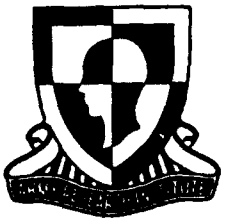
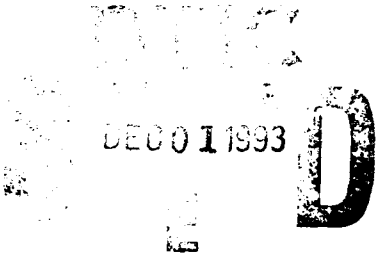


U.S. Army Research Institute
for the Behavioral and Social Sciences

Research Report 1641

Family Service Providers' Evaluations of Medical Activities, Dental Activities, and Mental Health Services

Jacquelyn Scarville
U.S. Army Research Institute



August 1993

U.S. ARMY RESEARCH INSTITUTE FOR THE BEHAVIORAL AND SOCIAL SCIENCES

A Field Operating Agency Under the Jurisdiction of the Deputy Chief of Staff for Personnel

EDGAR M. JOHNSON
Director

Technical review by

D. Bruce Bell
Sally Bell

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REPORT DOCUMENTATION PAGE

Form Approved
OMB No. 0704-0188

1. AGENCY USE ONLY (Leave blank)	2. REPORT DATE	3. REPORT TYPE AND DATES COVERED
	1993, August	Final Jul 92 - Sep 92

4. TITLE AND SUBTITLE
Family Service Providers' Evaluations of Medical Activities, Dental Activities, and Mental Health Services

5. FUNDING NUMBERS
63007A
792
2302
H01

6. AUTHOR(S)
Scarville, Jacquelyn

7. PERFORMING ORGANIZATION NAME(S) AND ADDRESS(ES)
U.S. Army Research Institute for the Behavioral and Social Sciences
ATTN: PERI-RP
5001 Eisenhower Avenue
Alexandria, VA 22333-5600

8. PERFORMING ORGANIZATION REPORT NUMBER
--

9. SPONSORING / MONITORING AGENCY NAME(S) AND ADDRESS(ES)
U.S. Army Research Institute for the Behavioral and Social Sciences
5001 Eisenhower Avenue
Alexandria, VA 22333-5600

10. SPONSORING / MONITORING AGENCY REPORT NUMBER
ARI Research Report 1641

11. SUPPLEMENTARY NOTES
--

12a. DISTRIBUTION / AVAILABILITY STATEMENT
Approved for public release; distribution is unlimited.

12b. DISTRIBUTION CODE
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13. ABSTRACT *(Maximum 200 words)*

Family service providers at 33 locations worldwide evaluated the available Medical Activities (MEDDACs), Dental Activities (DENTACs), and mental health services. Respondents strongly agreed that there was a need for these services, and most knew about the services and had made client referrals. Overall, service staff were perceived as competent or very competent, and the respondents were satisfied or very satisfied with the services.

Although none of the three services examined had systemic problems with lack of privacy or poor publicity, some services in specific geographic regions did have reports of inconvenient hours, poor repairs, and overcrowding. There were reports of understaffing and long waiting times for MEDDACs and DENTACs in all three regions (CONUS, Europe, other OCONUS). Further, there was evidence that mental health services were also coping with staffing problems.

14. SUBJECT TERMS		15. NUMBER OF PAGES
Army services	DENTAC	39
Family support	Mental health	16. PRICE CODE
Family services	MEDDAC	--

17. SECURITY CLASSIFICATION OF REPORT	18. SECURITY CLASSIFICATION OF THIS PAGE	19. SECURITY CLASSIFICATION OF ABSTRACT	20. LIMITATION OF ABSTRACT
Unclassified	Unclassified	Unclassified	Unlimited

NSN 7540-01-280-5500

Standard Form 298 (Rev. 2-89)
Prescribed by ANSI Std Z39-18
298-102

Research Report 1641

Family Service Providers' Evaluations of Medical Activities, Dental Activities, and Mental Health Services

Jacquelyn Scarville
U.S. Army Research Institute

Leadership and Organizational Change Technical Area
Paul A. Gade, Chief

Manpower and Personnel Research Division
Zita M. Simutis, Director

U.S. Army Research Institute for the Behavioral and Social Sciences
5001 Eisenhower Avenue, Alexandria, Virginia 22333-5600

Office, Deputy Chief of Staff for Personnel
Department of the Army

August 1993

Army Project Number
2Q263007A792

Manpower and Personnel

FOREWORD

The Army Family Research Program (AFRP) began in November 1986 as an integrated research project mandated by both the Chief of Staff, U.S. Army, White Paper, 1983: The Army Family and the annual Army Family Action Plans (1984 to present). The research supports the Army Family Action Plans and Army family programs and policies by (1) determining the demographic characteristics of Army families, (2) identifying motivators and detractors to soldiers' remaining in the Army, (3) developing methods of increasing family adaptation to Army life, and (4) increasing operational readiness.

The U.S. Army Research Institute for the Behavioral and Social Sciences (ARI), with assistance from the Research Triangle Institute (RTI), Caliber Associates, Human Resources Research Organization (HumRRO), the University of North Carolina, and Decision Science Consortium, Inc., is conducting this research under Task 2302C2, which is part of ARI's Advanced Development (6.3A) Program.

The AFRP was initially briefed to the Health Services Command (HSC) in San Antonio on 14 May 1990. This briefing provided ARI researchers with the opportunity to identify and respond to HSC concerns. This report, which contains family service providers' evaluations of Medical Activities, Dental Activities, and mental health services, is one of a series of three reports on the HSC. A previous report examines the demography of HSC soldiers and their families, and a third report examines the job attitudes of HSC personnel.

EDGAR M. JOHNSON
Director

FAMILY SERVICE PROVIDERS' EVALUATIONS OF MEDICAL ACTIVITIES, DENTAL ACTIVITIES, AND MENTAL HEALTH SERVICES

EXECUTIVE SUMMARY

Requirement:

The Army Family Research Program (AFRP) is a multiyear investigation of the factors affecting soldier retention and readiness and soldier and family well-being. This report shows service providers' evaluations of one aspect of the Army family service delivery system: medical, dental, and mental health services. Family service providers worldwide evaluated these three services.

Procedure:

Service providers (N=793) at 81 sites from 33 locations in the continental United States (CONUS), Europe, and other locations outside of the continental United States (other OCONUS) evaluated the Medical Activities (MEDDACs), Dental Activities (DENTACs), and mental health services available at their site or within a 1-hour drive. Respondents included project directors or their designees at the 3 services as well as their counterparts from the other 15 family support services referenced in the AFRP Family Service Provider Survey (FSP).

The respondents were asked whether there was a need for the service, whether they had been briefed on it, and whether they made referrals to the service in question. They were also asked to indicate their level of satisfaction with the service and to assess staff competency. Finally, the respondents were asked to indicate whether the following were problems for the service at their site: lack of privacy, poor publicity, inconvenient hours, facilities in poor repair, facilities overcrowded or understaffed, and excessive waiting time.

At each site, individual responses were combined to create a raw average of the responses for each survey question. These averages were then weighted and combined into 33 locations. The AFRP service provider database consists of the weighted mean of every survey item for each of the 33 locations.

Findings:

The results show that family service professionals strongly

believed that there was a need for these Army services. There was overwhelming agreement that these services were needed by soldiers and their families at the locations. Respondents in all locations knew about the services, and most had made at least one referral. The three services were also highly regarded by service providers. Staffs were perceived as competent or very competent, and overall satisfaction with the services was generally high, especially with DENTACs.

There was little evidence that any of the three services suffered from lack of privacy and poor publicity. Beyond that, however, the constellation of problems varied for each of the services examined. For MEDDACs, there were scattered reports of inconvenient hours for CONUS and European locations. Overcrowding was a problem for CONUS and some European locations also. However, more widely reported were understaffing and excessive waiting times. These latter issues were frequently reported in all three geographic regions.

Overall, there were fewer reports of problems at DENTACs. Overcrowding was noted at some of the European locations. However, as with MEDDACs, there were frequent reports of understaffing and excessive waits. Again, these problems were reported in all three regions, although there was evidence that they were more widely experienced in Europe.

There were scattered reports of CONUS mental health facilities being in poor repair, but this problem overall was not widely reported. Instead, there were reports that some mental health services in Europe and, to a lesser extent, in CONUS suffered from overcrowding. Understaffing was reported in all regions, although excessive waits were largely a problem for CONUS mental health services only.

Utilization of Findings:

The findings suggest that, in 1989, some medical, dental, and, to a lesser extent, mental health services were facing challenges in configuring human resources to meet the demand for services. This has important implications for providing services in an environment of downsizing and its concomitant shift to a CONUS-based Army. Preexisting problems with understaffing, overcrowding, and long waiting periods may be exacerbated by an increased demand for health services in CONUS. The findings suggest that health planners explore the impact of Army realignment on the demand for and use of medical, dental, and mental health services. In particular, attention should be paid to the extent to which realignment changes patterns of service demand and use and health manpower requirements.

FAMILY SERVICE PROVIDERS' EVALUATIONS OF MEDICAL ACTIVITIES, DENTAL ACTIVITIES, AND MENTAL HEALTH SERVICES

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Family Service Providers' Evaluations of Medical Activities, Dental Activities, and Mental Health Services

INTRODUCTION

The Army Family Research Program (AFRP) is a multiyear project, designed, in part, to identify the predictors and correlates of family well-being. An important area of investigation was determining the availability and adequacy of family support services. To this end, family service providers at 34 installations worldwide were asked to submit evaluations of the constellation of Army family services/programs available either on-post or within a one-hour drive. This report presents family service providers' evaluations of Medical Activities (MEDDACs), Dental Activities (DENTACs), and mental health services at multiple sites in the continental United States (CONUS) and abroad.

Army family research demonstrates that family support programs and services are important in assisting families to adapt to the rigors of military life (Bowen & Neenan, 1990). Researchers at Rand identified the relationship between service use and soldiers' sense of well-being (Burnam, Meredith, Sherbourne, Valdez, & Vernez, 1992). Their finding that soldiers with a low sense of well-being were more likely than those with high well-being to use medical, mental health, and counseling services suggests that these services are important resources to those with emotional or other difficulties. Further, the researchers found that service use is also associated with location—soldiers in CONUS locations were more likely than those stationed elsewhere to use medical and mental health services. However, the Rand researchers also found that OCONUS soldiers were more likely than their counterparts stationed in the United States to use counseling services (Burnam et al., 1992).

Satisfaction with the community and the resources available therein is also a key factor in family well-being (Orthner, Early-Adams, Devall, Giddings, Morley, & Stawarski, 1987). Tisak (1992), for example, presents preliminary evidence that satisfaction with the quality and availability of medical and dental care has a positive effect on officers' perceptions of their quality of life.

Several research investigations suggest that, overall, at least half of the soldiers and their families are satisfied with Army medical and dental care. For example, in 1985, slightly over half of Army officers (54%) and enlisted personnel (58%) were satisfied with their medical care. At least half of the respondents (52% of officers and 61% of enlisted personnel) were also satisfied with Army dental care. Among officers,

satisfaction with both services was somewhat higher for women than for men (LaVange, McCalla, Gabel, Rakoff, Doering, & Mahoney, 1986).

Research on Army wives' perceptions of Army medical services shows that, in 1987, over 90% of those surveyed had used (or had a family member who had used) the services at their current location, although less than half (49%) were satisfied with the overall quality of medical care (Griffith, Gabel, & Stewart, 1988). When asked about specific aspects of the services, almost two-thirds were satisfied with the hours of operation. Despite this satisfaction with hours, however, there appear to be problems with the accessibility and availability of medical and dental services. Only 35% of the wives were satisfied with the time between the first call and appointment. Fully 49% were dissatisfied with this aspect of care. And 37% of the wives were dissatisfied with the availability of Army medical care, and 38% were dissatisfied with the availability of Army dental care.

Perceptions of and satisfaction with Army health and other family programs and services have important implications not only for personal and family well-being, but also for the larger Army. Family well-being and adaptation to the Army are important because they influence soldier retention and several of the predictors of retention such as the spouse's support for the soldier's Army career (Griffith, Rakoff, & Helms, 1992). In addition, family adaptation has also been shown to have an indirect effect on unit readiness (Sadacca, McCloy, & DiFazio, 1992).

Satisfaction with health programs, specifically, has been demonstrated to be related to the soldier's intention to remain in the service. Griffith, Rakoff, and Helms (1992) demonstrated that plans to remain in the service are positively related to the soldier's perception of the overall Army community. One of the aspects of the community specifically examined in this research was the quality of Army family medical care.

Data and Sample

The worldwide AFRP data collection occurred during the 1989 calendar year at sites in the United States and abroad. Each of 82 sites received a packet containing 18 family service provider surveys (FSP). (Information on AFRP survey design and methodology is available in Research Triangle Institute, Caliber, & Human Resources Research Organization, 1992). At most sites (particularly in CONUS), the installation project officer distributed one FSP to the project directors (or their representatives of each of the 18 military family services

inquired about in the survey.[1] A total of 793 service providers returned an FSP evaluating their own and other services available at that site. Since respondents' positions or titles were not recorded (to maintain confidentiality) there is no way to determine what percentage of these respondents worked in MEDDAC, DENTAC, or mental health services.

Because some of the sites were small and contained personnel who used Army services at nearby installations (particularly in Europe), the sites were combined to represent 34 larger locations. At each site, individual responses were combined to create a raw average for each survey question. These averages were then weighted and combined into locations.[2] Since one site failed to return any survey forms, the analyses are based on data representing 81 sites combined into 33 locations.[3]

Nineteen locations were in CONUS, nine were in Europe and the remaining five locations were in other locations outside of the United States (other OCONUS). MEDDAC, DENTAC and mental health services were available at all locations. The AFRP service provider database, in summary, does not contain the responses of individual providers but consists of the weighted mean of every survey item for each of the 33 locations. These weighted means represent a composite evaluation of the services offered in a given location. Therefore, the unit of analysis is location, not individual service provider. Table 1 summarizes the number of service provider forms, sites and locations included in the database.

Table 1

Locations, sites, and respondents of family service provider data

Region	Locations	Sites	Provider forms returned
CONUS	19	22	255
Europe	9	49	472
Other OCONUS	5	10	66
TOTAL	33	81	793

[1] See copy of the survey in Appendix A for the 18 services included in the survey.

[2] Weights were based on the relative number of soldiers at a particular site within a particular location.

[3] All locations contain a minimum of five service provider forms.

The findings section reports location means for each of the geographic regions (CONUS, Europe and other OCONUS). Although there are only 5 locations not in CONUS or Europe, these data are also reported because they represent the responses of 66 individual service providers at 10 sites around the world. However, because of the relatively small number of respondents, the data for other OCONUS should be considered suggestive rather than definitive.

Methodological Issues

Two methodological considerations which must be borne in mind when evaluating these findings concern the (1) AFRP service provider sample and (2) use of weighted averages in the database.

The AFRP service provider sample may be biased. If disproportionately more providers from MEDDAC, DENTAC, or mental health services returned surveys than providers from other programs, we might expect their responses to bias the results. For example, evaluations of staff competence or assessments of the service's problems might be inflated. To maintain confidentiality, AFRP data collectors did not identify the agencies and positions of providers responding to the survey. Therefore, it is impossible to determine whether any service provider group was disproportionately represented.

Overrepresentation of a particular group in the family service provider database is not inherently undesirable, however. One might argue that people associated with the services are more knowledgeable about their strengths and weaknesses. Because they are more informed, they may be more desirable respondents.

In addition to not tracking the types of respondents, the data collection procedures also did not allow for the tracking of respondent response rates at the various sites. Therefore, given these methodological concerns, readers should be advised that no claim is made that the AFRP family service provider sample is representative of the population of service providers. Although other AFRP samples (e.g., soldier database) are statistically accurate representations of their larger populations, this assertion cannot be applied to the service provider sample. And, given these concerns about the sample, application of statistical tests is less than meaningful. Readers should consider the data suggestive (rather than definitive) and broadly indicative of what **some** providers are experiencing at Army healthcare facilities.

A second methodological constraint concerns the use of averages instead of individual provider evaluations. As previously mentioned, the family service provider database consists of the averaged responses instead of the individual responses of service providers. Averages (means) are somewhat

less informative than the frequency distributions because means do not give evidence of the pattern of responses and amount of variance for a particular questionnaire item. Practically, this means that the construction of averages cancels extreme responses. For example, averaging an equal number of "very satisfied" (coded 1) and "very dissatisfied" (coded 5) responses yields an average of "no opinion" (coded 3) which is indistinguishable from a response pattern in which all of the respondents had no opinion. These two response patterns obviously have very different interpretations and meanings. Averages obscure these differences.

In addition, to examine responses by geographic region, it is necessary to create a regional average of the location means. Averaging averages may compound the aforementioned interpretation problems.

To address this problem in part, means **and** standard deviations are presented in tables in Appendix B to inform readers of the extent to which the responses varied from the mean. Readers should bear in mind that smaller standard deviations mean that the responses tend to be clustered close to the mean; larger standard deviations reflect a pattern in which more responses are at a distance from the mean.

Variables

There are three categories of variables in the AFRP provider database: (1) program need, (2) provider knowledge of and satisfaction with the service, and (3) staff competence and problems of the services.

Service need was determined by agreement with the following: "People assigned here need this service." Responses took the form of a 5-point scale with the following categories (and coding): strongly agree (1), agree (2), no opinion (3), disagree (4), and strongly disagree (5).

Provider knowledge was demonstrated by responses to the following "I have been briefed on this service." Providers who had been briefed were coded as 1; those not briefed were coded as 0. The data, therefore, represent the proportion of family service providers at a given location who were briefed on each service.

In addition more information was collected on whether providers had ever **referred** clients to the services. Having referred a client to the service was coded as 1, never having made a referral to the service was coded as 0. In aggregate, these data represent the proportion of service providers who had ever referred a client to the examined services.

Staff competence is indicated by the following "Overall, the service staff is ...." with five response categories (and codes): very competent (1), competent (2), average (3), incompetent (4), and very incompetent (5).

Service providers indicated **provider satisfaction** by responding to "Overall, how satisfied are you with this service." Responses represent a 5-point scale with the following categories: very satisfied (1), satisfied (2), no opinion (3), dissatisfied (4) and very dissatisfied (5).

Finally, service providers were asked to indicate whether MEDDACs, DENTACs, and mental health services suffered from any of the following **problems**:

- facilities in poor repair
- facilities too crowded
- inconvenient hours
- lack of privacy
- poor publicity
- understaffed
- waiting time too long.

Responses were coded such that a 1 indicates the presence and a 0 indicates the absence of this particular problem. Therefore, the data represent the proportion of service providers at a given location who report that there were problems with a particular service.

Of primary interest, of course, is identifying the extent to which services are characterized by the aforementioned problems. To accomplish this, I assumed that a service probably had a particular problem if at least 25% of the respondents at that location so reported. Although this is not definitive evidence of the existence of a particular problem, reports by one-quarter of family service providers **suggests** that a given problem may indeed be present. This 25% cut-off also reduces the likelihood that respondents with a rare, unpleasant experience (who report a problem which, under usual conditions, does not exist) will bias the findings such that services appear to be plagued by problems.

FINDINGS

Medical Activities

Service Need. There was a clear consensus that Army Medical Activities were needed at the locations studied. Virtually all of the respondents at over one-third of the locations strongly agreed that there was such a need. Providers at the other locations also, generally agreed on the need for medical services.

Service Knowledge. The majority of providers also indicated that they had been briefed on MEDDAC services. Table 2 shows that, on average, at least two-thirds of the service providers in each region had been briefed on MEDDAC services. Providers in CONUS or European locations were somewhat more likely to have been briefed than those at other locations.

Providers were not only knowledgeable about MEDDAC services, they were also referring clients. On average, at least 75% of the providers in the three regions had made referrals to MEDDACs. At 35% of the locations, over 90% of the providers reported having made referrals.

Table 2

Mean proportion of service providers in each region who were briefed on or made referrals to MEDDACs*

	CONUS	Europe	Other OCONUS	Total
Briefed	79%	77%	65%	77%
Referrals	85%	75%	88%	82%

* Percents represent regional means

Service Evaluation. Overall, the family service providers rated MEDDAC staff highly. At all locations MEDDAC staff were rated at least average. At 61% of the locations, service providers rated MEDDAC staff between very competent and competent. Perceptions of staff competence were relatively consistent across regions.

Consistent with the overall high staff ratings and client referrals, the majority of respondents also indicated that they

were at least satisfied with MEDDAC services. Fourty two percent of the locations had ratings between very satisfied and satisfied. Over half of the locations (55%) had ratings between satisfied and no opinion. Satisfaction did not vary across the three regions.

There is little evidence that lack of privacy and poor publicity were MEDDAC problems. Overall, fewer than one-fifth of respondents for the former and less than one-eighth for the latter reported such problems at any given location. Therefore, although some respondents did indeed report such difficulties, they were clearly a minority. Table 3 shows that at none of the locations did 25% or more providers report these problems.

Table 3

Percent of locations with evidence of the following problems: MEDDACs*

	CONUS	Europe	Other OCONUS	Total
No privacy	-	-	-	-
Poor publicity	-	-	-	-
Inconven. hours	5.7	9.3	-	5.1
Poor repair	12.4	-	-	6.6
Too crowded	49.9	19.9	-	24.1
Understaff	77.1	100	63.8	82.2
Wait too long	81.9	87.7	51.8	79.1

* Cell percents represent the proportion of locations in each region in which an average of 25% or more service providers reported specific MEDDAC problems. A dash indicates that fewer than 25% of the respondents in every location in that region reported the problem.

There is somewhat stronger evidence, however, that inconvenient hours and poorly repaired facilities were more widespread. Inconvenient hours were reported more for facilities

in Europe and CONUS than for those in other locations. Facilities in CONUS were particularly likely to suffer from poor repair. Although at almost half of the CONUS locations, none of the respondents reported poor repair as a problem, at about 12% of the locations, one-quarter or more indicated it was a problem. This pattern suggests that, overall, MEDDAC facilities are well maintained, although there are a few locations (in CONUS) which are in need of more extensive upkeep. These repair problems in CONUS locations undoubtedly reflect the greater demand for medical services because of retirees and family members.

The most widely reported problems were those relating to service delivery resources. Overcrowding, understaffing and excessive waits were the problems most frequently reported by the family service providers in all three geographic regions. Service providers frequently reported that CONUS MEDDACs were affected by these 3 problems. At two-thirds of the CONUS locations, between 20% and 50% of the respondents reported overcrowding. Seemingly, the demand for services in CONUS in 1989 taxed the available personnel resources. In Europe and other OCONUS locations, although there were fewer reports of overcrowding and other problems, there were more reports of understaffing and excessive waits. One-quarter or more of respondents at <u>all</u> European locations reported MEDDAC understaffing. About 88% of European locations also had similar reports of excessive waits. Perhaps, since facilities in these locations experience a lower demand for services, staffing levels are lower. However, it appears that even with the reduced demand, from a patient's point of view, staffing is still inadequate.

Dental Activities

<u>Service Need</u>. As for Medical Activities, there was agreement among service providers at all locations that Dental Activities were also needed by community members. The evaluations averaged between strongly agree and agree at all 33 locations.

<u>Service Knowledge</u>. Service providers were knowledgeable about DENTAC services. Table 4 shows that, on average, 71% of the respondents at the locations had been briefed. At least half of the respondents had been briefed on DENTAC services at the majority of locations. In addition, providers also referred clients to DENTACs. Overall, slightly over half had made a DENTAC referral. At 75% of the locations, at least half of the providers had made referrals.

Table 4

Mean proportion of service providers in each region who were briefed on or made referrals to DENTACs*

	CONUS	Europe	Other OCONUS	Total
Briefed	73%	69%	69%	71%
Referrals	54%	58%	59%	56%

* Percents represent regional means

Service Evaluation. Overall, respondents were satisfied with their DENTACs. At almost two-thirds of the locations, mean provider evaluations were between very satisfied and satisfied. At the rest of the locations, evaluations averaged between satisfied and no opinion.

Consistent with the providers' high satisfaction with the services, providers also judged DENTAC staff to be quite competent. On a scale from 1 to 5 (where 1 is very competent and 5 is very incompetent), respondents' mean rating of DENTAC staff was 1.65. DENTAC staff at 90% of the locations had mean ratings between competent and very competent (ratings between 1 and 2). At the remainder of locations, staff were rated between competent and average (ratings between 2.01 and 3).

Table 5 shows that there was little evidence that Dental Activities had systematic problems with inadequate privacy, publicity, hours or repairs. Although there were some scattered reports, the majority of service providers reported that these problems **did not** exist.

There was evidence that overcrowding may be a problem at some DENTAC facilities in Europe. And, as was true for MEDDACs, understaffing and long waits were also problems for DENTACs in all three regions. Overall, about 45% of the locations had at least one-fourth or more of its respondents reporting inadequate staffing. Almost half of the locations had at least one-fourth of the respondents reporting excessive waits. Reports of excessive waits seemed to be tied to geographic region; CONUS had the fewest and Europe had the most reports. Overall, although fewer service providers reported problems for DENTACs than for MEDDACs, Dental Activities in Europe also seemed to be troubled by service delivery problems of overcrowding, understaffing and excessive waits.

Table 5

Percent of locations with evidence of the following problems: DENTACs*

	CONUS	Europe	Other OCONUS	Total
No privacy	-	-	-	-
Poor publicity	-	-	-	-
Inconven. hours	-	-	-	-
Poor repair	-	-	-	-
Too crowded	-	6.4	-	2.0
Understaff	42.2	50.2	42.2	44.7
Wait too long	27.2	89.5	42.2	49.0

* Cell percents represent the proportion of locations in each region in which an average of 25% or more service providers reported specific DENTAC problems. A dash indicates that fewer than 25% of the respondents in every location in that region reported the problem.

Mental Health Services

Service Need. As with the other services previously examined, providers at all locations agreed there was a need for mental health services. At over 95% of the locations, service providers, on average, either agreed or strongly agreed that mental health services were needed by people in that community.

Service Knowledge. Providers were knowledgeable about the mental health services available. At least one-quarter of respondents at all locations had been briefed on mental health services. Table 6 demonstrates that on average, about 64% of the providers had attended a mental health services briefing. More providers reported briefings in CONUS than in Europe or other OCONUS locations.

All locations contained providers who reported making referrals to mental health services. Table 6 shows that overall, 66% of the respondents had made such a referral. Additional analyses show that many providers at given locations made referrals. At about 90% of the locations, at least **half** of the providers had made such a referral. We also note the same regional pattern as noted above - fewer respondents in Europe and other OCONUS locations had made a referral than had those in CONUS. These patterns suggest the presence of an association between provider knowledge of mental health programs and client referrals. It is reasonable to expect that family service providers with a formal introduction to a service or program may indeed be more likely to refer clients.

Table 6

Mean proportion of service providers in each region who were briefed on or made referrals to Mental Health Services*

	CONUS	Europe	Other OCONUS	Total
Briefed	70%	54%	64%	64%
Referrals	73%	54%	68%	66%

* Percents represent regional means

Service Evaluation. Overall, satisfaction with mental health services was somewhat lower than that with MEDDACs and DENTACs. Nevertheless, providers were, on average, satisfied with the mental health facilities available at their current location. At the majority of locations (8 out of 10), mean satisfaction scores ranged between satisfied and no opinion.

In addition, provider's assessment of mental health staff competency was somewhat lower than their assessments of the two other services. Respondents at 62% of the locations reported that mental health staff were between very competent and competent. Another third rated staff between competent and average.

Table 7

Percent of locations witn evidence of the following problems: Mental Health Services*

	CONUS	Europe	Other OCONUS	Total
No privacy	-	-	-	-
Poor publicity	-	-	-	-
Inconven. hours	-	-	-	-
Poor repair	3.4	-	-	1.8
Too crowded	9.7	39.8	-	17.6
Understaff	37.9	51.7	42.2	42.9
Wait too long	20.3	-	-	10.8

* Cell percents represent the proportion of locations in each region in which an average of 25% or more service providers reported specific problems at the Mental Health Service. A dash indicates that fewer than 25% of the respondents in every location in that region reported the problem.

As noted with the other services, lack of privacy, publicity or inconvenient hours were not widely reported as problems. Most problematic for all locations was understaffing. Overall, about 43% of the locations had at least one-fourth of their respondents reporting this difficulty. Poorly repaired facilities and excessive waits were noted in CONUS although they were not widely reported in the other regions. Overcrowding was a problem for almost 40% of the locations in Europe although it was reported less frequently in CONUS and other OCONUS locations.

SUMMARY AND IMPLICATIONS

Summary

Several findings are consistent across services and locations. Providers felt strongly that there was a need for all three types of services although more providers expressed a need for MEDDACs than for either of the other two services. The majority of providers at the 33 locations had also received some information on each of the services and were knowledgeable enough to make client referrals. On the whole, respondents were very satisfied with all three services, especially DENTACs. Although the staff at all three services were, on average, rated as very competent, ratings for DENTAC staff were somewhat higher than for staff at MEDDACs and mental health services.

Lack of privacy and poor publicity were not generally perceived as problems for any of the services examined. However, inconvenient hours and poorly repaired facilities were reported in some geographic regions. Inconvenient hours were noted for CONUS and European MEDDACs. Facilities being in poor repair was more widely reported for MEDDACs and mental health services in the continental U.S. than for other regions.

On the other hand, there was consistent evidence that users were coping with overcrowding, understaffing and excessive waits at all of the services. Overcrowding was a problem for mental health services and MEDDACs in CONUS and Europe. There was some evidence that DENTACs in Europe were also overcrowded. Understaffing was widely reported for all services at all locations. MEDDACs in particular appear to be understaffed. Similarly, there were widespread reports of excessive waits for both MEDDACs and DENTACs in all regions. Excessive waits is also a problem for some mental health facilities in CONUS.

These findings parallel previous research (see Griffith, Gabel & Stewart, 1988) that Army health facilities largely have adequate hours of operation and that, overall, most respondents are satisfied with Army healthcare. However, as previously noted in 1987, long waiting times continues to be a problem. Undoubtedly, complaints of overcrowding and understaffing in this research are also related to reports of excessive waits. More recent research conducted in 1992 found that at least four out of ten Army spouses were dissatisfied with "time spent waiting to see a doctor/medical support staff" or "time between first call for appointment and being seen (Army Personnel Survey Office, in process)." Clearly, these data from multiple research investigations suggest that the quality of care (as indicated in this analysis by perceptions of staff competency and service satisfaction) is high. However, a continuing problem for Army health services is getting patients treated and through the

system in what patients (or family support professionals) would consider a timely manner.

Limitations

One important factor for the reader to remember is that this data reflects only one perspective of health care services - that of providers. The providers' perspective may be at odds with that of clients/patients. Providers are undoubtedly more knowledgeable than family members of the strengths and weaknesses of the Army support system and their responses may be colored by their own successes and failures within that system. Their experiences in facing the challenges of family support (e.g., limited resources) may predispose providers to be sympathetic to the challenges faced by their peers in other areas. On the other hand, providers who have successfully resolved similar problems in their own domain may be more critical of others who have not. In short, providers may be more or less critical than clients/patients because of their experiences within the Army family support system.

Three other limitations reflect ambiguities with the survey items. The first concerns the nature of the briefings attended by providers. Although the respondents generally acknowledged receiving a briefing on the various services, we lack information on the nature and content of these presentations. We do not know whether these briefings were: (1) individual or group presentations, (2) part of a formal introduction to a location's family services or whether they were given on an ad hoc basis, and (3) targeted especially for providers or toward the Army community at large (i.e., including family members). We also lack information on how extensive these briefings were.

A second ambiguity reflects unclear wording in the questionnaire. Excessive waiting time was one of the more frequently reported problems by providers at locations in each of the three geographic regions. Yet, the interpretation of these findings is equivocal since the question is ambiguously worded. It is not clear whether "waiting time too long" reflects excessive time to get an appointment or whether it reflects excessive time spent in a waiting room once the patient has arrived at the office. So, although we cannot be sure exactly what respondents are reporting in this regard, we can conclude that either (or both) of these issues bear further examination and evaluation.

A third ambiguity with the survey wording concerns the response categories to question #5 on staff competence. The response categories comprise a 5-point scale with categories of very competent, competent, average, incompetent and very incompetent. One might argue that the midpoint, "average," is not a true midpoint and reflects a bias towards competence based

on the assumption that, in most cases, staff members will possess a minimal amount of competency. A true midpoint might, instead, be "neither competent nor incompetent." Therefore, as currently designed, there are three positive and two negative response possibilities. Usually it is more desirable to have two positive, two negative, and one neutral category.

Implications

The current changes in Army personnel and other resources will undoubtedly have implications for health care providers and services. The Army of the future will be smaller and rapidly deployable with the majority of its personnel in CONUS locations and with many soldiers home-based. Although there will be fewer active duty personnel, there will be a large population of Army veterans and retirees who are entitled to health care and other benefits. Current research on military health care facilities needs to be examined in light of these changes and with an eye toward identifying how current resources might be adapted to meet the demands of this new Army.

In the long run, these changes in the Army may result in a greater demand for health services by retirees and veterans, although this may be somewhat offset by reduced active duty demand. In addition, as installations in Europe close and personnel are reassigned to CONUS locations, the demand for stateside medical and dental services will increase.

We also need to consider how downsizing and realignment are likely to affect the need for medical, dental and mental health services in the short run. Downsizing often increases the personal and family stress experienced by not only those who leave the organization, but also by the survivors, those who remain. An increase in soldier and family stress levels may prompt an increase in referrals to and demand for mental health and MEDDAC services.

The most frequently reported problems faced by services examined in this report (understaffing, overcrowding, waiting times too long) essentially reflect inadequate staffing and slow movement of patients through health facilities. These problems will be worsened by the increased patient load which may occur as we struggle with the consequences of downsizing and move toward a CONUS based Army.

Stretching current resources to meet a greater demand for services places tremendous stresses on health care personnel and facilities. Stretching preexisting staff to meet increased demands for service may compromise the quality of care delivery and reduce perceptions of staff competence and client satisfaction. An increased demand for services also places additional stresses on current facilities which may have been

designed to serve fewer clients and slower traffic. Therefore, an increase in the demand for CONUS medical, dental and mental health services may require not only additional staff in CONUS but may also require increased facility maintenance. At some densely populated locations in the United States, it may also be necessary to upgrade and expand facilities and equipment.

Clearly, the implication of this is that there is a need to systematically evaluate the impact of Army structural change on health service resources, in general, and on personnel and facilities, specifically. In particular, further examination of excessive waits and understaffing in MEDDACs and how downsizing is likely to impact these problems would be quite valuable. In the absence of such research, however, readers may want to more generally consider how to minimize the negative consequences of realignment and downsizing on the health of soldiers, family members and veterans.

Since depression and loss of self esteem are among the many psychological consequences of downsizing, forced relocation and job loss, health care providers may want to ensure that medical and mental health services (especially in CONUS) are readily available and widely publicized. Counseling will be particularly important in assisting soldiers in making a smooth transition into civilian life. This assistance is especially important at posts where large numbers of soldiers (particularly young enlisted soldiers who may have few job skills and experience) are entering civilian life. In addition, providing mental health professionals with information on the array of instrumental services and programs available to assist transitioning soldiers and family members in both the community (local employment agencies and state services) and within the Army (transition assistance programs, Army Career Alumni Program, etc.) enables providers to better meet the instrumental needs of their clients.

Similarly, Army leadership must ensure that transitioning soldiers and their families are aware of the entitlements associated with their new status and know how to access health care as civilians.

Consideration might also be given to reassigning staff currently at health care facilities in Europe (and in some US locations) which are closing or scheduled to close. Their transfer to CONUS locations which are likely to experience the greatest increases in demand for care would be most valuable. Extra mental health and medical professionals might be temporarily assigned to posts which are scheduled to close or experience vast reductions in force. Both medical and non-medical personnel (such as job and relocation counselors) might be alerted to look for symptoms of stress. It would be helpful

for them to remain in their temporary assignments until any surge in demand for service wanes.

A needs assessment might also be conducted to evaluate the potential demand for medical and dental services at installations where considerable numbers of soldiers and their families are likely to home base.

Ultimately, in times of transition, we must be proactive by evaluating the potential impact of change on health care providers and the patients they serve. We must plan ahead to meet the challenges of a new environment.

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APPENDIX A

FAMILY SERVICE PROVIDER SURVEY

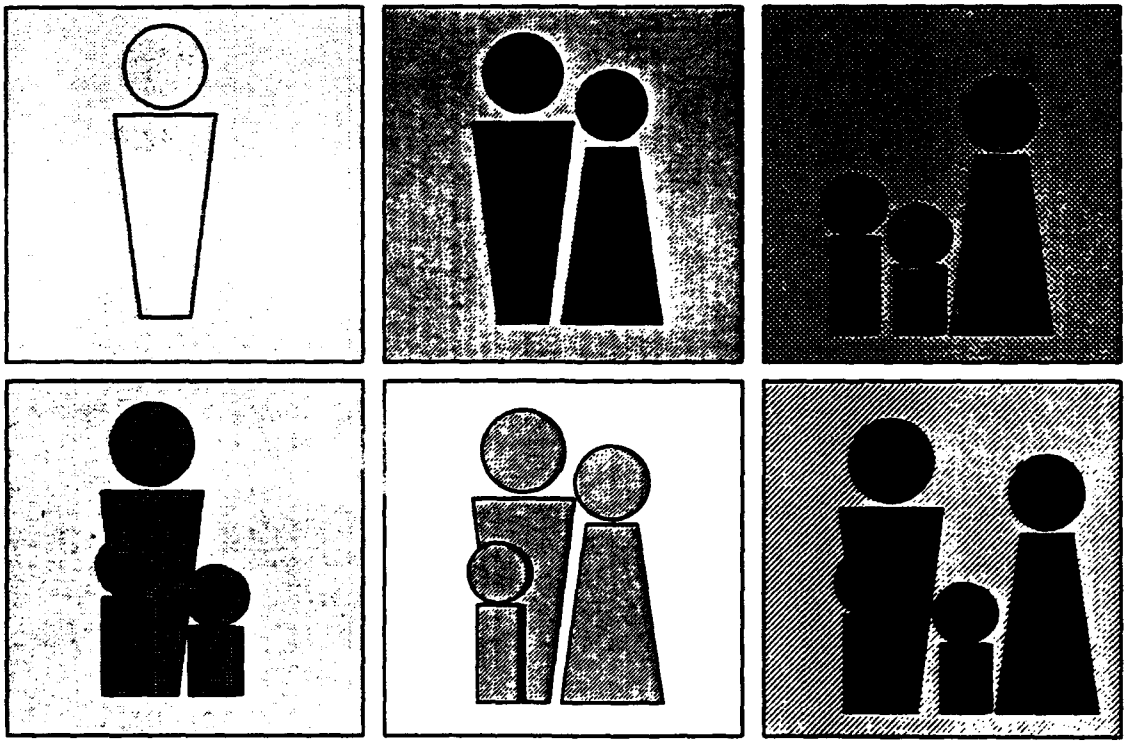
SURVEY APPROVAL AUTHORITY: U.S. ARMY SOLDIER SUPPORT CENTER
SURVEY CONTROL NUMBER: ATNC-AO-89-10G RCS: MILPC-3

Army Family Research Program

Bar Code Label Here

1989 Army Soldier and Family Survey

SURVEY OF FAMILY SERVICES



SURVEY OF MILITARY FAMILY SERVICES AT

We need your opinions on a number of local family-related services provided by the military. The questionnaire below contains a listing of services across the top with questions and ratings down the side. Some of the ratings ask your level of familiarity with the service, and others ask you to rate different aspects of the service. Please circle the number that best describes the service.

	Army Community Service (ACS)	Army Education Center	Army Emergency Relief (AER)	Child Development Services (CDS)	Community Life (Mayor's) Office	Dental Activity (DENTAC)	Family Life Center (Chaplains)	Family Member Employment Assistance Program	Financial Planning Assistance	Housing Referral Office (Off-post)	Government Housing C
1. People assigned here need this service.											
Strongly Agree	1	1	1	1	1	1	1	1	1	1	1
Agree	2	2	2	2	2	2	2	2	2	2	2
No Opinion	3	3	3	3	3	3	3	3	3	3	3
Disagree	4	4	4	4	4	4	4	4	4	4	4
Strongly Disagree	5	5	5	5	5	5	5	5	5	5	5
2. Service is provided by the military at this location or within 1 hour's drive.											
No, service not provided by military within one hour's drive.	2	2	2	2	2	2	2	2	2	2	2
If no, skip to next service →											
Yes, service provided at this location	1	1	1	1	1	1	1	1	1	1	1
Yes, service provided within one hour's drive, but not at this location	3	3	3	3	3	3	3	3	3	3	3
Answer items 3 to 7 for this service AT THE CLOSEST FACILITY ONLY											
3. I have been briefed on this service.											
Yes	1	1	1	1	1	1	1	1	1	1	1
No	2	2	2	2	2	2	2	2	2	2	2
4. I have referred people here to this service.											
Yes	1	1	1	1	1	1	1	1	1	1	1
No	2	2	2	2	2	2	2	2	2	2	2
5. Overall, the service staff is:											
Very Competent	1	1	1	1	1	1	1	1	1	1	1
Competent	2	2	2	2	2	2	2	2	2	2	2
Average	3	3	3	3	3	3	3	3	3	3	3
Incompetent	4	4	4	4	4	4	4	4	4	4	4
Very Incompetent	5	5	5	5	5	5	5	5	5	5	5
6. Overall, how satisfied are you with this service?											
Very Satisfied	1	1	1	1	1	1	1	1	1	1	1
Satisfied	2	2	2	2	2	2	2	2	2	2	2
No Opinion	3	3	3	3	3	3	3	3	3	3	3
Dissatisfied	4	4	4	4	4	4	4	4	4	4	4
Very Dissatisfied	5	5	5	5	5	5	5	5	5	5	5
7. Program's/Service's Problems (Circle if applies)											
Facilities in Poor Repair	1	1	1	1	1	1	1	1	1	1	1
Facilities Too Crowded	1	1	1	1	1	1	1	1	1	1	1
Inconvenient Hours	1	1	1	1	1	1	1	1	1	1	1
Lack of Privacy	1	1	1	1	1	1	1	1	1	1	1
Poor Publicity	1	1	1	1	1	1	1	1	1	1	1
Understaffed	1	1	1	1	1	1	1	1	1	1	1
Waiting Time Too Long	1	1	1	1	1	1	1	1	1	1	1

SURVEY OF MILITARY FAMILY SERVICES AT (PART II

What is your current Rank or Civil Service Grade? _____

How long have you been at this post? _____yrs. _____mos.

	Judge Advocate General (JAG)	Medical Activity (MEDDAC)	Mental Health Services	Recreational Services On-post	Schools (DODDS or Section 6)	Transportation Office	Youth Services
1. People assigned here need this service.							
Strongly Agree	1	1	1	1	1	1	1
Agree	2	2	2	2	2	2	2
No Opinion	3	3	3	3	3	3	3
Disagree	4	4	4	4	4	4	4
Strongly Disagree	5	5	5	5	5	5	5
2. Service is provided by the military at this location or within 1 hour's drive.							
No, service not provided by military within one hour's drive.	2	2	2	2	2	2	2
If no, skip to next service →							
Yes, service provided at this location	1	1	1	1	1	1	1
Yes, service provided within one hour's drive, but not at this location	3	3	3	3	3	3	3
Answer items 3 to 7 for this service AT THE CLOSEST FACILITY ONLY							
3. I have been briefed on this service.							
Yes	1	1	1	1	1	1	1
No	2	2	2	2	2	2	2
4. I have referred people here to this service.							
Yes	1	1	1	1	1	1	
No	2	2	2	2	2	2	
5. Overall, the service staff is:							
Very Competent	1	1	1	1	1	1	
Competent	2	2	2	2	2		
Average	3	3	3	3	3		
Incompetent	4	4	4	4	4		
Very Incompetent	5	5	5	5	5		
6. Overall, how satisfied are you with this service?							
Very Satisfied	1	1	1	1	1		
Satisfied	2	2	2	2	2		
No Opinion	3	3	3	3			
Dissatisfied	4	4	4	4			
Very Dissatisfied	5	5	5	5			
7. Program's/Service's Problems (Circle if applies)							
Facilities in Poor Repair	1	1	1	1			
Facilities Too Crowded	1	1	1	1			
Inconvenient Hours	1	1	1				
Lack of Privacy	1	1	1				
Poor Publicity	1	1	1				
Understaffed	1	1	1	1			
Waiting Time Too Long	1	1	1	1			

CONFIDENTIALITY

This research is being conducted by Research Triangle Institute, Caliber and Human Resource Research Organization under contract with the U.S. Army Research Institute for the Behavioral and Social Sciences (ARI). An important objective of the research is to assess the effects of family programs and other factors on soldier and unit readiness, soldier retention, and family adaptation. The attached instrument asks you for information on family programs at your installation.

Your participation in voluntary but your answers are very important because they provide needed information on programs and services. The information you provide will be held as confidential in accordance with Public Law 93-573, which is called the Privacy Act of 1974. The completed forms will be seen only by staff of the civilian contractors. The contractors will not release personally identifiable data collected under this contract to anyone in the Army or other agencies, except as necessary to allow future contact for research purposes or to merge data records in ways allowed by law and regulation. The information you provide and some personnel data obtained from records will be combined with survey data from soldiers and spouses to prepare a report.

Authority to conduct this research is contained in 10 United States Code Sections 137 and 2358, which authorize retention of military personnel and research to accomplish this objective.

APPENDIX B

MEANS AND STANDARD DEVIATIONS

Table B-1

Mean Service Provider Evaluations of MEDDACs

	Range	CONUS	Europe	OCONUS	Total
Need	1-5*	1.12 (.24)	1.20 (.04)	1.20 (.20)	1.10 (.21)
% briefed	0-1	.79 (.20)	.77 (.09)	.65 (.13)	.77 (.18)
% referrals	0-1	.85 (.17)	.75 (.10)	.88 (.19)	.82 (.17)
Staff competence	1-5**	1.88 (.64)	1.90 (.33)	1.79 (.62)	1.87 (.55)
Satisfaction	1-5***	2.11 (.65)	2.01 (.87)	2.06 (.32)	2.07 (.65)
Poor repair	0-1	.09 (.16)	.13 (.06)	.10 (.11)	.10 (.13)
Inconvenient hrs	0-1	.09 (.11)	.12 (.17)	.06 (.09)	.09 (.13)
Lack of privacy	0-1	.05 (.07)	.11 (.08)	.02 (.07)	.07 (.08)
Poor publicity	0-1	.03 (.06)	.02 (.05)	.05 (.06)	.03 (.06)
Too crowded	0-1	.24 (.16)	.24 (.16)	.11 (.06)	.22 (.16)
Understaffed	0-1	.38 (.17)	.38 (.21)	.31 (.29)	.37 (.20)
Wait too long	0-1	.41 (.23)	.36 (.25)	.34 (.36)	.38 (.25)
N locations		19	9	5	33

Coding:
* 1=Strongly agree through 5=Strongly disagree
** 1=Very competent through 5=Very incompetent
*** 1=Very satisfied through 5=Very dissatisfied

Standard deviations in parentheses

Table B-2

Mean Service Provider Evaluations of DENTACs

	Range	CONUS	Europe	OCONUS	Total
Need	1-5*	1.30 (.23)	1.09 (.11)	1.34 (.26)	1.24 (.25)
% briefed	0-1	.73 (.16)	.69 (.10)	.69 (.43)	.71 (.20)
% referrals	0-1	.54 (.16)	.58 (.07)	.59 (.46)	.56 (.21)
Staff competence	1-5**	1.69 (.39)	1.54 (.33)	1.76 (.47)	1.65 (.39)
Satisfaction	1-5***	1.98 (.43)	1.85 (.43)	1.87 (.76)	1.92 (.48)
Poor repair	0-1	.02 (.06)	.04 (.09)	.00 (.00)	.02 (.07)
Inconvenient hrs	0-1	.04 (.08)	.05 (.09)	.02 (.05)	.04 (.08)
Lack of privacy	0-1	.01 (.06)	.01 (.02)	.00 (.00)	.01 (.05)
Poor publicity	0-1	.03 (.08)	.02 (.03)	.04 (.08)	.03 (.07)
Too crowded	0-1	.05 (.10)	.17 (.09)	.02 (.03)	.08 (.12)
Understaffed	0-1	.19 (.14)	.27 (.12)	.20 (.32)	.22 (.17)
Wait too long	0-1	.18 (.18)	.35 (.16)	.17 (.15)	.23 (.21)
N locations		19	9	5	33

Coding:
* 1=Strongly agree through 5=Strongly disagree
** 1=Very competent through 5=Very incompetent
*** 1=Very satisfied through 5=Very dissatisfied

Standard deviations in parentheses

Table B-3

Mean Service Provider Evaluations of Mental Health Services

	Range	CONUS	Europe	OCONUS	Total
Need	1-5*	1.39 (.39)	1.36 (.29)	1.41 (.26)	1.38 (.34)
% briefed	0-1	.70 (.23)	.54 (.09)	.64 (.30)	.64 (.23)
% referrals	0-1	.73 (.17)	.54 (.20)	.68 (.20)	.66 (.22)
Staff competence	1-5**	1.96 (.50)	1.91 (.39)	1.99 (.60)	1.95 (.48)
Satisfaction	1-5***	2.31 (.44)	2.54 (.36)	2.21 (.35)	2.37 (.43)
Poor repair	0-1	.09 (.12)	.11 (.13)	.07 (.08)	.09 (.12)
Inconvenient hrs	0-1	.04 (.08)	.02 (.04)	.02 (.07)	.03 (.07)
Lack of privacy	0-1	.03 (.06)	.05 (.08)	.05 (.06)	.04 (.07)
Poor publicity	0-1	.05 (.08)	.07 (.06)	.05 (.06)	.05 (.07)
Too crowded	0-1	.09 (.13)	.16 (.24)	.12 (.11)	.11 (.17)
Understaffed	0-1	.22 (.12)	.25 (.28)	.18 (.11)	.23 (.18)
Wait too long	0-1	.18 (.17)	.13 (.13)	.09 (.14)	.15 (.16)
N locations		19	9	5	33

Coding:
* 1=Strongly agree through 5=Strongly disagree
** 1=Very competent through 5=Very incompetent
*** 1=Very satisfied through 5=Very dissatisfied

Standard deviations in parentheses