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Assessing clients' satisfaction with psychological services: Development of a multidimensional Client Satisfaction Survey Questionnaire*

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The aim of this project was to develop a client satisfaction questionnaire that would enable users' views to be incorporated in service evaluation.

Client satisfaction surveys and other quality assurance methods are described and discussed and some related issues are outlined. The development, piloting and use of a new and multi-dimensional client satisfaction survey questionnaire with clients of the specific adult mental health (AMH) service are presented, analysed and discussed.

The study utilised a number of experts (colleagues, client-volunteers, supervisors, administrative manager, Community Health Council) in order to investigate face and content validity of the new scale. To investigate test-retest reliability, the questionnaire was administered twice within two weeks to the same clients (N_1=61, N_2=45).

Results indicate that the new client satisfaction questionnaire (CSSQ-C) is a valid instrument with good psychometric properties (internal and test-retest reliability).

Context and historical perspective

IN THE LAST DECADES UK HEALTH policy has been concerned with quality, evaluation and satisfaction. This may stem from adoption of successful private practices, practitioners' concerns about improvement, pressures from patients and their families and governmental support for quality assurance activity (Lavender, Leiper, Pilling & Clifford, 1994; Stallard, 1996). In 1980s and 1990s, the government and various papers within the National Health Service (NHS)/Department of Health, such as the Griffiths' Report (Griffiths, 1983), the Patients' Charter (Trinder, Mitchell, Newnes & Todd, 1994) and College of Health (1998) redressed the balance of power between providers and receivers and advocated consumers' engagement in service evaluation. Relevant literature (Stallard & Chadwick, 1991) and users' movements have further contributed to the progress in this area. The political and professional climate, such as consumerism and market economy (Stallard, 1996), accountability, semi-commercialisation of the NHS (Murray & Hewitt, 1996) and attempts to respond to clients' needs (Williams & Wilkinson, 1995) have resulted in patients' perceptions, expectations and satisfaction with the system becoming relevant to the development of standards, services and policies. The benefits of involving patients in service evaluation/clinical audit include patients' improved morale and relationships with staff, and their greater influence and sense of ownership of services (College of Health, 1998). The trend of service evaluation has become an important aspect of clinical governance, incorporated in most psychology departments within the NHS (Squier, 1994), and unmonitored therapeutic practice has become unacceptable (Parry, 1992).

* A copy of the complete questionnaire may be obtained from the first author.

Methods of evaluating, monitoring and improving the quality of services

Evaluations of service delivery vary in their complexity, expense, inclusiveness, specificity and representativeness. For example, Parry (1992) specifies service evaluation, operational research, quality assurance, total quality management, audit (service, professional or medical), and their combinations. Lavender *et al.* (1994) distinguished between internal (led by internal standards and staff and disregardful of the wider picture) and external (led by more formal assessment and external staff and standards) reviews of services, both necessary. *Internal review procedures* include professional supervision, appraisal systems, audit, clinical review meetings, peer review, case discussion/presentations and quality circle. *External review procedures* include inspectorates/committees, programme evaluation based on outcome measures, standard-based approaches, individual case review and case management monitoring, organisational development consultancy, consumer representative on planning groups and *service satisfaction surveys*. Some of key issues associated with service evaluation are its difference from applied research, commissioning, ethics, a need for specific research methods or skills, 'multi-factor' outcomes and a multidisciplinary approach, ensuring appropriate feedback, anticipation of changes, compatibility of monitoring and improvement (Turpin, 1994; Lavender *et al.*, 1994).

Clients' involvement varies, from establishing satisfaction and baselines to planning services and promoting effectiveness (College of Health, 1998). It also entails being involved formally (through committees) or informally (via the media), or as subjects of data collection. No final advantage was established between direct ('How satisfied…?') or indirect questions ('Did your therapist understand…?'), interview or questionnaire, census or sample (Fitzpatrick, 1992a, 1992b).

In addition to current clients, some comprehensive approaches simultaneously gather information from past clients (e.g. continuously, on a monthly basis; Damkot *et al.*, 1983), patients' relatives/cares and relevant professionals (e.g. Ruggery & Dall' Agnola, 1993) or a person unconnected with the care of users (Trinder, Mitchell & Todd, 1994). Specifically relating to psychotherapy outcome, Barkham *et al.* (1998) suggested the use of a routine, core and standardised battery (CORE). This involves clients' pre- and post-therapy completion of a psychometric instrument which aims to assess their symptoms, distress, functioning and risk. Therapists are required to complete their pre- and post-therapy assessment forms related to their clients' motivation, types of treatment, etc. However, this comprehensive assessment does not tap into clients' views of their services and relevant engagement and satisfaction.

Client satisfaction surveys

Until the 1970s client satisfaction, defined as 'the extent to which treatment gratifies the wants, wishes, and desires of clients' (Lebow, 1982), was believed to be unrelated to service quality and outcome (Damkot, Pandiani & Gordon, 1983). However, having been introduced by health managers (Fitzpatrick, 1992b), subsequently recommended by the government, well-accepted by users and promoted by professional bodies (College of Health, 1998), client satisfaction surveys have become linked to service quality, outcome (Damkot, Pandiani & Gordon, 1983; Parry, 1992; Cape, 1995), i.e. clinical effectiveness and service improvement (Dagnan & Fish, 1991) and thus clinical governance. Despite poor methodological bases (Stallard, 1996) and a frequent lack of explanations for what needs improving (Williams & Wilkinson, 1995), this influential (College of Health, 1998), external review procedure (Lavender *et al.*, 1994) has become a systematically studied (Larsen, Attkisson, Hargreaves & Nguyen, 1979; Stallard & Chadwick, 1991) and most commonly used method of reviewing services (Stallard, 1996).

As a form of audit ('consumer audit'; Spencer, 1995) and systematic critical analysis of the quality of medical care (Parry, 1992; Cape, 1995), a client satisfaction survey aims at finding out if certain practices meet some pre-set standards (Paxton, 1995). With its quantitative and qualitative data that recommend specific changes (Trinder *et al.*, 1994), it remains an economical (Fitzpatrick, 1992a) and systematic way of demonstrating concern for consumers' involvement (Williams & Wilkinson, 1995; Hutchings & Pope, 1998), satisfaction (Fitzpatrick, 1993), care and services' improvement (Dagnan & Fish, 1991). Policies and managers that encourage user participation may, therefore, be desirable.

Both outcome (including knowledge, attitudes, behaviours, and consensus between the therapist and clients; Dagnan & Fish, 1991) and client satisfaction are complex, distinct (Hutchings & Pope, 1998; Stallard & Chadwick, 1991) but somewhat intertwined variables. Though there was no relationship between client satisfaction with resources and improvement (Hutchings & Pope, 1998; Squier, 1994; Stallard, 1996), the power of (satisfactory) therapeutic relationship in predicting outcome has been noted (Brunning, 1992; Hutchings & Pope, 1998). Not surprisingly, audits are becoming a significant component of clinical effectiveness and focusing on multi-factors.

The determinants of satisfaction are context specific and multi-dimensional (Stallard, 1996; Brunning, 1992; Fitzpatrick, 1992a; Squier, 1994). Usually three (e.g., Squier, 1994) or four (e.g. Brunning, 1992) but also up to 11 dimensions (humaneness, informativeness, overall quality, competence, bureaucracy, access, cost, facilities, outcome, continuity, attention to psychosocial problems; Fitzpatrick, 1992a) of client satisfaction have been identified. Reducing the complexity of client satisfaction to broad dimensions has inherent problems, and the construction of a uni-dimensional and multi-purpose general satisfaction questionnaire is unachievable (Stallard, 1996).

Consumer satisfaction surveys with multi-dimensional measures, i.e. Likert summed scales (Fitzpatrick 1992a, 1993), are more reliable, precise and discriminative than individual items with 'yes-no' or 'yes-unsure-no' (e.g. Squier, 1994) answers. With additional open-ended questions they produce the most useful data (Damkot *et al.*, 1983; Frith-Cozens, 1993) and are in the best position to comment on certain aspect of services, e.g. 'acceptability of treatment' (Firth-Cozens, 1993). It appears that consumers/clients' opinions are a necessary element of self-review, service and programme evaluation, planning and development (Damkot *et al.*, 1983) and outcome (Stallard, 1996).

The study

Specific problems and study objectives

The *specific* aim of this study was to develop an accepted and valid *(qualitative objectives)*, internally consistent and test-retest reliable *(quantitative objectives)* multidimensional scale to assess client satisfaction with a specific service (AMH Specialty within the Department of Psychological Services). The new questionnaire should be a theory-free, empirical/pan-theoretical measure in which the construct 'satisfaction' is defined only by its items. It should overcome some shortcomings of previous measures and enable successive within-service comparison. Other questionnaires are not applicable to this specific environment, are outdated or lack discriminative power, a full range of responses, validity and/or reliability, i.e. standardisation (Larsen *et al.*, 1979; Fitzpatrick, 1992a; Stallard, 1996). For example, the previous Departmental questionnaire was atheoretical, disorganised, with no reported psychometric characteristics and dated. Even in the 'best candidates' questionnaires, questions sometimes appear imprecise (e.g. about the suitability of place of appointment) and are more likely to elicit responses about the behaviours of referring agents than of psychology services (see Squier, 1994). Also, the range of response

options sometimes appears incomplete with a positive bias (see Larsen *et al.*, 1979) that could only result in the 'skewed' picture.

The new questionnaire aims to improve its relevance for clients by involving them in its design, to increase the usefulness of data and response rate by offering a simple multi-choice response set, episode-specific and open-ended questions/comments and to incorporate more recent findings about the relevant surveys and ongoing service change.

Method

Preliminary/Qualitative investigations

A comprehensive, 37-item satisfaction survey questionnaire, developed by colleagues (1990, unpublished) at the Department, was used as the starting point in developing the new questionnaire. Many relevant changes of this outdated questionnaire (and the item pool of 60 questions) took place, including an increase in the questions' discriminative power by using a five-point scale. Eight questions were excluded (e.g. two for concerning GPs' rather than the Department's Service, two for being repetitious with a different scale), some modified, and several new ones, as well as place for comments were added.

Squier's (1994) Client Satisfaction Survey Questionnaire was consulted and the new measure became organised into sections and subsections, with a fourth section ('general satisfaction') being added. Several questions concerning therapeutic relationship and outcome from Squier's (1994) questionnaire were shortened and changed to a five-point scale response format; the term 'clinical psychologist' was replaced by 'therapist', to accommodate various helping professionals (e.g. psychologists, counsellors). One question was adapted ('counsellor' to 'therapist') and another modified (from asking directly to asking indirectly) versions of two questions from Damkot *et al.* (1983) Client Satisfaction Survey Questionnaire. Furthermore, two questions, one from the Service Evaluation Questionnaire (Blakey, Sinclair & Taylor, 1994) and another from Larsen *et al.* (1979) Client Satisfaction Scale, were shortened and changed to a five-point scale response format.

The newly-developed questions particularly aimed to elicit more information about clients' background/socio-demographic data, appointments, the type of therapist (e.g. counsellors) and to accommodate new, specific circumstances (e.g. providing information on nature of therapy).

Investigations of the likely *acceptability* of the new questionnaire were undertaken using several professional and administrative colleagues. To ensure *face and content* validity, the early versions of the questionnaire were tested, investigated and discussed with a range of 'experts' (five clients/outpatient-volunteers, two ex-clients, five counsellors, four clinical psychologists, one clinical/counselling psychologist, one counselling psychologist-trainee, administrative manager, the Chief Officer of the local Community Health Council, a statistician and an university lecturer), resulting in various changes.

Main study

Participants

The target, main *(test-retest)* participant group came from the AMH clients. Sixty-one clients consented, completed and returned the questionnaire at Time 1. Subsequently, 45 of them returned a second questionnaire at Time 2. They were all clients of the participating therapists (three counsellors, one clinical psychologist, one clinical/counselling psychologist, one counselling psychologist-trainee), with the selection of therapist-participants being dictated by the employment situation. The inclusion criterion for clients was frequency of appointment (i.e. only those seen on a weekly or a fortnightly basis); the exclusion criterion was clients presenting with acute or psychotic-type crisis (no such clients were reported).

Measure

The first two ('auxiliary') sections of the new questionnaire concern basic background information of clients, health status, the type of therapist they saw and their appointments

with the Department. Because of ethical reasons (i.e. to remain open), this was placed at the beginning rather than hidden at the end of the questionnaire, the latter suggested by Oppenheim (1992).

The main questions are divided into principle sections/summed scales: *Evaluation of Service Contact* (consisting of 11 questions organised in four subsections: Information to Clients, Appointment Systems, Public Areas/Reception, Reception Staff/Contacts), *Evaluation of the Therapist* (13 questions), *Evaluation of the Outcome* (eight questions) and *General Satisfaction* (three questions). Altogether, there are seven open-ended questions (about information to clients, appointment system, therapeutic relationship, outcome and the Service in general) and a place for comments attached to each subsection.

The principal response format is forced-choice five-point, bipolar quality rating scale. Questions usually ask directly about the level of satisfaction (Very unsatisfactory, Quite unsatisfactory, Uncertain, Quite satisfactory, Very satisfactory). In order to maximise ease of completion, no attempt was made to counteract a possible (consistent direction) response-set halo effect by randomisation of the direction of the scale, as previously suggested (Oppenheim, 1992; Fitzpatrick, 1992).

Procedure

Therapists/administrators of the questionnaire received a brief training to learn how to introduce and conduct their administration and maintain neutrality and confidentiality, and were given written instructions ('reminder').

Prior to the questionnaire administration, all participants were given an information sheet by their therapists which explained the voluntary and anonymous nature of the study and other relevant details, and expressed gratitude for their participation; the same paper included a consent form that needed signing.

To calculate test-retest reliability, the same questionnaire was administered to participants by their therapist twice within two weeks: once at the end and, again, at the beginning of another therapy session. No names were required on the questionnaires but to enable the first and second responses to be matched, all participants were asked to include the same anonymous code with both questionnaires. The main instructions requested them to tick the most appropriate response of those offered and encouraged them to reply to every question and to use the space for comments.

Upon leaving the appointment, the participants gave their completed questionnaires to the receptionists, while their consent forms stayed with their therapist (thus stored separately from the completed questionnaires). The completed and collected questionnaires were given to the researcher in batches; neither the therapists nor the receptionists (or researcher) were able to link the consent forms and the questionnaires.

Data analysis

The responses were qualitatively interpreted and quantitatively analysed using the SPSS data analysis system (SPSS, 1998).

Participants groups were compared and demographic characteristics were analysed using means and frequency counts.

Each closed item on the questionnaire (evaluation sections) was treated as 'pseudo-interval' scale and parametric (e.g. Larsen *et al.*, 1979), with a score ranging from 1 (Very dissatisfied or its equivalent) to 5 (Very Satisfied or its equivalent). A total satisfaction score was calculated for each subscale by summing the item scores; the higher the score, the higher the satisfaction level.

Missing responses to items on the questionnaire were not imputed; instead, they were omitted from the analysis, as their contribution to satisfaction remains ambiguous.

Indices of internal consistency reliability (Cronbach's alpha) and score test-retest stability (Pearson correlation) were computed across the four subscales within the questionnaire.

Open-ended responses/comments were classified within the four subscale domains of the questionnaire and within four types: positive, negative, inaccessible and constructive remarks.

Results and discussion

Response rate

Of 65 clients approached to participate in the study, 61 (94 per cent) completed the questionnaire at Time 1. (By selecting all clients of the participating therapists, any biased sampling on this level has been avoided.) Forty-five (74 per cent) of the respondents, i.e. 69 per cent of those approached, also completed the questionnaire at Time 2.

A loss of 16 (26 per cent) clients between Time 1 and Time 2 may be partly explained by the participants' cancellations and non-attendances; similar rates are reported elsewhere (Shalan & Palmer, 1998). Unknown differences between respondents and non-respondents, i.e. positive sampling biases due to high drop-out, may interfere with the interpretation of results but no significant difference is observed in distributions of the participants' gender, problems' severity and age at Time 1 and Time 2.

The obtained response rate is high, bearing in mind that, for just one questionnaire, response rates are usually about 50 per cent, ranging from 21 per cent to 85 per cent (Stallard, 1996). The combination of guaranteed anonymity and confidentiality, direct contact, the possibility of clarifying any item ambiguities as well as the participants' current semi-dependent status and wish to please (as once demonstrated by Trinder, Mitchell, Newnes & Todd, 1994) are likely to have contributed to the response rate. Every effort was made for the instrument to be attractively set out and no attempt was made to counteract a possible response set halo effect by randomisation of the direction of the scale, as previously suggested (Oppenheim, 1992; Fitzpatrick, 1992); these have made the questionnaire more user friendly and maximised ease of completion and the return rate.

Socio-demographic and health information

The majority (70 per cent) of participants were females (similar to that expected nationally; e.g. Kellett, Newman & Beail, 1999), with both gender having moderate to disabling problems (approx. 96 to 98 per cent) and being aged 16 to 56 (97 to 98 per cent). Comparing with the general population in Cumbria (Office for National Statistics, 2000a; 2000b), fewer client-participants in this study are in employment (77 per cent) and romantic relationship (80 per cent). As this sample was one third of all clients attending the AMH during the study duration, it is assumed that the client sample used is representative of the range of score of the total population of clients of the Department's AMH Service.

It has been found that different groups express different levels of satisfaction (Fitzpatrick, 1992a; William & Wilkinson, 1995); these findings justify the inclusion of questions relating to background information and health status in satisfaction questionnaires.

Qualitative objectives

Acceptability and clarity

Client-volunteers' involvement in the questionnaire design, i.e. wording of questions has been helpful. Their positive reactions to the questionnaire, a high response rate, no direct refusals and the absence of reported discomfort, difficulties and negative reactions to the questionnaire indicate satisfactory acceptability and clarity. However, despite efforts to minimise social desirability in the information sheet, clients' wish to please has perhaps been elevated by the direct involvement and presence of the therapist during the completion of the questionnaires.

Face and content validity

As judged by positive reactions and the substantive agreement between all relevant parties with regard to relevance, comprehensiveness, dimensionality and usefulness,

the new instrument's questions have appeared to be pertinent and appropriate (face validity) and cover relevant areas (content validity). (Unfortunately, relating to environmental specificity, other ways of measuring validity are difficult to examine and obtain.)

No additional questions or areas were suggested but various improvements resulted from feedback. Repetitive and irrelevant questions were deleted, questions were simplified by replacing technical jargon with more common terms, and suggestions relating to instructions, wording, readability, layout and length were incorporated.

Quantitative objectives

Internal consistency reliability

Internal consistency reliability for each of the four subscales of the new measure at both Time 1 and Time 2 is greater than 0.80 (Table 1). Given the number of items are relatively few in each of the four subscales, these alpha coefficients are very satisfactory. This indicates homogeneity of meaning of each four subscales and justifies their inclusion, i.e. multi-scale approach.

Test-retest reliability

The high correlations for the data obtained on all four subscales (Table 2) indicate the questionnaire's satisfactory test-retest reliability. (The number of cases varies slightly between analyses because of some specific missing data from some clients. Furthermore, Spearman rho, as a conservative check on the value of a Pearson *r*, was also computed and found to be very similar, i.e. 0.766 to 0.881, to the calculated Pearson *r*.)

The meaning of client satisfaction is here construed as a relatively fixed attribute, with the construct hypothesised to possess high stability over time (two weeks). (As all participants were undergoing therapy that was directed at inducing changed perceptions, one may ask whether it makes sense to expect high test-retest reliability.)

Open-ended questions and comments

Both open-ended questions and comments have appeared fruitful and justified their inclusion; some dissatisfaction with the Service was particularly observed in them. They have produced spontaneous answers, information and suggestions to be further investigated and potentially implemented. Altogether only four participants (six at Time 1) have not replied to any of the open-ended questions; 27 (23 at Time 1) have used space for comments provided after each section (up to four times). The majority of open answers/comments concerned therapeutic relationship and was positive, which raises the question of the relative importance of therapists' quality.

Client satisfaction/Normative data

Given the purpose of this study and limited space, some preliminary investigations of the level of client satisfaction within the Department's AMH Specialty are not presented here. In short, the results showed some similarities with other client satisfaction instruments, e.g. more variation in answers to episode-specific questions (e.g. Fitzpatrick, 1992b) and an overall positive bias and poor discriminability (e.g. Bucknall, 1994). Positive comments usually referred to therapists' quality and activities that inspired openness, and negative concerned physical environment.

Items were frequently (e.g. 71 per cent of respondents' rating on Subscale B/Time 1) rated 5 (very satisfactory) but were rarely rated 1 (very unsatisfactory) or 2 (unsatisfactory). That no items were rated unsatisfactory on the subscale D/General Satisfaction confirms findings (e.g. Fitzpatrick, 1992b) that episode-specific questions result in more variation in answers and enable easier comparison.

General discussion about the questionnaire

The need for such questionnaires may be becoming more prevalent within the context of clinical governance but not everybody supports their use. For example, one non-

Table 1: Internal consistency reliability analysis of subscales (coefficient alpha).

Subscale	*N* of Items	Time 1		Time 2	
		N of Cases	Alpha	*N* of Cases	Alpha
1. Service Contact	11	55	.864	43	.834
2. Therapeutic Relationship	13	55	.835	43	.933
3. Outcome Benefit	8	57	.914	45	.909
4. General Satisfaction	3	60	.849	45	.858

Table 2: Test-retest reliability analysis of subscales (Pearson correlation).

Subscale	*N* of Cases	Pearson *r*	Statistical significance (2-tailed)
1. Service Contact	43	.739	$p<0.01$
2. Therapeutic Relationship	43	.840	$p<0.01$
3. Outcome Benefit	44	.871	$p<0.01$
4. General Satisfaction	45	.815	$p<0.01$

participating therapist told the researcher that 'this sort of study may detract clients from the feel of counselling'. Reported mixed feelings, negative assumptions and therapists' objections to patients satisfaction surveys usually revolve around concerns that the questionnaire may interfere with the therapeutic relationship, or that they may consist of ill-considered answers and uncover widespread dissatisfaction (Fitzpatrick, 1992a), or be a way to check up on professionals (Spencer, 1995) by managers responsible for performance indicators. Sometimes, the needs of relevant parties may indeed be contradictory (Parry, 1992), which may result in low relevance of satisfaction data for management (Larsen *et al.*, 1979), negative views on consumers/patients as competent evaluators (Stallard, 1996) and lack of reports on the implementation of changes following the user participation (Cape, 1995; Stallard, 1996).

Limitations of the study and future recommendations

Some *limitations of the study* need emphasising. Three per cent of the AMH annual referrals were sampled in this study; this is relatively small. It might be of value to consider somewhat larger (e.g. 10 per cent) sample which would require 200 clients and all therapists but would yield data more representative of the AMH client population. Two therapists' (both counsellors) unforeseen absences from work reduced the data available for a meaningful comparison of response rate between clients of different professional groups. Permitting the satisfactory number of participants, all sort of subgroup analysis may take place in the future, e.g. comparing satisfaction of clients of different therapists (e.g. psychologist vs. CBT therapist, 'technique-centred' vs 'client-centred'), or of those attending different places of appointments.

It is not always easy to transfer client dis/satisfaction into descriptive statistics (Williams & Wilkinson, 1995); the accuracy of the paper and pencil methods, subjective self-report measures and the meanings of Likert scales results (Oppenheim, 1992) are some of the general issues. So, the present results provide some baseline data about satisfaction though the same quantitative results may have different meaning (Oppenheim, 1992). The findings could not be generalised to other services; between-service comparisons are almost impossible (Stallard, 1996). However, the comparison can be made within the specific service (time-series analyses); if the same questionnaire, time of its administration, sampling and contacting methods are used, then even somewhat general between-service comparison may be possible.

The consistent direction of the scale appears to be a more desirable and helpful format for participants, particularly for those who are rushed, impatient and with poor literacy skills. However, this could also result in a response set halo effect.

Despite efforts to minimise bias (e.g. encouraging choice and openness, reassuring), the distribution of client satisfaction showed an overall positive bias. Similar high levels of reported satisfaction and social desirability (and thus poor variation) have been reported elsewhere (e.g. Bucknall, 1994; Fitzpatrick, 1992a). In this study the problem may be compounded by the presence of the (participating) therapist during the data collection and the choice of sample in that the participants were currently in therapy. The importance of the therapeutic relationship may result in the clients' inhibition to express dissatisfaction with other aspects of services (e.g. physical resources). Although anonymous, user expectation (Stallard, 1996) may be a relevant factor; the participants' positive responses may indicate that they perceive their expression of dissatisfaction as being risky and negative. So, high total satisfaction needs to be treated with caution as it has been obtained within specific context. A postal application of the questionnaire may secure higher level of anonymity and maybe more honest answers but such applications are known to compromise response rate (Stallard, 1996). The use of external assessment agency would be most helpful with the issue of the researchers using their own clients but this would be an expensive answer for the NHS.

Satisfaction could be assessed after assessment, during treatment, from shortly after to a few years after discharge, the latter being associated with memory distortion, recall bias and a possibility of outdated data (Stallard, 1996). A majority of participants here were in mid-therapy (during care); this may make the questionnaire more sensitive to dissatisfaction but prohibits calculation of association between satisfaction and outcome. In line with this, several clients therefore found a few questions on the subscale C/Outcome Benefit non-applicable, as if these questions are only appropriate for the users at the point of their discharge.

Regarding the future direction, as the current sample size was too low for a definite factor analysis, the aim of another project is to obtain sufficient numbers of cases (e.g. at least 100 or ideally 200) for a confirmatory factor analysis. In a recent development, using the questionnaire, all clients of all AMH-therapists have been asked to participate at the time of discharge; sampling responses thus may enable better insight into outcomes. The assessment of their satisfaction with the service provides a good basis for a within-service comparison. Normative data collected here may provide a starting point to this comparison. Using some additional, objective indices (e.g. therapeutic ending, non-attendance), external reviews and post-questionnaire interviews with a small sample of clients would be of further use in measuring satisfaction with the service.

Conclusion

By working together, patients/clients, clinicians, managers and wider community may achieve the best improvement, effectiveness, efficacy and satisfaction; focusing on both effectiveness and satisfaction seems the most appropriate.

Providing a service that is accessible, comprehensive and of high quality meets the needs of all agencies involved. Quantifying satisfaction with specific aspects of services, as well as collecting qualitative data, contribute to assuring quality of services and is beneficial to both service users and providers.

The current questionnaire possesses satisfactory face and content validity and good psychometric properties (internal and test-retest reliability). It appears to be a well accepted, useful and both a specific and general four-dimensional measure of client satisfaction used within the Department of Psychological Services' AMH Specialty.

It can be easily completed in 10 to 20 minutes and may be adapted to other similar psychology departments and contribute to within-service comparisons.

Some of the findings (such as multi-dimensionality of client satisfaction and high levels of reported satisfaction with the service received) are reflective of findings in the literature.

Data provided may be utilised for assuring quality of services/governance, for both clinical (e.g. data on problem's severity, therapeutic relationship, outcome) and organisational (e.g. physical environment, waiting time) purposes.

The questionnaire's current use by a colleague for evaluation of AMH clients' relevant views is bringing the psychological service closer to its users. It is hoped that the findings will be implemented and result in positive changes, including the more regular evaluation of clients' views about the service provider.

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DEPARTMENT OF PSYCHOLOGICAL SERVICES

CLIENT SATISFACTION SURVEY QUESTIONNAIRE - C

Date:_____

Please tick the appropriate response to each question and, if appropriate, use the space for comments provided at the end of each section:

BASIC INFORMATION ABOUT YOU

X1. Your gender: ❑*M* ❑*F*

X2. Your age group: ❑*16-25* ❑*26-35* ❑36-45 ❑*46-55* ❑*56-65* ❑*66+*

X3. Are you: ❑*Unemployed* ❑*Employed* ❑*Retired* ❑*Student* ❑*Other; please specify:*_____

X4. When you were referred to our Service, were you in a romantic/sexual relationship*:*
❑*No* ❑*Not sure* ❑*Yes–casual* ❑*Yes-not living with a partner* ❑*Yes-living with a partner*

X5. How severe would you rate your problems when you first came to see a therapist*?*
❑*Disabling* ❑*Severe* ❑*Moderate* ❑*Mild* ❑*No problem*

Any comments about the above:

BASIC INFORMATION ABOUT YOUR APPOINTMENTS WITH US

Y6/ Please state approximately how long you waited for your first appointment?_____weeks.

Y7/ Overall what was the number of appointments that you received*?* ❑*1* ❑*2-7* ❑*8-13* ❑*14-19* ❑*20-25* ❑*26-31* ❑*32+*

Y8/ What was the length of time offered between appointments*?* _____*weeks.*

Y9/ What type of therapist did you see*:* ❑*Clinical/Counselling Psychologist* ❑*Counsellor* ❑*Trainee Psychologist/Counsellor* ❑*Other, DK*

	Psychology *Department (Which one?)*	***GP Surgery***	***Carleton Clinic***	***Local Hospital***	***Home***	***Other***
Y10/ Where were your appointments with a therapist held*?*	❑ *East* ❑ *West*	❑(Which one?) (_____)	❑	❑(Which one?) (_____)	❑	❑(Where?) (_____)
Y11/ In your opinion, what is the most suitable place for appointments*?*	❑	❑(Which one?) (_____)	❑	❑(Which one?) (_____)	❑	❑(Where?) (_____)

Any comments about the above:_____

EVALUATION OF SERVICE CONTACT

INFORMATION TO CLIENTS	*Very Unsatisfactory*	*Quite unsatisfactory*	*Uncertain*	*Quite satisfactory*	*Very satisfactory*
A1. How adequate was the information you received from our Service prior to your first appointment?	❑	❑	❑	❑	❑

What information, if any, would you have found useful or troublesome*:* ……

A2. How helpful was the questionnaire received with your first appointment letter*?*	❑	❑	❑	❑	❑

Any comments:

APPOINTMENT SYSTEM

A3. How happy were you with the waiting time to first see a therapist*?*	❑	❑	❑	❑	❑
A4. Was the appointment time convenient for you*?*	❑	❑	❑	❑	❑
A5. How satisfactory was this interval*?*	❑	❑	❑	❑	❑
A6. How satisfactory was the overall number of appointments*?*	❑	❑	❑	❑	❑

If unsatisfactory, a/ what number would have been satisfactory*?* _____
b/ what interval would you think was best? _____

Any comments*:*

PUBLIC AREAS AND RECEPTION/PHYSICAL ENVIRONMENT

A7. Was the appointment location easy to get to*?*	❑	❑	❑	❑	❑
A8. How did you find the reception arrangements*?*	❑	❑	❑	❑	❑
A9. Did you find the waiting facilities satisfactory*?*	❑	❑	❑	❑	❑
A10. Was the room in which you saw the therapist suitable*?*	❑	❑	❑	❑	❑

RECEPTION STAFF/CONTACTS

A11. Were you satisfied with the reception staff's manner?	❑	❑	❑	❑	❑

Any comments:

EVALUATION OF THE THERAPIST

	Very poorly	*Quite poorly*	*Uncertain*	*Quite well*	*Very well*
B1. How adequately do you feel the therapist listened to you?	❑	❑	❑	❑	❑
B2. How much do you feel the therapist understood your problems?	❑	❑	❑	❑	❑

	Very Unsatisfactory	*Quite unsatisfactory*	*Uncertain*	*Quite satisfactory*	*Very satisfactory*
B3. Did the therapist provide you with all the information you felt you required?	❑	❑	❑	❑	❑
B4. How would you rate your therapist's manner?	❑	❑	❑	❑	❑
B5. How satisfied were you with your therapist's view on the time to end the therapy?	❑	❑	❑	❑	❑
B6. How satisfied are you with the advice on how to contact your therapist again, if need be?	❑	❑	❑	❑	❑
B7. How satisfying was your therapeutic relationship?	❑	❑	❑	❑	❑
B8. Overall, how satisfied are you with the therapist that you saw?	❑	❑	❑	❑	❑

	Very poor	*Quite poor*	*Uncertain*	*Quite well*	*Very well*
B9. How clear and understandable were your therapist's explanation?	❑	❑	❑	❑	❑
B10. How would you rate your therapist's sincerity?	❑	❑	❑	❑	❑

	Definitely not	*No, in general*	*Uncertain*	*Yes, in general*	*Yes, definitely*
B11.Did you feel you could trust your therapist?	❑	❑	❑	❑	❑
B12.Did you find your therapist supportive?	❑	❑	❑	❑	❑
B13.Did you feel free to tell the therapist your feelings and thoughts (eg., could you disagree)?	❑	❑	❑	❑	❑

B14. Regarding the therapeutic relationship, could you note your ideas about what was most:
helplful:_____
unhelpful:_____

Any comments about your therapist/therapeutic relationship?

EVALUATION OF OUTCOME

	Definitely worse	*Probably worse*	*Uncertain*	*Probably better*	*Definitely better*
C1.How are you coping now?	❑	❑	❑	❑	❑
C2. How is your understanding of yourself as a result of your treatment?	❑	❑	❑	❑	❑
C3. How are your relationships with others as a result of your treatment?	❑	❑	❑	❑	❑
C4. How is the quality of your life as a result of your treatment?	❑	❑	❑	❑	❑
C5. How is your confidence as a result of your treatment?	❑	❑	❑	❑	❑
C6. How is your worry as a result of your treatment?	❑	❑	❑	❑	❑

	Much worse	***Worse***	***Uncertain***	***Better***	***Much better***
C7. What was the result of the therapy in terms of your original problems?	❑	❑	❑	❑	❑

	Disabling	***Severe***	***Moderate***	***Mild***	***No problem***
C8. How would you rate your problems now, as a result of your therapy?	❑	❑	❑	❑	❑

C9. Could you describe how our Service affected you?……

Any comments about the outcome of your therapy:

GENERAL EVALUATION

	Definitely not	***Probably not***	***Uncertain***	***Probably yes***	***Definitely yes***
D1. Did you get the right kind of help?	❑	❑	❑	❑	❑
D2. Would you recommend our Service to a friend with similar difficulties?	❑	❑	❑	❑	❑

	Very dissatisfied	***Dissatisfied***	***Uncertain***	***Satisfied***	***Very satisfied***
D3. Overall, how satisfied are you with the Psychology Service?	❑	❑	❑	❑	❑

D4. Regarding our Service in general, could you state what you
like most:_____
dislike most:_____

D5. Please, could you give us any ideas on how we could improve the Psychology Service?

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE

Please, return to: Department of Psychological Services