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Do Noncontingent Incentives Increase Survey Response Rates among Mental Health Providers? A Randomized Trial Comparison

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Abstract

Surveys can be a useful tool for mental health services research. Unfortunately, clinicians typically show low response rates to surveys. To determine whether noncontingent incentives would increase responses among clinicians, we compared no incentive versus four incentives (mood magnet, \$1, \$2, \$5) on response to a 7-page self-report survey of mental health assessment and treatment practices in a sample of 500 clinicians from the 5 largest professional guilds. Noncontingent monetary incentives significantly increased response rate compared to no incentive across all disciplines. Noncontingent monetary incentives are discussed as a cost-effective method for increasing survey response rate among mental health clinicians.

Keywords

response rate; survey research; incentives; mental health services

Large-scale surveys can provide a cost-effective means of sampling a large number of individuals regarding specific attitudes and behaviors. In keeping with the emphasis outlined in the National Institute of Health Roadmap Initiative on translating basic and applied scientific discoveries into healthcare practices, provider surveys can offer a practical, cost-effective means of obtaining practice-based data regarding (a) typical assessment and treatment practices, clientele, and referral processes, (b) attitudes of clinicians toward research findings and evidence-based practices, and (c) adoption of research-supported assessment and treatment methods both before and after dissemination and implementation interventions (see, e.g., Cashel, 2002; Jensen-Doss, Hawley, Lopez, & Osterberg, in press; Walrath, Sheehan, Holden, Hernandez, & Blau, 2006). While self-report quantitative surveys are limited by subjectivity, and by the depth of information they can provide, they can be used to obtain a broad range of information from a much larger and geographically spread sample than would be possible with more intensive interview-based or observational research. As such, provider surveys can supplement and complement the information gained from more fine-grained methods, such as in-depth interviews or observational coding, which would be impractical with a very large sample.

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Surveys are most useful to the extent that they result in a representative and unbiased sample of respondents who reply to the items in an accurate manner. There are several important threats to obtaining valid, representative responses from a survey, including sampling bias (i.e., the sample surveyed may not accurately represent the larger population of interest), self-selection bias (i.e., non-response bias; those who choose to respond may be different in some way from those who choose not to respond) and response bias (even amongst those who respond, they may feel pressure to respond to items in a particular way). One of the most difficult problems facing researchers interested in using survey methods is self-selection bias. Even if the sample selected for a survey adequately represents the population of interest, the surveys actually returned may not represent the larger population if only certain types of individuals choose to respond. One of the most widely discussed ways to minimize this bias is to employ survey methods that have been shown to maximize response rates.

Past surveys of mental health service providers have shown them to be consistently poor responders, with typical response rates in the range of 25–40% (e.g., Archer, Maruish, Imhof & Piotrowski, 1991; Cashel, 2002; Jensen-Doss et al., in press; Piotrowski & Keller, 1989; Rosenberg & Beck, 1986; Silver & Silver, 1983; Tuma & Pratt, 1982; Weersing, Weisz, & Donenberg, 2002). As such, it is important to identify cost-effective methods to increase response rates among this population if we are to make the most of survey research in the study of mental health services. A variety of methods have been proposed to increase response rate, such as including token incentives with the initial mailing, using first-class stamps, hand-addressing and personally signing cover letters, promising monetary remuneration upon return of the survey, and sending reminders or follow-up mailings (e.g., Dillman, 2000). In particular, modest noncontingent incentives (e.g., small cash amounts ranging from 25 cents to a few dollars or nonmonetary tokens such as a tea bag or coupon for free coffee) have consistently been found to increase response rates among laypersons and other professionals (e.g., Berry & Kanouse, 1987; Brennan, Hoek, & Astridge, 1991; Church, 1993; Everett, Price, Bedell & Tellijohann, 1997; Harvey, 1987; Hopkins & Gullickson, 1992; Singer, Groves, & Corning, 1999; Yammarino, Skinner & Childers, 1991). There is also some indication that monetary incentives yield higher response rates than nonmonetary incentives (e.g., Brennan et al., 1991; VanGeest, Johnson, & Welch, 2007) and that, when monetary incentives are used, higher amounts yield higher response rates (e.g., Asch, Christakis, & Ubel, 1998; Halpern, Ubel, Berlin, & Asch, 2002; Jobber, Saunders & Mitchell, 2004; VanGeest et al., 2007). However, the usefulness of noncontingent incentives for increasing response rates among mental health service providers has not been examined. The aim of the current study is to examine the effect of including noncontingent incentives, both monetary and nonmonetary, on response rates within a sample of mental health service providers.

In this study, we investigated the effects of noncontingent incentives on response rates among mental health service providers from the 5 most prevalent mental health disciplines: counseling, marriage and family therapy, psychiatry, psychology and social work. We randomly assigned participants to 5 incentive conditions: no incentive, feelings magnet, \$1 bill, \$2 bill, and \$5 bill. None of these incentives were intended to fully compensate a mental health professional for the time spent completing a survey. Given the extensive research showing that noncontingent token incentives increase response rates among the general public and among other professionals, we hypothesized that providing an incentive would significantly increase mental health provider response rate over no incentive. Some prior research also suggests that cash incentives may outperform nonmonetary incentives (VanGeest, Johnson, & Welch, 2007) and that, among cash incentives, higher values outperform lower values (Asch et al., 1998; Halpern et al., 2002; Jobber et al., 2004), so we sought to determine whether this would also hold true among mental health providers.

Method

This study was conducted as part of the pilot phase of a larger survey project intended to characterize treatment as usual for children and adolescents with anxiety, depression, and disruptive behavior disorders. We used the Tailored Design Method (see Dillman, 2000) to develop a seven page survey covering provider demographics, work setting and caseload characteristics, and assessment and treatment strategies used in their practice. It is worth noting several other aspects of the Tailored Design Method that we used across all conditions, including (a) personally addressed and hand-signed cover letters with first class stamps on both the individually addressed outgoing envelope and the return envelope, (b) unique survey appearance with landscape orientation, gray-scale gradients and photographs of children to increase salience and help the survey stand out from other mail, (c) formatting features designed to help participants complete and return it with ease (e.g., important words were bolded or italicized and each section of the survey was grouped using borders; return address information was placed on both the front and back cover of the survey) and (d) two follow-up mailings including a thank you/reminder postcard sent to the entire sample and a 2nd survey sent to non-respondents, both of which were also personally addressed and hand-signed. In addition, a separate postage-paid postcard was included that respondents could return with their completed address if they wished to receive a summary of the survey findings.

We mailed the survey to 500 mental health providers randomly selected from guild membership lists, 100 from each of five professional organizations (American Counseling Association, ACA; American Association for Marriage and Family Therapy, AAMFT; American Academy of Child and Adolescent Psychiatrists, AACAP; American Psychological Association, APA; National Association of Social Workers, NASW). Each of these organizations boasts the largest membership of any guild within their respective disciplines and each has procedures in place to obtain mailing lists of random, representative samples of their membership. From each guild, we selected members within the 50 United States who indicated clinical interest or practice with children, adolescents or families. We randomly assigned 20 from each guild organization to one of five incentive conditions: no incentive, feelings magnet (see <http://portal.creativetherapystore.com>), \$1 bill, \$2 bill, or \$5 bill. We conducted up to three mailings (initial survey with incentive, postcard, follow-up survey) and examined the proportion who responded. We compared response rates using a series of chi square tests for homogeneity. We calculated power to test for differences in response rates across the 5 incentive conditions as 0.96 for the overall chi square test of homogeneity, and ranging from 0.81 to 0.99 for the follow-up comparisons between specific incentives and disciplines, using the criterion effect size $w=0.20$ (halfway between a “small” and “medium” magnitude of association; Cohen, 1988).

Results

Overall Response Rate

Of the 500 surveys sent, 6 surveys were undeliverable leaving an adjusted sample of 494. Two-hundred fifty-five completed surveys were returned for an adjusted response rate of 51.62% (255/494). Of the 255 returned surveys, 59 participants responded to the first survey, 121 responded after the reminder postcard, and 75 responded after the second survey. Another 20 participants declined to participate in the study either explicitly or implicitly (10 individuals stated that they were not interested in participating in the study; another 10 individuals returned a blank survey). Of the 20 individuals who declined to participate, 8 did so after the first mailing, 5 after the postcard reminder, and 7 after the final mailing. Two-hundred and nineteen participants did not respond to any of the mailings.

Response Rate by Incentive

Response rates ranged from a low of 39.8% for the no incentive condition to a high of 64.6% for the \$5 bill incentive condition (see Table 1). There was a significant difference in response rate across the 5 incentive conditions indicating that one or more incentive conditions yielded significantly higher response rates than another $\chi^2(4, n = 494) = 19.19, p < 0.001$.

To further examine these differences, we ran a series of 2×2 chi square tests of homogeneity to test the specific associations found in prior survey research with laypersons and non-mental health professionals, using a modified Bonferroni corrected p value of 0.025 (Keppel, 1991): (a) no incentive (39.8%) versus any incentive (54.5%), (b) nonmonetary gift incentive (41.8%) versus monetary incentive (58.7%), and (c) lower versus higher cash values (51% for \$1 bill, 60.6% for \$2 bill, and 64.6% for \$5 bill). As expected, we found that inclusion of a noncontingent incentive resulted in a higher response rate than no incentive $\chi^2(1, n = 494) = 6.84, p < 0.01$. We next compared type of incentive (money versus mental health-related gift) and found that the monetary incentive conditions resulted in significantly higher response rates than the feelings magnet $\chi^2(1, n = 396) = 8.48, p < 0.01$. However, when we examined the benefits of each level of monetary incentive versus the feelings magnet separately, we found the differences between the feelings magnet and the \$1 bill were not significant $\chi^2(1, n = 198) = 1.67, p = 0.20$, whereas the higher response rates for the \$2 bill and \$5 bill over the feelings magnet were each significant $\chi^2(1, n = 197) = 6.94, p < 0.01$ and $\chi^2(1, n = 197) = 10.29, p < 0.01$ respectively. We then compared the three monetary incentive conditions to one another to determine whether higher cash values resulted in significantly higher response rates using a 3×2 chi square. Despite the trend seen in Table 1 for larger monetary incentives to outperform smaller monetary incentives (\$5 bill > \$2 bill > \$1 bill), this effect did not reach significance in our sample $\chi^2(2, n = 298) = 4.04, p = 0.13$.

Response Rate by Guild

When examined by discipline, response rates ranged from a low of 36.7% for psychiatrists to a high of 64.3% for social workers (see Table 2). There was a significant difference in response rate across the 5 disciplines indicating that one or more disciplines responded at a significantly higher rate than another discipline $\chi^2(4, n = 494) = 16.68, p < 0.01$. We then compared the response rates of the five disciplines with a series of post-hoc 2×2 comparisons, using a modified Bonferroni corrected p value of 0.02 (Keppel, 1991). Psychiatrists showed significantly lower response rates than counselors $\chi^2(1, n = 197) = 8.58, p < 0.01$ and social workers $\chi^2(1, n = 196) = 14.88, p < 0.001$; no other differences between disciplines in response rate reached significance (all $p > 0.02$).

Response Rate by Guild and Incentive

We also examined whether the disciplines differed significantly in their response to the incentive conditions. We employed a $5 \times 5 \times 2$ loglinear chi-square model to test whether there were significant differences across disciplines in the incentive-response rate association. We allowed the previously identified associations between discipline and response, and between incentive and response, but we held the incentive-response rate association constant across disciplines. In other words, the model allowed the two-way interactions but not the three-way interaction, such that the chi square tested the null hypothesis of no three-way interaction. The chi square was nonsignificant $\chi^2(32, n = 494) = 16.62, p = 0.99$ indicating that counselors, marriage and family therapists, psychiatrists, psychologists, and social workers did not significantly differ in their response to the various incentives.

Discussion

Survey methods can provide a practical, cost-effective approach to answering many key issues relevant to mental health services research, particularly those surrounding provider attitudes and practices. Given low response rates found in previous surveys of mental health providers, the present study examined the relative impact of various noncontingent incentives on participation rates in a survey of counselors, marriage and family therapists, psychiatrists, psychologists, and social workers. When no incentives were provided, participation in our sample was low (39.8%) and similar to rates found in past surveys of mental health providers (e.g., Cashel, 2002; Jensen-Doss et al., in press; Weersing et al., 2002). Participation rates were significantly higher when noncontingent incentives were included with the initial survey mailing (54.5%), with monetary incentives eliciting higher response rates (58.7%) than a token gift (41.8%). While there was a trend for higher dollar amounts to result in higher response rates, this trend was not statistically significant in our sample. We also saw that the disciplines differed in their overall rate of responding, with psychiatrists being the least likely to respond and social workers the most likely to respond to the survey. However, there were no significant differences between the disciplines in their response to the incentives, indicating that noncontingent incentives increase response rate in a similar manner for all 5 disciplines.

Taken together, these findings suggest that including modest, noncontingent incentives is an effective method to increase response rates for surveys of mental health providers. Consistent with previous research, (e.g., Church, 1993; Everett et al., 1997; VanGeest et al., 2007; Singer et al., 1999), our findings also suggest that cash may work better than nonmonetary incentives. As noted above, the trend for higher cash amounts to outperform lower amounts seen in other populations (e.g., Asch et al., 1998; Halpern et al., 2002; Jobber et al., 2004), was apparent but not statistically significant in our sample.

Decisions about incentives must be made considering all factors related to the cost of a survey. Although surveys can be a cost-efficient means of sampling large groups, investigators still need to spend time and money wisely. The labor that goes into a large mail survey is substantial. As such, researchers should consider which incentive results in the lowest cost per returned survey, accounting not just for the cost of the incentive, but also for printing, mailing and labor costs associated with each contact (e.g., we employed up to 3 contacts in this study). Depending on these additional costs, a higher incentive may actually result in lower cost per returned survey (e.g., where labor and mailing costs are high, a larger incentive may be warranted; where labor and mailing costs are low, a smaller incentive with additional contacts to nonrespondents may be more cost-effective; see Asch et al., 1998 and Halpern et al., 2002).

Additional Directions for Improving Survey Research within Mental Health Services

The present study examined one possible method to address the challenge of low provider response rates within mental health services survey research: the inclusion of a noncontingent incentive with the initial mailing. We chose to examine the effect of incentives on response rates because we found no existing studies demonstrating this effect with mental health providers. We felt that mental health providers unique status as helping professionals with expectations of service to the greater public health might make them respond to incentives differently than other groups. Other methods for increasing response rates could also be examined with mental health providers, including using first-class stamps, handsigning cover letters printed on official guild or university letterhead, minimizing the length of surveys, and using repeated contacts to attract nonresponders (see Dillman, 2000).

Increasing response rate is one way to attempt to minimize self-selection bias, but even with high response rates there are other important challenges to successful survey research. It is critical that survey items are clearly and carefully worded to avoid misunderstanding or careless

responding, and to minimize any pressure to respond in a certain manner. Inclusion of loaded items may inadvertently bias responding toward the perceived “correct” response (e.g., “Do you use evidence-based treatments?”). Even with relatively high response rates, it is possible that survey design and item wording might selectively pull for certain types of providers to respond over others (e.g., providers who do, in fact, value treatments supported by scientific research). Additionally, survey length and differential survey demands may contribute to self-selection biases to the extent that they affect some groups of participants and not others. For example, in our survey, there were several skip-out sections depending on whether the respondent (a) provided direct services to youths, (b) worked in private practice or an agency setting, (c) conducted assessments with youths, (d) provided any treatment to youths, and (e) had provided therapy to a youth with anxiety, depression or disruptive behavior problems in the past year. As such, the demands in terms of time and effort to respond to the survey could vary considerably depending upon the potential respondent's training background and current work situation. Future research on the impact of unbalanced demand characteristics on response rates, and the interaction between demand characteristics and other factors such as incentive amount, would be useful to the field.

Most surveys of mental health services have used guild membership lists to generate survey samples (e.g., Cashel, 2002; Rae, Jensen-Doss, Bowden, Mendoza & Banda, 2008; Weersing et al., 2002). The reliance on guild membership lists may in part be due to the difficulty in obtaining national or state lists of all licensed providers (e.g., when we began this research we found only two states with available on-line listings of all licensed mental health providers in their state), while guild membership lists are readily available for a reasonable fee. However, the extent to which guild members are representative of the general population of providers within that guild's discipline is not well understood and is worthy of future research. This brings us to a final note about guild membership lists. Although membership lists are readily available, they vary substantially in the amount and type of information given about the provider members. Improved reporting quality and consistency across guilds in the information gathered about members would allow mental health services survey researchers to maximize the likelihood that the providers sampled are actually the subgroup of interest (e.g., providers who treat geriatric adults).

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Table 1

Provider Response Rates by Incentive Condition

	Incentive Condition					Total N (%)
	No Incentive N (%)	Magnet N (%)	\$1 Bill N (%)	\$2 Bill N (%)	\$5 Bill N (%)	
Respondents	39 (39.8%)	41 (41.8%)	51 (51.0%)	60 (60.6%)	64 (64.6%)	255 (51.6%)
Nonrespondents	59 (60.2%)	57 (58.2%)	49 (49.0%)	39 (39.4%)	35 (35.4%)	239 (48.4%)
Total	98 (100%)	98 (100%)	100 (100%)	99 (100%)	99 (100%)	494 (100%)

Table 2

Provider Response Rates by Discipline

	Discipline					Total N (%)
	Psychiatrists N (%)	MF Therapists N (%)	Psychologists N (%)	Counselors N (%)	Social Workers N (%)	
Respondents	36 (36.7%)	49 (49.5%)	50 (50.0%)	57 (57.6%)	63 (64.3%)	255 (51.6%)
Nonrespondents	62 (63.3%)	50 (50.5%)	50 (50.0%)	42 (42.4%)	35 (35.7%)	239 (48.4%)
Total	98 (100%)	99 (100%)	100 (100%)	99 (100%)	98 (100%)	494 (100%)