Factors which influence client satisfaction with the services of community development corporations

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FACTORS WHICH INFLUENCE CLIENT SATISFACTION WITH
THE SERVICES OF COMMUNITY DEVELOPMENT CORPORATIONS

A Dissertation
Submitted to the Graduate Faculty of the
Louisiana State University and
Agricultural and Mechanical College
in partial fulfillment to the
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in

The School of
Human Resource Education and Workforce Development

by
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Abstract

The primary purpose of this study was to determine factors which influence client satisfaction with the services of community development corporations (CDCs) in metropolitan regions of Louisiana. The CDCs were evaluated based on five specific criteria: housing, social services, workforce development, educational enrichment, and community outreach. The objectives addressed were: description of clients, levels of client satisfaction, and relationships between satisfaction and selected demographic characteristics.

The instrument used in this study was a researcher-designed survey questionnaire used to collect client information. It was comprised of two sections – demographics and client satisfaction.

The target population for this study was adult clients of at least 18 years of age who participated in housing programs operated by CDCs in the state of Louisiana. This study focused on selected CDCs which provided housing in the cities of Baton Rouge and New Orleans, Louisiana. The entire population of 458 Louisiana CDC clients in Baton Rouge and New Orleans was surveyed. Data were collected by mailed questionnaire. After two mailings, a telephone contact, and on-site follow-up, the researcher received a 45.2% usable response rate.

The population studied included clients serviced by CDCs from the year 1994 through the present, who currently reside in a housing development of the CDC. Variables examined included: age, race, gender, marital status, household income, education level, number of children, household members over the age of 18, length of participation in CDC, and client region.
Findings of the study revealed that household income and education could be determining factors in promoting client satisfaction with the services of CDCs. A model was identified using multiple regression analysis which explained 18.1% of the variance in the extent to which client’s overall satisfaction can be explained by the data. Five variables, household income, education, number of children under 18, gender, and race were identified in the model.
Chapter 1 - Introduction

Often, people in neighborhoods across the nation have an opinion about the environments in which they live. People from all walks of life, regardless of their socio-economic status or education, sincerely desire to live and work in environments that are conducive to safely rearing a family and earning a living. The American dream, that citizens seek, is occasionally marred by the lack of positive leadership and influence within their respective communities. It is furthermore quite unfortunate that individuals who earnestly strive to attain a better standard of living are often refused that right due to blight, poor infrastructure, and unorganized communities (Steinbach, 2000). The need for development in these communities is noticeable and undeniable.

In the 1960’s, (Stoutland, 1999) community development corporations (CDCs) began to sprout up as an effort to help solve problems in neighborhoods. According to Stoutland, the mission of these organizations is to ultimately improve the quality of life and increase the standard of living in low-income neighborhoods. It is apparent through incidences covered in the media that American suburbs are not immune to the effects of crime, poverty, and the lack of basic necessities. According to the Center for Media and Public Affairs, crime was the most prevalent topic addressed on network evening news between 1993 and 1996, with one out of seven news stories being crime related. Reporting of crime by the media has extensive effects on many special interest groups and various sectors of the population (News Medias Coverage of Crime and Victimization, 2001).

Despite the devastating affects of crime, efforts are being made by communities to fight back and reclaim or create peace in their environments. In an effort to combat crime and poverty, the St. Nicholas Neighborhood Preservation Corporation – a 20-
year-old CDC in Brooklyn, New York, has formed partnerships with community-based organizations, neighborhood residents, and area businesses to coordinate local job creation efforts and business enterprise development (Pitt, 1998). There are many community and faith-based initiatives under way in cities across the United States that do similar work (Rockefeller Foundation, 1997). Even though grassroots efforts to combat societal problems exist, they are not consistently effective. The Mississippi Action for Community Education (MACE) works as an advocate for fighting policies that perpetuate poverty. This CDCs’ primary focus is that poor and rural areas do not get their fair share of grant funds to be used for development (Sampson, 2004). The people that CDCs serve, commonly referred to as clients, have largely benefited from the efforts of these nonprofit organizations, but there remains a great deal of work to be done.

CDCs have mostly been concerned with community development and revitalization to address problems in American cities. CDCs community-based approach is now widely viewed as the nation’s best strategy for community revitalization (Steinbach, 1997). However, neglected areas full of eyesores, crime, and poverty remain in any given city in the nation. Hundreds of CDCs around the country “serve to improve and stabilize neighborhoods in trouble” through building new homes, refurbishing old ones, improving rental opportunities, and helping more families move from rental to home ownership (Clark, 2001, p. 25).

Many nonprofit entities maintain their livelihood by helping people. For example, in Baton Rouge, Louisiana, LISC Baton Rouge has helped to provide support of the creation of 176 housing units and Caleb CDC has developed more than 140 single housing units (Clark, 2001) for underprivileged families. According to the 2002
Louisiana Funding Guide, published by the Louisiana Association of Nonprofit Organizations (LANO), most nonprofits are not selling a product; they are selling an idea – that communities can be improved by the investment of time, talent and resources of volunteers, community leaders and foundations. The better one can run a nonprofit, the more people you will be able to help and possibly the more people will be willing to help you (Louisiana Association of Nonprofit Organizations, 2002). But unless satisfaction is addressed, the extent to which Louisiana families and citizens are helped will continue to be limited.

Other than LANO, there is no organizational network that strives to “strengthen, promote, and build the capacity of Louisiana’s nonprofit sector” according to the conducted research (Louisiana Association Nonprofit Organizations, 2002, p.3). Research on how CDCs affect residents is vital, although difficult to execute (De Souza Briggs & Mueller, 1997). The need to capture satisfaction levels is important in identifying the programs and services that contribute to the sustainability of CDCs so that practitioners and decision makers can channel the appropriate funding into the most efficient and effective programs. For example, in an effort to continue funding, the University of Florida’s Extension program surveyed how effective they were in providing information to the public (Warnock, 1992). For 30 days, they surveyed all clients who requested educational information from the Extension office. They were asked to provide requested “descriptive demographic information and were told they may be asked to participate in a clientele satisfaction study. From there, county agents conducted the client survey.” Fifty names were randomly drawn from the listing of people receiving educational information. “Thirty to 40 survey responses were obtained and the survey team compiled a final report.” Involving clientele and volunteers in
program evaluation “enabled them to speak from firsthand experience about the effectiveness of Extension programs in Florida” (Warnock, 1992, para. 5-9). Volunteers and clients tend to be more credible than employees in justifying the work, according to the study results. As a result of positive reinforcement received from their clientele through survey results, workers took greater pride in their work. From this, they created ways to improve the information transfer and better collaborate between university organizations. Their ability to reach more people in their environment increased, resulting from the survey on client satisfaction. Client satisfaction surveys have the potential “to set performance targets, develop action plans, and improve efficiency” (Client Satisfaction Surveys, 1998, p. 3). Surveys can serve as instruments of accountability when they are properly given and interpreted. In Australia, government agencies frequently use surveys to determine the level of client satisfaction with service quality. It is also quite common for survey results to be reported in annual reports (Client Satisfaction Surveys, 1998). Such practices can be indicators alluding to the importance of research and reporting on client satisfaction.

Because survey research is more unusual in the nonprofit sector, the notion of providing research-based programs brings about a sense of confidence. It is reported that the measurement of client satisfaction should take on a business approach in order to procure funding and possibly positively affect legislation on the organization’s behalf (Warnock, 1992). Conducting satisfaction surveys can also empower important stakeholders who are often left out of program evaluation. “Opening lines of communication between all people and program levels in the evaluation process is empowering to those who are involved in the process” (Warnock, 1992, para. 14). Client satisfaction research may indicate to businesses and organizations how they are
doing and where they are going in terms of addressing the needs of their clientele, which makes exploring satisfaction worthwhile.

**Purpose of the Study**

According to the conducted research, there are limited quantitative measurements of studies that specifically examine measuring client satisfaction with the services of CDCs as measured by clients in America (De Souza Briggs & Mueller, 1997). There is little production of analyses that deliberately quantify satisfaction levels of people serviced by CDCs. Therefore, the purpose of this study is to determine factors which influence client satisfaction with the services of CDCs in metropolitan regions of Louisiana. The following objectives were formulated to help guide the researcher:

1.) To describe clients who receive housing services of CDCs in Louisiana on the following demographic characteristics:

   a. Age
   b. Race
   c. Gender
   d. Marital status
   e. Household income
   f. Education level
   g. Number of children
   h. Household members over the age of 18
   i. Length of participation in CDC
   j. Client region
   k. Household size
2.) To determine client’s overall satisfaction with the housing programs of CDCs as measured by the mean of the 14-item scale measuring housing program satisfaction. This mean was designated client’s overall satisfaction.

3.) To determine the satisfaction of clients of CDCs in Louisiana based on the services they received in:
   a. Housing
   b. Social services
   c. Workforce development
   d. Educational enrichment
   e. Community outreach

4.) To determine if a relationship existed between client’s overall satisfaction and the following selected demographic characteristics:
   a. Age
   b. Race
   c. Gender
   d. Household income
   e. Education level
   f. Number of children
   g. Household members over the age of 18
   h. Length of participation in CDC
   i. Client region
   j. Household size
5.) To determine if a model existed that significantly increases the researcher’s ability to accurately explain the overall satisfaction level of CDC clients from the following selected demographic characteristics:

   a. Age
   b. Race
   c. Gender
   d. Marital status
   e. Household income
   f. Education level
   g. Number of Children
   h. Household members over the age of 18
   i. Length of participation in CDC
   j. Client region
   k. Household size

**Definition of Terms**

1.) Community: “both the place in which organizing occurs and to the group among which organizing is happening.” It involves “issues and bonds that link people together” (Rubin & Rubin, 1992, p.82).

2.) Community Building: when CDCs assemble people to help society through missions that ultimately rebuild communities’ social structure, economic base, and physical appearance by “building on the individual character and resources of that neighborhood and addressing its particular needs” (Ewalt, Freeman, & Poole, 1998, p. 12).

3.) Community Development Corporations: nonprofit organizations that originate from determined residents interested in neighborhood revitalization; including the
development of affordable housing to attract homeowners back into their neighborhoods, promote economic development, and development of social services (Walker, 2003).

4.) Impact Evaluation: “measures the outcomes that affect the community” and determines if the “overall objectives of the development project has been accomplished.” It includes “measurements of program success based on reports of personal satisfaction” in the absence of the program (Rubin & Rubin, 1992, p. 412).

5.) Partnership: when CDCs are practical and work with other organizations to aid in reviving neighborhoods though “consensus building and taking advantage of opportunities provided by local government and the private sector to influence community policy” (Ewalt, Freeman, & Poole, 1998, p. 275).
Chapter 2 - Review of Literature

Introduction

For decades, people in America have benefited from the grassroots efforts of people who have made deposits in the communities in which they live and work. The efforts of individuals who believe in what they do shine throughout compartmental regions in this nation. According to Steinbach (1997), the chief contribution of community development corporations (CDCs) has been to pioneer an innovative approach to fighting poverty. CDCs have made important contributions to society. This review of related literature will present a historical overview of CDCs in the United States of America, the present state of CDCs, the functions of CDCs, CDC users, the impacts of CDCs on community development, community development trends, the importance of client satisfaction, satisfaction and dissatisfaction with CDC performance, the impacts of CDCs on American society, the importance of this study, and finally, the benefits of nonprofit research of CDCs.

Historical Overview

The participation of nonprofit organizations in the provision of housing for low-wealth households has a solid foundation. Since settlement housing in the late nineteenth century, nonprofit organizations in America have been involved in building and operating a wide variety of housing developments. The roots of the modern CDC movement are traced back to sometime in the 1960’s, beginning with programs sponsored by the Ford Foundation, and the community action agency programs of the federal government (Robinson, 1996; Smith, 2003). These programs were originally designed to demonstrate that grassroots nonprofit organizations could empower lower-income people both economically and socially by stabilizing the community and
preserving family wealth (Berger & Kasper, 1993). The focus of many programs was primarily dictated by the source of program funding support that was directed toward housing provision. The concept of nonprofit housing development is not new. This type of housing development has experienced unparallel growth as far as the importance of nonprofit housing providers, especially CDCs, to serve as the trendsetter for influencing housing policies nationally (Schill, 1994).


Since the initiation of the official movement, many have adopted the vision of community-based leadership and work in housing production and job creation, according to the National Congress for Community Economic Development (NCCED) (1998). Vidal (1992) considered community development to have taken place when members of the community experience a state of change displayed by activism, labor, or capital. The scope of CDC activities includes, but is not limited to, housing development and management. CDCs need business and economic development, commercial real estate rehabilitation, labor training, social/community services, and community financial services (Smith, 2003). CDCs also produce single-family housing, multi-family housing, rental housing, and for-purchase housing in unstable neighborhoods abandoned, mostly funded by private developers. Many CDCs operate within the boundaries of government regulations except when private-sector financial institutions are involved with lending. The high risk based on the location associated
with CDC neighborhoods usually limits the interest of traditional financial institutions. CDCs generally have a rich and multi-faceted history that can be used to draw a great deal of understanding about the current society in which we live. However, when discussing CDCs’ history, most scholars, according to Stoutland (1999), refer to three generations – the 1960’s, the 1970’s and the 1980’s.

**First Generation – 1960’s**

The need for the first community development organizations arose out of activist groups that formed in response to problems within the community such as urban riots and civil unrest. By the end of the decade, there were between 40 and 100 CDCs (Stoutland, 1999). Many early CDCs were involved in the development of housing. However, business creation and workforce development were the initial goals. CDCs that began later tended to focus on housing and economic development (Stoutland). The nonprofit activities that were focused on business management, commercial property development, and promoting job training programs slowly began to become more dynamic. Although not well documented, it seems that CDCs drifted away from business development after many ventures failed and economic conditions worsened in the inner cities. Over time, the funding for community development projects decreased (Halpern, 1994). According to a national study of CDCs by the National Congress for Community Economic Development (1998), CDCs have served Americans through forming housing development groups, providing private sector jobs, and producing units of affordable since their introduction in the 1960’s.

CDCs are normally organized by residents, small business owners, churches, and local stakeholders to assist in improving the economic and structural situations of low or moderate-income communities. CDCs typically focus on the production of
affordable housing and creating employment opportunities for community residents. Jobs are often created through small business lending or commercial development projects. Some CDCs also provide a variety of social services to their target area (NCCED, 1998).

Community activists and people who simply had a desire to help others were the founders of the first CDCs (Zdenek & Steinbach, 1998). The most well known organizations grew out of African-American social movements, including the civil rights movement, separate ghetto (under-privileged) economic development efforts, and black capitalism. Some CDCs in the first two generations were part of other ethnic organizing movements, including Latino social movements for civil and economic rights. Many groups had religious roots such as the Woodlawn Organization on the South Side of Chicago, the New Communities Corporation in New Jersey, and the Opportunities Industrialization Center formed by the Zion Baptist Church in Philadelphia, Pennsylvania (Pierce & Steinbach, 1987). This era represented the initial formation of faith-based community development as well as local control and partnerships within communities.

**Second Generation – 1970’s**

During the 1970’s, a “second wave” of CDCs arrived on the scene. These organizations were smaller and more focused than their 1960’s forerunners, and developed from urban protest movements, tenant associations, and organizations formed to support the growing influx of immigrants (Steinbach, 1997). They took a reserved approach to community development. Like their predecessors, many second generation CDCs received federal support. According to Steinbach, competition for funds became fierce during the Reagan Administration, which dismantled many of the
programs that had provided support to CDCs. Along with reduced funds came a reduction of housing, job programs, and social supports. CDCs responded by turning to state and local governments and private sector institutions for support.

Many of the earliest CDCs in the United States had ties to the civil rights and anti-poverty movements. Between 1970 and 1980, the Office of Economic Opportunity and its successor agency, the Community Services Administration, funded about 40 CDCs nationwide (Steinbach, 2000). With generous federal support behind them, the second generation CDCs had expansive agendas, elite groups of professional and technical consultants, elaborate housing and commercial ventures, and broad social service programs. Examples of second generation CDCs included the Watts Labor Community Action Committee, the Spanish Speaking Unity Council, the Mississippi Action for Community Education, and the East Los Angeles Community Union. Although some early CDCs faltered, many remain active today.

**Third Generation – 1980’s**

In the 1980’s the third generation expanded nationwide. When CDCs became more popular, a growth surge occurred, adding hundreds of groups. The development corporations were primarily organized around the provision of affordable housing, and experienced growth despite large cuts in federal funds that began in 1981 and continued throughout that decade in the Reagan and Bush Administrations (Vidal, 1992). Even though the organizations continued to receive some funding from the federal government, it was difficult to depend on these streams of funding for sustainability. In particular, federal funds for operating support dropped dramatically. However, their enduring nature and ability to be flexible caused CDCs to turn to local sources of support (Halpern, 1994). This sparked the organizational creativity needed to seek for
alternative sources of funding and support both from the private sector and public sector, especially faith-based entities. The rapid expansion of CDCs and the search for public and private funding is now common. During the 1990’s at least 1,000 new CDCs were organized and began to operate in the United States (NCCED, 1998).

**Present State of CDCs**

CDCs currently operate in a number of areas of developing the community. Since low-income communities are plagued by “deteriorating properties, absentee landlords, problem tenants, and an increase in drug-related crimes,” many potential community developers have surfaced (O’Brien, 2004, p.74). Faith-based organizations have been involved in community development activities from the beginning and presently remain active. African-American churches have stepped up to the challenge of job creation and the restoration of neighborhoods with similar enthusiasm and resources that were exhibited during the struggle for civil rights, according to Winston (1995). Churches have realized that they cannot rely on external organizations to save their neighborhoods (Winston).

CDCs launched by churches and other faith-based institutions are particularly on the rise – with African-American churches leading the way. Religious congregations have been integral to the community development movement since the early 1970’s and remain as an influence in many communities. Hundreds of CDCs began in church basements (Steinbach, 2000) and religious groups have contributed millions of dollars for organizing projects and helping change occur in communities. Many local churches rally together to supply contributions, staff services, volunteers and meeting space to assist in community networks and development. They work toward persuading people to fill collection plates or coordinating fundraisers for CDC projects. Among the most
prominent CDCs started by faith-based organizations are Bethel New Life in Chicago (Lutheran), New Community Corporation in Newark (Catholic), Jubilee Housing in Washington, DC (Church of the Savior) and Abyssinian Development Corporation in New York City’s Harlem neighborhood (African Methodist Episcopal) (Steinbach, 2000).

**The Functions of CDCs**

CDCs operate in a number of aspects and provide a variety of services to clients. CDCs primary focus is to address the failure of mainstream government and market structures to provide decent housing, safe neighborhoods, good jobs, social supports, and citizen participation opportunities for millions of Americans living in poor communities (Steinbach, 1997). All CDCs share a common commitment: to help people on the lowest steps of the economic ladder attain a better quality of life.

Numerous studies have focused on the effectiveness of the project completion ability of CDCs, but examination the benefits or results of those projects have not been emphasized (Cowan, Rohe, & Baku, 1999; Gittell & Wilder, 1999). According to Rubin and Rubin (1992), there have been only some attempts to measure the outcomes of community development projects. More specifically, there has not been adequate scholastic focus towards assessing the quantitative neighborhood impact of CDC presence relative to their ability to influence real estate and economic development (Berger & Kaser, 1993). Community development literature frequently contains requests for appropriate CDC evaluation, but due to narrowly defined goals, the bulk of CDC efforts are consumed by housing alone (Glickman & Servon, 2003). This notion furthermore questions the need for quantitative expression of satisfaction with CDCs and their services.
Some CDCs function as tools to reinvest in communities. Many of these organizations provide a return on investment for private citizens in the areas served. Increased activity in the economic direction and real estate market tends to promote higher demand as well as provide increases in the value of area properties (Smith, 2003). Despite the negative social factors that contribute to the constant deterioration of CDC-designated neighborhoods, housing appreciation in the areas served by CDCs tends to be higher than those neighborhoods in cities not represented by CDCs. The decisions of policy makers rely on tracking progress. A first step in responding to the demands for quantitative evidence is to produce research that is valid and reliable, especially for nonprofit real estate development (Rasey, 1994).

CDCs function as an avenue for retail development and have been successful at it for over 25 years. Although the number of CDC retail developments is relatively small, most of the developments initiated by CDCs have functioned successfully. CDC developments have acted as the backbone of neighborhood retail centers and major business ventures such as supermarkets and shopping centers (Blackstone, 2002). It is also important to recognize CDCs as an advocate combating the not-in-my-backyard (NIMBY) mindset. This mindset places substantial constraint on housing policy and promotes a selfish desire to give up responsibility for important community services (Ferguson & Dickens, 1999). Therefore, NIMBY attitudes surround many housing issues because many individuals perceive various sources, including minorities, housing values, traffic, and crime as threats (Ferguson & Dickens). People end up voicing these attitudes, resulting in hindered implementations of good policies that would make housing more accessible and affordable.
CDC Users

Overall, one in three Americans “lack affordable housing units” (Gottlieb et al., 2004, p.14). The U.S. Department of Housing and Urban Development (HUD) has established an affordable housing framework that has been adopted as a common standard. According to HUD, households should not spend more than 30% of their monthly income toward housing expenses, including utilities (U.S. Census Bureau, 2000). The census data furthermore indicates that many households pay in excess of 30 and 35% of their monthly income for housing. According to the National Low Income Housing Coalition (2002), 34.2% of people in Louisiana pay in excess of 30% of their income for housing. Therefore, CDCs must provide a service to individuals who desire standard housing, but cannot afford it. Many households live above their means, which stresses the notion that the impact of high housing costs on lower income households is under-emphasized in the available data (Gottlieb et al., 2004).

A wide variety of people use CDCs. Currently there are geographic areas where CDCs operate that range from a few square blocks of an urban neighborhood to rural areas that serve more than one county or parish. Their target populations are equally varied -- White, Black, Hispanic and Asian-Americans, Indians, Eskimos, women, farmers, immigrants, welfare recipients, small business owners, juveniles, and the homeless (Steinbach, 2000). In Louisiana, the majority of people served are African-Americans due to higher concentrations of minorities in southern parts of the nation (USA Today, 2005). CDCs encounter a wide range of organizational challenges, such as the inability to practice sound financial management or the lack of compliance with diverse and often complicated legal requirements (Louisiana Association of Nonprofit Organizations, 2002). In spite of these challenges, compared to the mainstream of
public policy today, CDCs have made notable accomplishments in fighting poverty for
decades (Zdenek & Steinbach, 1998).

**Impacts of CDCs on Community Development**

One question that has surrounded CDC activity is the level of effectiveness or
impact of CDCs over their nearly 30-year history (Rossi, 1999; Twelvetrees, 1997;
Vidal, 1992). Determining the impact of CDCs on community development depends on
researcher’s ability to determine whether or not CDCs are successful in the execution of
development projects. It is necessary for CDCs to have the staff and capacity to
determine the financial feasibility of particular projects (Keating, 1990). A study by
Gittell & Vidal (1998) revealed that CDC organizational competence can be indicated
by the perceived strength of the staff, director, and executive board. These components
were considered important for the success of CDC project completion. Success in
planned projects, however, does not translate into measurable community impact.
Although some local governments have been responsive to addressing housing
problems, the long term impact seems to come from local government sponsorship,
public and private partnerships, community networks, and pre-organization (Keating,
1990). Keating surveyed city governments and the directors of statewide housing
coalitions in 32 states. Although it was difficult to measure, he found evidence of
progressive statewide housing coalitions providing the most significant impact on state
housing policies. Keating (1990) reported that although CDCs have had a positive
impact on their communities, the impact was minimal. Based on the lack of literature,
CDCs in Louisiana remain in need of additional documentation that examines whether
or not they have made a consistent or notable contribution to their neighborhoods.
Studies by Rubin (1994) and Pierce & Steinbach (1987) suggested that the impact of CDCs is not sufficient to change the negative results and the deterioration caused by market forces. Such a limited view of CDC impact is additionally publicized by Marquez (1993) and Stoecker (1997), who suggested that positive results in communities are not attributable to CDC efforts as there is little support for the presumption that the impact of redevelopment would not have occurred despite their involvement.

CDCs and other nonprofit community organizations originate within neighborhoods from the efforts of residents who are determined to revitalize the communities in which they live (Walker & Weinheimer, 1999). For example, a long-term community self-renewal program that focuses on developing a community vision, sponsored by the Extension Service of the University of Minnesota, led to community action over a 20-year time-span. Despite these efforts, many long-term community issues remain because concerned citizens do not bring the true issues at hand to the forefront. As a result, people within the communities assemble themselves and eventually branch out and touch the lives of others through a process called community building. According to Sandmann (1991):

> Project Future communities have recaptured a sense of pride, empowerment, and opportunity in towns and cities where five years ago businesses and people were leaving. Citizens in dozens of Louisiana communities are using the flexible framework of Project Future to successfully design and build their communities of the 21st century. (para. 2)

The community development process usually begins with some type of information gathering through surveys, focus groups, or electronic media. With proper funding, the evaluation of specific CDC impacts can be done. University extension
agents or other public workers often start the groundbreaking for the process of information gathering to take place (Hogue, 1993). Most state extension services provide several leadership-training programs to help people in local communities to become leaders.

In order to make an impact in a community, it is important for CDCs to comply with all state and federal regulations to prevent organizations from breaking the law while doing a good deed. According to the NCCED (1998), a CDC is legally the same as any other nonprofit entity organized under section 501 (c) (3) of the Internal Revenue Code. Local residents that are interested in forming a CDC should get together and develop a set of by-laws, file for incorporation with their state government, and then apply with the federal Internal Revenue Service for designation as a tax-exempt non-profit organization. The IRS designation is necessary to enable an organization to obtain grants and gifts from government, corporate, foundations, or individuals.

**Community Development Trends**

Traditionally, community development has been concerned with homeownership and entrepreneurship (Ferguson & Dickens, 1999). Since the 1980’s, CDCs have emerged as charitable providers of special-needs housing (Rasey, 1994). Grassroots campaigns for neighborhood revitalization take place all over the nation. Hands-on leaders make sacrifices on a daily basis for the improvement of the lives of others. One must be special to accept the calling of servanthood. In addition, one should recognize that before a community begins to be improved, it must be recognized as a community. This should not be based on geographical boundaries determined by the government. It should, rather, be established by the perceived sense by residents who recognize that they are all in the struggle together. Although difficult, many
community organizations face the economical and moral dilemma of neighborhood revitalization. Most CDCs serve the purpose of helping with financial and technical problems in communities through neighborhood revitalization groups (Clark, 2001).

Leadership and development must work together simultaneously in order for successful community economic development to happen. The process of community development does not immediately occur because of economic development, and has not had a tendency to do so. Community leadership and development usually takes place when citizens take action to empower not only the local community, but the individual as well. Economic development usually focuses on creating jobs and helping a community improve by promoting the economy to improve. Both community and economic development are considered to be types of “development” and involve varying levels of leadership. However, they are quite different in the leadership varieties and amounts of individual involvement. The distribution of community benefits revolves around types of development and demonstrates two different ways of relating leadership (Campbell, 2001). Action agency programs were designed in theory to show that grassroots nonprofit organizations could socially and economically empower lower-income people by stabilizing the community and protecting family wealth (Berger & Kasper, 1993).

A nationwide survey of CDCs released by the National Congress for Community Economic Development identified the achievements of 3,600 of CDCs in the United States. Since 1968, CDC organizations together have constructed 550,000 units of affordable housing, developed 71 million square feet of commercial or industrial space in low-income neighborhoods, loaned over $1.9 billion dollars to 59,000 businesses, and created 247,000 jobs (NCCED, 1998). Despite the successes of
CDCs, they have generally experienced problems as a whole. Poverty and homelessness remain a problem, especially in urban American cities. Black and impoverished communities faced serious challenges when attempts were made to gain equal shares of grant monies and government funds for basic public services (Sampson, 2004).

Community development efforts face many hurdles and red tape. A primary problem is lack of adequate housing. Despite the popular Community Development Block Grants, many community-based development organizations (CDBOs) are paralyzed by the fear of fiscal cuts. “Community-based development organizations are nonprofit, housing and commercial developers who do the difficult job of providing service and leadership in communities that need help and that other agencies cannot or will not serve” (Vidal, 1992, p.111). The National Congress for Community and Economic Development (1998) reported that only eight out of 10 CDCs are involved in housing activities. Another problem is having an accurate, level measure of effectiveness and efficiency for community development activities, as identified by Hughes (1999). “The relationship between evaluation and community-based organizations has been tense, creative, and highly demanding of all participants” (Richards, 1995). According to Richards, the industry must make progress in improving the use of research and evaluation at the community level. This progress is necessary in all facets of developing communities, especially the provision of housing.

Although CDCs produce housing for the homeless and very low-income renters, not all of their housing is for the poorest of the poor. Many CDCs put working class families on the road to homeownership. Homeownership has become a key strategy for stabilizing communities. CDCs on average manage a little over half (59%) of the
housing units they generate (NCCED, 1998). With CDC property management coverage, there remains nearly 40% of housing that is privatized or nonexistent. Many property management problems could likely be contributed to these types of gaps in services. Many of the problems in American society “may well rest in the power” of CBDOs “to develop practical approaches and remove barriers to promote greater opportunities for people” (Hughes, 1999, p.125). The individuals who truly need assistance face neglect due to lack of program expansion and few public advertisements of the available community development programs.

The proponents of CDCs argue that development organizations have, in the past, made useful contributions to society. David Rusk (1999) however, devalued the merit of relying on local nonprofit organizations for urban redevelopment. The problems of urban America, according to Rusk, can be blamed on government land-use policies that at the cost of providing help to needy areas, suburban development is financed. He proposed a political strategy built around a coalition of interested parties, including local governments that connect underserved urban areas with prime-time suburbs according to region. Furthermore, Louisiana CDCs, as with numerous CDCs, are linked to the broader economy through a hierarchy of organizations that include many of those suggested by Rusk (1999).

There are many that champion the efforts and successes of CDCs. As with any argument, there is a downside. Another recent trend in the CDC industry is the faith-based movement. Major questions and concerns have been raised about CDCs and the faith-based initiative. For instance, a use of a term, “faith-based” that is not defined in law or practice is usually taken to be synonymous with “religious” tends to pose problems (NCCED, 1998). Moreover, many argue that George W. Bush’s faith-based
initiative may result in the improper use of religious public funds unless each program is closely monitored (NCCED).

In addition to the faith-based initiative, a CDC trend that is not so common has been real estate market studies. Quercia (2000) performed a study on the rate of house price appreciation and market instability in underserved areas in America. This study addressed the measurement of property value and its relation to property environment. This commonly used strategy resulted in experts in the field ultimately measuring success based on capital gains of CDC housing transactions. Those areas identified as underserved were similar to the communities served by CDCs. The results from the study indicated that property values were as high or higher than values in other areas with comparatively low or median incomes. For example, a study of the subsidized housing program in New York City by Schwartz (1999) indicated that a well-funded program could truly have a social impact on the community. The results of the study suggested that subsidized housing investments correlate most strongly with reductions in vacant units and vacant lots. Schwartz also reported significant correlations with reductions in welfare rolls and violent crime but uneven economic impacts of these factors. There remains, however, the questions of how the impact that nonprofit housing development has on the local real estate market and how those trends differ between areas served by nonprofit CDCs and areas that are not.

**The Importance of Client Satisfaction**

Addressing satisfaction is a key part of the development of a nonprofit to find out what services are important to them (Schmidt & Strickland, 1998). A report published as a part of the Independent Sector’s Measures Project (Wiener, Kirsch & McCormick, 1996), was the result of an initiative launched to gather information on
contributions of the nonprofit sector. More than 900 organizations and religious congregations participated in this study. Survey data were collected on the costs and quality of services provided, demographics of clients served, and external evaluations of programs. According to the survey results, the rates of data collection among these types of organizations varied significantly: 58% of nonprofits and 21% of religious congregations reported on the quality of services they provided. Sixty-eight percent of nonprofits tracked client satisfaction with service and 34% of religious congregations tracked client satisfaction data. Sixty-one percent of nonprofits use external evaluations of their activities, while only 38% of religious congregations utilize outside evaluation (Kujawski, 2002). It is important to gather and analyze information about the effectiveness of programs because there are often few resources available to fund nonprofit and faith based evaluations. Only 59% of nonprofits and 39% of religious congregations developed strategic plans (Kujawski, 2002). More nonprofits would incorporate outcome measurement tools if adequate technical assistance were available, according to the study results. The results also showed that nonprofits are beginning to use outcome measurement for various reasons. Findings such as these can probably be explained by the fact that religious congregations are rarely asked by outside sources for outcome evaluations. According to Kujawski, less than seven percent of nonprofits actually have plans to implement the measure of their accomplishments. It was reported that challenges to measurement include lack of training and the belief that some successes are “intangible and therefore not easily measured” in the nonprofit world (Kujawski, 2002, para. 12). Other barriers include the lack of knowledge on how to measure results, limited research funding, and difficulty in contacting former clients. These barriers usually result in a lack of progress for need fulfillment and an unclear
focus on what service elements community clients truly need.

An example of need fulfillment is New Community Corporation (NCC), one of the largest nonprofit housing corporations in the nation. It began in 1968 as a grassroots venture between a local church and community residents. NCC was created to revitalize a section of Newark, New Jersey and was birthed out of needs arising from Newark riots in 1967. NCC focuses on creating a stable economic base and is a comprehensive CDC. This CDC focuses on a variety of services, including affordable housing, job creation, quality health care, education, childcare, economic development, and community arts. NCC could be considered faith-based, as it places a strong emphasis on religious faith and moral values as a means for positive changing with the community (www.newcommunity.org). This CDC has state-of-the-art crime prevention methods. A 110-person, 24-hour security department patrols the community by vehicle and on foot and monitors community activity from a base station via two-way radio and video equipment. The community, current and prospective housing tenants, and CDC staff, are directly involved in helping develop standards for housing and recreational activities. The majority of their housing developments are self-contained, with on-site support services and video surveillance. In an effort to meet resident needs, landscaping and ground maintenance are available at the majority of housing sites. The CDC additionally maintains good organizational partnerships with various departments in city government.

Client satisfaction in the nonprofit sector has become more important in recent years due to the reality that many nonprofits, including CDCs, aim to fund their programs through federal and state grants. Program evaluation and client satisfaction has been stressed more because of the Government Performance and Results Act
(Housing and Community Development Consulting, 2004). This act aims to improve the performance of government services and tracks the progress of various agencies and their programs. For example, the U.S. Department of Housing and Urban Development’s (HUD) Office of Policy Development and Research sought to evaluate the satisfaction of its program personnel and clients. HUD conducted three surveys, one of which was a client questionnaire that measured the client perspective of housing assistance recipients. HUD obtained information about the population served by the programs and their needs. The department also learned how the programs are used in conjunction with other programs. HUD surveyed client satisfaction to meet the challenges associated with the requirements of the Government Performance and Results Act. The findings indicated that program flexibility helps meet clients’ housing needs and preferences, and that clients reported high satisfaction levels with their housing.

Examining satisfaction levels is important because it provides a basis of research in guiding appropriate funding through the proper channels (Schmidt & Strickland, 1998). Now that philanthropic funding is being provided to the organizations that can be catalysts for change, research is needed to determine whether or not the financial contributions are effective, and if not, what are the areas of improvement? The satisfaction levels of clients may be a result of the effectiveness of program service delivery (Client Satisfaction Surveys, 1998). Through proper evaluation and accountability, the chosen policies and procedures can reinforce or redirect resources into the most important populations that deserve high-quality service (Housing and Community Development Consulting, 2004). Involving clients in developing their own measures of evaluation may help achieve proper satisfaction goals. According to
Richards (1995), “enabling the community effected by the program being evaluated to play a significant role in the evaluation from start to finish” makes research work best. Researchers and grassroots workers alike must recognize the value of reinvesting in and retaining community resources.

**Satisfaction and Dissatisfaction with CDC Performance**

Various views of CDC performance exist in both private and public sectors. Some political constituencies have claimed ownership of CDCs. CDC performance has been described as both complementary to government and an alternative to government. Traditionally, there have been no public voices of approval or disapproval with the professional performance of CDCs.

In the 1960’s, CDCs were viewed as complementary to government. Their role was to encourage neighborhood development, fight poverty, and deliver social services – with generous federal backing which helped to sustain and develop them (Steinbach, 2000). When the Reagan administration took control, things changed. Political conservatives adopted the philosophy that the United States should rely on philanthropies, nonprofit organizations, and religious groups to address problems in the citizenry instead of government. As a result, conservatives saw CDCs as alternatives to government (Steinbach, 2000). CDCs continue to enjoy broad political support even though they must rely on the development of alliances with state and local community partnerships. According to Steinbach (2000), political association has the potential to increase CDC performance and societal respect for community development.

CDCs’ positive performance reflects societal progress, but their limitations clearly demonstrate weaknesses in society. Because they are voluntary and self-governing, CDCs are not customary in nearly enough areas where they can be more
versatile. The capacity of CDC activity is nowhere near the size needed to produce the scale of activities required to notably reduce poverty, let alone have widespread satisfaction performance. Some critics are dissatisfied with the way CDCs have allowed society to pacify poor communities, instead of making the necessary socio-economic adjustments that would more significantly address poverty and its related issues (Steinbach, 2000). According to Steinbach, some CDC critics reported that neighborhoods with active CDCs still experienced increasing poverty rates from 1970 – 1990, at about nearly the same rate as communities without CDCs.

Practitioners likely question the effectiveness of CDCs as organizations that contribute to societal change. According to Steinbach (2000), professionals in the industry mostly agree that bettering internal management would help the performance of CDCs and their impact. Even though community development has become a multi-billion dollar industry, it more closely resembles a political movement due to the management process and leadership techniques. Most CDC directors are entrepreneurial leaders, not managers. For example, many of the executive directors who lead Louisiana communities formerly held a job in the public sector, serving as social workers or educators (Walker, 2003). While CDC staffs are among the most dedicated workers, the field has done little to make sure that performance standards are professionally consistent. Efforts to train CDC boards, promote staff development, or develop resource packages, are not popular actions in CDC management. Overall, investments from CDC supporters for capacity building and management could significantly influence CDC performance satisfaction or the lack thereof (Steinbach, 1997).
Impacts of CDCs on American Society

Of all the work done by CDCs, it is important to recognize the significant impact these organizations have made in the United States. Cowan, Rohe, & Baku (1999) identified several factors that increase efficiency of CDCs: tenure of the executive director, well-trained staff, and a concise mission statement. They argued that organizations with a clear focus and a sense of purpose consistently outperformed organizations lacking a clear mission. Twelvetrees (1997) and Berger & Kasper (1993) identified connections to political officials and corporations as attributes that directly influence CDC outcomes and impacts. The four factors to CDC impact and success identified by Gittell & Wilder (1999) were a clear mission, sophisticated staff, political influence, and financial capital.

Most CDCs work in urban areas, serving target areas of up to 50,000 people. Nevertheless some of the oldest and largest CDCs operate in rural areas, many covering a broad range of people as well. There remains the possibility that potential clients are not aware of the services that these organizations provide to communities. For example, the Community Enterprise Development Corporation of Alaska promotes rural development throughout the entire span of the nation’s largest state. Until research was collected about this organization, few citizens were aware that services in America were available to other nonprofit organizations upon request. An additional example of broad community coverage is the Mississippi Action for Community Education whose programs target 40 counties in the Mississippi Delta. Another example of expansive CDC progress is Kentucky’s Mountain Association for Community Economic Development, which has a target area that spans all of central
Appalachia (Steinbach, 2000). Across the nation, CDCs have a massive span and ability to reach diverse populations.

CDCs operate in every state and region: 27% in the Northeast; 25% in the North Central; 28% in the South; and 20% in the West (NCCED, 1998). Until the mid-1980’s, the Northeast and Midwest, with longer traditions of community organizing, had significantly more CDCs than the rest of the country (Steinbach, 2000). There is a remarkable difference in the vast progress of CDCs in Northern areas compared to the elementary practices of CDCs in the South. In recent years, however, the numbers of CDCs have grown most rapidly in the South and West.

Boston, Cleveland, Chicago, New York, Miami and Washington, DC are cities that have mature community development systems and the largest number of capable CDCs. Other cities considered in the top tier of CDC activity are Minneapolis-St. Paul, Detroit, Philadelphia, Denver, Pittsburgh and Baltimore. CDC networks in Columbus, Oakland, Indianapolis and Seattle are gaining strength and capacity, but they do not yet rank with the strongest community development sectors. CDC networks are on the ground and growing in Atlanta, Los Angeles, Portland, Dallas, Phoenix, Newark, Kansas City and San Antonio (Walker & Weinheimer, 1999).

Unlike the earliest generation CDCs, most groups today are relatively modest in size and budget. NCCED reports the median CDC budget as ranging from $200,000 to $400,000 annually, and the median size of a CDC staff is six. The staff generally includes a director; one or two people working on development, with the remaining staff involved in community building and support activities, such as helping people qualify for home mortgages or accessing quality childcare. The median age for CDCs is about 15 years (NCCED, 1998).
Some CDCs, however, are massive organizations – with large staffs, wide ranging activities and heavy real estate involvement. For example, the aforementioned 31-year-old New Community Corporation (NCC) is the largest employer of Newark residents, providing jobs for more than 1,400 people. NCC has developed 3,000 homes and apartments. It provides safe and affordable daycare services to over 700 children and additional support services to hundreds of families. NCC’s shopping center is perhaps its most dramatic success, with a supermarket and a variety of other retail outlets and restaurants. NCC’s real estate assets exceed $250 million and their housing, commercial development, training and social service programs assist an estimated 25,000 people daily (Zdenek & Steinbach, 1998). Despite the success of NCC, based on the conducted research, there is no specific explanation pertaining to satisfaction measurement of this CDC. Overall, the progress of CDCs and the contributions they have made toward improving American society may provide an explanation of their value as an answer to encouraging economic activity in blighted communities. The availability of vast services that improve the economy is likely to promote community building and improve the environment that our nation’s children grow up in, positively affecting society.

**Importance of This Study**

Economic social activity affects almost every level of society. According to Steinbach (1997), CDCs assume responsibility for housing and commercial development projects by starting their own businesses and providing capital to other businesses in their target areas. For example, the East Los Angeles Community Union CDC raised funds to develop a 56-acre complex on the site of an abandoned tire plant and battery factory. Studying CDC effectiveness is useful, because the efforts of this
CDC resulted in an industrial park that housed 51 businesses and employed over 2,000 people. This CDC opened additional industrial parks and re-invested the monies back into their community. CDCs are important entities for forming necessary cores within community building by using local influence and outsource funding.

The literature suggested that the study of community development is important because change is based on ordinary people who are moved to political and social action where they live and work, given capital — the key factor they lack (Keating, Rasey, & Krumholz, 1999). A prime example is Community Equity Investments, Inc., a CDC in Florida that undertakes business lending. Since 1982, this CDC has loaned over $7 million to 250 small businesses and help to created 1,000 jobs in their community (Steinbach, 1997). CDCs normally act as a conduit for cash from outside sources. Studying CDC activity can explain how CDCs act as an intermediary for money from external sources and presents an opportunity to renew the efforts of private investors and simultaneously improve the economic health of the community (Stoutland, 1999).

A study of 128 CDCs, conducted by the New School of Social Research, found that more than 90% of CDCs begin with individuals or small groups (Vidal, 1992). The importance of examining these organizations is interwoven into many aspects of American society. For instance, positive CDC performance affects the tax dollars of Americans, which the government can ultimately channel into programs that help people. Community development has the potential to reduce crime and poverty and create communities that are satisfied, both environmentally and economically.

Community development is concerned with the development of geographic communities physically, economically and socially. Corporations for community
development have two basic goals: to improve the quality of life of all members of the community, and to involve members of the community in the process (Campbell, 2001). Community leadership, complementarily, involves the body of citizens who believe in themselves and others, as well as community (Hogue, 1993). Being inclusive brings a wide cross-section of people together to contribute in meaningful ways and have skills beneficial to the community, according to Hogue. Constructing a cross-section of people usually involves considering the culture, age ranges within the community, and the ethnic diversity represented. Community leadership is additionally concerned with how people bring about change and investment in the community. This study is important in identifying client perceptions on satisfaction with leadership of communities and can be beneficial to all involved parties – those who CDCs serve, both directly and indirectly.

The Benefits of Nonprofit Research of CDCs

Painting a picture of the need for help in a community is very important to philanthropists and funding agencies. Census data in the United States serves as an instrument used to channel funding to the areas in the nation that demonstrate the most need based on the population (Walker, 2003). Demographics play a significant role in the target of areas of interest and in the need for selecting and developing geographic locations. According to DeSouza Briggs and Mueller (1997), community development practitioners and policy makers look for new ways to deliver social services through nonprofit research, especially concerning the areas of finance and accountability.

According to the National Association of Realtors and Office of Federal Housing Enterprise (2003), Louisiana is ranked number 22 in the nation for change in average housing price in 2003. The percent change is an estimated 4.45% (National
Association of Realtors, 2003). The numbers of people who remain in poverty, especially in Louisiana, are staggering based on the percentages provided by the census data. Nonprofit organizations and consultants heavily depend on census and real estate data for the pursuit of donations for nonprofit development (Walker, 2003). Nonprofit research of CDCs is quite useful and could have a number of implications and benefits. This beneficial research would likely answer questions regarding housing, the real estate market, economic growth, and a number of social issues – including satisfaction with services.

Overall, Louisiana could benefit from nonprofit research and the data that measures client satisfaction of people who receive the services of CDCs. Because of the strong tie between CDCs, state and local governments, and the private sector, it is important to address their role in American society as well as the impact they have made. CDCs have made notable contributions to the community development field. People in America have truly benefited from the efforts of people who have made the communities in which they live and work better places by working hard to fight poverty and make positive contributions to society.
Chapter 3 – Methodology

Population and Sample

The target population for this study was defined as adult clients of at least 18 years of age who participated in housing programs operated by CDCs in the state of Louisiana. The accessible population was defined as adult clients (at least 18 years of age) who participated in housing programs in the metropolitan areas of Baton Rouge and New Orleans. There were 40 CDC organizations in the entire population for Louisiana. Twenty-eight of these organizations were located in Baton Rouge and New Orleans. The listings were derived electronically from the Local Initiatives Support Corporation (Community Development Corporations, 2003) for Baton Rouge and the Center for Urban and Regional Equity for New Orleans. Out of the 28 organizations located in the two cities, 17 provided housing services and therefore qualified to be included in this study. The list of all individuals that participated in housing programs offered by one of these CDC organizations was compiled into a Microsoft Excel spreadsheet format and used as the population database. The entire accessible population (N=458, 100%) was included in the study, therefore the study was classified as a census.

Instrumentation

A survey instrument was developed by the researcher for the purposes of this study (see Appendix A). Selected questions from a study by Maximus Corporation (Louisiana Division of Administration, 2002) that addressed Louisiana low-income families were used in the development of the instrument for this study. Content validity of the instrument was established through a review by a panel of experts consisting of four individuals who have extensive expertise (including executive and administrative
experience) in the community development field and three individuals with recognized expertise in the area of instrument development. Appropriate revisions were made in the instrument based on the recommendations made by members of the validation panel and the instrument was prepared for distribution to the members of the pilot test sample. Correspondence regarding the instrument is located in Appendix B. For clarity purposes, the researcher labeled two sections as Demographics and Client Satisfaction. The demographics section of the instrument was designed to gather demographic information and selected information related to program participation. The client satisfaction section was designed to measure the satisfaction of clients with factors pertaining to the CDC program(s) in which they participated. A variety of response formats was used in the measuring instrument as appropriate to accomplish the respective study objectives. The demographic section of the instrument requested respondents to either mark the most appropriate response or write in the relevant information. Scales used in the survey included five point Likert-type scales with response descriptors ranging from “Strongly Disagree” to “Strongly Agree” in one section and “Very Dissatisfied” to “Very Satisfied” in another section. Household income categories were derived using an income split from income graphs used in a different survey and were divided into increments of $10,000 (GVU’s 5th WWW user survey, 1996). Prior to administering the instrument, approval for exemption from institutional oversight was obtained from the Louisiana State University Institutional Review Board (IRB) for human research subject protection. A copy of the IRB exemption form is located in Appendix C.
Pilot Test Procedures

In addition to the content validation of the instrument, 20 individuals who were CDC clients were asked to complete the survey, and notes were taken regarding the amount of time, readability, and user-friendliness of the survey. During the pilot test, a comments field was provided as an addendum to the survey for suggested modifications. Two modifications to the survey instrument were made. The survey was edited based on clarity issues raised by the panel and a section was added for comments. After the changes were made in the instrument resulting from the pilot test, it was submitted to another panel of experts consisting of CDC administrators to ensure that the changes had not detracted from its content validity. After the review of this panel, the final instrument was prepared for distribution to the members of the research sample.

Data Collection Procedure

The researcher first met with a city contact located in both metropolitan target areas. Contacts were chosen based on their knowledge about CDC organizations and their extensive experience with the key community development leaders in their city. The city contacts were well-known names in the field who had worked with CDCs for 15 years or more. From the city contact, the researcher was provided information regarding the directors of CDCs that provided housing in targeted regions. The researcher then telephoned the director of each organization and requested a listing of CDCs in their jurisdiction. The directors provided a listing of 40 CDCs located in the state of Louisiana. From the list, the researcher identified a total of 28 CDCs in the Baton Rouge and New Orleans metropolitan areas. Once all data was provided, a compilation list of 28 CDCs was made. The researcher telephoned the organizations as
a follow-up measure to confirm their current capacity to provide housing. Of the 28 CDCs’ in the compilation list, only 17 indicated that they provided housing services. Organizational names and contact information from the CDCs’ that provided housing were entered into an Excel spreadsheet to serve as a master list. The researcher made calls to the 17 CDCs requesting the mailing addresses of individuals who had received housing services. The requested information, from the 17 qualifying CDCs, was faxed or mailed to the researcher from each organization. Included in this information were the rosters of the first-time homebuyer education courses. Next, client participation lists were created and the data were entered into a Microsoft Access database. For the purpose of tracking nonrespondents, subjects and surveys were assigned corresponding numbers. The entire population (458 clients) was mailed a cover letter that explained the purpose of the study (see Appendix D), a self-addressed stamped return envelope, and a copy of the survey instrument.

A total of 87 completed surveys (19%) were received within three weeks after the first mailing. The first nonresponse follow-up mailing was a reminder postcard mailed to all individuals who had not responded within the three week requested deadline. The survey data were processed on computer systems using Statistical Package for the Social Sciences software, a comprehensive statistical analysis program designed to generate frequencies, cross tabulations, and statistical tests of significance. According to Miller and Smith (1983), researchers can compare early and late respondents to “determine differences between the groups” (p.48). The purpose of comparing early and late respondents is to “estimate the nature of the replies of nonrespondents” through late respondents (p.48). According to Miller and Smith, late respondents and nonrespondents are similar. The researcher categorized the
respondents into early and late groups. Early respondents were determined by the time frame (according to the postmark date) in which the survey was returned in the mail. Since there was a three-week time period, the responses received within the first 10 days were categorized as early. The responses received on days 11 through 21 were considered as late. Forty-four responses (50.57%) were received in the mail and considered to be early respondents. Forty-three responses (49.43%) received were considered to be late respondents. To determine if there were any significant differences in the responses of early and late respondents, a comparison using the responses on the dependent variable (overall satisfaction score) was done ($t_{84} = .081$, $p = .94$). No differences were found between early respondents ($M = 3.79$, $SD = .817$) and late respondents ($M = 3.78$, $SD = .782$).

During the course of the study, the opportunity came to gather data from several education classes as they were being conducted from a group of the same people who were in the study. With the approval of the graduate committee, data were obtained from this group. Respondents participating in the classes were provided with a survey, and instructed not to respond to the survey if they had already completed a response that was mailed to them. The respondents who submitted a survey questionnaire on-site were included in the accessible population and had not returned the mailed survey. This was determined by using the client participation lists and the numbers assigned to subjects and surveys. They completed the questionnaire at the housing office and were allowed to respond to the survey questionnaire without having to send it by mail. Respondents were also asked to ignore any postcard follow-ups in the mail. The researcher was given copies of the sign-in rosters, which were used to double check to make sure that there were no respondents who responded to more than one survey. As a
result of the data collection during the classes, 98 surveys were yielded. Four weeks after the first mailing, a telephone follow-up was done and yielded responses for 22 surveys.

According to Next Step Marketing (Research and Marketing Tips, 2002), less-educated people rarely respond to mail surveys. Miller and Smith (1983) reported that “sending postcards…as follow-ups to the questionnaire have been successful at improving response rates” (p. 46). Survey System Corporation reported that populations of low education or literacy levels can have response rates from mail surveys that “can be too small to be useful” (Survey Software, 2004, para. 18). Walonick (1997, p.17) argued that demographic characteristics of non-respondents have been thoroughly researched and “that most studies have found that non-response is associated with low education.” In addition to non-response being associated with low education, according to Walonick (1997), single males have a higher rate of non-response than females. The researcher employed a number of techniques proven to be factors that may increase response rates. Some of these techniques were identified by Smith and Miller (1983) as strategic approaches for improving response rates such as: “using stamped outgoing and return envelopes,” “assuring confidentiality,” “specifying in the cover letter a deadline date to receive a response,” “keeping questionnaires short,” and using colored paper (p.47).

Because this population was anticipated to not respond well to surveys, and due to the mixed results of research findings, the researcher used several methods of follow-up. A postcard reminder was sent to all non-respondents three weeks after the first mailing (see Appendix E). A final follow-up was done by conducting a telephone survey of all the nonrespondents with accessible telephone numbers (n = 70). Clients
were asked to answer the survey over the telephone or agree to be sent another one. The telephone survey script is found in Appendix F. As a result of the telephone follow-up, 22 surveys were yielded.

Based on the data collection procedures, each respondent was assigned to one of four groups – labeled “early” for early respondents (10 days after first mailing), “late” for late respondents (after postcard reminder), “telephone” for respondents who were surveyed verbally via telephone (four weeks after first mailing), and “on-site” for those surveyed during CDC education courses.
Chapter 4 – Findings

The purpose of this study was to determine factors which influence client satisfaction with the housing services of community development corporations (CDCs) in metropolitan regions of Louisiana. This chapter will present the data and discuss the findings, which are organized according to the objectives of this study.

Of the 458 surveys sent, a total of 207 usable responses were received by the researcher. The usable response rate was 45.2%. Other studies examining community development and housing also reported low response rates. For instance, a community-based development organizations study by Hughes (1999) yielded a response rate of 48%. Another 2004 community housing study had a 54% response rate (O’Bryant, 2004, p. 74).

Objective One

Objective one was to describe clients who receive housing services of CDCs in Louisiana on the demographic characteristics of (a) Age, (b) Race, (c) Gender, (d) Marital status, (e) Household income, (f) Education level, (g) Number of children, (h) Household members over the age of 18, (i) Length of participation in CDC, (j) Client region, and (k) Household size.

Age

Survey respondents were requested to, “Please indicate your age as of your last birthday.” The following six age groups were provided as response options: “18-25,” “26-35,” “36-45,” “46-55,” “56-64,” and “65+ years.” The age category that was
selected by the largest number of respondents \((n = 73, 35.3\%)\) was “26-35.” The second most frequently reported age group \((n = 58, 28.0\%)\) was the “36-45” category. The age group that was reported by the fewest respondents \((n = 0, 0\%)\) was the “65+ years,” and the “56-64” age group was indicated by only 11 (5.3%) of the respondents (see Table 1).

Table 1

<table>
<thead>
<tr>
<th>Age</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-25</td>
<td>29</td>
<td>14.0</td>
</tr>
<tr>
<td>26-35</td>
<td>73</td>
<td>35.3</td>
</tr>
<tr>
<td>36-45</td>
<td>58</td>
<td>28.0</td>
</tr>
<tr>
<td>46-55</td>
<td>36</td>
<td>17.4</td>
</tr>
<tr>
<td>56-64</td>
<td>11</td>
<td>5.3</td>
</tr>
<tr>
<td>65 or more</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>207</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Race

Regarding the variable Race, respondents were asked, “Which of the following best describes you?” The options provided in the survey were “White,” “Black,” “Hispanic,” “Asian,” and “Other.” The majority \((n = 172, 83.1\%)\) of the respondents in this study indicated that they were “Black.” Additionally, 13.5\% \((n = 35)\) reported their race as “White” (See Table 2). Given the small number of respondents who reported race in the other categories (“Hispanic” and “Asian”), the researcher determined that the most appropriate procedure for using this data in subsequent data analysis was to collapse the categories of Race into a dichotomous variable defined as “Black” and
“Not Black.” When the data was reorganized in this manner, the resulting description of the respondents was that the majority of the respondents ($n=172$, 83.1%) were “Black” and 35 (16.9%) were identified as “Not Black.”

Table 2  
**Race of Clients who Receive Services of CDCs in Louisiana**

<table>
<thead>
<tr>
<th>Race</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black</td>
<td>172</td>
<td>83.1</td>
</tr>
<tr>
<td>White</td>
<td>28</td>
<td>13.5</td>
</tr>
<tr>
<td>Hispanic</td>
<td>5</td>
<td>2.4</td>
</tr>
<tr>
<td>Asian</td>
<td>2</td>
<td>1.0</td>
</tr>
<tr>
<td>Total</td>
<td>207</td>
<td>100.0</td>
</tr>
</tbody>
</table>

**Gender**

Survey respondents were requested to mark if they were male or female in item 3 of the survey. Females (79.6%, $n=164$) were more numerous than males (20.4% or $n=42$) among the respondents. Only one client did not respond when asked gender (see Table 3).

Table 3  
**Gender of Clients who Receive Services of CDCs in Louisiana**

<table>
<thead>
<tr>
<th>Gender</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>164</td>
<td>79.6</td>
</tr>
<tr>
<td>Male</td>
<td>42</td>
<td>20.4</td>
</tr>
<tr>
<td>Total</td>
<td>206</td>
<td>100.0</td>
</tr>
</tbody>
</table>
Note. One of the study participants did not provide data for the variable gender.

Marital Status

The survey offered six choices in the marital status category: single, married, widowed, divorced, living with partner, and other (please specify). No respondents marked “other.” The most frequently occurring response was single (n=87, 42.2%) while 34.0% (n=70) indicated that they were married as shown in Table 4.

Table 4

<table>
<thead>
<tr>
<th>Status</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>87</td>
<td>42.2</td>
</tr>
<tr>
<td>Married</td>
<td>70</td>
<td>34.0</td>
</tr>
<tr>
<td>Divorced</td>
<td>34</td>
<td>16.5</td>
</tr>
<tr>
<td>Widowed</td>
<td>14</td>
<td>6.8</td>
</tr>
<tr>
<td>Living with Partner</td>
<td>1</td>
<td>0.5</td>
</tr>
<tr>
<td>Total</td>
<td>206</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Note. One of the study participants did not provide data for the variable marital status.

Household Income

Household income categories were derived using an income split from income graphs in a 1996 survey (GVU’s 5th WWW user survey, 1996). The categories were divided into increments of $10,000. The survey item requesting information about income was worded: “What is your annual household income?” Clients were given the options of “under $10,000,” “$10,001- $20,000,” “$20,001-$30,000,” “$30,001-$40,000,” and “over $40,000” (see Table 5). The most frequently reported (n=56, 27.5%) household income level was the $10,001 to $20,000 per year category. Additionally, 25.5% (n=52) of respondents reported their annual household income as
between $20,001 and $30,000 per year. It should be noted that 34 (16.6%) of the clients indicated that their annual household income was under $10,000.

Table 5

**Annual Household Income of Clients who Receive Services of CDCs in Louisiana**

<table>
<thead>
<tr>
<th>Income</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under $10,000</td>
<td>34</td>
<td>16.6</td>
</tr>
<tr>
<td>$10,000 - $20,000</td>
<td>56</td>
<td>27.5</td>
</tr>
<tr>
<td>$20,001 - $30,000</td>
<td>52</td>
<td>25.5</td>
</tr>
<tr>
<td>$30,001 - $40,000</td>
<td>27</td>
<td>13.2</td>
</tr>
<tr>
<td>Over $40,000</td>
<td>35</td>
<td>17.2</td>
</tr>
<tr>
<td>Total</td>
<td>204</td>
<td>100.0</td>
</tr>
</tbody>
</table>

*Note.* Three of the study participants did not provide data for the variable household income.

**Education Level**

Clients were asked, “What is your highest level of education completed?” The most frequently occurring response was “Some college” (n = 89, 43%). Most of respondents had attained an education level of at least high school, with only seven (3.4%) reporting “Under 12th grade” (see Table 6).

Table 6

**Education Level of Clients who Receive Services of CDCs in Louisiana**

<table>
<thead>
<tr>
<th>Education</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 12th Grade</td>
<td>7</td>
<td>3.4</td>
</tr>
<tr>
<td>GED</td>
<td>15</td>
<td>7.3</td>
</tr>
<tr>
<td>High School Graduate</td>
<td>39</td>
<td>18.8</td>
</tr>
<tr>
<td>Some College</td>
<td>89</td>
<td>43.0</td>
</tr>
<tr>
<td>College Graduate and beyond</td>
<td>57</td>
<td>27.5</td>
</tr>
<tr>
<td>Total</td>
<td>207</td>
<td>100.0</td>
</tr>
</tbody>
</table>
Number of Children

Another characteristic on which respondents were described was number of children in the home. Item 7 in the survey asked, “How many children under the age of 18 live with you?” Respondents were provided a space to write their response for this item. Fifty-three (29.2%) respondents indicated that they had two children who were less than 18 years of age who lived with them. Additionally, 52 respondents (28.6%) indicated that they had no children under 18, while forty-five (24.7%) indicated that they had one child under 18. A total of 32 (17.5%) respondents had three or more children under 18 in the home (see Table 7).

Table 7

| Number of Children Under Age 18 Who Live With Clients who Receive Services of CDCs in Louisiana |
|-------------------------------------------------|---------------------|-----------------|
| Number of Children Under 18                     | n                   | %               |
| 0                                               | 52                  | 28.6            |
| 1                                               | 45                  | 24.7            |
| 2                                               | 53                  | 29.2            |
| 3                                               | 21                  | 11.5            |
| 4                                               | 7                   | 3.8             |
| 5                                               | 4                   | 2.2             |
| Total                                           | 182                 | 100.0           |

Note. Twenty-five of the study participants did not provide data for the variable number of children. This variable had a mean score of 1.44 and a standard deviation of 1.25.

Household Members Over the Age of 18

Clients were asked to provide information about the people who lived with them who were 18 or older. They were given the following seven response options and were asked to “check all that apply:” (1) Spouse; (2) Parent; (3) Domestic Partner; (4)
Brother/Sister (Sibling); (5) Grandparent; (6) Adult Child; and (7) Other. The household member over the age of 18 that was reported by the largest number of respondents was “Spouse” (n = 70, 33.8%). The second most frequently reported (n = 46, 22.2%) adult household member was “Adult Child.” The number of respondents that indicated each of the adult household member responses is presented in Table 10. The “Other” option was marked by 25 (12.1%) of the respondents in the study. Respondents were provided a space to specify the other adult household member. These individuals and the number of respondents reporting each includes: grandchild (n = 14); cousin (n = 7); aunt (n = 2); sister-in-law (n = 1); and friend (n = 1) (See Table 8).

Table 8

<table>
<thead>
<tr>
<th>Household member</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spouse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>70</td>
<td>33.8</td>
</tr>
<tr>
<td>No</td>
<td>137</td>
<td>66.2</td>
</tr>
<tr>
<td>Total</td>
<td>207</td>
<td>100.0</td>
</tr>
<tr>
<td>Adult Child</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>46</td>
<td>22.2</td>
</tr>
<tr>
<td>No</td>
<td>161</td>
<td>77.8</td>
</tr>
<tr>
<td>Total</td>
<td>207</td>
<td>100.0</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>25</td>
<td>12.1</td>
</tr>
<tr>
<td>No</td>
<td>181</td>
<td>87.9</td>
</tr>
<tr>
<td>Total</td>
<td>206</td>
<td>100.0</td>
</tr>
<tr>
<td>Sibling</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>18</td>
<td>8.7</td>
</tr>
<tr>
<td>No</td>
<td>189</td>
<td>91.3</td>
</tr>
<tr>
<td>Total</td>
<td>207</td>
<td>100.0</td>
</tr>
<tr>
<td>Parent</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>13</td>
<td>6.3</td>
</tr>
<tr>
<td>No</td>
<td>179</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>206</td>
<td></td>
</tr>
</tbody>
</table>

(table continues)
Grandparent

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>4</td>
<td>203</td>
<td>207</td>
</tr>
<tr>
<td></td>
<td>1.9</td>
<td>98.1</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Domestic Partner

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>206</td>
<td>207</td>
</tr>
<tr>
<td></td>
<td>0.5</td>
<td>99.5</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Note. One of the study participants did not provide data for categories “other” and “parent” for the variable household members over the age of 18. Respondents in category “Other” included the following: grandchild (n = 14); cousin (n = 7); aunt (n = 2); sister-in-law (n = 1); and friend (n = 1).

Length of Participation in CDC

Clients were asked to indicate how long they had participated in programs sponsored by their CDC. The majority (n = 117, 60.0%) of respondents marked that they had participated in programs sponsored by their CDC for “under 2 years.” Sixty-seven respondents (34.4%) indicated they had participated “2-5 years.” Ten clients (5.1%) indicated “6-10 years.” Only one respondent (0.5%) had participated in CDC programs for “more than 10 years,” as shown in Table 9.

Table 9

<table>
<thead>
<tr>
<th>Length of Participation</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 2 years</td>
<td>117</td>
<td>60.0</td>
</tr>
<tr>
<td>2 – 5 years</td>
<td>67</td>
<td>34.4</td>
</tr>
<tr>
<td>6 – 10 years</td>
<td>10</td>
<td>5.1</td>
</tr>
<tr>
<td>More than 10 years</td>
<td>1</td>
<td>0.5</td>
</tr>
<tr>
<td>Total</td>
<td>195</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Note. 12 of the study participants did not provide data for the variable length of participation.

Client Region

Item 10 in the survey asked, “What region do you live in?” Nine response options were provided, including: “Alexandria/Central”; “Lake Charles/Southwest”;
“Shreveport/Northwest”; “Baton Rouge/Southeast”; “Monroe/Northeast”; “Houma/Thibodeaux”; “Lafayette/Acadiana”; “New Orleans/Northshore”; and “Other (please specify).” One hundred five respondents indicated Baton Rouge as the region where they lived. In New Orleans, there were 99 respondents. The variable, client region, was measured in nine initial categories of response. However, the responses in all of the categories of response except “Baton Rouge/Southeast” and “New Orleans/Northshore” were judged by the researcher to be inadequate to use as separate independent variables in the analysis because of the small number of respondents. Therefore, the researcher classified all of the respondents as either “Baton Rouge” or “Not Baton Rouge.” Included in the “Not Baton Rouge” category were New Orleans (n = 99, 47.8%), Shreveport (n = 1, 0.5%), Alexandria (n = 1, 0.5%), and Other (not specified) (n = 1, 0.5%). Since three respondents marked categories in places other than Baton Rouge or New Orleans, there is a possibility that they may have moved from these cities to the Baton Rouge and New Orleans locations. Slightly over 50% (n = 105, 50.7%) of respondents indicated Baton Rouge as the region where they reside, from the marked responses on the survey as presented in Table 10.

Table 10

<table>
<thead>
<tr>
<th>Client Region</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baton Rouge</td>
<td>105</td>
<td>50.7</td>
</tr>
<tr>
<td>New Orleans</td>
<td>99</td>
<td>47.8</td>
</tr>
<tr>
<td>Shreveport</td>
<td>1</td>
<td>0.5</td>
</tr>
<tr>
<td>Alexandria</td>
<td>1</td>
<td>0.5</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>0.5</td>
</tr>
<tr>
<td>Total</td>
<td>207</td>
<td>100.0</td>
</tr>
</tbody>
</table>
**Household Size**

For the purposes of calculating household size, each provided response for the variable, household members over the age of 18, was assigned a “1” if it was marked by the respondent or a “0” if left blank. Even if the respondent lived alone, their response was included in the total count. The variable, household size was a calculated variable; and was derived from the sum of items included in the variables “number of children” and “household members over the age of 18,” in addition to the respondent. Table 11 lists the total numbers of individuals per household.

Table 11

**Household Size of Clients who Receive Housing Services of CDCs in Louisiana**

<table>
<thead>
<tr>
<th>Number of people in household</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>14</td>
<td>6.8</td>
</tr>
<tr>
<td>2</td>
<td>70</td>
<td>33.8</td>
</tr>
<tr>
<td>3</td>
<td>40</td>
<td>19.4</td>
</tr>
<tr>
<td>4</td>
<td>44</td>
<td>21.2</td>
</tr>
<tr>
<td>5</td>
<td>25</td>
<td>12.1</td>
</tr>
<tr>
<td>6</td>
<td>10</td>
<td>4.8</td>
</tr>
<tr>
<td>7</td>
<td>4</td>
<td>1.9</td>
</tr>
<tr>
<td>Total</td>
<td>207</td>
<td>100.0</td>
</tr>
</tbody>
</table>

*Note.* This variable had a mean of 29.57 and a standard deviation of 21.55.

The most frequently occurring household size (n = 70, 33.8%) was two people. There were 40 households (19.4%) with three occupants. Forty percent (n = 83) of households had four or more people.
Objective Two

The second objective of the study was to determine client’s overall satisfaction with the housing programs of CDCs as measured by the mean of the 14-item scale measuring housing program satisfaction. Items 1-14 from part B of the survey were designed to collect information on client’s satisfaction with the components of CDC service. Cronbach’s alpha, which is a measure of internal consistency, was used to estimate the reliability of the 14-item scale. The calculated alpha was determined to be \( \alpha = .97 \). Study participants were asked to respond to the 14 items in the scale using a five point Likert-type scale with the following values: “Strongly Disagree” = 1; “Disagree” = 2; “Unsure” = 3; “Agree” = 4; and “Strongly Agree” = 5. Each of the items included in the 14 item scale began with the wording “I am satisfied with . . .” therefore, higher levels of agreement with the items in the scale indicated higher levels of satisfaction with the services of the CDC. The following scale was used to interpret the responses to the items:

- \( 1.00 – 1.50 \) = Strongly Disagree
- \( 1.51 – 2.50 \) = Disagree
- \( 2.51 – 3.49 \) = Unsure
- \( 3.50 – 4.49 \) = Agree
- \( 4.50 – 5.00 \) = Strongly Agree

To aid in interpreting the results of the study, the researcher established a level of satisfaction scale to correspond with the responses received on the Likert-type Agree/Disagree scale. For purposes of this study, a “Strongly Disagree” mean response (1.00 to 1.50) was described as “Very Dissatisfied;” a “Disagree” mean response (1.51 to 2.50) was described as “Dissatisfied;” an “Unsure” mean response (2.51 to 3.49) was
described as “Neutral;” an “Agree” mean response (3.50 to 4.49) was described as “Satisfied;” and a “Strongly Agree” mean response (4.50 to 5.00) was described as “Very Satisfied.”

In items 1-14 of part B of the survey, participants were asked to rate their CDC by responding to a series of statements and by marking items on a scale of 1-5 that most closely identified how much they agreed or disagreed with the statement. The item from the 14 item scale that received the highest rating ($M = 4.03$, $SD = .91$) was “I am satisfied with what I learned through the CDC about purchasing a home.” Using the interpretive scales established by the researcher, the mean response to this item was classified as “Agree” indicating that the respondents were “Satisfied” with this aspect of the CDC housing services.

The item which received the lowest rating was “I am satisfied with the way the CDC follows-up after housing purchase” ($M = 3.56$, $SD = 1.13$). Even though this item received the lowest rating, it was still classified in the “Agree” category of the interpretive scale established by the researcher which indicates that the clients were “Satisfied” with this aspect of the housing services they received also (See Table 12). In addition to examining the responses to the individual items in the housing satisfaction scale, the researcher computed an overall housing satisfaction score which was defined as the mean of the 14 items included in the scale. This score was determined to be 3.89 ($SD = .82$) which is also described as “Agree” using the researcher established interpretive scale which indicates that the respondents were “Satisfied” with the overall housing services they received from the CDC.
Table 12

**Satisfaction with Selected Aspects of Housing Program Services Among Clients who Received Housing Services of CDCs in Louisiana**

<table>
<thead>
<tr>
<th>Factor</th>
<th>n</th>
<th>M</th>
<th>SD</th>
<th>Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am satisfied with what I learned through the CDC about purchasing a home.</td>
<td>201</td>
<td>4.03</td>
<td>.91</td>
<td>A</td>
</tr>
<tr>
<td>I am satisfied with the help I received from the CDC.</td>
<td>202</td>
<td>4.01</td>
<td>.90</td>
<td>A</td>
</tr>
<tr>
<td>I am satisfied with what I learned through the CDC about budgeting.</td>
<td>203</td>
<td>4.00</td>
<td>.88</td>
<td>A</td>
</tr>
<tr>
<td>I am satisfied with the CDC’s housing programs.</td>
<td>201</td>
<td>3.99</td>
<td>.90</td>
<td>A</td>
</tr>
<tr>
<td>I am satisfied with what the CDC taught me about the mortgage loan process.</td>
<td>200</td>
<td>3.98</td>
<td>.94</td>
<td>A</td>
</tr>
<tr>
<td>I am satisfied with the CDC’s housing counselor.</td>
<td>201</td>
<td>3.96</td>
<td>.97</td>
<td>A</td>
</tr>
<tr>
<td>I am satisfied with the way CDC staff members do their jobs.</td>
<td>203</td>
<td>3.92</td>
<td>.99</td>
<td>A</td>
</tr>
<tr>
<td>I am satisfied with the credit counseling given by the CDC.</td>
<td>203</td>
<td>3.88</td>
<td>.96</td>
<td>A</td>
</tr>
<tr>
<td>I am satisfied with the way the CDC communicates with me.</td>
<td>203</td>
<td>3.87</td>
<td>1.03</td>
<td>A</td>
</tr>
<tr>
<td>I am satisfied with the way the CDC responds to my questions.</td>
<td>202</td>
<td>3.87</td>
<td>.98</td>
<td>A</td>
</tr>
<tr>
<td>I am satisfied with what I learned through the CDC about taking care of my home.</td>
<td>202</td>
<td>3.87</td>
<td>.97</td>
<td>A</td>
</tr>
<tr>
<td>I am satisfied with the help I received from the CDC in making my housing affordable.</td>
<td>202</td>
<td>3.81</td>
<td>.98</td>
<td>A</td>
</tr>
<tr>
<td>I am satisfied with the way the CDC has improved my community.</td>
<td>201</td>
<td>3.79</td>
<td>.93</td>
<td>A</td>
</tr>
</tbody>
</table>

55 (table continues)
I am satisfied with the way the CDC follows-up after housing purchase.  

Overall Satisfaction Score

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>200</td>
<td>3.56</td>
<td>1.13</td>
<td>A</td>
</tr>
<tr>
<td>205</td>
<td>3.89</td>
<td>.82</td>
<td>A</td>
</tr>
</tbody>
</table>

\[a\] Response scale: 1 = Strongly Disagree, 2 = Disagree, 3 = Unsure, 4 = Agree, 5 = Strongly Agree.
\[b\] Interpretive scale: 1.00 – 1.50 = Strongly Disagree (SD) (Very Dissatisfied); 1.51 – 2.50 = Disagree (D) (Dissatisfied); 2.51 – 3.49 = Unsure (U) (Neutral); 3.50 – 4.49 = Agree (A) (Satisfied); and 4.50 – 5.00 = Strongly Agree (SA) (Very Satisfied).

Objective Three

The third objective was to determine the satisfaction of clients of CDCs in Louisiana with the services they received in (a) Housing, (b) Social services, (c) Workforce development, (d) Educational enrichment, and (e) Community outreach.

The survey instrument contained an item structured with a Likert-type response scale. Respondents were asked to “check and rate each service/program” that they had received from their CDC in the past 10 years. They were given the options of Very Dissatisfied; Dissatisfied; Neutral; Satisfied; and Very Satisfied. Responses were scored as follows: 1=Very Dissatisfied; 2=Dissatisfied; 3=Neutral; 4=Satisfied; and 5=Very Satisfied. Table 15 gives an overview of the average satisfaction of clients who receive these services of CDCs in Louisiana. The following scale was used to interpret the results:

1.0 – 1.50 = Very Dissatisfied
1.51 – 2.50 = Dissatisfied
2.51 – 3.49 = Neutral
3.50 – 4.49 = Satisfied
4.50 – 5.00 = Very Satisfied

The CDC service that received the highest satisfaction rating was “Housing” (M = 3.94, SD = 1.13). This mean rating was classified as “Satisfied” using the interpretive...
scale established by the researcher. One other service offered by the CDC received a rating in the “Satisfied” category. “Educational Enrichment” received a rating of 3.68 (SD = 1.00) by respondents in the study. The remaining services included in the survey instrument received ratings that placed them in the “Neutral” category on the researcher established interpretive scale (See Table 13).

Table 13

<table>
<thead>
<tr>
<th>Services</th>
<th>n</th>
<th>M</th>
<th>SD</th>
<th>Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Housing</td>
<td>193</td>
<td>3.94</td>
<td>1.1</td>
<td>S</td>
</tr>
<tr>
<td>Educational Enrichment</td>
<td>120</td>
<td>3.68</td>
<td>.99</td>
<td>S</td>
</tr>
<tr>
<td>Community Outreach</td>
<td>116</td>
<td>3.46</td>
<td>.95</td>
<td>N</td>
</tr>
<tr>
<td>Social Services</td>
<td>131</td>
<td>3.45</td>
<td>1.0</td>
<td>N</td>
</tr>
<tr>
<td>Workforce Development</td>
<td>115</td>
<td>3.41</td>
<td>.89</td>
<td>N</td>
</tr>
</tbody>
</table>

Note. Clients were asked to provide responses for and rate only the services they had received.

- Response scale: 1 = Very Dissatisfied, 2 = Dissatisfied, 3 = Neutral, 4 = Satisfied, 5 = Very Satisfied.
- Interpretive scale: 1.00 – 1.50 = Very Dissatisfied (VD) (Very Dissatisfied); 1.51 – 2.50 = Dissatisfied (D) (Dissatisfied); 2.51 – 3.49 = Neutral (V) (Neutral); 3.50 – 4.49 = Satisfied (S) (Satisfied); and 4.50 – 5.00 = Very Satisfied (VS) (Very Satisfied).

To further examine the utilization of CDC housing services among currently participating clients, respondents were provided a list of housing services that are offered by CDCs and asked to indicate whether or not they had participated in or received each of the services identified. The largest group of respondents (n = 51, 25.2%) indicated that they had not received any of the services (“None of the Above”) identified in the instrument. The service that was identified by the largest group of
respondents (n = 27, 13.4%) was “Rental housing.” Additionally, 22 (10.9%) of the respondents indicated that they had received “New Home Construction” services from their CDC. Data regarding participation in housing services is presented in Table 14.

Table 14

Client Participation in Housing Services offered by Louisiana Community Development Corporations

<table>
<thead>
<tr>
<th>Services</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>None of the Above</td>
<td>51</td>
<td>25.2</td>
</tr>
<tr>
<td>Rental Housing</td>
<td>27</td>
<td>13.4</td>
</tr>
<tr>
<td>New Home Construction</td>
<td>22</td>
<td>10.9</td>
</tr>
<tr>
<td>Homeowner Counseling</td>
<td>17</td>
<td>8.4</td>
</tr>
<tr>
<td>Apartments</td>
<td>9</td>
<td>4.5</td>
</tr>
<tr>
<td>Home Repair, Weatherization</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Co-op Housing Counseling</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Note. 5 of the study participants did not provide data for this item.

Clients were asked two direct questions regarding their satisfaction with the housing services in items 14 and 15 of the survey instrument. For the question “Were you satisfied with the housing services you received?” Respondents were given the options of “Yes” or “No.” The majority of respondents (n=152, 77.6%) indicated that they were satisfied with the housing services they had received. There were 44 (22.4%) respondents who marked “No”, indicating that they were not satisfied with the housing services received. Data were missing for 11 respondents for this item.
Regarding the question (survey item 15) “Is there anything you would change about your housing experience?” respondents were given the options of “Yes” or “No.” Nearly 60 percent of respondents (n=116, 58.9%) indicated that they would not change their housing experience. Forty-one percent (n=81) of respondents who marked survey item 15 indicated that they would change something about their experience with the CDC housing services. Data were missing for 10 respondents for this item. Other than a comments section, there was no further exploration of reasons why they were satisfied with their housing services or not. For respondents who wrote-in comments, the feedback about desired housing changes as indicated by respondents are listed as written (errors included) in Appendix G. Comments included opinions of home ownership, management, and property maintenance.

**Objective Four**

Objective 4 was to determine if a relationship existed between client’s overall satisfaction and the selected demographic characteristics. The strength of the correlations was interpreted using Davis’ proposed set of descriptors (Davis, 1971). The coefficients and their descriptive scale are as follows:

<table>
<thead>
<tr>
<th>Coefficient</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>.01 to .09</td>
<td>Negligible association</td>
</tr>
<tr>
<td>.10 to .29</td>
<td>Low association</td>
</tr>
<tr>
<td>.30 to .49</td>
<td>Moderate association</td>
</tr>
<tr>
<td>.50 to .69</td>
<td>Substantial association</td>
</tr>
<tr>
<td>.70 or higher</td>
<td>Very strong association</td>
</tr>
</tbody>
</table>
A Kendall’s tau correlation coefficient was calculated to determine if a relationship existed between client’s overall satisfaction and the ordinal variables age, household income, education level, and length of participation. A Pearson’s Product Moment correlation coefficient was calculated to determine if a relationship existed between overall satisfaction and the interval variables number of children, household size, and household members over the age of 18. Each of the selected variables in the objective was used as the independent variable and the association between each independent variable and the overall satisfaction score was examined.

Based on the computed Kendall’s tau correlation coefficients (see Table 17), there was a significant low negative association ($r = -.19$, $p = .01$) between household income and client’s overall satisfaction. Although very minimal, clients who had lower household incomes tended to have higher satisfaction with the services received. The variables age, education level, and length of participation were not found to be significantly related to overall satisfaction (See Table 15).

Table 15

**Relationship between Overall Satisfaction and Selected Characteristics for Clients of Louisiana CDCs who Provide Housing**

<table>
<thead>
<tr>
<th>Variable</th>
<th>$r$</th>
<th>$n$</th>
<th>$p$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Household income</td>
<td>-.19</td>
<td>203</td>
<td>.01</td>
</tr>
<tr>
<td>Length of participation</td>
<td>.09</td>
<td>205</td>
<td>.12</td>
</tr>
<tr>
<td>Education level</td>
<td>-.07</td>
<td>205</td>
<td>.21</td>
</tr>
<tr>
<td>Age</td>
<td>-.03</td>
<td>205</td>
<td>.56</td>
</tr>
</tbody>
</table>

*, Kendall’s Tau correlation coefficients when the Pearson Product Moment correlations were examined between the variables measured on an interval scale and overall satisfaction; one significant relationship was identified (See Table 16).
Number of children under 18 was negatively correlated with client’s overall satisfaction and showed a low association ($r = -0.18$, $p = 0.01$). This was an indication that respondents with fewer children tended to have higher overall satisfaction with the services received. Household members over age 18 and household size proved to be negligible associations identified in the analysis based on the Pearson’s coefficient calculation (See Table 16).

Table 16

<table>
<thead>
<tr>
<th>Variable</th>
<th>$r$</th>
<th>n</th>
<th>$p$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of children</td>
<td>-0.18</td>
<td>180</td>
<td>0.01</td>
</tr>
<tr>
<td>Household members over 18</td>
<td>0.12</td>
<td>203</td>
<td>0.09</td>
</tr>
<tr>
<td>Household size</td>
<td>-0.09</td>
<td>178</td>
<td>0.21</td>
</tr>
</tbody>
</table>

Another variable which was examined to determine if a relationship existed with client’s overall satisfaction score was the variable gender. To accomplish this, the researcher determined that the most suitable statistical procedure to use for maximizing interpretability of the results was to compare the scores by categories of the independent variable. This was accomplished using an independent t-test. A significant difference was found for the variable gender ($t_{202} = 2.40$, $p = 0.02$). Female respondents ($M = 3.96$, $SD = 0.75$) tended to have higher overall satisfaction scores than males ($M = 3.62$, $SD = 0.98$).

To determine if a relationship existed between client’s overall satisfaction score and the variable client region (defined as Baton Rouge or Not Baton Rouge), the researcher determined that the most suitable statistical procedure to use for maximizing
Objective Five

Objective 5 was to determine if a model exists which explains a significant portion of the variance in the overall satisfaction level of CDC clients from the demographic characteristics (a) Age; (b) Race; (c) Gender; (d) Marital status; (e) Household income; (f) Education level; (g) Number of children; (h) Household members over the age of 18; (i) Length of participation in CDC; (j) Clients region; and (k) Household size. This objective was accomplished by calculating a multiple regression analysis using stepwise entry of the variables with client’s overall satisfaction score as the dependent variable. Other variables were treated as independent variables, and stepwise entry of the variables was used because of the exploratory nature of this portion of the study. In conducting the multiple regression
analysis, seven of the variables which were categorical in nature had to be recoded as a series of dichotomous variables before entry in the analysis. These variables included age, race, marital status, household income, education level, client region, and length of participation in CDC. Gender, a categorical variable, is by nature dichotomous and was not reorganized. The variable, client region, was reorganized as a dichotomous variable and coded as “Baton Rouge” or “Not Baton Rouge.” The variable, length of participation in CDC, was reorganized as a dichotomous variable and coded as “Less than two years” and “two years or more.” For the variable marital status, “binary coding” was used to construct four “yes or no” variables. Variables created were whether or not respondents were single, whether or not respondents were married, whether or not respondents were widowed, and whether or not respondents were divorced. The category of marital status, living with a partner, included only one respondent and was therefore not used as a separate variable in the analysis. In each instance, yes was coded as a “1” and no was coded as “0.”

Recoding was also used for the variable, education level, resulting in five constructed “yes or no” variables. The variables created were whether or not respondents education was under 12\textsuperscript{th} grade, whether or not they were a high school graduate, whether or not they had received a GED, whether or not they had received some college, and whether or not they were a college graduate or beyond.

Recoding was also used for the variable, household income, resulting in five constructed “yes or no” variables. The variables created were whether or not respondents had annual household incomes under $10,000; whether or not their income was between $10,001 and $20,000; whether or not their income was between $20,001 and $50,000; whether or not their income was between $50,001 and $100,000; and whether or not their income was above $100,000.
and $30,000; whether or not their income was between $30,001 and $40,000; and whether or not their income was over $40,000.

For the variable race, there were insufficient numbers to include all ethnic groups in the analysis. Therefore, the variable race was set as “Black” or “Not Black.”

For descriptive purposes, correlations between the factors that were used as independent variables and the dependent variable, client’s overall satisfaction, are presented in Table 20. The characteristic, “Whether or not they had an annual income over $40,000” had the strongest association with the dependent variable, client overall satisfaction ($r = .23, p <.01). This was described as a low association using Davis’ descriptors. The characteristic with the next highest association with the dependent variable was “Whether or not they had participated in CDC under 2 years” ($r = .19, p =<.01$). Ten other characteristics had low associations (Davis, 1971) with the dependent variable with the $r$ values ranging from a high of $r = .19$ to a low of $r = .10$ as shown in Table 17.

Table 17

<table>
<thead>
<tr>
<th>Relationship between Overall Satisfaction with Housing Services of the CDC and Selected Demographic Characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Characteristic</td>
</tr>
<tr>
<td>Whether or not annual income over $40,000</td>
</tr>
<tr>
<td>Whether or not participated in CDC under 2 years</td>
</tr>
<tr>
<td>Whether or not female</td>
</tr>
<tr>
<td>Whether or not had children under 18</td>
</tr>
<tr>
<td>Whether or not had high school education</td>
</tr>
<tr>
<td>Whether or not had GED</td>
</tr>
</tbody>
</table>

(table continues)
<table>
<thead>
<tr>
<th>Variable</th>
<th>N</th>
<th>B</th>
<th>SE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Whether or not had some college</td>
<td>177</td>
<td>-0.15</td>
<td>0.02</td>
</tr>
<tr>
<td>Whether or not college graduate</td>
<td>177</td>
<td>0.15</td>
<td>0.02</td>
</tr>
<tr>
<td>Whether or not single</td>
<td>177</td>
<td>-0.15</td>
<td>0.03</td>
</tr>
<tr>
<td>Whether or not annual income under $10,000</td>
<td>177</td>
<td>-0.13</td>
<td>0.04</td>
</tr>
<tr>
<td>Whether Baton Rouge or not</td>
<td>177</td>
<td>-0.13</td>
<td>0.05</td>
</tr>
<tr>
<td>Whether or not less than high school education</td>
<td>177</td>
<td>-0.10</td>
<td>0.09</td>
</tr>
<tr>
<td>Whether or not between 26-35</td>
<td>177</td>
<td>-0.09</td>
<td>0.11</td>
</tr>
<tr>
<td>Whether or not income between $20,000-$30,000</td>
<td>177</td>
<td>-0.09</td>
<td>0.12</td>
</tr>
<tr>
<td>Household size</td>
<td>177</td>
<td>-0.09</td>
<td>0.12</td>
</tr>
<tr>
<td>Household members over age 18</td>
<td>177</td>
<td>0.08</td>
<td>0.13</td>
</tr>
<tr>
<td>Whether or not divorced</td>
<td>177</td>
<td>0.08</td>
<td>0.13</td>
</tr>
<tr>
<td>Whether black or not</td>
<td>177</td>
<td>0.07</td>
<td>0.15</td>
</tr>
<tr>
<td>Whether married or not</td>
<td>177</td>
<td>0.07</td>
<td>0.15</td>
</tr>
<tr>
<td>Whether or not income between $10,000-$20,000</td>
<td>177</td>
<td>-0.05</td>
<td>0.26</td>
</tr>
<tr>
<td>Whether or not between 36-45 years of age</td>
<td>177</td>
<td>0.04</td>
<td>0.29</td>
</tr>
<tr>
<td>Whether or not income between $30,000-$40,000</td>
<td>177</td>
<td>0.04</td>
<td>0.27</td>
</tr>
<tr>
<td>Whether or not under 26 years of age</td>
<td>177</td>
<td>0.03</td>
<td>0.33</td>
</tr>
<tr>
<td>Whether or not over 45 years of age</td>
<td>177</td>
<td>0.03</td>
<td>0.33</td>
</tr>
<tr>
<td>Whether or not a widow</td>
<td>177</td>
<td>0.02</td>
<td>0.41</td>
</tr>
</tbody>
</table>

Prior to conducting the regression analysis, the researcher tested the data for violation of the assumption underlying the use of regression analysis that no high levels of multicollinearity exist among the independent variables. There are a number of techniques used to test this assumption; however, according to Lewis-Beck (1980) the
preferred method of testing for multicollinearity is to “Regress each independent variable on all the other independent variables” (p.60).

This technique was used for the regression analysis conducted in the study. No multicollinearity problems were found in the data among the independent variables using this technique. Therefore, the researcher proceeded with the regression analysis.

The results of the analysis when overall satisfaction was regressed on the selected characteristics is presented in Table 18. A total of five variables entered the regression model indicating that they added a significant amount of explained variance to the model. The variable that entered the model first was “Whether or not the respondent’s household income was more than $40,000.” Considered alone this variable explained 5.5% of the variance in the client’s overall satisfaction score ($F_{\text{change}} = 10.120, p = .002$). The nature of the influence of this variable on client’s’ overall satisfaction score was such that those with income levels over $40,000 tended to have higher satisfaction scores than those with incomes of $40,000 or less.

The second variable that entered the regression model as a significant explanatory factor was “Whether or not the highest level of education completed was a high school.” This variable added 4.8% to the total explained variance ($F_{\text{change}} = 9.259, p = .003$). The nature of the influence of this variable on overall satisfaction was such that clients who indicated that high school was their highest level of education completed tended to have higher levels of satisfaction with CDC services.

The third variable that entered the regression model was the number of children under the age of 18 living in the home ($F_{\text{change}} = 5.654, p = .02$). The nature of the influence of this variable was such that clients with fewer children tended to have higher levels of satisfaction with services received. Additionally, the variable gender
entered the model as a significant explanatory factor ($F_{\text{change}} = 5.583, p = .02$). The influence of this variable was such that female clients tended to have higher levels of overall satisfaction scores than did male clients.

Finally, the variable, race (operationalized as “Whether or not the respondent was Black”) entered the model as a significant explanatory factor ($F_{\text{change}} = 4.742, p = .03$). The nature of the influence of this variable was such that Black respondents tended to have higher levels of satisfaction that those who were not Black. The significant five variable model explained a total of 18.1% of the variance in overall client satisfaction ($F_{5,171} = 7.552, p < .001$).

Table 18

**Summary of Multiple Regression Analysis with Overall Satisfaction Level of CDC Clients and Selected Demographic Characteristics**

<table>
<thead>
<tr>
<th>Model/ Source of Variation</th>
<th>Df</th>
<th>MS</th>
<th>$F$</th>
<th>$p$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regression</td>
<td>5</td>
<td>4.11</td>
<td>7.552</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Residual</td>
<td>171</td>
<td>.544</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>176</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Variables in the Equation**

<table>
<thead>
<tr>
<th>Variables</th>
<th>R$^2$</th>
<th>R$^2$</th>
<th>$F_{\text{change}}$</th>
<th>$p$</th>
<th>Beta</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Cumulative</td>
<td>Change</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Household income over $40,000</td>
<td>.055</td>
<td>.055</td>
<td>10.120</td>
<td>&lt;.01</td>
<td>.264</td>
</tr>
<tr>
<td>High school education</td>
<td>.102</td>
<td>.048</td>
<td>9.259</td>
<td>&lt;.01</td>
<td>.242</td>
</tr>
<tr>
<td>Children under 18</td>
<td>.131</td>
<td>.028</td>
<td>5.654</td>
<td>.02</td>
<td>-.212</td>
</tr>
<tr>
<td>Gender</td>
<td>.158</td>
<td>.027</td>
<td>5.583</td>
<td>.02</td>
<td>.186</td>
</tr>
<tr>
<td>Variables</td>
<td>t</td>
<td>p</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>------------------------------------------------</td>
<td>-----</td>
<td>----</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Whether or not income between $30,000-$40,000</td>
<td>1.73</td>
<td>.086</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Whether or not participated in CDC under 2 years</td>
<td>1.66</td>
<td>.100</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Whether or not single</td>
<td>-1.63</td>
<td>.103</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Household size</td>
<td>1.62</td>
<td>.105</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Whether or not annual income under $10,000</td>
<td>-1.62</td>
<td>.108</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Whether or not divorced</td>
<td>1.32</td>
<td>.190</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Household members over 18</td>
<td>1.19</td>
<td>.232</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Whether or not college graduate</td>
<td>1.19</td>
<td>.235</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Whether or not under 26 years of age</td>
<td>1.14</td>
<td>.257</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Whether or not between 26-35 years of age</td>
<td>-1.14</td>
<td>.257</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Whether Baton Rouge or not</td>
<td>-1.05</td>
<td>.297</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Whether or not widowed</td>
<td>.923</td>
<td>.357</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Whether or not income between $10,000-$20,000</td>
<td>.746</td>
<td>.457</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Whether or not had GED</td>
<td>-.738</td>
<td>.462</td>
<td></td>
<td></td>
<td></td>
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<td>Whether or not income between $20,000-$30,000</td>
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<td>Whether or not had some college</td>
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<td>Whether or not married</td>
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<td>Whether or not between 36-45 years of age</td>
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Chapter 5 – Summary, Conclusions, and Recommendations

Summary

Purpose and Objectives

The purpose of this study was to determine factors which influence client satisfaction with the services of CDCs in metropolitan regions of Louisiana. The following objectives were formulated to guide the researcher:

1.) To describe clients who receive housing services of CDCs in Louisiana on the following demographic characteristics:
   a. Age
   b. Race
   c. Gender
   d. Marital status
   e. Household income
   f. Education level
   g. Number of children
   h. Household members over the age of 18
   i. Length of participation in CDC
   j. Client region
   k. Household size

2.) To determine client’s overall satisfaction with the housing programs of CDCs as measured by the mean of the 14-item scale measuring housing program satisfaction. This mean was designated client’s overall satisfaction.
3.) To determine the satisfaction of clients of CDCs in Louisiana based on the services they received in:
   a. Housing
   b. Social services
   c. Workforce development
   d. Educational enrichment
   e. Community outreach

4.) To determine if a relationship existed between client’s overall satisfaction and the following selected demographic characteristics:
   a. Age
   b. Race
   c. Gender
   d. Household income
   e. Education level
   f. Number of children
   g. Household members over the age of 18
   h. Length of participation in CDC
   i. Client region
   j. Household size

5.) To determine if a model existed that significantly increases the researcher’s ability to accurately explain the overall satisfaction level of CDC clients from the following selected demographic characteristics:
   a. Age
   b. Race
c. Gender
d. Marital status
e. Household income
f. Education level
g. Number of Children
h. Household members over the age of 18
i. Length of participation in CDC
j. Client region
k. Household size

**Methodology**

The population for the study was adult clients (at least 18 years of age) who participated in housing programs in the metropolitan areas of Baton Rouge and New Orleans. There were 40 CDC organizations in the entire population for Louisiana. Twenty-eight of these organizations were located in Baton Rouge and New Orleans. Seventeen organizations were selected for participation in the study. The listings were derived electronically from the Local Initiatives Support Corporation (Community Development Corporations, 2003) for Baton Rouge and the Center for Urban and Regional Equity for New Orleans. The study was classified as a census, as the entire accessible population (N=458, 100%) was included in the study.

A researcher-designed questionnaire was used in the study. The instrument used in this study contained two sections. The demographics section was designed to gather demographic information and selected information related to program participation. The client satisfaction section measured client perceptions of CDC performance.
Portions of the survey required that clients use a Likert-type response scale that was assigned scores to measure satisfaction.

Of the 458 surveys sent, a total of 207 usable responses were received by the researcher. Forty-four responses were received in the mail and considered to be early respondents. Forty-three responses received were considered to be late respondents. Ninety-eight surveys were received and classified as on-site respondents. As a result of telephone follow-up procedures, there were 22 respondents. The total usable response rate for this study was 45.2%.

Permission for this study was requested and granted from University administrators. Permission for access to pertinent data and approval for conducting the study was requested and approved by the Institutional Review Board (IRB).

Findings

Objective One

Findings for Objective One indicated that the responding clients were predominately in the age categories of 26-35 (n = 73, 35.3%) and 36-45 (n = 58, 28.0%). The respondents were primarily black (n = 172, 83.1%) and female (n = 164, 79.6%). The most frequently occurring response for marital status was single (n = 87, 42.2%). The most frequently reported household income level (n = 56, 27.5%) was in the $10,001 to $20,000 per year category. The respondents primarily reported having attained an education level of at least high school, with the most frequently occurring response as “some college” (n = 89, 43%). The majority (n = 117, 60.0%) of respondents marked that they had participated in programs sponsored by their CDC for “under 2 years.” The respondents primarily reported living in either Baton Rouge (n = 105, 50.7%) or New Orleans (n = 99, 47.8%).
Objective Two

Findings for Objective Two indicated that responding clients were satisfied with the housing services they have received. Participants were asked to rate their CDC by responding to a series of statements and by marking items on a scale of 1-5. Clients Overall Satisfaction Score was 3.89, indicating that they were satisfied with the services received.

Objective Three

Findings for Objective Three indicated that the CDC service that received the highest satisfaction rating was “Housing” ($M = 3.94$, $SD = 1.13$). This mean rating was classified as “Satisfied” using the interpretive scale established by the researcher.

To further examine the utilization of CDC housing services among currently participating clients, respondents were provided a list of housing services that are offered by CDCs and asked to indicate whether or not they had participated in or received each of the services identified. The largest group of respondents ($n = 51$, 25.2%) indicated that they had not received any of the services (“None of the Above”) identified in the instrument. The service that was identified by the largest group of respondents ($n = 27$, 13.4%) was “Rental housing.” Additionally, 22 (10.9%) of the respondents indicated that they had received “New Home Construction” services from their CDC.

The majority of respondents ($n=152$, 77.6%) indicated that they were satisfied with the housing services they had received. There were 44 (22.4%) respondents who marked “No”, indicating that they were not satisfied with the housing services received. Nearly 60 percent of respondents ($n=116$, 58.9%) indicated that they would not change their housing experience. Forty-one percent ($n=81$) of respondents in this study
indicated that they would change something about their experience with the CDC housing services.

**Objective Four**

Findings for Objective Four indicated that there was a negligible association between most of the variables for client’s overall satisfaction. According to the Davis’ (1971) interpretation scale, little if any correlation existed between most of the variables. Based on the Kendall’s tau correlation analysis, there was a low association (r = -0.19) between household income and client’s overall satisfaction, and was negatively correlated. Although very minimal, clients who had lower household incomes tended to have higher satisfaction with the services received. The variables age, education level, and length of participation proved to be negligible associations identified in the analysis. Number of children under 18 was negatively correlated with client’s overall satisfaction and showed a low association (r = -0.18). This was an indication that respondents with fewer children tended to have higher overall satisfaction with the services received. Household members over age 18 and household size proved to be negligible associations identified in the analysis based on the Pearson’s coefficient calculation. Another variable which was examined to determine if a relationship existed with client’s overall satisfaction score was the variable gender. A significant difference was found for the variable gender. Female respondents (M = 3.96, n = 162) tended to have higher overall satisfaction scores than males (M = 3.62, n = 42).

A significant difference was found for the variable region. Respondents classified as “Baton Rouge” (M = 3.98, n = 100) tended to have higher overall satisfaction scores than respondents categorized as “Not Baton Rouge” (M = 3.80, n = 105). No significant differences were found for the variable race.
Objective Five

Findings for Objective Five indicated that the characteristic, “Whether or not they had an annual income over $40,000” had the strongest association with the dependent variable, client overall satisfaction ($r = .23$, $p < .01$). This was described as a low association using Davis’ descriptors. The characteristic with the next highest association with the dependent variable was “Whether or not they had participated in CDC under 2 years” ($r = .19$, $p = <.01$).

According to regression analysis for the model, which has been tested against client’s overall satisfaction ($R = .234$, $R^2 = .055$, $p < .05$), a total of five variables entered the regression model, indicating that they added a significant amount of explained variance to the model. The variable that entered the model first was “Whether or not the respondent’s household income was more than $40,000.” Considered alone this variable explained 5.5% of the variance in the client’s overall satisfaction score ($F_{\text{change}} = 10.120$, $p = .002$). The nature of the influence of this variable on client’s’ overall satisfaction score was such that those with income levels over $40,000$ tended to have higher satisfaction scores than those with incomes of $40,000$ or less.

The second variable that entered the regression model as a significant explanatory factor was “Whether or not the highest level of education completed was a high school.” This variable added 4.8% to the total explained variance ($F_{\text{change}} = 9.259$, $p = .003$). The nature of the influence of this variable on overall satisfaction was such that clients who indicated that high school was their highest level of education completed tended to have higher levels of satisfaction with CDC services.

The third variable that entered the regression model was the number of children under the age of 18 living in the home ($F_{\text{change}} = 5.654$, $p = .02$). The nature of the
influence of this variable was such that clients with fewer children tended to have higher levels of satisfaction with services received. Additionally, the variable gender entered the model as a significant explanatory factor ($F_{\text{change}} = 5.583, p = .02$). The influence of this variable was such that female clients tended to have higher levels of overall satisfaction scores than did male clients. In addition, the variable race entered the model as a significant explanatory factor ($F_{\text{change}} = 4.742, p = .03$). The nature of the influence of this variable was such that Black respondents tended to have higher levels of satisfaction that those who were not Black. The significant five variable model explained a total of 18.1% of the variance in overall client satisfaction ($F_{5, 171} = 7.552, p < .001$).

**Conclusions, Implications, and Recommendations**

1. Clients of CDCs in Louisiana were young.

   This conclusion is based on the findings that 49.3% of the respondents in this study were 35 years of age or younger and 77.3% were 45 years of age or younger. Since almost half of the clients in this study 35 years of age or less, a potential implication is that they are not as financially secure as their older counterparts and therefore have a greater need for the services. Since many clients were from younger groups, there is probably a need for services in addition to housing services. Additional services could possibly include childcare, workforce training, educational programs, transportation assistance, and other social services. The need for care based on a solid foundation is important to this population and planners of CDC programs could incorporate various outreach components within their structure to support the needs of younger clients.
Based on this conclusion and these implications, the researcher recommends that personnel of CDCs design and plan programs offered by the CDC to meet the needs of these younger clients. These services might include childcare services, computer and technology training, and transportation assistance, especially on properties not accessible to a bus route. Within housing services, the researcher recommends that designers of homes provided by CDCs take into account issues important to younger clients such as room for growth, since many of the families will be growing as new children are added to the families. The researcher additionally recommends that recreational facilities for children be available in the immediate area. This not only could improve the interaction among residents, but it also could be a deterrent for children to leave the housing site for some of their entertainment needs.

2. Clients have low income levels.

This conclusion is based on fact that almost half of the respondents in this study have incomes under $20,000 and the official federal guidelines indicate that for a family of four, below $20,000 is the poverty level (U.S. Census Bureau, 2000). This conclusion is consistent with the literature reported by Stoutland (1999), that the mission of CDC organizations is to ultimately improve the quality of life and increase the standard of living in low-income neighborhoods. According to Steinbach (1997), the chief contribution of community development corporations (CDCs) has been to pioneer an innovative approach to fighting poverty. Since most clients of CDC organizations have low income levels, CDCs are making contributions to this group.

An implication of this conclusion is that CDCs are addressing a need. These services can help clients to “break the poverty cycle” so that they may eventually improve their status in life. The need for external intervention makes it even more
important that CDCs provide additional services to supplement the housing services such as: educational services, workforce training, recreational activities, life-skills training, and social empowerment. The need for community development strongly relates to economic development because those who reside within a community contribute to its economic base. Instead of depending on the system for assistance, able-bodied citizens within a community contribute to the system and support its tax-base as well. CDC programs were originally designed to demonstrate that grassroots nonprofit organizations could empower lower-income people both economically and socially by stabilizing the community and preserving family wealth (Berger & Kasper, 1993). Leadership and development must work together simultaneously in order for successful community economic development to take place. The process of community development does not immediately occur because of economic development, and has not had a tendency to do so. Community leadership and development usually takes place when citizens take action to empower not only the local community, but the individual as well. Economic development usually focuses on creating jobs and helping a community improve by promoting the economy to improve. Both community and economic development are considered to be types of “development” and involve varying levels of leadership. Most CDCs serve the purpose of helping with financial and technical problems in communities through neighborhood revitalization groups (Clark, 2001).

Therefore, the researcher recommends that the leaders of CDCs increase the emphasis on housing services. The bottom line is that people need to know they have a place to sleep at night. It is imperative that all people, particularly Americans, who live in one of the wealthiest nations in the world, can be guaranteed food, clothing, and
shelter. An additional recommendation is that further research be conducted to identify the actual additional needs of clients of CDCs. There is no purpose in providing services that are not needed to individuals. For example, if services for an on-site Laundromat are needed, and there is no platform or means for clients to articulate their needs, the clients probably will experience their need being delayed or denied. The researcher also recommends that CDC organizations learn to effectively communicate to clients of CDC’s additional services that are available. It is pointless to have grant monies for programs intended to be implemented, yet utilized by no one. CDC planners should identify ways to employ local community members who are clients of CDCs as members of CDC staff offices. This might be accomplished through acquisition of grant funding or simply hiring of qualified clients for jobs that are available. This creates a win-win situation for all parties involved – the clients, the CDC staff, the stakeholders, and the community at-large.

3. Clients were satisfied with housing services.

This conclusion was based on the findings reported by CDC clients who received the services of CDCs in Louisiana. The housing satisfaction average was 3.89, which indicates that clients were satisfied with the housing services received. In addition, clients were asked a question regarding their satisfaction with the housing services in item 14 of the survey instrument. For the question “Were you satisfied with the housing services you received?” Respondents were given the options of “Yes” or “No.” The majority of respondents (n=152, 77.6%) indicated that they were satisfied with the housing services they had received.

This is an implication that conducting research in this area is important, as supported by the literature. Client satisfaction in the nonprofit sector has become more
important in recent years due to the reality that many nonprofits, including CDCs, aim to fund their programs through federal and state grants. Program evaluation and client satisfaction has been stressed more because of the Government Performance and Results Act which aims to improve the performance of government services and tracks the progress of various agencies and their programs. The findings of this study indicated that program flexibility helps meet clients’ housing needs and preferences, and that clients reported high satisfaction levels with their housing (Housing and Community Development Consulting, 2004).

In light of this finding, it is imperative that practitioners identify other ways to measure quality of services and effectiveness of services provided to clients of CDCs. The primary reason for exploring other measurement strategies is to delineate between client satisfaction based on exceptional CDC performance versus client satisfaction due to limited alternatives. CDC clients’ high levels of satisfaction could be because of the exceptional quality of services or it could be just simply that something is better than nothing. The high reported levels of satisfaction could be the application of the principle of relative deprivation, which is the perception that a person’s status is dependent on those personally compared against. Therefore, the researcher recommends additional studies be done to further explore this notion.

4. Most clients of CDCs in Louisiana are female.

This conclusion is based on findings that 79.6% of the respondents in this study were female. This could be an implication that females tend to need to services more so than males. This could additionally implicate that females tend to have custody of minor children, and have more difficulty in gaining employment if they have young children. It is likely that females are more willing to ask for assistance than their male
counterparts, resulting in a higher population of females who use CDC services. The literature supports the notion that females tend to have higher survey response levels than males. According to Walonick (1997), single males have a higher rate of non-response than females, which may also be an indicator of why there were more females in this study.

The researcher recommends that CDC organizations and stakeholders partner with the Louisiana Department of Social Services to strategize effective service delivery. There could also be sub-contracting of grant monies to eliminate the “middle man” and encourage community development by citizens instead of by government or institution. The social services department could also provide critical data regarding specific areas of service delivery that are needed in the various geographic regions of this state. CDCs should have help with identifying other needed services, especially childcare. Although the department of social services currently has programs in place to assist with childcare, they could take it even a step further by possibly building state-run daycare centers on or near properties owned by CDCs. This is another opportunity to recycle service delivery dollars and be more financially efficient as well.

The researcher additionally recommends that CDCs begin to get the message to women about the availability of services (housing and others) – especially those that may be victims of domestic abuse (including spousal and child abuse), displaced homemakers, students, etc. This dissemination of information could be done through sites that women often visit, including grocery stores, parish health units, doctor’s offices (especially pediatricians), day care centers, and female restrooms.

5. A large number of the clients of CDCs in Louisiana are single.
This conclusion is based on the finding that 42.2% of respondents in this study were single. This could be an implication that the single population may be more vulnerable and susceptible to needing services offered by CDCs, especially if they are single parents. The researcher believes that this high percentage of single people should be a concern for not only CDC decision-makers, but social service delivery organizations across the board. Social services are very important and it is vital that the components that contribute to client satisfaction are addressed. There is simply not enough emphasis placed on the needs of single people. Generally speaking, married people have support from their spouses and sufficient help with the responsibilities which accompany managing a home life. Therefore, the researcher recommends that CDCs design programs that are set up to meet the needs of single individuals. For example, a mother’s night out to accomplish certain needed activities could be a huge help to a person who would otherwise have no option for taking care of normal and routine daily activities. CDC organizations could also partner with Big Brother/Big Sister or Big Buddy programs in major metropolitan areas to assist single parents in their need for occasional solitude or business dealings. The researcher recommends further research to identify needs of single clients.

6. Most clients of CDCs are well educated.

This conclusion is based on the finding that 89.3% of respondents in this study had at least a high school diploma. This is in contrast to literature in a study by Steinbach (1997), which says that the chief contribution of community development corporations (CDCs) has been to pioneer an innovative approach to fighting poverty. Poverty is commonly associated with low education. Another study by Sampson (2004) reported that poverty and homelessness remain a problem, especially in urban American...
cities despite CDC successes. Black and impoverished communities faced serious challenges when attempts were made to gain equal shares of grant monies and government funds for basic public services (Sampson, 2004). The fact that many CDC clients in this study had higher education levels could be an implication that the opportunity exists to “break the cycle” with the educational level of these individuals. Many clients in this population have the ability to change their circumstances – they simply need the opportunity and the encouragement to do so. Further, this finding emphasizes the changing face of today’s community development clientele, reiterating the fact that many clients today are not necessarily dependent upon services provided by CDCs and possibly have options for alternatives. This made the anticipated concerns regarding low literacy and education levels not relevant.

Based on this finding and these conclusions, the researcher recommends that programs to make clients aware of opportunities be designed and made available. The researcher furthermore recommends that clients are encouraged to take advantage of these opportunities.

7. CDC clients have received services for less than two years.

This conclusion is based on the finding that 60.0% of respondents in this study indicated that they had participated in programs sponsored by their CDC for “under 2 years.” This could mean an implication that CDC programs are not well established in the South. This is consistent with the literature by Steinbach (2000), which iterated that states in the Northeast and Midwest had longer traditions of community organizing and had significantly more CDCs than the rest of the country until the mid-1980’s. There is a remarkable difference in the vast progress of CDCs in Northern areas compared to the elementary practices of CDCs in the South. This could also be an implication that
service programs are not making notable efforts towards exposure to the community and recruitment of clients. It is possible that CDCs in Baton Rouge and New Orleans do not have a solid history and therefore fail to attract and maintain clients who consistently and continually utilize the services. This finding could also imply that many clients of CDCs have not had enough time to experience CDC services or determine whether they are satisfied or not.

Based on this finding, the researcher recommends that CDCs seek ways to prolong the time invested by their clients into CDC programs. The researcher believes that the funding provided to CDCs is far too great for programs to be short lived and without accountability. The researcher additionally recommends that community development professionals use this knowledge in the planning of programs that will continue to positively affect and retain CDC clients statewide.
References


Louisiana Division of Administration. (2002). *Comprehensive needs assessment of low-income families in Louisiana: Volume two: Detailed findings*. Maximus


Development.


Appendix A: Survey Instrument

Survey of Louisiana Community Development Corporations — Services & Support

Your participation is essential to the effectiveness of the study. Factors which influence client satisfaction with the services of community development corporations. This survey will help inform us of your opinions and needs. It will possibly improve the housing services you receive. Please answer each question to the best of your knowledge. There will be only (1) one response per item, unless otherwise indicated. For fill in the blanks, please write legibly.

ABOUT YOU...

1. Please indicate your age as of your last birthday
   □ 18-25  □ 26-35  □ 36-45  □ 46-55  □ 56-64  □ 65+ years

2. Which of the following best describes you?
   □ White  □ Black  □ Hispanic  □ Asian  □ Other: ________________________________
   (please specify)

3. Are you:
   □ Male  □ Female

4. What is your marital status:
   □ Single  □ Married  □ Widowed  □ Divorced  □ Living with Partner  □ Other: ________________________________
   (please specify)

5. What is your annual household income?
   □ under $10,000  □ $10,001-$20,000  □ $20,001-$30,000  □ $30,001-$40,000  □ over $40,000

6. What is your highest level of education completed?
   □ Under 12th grade  □ High School Graduate  □ GED  □ Some College  □ College Graduate & Beyond

7. How many children under the age of 18 live with you? ________________________________
   (write # here)

8. Which of the following best describes those who live with you who are 18 or older?
   (check all that apply)
   □ Spouse  □ Domestic Partner  □ Grandparent  □ Adult Child
   □ Parent  □ Brother/Sister  □ Other: ________________________________

9. Which of the following best describes where you live?
   □ Urban  □ Suburban  □ Rural
   □ City  □ Country  □ Other: ________________________________

10. What region do you live in?
    □ Alexandria/Central  □ Baton Rouge/Southeast  □ Lafayette/Acadia
    □ Lake Charles/Southwest  □ Monroe/Northeast  □ New Orleans/Northshore
    □ Shreveport/Northwest  □ Houma/Thibodeaux  □ Other: ________________________________
11. How long have you participated in programs sponsored by your CDC?
☐ under 2 years    ☐ 2-5 years    ☐ 6-10 years    ☐ more than 10 years

12. Check and rate each service/program you have received from your CDC in the past 10 years. 
VD=Very Dissatisfied;  D=Dissatisfied;  N=Neutral;  S=Satisfied;  VS=Very Satisfied.

☐ Housing  (new and rehabilitated single family homes, multi-family homes, apartments, homebuyers’ assistance programs)

☐ Social Services  (services to teens, aid to needy families, childcare, employment assistance, food & clothing provision)

☐ Workforce Development  (Job training, computer training, workforce services, employment training)

☐ Educational Enrichment  (adult education, literacy programs, after school programs, tutoring, computer labs, childhood, daycare)

☐ Community Outreach  (transportation, senior/elderly programs, healthcare, substance abuse treatment, community service)

13. Have you participated in or received any of the following? (check all that apply)
☐ New home construction
☐ Home repair, weatherization
☐ Rental housing
☐ Co-op housing counseling
☐ Apartments
☐ Home owner counseling
☐ None of the Above
☐ Other: __________________________
   (please specify)

14. Were you satisfied with the housing services you received?  ☐ Yes  ☐ No
If no, why not? __________________________
   (please explain)

15. Is there anything you would change about your housing experience?  ☐ Yes  ☐ No
If yes, what? __________________________
   (please explain)

OVER
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<th>Rate Your Community Development Corporation (CDC). For each statement, indicate how much you agree or disagree. Check unsure if you have no opinion or are uncertain about the statement.</th>
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<tr>
<td>1. I am satisfied with the CDC's housing programs.</td>
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<tr>
<td>2. I am satisfied with the CDC's housing counselor.</td>
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<tr>
<td>3. I am satisfied with what I learned through the CDC about purchasing a home.</td>
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<tr>
<td>4. I am satisfied with credit counseling given by the CDC.</td>
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<tr>
<td>5. I am satisfied with the way CDC staff members do their jobs.</td>
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<tr>
<td>6. I am satisfied with the way the CDC communicates with me.</td>
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<tr>
<td>7. I am satisfied with what I learned through the CDC about budgeting.</td>
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<tr>
<td>8. I am satisfied with what the CDC taught me about the mortgage loan process.</td>
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<tr>
<td>9. I am satisfied with the way the CDC responds to my questions.</td>
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<tr>
<td>10. I am satisfied with the help I received from the CDC.</td>
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<tr>
<td>11. I am satisfied with what I learned through the CDC program about taking care of my home.</td>
</tr>
<tr>
<td>12. I am satisfied with the help I received from the CDC in making my housing affordable.</td>
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<tr>
<td>13. I am satisfied with the way the CDC has improved my community.</td>
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<tr>
<td>14. I am satisfied with the way the CDC follows-up after housing purchase.</td>
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<tr>
<td>15. List the top three programs/services offered by your CDC?</td>
</tr>
</tbody>
</table>

16. What new services would you like to see added to CDC?

17. Additional Comments:

Thank you for completing our survey!

Please mail to: (o)CDC Survey - P.O. Box 52846: Baton Rouge, LA 70892
From: xavier_briggs@harvard.edu
To: sharr17@paws.lsu.edu
CC:
Subject: Re: Request for information - Social effects of CD survey instrument
Date: Fri, 20 Aug 2004 17:09:35 -0400

Hi Shanta --

I promise to have a look for this in the coming week. The instrument may be hard to come by, I'm afraid. I got involved in the social effects study quite late, and my original assignment was merely to analyze and report on the ethnographic data. I didn't design the data collection or participate in it--that happened several years before I signed on--and I find that I have the data file in SPSS format for the survey component of the study, but I don't seem to have the questionnaire (instrument) in electronic copy.

Next week, I will see if it is in my hardcopy file for this project. If I don't have it, my co-author Elizabeth Mueller at UT Austin would be worth a try. She focused on the survey statistics and is more likely than I to have kept the survey instrument on hand. Or my other co-author, Mercer Sullivan, who designed the survey and who now teaches at Rutgers, I think. His files may be the best of all. I doubt that the Community Devt Research Center, where all this work was based 1989-1997, kept these files on hand after we all departed.

I'll see what I can turn up. Pls email me again in a week if you don't hear back. If you're in a hurry, contact Liz and Mercer now.

Best wishes -- Xav

Xavier de Sousa Briggs
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(voice) +1 617-496-2776 (fax) +1 617-496-6372

Director, The Art and Science of Community Problem-Solving Project at Harvard University
www.community-problem-solving.net
8/20/04

Dr. Briggs:

Hi! My name is Shanta Proctor, a doctoral student at Louisiana State University in Baton Rouge, Louisiana. I am conducting a study on "factors which influence constituent satisfaction with the services of community development corporations."

I am looking for the measures (instruments) you used in "From Neighborhood to Community: Evidence on the Social Effects of Community Development Corporations." Unfortunately, the links on the Aspen Roundtable website do not work at this time. I was referred to you by Dr. Anderson.

Can you provide me a copy of your surveys, including the 190-item survey used to collect data for that study? I would additionally like to schedule a time to call you and have conversation, for am I extremely impressed with your accomplishments. I appreciate your assistance.

Most Sincerely,

Shanta Harrison Proctor
Ph.D. Candidate
Louisiana State University
P.O. Box 52846
Baton Rouge, LA 70892
225.882.2333 (c)
225.219.9718 (o)
sharr17@lsu.edu
September 24, 2004

Mr. Lynn Ashley
Division of Housing and Neighborhood Development
Affordable Housing Bureau
1340 Poydras St., Ste. 1100
New Orleans, LA 70112

Dear Mr. Ashley:

This letter is written as a request for information on the housing population in New Orleans. I am currently conducting a study, “Factors which Influence Client Satisfaction with the Services of Community Development Corporations.” This study will explore the satisfaction levels of people who have received housing services directly from CDCs or through a referral. The information will also be disseminated to nonprofit development organizations after completion of the study.

I therefore humbly request the addresses of individuals in New Orleans who have received services from CDCs. The data that will be gathered is completely confidential, and individual level information will not be shared with community development staff or practitioners. Your help in this matter is greatly appreciated as we together make an effort to contribute to the existing body of knowledge in this field.

Respectfully,

[Signature]
Shanta Harrison Proctor
Student Researcher
Louisiana State University
Hello, Ms. Proctor:

How many times can we say “FINALLY”!?! Seriously, the attached list represents recipients of soft second mortgage assistance through New Orleans Affordable Housing, an agency the City funds for the above referenced program.

Those cases extend from 2001 through 2003 and total 330. In the few instances where the home buyer’s name is absent, I have lined through those cases. The lists, however, do not show any zip codes, so you will have to resort to a zip code directory for that data.

Please let me know if additional assistance is required.

From the desk of...
Lynn W. Ashley
Affordable Housing Bureau Chief
504-299-4864
Appendix C: IRB Exemption

IRB #: 2762    LSU Proposal #:    Revised: 03/24/2004

LSU INSTITUTIONAL REVIEW BOARD (IRB) for 578-8632 FAX 6792
HUMAN RESEARCH SUBJECT PROTECTION Office: 203 B-1 David Boyd Hall

APPLICATION FOR EXEMPTION FROM INSTITUTIONAL OVERSIGHT

Unless they are qualified as meeting the specific criteria for Study exempted
Institutional Review Board (IRB) oversight, ALL LSU research/projects involving living humans
as subjects, or samples or data obtained from humans, directly or indirectly, with or
without their consent, must be approved or exempted in advance by the LSU IRB. This form
helps the PI determine if a project may be exempted, and is used to request an exemption.

Instructions: Complete this form.

Exemption Applicant: If it appears that your study qualifies for exemption send:

(A) Two copies of this completed form,
(B) a brief project description (adequate to evaluate risks to subjects
and to explain your responses to Parts A & B),
(C) copies of all instruments to be used. If this proposal is part of a
grant proposal include a copy of the proposal and all recruitment
material.
(D) the consent form that you will use in the study
to: ONE screening committee member (listed at the end of this form) in the
most closely related department/discipline or to IRB office.

If exemption seems likely, submit it. If not, submit regular IRB
application. Help is available from Dr. Robert Mathews, 578-8632,
irb@lsu.edu or any screening committee member.

Principal Investigator Shanta Harrison-Proctor Student? Y/N

Ph: 225/774-7880 E-mail sharr17@lsu.edu Dept/Unit Human Resource
Education
If Student, name supervising professor Dr. Geraldine Johnson Ph: 578-2464
Mailing Address 142 Old Forestry Bldg., LSU Ph: 578-5748
Project Title Factors Which Influence Constituent Satisfaction with the
Services of Community Development Corporations

Agency expected to fund project
Subject pool (e.g. Psychology Students) Clients of Community Development
Corporations
Circle any "vulnerable populations" to be used: (children <18; the
mentally impaired, pregnant women, the aged, other). Projects with
incarcerated persons cannot be exempted.
I certify my responses are accurate and complete. If the project
scope or design is later changed I will resubmit for review. I will obtain
written approval from the Authorized Representative of all non-LSU
institutions in which the study is conducted.

PI Signature Shanta J. Proctor Date 9/1/04 (no per signatures)

Reviewing Committee Action: Exempted / Not Exempted Category/Paragraph

Mathews

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Part A: DETERMINATION OF "RESEARCH" and POTENTIAL FOR RISK

This section determines whether the project meets the Department of Health and Human Services definition of "research" and if not, whether it nevertheless presents more than "minimal risk" to humans that makes IRB review prudent and necessary.

1. Is the project a systematic investigation designed to develop or contribute to generalizable knowledge?

(Note "systematic investigation" includes "research development, testing and evaluation"; therefore some instructional development and service programs will include a "research" component).

☐ YES

☐ NO

2. Does the project present physical, psychological, social or legal risks to the participants reasonably expected to exceed those risks normally experienced in daily life or in routine diagnostic physical or psychological examination or testing? You must consider the consequences if individual data inadvertently become public.

☐ YES Stop. This research cannot be exempted--submit application for IRB review.

☐ NO Continue to see if research can be exempted from IRB oversight.

3. Are any of your participants incarcerated?

☐ YES Stop. This research cannot be exempted--submit application for IRB review.

☐ NO Continue to see if research can be exempted from IRB oversight.

4. Are you obtaining any health information from a health care provider that contains any of the identifiers listed below?

   A. Names
   B. Address: street address, city, county, precinct, ZIP code, and their equivalent geocodes. Exception for ZIP codes: The initial three digits of the ZIP Code may be used, if according to current publicly available data from the Bureau of the Census: (1) The geographic unit formed by combining all ZIP codes with the same three initial digits contains more than 20,000 people; and (2) the initial three digits of a ZIP code for all such geographic units containing 20,000 or fewer people is changed to '000'.

(Note: The 17 currently restricted 3-digit ZIP codes to be replaced with '000' include: 036, 059, 063, 102, 203, 556, 692, 790, 821, 823, 830, 831,
C. Dates related to individuals
   i. Birth date
   ii. Admission date
   iii. Discharge date
   iv. Date of death
   v. And all ages over 89 and all elements of dates (including year) indicative of such age. Such ages and elements may be aggregated into a single category of age 90 or older.
D. Telephone numbers;
E. Fax numbers;
F. Electronic mail addresses;
G. Social security numbers;
H. Medical record numbers; (including prescription numbers and clinical trial numbers)
I. Health plan beneficiary numbers;
J. Account numbers;
K. Certificate/license numbers;
L. Vehicle identifiers and serial numbers including license plate numbers;
M. Device identifiers and serial numbers;
N. Web Universal Resource Locators (URLs);
O. Internet Protocol (IP) address numbers;
P. Biometric identifiers, including finger and voice prints;
Q. Full face photographic images and any comparable images; and
R. Any other unique identifying number, characteristic, or code; except a code used for re-identification purposes; and
S. The facility does not have actual knowledge that the information could be used alone or in combination with other information to identify an individual who is the subject of the information.

☐ YES Stop. This research cannot be exempted—submit application for IRB review.
X NO Continue to see if research can be exempted from IRB oversight.

Part B: EXEMPTION CRITERIA FOR RESEARCH PROJECTS

Research is exemptable when all research methods are one or more of the following five categories. Check statements that apply to your study:

☐ 1. In education setting, research to evaluate normal educational practices.
2. For research not involving vulnerable people (prisoner, fetus, pregnancy, children, or mentally impaired): observe public behavior (including participatory observation), or do interviews or surveys or educational tests:

The research must also comply with one of the following:

either that

a) the participants cannot be identified, directly or statistically;

or that

b) the responses/observations could not harm participants if made public;

or that

c) federal statute(s) completely protect all participants' confidentiality;

or that

3. For research not involving vulnerable people (prisoner, fetus, pregnancy, children, or mentally impaired): observe public behavior (including participatory observation), or do interviews or surveys or educational tests:

• all respondents are elected, appointed, or candidates for public officials.

4. Uses only existing data, documents, records, or specimens properly obtained.

The research must also comply with one of the following:

either that:

a) subjects cannot be identified in the research data directly or statistically, and no-one can trace back from research data to identify a participant;

or that

b) the sources are publicly available

5. Research or demonstration service/care programs, e.g. health care delivery.

The research must also comply with all of the following:

a) It is directly conducted or approved by the head of a US Govt. department or agency.
and that

b) it concerns only issues under usual administrative control (48 Fed Reg 9268-9), e.g., regulations, eligibility, services, or delivery systems;

and that

c) its research/evaluation methods are also exempt from IRB review.

6. For research not involving vulnerable volunteers [see "2 & 3" above], do food research to evaluate quality, taste, or consumer acceptance. The research must also comply with one of the following:

either that

a) the food has no additives;

or that

b) the food is certified safe by the USDA, FDA, or EPA.

NOTE: Copies of your IRB stamped consent form must be used in obtaining consent. Even when exempted, the researcher is required to exercise prudence in protecting the interests of research subjects, obtain informed consent if appropriate, and must conform to the Ethical Principles and Guidelines for the Protection of Human Subjects (Belmont Report), 45 CFR 46, and LSU Guide to Informed Consent; (Available from OSP or http://app1022.lsu.edu/osp/osp.nsf/3Content/LSU%20IRB%20Documents)

HUMAN SUBJECTS SCREENING COMMITTEE MEMBERS can assist & review:

COLLEGE OF ARTS AND SCIENCES: MASS COMMUN/SOC WK/AG:
Dr. Noell * (Psych) 578-4119 Dr. Nelson (Mass C)
578-6686
Dr. Geiselman * (Psych) 763-2695 Dr. Archambeault (Soc Wk)
8-1374
Dr. Beggs (Socio) 578-1119 Dr. Rose (Soc
Wk) 578-1015
Dr. Honeycutt (Comm. Stu.) 578-6676 Dr. Keenan* (Hum Ecol)
578-1708
Dr. Dixit (Comm Sc./Dis) 578-3938 Dr. Belleau (Hum Ecol)
578-1533

ED/LIBRARIES/INFO SCI BUSINESS
Dr. Kleiner (Middleton) 578-2217 Dr. Biswas (Marketing)
578-8818
Dr. Culross (Education) 578-2254
Dr. Landin* (Kinesiol) 578-2916
Dr. MacGregor (ELRC) 578-2150
Dr. Munro* (Curric & I) 578-2352
(* = IRB member)
Appendix D: Cover Letter

September, 2004

Dear Sir or Madam:

Research on client satisfaction of Community Development Corporations (CDCs) is not very common. CDCs provide a wide variety of services. For example, homebuyers' assistance programs, employment assistance, tutoring, computer training, and community service, to name a few. You were selected to participate in this study because you have either graduated from a homebuyer education program, received services from a CDC directly, or because of a referral.

The attached survey will be used to gather your opinions and needs as it relates to the services of CDCs. The research will be used as an indicator to CDCs on what they are doing right, versus what they can improve.

The information you provide is completely confidential. Your answers will not be shared with the staff members of CDCs. We as community development specialists basically would like to know if what we are doing is effective. We also are interested in what people in Louisiana can do to make our communities better.

Your input is important. Please complete the survey and return in the self-addressed stamped envelope no later than October 15th. The survey is only 3 pages long and should take about 10 minutes to complete. Thank you for taking time out to help yourself and others.

Sincerely,

Shanta Harrison Proctor
Student Researcher
This card is sent to remind you that we have not received your response for the Survey of Louisiana Community Development Corporations. The survey was mailed 3 weeks ago, and we are really interested in hearing from you. We need you to mail the completed survey in the self-addressed & stamped envelope that was provided. Or, if it would be more convenient, you could submit your answers by telephone—simply call it in! Your input is very important, thanks for your time.

To answer survey by telephone, please call 225-692-2333.
Appendix F: Telephone Survey Script

Good Morning/Afternoon. My name is Shanta Proctor from the School of Human Resource Education at LSU in Baton Rouge.

May I speak with (Mr. or Ms.) (Last Name)

Good Morning /Afternoon (Mr. or Ms.) (Last Name)

I’m calling about the survey of Louisiana community development corporations that we sent to you. Have you received it?

A. If no ....... Do you mind taking a few minutes to answer the survey over the telephone or would you rather I send you another one?

If the person requests another survey sent, verify the address and send another. (Continue with script).

B. If yes ....... The reason I am calling is because your response is very important to me and the results of my study that will help our communities. Do you mind taking a few minutes to complete the survey now?

C. If yes ....... Ask all the questions on the survey.

Thank you very much. I truly appreciate you taking out time to answer the survey.

Thank the client and end the conversation.

D. If no ....... Would you rather I call you back at another time?

F. If yes ....... When would be a good time to call back? (Make return call).

F. If no ....... Do you mind taking a few minutes to fill out the survey and return it to me in the self-addressed stamped envelope?

Thank the client and end the conversation, regardless of response preference.
Appendix G: Housing Changes Indicated by Respondents

To the “If yes, what?” portion of the survey item which addressed change about housing experience, respondents identified changes such as:

“I would change the unhospitable attitudes of the staff, it is bad for business”;  
“Good management, or better”;  
“There is a ditch in front of my house that wasn’t covered up and it should have [been].”;  
“I would have purchased a home earlier in life”;  
“Make the contact info, and the correct info available to those in need – it can be and was very discouraging receiving the wrong info and getting the run around;”  
“Communicate with a different person who will call me back”;  
“Quicker response time”;  
“Being able to use housing certificate”;  
“I would have took the time to become more knowledgeable about the home I got. Because it needs more repairs than I can afford to pay!”;  
“Monitor very closely the floors and walls. We had to repaint the walls, clean the paneling and when the carpet was cleaned the carpet had cigarette burns in it”;  
“I would fire the bulk of the people that work there and hire intelligent people that are trained and kind”;  
“The attitudes (very negative) of employees. They feel as though they can talk to you any way and they can do anything to you”;  
“When someone moves out I think that they should give them a new stove, refrigerator and new carpet”;
“That they be more sensitive to the needs of their clients”;

“Save more money for a down payment on a better house/ neighborhood”;

“ I was asked to wait a month or so (before moving in) so necessary repairs could be made as they were not complete (i.e.: bath, etc.)”;

“Should have updated home – air conditioning, refrigerator, stove, water heater, etc”;

“More counseling”;

“Different contractors”;

“Need follow-ups after purchasing house ( I did not receive)”;

“I was unable to use my homeowners’ certificate due to buying in Denham Springs”;

“We need washer and dryer outlets or a laundry mat in our facility”;

“A place where children can play and more activities for them”;

“Get something in writing about whenever there is a maintenance problem – fix the problem as soon as possible”;

“These houses are being put up too fast and things are falling apart”;

“Make sure my credit record is clear before trying to purchase or qualifying to purchase a house”;

“They should ask the people that are buying homes what they would like done in the home”;
Vita

Shanta Harrison-Proctor is a native of Baton Rouge, Louisiana. She is married to William J. Proctor III, who works as a site director for the Federal Emergency Management Agency and owns a photography business. They are the parents of three daughters, Kaitlynn, Cassia, and Kristen. Shanta is the daughter of Patricia and the late Walter L. Harrison, Sr. She a graduate of Glen Oaks High School and received a Bachelor of Arts degree in political science from Southern University and A&M College in 1999. Shanta earned a master’s degree in vocational education from Louisiana State University in 2002.

Shanta’s professional career includes a wide array of experiences. While working on her degree in political science, she worked as a researcher with the Louisiana State Senate, where she remained for five years. She student taught at LSU during the spring 2002 semester, under the leadership of her major professor, Dr. Geraldine Johnson. Since that time, she has done contract work with non-profit organizations in the Baton Rouge area. She is currently an employee of the Governor’s Office in the State of Louisiana working in Women’s Policy as a Policy Analyst and Webmaster.

Mrs. Proctor has received numerous awards and is involved with many extracurricular activities. Shanta works as a private consultant and has performed program evaluations on local nonprofit organizations. She is heavily involved in Anointed Life, her local church where she formerly worked as Program Coordinator and assumes numerous leadership roles. Shanta was a recipient of the Huel Perkins Doctoral Fellowship at LSU. She is additionally a member of The Compact for Faculty Diversity, was honored as a Southern Regional Education Board Doctoral Scholar, was
awarded a Louisiana Higher Education Award, is a member of the LSU Alumni Association, and is a volunteer with the LSU Community University Partnership (CUP).

The degree of Doctor of Philosophy will be conferred on Shanta at the August 2006 Commencement.