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ABSTRACT

To better understand factors contributing to an identified early attrition rate for families referred to a child guidance clinic, a procedure was developed for assessing their satisfaction with clinic services. Brief Client Satisfaction Questionnaires (N=3) were developed to assess clients' attitudes and reactions to an initial screening and diagnostic appraisal sequence of interviews which identified the greatest attrition. These questionnaires were issued to a sample of 238 families during a nine-month period, and return rates of 80% were achieved. Three classes of variables were examined for possible association with premature termination from services: (a) client satisfaction measured by questionnaire responses; (b) demographic client characteristics; and (c) clinician characteristics. Premature terminators and clients who followed through with clinic services were indistinguishable on the basis of client satisfaction and demographic variables. Contrary to expectations, clients who terminated prematurely did not have greater levels of dissatisfaction with clinic services and procedures. (Author)

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"You've gotta keep the customer satisfied": Assessing client satisfaction

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Abstract

In order to understand the factors contributing to an identified early attrition rate for families referred to a child guidance clinic, a procedure was developed for assessing clients' satisfaction with clinic services. Three brief Client Satisfaction Questionnaires were developed to assess clients' attitudes and reactions to an initial screening and diagnostic appraisal sequence of interviews wherein the greatest attrition was identified. Questionnaires were issued to a sample of 238 families during a nine month period and return rates of 80% were achieved. Three classes of variables were examined for possible association with premature termination from services: (a) client satisfaction was measured by questionnaire responses, (b) demographic client characteristics, and (c) clinician characteristics. Premature terminators and clients who followed through with clinic services were indistinguishable on the basis of client satisfaction and demographic variables. Contrary to expectations, clients who terminated prematurely did not have greater levels of dissatisfaction with clinic services and procedures.

"You've gotta keep the customer satisfied": Assessing client satisfaction

Increasing emphasis on accountability in recent years has necessitated evaluation of the usefulness and effectiveness of community mental health programs. A straightforward approach to such evaluation has been to survey consumers as to their perceptions of mental health services received. McPhee, Zusman and Joss (1975) have reported that the direct assessment of clients' satisfaction with services has been a widely used evaluation approach in mental health. Surveys of clients' perceptions of services and satisfaction levels have been conducted in a variety of settings, including; inpatient (Eder & Kukulski, 1975; Quilitch, 1978), outpatient (Denner & Halprin, 1974; Hammer & Landsberg,1975; Hart & Bassett, 1975; Heinemann & Yudin, 1974; Littlepage, Kosloski, Schnelle, McNees & Gendrich, 1976), and telephone crisis intervention programs (Preston, Schoenfeld & Adams, 1975).

Previous studies have utilized a number of methods to assess client satisfaction, such as; telephone interviews (Denner & Halprin, 1974; Hammer & Landsberg, 1975; Hart & Bassett, 1975; Heinemann & Yudin, 1974; Littlepage et al., 1976; Preston et al., 1975), in-person interviews (Hart & Bassett, 1975), mailed questionnaires (Denner & Halprin, 1974; Hammer & Landsberg, 1975; Heinemann & Yudin, 1974), and questionnaires completed in-person by program participants (Eder & Kukulski, 1975; Quilitch, 1978). However, methodological problems, including a lack of standardized measures and procedures for assessing satisfaction, have been pointed out (Albers, 1977). The majority of studies have surveyed post-treatment client satisfaction

and neglected systematic assessment of clients' perceptions of services throughout their contacts with a given agency (e.g., Denner & Halprin, 1974; Hammer & Landsberg, 1975; Heinemann & Yudin, 1974; Littlepage et al., 1976). Consistently "high" satisfaction rates reported in the literature (65% to 85%) have also raised question concerning the influences of sampling problems, uncontrolled response biases and reluctance of clients to critically rate services provided (Albers, 1977; Preston et al., 1975).

A pervasive problem identified in mental health programs has been the premature termination or "dropout" of clients receiving outpatient treatment (Albers, 1975; Baekeland & Lundwall, 1975; Brandt, 1965; Littlepage et al., 1976; Scrivner, 1975). Typically defined as termination without the mutual agreement of the therapist, previous reports suggest that dropout rates of 50% or greater by the third appointment with an agency are not atypical (Baekeland & Lundwall, 1975; Brandt, 1965; Littlepage et al., 1976). Extensive literature has been devoted to the identification of factors related to premature termination from treatment (see Baekeland & Lundwall, 1975; Brandt, 1965). However, inconsistent findings regarding variables associated with dropout has led some investigators to conclude that characteristics are not identifiable that distinguish premature terminators from those clients who continue in treatment (Brandt, 1965; Morrow, Del Gaudio & Carpenter, 1977; Stern, Moore & Gross, 1975). Socioeconomic status has been the sole client characteristic that has been consistently correlated with termination from treatment, wherein premature terminators are predominated by lower socioeconomic classes (Stern et al., 1975, 1977).

The survey of client satisfaction has been a little used approach to the study of factors related to premature termination. The assumption that premature terminators tend to be dissatisfied with services and failures in treatment has been frequently advanced (Littlepage et al., 1976). However, previous studies suggest a lack of consistent relationships between client satisfaction and dropout. Kline, Adrian and Spevak (1974) found clients that terminated prematurely from treatment to be the least satisfied with services. In contrast, Littlepage et al. (1976) reported that clients who dropped out of therapy rated services as highly as those clients that followed through with treatment. A lack of positive correlations between the number of clinic visits kept by clients and satisfaction has also been pointed out (Hart & Bassett, 1975). These inconsistent findings have led Albers (1975) to conclude that no clear relationship between satisfaction levels and outcome in treatment has been identified with present methodologies.

While the majority of studies on premature termination have examined dropouts following the start of formal treatment, a limited number of investigators have reported data on pretherapy or intake dropout. Few consistent differences have been found between clients that drop out prior to the start of therapy and those who drop out later. There is some suggestion that dropouts during the intake process tend to be of lower socioeconomic status (Brandt, 1965), to give more excuses when scheduling appointments (Bernal & Kreutzer, 1976), and to be more reluctant to accept responsibility for their problems (Brandt, 1965).

Although the premature termination of adult clients has received the greatest attention, studies of dropouts from family and child mental

health programs have also been reported. Significant differences between dropouts and those who continue in child-related treatment have not consistently been found. However, the primary influence of the parent in determining continuation in treatment has been emphasized. Correlations have been found between dropout and the parent's socioeconomic status, awareness of the child's problems, as well as acceptance and expectations of mental health services. (Baekeland & Lundwall, 1975; Brandt, 1965; Garcea & Irwin, 1962).

The Battle Creek Child Guidance and Adult Clinic (BCCGAC) provides traditional outpatient guidance services to children/youth, parents and families. In keeping with the traditional child guidance model, a relatively routine screening and diagnostic assessment is made of families immediately following referral. A parent typically makes a referral of a child to the BCCGAC by telephoning the clinic and providing specific referral information. Once the referral is made a screening and diagnostic study is begun with the parent(s) seen first for a screening interview by a staff member. Subsequently, the child is seen for an individual clinical, psychological and/or psychiatric evaluation interview as needed. The final "interpretive" interview involves the presentation of a diagnostic formulation and treatment recommendation to the parent(s). While there are variations in the numbers and types of interviews conducted in the screening and diagnostic sequence, three to four interviews are typically held with a family.

An examination of the pattern of dropouts for families referred to the BCCGAC found that approximately 33% of all clients were seen for three or fewer clinic visits. That is, about one third of the families referred

did not complete the initial series of three to four screening and appraisal appointments and/or did not begin formal treatment when recommended. Therefore, the present investigation examined the factors potentially related to the BCCGAC early attrition rate. The purposes of the present study were: (a) to develop a standardized measure for the assessment of clients' satisfaction with outpatient services, (b) to develop a systematic procedure for assessing clients' attitudes and impressions of clinic services prior to formal treatment (i.e., throughout the initial intake and diagnostic evaluation sequence), and (c) to identify factors related to premature termination of families from child mental health services, including client satisfaction with services and demographic variables (i.e., client and therapist characteristics). It was hypothesized that clients who terminated prematurely would be characterized by greater dissatisfaction with Clinic procedures and services.

Method

Subjects

The study dealt with 238 families whose child (ranging in age from 1 to 18) was referred for outpatient mental health services over a 9-month period of time during 1977-78. While total child referrals during this period was 270, 32 families were eliminated from the sample because of extenuating circumstances (e.g., moved out of catchment area, family disruption due to death or serious illness, child removed from home, second referral from the same family, client unable to read, etc.). The sample included 355 parents who comprised the primary population studied. Characteristics of the families studied are summarized in Tables 1 and 2.

Instruments

Three brief Client Satisfaction Questionnaires (CSQs) were developed (see Appendix A) and routinely administered throughout the assessment sequence which typically involved three to four Clinic visits. All Clinic staff were utilized in determining the content of the items. The endeavor was to cover as comprehensively as possible the various aspects of known (from client remarks) and suspected client dissatisfaction, while keeping the response format and length of the questionnaires as straightforward and brief as possible.

The first questionnaire, labeled Form 1, was designed to assess reactions to the Clinic prior to the initial interview. This 9-item questionnaire inquired as to how the client learned about the Clinic, the client's feelings about contacting the Clinic, whether the referral was voluntary or required, and how the initial phone call and waiting period prior to the first appointments were perceived. Form 1 was administered when the parents arrived for the first screening appointment. Clients' reactions to each interview in the screening or appraisal sequence was assessed by a second CSQ, Form 2. This 12-item questionnaire inquired as to the clients' perceptions of the length of time since the previous contact, the reason for the visit, the clinician, the helpfulness of the Clinic in terms of understanding and correcting the problem, and the probability of returning for future visits. Form 2 was issued immediately following each evaluation interview. This questionnaire was also administered to children 14 years of age or older after being seen for evaluation. A third CSQ, Form 2S, is a shortened, 7-item version of Form 2, administered to parents following diagnostic interviews where only the child was seen.

Table 1

Demographic Characteristics of Referred Children in Sample (n=238)

Characteristic		Frequency	Percent
A) Sex	M	164	69
	F	74	31
B) Age	0-6	59	25
	7-12	100	42
	13-17	79	33
C) Race	White	207	88
	Black	28	11
	Other	3	1
D) Presenting problems [1]			
	Discipline/behav.	114	48
	Communication	93	39
	Poor peer-sib relations	89	37
	Temper	83	35
	Academic/learning	69	29
	Withdrawal-depressed	55	23
	Hyperactive	49	21
E) Diagnosis [2]			
	Adjustment/situational disturbance	116	50
	Behav.disorders	45	19
	Neuroses	30	13

[1] Parents typically listed more than one problem for the child. Presenting problems listed with less than 20% frequency not included in table.

[2] From Diagnostic and Statistical Manual, 2nd Ed. (DSM-II). Formal diagnosis was sometimes deferred through the evaluation study. Diagnostic categories not listed in table occurred at less than 10% frequency.

Table 2

Demographic Characteristics of Parents in Sample (n=355)

Characteristic		Frequency	Percent
A) Age			
Mothers	Mean age 33.8		
20-30		96	42
31-40		88	39
41-50		33	14
over 50		11	5
Fathers	Mean age 37		
20-30		35	26
31-40		56	42
41-50		27	20
over 50		16	12
B) Education			
Mothers			
Below h.s.		59	25
H.s.		103	44
Above h.s.		70	31
Fathers			
Below h.s.		34	26
H.s.		51	38
Above h.s.		48	36
C) Family Income			
Under 6000		78	34
6-12000		55	25
12-18000		47	20
18-24000		27	12
Over 24000		22	9
Mean income	$11,900		
Mdn. income	$ 9,600		
D) No. parents in home			
1		109	45
2		129	54

The CSQ items typically involved choices between "true", "false", or "uncertain" responses with the exception of three items on Form 1 that involved checking which of six to eight responses applied. Approximately 20% of all CSQ items were worded and scored negatively in order to help control for response bias. While there was an interest in constructing items that would provide unique information concerning satisfaction with different aspects of the Clinic's services, it was also important to have a single, overall measure of satisfaction. A scoring system was developed for each questionnaire and a total satisfaction score was derived for the clients following all interviews. Total scores were computed by assigning the values 2, 1 and 0 to "true", "uncertain", and "false" responses, respectively, associated with all positively stated items (i.e., 1, 4, 6, 7, 9, 10, 11, and 12). The values 0, 1, and 2 were assigned to "true", "uncertain", and "false" responses, respectively, for all negatively stated items (i.e., 2, 5, and 8). Item 3 was scored 2 for the "just right" and 0 for "too brief" or "too long". The sum of the item scores yields the total score.

In order to evaluate the adequacy of the items in the composite, correlations were computed between each item and the total test score. All correlations were positive and acceptably high. Hence, the total score can be viewed as an acceptable measure of general satisfaction with Clinic services.

Procedure

CSQ Form 1 was issued by the receptionist prior to the initial interview. The clinician, or interviewer, then issued Form 2 following the initial session. All subsequent CSQs (Form 2 or 2S) were issued by the clinician

following completion of each evaluation session. Clients were requested to complete the CSQs on the Clinic premises. All clients (families) seen for at least one interview were eligible for inclusion in the study.

During the study period, an overall questionnaire return rate of approximately 80% was achieved. Table 3 summarizes the CSQ return rates according to individuals as well as families represented in the study. Early in the study return rates were adversely affected by low issuance rates on the part of the staff. Consequently, a monetary incentive program was successfully instituted resulting in satisfactory coverage of eligible respondents.

As can be seen in Table 3, the return rates are very similar for total individuals and families, suggesting that the CSQs were typically issued to all eligible family members present. The relatively low return rates for interviews later in the evaluation sequence is attributable to a reduction in issuance rates by the staff. The issuance and return rates for children were so low that they could not be meaningfully included in the data analysis.

Demographic and other independent variables analyzed are listed in Table 5. Included are: general characteristics of a clinician, referral source, prior treatment, presenting problems, diagnosis, general family characteristics, as well as more specific child and parent attributes, and certain time intervals (number of days) between various appointments during the evaluation sequence. In the latter category, the number of days intervening between telephone referral and initial appointment, between initial appointment and interpretive interview, and between psychiatric interview and the previous interview were studied.

Table 3

Client Satisfaction
Questionnaire Return Rates

		Families Represented[a]			All Individuals Seen		
Type of Interview	CSQ Form	Number of Families	Number with CSQs	Percent	Total Parents Seen	Number with CSQs	Percent
Screening	1	238	236	99	355	332	94
Screening	2	238	193	81	355	285	80
Clinical	2 or 2S	66	63	96	91	88	97
Psychological	2 or 2S	24	21	88	29	26	90
Psychiatric	2 or 2S	94	54	57	134	81	60
Interpretive	2	188	118	63	278	176	63
Total		848	685	81	1242	988	80

[a] Families with at least one CSQ available for each type interview

The latter interval was selected because of frequent difficulties in scheduling psychiatric interviews due to the limited availability of such services.

The following criteria were utilized to classify the clients by termination status:

(1) The "follow through" category (n=155) includes those clients who completed the entire diagnostic sequence and accepted the Clinic's recommendations. When ongoing treatment was recommended, these clients kept at least one treatment session.

(2) Terminators were classified in one of the two following categories:

(a) "Termination by mutual agreement" between client and clinician (n=23). These cases met at least one of three criteria; namely, further evaluation was not indicated (i.e., problem insufficient to warrant further service), the problem was alleviated or resolved, and/or the referral was inappropriate (case may have been referred elsewhere).

(b) "Premature termination" (n=60) occurred where the client unilaterally decided to discontinue contacts with the Clinic. These cases met at least one of four criteria: namely, client decided the child not in need of help, client failed or cancelled one or more interviews without rescheduling, client indicated a plan to terminate due to dissatisfaction with the Clinic's services, and/or the reason given by the client for termination did not seem justified by the clinician.

The "termination by mutual agreement" subjects were combined with the "follow through" group and together they were viewed as having successfully

accomplished the pretherapy objectives (i.e., evaluation of the problem, mutually agreed upon a plan of intervention, and preliminary evidence of follow through). Thus, completion of the evaluation sequence together with client-clinician agreement on conditions under which termination should occur were used as the criteria against which the relative contributions of client satisfaction and demographic variables were weighed.

Seventy-six percent of the terminated clients were equally distributed over two interviews, that is, following the initial and the interpretive sessions. The remainder were relatively evenly distributed across the intervening interviews.

Results

The major analysis effort focused on the identification of variables that were related to premature termination. The results are presented in terms of mean differences and probability values for three classes of explanatory variables: (a) clinician or therapist, (b) CSQ responses or client satisfaction, and (c) demographic and other client characteristics.

While data were available on several clinician/therapist variables such as age and sex, there is little reason to describe the relationship between these variables and premature termination because the preliminary analysis of differences among 11 clinicians revealed nonsignificant ($p=.83$) effects on the premature termination classification. That is, the proportion of clients who were classified as premature termination cases did not differ significantly (or practically) across clinicians. Given the absence of differences, data were combined for all clients across clinicians for remaining analyses.

The relationship of CSQ total scores with the premature termination classification can be seen in Table 4. None of the comparisons of the

Table 4

Comparison of Follow Through and Premature Termination Groups on Total CSQ

CSQ Form	Person Completing CSQ	Interview When CSQ Completed	Mean Follow Through	Mean Premature Termination	p*
2	Mother	Screening	19.83	20.09	.66
2	Father	Screening	19.00	18.28	.45
2	Mother	Clinical	21.50	21.33	.93
2	Mother	Psychiatric	16.55	17.00	.84
2	Father	Psychiatric	19.00	19.33	.89
2	Mother	Interpretive	21.35	19.47	.07
2	Father	Interpretive	20.65	18.89	.28
2S	Mother	Clinical	12.03	11.83	.87
2S	Mother	Psychological	11.71	12.00	.85

*p values are probability values based on analysis of variance F tests on the mean differences between follow through and premature termination groups.

two groups yield p values below .05. Separate anlyses, not presented in detail here, were carried out on each item of the various CSQ forms. It was found that no item* individually discriminated between the premature termination and follow through groups. In addition, discriminant analysis procedures were employed to investigate the possibility that some linear combination of the item scores would discriminate between the two groups. Again, the results were disappointing, no combination of CSQ item scores discriminated between follow through and premature termination clients.

Demographic and other client characteristics constitute the third general class of variables employed to discriminate between follow through and premature termination groups. A summary of the variables employed and the associated probability values can be seen in Table 5. Two variables in this class have p values equal to or less than .05. These variables are "hyperactivity" and Mother's education."

The summary statistics for the hyperactivity variable are as follows:

		Treatment	Premature Termination
Hyperactive?	NO	140	42
	YES	29	18

If these frequencies are transformed into proportions, we find that .17 of the treatment group and .30 of the premature termination group were

* Some items yielded individual p values below .05 but when the appropriate simultaneous inference procedures were employed, no significant differences were identified.

Table 5

Demographic and Other Variables and Associated Probability Values*

VARIABLE	p
Referral Source	.17
Time Intervals	
Phone to Screening Interval	.60
Screening to Interpretive Interval	.64
Previous Interview to Psychiatric Interview	.50
Therapist Characteristics	
Sex	.68
Age	.57
Family Characteristics	
Family Size	.39
Number of Parents in Home	.70
Number of Children in Home	.49
Gross Income	.51
Which Parents Seen	.74
Mother Characteristics	
Age	.44
Race	.75
Education	.04
On Medicaid	.19
Marital Status	.19
Parental Status	.84
Employed	.64
Father Characteristics	
Age	.18
Race	.31
Education	.16
On Medicaid	.93
Marital Status	.40
Parent Status	.17
Employed	.58
Child Characteristics	
Age	.83
Sex	.36
Race	.69
Birth Order	.22
Prior Clinic Contact	.69
Prior Treatment Elsewhere	.38
Presenting Problems	
Underachievement	.57
Disruptive Class Behavior	.77
Discipline Problems	.34
Hyperactivity	.05
Disruptive Behavior	.94

Table 5 (continued)

VARIABLE	p
Stealing	.42
Lying	.91
Sassing	.33
Temper Tantrums	.28
Withdrawn	.90
Communication Problems	.72
Bedwetting	.29
Sleeping	.16
Immaturity	.60
Sibling Relationships	.58
Eating Habits	.96
Coordination Problems	.66
Diagnosis Classification	.78

*These probability values are based on analysis of variance F tests or chi square tests depending upon whether the response variable was sealed continuously or as a nominal classification.

classified as hyperactive. In the case of the "Mother's education" variable, we find the following descriptive statistics:

	Mean	Standard Deviation
Treatment Group	12.03	2.11
Premature Termination Group	12.88	4.04

While the tests on the difference between proportions in the case of "hyperactivity" and the difference between means (and standard deviations) in the case of "Mother's education" are statistically significant using conventional univariate procedures, the use of such procedures must be questioned when a large collection of variables is employed. When multivarite procedures that are designed to take into account the large number of variables included in this study are employed, no significant effects are identified among those analyzed in this class of variables.

In summary, none of the variables included in the three classes of explanatory variables reliably discriminated between treatment and premature termination groups. Not only did the individual variables fail to discriminate, but linear combinations of variables employed in complex discriminant function analyses were likewise unsuccessful.

Discussion

Contrary to prior expectations, premature terminators and clients who followed through with Clinic services were not distinguishable on the basis of the demographic and client satisfaction variables examined. However, similar findings have been reported. With regard to the demographic variables, a number of previous studies (40%) on dropout from child outpatient programs have failed to find significant differences between premature terminators and continuers in treatment (Baekeland &

Lundwall, 1975). While negative findings have been typical of the methodologically sound child therapy studies (e.g., Williams & Pollack, 1964), the more poorly designed and inappropriately analyzed studies have found significant effects related to client characteristics (Baekeland & Lundwall, 1975). Further, the significant relationships reported between demographic variables pertaining to socioeconomic status and premature termination have primarily been found in studies dealing with adult populations (Stern et al., 1975, 1977). The lack of relationship between client satisfaction levels and premature termination has also been reported previously (Littlepage et al., 1976). The present findings support the contention that clear relationships between client satisfaction and outcome in mental health programs are not readily identifiable (Alberts, 1975).

The definition of criteria for premature termination has been pointed out as a potential methodological problem in dropout studies (Baekeland & Lundwall, 1975; Brandt, 1965; Morrow et al., 1977). The extent to which these criteria are arbitrarily defined may mask relationships between premature termination and other variables. The present definition of premature termination emphasized the lack of agreement between the clinician and client as to the services needed. An arbitrary clinician-defined cut-off for termination (i.e., failure to complete the screening and diagnostic evaluation sequence) was utilized. The failure to find greater dissatisfaction levels among premature terminators suggests that clients may have received the services they desired despite the lack of agreement with the clinician as to the appropriate time for termination. It appears that the expectations of the client and therapist may differ considerably in terms of the services required and the anticipated outcomes.

Thus, what the clinician defines as "premature" may not be to the client. Difficulty in distinguishing between evaluation versus therapy (Brandt, 1965) and short-versus long-term therapy (Littlepage et al., 1976) are further examples of clients' inability to differentiate between arbitrary clinician definitions. Given these considerations, the validity of criteria for premature termination requires further specification and arbitrary clinician-defined criteria (e.g., number of interviews held) appear inadequate. Incorporation of objective measures of outcome or "success" of services, in addition to clinicians' judgments, is warranted.

To the extent that the method of defining the premature termination group was valid, it can be concluded that the clients seemed satisfied with this Clinic's services and procedures. Relatively high mean total scores on CSQs support overall high levels of client satisfaction prior to the start of therapy.

The failure of individual CSQ items to discriminate between premature termination and follow through groups suggests the possible operation of response biases by clients. Of particular interest were responses to items such as "I plan to return to the Clinic" (Form 2 item 11, Form 2S item 6) where no differences were found between groups. These data indicate that premature termination is not even predictable from what clients say they will do! Thus, the straightforward approach of directly asking clients about their perceptions and attitudes toward Clinic services yields little useful information in terms of predicting dropouts. Certain demand characteristics of the questionnaire administration procedure may also have influenced response sets. Since clients were asked to complete CSQs in the Clinic prior to leaving* implicit influences to

* due to poor return rates with mailed questionnaires in a pilot study

respond positively may have been operating. For example, CSQs were often issued by clinicians that the client knew would be seeing the family again. Further, the present study was conducted early in clients' contacts with the Clinic which is often a time of considerable distress for clients. Questionnaire responses may have been exaggerated in a positive direction by clients who felt the need to assure continued receipt of services. Continued development and validation of the CSQs are being carried out and utilization of a greater number of scale values (e.g., 1-7 options versus True-False-Uncertain) is of particular interest.

The present study potentially suffered from a lack of input from child clients. While parents have definite influences on the decisions to seek and continue services, (Baekeland & Lundwall, 1975), the influences of the child has not been delineated. The extent of negotiation between the child and parent(s) in making the decision concerning returning to the clinic requires further assessment. While the present study attempted to receive feedback from adolescents (14 years and older), low CSQ return rates resulted in adequate data. More systematic assessment of children's perceptions of mental health services would provide for interesting comparisons (e.g., with parents', dropout rate, etc). Since either the child or parent can have greater control in a given case, there is a source of confounding in the premature termination of families from child services that may not be present in adult services. The authors are presently utilizing the CSQ method of assessing client satisfaction with an adult population.

Finally, a primary purpose of any program evaluation study is the provision of information of potential use in program planning. The

present findings provide little in that regard. In terms of premature termination, it was not possible to identify specific client, therapist, or program characteristics that could be addressed in an effort to reduce the frequency of premature terminations. Taken with previous data, these results suggest that premature termination may not be the "problem" that is typically assumed as clients who terminate prematurely are not necessarily more dissatisfied and may not be premature at all. The degree to which mental health programs have control over variables that could be manipulated to alter termination rates also appears quite limited.

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APPENDIX A

Client Satisfaction Questionnaire Form 1

Client Satisfaction Questionnaire Form 2

Client Satisfaction Questionnaire Form 2S

BATTLE CREEK CHILD GUIDANCE & ADULT CLINIC

Questionnaire - Form 1

FATHER

Staff Member Seen:______________________ Date____________

1. I learned about the Clinic from: (Check one)

___Family doctor	___Employer
___School	___Phone Book
___Friend	___Service Agency (Name___________)
___Relative	___Other (Where?_______________)

	True	False	Uncertain
2. Coming to the Clinic was my own idea	( )	( )	( )
3. I did not voluntarily come to the Clinic.....	( )	( )	( )

I feel my coming to the Clinic is required of me by__________________________
what office or organization?

4. I felt no hesitation in contacting the Clinic...	( )	( )	( )

If I did hesitate, it was because.......
(Check which items apply)

___I don't really believe Clinic referral is needed.
___I was concerned about what others might think or say.
___I felt it was being required, rather than voluntary on my part.
___My husband (or wife) was against it.
___I felt unsure about what the Clinic does.
___I thought it would cost too much.
___I'd heard negative remarks about the Clinic from others.
(Can you say what_______________and by whom? - Please answer on the other side.)

5. Regarding the wait for my first appointment, I (check one)

___thought it was reasonable.
___wish it were shorter.
___wish it were longer.

			I didn't get one
6. I found the brochure describing the Clinic's services helpful..........................	( )	( )	( )

Answer the following 3 questions only if you made the first phone call to the Clinic:

7. My first phone call to the Clinic was helpful............................	( )	( )	( )

8. After my first phone call I felt (check which items apply)

___confused	___hopeful	___neutral
___relieved	___frustrated	___other?______________

9. I felt free to call the Clinic back if the problem became more critical...........	( )	( )	( )

BATTLE CREEK CHILD GUIDANCE & ADULT CLINIC

Questionnaire - Form 2

MOTHER
FATHER
ADULT

Staff Member Seen: ______________________ Date: __________

Interview: ______________________

		True	False	Uncertain
1.	I feel the length of time since my last contact with the Clinic (visit or phone call) was reasonable	( )	( )	( )
2.	I did not understand the purpose of this visit . . .	( )	( )	( )

3. I felt today's visit was:

______too brief
______just right
______too long

		True	False	Uncertain
4.	The person I talked with seemed to understand what I was worried about	( )	( )	( )
5.	The visit(s) didn't help me get a better understanding of the problem	( )	( )	( )
6.	I was given some suggestions or ideas that I could use right now	( )	( )	( )
7.	I feel more certain that the problem can be corrected	( )	( )	( )
8.	I don't know what the next step in the evaluation will be.	( )	( )	( )
9.	I agree with the recommendations made so far	( )	( )	( )
10.	So far my contact with the Clinic has been helpful.	( )	( )	( )

If not, briefly explain why______________________
____
____

		True	False	Uncertain
11.	I plan to return to the Clinic	( )	( )	( )
12.	I feel that I can call the Clinic at any time if the problem becomes more critical	( )	( )	( )

Additional Comments:

BATTLE CREEK CHILD GUIDANCE & ADULT CLINIC

Questionnaire - Form 2-S

MOTHER
FATHER
ADULT

Staff Member Seen:________________________________ Date:______________

Interview:____

	True	False	Uncertain
1. I feel the length of time since my last contact with the Clinic (visit or phone call) was reasonable	( )	( )	( )
2. I did not understand the purpose of this visit	( )	( )	( )
3. I felt today's visit was:			
_____too brief			
_____just right			
_____too long			
4. So far my contact with the Clinic has been helpful.	( )	( )	( )
If not, briefly explain why______________________			
5. I don't know what the next step in the evaluation will be.	( )	( )	( )
6. I plan to return to the Clinic	( )	( )	( )
7. I feel that I can call the Clinic any time if the problem becomes more critical.	( )	( )	( )

Additional Comments: