

Consumer Satisfaction
in the Oklahoma Mental Retardation Service System

Brief Report Number 12
Of a Series on the Well Being of People with
Developmental Disabilities in Oklahoma

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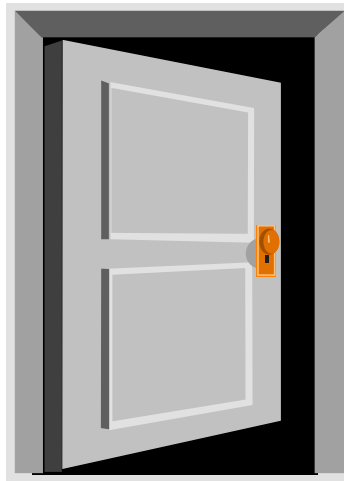
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Acknowledgement

Data have been obtained through a cooperative agreement with the Oklahoma State University Department of Sociology's Developmental Disabilities Quality Assurance Research Project. Since 1989, the Sociology Department at O.S.U. has conducted yearly independent assessments of consumer outcomes for approximately 3700 individuals receiving services from the Oklahoma Department of Human Services Developmental Disabilities Services Division.



“In 1990, these people were surrounded by walls.
In 1994, they're surrounded by doors.”

The quotation above is from David Loconto, a graduate student at Oklahoma State University. When he wrote this in 1995, Mr. Loconto was studying the well-being of people who moved from Hissom to community. He personally visited more than 200 Hissom class members in 1995.

Executive Summary

Service satisfaction data were collected from 1870 consumers in the Oklahoma mental retardation system. Satisfaction was generally high, but noticeably higher in community oriented programs. The opportunity to exercise choice was an important predictor of satisfaction.

Introduction

In the late 1970s and 1980s, there was an expectation that service programs should promote the development of additional skills for persons with mental retardation. Federal ICF/MR regulations introduced the concept of active treatment, which required an individualized program of services directed toward the development of skills thought necessary in the community. It would not be unreasonable to suggest that this model implied, at least to some extent, that a person with mental retardation was an individual who needed to be repaired.

Given the field's emphasis on developmental and behavioral change, most efforts to evaluate programs were specifically focused on skill attainment by individuals within programs. Conroy and Bradley's (1985) study of the closure of Pennhurst Center is typical of the type of outcome based program evaluation that derived from the developmental/habilitation model. The clinician's job was to promote consumer development; the evaluator's job was to attempt to determine whether the consumer actually changed as a result of programmatic intervention.

Times change. The emphasis on growth and change has significantly diminished, being supplanted by a growing interest in supporting individuals in a manner that promotes their life quality. Schalock (1994) described Quality of Life as a subjective phenomenon that reflects the congruence between a person's desired

conditions of living and his/her actual conditions of living. This is based on the person's phenomenology of life experiences, objective life conditions, and the perceptions of significant others. This is an imprecise definition, and its imprecision is reflected in Hughes (1995) review of Quality of Life research that reported on 1243 different measures of life quality having been used. Perhaps life quality is hard to define, but you know it when you see it. Smull (1995), in discussing person centered planning, suggested that programming efforts should address the discrepancies between how an individual lives and how he/she would want to live. Again we see the implication that life quality is a function of the match between an individual's ideal and his/her reality.

Goode (1998) offered a number of principles with which to define the quality of life. Although Goode seemed to rely less on the phenomenology of the person with mental retardation, his recommendations do seem to have universality. He noted that the experience of life quality is both social and individualized; it is greatest when individuals make their own decisions about needs and goals.

Campo, Sharpton, Thompson, and Sexton (1997) suggested that the concept of life quality would dominate the field of mental retardation through the 1990s and into the next century. Development is no longer the issue; consumer satisfaction with his/her life is. The field has shifted towards a greater emphasis on self-

determination, integration, and acceptance of the individual. This shift in focus has direct implications for program evaluators. Under a person centered service model, excellence is perhaps best defined by the extent to which a program promotes consumer satisfaction. This recognition was implicit in the 1987 amendment to the Developmental Disabilities Assistance and Bill of Rights Act, in which the federal government mandated each state to conduct routine consumer satisfaction surveys (Conroy and Feinstein, 1990). Without entirely refuting the social validity of enhanced consumer skill development, it is clear that program evaluation efforts must consider the life satisfaction of individuals who are receiving service.

Persons with mental retardation live in a variety of settings, ranging from maximal supportive care in Nursing Homes to semi-independence. Amado, Lakin, and Menke (1990) identified nine distinct residential options that serve persons with mental retardation, with each broad category serving literally thousands of individuals. It is certainly reasonable to question whether life quality varies as a function of one's residential setting. While choice should be respected with respect to living arrangement, it is certainly worthwhile to have an understanding of the level of satisfaction that is produced by each type of setting. The purpose of this study was to attempt to quantify consumer satisfaction across various residential settings within a statewide service system. In addition, we sought to identify

program and personal factors that were related to consumer satisfaction.

Methods

Subjects

The subjects for this investigation were 1870 individuals who were receiving program services in the Oklahoma mental retardation service system in 1997. This represents a skill-limited sample of the entire population of 3359 individuals who received services at that time. By skill-limited, we mean that our sample included only those who were willing and able to respond to the interviewer questions regarding Satisfaction. This means the sample is biased towards cognitively more capable individuals, and that the generalizability of the study must be limited to comparably capable individuals. As Campo, Sharpton, Thompson, and Sexton (1997) noted, this is a major shortcoming in consumer satisfaction research, however, the use of third party respondents to rate the satisfaction of less capable individuals seems to have at least an equal vulnerability.

The average respondent age was 45.5 years. Approximately 52% were male. Various community residences provided homes for 1137 (60.8%) consumers, while 733 (39.2%) lived in some sort of congregate care facility. A breakdown by classified level of mental retardation is as follows: No Mental Retardation, 60;

Mild Mental Retardation, 657; Moderate Mental Retardation, 425; Severe Mental Retardation, 263; Profound Mental Retardation, 87; Unclassified or Unknown, 378. Only 18.8% were classified as having either severe or profound mental retardation.

We sought to compare our responders with those consumers who were unable or unwilling to respond to our questions. There were 222 consumers who were unwilling to participate in the questionnaire, and there were 1261 who were unable to respond. These two groups were collapsed to create a single category of Nonresponder. An independent t-test revealed that the Responders were significantly older than the Nonresponders ($t=9.38$, $df=3349$, $p=.000$), whose mean age was 39.9 years. A significant difference was also detected with respect to level of mental retardation ($t=22.55$, $df=3333.64$, $p=.000$), with Responders being classified with lesser degrees of impairment. A gender difference was also noted, with males generally being less willing or able to respond to questions (Chi-square = 7.38, $df=1$, $p=.007$). From even these brief analyses, it is clear that the Responders and Nonresponders constitute different groups, and caution is urged with respect to generalizability.

Instrumentation

Oklahoma administers the Developmental Disabilities Quality Assurance Questionnaire (Oklahoma State University, 1992) for all consumers within its service system on an annual basis. This assessment is administered by interviewers contracted by the state, and it includes major sections on adaptive behavior, living site conditions, health, social interactions, community integration, challenging behavior, service planning, and consumer satisfaction.

Consumer satisfaction is specifically addressed by eight items in the questionnaire. These items, asked directly of the consumer, address the following topics: 1. Does consumer like living there?; 2. Does consumer like staff?; 3. Does consumer like food?; 4. Does consumer have enough clothes?; 5. Does consumer have friends?; 6. Does consumer have more than 1 good friend?; 7. Are staff nice?; and 8. Does consumer like day activities? These questions had a forced choice response format, with one option indicating satisfaction, one indicating dissatisfaction, and one indicating neither satisfaction nor dissatisfaction. The question regarding food quality was asked a second time in the interview, and the responses were in 88.3% agreement with the earlier responses. A Consumer Satisfaction Scale was created by summing the scores on each of the eight satisfaction items. A Cronbach's alpha of .74 suggested that this scale had sufficient reliability for research and program evaluation purposes.

A number of items from the DDQAQ were used in an effort to predict this summated Consumer Satisfaction score. These items included personal attributes (adaptive behavior score, presence of challenging behaviors, age, sex, and level of mental retardation), service measures (number of service hours and number of work hours), integration opportunities, and a number of specific items on self-determination. These predictor items are listed in Table 1.

Table 1
Items Use to Attempt to Predict Consumer Satisfaction

Challenging Behavior Frequency Scale
Adaptive Behavior score
Year of Birth
Level of Mental Retardation
Sex
Integration Opportunities per Week
Hours of Service per Month
Hours of Work per Month
Do you make money?
Do you pick what you eat at home?
Do you pick what you eat in a restaurant?
Do you pick the clothes you buy?
Do you pick the clothes you wear?
Do you pick your free time activities?
Do you pick your friends for free time activities?
Do you choose how to spend your own money?
Do you have friends visit?
Can your friends visit anywhere in your home?
Does your family visit?
Residential placement (recoded to community or congregate care)

Results

Table 2
Percent of Respondents Giving Favorable Ratings
to Satisfaction Questions

<u>How do you feel about?</u>	<u>Setting</u>					
	<u>A</u>	<u>B</u>	<u>C</u>	<u>D</u>	<u>E</u>	<u>F</u>
Living Here	60.6	66.7	92.3	79.2	71.6	87.0
Staff Here	67.4	68.9	94.3	90.6	83.0	92.5
Food Here	51.1	66.1	85.6	80.7	64.2	83.9
Quantity of Clothes	70.1	75.8	91.1	91.8	82.7	91.5
Existence of Friends	77.5	86.7	88.5	91.9	84.2	92.7
Existence of >1 Friend	69.1	78.6	84.5	84.3	76.3	83.8
Other Residents	56.3	76.4	88.2	82.7	74.6	87.1
Day Activities	70.1	84.2	92.6	89.8	84.6	87.2
Overall	65.3	75.4	89.6	86.4	77.7	87.0

A = Public ICF/MR

B = Private ICF/MR

C = Private Home

D = Group Home

E = Nursing Home

F = Other Community Placement

Initial inspection of the data addressed the overall responses to the eight satisfaction questions. Table 2 summarizes the percentage of persons who indicated satisfaction for each question. In general, levels of satisfaction were relatively high, ranging from 74.0 % for food quality to 88.5% for having friends. The mean satisfaction rating was 82.6% across the eight satisfaction items. Table 2 also presents the response patterns from each of the six residential categories. Chi-

square analyses of each of the responses across residential sites were conducted, and statistically significant results were obtained for each question. Inspection of standardized residuals suggested that persons living in Nursing Homes and Public ICF/MR programs reported lower degrees of satisfaction, while persons living in Group Homes and Other Community Placements reported higher levels of satisfaction.

One way analysis of variance was used to compare the summative Satisfaction Index across the six setting types, and statistically significant differences were detected ($F[5,1426]=41.8899$, $p=.0000$). Tukey post hoc analysis revealed that consumer satisfaction was lower in the three congregated care facilities (public ICF/MR, private ICF/MR, and Nursing Homes) than in the three community settings (private home, group home, community setting). In addition, reported consumer satisfaction was lower in the Public ICF/MR programs than in either the Private ICF/MR or Nursing Home programs. Satisfaction indices in the three community residential alternatives were indistinguishable.

Stepwise multiple regression was then used to attempt to predict the summative index of consumer satisfaction. A linear combination of seven predictor variables was able to explain approximately 19.9% of the variance in consumer satisfaction ($\text{MultR}=.4459$, $F[7,949]=33.638$, $p=.0000$). These seven predictor

variables, in stepwise order of entry in the equation, were 1) Choice of Free Time Activities, 2) Placement in community or congregate care, 3) Visits with the Family, 4) Frequency of Challenging Behavior, 5) Number of Hours Worked each Month, 6) Freedom to have Friends Visit, 7) Choice in how to Spend Money. Inspection of the beta weights in the derived equation revealed that increased opportunities for choice and integration, combined with reduced work hours, living in a community residential program, and lower challenging behavior frequencies were all associated with greater levels of consumer satisfaction. It should be noted that the largest single predictor of consumer satisfaction was increased choice in favorite activities.

Discussion

Consumer satisfaction was generally high across the six residential options offered in Oklahoma. This sort of positive finding parallels the larger body of work in which family members, rather than service consumers themselves, were asked to rate their degree of satisfaction with mental retardation services. For example, Spreat, Telles, Conroy, Feinstein, and Colombatto (1987) reported that 89% of the families of persons who lived in institutions were satisfied with the services provided to their family member. Conroy and Bradley (1985) reported even parents of persons living in Pennhurst Center, a program that was ordered by a court to close due to poor conditions, were satisfied with services provided there. Perhaps more important than the commonality of the results is the fact that this study directly polled service consumers. Ultimately, it is the satisfaction of these individuals that matters most.

Matikka and Vesala (1997) have suggested that there is an acquiescent response on the part of persons with mental retardation to service satisfaction surveys, and that such surveys may overestimate satisfaction. It should be noted that our survey included an acquiescence test, and persons who failed that test were not included in the analyses. Nevertheless, it remains possible to question that actual validity of the responses, and whether an 88% satisfaction rate is really 88%

or something less. It should be noted, however, that whether the satisfaction figures themselves are entirely valid estimates of actual satisfaction, it is clear that they vary as a function of where a person lives. Greater degrees of satisfaction are reported in community-based programs than in more traditional congregate care settings. Even if response acquiescence is a threat to validity, we were able to identify variation as a function of residential setting.

It is recognized that the characteristics of persons who live in different residential settings differ in various other ways. Nationally, there has been some suggestion that persons who live in the community are less cognitively challenged than persons who remain in congregate care settings. The skill-limited nature of our sample selection process somewhat mitigates this threat; persons with greater degrees of cognitive challenge were unable to participate in this survey. Obviously, the skill limited nature of our sample places limits on the generalizability of our findings. There is no reason to assume that our findings are applicable to persons with the types of cognitive deficits that would preclude participation in a study such as this.

We were interested in determining what factors, in addition to residential site, were predictive of satisfaction. Residential site and some personal characteristics were useful in predicting satisfaction, but it was noted that the single largest

predictor was the ability to exercise choice. Within the context of a stepwise regression model, it was necessary to use independent information about residential setting, the individual, and choice opportunities in order to maximize prediction. It is not just the setting, nor is it just the individual, nor is it just the opportunities for choice. It is all of the above.

It is also noteworthy that even with 19 possible predictor variables, it was possible to predict only about 20% of the variance in Satisfaction. To some extent, the reliability of the Satisfaction index (Cronbach's alpha = .74) may have suppressed the correlation magnitude, however, it seems likely that satisfaction is comprised of more subtle indicators than those measured within this study. As Hollins (1998) noted, perhaps there are some aspects of the human experience that have an intangible and immeasurable quality about them, and that this possibility is further complicated by the fact that two individuals may perceive the same service in entirely different manners.

To return to our original question regarding satisfaction, it must be recognized that while consumers in Oklahoma are generally satisfied with their lives as supported by the mental retardation system, the satisfaction is maximized in more integrated settings. These findings, combined with earlier research on the more objective positive outcomes associated with community placement; make a

convincing argument for continued expansion of the community system.

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