6.5% c=0
47. The clerical staff and secretaries seemed friendly and willing to help.	a=41.7% b=29.9% c=36.3%	a=58.3% b=64.2% c=54.4%	a=0 b=0 c=0	a=0 b=3.4% c=9.1%	a=0 b=3.4% c=0
48.I am more trusting of others since coming to the Mental Health Center.	a=8.3% b=15.5% c=18.2%	a=33.3% b=59.9% c=45.5%	a=29.1% b=15.5% c=9.1%	a=4.2% b=2.1% c-18.2%	a=25.0% b=6.5% c=9.1%
49. I am more understanding of others since coming to the Mental Health Center.	a=20.1% b=13.3% c=27.3%	a=37.5% b=48.9% c=18.2%	a=4.2% b=8.9% c=9.1%	a=0 b=0 c=0	a=37.5% b=29.8% c=45.5%
50. I feel closer to my family since coming to the Mental Health Center.	a=25.0% b=23.2% c=45.5%	a=37.5% b=57.2% c=45.5%	a=20.1% b=15.3% c=9.1%	a=8.3% b=0 c=0	a=8.3% b=4.4% c=0

TABLE 2

MEAN SCORES AND STANDARD DEVIATIONS FOR IMPROVEMENT CATEGORIES BY GROUPS

IMPROVEMENT CATEGORY	PSYCHOTHERAPY (n=24) X	s.d.	AFTER-CARE (n=45) X	s.d.	TERMINATED (n=11) X	s.d.
SYMPTOM ALLEVIATION	1.85	.557	2.02	.200	1.90	.519
INTERPERSONAL EFFECTIVENESS	1.96	.489	2.05	.317	1.98	.714
MARRIAGE AND FAMILY ADJUSTMENT	1.87	.557	1.98	.371	1.91	.583
SCHOOL AND EMPLOYMENT ADJUSTMENT	1.99	.656	2.03	.245	1.83	.387
SELF-CONCEPT AND SELF-MANAGEMENT	1.75	.436	2.02	.412	1.81	.539

TABLE 3

RESPONSE PERCENTAGES TO TERMINATION ITEMS

(n=11)

ITEM	STRONGLY AGREE	AGREE	DISAGREE	STRONGLY DISAGREE	DOES NOT APPLY
10. I stopped coming to the Mental Health Center because I felt I was not making any progress.	0	0	36.3%	36.3%	27.3%
17. I stopped coming to the Mental Health Center because my therapist and I agreed that I no longer needed the services.	27.3%	36.3%	18.2%	0	18.2%
27. I stopped coming to the Mental Health Center because I felt I was getting better.	27.3%	36.4%	9.1%	0	27.3%
43. I stopped coming to the Mental Health Center because I was treated unfairly.	0	0	27.3%	54.4%	18.2%
45. I stopped coming to the Mental Health Center because my therapist told me I no longer needed his services, although I felt that I did.	9.1%	18.2%	18.2%	27.3%	27.3%

TABLE 4

Mean scores for males and females on Improvement Categories according to marital status and education level

	GRAMMAR SCHOOL	HIGH SCHOOL	COLLEGE
SINGLE MALES			
Symptom Alleviation	2.28	-	1.64
Interpersonal Effectiveness	2.25	-	1.68
Marriage and Family Adjustment	2.13	-	1.62
School and Employment Adjustment	2.17	-	1.25
Self-Concept and Self-Management	2.32	-	1.48
MARRIED MALES			
Symptom Alleviation	1.95	2.08	1.65
Interpersonal Effectiveness	2.06	1.75	1.96
Marriage and Family Adjustment	2.03	1.74	2.08
School and Employment Adjustment	2.06	1.66	2.00
Self-Concept and Self-Management	2.15	1.82	1.65
MARRIED FEMALES			
Symptom Alleviation	1.77	1.92	2.01
Interpersonal Effectiveness	1.75	2.05	1.50
Marriage and Family Adjustment	1.75	1.80	1.46
School and Employment Adjustment	1.77	1.85	1.75
Self-Concept and Self-Management	1.82	1:93	1.61
DIVORCED FEMALES			
Symptom Alleviation	1.57	1.85	2.00
Interpersonal Effectiveness	1.56	2.38	2.28
Marriage and Family Adjustment	1.70	2.03	3.00
School and Employment Adjustment	1.00	2.17	-
Self-Concept and Self-Management	1.76	1.91	2.16
SINGLE FEMALES			
Symptom Alleviation	2.57	1.97	1.75
Interpersonal Effectiveness	2.68	1.88	1.50
Marriage and Family Adjustment	2.87	2.03	2.00
School and Employment Adjustment	3.12	2.01	1.83
Self-Concept and Self-Management	2.28	1.78	1.83

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APPENDICES

APPENDIX A

FOOTHILLS MENTAL HEALTH CENTER OF CALDWELL COUNTY
CLIENT SATISFACTION SURVEY

1. My therapist seemed genuinely concerned and willing to help me.
2. I am not as nervous since coming to the Mental Health Center.
3. I can get along better with people since coming to the Mental Health Center.
4. I am more willing to take my share of the responsibility for family problems.
5. I can handle my problems better since coming to the Mental Health Center.
6. I was not helped by coming to the Mental Health Center.
7. I had to wait too long before receiving help at the Mental Health Center.
8. I was embarrassed by coming to the Mental Health Center.
10. I stopped coming to the Mental Health Center because I felt I was not making any progress.
11. My grades in school have improved since coming to the Mental Health Center.
12. Services at the Mental Health Center are too expensive.
13. I drink less alcohol since coming to the Mental Health Center.
14. I use fewer non-prescription drugs since coming to the Mental Health Center.
15. I have had to be hospitalized for nervous or emotional problems since coming to the Mental Health Center.
16. I am able to handle family problems better since coming to the Mental Health Center.
17. I stopped coming to the Mental Health Center because my therapist and I agreed that I no longer needed the services.
18. I would recommend the Mental Health Center to my friends who have emotional or nervous problems.
19. I get along better in my work since coming to the Mental Health Center.
20. It is easier for me to make friends since coming to the Mental Health Center.
21. I worry less since coming to the Mental Health Center.
22. The medication I received at the Mental Health Center has helped me.
23. I feel better about my marriage since coming to the Mental Health Center.
24. I felt my therapist would be available after-hours if I needed him.

APPENDIX A (continued)

25. It is easier for me to make decisions since coming to the Mental Health Center.

26. I like myself better since coming to the Mental Health Center.

27. I stopped coming to the Mental Health Center because I felt I was getting better.

28. My appetite has improved since coming to the Mental Health Center.

29. I would recommend the Mental Health Center to my friends who have an alcohol or drug problem.

30. I am more likely to openly discuss my problems since coming to the Mental Health Center.

31. I would hesitate to return to the Mental Health Center in the future.

32. I am more likely to face my problems since coming to the Mental Health Center.

33. I am able to sleep better at night since coming to the Mental Health Center.

34. I could have solved my problems just as easily without the aid of the Mental Health Center.

35. I feel better physically since coming to the Mental Health Center.

36. People seem more friendly towards me since coming to the Mental Health Center.

37. I get along better in school since coming to the Mental Health Center.

38. I take an active part in more activities since coming to the Mental Health Center.

39. I understand my parents better since coming to the Mental Health Center.

40. I am more productive in my work since coming to the Mental Health Center.

41. I am more understanding of others since coming to the Mental Health Center.

42. I am more likely to express my feelings since coming to the Mental Health Center.

43. I stopped coming to the Mental Health Center because I was treated unfairly.

44. I miss fewer days of work or school since coming to the Mental Health Center.

45. I stopped coming to the Mental Health Center because my therapist told me I no longer neede his services, although I felt that I did.

46. I have more energy since coming to the Mental Health Center.

47. The clerical staff and secretaries seemed friendly and willing to help.

48. I am more trusting of others since coming to the Mental Health Center.

49. I am more understanding of my children since coming to the Mental Health Center.

50. I feel closer to my family since coming to the Mental Health Center.

APPENDIX B

FOOTHILLS MENTAL HEALTH CENTER CLIENT SATISFACTION SURVEY

ANSWER SHEET

I. Information: Please furnish the following information:

AGE:_____ SEX _____ MARITAL STATUS _____ LAST GRADE COMPLETED_____

II. Please read each statement on the survey and place one of the following numbers beside the appropriated number on the answer sheet. Please make no marks on the survey sheet containing the statements.

4- If you STRONGLY DISAGREE with the statement.

3- If you DISAGREE with the statement.

2- If you AGREE with the statement.

1- If you STRONGLY AGREE with the statement.

0- If the statement DOES NOT APPLY to you.

EXAMPLE: If you strongly disagree with item number one on the survey, you would place a 4 beside number one here on the answer sheet. Ex: (4)

1. (____)	14. (____)	27. (____)	40. (____)
2. (____)	15. (____)	28. (____)	41. (____)
3. (____)	16. (____)	29. (____)	42. (____)
4. (____)	17. (____)	30. (____)	43. (____)
5. (____)	18. (____)	31. (____)	44. (____)
6 (____)	19. (____)	32. (____)	45. (____)
7. (____)	20. (____)	33. (____)	46. (____)
8. (____)	21. (____)	34. (____)	47. (____)
9. (____)	22. (____)	35. (____)	48. (____)
10. (____)	23. (____)	36. (____)	49. (____)
11. (____)	24. (____)	37. (____)	50. (____)
12. (____)	25. (____)	38. (____)	
13. (____)	26. (____)	39. (____)	

Foothills Mental Health Center of Caldwell County

Office: 754-4552

Post Office Box 967 1006 Kirkwood Street N. W.

Lenoir, North Carolina 28645

March 18, 1974

Dear

The staff at Foothills Mental Health Center of Caldwell County is eager to provide the best of possible services to our clients. Sometimes, in order to do this, we need to ask the help of our clients in seeing how you, our former clients, regard our services. We would be extremely grateful if you could take the time to fill out the enclosed questionaire as truthfully and accurately as possible. All responses will be kept strictly confidential, and no one will know who answered what questions in what ways. Please place all responses on the green answer sheet according to the following instructions:

If you STRONGLY DISAGREE with an item on the survey, place a 4 by the appropriate number on the green answer sheet.
If you DISAGREE with an item on the survey, place a 3 by the appropriate number on the green answer sheet.
If you AGREE with an item on the survey, place a 2 by the appropriate number on the green answer sheet.
If you STRONGLY AGREE with an item on the survey, place a 1 by the appropriate number on the green answer sheet.

If the item DOES NOT APPLY then place a 0 by the appropriate number on the green answer sheet.

For example, if you STRONGLY DISAGREE with item number one on the survey, you would place a one by number one on the green answer sheet. EX. 1. (4) Please do the same for all fifty items on the survey. You need not make any marks on the survey containing the fifty statements. When you have finished, please place the green answer sheet in the stamped-self addressed envelope and place in the nearest mail box.

Again, we are greatly appreciative of your willingness to help us in our efforts to improve our service to the community. We look forward to your response.

Very sincerely yours,

Steve Maynard
Clinical Psychology Intern

Enclosures: Client Satisfaction Survey, Green Answer Sheet, and Self-Addressed, Stamped Envelope.