Community Mental Health Journal, Vol. 40, No. 1, February 2004 (© 2004)

Exploring the Consumer's and Provider's Perspective on Service Quality in Community Mental Health Care

Karen Mason, Ph.D.
Antonio Olmos-Gallo, Ph.D.
Donald Bacon, Ph.D.
Michael McQuilken, A.A.S.
Aimee Henley, Ph.D.
Steve Fisher, M.A.

ABSTRACT: A series of seven focus groups of community mental health care consumers were conducted to identify the factors that contributed to consumer satisfaction. Three major themes were identified: bonding with providers, provider competence/knowledge, and cultural/religious competence. These findings are compared with findings from several healthcare satisfaction studies. Four focus groups with providers were also conducted to identify barriers to service quality. The major theme identified was that providers strive to have more time with consumers but struggle with large caseloads and large amounts of paperwork. An important finding is that consumers want to have their culture and religion seamlessly woven into service delivery. Potential explanations for the consumers' and providers' discrepant perspectives, conclusions and future areas for research are explored.

KEY WORDS: consumers; providers; service; quality.

Karen Mason and Antonio Olmos-Gallo are affiliated with the Mental Health Corporation of Denver.

Donald Bacon is affiliated with the University of Denver.

Michael McQuilken, Aimee Henley, and Steve Fisher are affiliated with the Mental Health Corporation of Denver.

Address correspondence to Karen Mason, Ph.D., Mental Health Corporation of Denver, 4141 E. Dickenson Place, Denver, CO 80222; e-mail: kmason@mhcd.com.

> Remarkable treatments exist, and that's good. Yet many people—too many people—remain untreated. (George W. Bush, April 2002)

INTRODUCTION

One of the biggest challenges facing community mental health (CMH) today is that some of those who could benefit from treatment either never begin or fail to continue the treatment. Nearly two-thirds of all people with diagnosable mental disorders do not seek treatment (Kessler et al., 1996; Regier et al., 1993). For those who do seek treatment, drop out rates are as high as 40 to 60% (Kazden, Holland, & Crowley, 1997; Sue, Fujino, Hu, Takeuchi, & Zane, 1991). Untreated mental disorders can lead to lost productivity, unsuccessful relationships and distress (Surgeon General, 1999). This negative effect on individuals and society is unfortunate because effective treatments exist and recovery from major mental illness is possible (Harding, Brooks, Ashikaga, Strauss, & Breier, 1987; Harding & Zahniser, 1994). Despite the burden of untreated mental health disorders on health and productivity being only second to cardiovascular diseases (Murray & Lopez, 1996), little has been done to identify consumer requirements in CMH.

Some research has shown a relationship between overall satisfaction and adherence to treatment (Bradshaw, 2002; Echeburua, Fernandez-Montalvo, & Baez, 2001; Larsen, Attkisson, Hargreaves, & Nguyen, 1979; Pekarik, 1992; Wierzbicki & Pekarik, 1993;). Other research has shown that programs that specialize in serving minority communities are successful in encouraging minorities to begin and remain in treatment (Mathews, Glidden, Murray, Forster, & Hargreaves, 2002; Snowden, Hu, & Jerrett, 1995; Sue et al., 1991; Yeh, Tekeuchi, & Sue, 1994). Thus, to enhance engagement and retention in treatment, CMH must offer services that are responsive to the requirements of consumers and their families. However, CMH centers have yet to specifically define their consumers' requirements in order to determine the basis of consumer satisfaction and loyalty.

The determinants of consumer satisfaction is a topic that has been extensively researched in the marketing literature (Dabholkar, Shepherd, & Thorpe, 2000; Yi, 1990). One widely used conceptual model in that literature is Parasuraman, Zeithaml, and Berry's (1985) "gap analysis model," used to analyze the factors that lead to a gap between what consumers want and what providers deliver. An important contributor to this gap is the provider's understanding of what the consumer wants and the provider's ability and willingness to deliver it. This re-

search offers insight into this service quality gap by identifying the factors that contribute to consumer satisfaction, and by identifying the factors that providers perceive as barriers to service delivery.

Where consumer requirements are not known, a common method is to begin with qualitative methods such as focus groups to help define unknown variables (Omar & Schiffman, 1995; Parasuraman, Zeithaml, & Berry, 1988; Radwin, 2000). The primary goal of qualitative methods is to ensure that variables, which the researchers do not consider, but consumers deem important, are included in any future research (Ware, Tugenberg, Dickey, & McHorney, 1999). The purpose of the present research is to apply focus group research in the context of CMH in order to begin to understand consumer requirements related to satisfaction and the barriers to providing these. In this research, seven focus group sessions with consumers and four focus groups with providers were conducted and analyzed using Krueger and Casey's (2000) approach.

Satisfaction Studies in Healthcare

Healthcare satisfaction studies typically draw the same conclusion: relationships characterized by bonding and caring are key determinants to consumers' satisfaction. For example, Mowen, Licata, and McPhail (1993) found that the factor that accounted for the most variance in satisfaction (40%) in a hospital emergency room was trust. Lewis (1994) reviewed 221 studies in the U.K. and found that practitioner's behavior was one of three factors strongly related to patient satisfaction. Lewis emphasized that "bedside manner" is not a new concept but seems to be often overlooked by satisfaction surveys though "it also appears to be the aspect of care most consistently demanded by the consumer" (p.668). Beck, Daughtridge, and Sloane (2002) reviewed research on Physician-Patient Communication in the Primary Care Office and concluded that the quality of interactions influences satisfaction, recall, adherence, symptom resolution and quality of life. Other studies support the importance of the quality of the relationship as the key determinant of consumer satisfaction (Gremler, Gwinner, & Brown, 2001; Omar & Schiffman, 1995; Radwin, 2000). It is clear that consumers' perception of caring and trust in the provider is one of the most important factors which consumers use to determine quality care and on which their satisfaction depends.

Cultural Congruence

Of interest in this study was whether the congruence between provider and consumer, especially culturally congruent expectations, would be

related to satisfaction. There is a large body of literature to suggest the importance of culture. As stated succinctly by the Surgeon General (2001): "culture counts." Many studies have found better outcomes with race concordant relationships (Copper-Patrick et al., 1999; Mathews, Glidden, Murray et al., 2002; Sue, 1998) though the relationship to ethnicity of some aspects of treatment such as diagnosis is not yet clearly understood (Mathews, Glidden, & Hargreaves, 2002). These studies suggest that congruence between service providers and consumers may lead to consumer satisfaction, increased patient involvement and retention in care, and positive mental health outcomes.

Provider Satisfaction

There are equivocal findings in the literature on the relationship between employee satisfaction and consumer satisfaction. For example, whereas Winefield, Murrell and Clifford (1995) found no correlation between providers' satisfaction with how a visit went and patient satisfaction, Jimmieson and Griffin's (1998) research with clients and employees of an addictions agency found that organizational variables accounted for a significant proportion of variance in client satisfaction. These equivocal findings argue for the inclusion of provider satisfaction in a study on consumer satisfaction.

METHODS

Procedures

The focus groups were conducted at a large urban CMH center serving seriously and persistently mentally ill individuals. The consumer and provider focus group interviews were semi-structured with questions developed by a team of four providers/administrators, one consumer, and one program evaluator. The questions (see Appendix A) were based on the Mental Health Statistics Improvement Program Consumer Survey (1996, April). Agency members and doctoral students from a local university were trained on focus group methodology. The students facilitated the three provider focus groups in order to protect the confidentiality of the participants' comments, minimize interviewer bias, and minimize demand effects. Each consumer focus group was facilitated by one of the trained facilitators and attended by a note taker. Note takers produced an abridged transcript based on post-session debriefing and an audiotape (see Krueger & Casey, 2000).

Consumer Sample

Whereas quantitative researchers seek a sample that resembles a larger population in all its pertinent characteristics, qualitative researchers seek a sample that represents

types of people in a larger population. Krueger and Casey (2000) write: "Keep in mind that the intent of the focus group is not to infer but to understand, not to generalize but to determine the range, and not to make statements about the population but to provide insights about how people in the groups perceive a situation" (p. 83). (Also see Parasuraman, Zeithaml, and Berry's [1988] development of the SERVQUAL scale.) Therefore, the sample was representative for types of services: one team from each type of service in the agency was identified. With the assumption that some possible inaccurate contact information or last minute emergency may occur, a list of 20 potential participants was randomly generated for each team and 15 were invited in order to assure an ideal focus group size of six to eight participants (Krueger & Casey, 2000). Invitees were informed that they would be compensated $20 for their participation. Response rates ranged from 22% for assertive community treatment to 50% for the Clubhouse. Although it is not known how participants differed from non-participants, Peterson and Wilson (1992) argue that dissatisfied customers are as likely to respond to surveys as satisfied customers. Furthermore, it is clear from consumers' comments that our sample included both satisfied and dissatisfied consumers. However, the random sample representative of service delivery models, the respectable response rates, and the sample's similarity to agency wide demographics support that the sample is representative for this CMH center.

Consumer Demographics

A total of 42 consumers participated in seven separate groups. Of the 35 who completed the demographic form, nearly two-thirds (65%) were male. In terms of ethnicity, 49% self-identified as Caucasian, 29% as Hispanic, and 14% as African American. In terms of their living situations, 31% live with family, 26% live in their own apartment, 23% live in a group home, 14% live in an agency Congregate Apartment, and 6% live in other situations. Nearly half (47%) reported being in the 40–49 year old age range, while only one reported being in the 19–29 age range and one in the 60–69–age range. Five 13–15 year olds participated. The average length of treatment at the agency was 5.7 years with a range of two months to 13 years (the maximum possible based on the beginning of the agency).

Provider Procedures, Sample and Demographics

Three intact teams were recruited to participate from three types of services. Nineteen providers participated in these provider focus groups. All the agency program managers were invited to attend a focus group; four self-selected to attend. Groups began with participants completing the demographic form and giving signed consent for audiotaping. The list of questions used in the subsequent semi-structured interview can be found in Appendix B.

Of the 19 providers and 4 program managers who participated, 78% self-identified as Caucasian. Of those remaining, 22% self-identified as Asian ($n = 1$), Hispanic/Latino ($n = 1$), African American ($n = 1$), and Other ($n = 1$). Over half (57%) were women. Their ages were mainly in the 40–49 year old age range (35%) and the 50–59-age range (35%). A total of 43% reported having a master's degree, while 30% reported having a bachelor's. In terms of experience, 43% reported having been in the mental health field more than 10 years, 35% for 5–10 years. In terms of provider stability, over a quarter (33%) have been at their current *agency* 5–10 years, while 22% for 3–5 years. 17% have been at the agency less than 6 months, a statistic that speaks to turnover (which averages at 38% annually for the agency).

RESULTS

Patton (2002) writes "no formula exists for transforming [qualitative data into findings] . . . Guidelines, procedural suggestions, and exemplars are not rules" (pp. 432–433). He explains that "content analysis is used to refer to any qualitative data reduction and sense-making effort that takes a volume of qualitative material and attempts to identify core consistencies and meanings" (p. 453). The method of content analysis was identification of recurring themes and patterns (Patton, 2002) using abridged transcripts (Krueger & Casey, 2000), a methodology well documented in the qualitative research field (Heppner, Kivlighan, & Wampold, 1992; Peter Van Arsdale, Ph.D., personal communication, January 2001). Three researchers (a consumer researcher, a psychologist and a program evaluator) independently read each transcript across questions and across focus groups, reducing all statements into approximately ten themes, then resorting into five patterns, then recategorizing into approximately three trends. Each worked to identify emergent categories of meaning (Krueger & Casey, 2000; Ware, Tugenberg, Dickey, & McHorney, 1999) and then discussed their findings to consensus, a process called "analytical triangulation" (Patton, 2002, p. 464). The researchers reached consensus with very little divergence of opinion on the following themes.

Consumer Results

Three major themes were identified from the consumer focus group: bonding with providers, competence/knowledge, and cultural/religious competence. It is important to note that all three of these involve the consumer-provider relationship. Bonding for participants is built on the provider relating to consumers as full human beings, or as one participant put it, "The ideal counselor is someone who is concerned about [me and my family]; someone who really cares about me . . . someone who remembers things about me from past sessions, who is interested in my life and well-being as a whole." An important aspect of bonding is knowing the person as well as the illness, in contrast to the perception of one participant who lamented, "I believe in general they know my illness well, but I would like them to get to know me better."

Provider turnover has a negative effect on bonding. One participant observed, "It is hard to open up to someone because of the personal issues we have to talk about. You get used to someone and then they are gone." Some consumers may feel marginalized by the high turnover. As one participant put it, "I think that new case managers use [the

agency] as a launching pad for a better job. I believe they are using their clients for some sort of case study."

Another important aspect of bonding in the consumer-provider relationship is reliable access, as exemplified by providers being punctual for appointments, consumers being able to call the provider in between appointments, or the ability to schedule an appointment at convenient times or on short notice. Lack of reliable access was expressed well in the comment, "This case manager is very unreliable and she says she'll do something then doesn't do it, or that she'll come to our group home and she doesn't show up. She's too busy and stuff. I'm frustrated with providers being too busy."

Though bonding is critical to consumer satisfaction and to how consumers judge quality of care, bonding alone is not enough. The provider's competence was also considered very important. Consumers want a provider who can "help me understand what the problem is." The provider also needs to know "what helps and what does not help." And while provider knowledge of mental health diagnosis and treatment is highly valued, provider knowledge of tangential issues, such as payeeship, is also appreciated and builds rapport.

This competence and knowledge extends to the provider's attitude about recovery. Several participants seemed to feel empowered because their provider believed in their recovery. As one put it, "I thought I would never get better but my counselor believes in me that I can get better," or as another said, "[They] believe that a higher level of functioning is possible, the psychiatrist says I can decrease my medication soon."

Relating to a consumer as a full human being includes relating to them in the context of their culture and religion. Some participants expressed disappointment with cultural and religious service delivery. As one man put it, "I don't think they delve enough into people's historical background. They see behavior they don't understand and just give us medication to slow you down and change your behavior." Others expressed some reticence about discussing the issue openly with their provider, with comments such as "I'd rather they not ask, if you already get along, and you'd just start an argument," or "[talking about race] would sound smart, offensive." The fear of conflict reflected in these comments suggests that this is an issue that some consumers have strong feelings about, and yet sense barriers to discussing.

Provider Results

The provider focus groups offered a rich discussion of the fundamental conflict in the life of a provider. The providers identified several "intrin-

sic motivators" which add greatly to their job satisfaction, especially being able to work with consumers. At the same time, providers expressed frustration with several factors that diminish their ability to deliver high quality service, especially time away from consumers doing paperwork, although lack of salary and policy changes also affect provider satisfaction.

There are several intrinsic motivators that lead to provider satisfaction. One of the most important is the personal satisfaction they attain from working with consumers with the belief that even very ill consumers can recover and lead more fulfilling lives. Providers also value the flexibility and autonomy they experience in their jobs, and being part of a group of talented co-workers who are committed to helping others. As one participant said: "I enjoy the dedication and competence of coworkers and staff."

Given the satisfaction they draw from helping consumers, providers would like to spend more time working directly with consumers, but are frustrated by other demands on their time such as paperwork or large caseloads. One provider said "Paperwork is often a contributing factor in not providing the client with services needed when they needed them." Another participant said: "It is difficult to see clients in emergencies due to large caseloads." All of these demands leave very little extra time for providers. While they enjoy professional growth opportunities such as additional training, they lack the time to participate in these opportunities. One provider said: "It could be difficult to attend training due to caseloads and paperwork."

The low salaries of providers is a factor that typically detracts from their job satisfaction. One provider said that "90% of the providers has a second and/or third job with which they support themselves." The low salaries are probably a significant contributing factor to provider turnover, which, as noted earlier, is a major factor in consumer satisfaction.

Finally, there were some agency relations issues that affected provider satisfaction. In particular, some providers made reference to changes in the agency's policies that affect consumer treatment. One complained "the company makes decisions about changes but doesn't inform providers how to implement the changes." The perception of provider competence may then be diminished, or as one provider put it, "it frustrates consumers when a provider doesn't know what is going on with their case or what the process is for certain issues."

With regard to delivery of culturally competent services, providers felt that they were doing the best they could without many bi-lingual

or minority staff. Program managers lamented the "limited pool of candidates to choose from." Several providers wondered whether provision of culturally competent services was a consumer requirement or a company requirement. One said "The company makes a bigger issue of diversity than the clients do" and another said "The clients are very ill and rejected not only by the majority culture, but also by their own ethnic cultures. Clients want their basic needs met and seem to not have the time or energy to address cultural differences . . . clients identify with the culture of mentally ill individuals more than their ethnic heritage." It is interesting to note the divergence in perspectives with the providers sometimes focusing on the mental illness to the neglect of cultural or religious issues and consumers feeling that being treated as a whole person includes their culture and religion.

CONCLUSIONS

The first goal of this qualitative study was to identify what matters most to consumers in this CMH center. The results are consistent with the literature cited above where relationship issues are most often related to consumer satisfaction. Our findings suggest that whereas most CMH goals focus on outcomes (e.g., "did the consumer get better?"), consumers require a generally overlooked focus on the relationship with the provider in terms of bonding/caring, provider reliability and competence, and seamless integration of culture and religion. These relationships need to be characterized by accessibility (not turnover, not limited time with providers), bonding (based in being treated as a person not a mental illness), seamless integration of culture and religion in service delivery (as another way for providers to treat consumers as whole people), and clinical competence (in knowing how to deliver services that help the consumer get better and recover).

The second goal of this study was to analyze the gap between what consumers want and what providers are able to deliver. The study identified a gap caused by system barriers such as paperwork and caseloads, not provider barriers, such as willingness to spend time with consumers. In fact, it is interesting to note the similarity between consumer and provider needs. Both want more time with each other.

The consumers and providers diverged in the centrality of cultural and religious issues in service delivery. Whereas consumers clearly articulated their desire to have culture and religion seamlessly integrated into the service delivery, providers felt that the marginalization

of the mentally ill population was more central. The fact that providers seemed more focused on the mental illness than on cultural or religious issues could explain some of the mistrust that minorities feel toward providers, as documented elsewhere (Brown, Cohen, Johnson, & Smailes, 1999; Neal-Barnett & Smith, 1997).

Several options for addressing gaps might include ethnic match as it has demonstrated improved utilization (Mathews, Glidden, Murray et al., 2002). Some concerns with this option are the few CMH professionals of color (see demographics above) and the complexity of the relationship between ethnic match and diagnosis, for example (Mathews, Glidden, & Hargreaves, 2002). Formal training would mean less time with consumers but a supervision model that emphasizes the consumer's culture/religion and the recovery model that emphasizes the consumer's cultural and religious strengths in service delivery might be effective. Addressing the system barriers of paperwork and caseloads will require a traditional quality management analysis to identify ways to re-engineer service delivery to enable providers to spend more time with consumers while meeting regulatory requirements. A re-engineered system might affect consumer satisfaction both directly (by offering them more time with providers) and indirectly (by increasing provider satisfaction and reducing turnover since providers would be doing the more satisfying work). However, with budget crises raging, this point of satisfaction may not be met any time soon.

FUTURE RESEARCH

Qualitative methodologies are the preferred methodology for identifying variables of interest but its reach is limited. Quantitative research is now indicated to determine to what extent these consumer priorities exist in other centers, the strength of the relationship between consumer satisfaction and positive outcomes, which of these consumer requirements is the highest priority in a time of limited and dwindling resources, and a deeper understanding of the divergent perspectives on incorporating culture and religion in service delivery including determining to what extent culture and religion are symbols of being known as individuals apart from an illness.

Another important research focus would be to differentiate between satisfaction and loyalty. In the marketing literature, many researchers are looking past consumer satisfaction and are more concerned with consumer loyalty (Jones & Sasser, 1995; Neal, 1999). In business, repeat business, not satisfied consumers, is the end goal; in health care, treat-

ment adherence would be analogous to consumer loyalty. Given that people who stay longer in therapy benefit more (Orlinsky, Growe, & Parks, 1994), and that satisfaction with treatment seems to be related to duration in treatment (Bradshaw, 2002; Echeburua, Fernandez-Montalvo, & Baez, 2001; Larsen, Attkisson, Hargreaves, & Nguyen, 1979; Wierzbicki & Pekarik, 1993; Pekarik, 1992), further research on the correlates of treatment adherence is indicated. Another important area for future research includes how to re-organize mental health care systems to support the delivery of culturally and religiously competent services and to increase more time spent with consumers.

APPENDIX A: SEMISTRUCTURED INTERVIEW QUESTIONS FOR CONSUMER FOCUS GROUPS

Choice
1. How did you choose to come to [the agency]?
Transportation
2. When you come for treatment services, how do you get to your clinic?
Access
3. How easy is it to get treatment services at [the agency]?
Cultural Competency
4. Is the clinic you visit welcoming and respectful of your ethnic / cultural background?
Staff
5. Describe your experience with [the agency] staff.
Residential (only ask of adult consumers who live in [the agency] residence)
6. Describe your experience of living in the [the agency] home where you live right now.
General
7. When you think about good mental health services, what matters most?

If you have anything else, please write it on the back of the ½ sheet. Thank you for participating in this focus group.

APPENDIX B: SEMISTRUCTURED INTERVIEW QUESTIONS FOR PROVIDER FOCUS GROUP QUESTIONS

Access
1. What makes it easy or hard for you to provide services to a consumer whenever they feel they need them?

Consumer Service

2. What makes it easy or hard for you or your site to offer excellent consumer service?

Cultural Competency

3. Culturally competent services are responsive to the cultural concerns of racial and ethnic minority groups, including their languages, histories, traditions, values and beliefs (Surgeon General, 2001). How well does [the agency] support the delivery of culturally competent services?

General

4. Describe your experience of working at [the agency].

If you have anything else, please write it on the back of the ½ sheet. Thank you for participating in this focus group.

REFERENCES

Beck, R.S., Daughtridge, R., & Sloane, P.D. (2002). Physician-patient communication in the primary care office: A systematic review. *Journal of American Board of Family Practice*, *15*(1), 25–38.

Bradshaw, W. (2002, Jan). *A three year multiple baseline evaluation of cognitive-behavioral treatment of schizophrenia.* Paper presented at the 6th Annual conference for the Society for Social Work and Research. Washington, D.C.

Brown, J., Cohen, P., Johnson, J.G., & Smailes, E.M. (1999). Childhood abuse and neglect: Specificity of effects on adolescent and young adult depression and suicidality. *Journal of Child and Adolescent Psychiatry*, *38*, 1490–1496.

Bush, G.W. (April 29, 2002). President Says U.S. Must Make Commitment to Mental Health Care, University of New Mexico, Albuquerque, New Mexico. http://www.whitehouse.gov/news/releases/2002/04/20020429–1.html

Copper-Patrick, L., Gallo, J.J., Gonzales, J.J., Vu, H.T., Powe, N. R., Nelson, C., et al. (1999) Race, gender, and partnership in the patient-physician relationship. *Journal of the American Medical Association, 282,* 583–589.

Dabholkar, P.A., Shepherd, C.D., & Thorpe, D.I. (2000). A comprehensive framework for service quality: An investigation of critical conceptual and measurement issues through a longitudinal study. *Journal of Retailing, 76*(2) 139–173.

Echeburúa, E., Fernández-Montalvo, J., Báez, C. (2001). Predictors of therapeutic failure in slot-machine pathological gamblers following behavioural treatment. *Behavioural and Cognitive Psychotherapy, 29*, 379–383.

Gremler, D.D., Gwinner, K.P., & Brown, S.W. (2001). Generating positive word-of-mouth communication through consumer-employee relationships. *International Journal of Service Industry Management*. *12*(1), 44–59.

Harding, C.M., Brooks, G.W., Ashikaga, T., Strauss, J.S. & Breier, A. (1987). The Vermont longitudinal study of persons with severe mental illness: II. Long term outcome of subjects who retrospectively met DSM-III criteria for schizophrenia. *American Journal of Psychiatry*, *144*, 727–735.

Harding, C.M., & Zahniser J.H. (1994). Empirical correction of seven myths about schizophrenia with implications for treatment. *Acta Psychiatrica Scandinavica*, *90* (384), 140–146.

Heppner, P.P., Kivlighan, Jr., D.M., & Wampold, B.E. (1992). *Research Design in Counseling*. Pacific Grove, CA: Brooks/Cole Publishing Co.

Jimmieson, N.L. & Griffin, M.A.(1998). Linking client and employee perceptions of the organization: A study of client satisfaction with health care services. *Journal of Occupational and Organizational Psychology, 71*, 81–96.

Jones, T.O. & Sasser, W.E., Jr. (1995). Why satisfied consumers defect. *Harvard Business Review*, *73*(6) 88–99.

Kazden, A.E., Holland, L. & Crowley, M. (1997). Family experience of barriers to treatment and premature termination from child therapy. *Journal of Consulting and Clinical Psychology, 65*, 453–463.

Kessler, R.C., Nelson, C.B., McKinagle, K.A., Edlund, M.J., Frank, R.G. & Leaf, P.J. (1996). The epidemiology of co-occurring addictive and mental disorders: Implications for prevention and service utilization. *American Journal of Orthopsychiatry, 66*, 17–31.

Krueger, R.A., & Casey, M.A. (April 2000). *Focus Groups: A Practical Guide for Applied Research* (3rd ed.). Thousand Oaks, CA: Sage Publications.

Larsen, D.L., Attkisson, C.C., Hargreaves, W.A., & Nguyen, T.D. (1979). Assessment of client/patient satisfaction: Development of a general scale. *Evaluation and Program Planning*, *2*, 197–207.

Lewis, J.R. (1994). Patient views on quality care in general practice: Literature review. *Social Science and Medicine*, *39*(5), 655–670.

Mathews, C.A., Glidden, D., & Hargreaves, W.A. (2002). The effect on diagnostic rates of assigning patients to ethnically focused inpatient psychiatric units. *Psychiatric Services, 53*(7), 823–829.

Mathews, C.A., Glidden, D., Murray, S., Forster, P., & Hargreaves, W.A. (2002). The effect on treatment outcomes of assigning patients to ethnically focused inpatient psychiatric units. *Psychiatric Services, 53*(7), 830–835.

MHSIP Task Force (1996, April). *The MHSIP Consumer–oriented mental health report card. The final report of the Mental Health Statistics Improvement Program (MHSIP) task force on a consumer-oriented mental health report card. Technical Report.* Cambridge MA: The Evaluation Center at Human Services Research Institute.

Mowen, J.C., Licata, J.W., & McPhail, J. (1993 summer). Waiting in the emergency room: How to improve patient satisfaction. *Journal of Health Care Marketing*, *13*(2), 26–33.

Murray, C.J.L. & Lopez, A.D., eds. (1996). The global burden of disease and injury series, volume 1: A comprehensive assessment of mortality and disability from diseases, injuries, and risk factors in 1990 and projected to 2020. Cambridge, MA: Published by the Harvard School of Public Health on behalf of the World Health Organization and the World Bank, Harvard University Press.

Neal, D.W. (1999). Satisfaction is nice, but value drives loyalty. *Marketing Research, 11*(1), 21–23.

Neal-Barnett, A.M., & Smith, J. (1997) African Americans. In S. Friedman (Ed.), *Cultural issues in the treatment of anxiety* (pp. 154–174). New York: Guilford Press.

Omar, M.A., & Schiffman, R.F. (1995). Pregnant women's perceptions of prenatal care. *Maternal-Child Nursing Journal*, *23*(4), 132–142.

Orlinsky, D.E., Growe, K, E. Parks, B.K. (1994) Process and outcomes in psychotherapy. In A.E. Bergin & S. L. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (4th ed., pp. 270–378). New York: Wiley.

Parasuraman, A., Zeithaml, V.A., & Berry, L.L. (1988). SERVQUAL: A multiple-item scale for measuring consumer perceptions of service quality. *Journal of Retailing*, *64*(1), 12–40.

Patton, M.Q. (2002). *Qualitative Research & Evaluation Methods* (3rd Ed). Thousand Oaks, CA: Sage Publications.

Pekarik, G. (1992). Relationship of clients' reasons for dropping out of treatment to outcome and satisfaction. *Journal of Clinical Psychology, 48*, 91–98.

Peterson, R.A., & Wilson, W.R. (1992). Measuring customer satisfaction: Fact and artifact. *Journal of the Academy of Marketing Science*, 20(1), 61–71.

Radwin, L. (2000). Oncology patients' perceptions of quality nursing care. *Research in Nursing & Health*, *23*, 179–190.

Regier, D.A., Narrow, W.E., Rae, D.S., Maderschield, R.W., Locke, B.Z. & Goodwin, R.F. (1993) The de factor US mental and addictive disorders service system. Epidemiologic Catchment Area prospective 1-year prevalence rates of disorders and services. *Archives of General Psychiatry*, *50*, 85–94.

Snowden, L.R., Hu, T.W., & Jerrell, J.M. (1995). Emergency care avoidance: Ethnic matching and participation in minority-serving programs. *CMH Journal, 31*, 463–473.

Sue, S. (1998). In search of cultural competence in psychotherapy and counseling. *American Psychologist, 53*, 440–448.

Sue, S., Fujino, D.C., Hu, L.T., Takeuchi, D.T., & Zane, N.W. (1991). CMH services for ethnic

minority groups: A test of the cultural responsiveness hypothesis. *Journal of Consulting and Clinical Psychology, 59*, 533–540.

U.S. Department of Health and Human Services (1999). *Mental health: A report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health.

U.S. Department of Health and Human Services (2001). Mental Health: Culture, race and ethnicity—*A supplement to Mental Health: A report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health.

Ware, N.C., Tugenberg, T., Dickey, B., & McHorney, C.A. (1999). An ethnographic study of the meaning of continuity of care in mental health services. *Psychiatric Services, 50*(3), 395–400.

Wierzbicki, M., & Pekarik, G. (1993). A meta-analysis of psychotherapy dropout. *Professional Psychology: Research and Practice, 23*, 190—195.

Winefield, H.R., Murrell, T.G, & Clifford, J. (1995). Process and outcomes in general practice consultations: Problems in defining high quality care. *Social Science & Medicine*, *41*(7), 969–975.

Yeh, M., Takeuchi. D. & Sue, S. (1994). Asian American children in the mental health system: A comparison of parallel and mainstream outpatient service centers. *Journal of Clinical Child Psychology, 23*, 5–12.

Yi, Y. (1990). A critical review of consumer satisfaction. In Zeithaml, V. A. (Ed.), *Review of Marketing 1990*. American Marketing Association: Chicago. 68–123.