Client Satisfaction at a University Outpatient Psychology Clinic

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ABSTRACT

The present study surveyed client satisfaction at the Massey University Psychology Clinic. It aimed to provide feedback to the Psychology Clinic while at the same time investigating the broader issues of data collection and analysis. In an effort to collect honest opinions, and not just "grateful testimonials" from clients, special consideration was given to the methodology used. In particular a standardised scale was employed (the Client Satisfaction Questionnaire -31) and efforts were made to enhance the response rate, while keeping reactivity to a minimum. Forty of the forty eight clients surveyed returned the questionnaire by mail. In the absence of guidelines on how to analyse the data, a variety of techniques were employed designed specifically to answer the questions posed by the Psychology Clinic. While clients were generally satisfied with the Psychology Clinic, some aspects of the service which could be improved were identified. Confidence in the results is strengthened by the methodology used, and by the finding that client satisfaction with the Psychology Clinic was unrelated to their satisfaction with life in general. The methodology used to collect and analyse data proved useful and it is suggested that providers of similar services adopt the same strategies, thus enabling meaningful comparisons to be made between facilities.

Dedicated in loving memory to my
grandfather Jack Morris Blakeney

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SERVICE EVALUATION

INTRODUCTION

Awareness of an urgent need to evaluate health care services arose from a growing number of malpractice suits in the medical field (Zusman, 1988). The first discussions on evaluation in the mental health field took place in the United States in 1969, and service evaluation or Quality Assurance is now a requirement of both state and federal funding agencies in the US. Canada, too requires a comprehensive Quality Assurance programme under the auspices of the Canadian Council of Health Facility Accreditation (Eppel, Fuyarchuk, Phelps & Phelan, 1991).

In New Zealand, although awareness of the need for Quality Assurance in the health area came later, recent developments have been rapid. The first newsletter of the New Zealand Council on Healthcare Standards (NZCHS), was published in 1990, with the stated goal to "encourage the nations health services to attain the highest possible standards of care within the available resources" (NZHCS, 1990, p1). The NZCHS has introduced accreditation to New Zealand, along the lines of the United States, Canada and Australia. Now hospitals and community health services in New Zealand can chose to be independently assessed to determine if they meet sufficient of the standards to merit accreditation status. The New Zealand government has shown support for the NZCHS through grants totally more than $500,000. To date 17 healthcare services in New Zealand have been accredited (NZHCS, 1992) although none of these has been in the area of mental health.

While neither the NZ Psychological Society nor the NZ College of Clinical Psychologists has agitated for formal Quality Assurance in mental health services, initial discussions have favoured the idea. Further, several agencies contacted in the early stages of this study were taking steps towards service evaluation. This was especially so in private clinics contracting to government agencies. The need for the current study arose when staff of Massey University Psychology Clinic decided to

subject their service to comprehensive scrutiny. The different models used to evaluate services will be presented, followed by a discussion of the method chosen for the present evaluation.

MODELS OF SERVICE EVALUATION

Mental health services can be evaluated in a variety of ways and Lebow (1982a) organised these into five principal models: the organisational model, the care-process model, the efficacy model, the community impact model and the consumer evaluation model, the last of which was chosen for this study. To provide a context for the choice of consumer evaluation, a description of the respective models follows.

The Organisational Model

This model focuses on the organisational structure itself, that is, its material and human resources (Eppel, 1988). It assesses the appropriateness and viability of a facilities structure, the efficiency of its management, the number of services provided and the relationship of those services to community needs. Examples of data analysed for this model include records of how many clients have been seen in a year, the productivity of the staff, types of services available and the amount of money spent. Lebow (1982a) reports that of the five models discussed, the organisational model is the most frequently used. The main weakness of this model is that it does not address the vital issue of **quality** of services.

The Care-Process Model

In contrast to the structural emphasis of the organisational model, the care-process model directly assesses the quality of services offered. The focus here is on the effectiveness of service delivery through the assessment of therapists' behaviour.

While useful in theory, Lebow (1982a) reports that in practice, therapists are reluctant to open their treatment sessions to examination and this is compounded by the difficulty of establishing acceptable standards. Restraints of confidentiality and cost are also limiting factors. For these reasons, this method is rarely used.

The Efficacy Model

This model evaluates mental health treatment by the respective outcomes that are achieved. The degree of change can be assessed through psychometric measures such as the Hopkins Symptom Checklist, or alternatively the focus may be on the attainment of specific treatment goals. The strength of this model is that it tests the main purpose of mental health services, that is, the facilitation of change in clients. Lebow (1982a) warns however of the pragmatic difficulties of measuring outcome as well as the precarious relationship between treatment and outcome. He points out that an unsatisfactory outcome does not necessarily reflect poor treatment but may be due to factors beyond the control of the therapist.

The Community Impact Model

The community impact model assesses the influence a mental health service has on the community. At its most basic level this is measured by the mental health of the community, however such measurement is difficult and the relationship between centre activity and community mental health, is unlikely to be strong (Lebow 1982a). In a study of evaluation methods used in 164 mental health centres, Kirkhart & Attkisson (1986) report the community impact model to be the most infrequently used method of service evaluation.

The Consumer Evaluation Model

The consumer evaluation model focuses on client satisfaction and what the clients themselves think about the services they have received. Lebow (1982a) acknowledges that 'consumers' can include the residents of a community who could assess the service system as a whole, however it is more common for consumer evaluations to investigate the satisfaction of actual clients and the extent to which they are satisfied with the treatment provided. The consumer perspective is useful when examining the extent to which services are used, as client satisfaction is an important determinant of utilization. The strength of this method is that direct and inexpensive data can be gathered through the use of a questionnaire, however it has the weakness that client reports are open to distortion (Lebow 1982a). For example, clients may feel hesitant to report their true feelings about treatment, especially if anonymity is not guaranteed (Shista, Rinco, & Sullivan, 1986). Other methodological problems exist such as gaining a random sample and the merits of this model can only be assessed when the specific methods of data collection are considered.

Table 1.1 summarises the advantages and disadvantages of each model.

Table 1.1
Summary of the Five Models Proposed by Lebow (1982a) to Evaluate Mental Health Services

MODEL	ASSESSES	SOURCE	ADVANTAGES	DISADVANTAGES
Organisational model	1. Appropriateness and viability of organisational structure 2. Scope of operation 3. Efficacy of management 4. Quantity of services provided 5. Relationship of services to community demand	Clinic records	1. Ease and accuracy of collecting data	1. Cannot provide a complete description of quality, effectiveness and acceptability of services. Management data describes organisational functioning, not the process.
Care-process model	Effectiveness of service delivery and quality of service by comparing service to a standard practice	eg, video tapes of treatment sessions, facility records	Assesses actual behaviours of clinicians	1. Difficult to get data (reactivity and confidentiality problems) 2. Setting standards is difficult
Efficacy model	Outcome of treatment	Measure of change eg, Hopkins Symptom Checklist	Tests the purpose of most mental health facilities, ie, the facilitation of change in clients	1. Pragmatic difficulties of measuring outcome 2. Precarious nature of the relationship between treatment and outcome
Community impact model	Facility influence on the community	1. Measure of common knowledge of services 2. Mental health of the community	Ties in with basic goal of affecting the mental health of the entire community	1.The relationship between centre activity and communities mental health is unlikely to be strong 2. Difficult to measure mental health of the community
Consumer evaluation model	Consumers opinions about services	Clients or consumers	Direct and inexpensive	1. Distortions in client reports (eg, social desirability 2. Sampling problems

While none of the above models fulfils the requirements for complete service evaluation by themselves, a comprehensive evaluation can be achieved by using them in combination. The models used most frequently in conjunction are the organisational and consumer evaluation models thus giving both service provider and client perspectives on an individual service (Lebow 1982a). Use of these two models in combinations with others is somewhat redundant, but more importantly, expensive and usually beyond available financial resources.

The present study used the consumer evaluation model as a basis to evaluate the services at the Massey University Psychology Clinic, an outpatient psychological service. This would compliment the existing annual evaluation which fits under the guise of the organisational model. This existing evaluation included the number of clients seen, types and source of referral, psychologist workloads, nature and extent of student participation, and so forth. Client satisfaction too had been monitored previously at the clinic, but it had been conducted in an ad hoc manner.

RESEARCH BASED RATIONALE FOR CHOOSING THE CONSUMER EVALUATION MODEL

The search for the most appropriate method of service evaluation revealed the benefits of the consumer evaluation model. This use of this model not only provides helpful information to be used in the future planning of service provision, but evidence suggests that satisfied clients demonstrate the greatest therapeutic gain. Assessing the clients' views on treatment also fulfils and increasing need for accountability to the consumer.

Planning

Client satisfaction studies offer the recipients of mental health care an opportunity to offer their opinions about treatment. These opinions may be consonant or dissonant

with centre objectives and service providers can thus consider the appropriateness of their goals and objectives (Wolf, 1978) and ensure the service is consistent with the needs of those being served (El-Guebaly, Toews, Leckie, Harper, 1983; Kirkhart & Attkisson, 1986). Client feedback enables areas of dissatisfaction to be pinpointed and provides an indication as to where resources should be channelled. Together with other outcome data, client satisfaction studies provide planners and managers with information necessary to understand and improve service provision (Greenfield & Attkisson, 1989).

Attendance, Compliance and Therapeutic Benefits

Bringing user needs and service policies into closer agreement through client feedback has many positive repercussions. For example, Kincey, Bradshaw and Ley (1975) found that satisfied patients were more likely to comply with medical regimens. Their study of 61 patients attending a general practitioner for the first time showed that compliance (intent to take the doctors advice or instruction) was significantly related to satisfaction. Similarly Sackett and Hayne (1976) found satisfaction to be related to taking medication and appointment keeping. Ware and Snyder (1975) have identified patient satisfaction as one of several important determinants of the utilization of medical services. In the area of mental health Attkisson and Zwick (1982) found that clients who dropped out of treatment in the first month, and clients who missed a greater number of their scheduled appointments tended to be less satisfied with services. They also found that client satisfaction was related to client ratings of improvement. More recently Zastowny (1989) identified dissatisfaction with services as a barrier to future utilization with increased dissatisfaction being related to a greater drop out rate: suggesting that dissatisfied patients are more likely to 'doctor shop'. The link between client satisfaction and compliance to treatment is especially relevant to mental health treatment because often in therapy clients are expected to play an active and self-directing part in treatment (Prager & Tanaka, 1980). While hospital staff have some control over

whether in-patients adhere to treatment, in an outpatient setting, that responsibility lies much more with the client.

Increased Need for Accountability

Accountability and the term Quality Assurance are emerging as the catch phrases of the nineties in all avenues of service delivery. In the area of business marketing it is accepted that Quality Assurance is no longer just a matter of conforming to internal standards and specifications (Day, 1977), but must extend to include the customers perspective as well. Although quality control in service industries is different from that of manufacturing, today's consumers of health and mental health so too have come to expect that service providers have a responsibility to the people they serve (Eppel, 1988; Fauman, 1990; Kirkhart & Attkisson, 1986; Sorensen, 1977).

While the NZCHS, is increasing consciousness of these issues in New Zealand hospitals and community health centres, the user pays philosophy is generating a new awareness in the New Zealand public of their rights. The traditional doctor-patient relationship is being transformed and the recipients of health care are now demanding some form of accountability.

The idea of conceptualising clients as consumers is important in both the private and the public health sector. In the public sector, although managers do not have the financial incentives to ensure that they provide a high quality service, Quality Assurance is still vitally important. Poor, non-mobile and other disadvantaged citizens have practically no alternatives to public mental health centres and it is important that an adequate service is available to these groups. With no profit motive the determination of service quality, adequacy and appropriateness is the responsibility of service providers (Larsen, Attkisson, Hargreaves, & Nguyen, 1979).

In private practice an acceptable level of consumer satisfaction is necessary to prevent clients from seeking treatment elsewhere as unsatisfied clients are likely to

"shop around". Consumer satisfaction is therefore vital to the centres performance and survival in a competitive market (Greenfield & Attkisson, 1989).

DEFINING CLIENT SATISFACTION

Despite the frequency with which client satisfaction studies are used to evaluate services, no explicit definition of client satisfaction in relation to mental health services exists (Pascoe, 1983).

In his review of client satisfaction research Lebow (1983b) groups client satisfaction into narrow and broad / uni- and multi- dimensions. The **narrow** definition of client satisfaction is "the extent to which service gratifies the wants wishes or desires for treatment" (p 212). However, the **broader** approach taken by some studies measures client satisfaction indirectly, for example by monitoring spontaneous complaints about treatment, rates of premature termination, positive outcome, completion of treatment, return to facility, and treatment obtained elsewhere. For example, consistently high ratings of treatment outcome may be taken as evidence that clients are satisfied with the services they received. This broader conceptualization of client satisfaction however presents problems as it is an indirect evaluation by clients of the services they received. For example, premature dropout may be due to pragmatic factors such as childcare or transport difficulties and is not necessarily an indicator of client dissatisfaction. Along the lines of Lebow's earlier suggestion about choice of models, a combination of both narrow and broad views of client satisfaction is possible. Any agency would be wise to take note of any unsolicited comments both negative and positive, but would be unwise to act on these alone. A standard, specific and routine assessment of satisfaction coupled with any vicarious and broad feedback is probably the most comprehensive approach.

When surveys of client satisfaction are conducted researchers, and mental health service managers have tended to develop their own questionnaires in an ad-hoc manner (Lebow, 1983c). Such studies are referred to as 'consumer' satisfaction,

'patient' satisfaction and 'client' satisfaction studies with very few definitions of the constructs measured.

The present study uses Lebow's definition of client satisfaction as "the direct inquiry into the adequacy of mental health treatment itself and of the surrounding milieu" (1982b, p1011). While such a definition is useful it does not answer all the questions regarding client satisfaction as a construct and controversy exists as to whether client satisfaction is a unidimensional or multidimensional construct. Those who subscribe to the **unidimensional** theory maintain that clients form an overall impression about treatment and are unable to differentiate between the various aspects of service delivery (Jansen & Aldrich, 1973; Larsen et al., 1979). These researchers refer to client satisfaction as a 'global' construct.

Alternatively **multidimensional** theory suggests that clients can distinguish between the main characteristics of a service, such as treatment outcome and cost, and independently evaluate them (Love, Caid, & Davis, 1979; Tessler, 1975; Ware, Davies-Avery, & Stewart, 1978). The utility of measuring satisfaction with the different dimensions of a service is obvious as managers can then evaluate each aspect of the service separately and use the information to decide where resources should be channelled. While global measures provide good indicators of how a service is viewed by its clients, they do not reveal why clients feel this way. To determine which specific aspects of the service the client likes, dislikes, or thinks could be improved, more information is needed.

RESERVATIONS IN USING CLIENT SATISFACTION DATA

The appropriateness of using client satisfaction data to evaluate mental health services has been questioned by some researchers (Lebow, 1982a). Most criticisms can be grouped into three sets of concerns - problems in obtaining valid measures; the client's ability to judge treatment; and whether treatment outcome data is a better determinant of effective treatment. Rather than deeming client satisfaction studies to

be invalid, these concerns should be addressed prior to the collection of client satisfaction data to ensure maximal validity. The particular concerns were as follows:

Problems in Obtaining Valid Measures

Lebow's (1982a) criticism of client satisfaction studies is that responses are subject to bias and distortion. He suggests that the client's desire to give socially desirable responses, acquiescence to the positive phrasing of questions, a positive halo response and the demand characteristics of the rating situation all threaten the validity of the information obtained. If client satisfaction data is to be used to evaluate services, the reported levels of satisfaction must accurately reflect the actual service received and not be biased in these ways. While these and other methodological problems must be acknowledged, Lebow himself (1983) proposes they can be overcome with methodological care allowing reasonable confidence in the accuracy of findings.

Clients Ability to Judge Treatment

Another reservation about client satisfaction data is that the therapist and client can differ substantially in their views of psychological assessment and treatment, for example a therapist may report an adequate outcome whereas the client may not. Questions arise as to whose opinion is important, the clients, the therapists, neither or both. Perhaps, as Lebow (l983c) suggests, it is just that the therapist and client are approaching the situation from different viewpoints of the service provider and consumer.

However, there is a body of research which supports the notion that clients **can** accurately judge the outcome of therapy they receive. For example, client satisfaction has been found to be positively correlated with measures of treatment outcome (Attkisson & Zwick, 1982; Deane, in press; Larsen et al., 1979) and drop

out rates (Larsen et al., 1979). In Larsen et al.'s study, clients who dropped out of treatment within the first month tended to be less satisfied than those who remained in treatment. Of those clients remaining in treatment, those who missed their scheduled appointments were generally less satisfied with the services available to them. Client satisfaction has also been found to be positive correlated to therapist ratings of success (Deane, in press; Plutchik, Karasu, Conte, Siegel & Lerret, 1978).

In the area of medical health, evidence has emerged to show that client satisfaction does reflect the care received. Satisfaction has been shown to be higher when payment plans were explained, and when providers showed a personal interest in their patients (Ware et al., 1978), when providers spent more time with their patients (Linn 1975), when they saw the same physician, and when waiting room times were shorter (Linn, 1975).

Treatment Outcome is a Better Determinant of Effective Treatment

Measures of symptom severity and psychological functioning at the end of treatment are referred to as outcome, or effectiveness data. It has been argued that such outcome data is more important than client satisfaction which is irrelevant provided good treatment outcome is achieved (Scheirer, 1987). It has already been demonstrated however, that the way a client feels about treatment effects the treatment process. Dissatisfied clients are more likely to miss their appointments, and when they do attend, will be less likely to do what is asked of them. As an independent variable, client satisfaction contributes to the behaviour of the client. While outcome data establish the proportion of people who obtained positive results from therapy - for example, 60% of clients may have improved symptomatology, such data does not provide information as to why the remaining 40% were not helped. When the emphasis is on outcome of therapy, the process is ignored.

In conclusion, this chapter has introduced five models of service evaluation and emphasised the consumer evaluation model which will be used in this study. The terms consumer evaluation and client satisfaction were clarified and the drawbacks in the use of client satisfaction studies briefly examined. A full discussion of the methodological problems associated with client satisfaction data will follow in Chapter two and strategies introduced to overcome them.

CHAPTER TWO
METHODOLOGICAL CONSIDERATIONS

It was argued in chapter one that to truly know how a service is received, the users perspective is required. This is an important adjunct to the more routinely collected organisational data which gathers information from the service providers perspective. The methodological problems inherent in client satisfaction research were introduced in chapter one. The validity of methods commonly used to collect client satisfaction data have been questioned (Lebow, 1982a, 1982c, 1983c, 1984, 1987; Nguyen, Attkisson & Stegner, 1983; Tanner, 1981) and the suggestion made that positive findings may result as much from the methodology used as from real satisfaction experienced by clients (Lebow, 1984). The mode of data collection, the sample chosen to take part in the study, the timing of an assessment and even the person conducting the study, can all affect the outcome. Such variables however are rarely taken into account and as data is often collected as a public relations exercise or to meet government funding requirements, no incentive exists to reduce such a bias through methodological care (Lebow, 1984).

A detailed discussion of the methods of data collection with an emphasis on methods for enhancing validity is presented here, followed by a brief discussion of the techniques used to analyse data.

METHODS OF CLIENT SATISFACTION DATA COLLECTION

Client satisfaction data can be collected **indirectly**, for example, by monitoring complaints about a service, or **directly** through structured interviews and written questionnaires.

Indirect Methods

The broader view of satisfaction discussed in chapter one measures satisfaction indirectly through monitoring spontaneous feedback and 'dropout' rates. It is misleading to use complaints that arise about a service as indices of client satisfaction as these do not represent clients typical feelings about a service but reflect more the opinions of the assertive clients (Lebow, 1982b). Using dropout rates as an index of dissatisfaction is also problematic. Assuming clients who drop out are dissatisfied is also misleading; although it might be assumed that satisfied clients will attend therapy until a mutually agreed termination date, some may cease treatment earlier for unrelated reasons. At the same time dissatisfied clients may continue purely because of a lack of alternatives, as with poor clients attending a public facility.

Direct Methods

Direct methods include collecting data through the use of a structured interview or a questionnaire. Structured interviews are criticised as clients may feel less able to say negative things about a service directly to the person conducting the interview. In their 1981 study Le Vois, Nguyen and Attkisson discovered that ratings of client satisfaction were 10% higher with structured interviews, as opposed to written questionnaires.

The use of a questionnaire not only overcomes the problem of clients not feeling able to say negative things about a service to an interviewer, but also has the advantage of being direct, straightforward and directly related to satisfaction, provided good psychometric properties exist (Lebow, 1983c).

While it is common practice in the field of client satisfaction for researchers to devise their own questionnaire without following the standard procedure for scale development (Lebow, 1984; Pascoe, 1983), standardized scales are preferred for two

reasons. Firstly, as the validity of client satisfaction data is dependent on the viability of the measures used, it is preferable that a standardised and well validated instrument is employed (Lebow, 1982c, 1984). Secondly, comparison between agencies is only possible when standardized scales are used, and is not possible when the content of questionnaires varies widely from one study to the next (Tanner, 1989). While one mental health facility may report that 80% of clients are satisfied, this has little real meaning without norms to compare this rate of satisfaction to. The trend toward independent scale development has meant an absence of norms against which to compare results across different mental health facilities and countries.

OBSTACLES TO OVERCOME IN THE COLLECTION OF CLIENT SATISFACTION DATA

Sampling Bias

A sampling bias occurs when the respondent group does not represent the population of clients. This can occur through the unrepresentative selection of clients asked to participate in the survey and through unrepresentative patterns in client responding.

Three groups of clients are often neglected in the client satisfaction studies: those that attend the clinic only once, those who 'drop out' and those with severe psychopathology. Clients who attend a single session are often missed because they are in the system for such a short time. Nonetheless such clients are highly likely to have been dissatisfied for one reason or another and their opinions about treatment and should not be ignored. Other clients drop out later during treatment and it is important to include them in the sample, since dissatisfied clients are the ones most likely to discontinue treatment (Lebow, 1982c). Likewise clients with severe psychopathology may still respond appropriately. Lebow recommends "a conservative stance" , removing only those clients with extreme dysfunction.

Although a representative sample may be invited to take part in a survey, ensuring that a representative group actually respond to that invitation is difficult. For example the average rate of responding in a review of 63 Community Mental Health Centres is 57% (Lebow 1983b).

Summary statistics are somewhat misleading and Table 2.1 shows the response rates for five methods of data collection: mailed questionnaires, telephone interview, mail and phone contact combined, interviews in clients homes and questionnaires or interviews at the treatment facility. While mailed questionnaires average a 40% response rate, on average 82% of clients respond to questionnaires or interviews at the treatment facility.

The possible differences between respondents and non respondents means an inherent sampling bias can occur when response rates are low.

Table 2.1
Response rates for five methods of data collection (Lebow 1983b)

Method used	Percent responding
Mailed questionnaire	40
Telephone interviews	43
Mail and phone contact combined	55
Interviews at clients' home	64
Questionnaires/interview at treatment facility	82

Positive Response Patterns

Most studies have resulted in positive attitudes being expressed about the mental health care. (Larsen et al.,1979; Lebow, 1982a, 1987; Lorefice, Borus & Keefe 1982; Nguyen et al., 1983). While high ratings of satisfaction can be taken as

evidence of the high standard of treatment being provided, it can also be argued that such findings merely represent 'grateful testimonials' and other demand characteristics of the rating situation (Campbell 1968, cited in Nguyen et al., 1983). The person conducting the survey is one factor that can inflate responses as reactivity is likely to be higher when the questionnaire is presented by someone at the clinic, for example a secretary, or the therapist that provided the treatment. Lebow (1982c) particularly discourages the use of the therapist and recommends a totally independent evaluator is used. To overcome the problem of the sampling bias, consumer satisfaction questionnaire are often presented to the client at the treatment facility. Although this results in the highest response rate, it also increases reactivity (Lebow 1983b). It is important to create an environment in which clients feel comfortable to express their negative opinions about a service. Having the client answer the survey away from the treatment facility, guaranteeing anonymity, and asking clients to report the negative as well as the positive things about the service encourages more honest answers (Lebow, 1982c).

Timing of the Study

The timing of a satisfaction survey is another factor that can affect the outcome. Data can be collected after the first session, after a set number of sessions, after a certain amount of time after the first session, at a random point in treatment , at termination, or a short time after termination. Lebow (1982c) favours the assessment of satisfaction at multiple points of time, for example, early in treatment, at termination and at post-treatment. This has the advantage of following the natural history of client satisfaction. However the data is more difficult to obtain as research has shown that only about 50% of clients return a mailed questionnaire (Lebow, 1983b) and with three mailings, the attrition rate is multiplied. While collecting the data on the premises is likely to result in an adequate response rate, this creates problems of reactivity as discussed earlier. If the client reaction to the whole of treatment is the interest, Lebow (1984) recommends assessment a short time after the close of treatment.

Families

In family therapy involving multiple clients it is necessary to consider carefully who or whom will be targeted to provide satisfaction data. In the case of young children, Lebow (1982c) suggests that the parents are the best ones to provide the data. Assessing the views of all the family members is possible but raises the problem of disproportionately representing the family in the overall distribution of cases. Lebow suggests averaging the responses of different family members as a better alternative, however when families have mixed views this cancels out their independent views. This can be overcome by calling such families as "mixed in view" and including this as a possible outcome alternative in the analysis.

In conclusion, there are many inherent flaws in the collection of client satisfaction data which artificially inflate the responses achieved. For the purposes of the present study careful consideration will be given to the methodology used.

METHODS OF DATA ANALYSIS.

In contrast to the research that exists on pragmatic decisions relating to data collection (El-Guelbaly et al., 1983; Lebow 1982a, 1982c, 1983b, 1983c, 1984) little research can be found to guide the analysis of data. Commonly means and standard deviations are the only statistics reported in client satisfaction studies (De Brey 1983; Sabourin, Laferriere, Sicuro, Coallier, Cournoyer, & Gendreau, 1986; Soelling and Newell, 1983). A satisfaction survey requires considerable planning and resources and a wealth of information is obtained, which if utilized, can help facility management with future planning. However, there is little point in collecting the information if the methods of analysing data are crude and the information is not utilized. Although Lebow (1982a, 1983c) criticises the "primitive" methods of data analysis commonly used, he gives no suggestion as to how data should be analysed.

CHAPTER THREE
RELATIONSHIP OF CLIENT VARIABLES TO SERVICE SATISFACTION

Not only is it important to chose the appropriate model of service evaluation, as discussed in chapter one, and to use the best method of collecting data for that model as discussed in chapter two, it is also important to address characteristics of the clients themselves that can effect the responses they make.

DEMOGRAPHIC VARIABLES

Studies examining the relationship between demographic variables and service satisfaction have resulted in contradictory findings. While some studies have found small but significant relationships (Pascoe, 1983; Ware et al., 1978), other researchers found no relationship between demographic variables and service satisfaction (Fox & Storms, 1981; Lebow, 1983b).

In their review of 13 studies in the **medical field**, Ware et al. (1978) found small relationships between age, education, family size, income and occupational level. Similarly Pascoe (1983) reports age and sex to be most significantly related to client satisfaction with greater satisfaction being associated with being older and female. The amount of variance however was small. Tanner (1981b) found contradictory findings in his review of **mental health**, with age and sex being related to satisfaction while race and marital status were not.

Lebow (1983b), also in the area of mental health, found that age, sex, race, medical status, income, social class and education did not relate to the extent of satisfaction, and concluded that demographic variables are not good predictors of satisfaction with mental health services. Fox and Storms (1981) report similar findings. Pascoe (1983) argues that whether a relationship was found or not can

usually be traced to differences in the particular service dimensions that were assessed.

TREATMENT VARIABLES

The relationship of client satisfaction to the different treatment groups has also been investigated. A study by Woodward, Santa-Barbara, Levin, & Epstein.(1978) found that poor prognosis in outpatient family therapy was related to lower satisfaction. Similarly, both Le Vois et al. (1981) and Attkisson and Zwick (1982) found lower satisfaction for the more disturbed compared to the less disturbed clients. However, since studies have failed to consistently find differences across the type of problem, it is difficult to draw conclusions (Lebow, 1983c). Assessing client satisfaction at the specific levels of treatment groups is useful on a more practical level, as combining all clients might mask areas of dissatisfaction for one client group at a particular treatment facility.

LIFE SATISFACTION

The relationship between clients satisfaction with services and their general satisfaction with life has also been investigated. This relationship is important as client satisfaction studies will be more meaningful if service satisfaction is independent of how satisfied clients feel about the other aspects of their lives.

Definition

According to Argyle (1992) life satisfaction is a component of the wider psychological construct, happiness, where happiness is made up of positive emotions - fun, joy, euphoria, as well as satisfaction with life - including job, spouse and home. Argyle suggests life satisfaction is greater when the gap between aspirations and achievements is smaller.

Diener, Emmons, Larsen & Griffin (1985) have identified life satisfaction to be a component of subjective well being which they believe is made up of positive affect, negative affect and life satisfaction. While positive and negative affect represent emotions, life satisfaction is a cognitive judgement. Diener et al., used the idea of asking subjects for an overall judgement of their life when developing the Satisfaction With Life Scale (SWLS).

Previous Research

Weiss (1988) endorses the rationale for including life satisfaction in studies of patient satisfaction in the medical field and comments on the lack of empirical research in the area. In the area of mental health Lebow (1983b) also suggests that attention should be focused on life satisfaction which he terms a "covarying conditions" to service satisfaction.

While Le Vois et al. (1983) found satisfaction with day treatment was related to general satisfaction with life, Attkisson et al. (1983) report the opposite, that a rating of general life satisfaction explained less than 2% of the variance in service satisfaction. In a related study, Linn and Greenfield (1982) found that depression accounted for less than 1% of the variance in ratings of service efficacy made by chronically ill patients. Although they did not assess life satisfaction directly, it could be expected that depressed patients would report low levels of life satisfaction. In an attempt to explain these conflicting findings, Roberts, Pascoe & Attkisson (1983) introduced the concepts of micro and macro measures.

Micro measures require recipients to respond to items referring specifically to the service they have received in a particular agency, while **macro** measures inquire about general aspects of healthcare delivery (Pascoe & Attkisson, 1983) which are thought to match the evaluation of the recipients own healthcare.

Roberts et al. (1983) suggest that rather than assessing satisfaction with healthcare per se, macro measures tap generalised positive and negative orientations. That is these measures of satisfaction may be affected by clients' overall satisfaction with life in general. Roberts et al., investigated this proposition using the Client Satisfaction Questionnaire (CSQ), a micro measure and the Patient Satisfaction Questionnaire (PSQ), a macro measure. Although they found no correlation between satisfaction with mental health services measured by CSQ and life satisfaction, a correlation was found between the PSQ and reported life satisfaction. Only the more direct measure (the CSQ) was able to tap satisfaction with mental health service directly, and was not contaminated by the degree of satisfaction with life in general.

The present study examined the relationship between client satisfaction and the demographic variables age, sex, education and social class. The relationship between client satisfaction and life satisfaction was also assessed. A sample size of 40 meant there were insufficient clients seen in the different treatment groups (such as depression, anxiety, family therapy, post traumatic stress disorder) to examine any differences in satisfaction between these groups. Instead differences in satisfaction between the neuropsychological clients and all other clients was investigated.

CHAPTER FOUR
THE PRESENT STUDY

To maintain a high quality service it is important that mental health facilities are regularly evaluated. The present study evaluates a university based outpatient psychology clinic along consumer evaluation or client satisfaction lines. This, in conjunction with an annual evaluation conducted along organisational lines, would then represent a comprehensive approach to service evaluation, including both the service provider and consumers perspectives.

The methodological problems associated with client satisfaction studies were outlined in chapter two, and in planning the present study careful consideration was given to overcoming these problems. Accordingly a standardized questionnaire was selected with established psychometric properties which would enable comparison between similar services. The issue of a positive sampling bias was addressed by inviting **all** clients finishing their contact at the Psychology Clinic over the period of data collection to take part in the study, whether they had stopped coming to the clinic by mutual arrangement or discontinued on their own initiative. Additional measures to enhance the response rate, and further reduce the response bias, included addressing reasons why the client might be unable to complete the questionnaire (such a moving house or going on holiday), providing a stamped addressed envelope, and following up non respondents with a telephone call.

In setting up the study, the guidelines suggested by Lebow (1982a, 1983c) to reduce the reactivity arising from the demand characteristics of the rating situation were followed. In particular an independent evaluator was used to collect the data, anonymity was guaranteed, clients competed the questionnaire away from the treatment facility and clients were asked directly to consider the bad as well as the good aspects of the clinic when answering the questionnaire.

At this point it is important to clarify the meanings of several key concepts that are central to this research. Firstly, in the present investigation Lebow's, definition of **client satisfaction** is used, that is "the direct inquiry into the adequacy of mental health treatment itself and the surrounding milieu (1982a, p.1011). **Global satisfaction** is used to refer to the clients' satisfaction with the service as a whole. In contrast **dimensions of satisfaction** refers to the different components of service provision, for example, physical surroundings, office procedure or the treatment staff. **Reactivity** is the term used to refer to the contamination of responses due to the demand characteristics of the rating situation.

OBJECTIVES AND HYPOTHESES

This study had two main objectives. The first concerned the scientific investigation of client satisfaction, and it is in association with this objective that the research hypothesis are presented. The second objective was to provide feedback on specific questions that the Psychology Clinic had about its service. These questions had provided the initial impetus for the study.

OBJECTIVE 1. Scientific Investigation of Client Satisfaction

Five hypotheses were generated in associated with the first objective of the present study, to scientifically investigate the nature of client satisfaction and the measurement of this construct. These were as follows:

Hypothesis 1.

Use of an independent evaluator, a guarantee of anonymity, individual explanation of the purpose of the study to clients (by phone or in person) provision of a stamped addressed envelope, and attention to other reasons why the clients would not send back the questionnaire (eg, writing problems) will combine to produce a response rate higher than the 55% average for mail and phone contact, reported by Lebow (1983b).

Hypothesis 2.

Explaining the purpose of the study to each client in person will produce a higher response rate than explaining it to them by telephone.

Hypothesis 3.

Global satisfaction with the Psychology Clinic will be unrelated to general life satisfaction.

Hypothesis 4.

Global satisfaction with the Psychology Clinic will be unrelated to the demographic variables:

a. Sex

b. Age

c. Socio-economic status

Hypothesis 5.

Clients can distinguish between and differentially evaluate the nine different dimensions of satisfaction measured by the CSQ-31.

OBJECTIVE 2. Providing Clinic Feedback

The second objective of this study was to provide feedback to the Psychology Clinic about how clients viewed the service provided. The specific questions that had provided the impetus for the study were:

1. What do clients like about the service?
2. What do clients dislike about the service ?
3. What components of the service determine global satisfaction ?
4. Were there differences in satisfaction between:
    i. Fee paying and non fee paying clients ?
    ii. Clients attending with neuropsychological problems and all other clients ?
    iii The clients of senior and assistant clinical psychologists?
5. How does the service compare to other similar facilities ?

In the absence of any guidelines on how to analyse data, the methods chosen were aimed at answering the questions generated by the Psychology Clinic.

CHAPTER FIVE
METHOD

RESEARCH SETTING

This study was conducted at the Psychology Clinic at Massey University. The clinic is an outpatient facility staffed by eight part time senior psychologists, one full time and three part time assistant clinical psychologists, and a half time secretary. It aims to deliver a high quality clinical psychology service and provides placement experience for post graduate students in clinical psychology training courses. With the permission of clients, these students predominantly sit in with senior clinical psychologists during sessions, but they may conduct interviews and some psychometric assessment under supervision.

Clients seen at the clinic are referred for assistance with psychological problems caused by neuropsychological disorders, especially head injuries, sexual abuse, chronic back pain, relationship problems, depression, anxiety, post traumatic stress disorder, and family problems. Referrals come from a large number of sources including the Accident Compensation Corporation, Palmerston North Hospital, especially the Rehabilitation Unit and Manawaroa Centre for Psychological Medicine, other psychiatrists/psychologists, specialist physicians such as neurologists, Children and Young Persons Service, Police, Employee Assistance Programme (EAP) and other government agencies, the Family Court and solicitors. Approximately 10% of clients refer themselves.

Although most clients are from the Palmerston North area, they also come from as far afield as Wellington, Wanganui, Taranaki and Hawkes Bay. Clients referred for assessment outnumber those referred for treatment or counselling, however some clients receiving initial assessment go on to receive counselling or treatment. The Psychology Clinic currently receives at least five new referrals a week.

The clinic is fee paying agency, although ACC and other government agencies pay the fees of the clients they refer. Fees are subject to a sliding scale which ranges from $15 to $50 per hour, depending on income and number of dependents.

THE RESEARCHER

The problem of a positive response bias has already been discussed. In an effort to minimize this problem previous research suggests that all client satisfaction studies should be conducted by an individual evaluator. Clients are more likely to be honest about their opinions if the person collecting the information is not working at the setting.

In accordance with this the study was conducted by an independent evaluator (IE) who is working within the Psychology Department but not at the Psychology Clinic. The IE was not known to any of the clients.

THE PARTICIPANTS

Those clients attending the clinic with chronic back pain were not included in the study due to concurrent research involving this group of clients. All other clients finishing at the Psychology Clinic within the five month period that data was being collected were asked to participate in the study. Clients with memory deficits or problems of judgement of a severity which would make it difficult to respond would not be included in the study. As was anticipated two clients were excluded from the study due to such impairments. It was predicted that some clients (especially from the neuropsychology group) would have special needs and every effort was made to accommodate these. For example in three cases a relative was asked to help the client complete the questionnaire. Relatives who had attended the clinic with the client throughout the assessment or treatment were invited to complete a separate questionnaire. However as the responses of the clients and their families were

similar in all instances, only the clients questionnaires were kept in the analysis. Table 5.1 lists the characteristics of the participants.

Table 5.1
Characteristics of the Sample

SEX	
Male	22
Female	18
AGE	
0-21 years	
21-30 years	14
31-40 years	11
41-50 years	9
> 50 years	2
EDUCATION	
Some high school	7
Completed fifth form	15
Completed sixth form	7
Completed seventh form	1
Attended university	10
INCOME	
Nil	2
Less than $10 000 per year	4
$10 000 to $20 000 per year	8
$21 000 to $35 000 per year	13
$36 000 to $50 000 per year	8
Over $50 000 per year	5
ETHNIC ORIGIN	
European	37
Maori	2
Other	1
REASON FOR ATTENDING CLINIC	
Neuropsychological problems	26
Post traumatic stress disorder	4
Relationship problems	5
Sexual abuse assessment	1
Family problems	1
Other	4

MEASURES

Client Satisfaction Questionnaire (CSQ)

In this study client satisfaction was measured using the Client Satisfaction Questionnaire -31 (CSQ-31, Larsen et al., 1979) with an additional four questions relating specifically to the Psychology Clinic. Larsen et al., encourage the addition of questions specific to each facility which, they state, will not affect the psychometric properties of the original scale. The CSQ-31 was chosen because it covers a wide range of service provision components and has a psychometrically sound measure of global satisfaction, (the CSQ-8) as its core. The CSQ-8 has been used previously with New Zealand outpatient psychotherapy clients (Deane 1992) which allows direct comparison of satisfaction ratings with consumers receiving similar services. A supplementary information sheet for collecting demographic and background information is provided with the CSQ-31.

The psychometric characteristics of the CSQ-31 and the global satisfaction scale (CSQ-8) are described separately below.

CSQ-31. The CSQ-31 consists of 31 likert-type items with four response choices with "1" indicating maximum dissatisfaction and "4" indicating maximum satisfaction. Nine dimensions of satisfaction are tapped by the CSQ-31. These are Office procedures, Support staff, Physical surroundings, Type of service, Amount of service, Quality of service, Outcome, Treatment staff and General satisfaction. Each dimension is assessed by a minimum of three questions. Table 5.2 contains an example item for each dimension (see Appendix I for all items).

The theoretical base for the CSQ-31 emerged from a literature search whereby Larsen et al. (1979), identified nine potential determinants of satisfaction with mental health services. Thirty two mental health professionals then ranked the nine items in each category according to how well the item reflected the dimension in question.

Items were ranked from best (9) to worse (1). Items receiving a mean rank of 5 or higher were kept in the pool leaving a pool of 45 items which were then rated by 31 members from various California County Mental Health Advisory Boards. The three top ranked items in each category were selected for the final questionnaire as well as an additional four items where the content was sufficiently different to justify inclusion. The resulting questionnaire (CSQ-31) has a minimum of three items on each of the nine service dimensions.

Table 5.2
Dimensions and Example Questions From the CSQ-31

Dimension of satisfaction	Item number	Example of an item
Office procedures	1, 2, 18, 22	When you first came to the Psychology Clinic were you seen as promptly as you felt necessary ?
Physical surroundings	3, 6, 12	How convenient is the location of our building ?
Support staff	14, 24, 28	How interested has the receptionist/secretary been in helping you ?
Type of service	7, 9, 13, 25	Considering your particular needs, how appropriate are the services you received ?
Quantity of service	4, 15, 26	Have you received as much help as you wanted ?
Treatment staff	11, 17, 19, 30	How knowledgeable and competent was the person with whom you worked most closely ?
Quality of service	5, 21, 29	How would you rate the quality of service you received ?
Outcome	8, 10, 16	You came to the clinic with certain problems, how are these problems now ?
General satisfaction	20, 23, 27, 31	If you were to seek help again would you come back to our programme ?

The CSQ-31 has two parallel forms each containing 18 items, 5 of which are common to both forms. The parallel forms (CSQ18-A, CSQ18-B) correlated significantly ($r=.822$, $p < .01$) with each other indicating a high of split half reliability. Attkisson and Zwick (1982) reported the alpha coefficient of the CSQ-18

was .91 but unfortunately they did not specify whether this was for form A or form B. Similarly the alpha coefficient for the whole 31 items is not reported and no validity information is provided.

CSQ-8. Embedded within the CSQ-31, is the CSQ-8; a measure of global satisfaction, made up of questions 5, 7, 10, 20, 21, 23, 27, 31. The CSQ-8 has been endorsed in the literature as a reliable and valid way of assessing client satisfaction (Attkisson & Zwick, 1982; Lebow, 1982c, 1983, 1983b; Pascoe,Attkisson & Roberts, 1983).

After extracting the CSQ-8 from the CSQ-31, Attkisson and Zwick (1982) reported an alpha coefficient of .93. A similar alpha coefficients of .92 was found in a New Zealand study by Deane (in press). This high degree of internal consistency indicates that the 8 item scale provides a homogeneous estimate of general satisfaction with services. This internal consistency was confirmed by factor analysis which showed only one factor for the scale (Nguyen, Attkisson & Stegner, 1983).

Attkisson and Zwick (1982) theorised that client satisfaction should be associated with service utilization and that those clients who missed appointments or dropped out of therapy would be less satisfied. As expected clients dropping out of treatment within the first month tended to be less satisfied (as measured by the CSQ-8) than those still in treatment ($r = .37$, $p < .01$). Similarly clients who missed a greater percentage of their scheduled appointments tended to be less satisfied with the service. Attkisson and Zwick also hypothesised that greater improvement in therapy would be related to greater satisfaction. This also, was confirmed and significant relationships were found between client satisfaction and client ratings of improvement, therapists ratings of the clients progress and improvements on self report symptom checklists.

Further evidence for the validity of the CSQ-8 has been found in New Zealand. In his study of psychotherapy outpatients, Deane (in press) found scores on the CSQ-8 to be positively rated to three measures of change.

1. Therapists ratings of change on the Brief Hopkins Psychiatric Rating Scale (Derogatis, 1978).
2. Client ratings of change on the Hopkins Symptom Checklist-21 (Green, Walkey, McCormick, & Taylor, 1988).
3. Client ratings of change on the State Trait Anxiety Inventory (Speilberger, 1983).

Deane examined the possibility that the positive relationship between service satisfaction and symptom change was due to a halo effect resulting from low symptom levels. That is, low symptoms levels cause clients to be satisfied with things in general, including the service. However correlations between change scores and satisfaction remained when concurrent follow up ratings controlled for BHPRS and STAI-Y2 and Deane concluded that change in symptom severity is independent of halo effects. It should also be noted that the therapists ratings of symptom change were independent of client ratings and these would not be influenced by halo effects.

Thus the CSQ-8 emerges as both a reliable and valid measure of global satisfaction with mental health services

In the present study to make the CSQ-31 more suitable for a New Zealand sample, American spelling was changed to English and the word "program" was replaced with the words "the Psychology Clinic". An example of this is question 27, where the original question: "To what extent has our program met your needs ?" was changed to: "To what extent has the Psychology Clinic met your needs ?", The supplementary information sheet was reworded to include appropriate referral sources, and income levels, and New Zealand levels of schooling.

Additional questions. Four additional questions relevant to the Psychology clinic in particular were added to the CSQ-31. As already stated, Larsen et al. (1979) propose that the addition of extra questions should not alter the psychometric properties of the

CSQ-31 and provides additional information useful to the particular setting. These questions were put at the end of the original 31 items so as to not affect the psychometric properties of the questionnaire. They related to how well the clients problems had been explained to the therapist prior to their first visit (Q.32), ease with which the clinic could be contacted (Q.33), clients understanding of their reasons for attending the clinic (Q.34) and special arrangements that had to be made to attend the clinic, for example child care (Q.35, see Appendix I for full items).

The satisfaction with life scale (SWLS)

The SWLS is a 5-item scale, devised by Diener et al. (1985) to measure life satisfaction as a cognitive judgemental process. The SWLS has a two month test-retest correlation coefficient of .82, and coefficient alpha of .87. The items show a high factor loading on one single common factor (Deiner 1984). Scores on the SWLS correlate moderately with other subjective well-being scales such as Cantril's (1965) self anchoring ladder (.0.62), Gurin et al's (1960) happiness scale (0.59) and Andrews and Withey's Life 3 scale (0.68), cited in Diener et.al (1985). As expected it has low correlations with the Affect Intensity Measure (AIM) and the Marlowe-Crowne (1964) scale of Social Desirability (.02).

Life 3.

Life 3 (Andrews & Withey, 1976) is just one item which is designed to predict how respondents feel about their "life-as-a-whole". Responses are rated on a seven point scale, the range being; "Terrible", "Very dissatisfied", Mostly dissatisfied", Mixed, about equally satisfied and dissatisfied", "Mostly satisfied", "Very satisfied" and "Delighted". Life 3 correlates with 13 other measures of global satisfaction designed also by Andrews and Withey, including Changes desired, 7-pt. Satisfaction, 7-pt. Happiness and Ladder:best. Andrews and Withey suggest that Life 3 has a

"central position" among scales that measure evaluations of life as a whole. They report the reliability to be .07 and the validity as .08.

PROCEDURE

Prior to the First Contact

Regular weekly meetings with the director of the Psychology Clinic were held to establish which clients would have their last appointment in the following week.

There were two groups of clients. For the first three months of data collection clients were seen by the independent evaluator at the clinic. The remaining participants were contacted by the independent evaluator by telephone. Clients who the independent evaluator was unable to see due to timing difficulties and clients who stopped attending without prior arrangement were also assigned to the telephone group.

First Contact

Group one. At the conclusion of their last visit clients were told by the psychologist that a client satisfaction study was being conducted at the Psychology Clinic and asked if the independent evaluator could talk to them briefly about taking part in the study. Guidelines were given to all therapists outlining what they should say at this stage (see Appendix II). It was stressed by the therapist that non participation would in no way effect any future contact with the clinic.

The following procedure was adopted for the clients meeting with the independent evaluator.

1. The clients were introduced to the independent evaluator by their therapist who then left the room.

2. It was explained to the clients that the study was being conducted to establish the clients' view of the service and that all clients finishing at the clinic were being asked to participate. It was stressed that clients were not required to take part in the study, and further that their responses would be anonymous. Thus non participation would in no way affect any future treatment they might like to receive later.
3. The clients were given an information sheet to read outlining the purpose of the study (see Appendix III). This emphasized the collection of group not individual data and asked the clients to think about the bad as well as the good things about the clinic.
4. Any questions were answered.
5. Any reasons why the client would be unable to complete the questionnaire such as going on holiday or physical disabilities were discussed. In the case of reading difficulties arrangements to help the client complete the questionnaire would be made. Relatives who accompanied clients were invited to fill out a separate questionnaire.
6. Those clients interested in being included in the client satisfaction study were asked to sign a consent form (see Appendix IV) in which they agreed to take part in the study.
7. A contact address was obtained so that the questionnaire could be sent. A contact telephone number was also requested.

Group two: On their last visit, clients in group two were told by their therapist that a client satisfaction survey was being conducted at the Psychology Clinic by an independent evaluator, not otherwise working at he clinic. These clients were asked if it was alright for the independent evaluator to contact them by telephone to discuss the study. It is clinic practice that the clients who stop attending the clinic prematurely are contacted by mail and a paragraph advising clients of the study was included in this correspondence.

During the telephone conversation the independent evaluator introduced herself to the client. Otherwise steps 2, 4, 5 and 7, were the same as for group one.

Receiving the Questionnaire.

Group one. One week after their last visit to the Psychology Clinic a covering letter was sent to the participants with the questionnaire, reminding them that answers would be anonymous and would not effect any future contact they might have with the clinic. This letter also stressed that in order to improve its service the Psychology Clinic was interested in the negative as well as the positive things clients had to say (see Appendix V). A stamped addressed envelope was included to assist participants returning the questionnaire.

Group two. One week after their last visit to the Psychology Clinic the questionnaire was sent to the participants. The covering letter sent with the questionnaire for this group covered all the points in the covering letter for group one, as well as the information included in the information sheet that group one received during their meeting with the independent evaluator (see Appendix IV). It stressed the need for honest answers and encouraged clients to consider both the negative and positive aspects of the clinic. A stamped addressed envelope was included to assist participants returning the questionnaire.

Follow up Telephone Call.

The research suggests that up to five follow up phone calls might be made to non respondents but the Massey University Human Ethics Committee felt that this would unduly badger the client. For this reason only one follow up phone call was made if a response was not received within eleven days of posting. During this telephone call any reasons why the client did not want to complete the questionnaire were addressed (see Appendix VII, for a typical text of the follow up telephone conversation).

If the questionnaire had been lost a replacement was sent. If the client did not want to do the questionnaire but offered a verbal opinion about the clinic this

was recorded and no further contact made. Any further questions the client had were answered.

The Returned Questionnaire.

Each returned questionnaire was immediately assigned a code number which was transferred to a master sheet containing the clients names. This master sheet was the only way the code number could be connected to the clients actual name. Two copies of the master sheet were made. One of these was kept at the independent evaluator's home in a locked filing cabinet and the other copy in a secure drawer in the Psychology Department office. This procedure meant that the questionnaires themselves were identified only by a code number.

ETHICAL ISSUES

This study was designed in accordance with the ethical guidelines of the New Zealand Psychological Society and has been approved by the Massey University Human Ethics Committee. The main ethical issues to be considered were informed consent and confidentiality.

As outlined in the procedure, clients in group one were given an information sheet which briefly summarized the study and informed them that they were under no obligation to take part (see Appendix III). They were then asked to sign a separate consent form (see Appendix IV). Clients in the second group were told about the study over the phone, and informed that they were under no obligation to take part in the study. These clients received all the relevant information about the study on the covering letter sent with the questionnaire, and were invited to telephone the independent evaluator if they had any questions. It was not possible to require the participants contacted by phone to return a consent form with their questionnaire as having to name the questionnaire can inflate responses by as much as nine percent (Soelling &

Newell, 1983). Instead, consent was inferred from the completion and return of the questionnaire.

Anonymity was assured to all clients by the independent evaluator, either in person or by telephone, and in writing on the information sheet and covering letter. The psychologists at the clinic did not know which of their clients agreed to take part in the study and which clients did not, hence not wanting to fill out the questionnaire did not disadvantage them in any way.

As anonymity was guaranteed to those clients who took part in the study, a problem was foreseen when the answers to the questionnaire resulted in a concern which needed following up. There were potentially two situations in which this could arise. Firstly a client might report a complaint about the service, serious enough for the independent evaluator to feel that the client should be recontacted and the complaint investigated. Secondly the client might indicate on the satisfaction questionnaire the need for more treatment even though they have stopped coming to the clinic. In both these instances it would be necessary to recontact the client and thus threaten anonymity.

If either of these two problems had arisen it was decided that the independent evaluator would make the first contact with the client who would be invited to discuss the problem with the Director of the Clinic. The independent evaluator would explain to the client that in order to take the matter further, anonymity would have to be waived. The procedure of contacting the client through an independent person and inviting them to take things further was first suggested by Pandianiet, Kessler, Gordon, and Damkot (1982). As anonymity had already been guaranteed the decision as to whether to take the matter further rested with the client. If the client to be recontacted was one of the directors own clients, the independent evaluator would approach the clinical coordinator in order to avoid a clash of interests. As it turned out, it was not necessary to trace any clients for the reasons outlined above.

CHAPTER SIX:
RESULTS

This study arose from a request from the Psychology Clinic at Massey University and had two discrete objectives. It sought to scientifically investigate client satisfaction and how it is measured, and also to provide feedback to the Psychology Clinic.

OBJECTIVE 1. Scientific Investigation of Client Satisfaction

The results of the five research hypothesis generated to investigate client satisfaction and its measurement will follow.

Hypothesis 1

Use of an independent evaluator, a guarantee of anonymity, individual explanation of the purpose of the study to clients (by phone or in person), provision of a stamped addressed envelope, and attention to other reasons why the clients would not send back the questionnaire (e.g. writing problems) will combine to produce a response rate higher than the 55% average for mail and phone contact, reported by Lebow (1983b) .

Questionnaires were received back from 83% of the clients surveyed. This is 28% higher than the average rate reported by Lebow (1983b) in a review of 63 Community Mental Health Centres, for phone and mail contact combined. It was impossible to empirically test separately the effectiveness of each technique employed to enhance the response rate as they were presented as a package.

Twelve of the 48 clients surveyed did not return their questionnaire within 10 days and received a follow-up phone call. This resulted in a further four clients returning their questionnaire, increasing the overall response rate from 75% to 83%.

Hypothesis 2

Explaining the purpose of the study to each client in person will produce a higher response rate than explaining it to them by telephone.

This hypothesis was not confirmed. As shown in Table 6.1, no significant difference was found between the response rates of those clients who saw the independent evaluator at the clinic (81 %) and those that were contacted by phone (85 %) χ^2 (1, N =40) = .06 , p >.05. Further no significant difference in global satisfaction was found between the *in person* group (M =28.30) and the *by phone* group (M = 27.41), t(38) = -.67, p > .05.

Table 6.1
Results From the In-Person and By-Phone Groups

Groups	N	Response rate	CSQ-8 score
In person	22	81%	28.31
By phone	18	85%	27.41

While there was no difference in the final response rate it was important to consider whether one group required the follow up phone call more than the other. However, as Table 6.2 demonstrates, both the *in person* and *by phone* groups required follow up phone calls, which resulted in additional questionnaires being received back from both groups.

Table 6.2
Response Rates Before and After Follow Up for the In-Person and By-Telephone groups

Group	Number contacted	Number, (%) returned after initial contact	Total returned after follow up
In person	27	19 (70%)	22 (81%)
By phone	21	17 (80%)	18 (85%)

Hypothesis 3

Global satisfaction with the Psychology Clinic will be unrelated to general life satisfaction.

This hypothesis was confirmed as no correlation was found between the CSQ-8 and life satisfaction ($r = .09$, $p > .05$).

Multiple regression analysis provided further support for this hypothesis. Life satisfaction was included as an independent variable in an all-in multiple regression analyses to assess the relationship between the dependent variable global service satisfaction and a group of independent variables (within Objective 2).

Prior to the analysis the assumptions necessary for multiple regression analysis were checked. The required case to independent variable ratio of 5 to 1 was met, however the sample size of 40 is smaller than 50, recommended for multivariate analysis (Tabachnick & Fidell, 1989). The strength of the analysis is therefore weakened. Frequency and residuals plots were examined for normality, linearity, homoscedasticity, multivariate outliers and independence. The distribution of scores for the CSQ-8 had a moderate negative skew, however this was insufficient to violate the assumption of normality. All other assumptions for multiple regression were met.

When entered into the regression as an independent variable, life satisfaction did not significantly predict overall service satisfaction, (Beta = .017, t=.805).

To conclude, both t-test and multiple regression analysis found satisfaction with the Psychology Clinic to be unrelated to self reported life satisfaction.

Hypothesis 4

Global satisfaction with the Psychology Clinic will be unrelated to the demographic variables a. sex, b. age, c. socio-economic status.

4a. Sex

No significant difference was found between male (M = 28.00) and female (M = 28.50) ratings on the CSQ-8, t(37) = -.41, p > .05.

4b. Age

Age was dichotomized at the medium to form two equal groups, with all clients less than 32 years forming the first group. There was no significant difference between the rates of satisfaction measured by the CSQ-8 for the younger clients (M = 27.20) and the older clients (M = 28.75), t (38) = -1.20, p >.05.

4c. Socio-economic status (SES)

SES was established using the revised socio-economic index for New Zealand (Elley & Irving, 1976) which classifies occupations from 1-6. The clients were then divided into high SES (categories 1 and 2) medium SES (categories 3 and 4) and low SES (categories 5 and 6). Using a one way analysis of variance (ANOVA) no significant differences were found between scores on the CSQ-8 for low (M = 28.60), medium (M =27.56) and high (M = 27.00) SES groups, F(2,34) = .38, p > .05.

In conclusion sex, age and SES were not related to global satisfaction (CSQ-8) with the Psychology Clinic.

Hypothesis 5

Clients' can distinguish between and differentially evaluate the nine different service dimensions measured by the CSQ-31.

Prior to analysis nine variables were formed to reflect the nine dimensions of satisfaction, embedded in the CSQ-31. These variables are called Office procedures, Support staff, Physical surroundings, Type of service, Quantity of service, Treatment staff, Quality of service, Outcome and General satisfaction.

Simple correlations were computed to examine the bivariate relationships among these nine variables. These correlations give some support for the multi-dimensional nature of client satisfaction as a construct and the ability of the CSQ-31 to measure the different dimensions. If clients had been unable to distinguish between the different service dimensions, significant correlations would have been expected between all nine dimensions. This did not occur. Table 6.3 shows that neither Physical surroundings nor Support staff correlate significantly with each other or any of the other eight dimensions of satisfaction. Similarly, Office procedure does not significantly correlate with Type of treatment, Quality of treatment or Outcome. In contrast, if clients were unable to distinguish between and independently evaluate the service dimensions, significant correlations would be expected.

Although significant correlations exist between Kind of service, Treatment staff, Quality of service, Outcome, Quantity of service and General satisfaction, this seems logical. For example, a client who is dissatisfied with the quality and/or the nature of treatment would be unlikely to be satisfied with treatment outcome.

Table 6.3.

Simple Correlations Among Physical Surrounding (Physical), Support Staff, Type of Service (Type), Treatment Staff, Quality of Service (Quality), Outcome, Quantity of Service (Quantity), General Satisfaction (General) and Office Procedures (Procedure)

	Physical	Support staff	Type	Treatment staff	Quality	Outcome	Quantity	General	Procedure
Physical	1.000								
Support staff	.186	1.000							
Type	-.062	-.079	1.000						
Treatment staff	.311	.031	.587**	1.000					
Quality	.280	.006	.666**	.783**	1.000				
Outcome	.017	.153	.627**	.444*	.439*	1.000			
Quantity	.095	.105	.690**	.655**	.629**	.602**	1.000		
General	.128	.108	.683**	.742**	.676**	.757**	.727**	1.000	
Procedure	.194	-.315	.165	.561**	.311	.086	.300	.218	1.000

1-tailed signif: * -.05 ** -.01

OBJECTIVE 2 Feedback to the Psychology Clinic

The second objective of this study was to provide feedback to the Psychology Clinic about how the clients viewed the service they provided. Five questions guided this part of the study and these were:

1. What do clients like about the service ?
2. What do clients dislike about the service ?
3. What components of the service determine global satisfaction ?
4. Were there differences in satisfaction between:
   - i Fee paying and non fee paying clients ?
   - ii Clients attending with neuropsychological problems and all other clients ?
   - iii The clients of senior and assistant clinical psychologists ?
5. How does the service compare to other similar facilities ?

The CSQ-31 was chosen in this study for its comprehensive coverage of the different aspects of service delivery and because it has a psychometrically sound measure of global satisfaction (the CSQ-8) as its core.

Examination of the alpha coefficients for each dimension of satisfaction measured by the CSQ-31 revealed moderate to high levels of internal consistency for all dimensions but Office procedures (see Table 6.4). The low alpha coefficient for Office procedures appears to result from the high degree of satisfaction with clinic confidentiality but some dissatisfaction with the length of the waiting list.

After extracting the CSQ-8 from the larger scale an alpha coefficient of .91 was found, indicating high internal reliability.

Table 6.4
Alpha Coefficients of the Nine Dimensions of Satisfaction Measured by the CSQ-31

Variable	Alpha Coefficient
Outcome	.87
Quantity	.75
Treatment staff	.75
Quality	.63
Support staff	.57
Physical	.61
Office procedures	.15
Type	.63
General	.88

Despite the frequency with which it has been used there are no guidelines about how the information collected from the CSQ-31 should be analysed. Most studies merely provide overall means and standard deviations (Lebow 1982) and sometimes reliability information (De Brey, 1983; Soelling & Newell, 1983; Sabourin et al., 1989). While means and standard deviations provide some guide to client responses their utility is limited and they do little to guide service providers to the aspects of a service that need improving. For example, Sabourin et al. (1989) found a mean score of 28.2 and a standard deviation of 3.1, on the CSQ-8 and similar results were found in the present study (M=27.98, SD = 3.5). This tells service providers very little and the information provided in satisfaction surveys can be utilized more effectively.

In the absence of any guidelines, the present study used a variety of techniques to analyse the data, aimed specifically at answering the questions generated by the Psychology Clinic.

Identifying What Clients Like About the Psychology Clinic

To determine what clients like about a service it is first necessary to separate satisfied from dissatisfied responses, but CSQ guidelines do not specify how this should be done. Since the structure of each response set is such that ratings of "1" and "2" represent dissatisfied responses while scores of "3" and "4" represent satisfied responses, the obvious way to separate the two groups (ie, satisfied and dissatisfied) is to use "3" as the cut of point. Thus for the purposes of this study a client was considered dissatisfied if they rated an item "1" or "2" and satisfied if they rated an item "3" or "4".

Minimum and Maximum Scores. Having separated satisfied and dissatisfied responses, the minimum and maximum scores for each item (see Table 6.5) can now be examined in context. For example, item number 22 (clinic confidentiality) had a minimum score of "3". The fact that no client scored a "1" or "2" on this item indicates that no client was dissatisfied with it. Four other items from the CSQ-31 received a minimum score of "3". Three of these items were about the secretary/receptionist and the other item (Q.11) was about the treatment staff.

Table 6.5.
Results of the Client Satisfaction Questionnaire, For Each Item, N = 40

VARIABLE /item	Item no.	Min	Max	Mean	S.D	Percent satisfied
OFFICE PROCEDURE						
Seen as promptly as felt necessary	1	1	4	3.30	.88	82.50
Clinic more concerned with helping than office procedures	2	2	4	3.80	.46	97.50
Fee that was charged	18	2	4	3.13	.40	97.50
Clinic confidentiality	22	3	4	3.47	.51	100.00
PHYSICAL SURROUNDINGS						
Comfort and attractiveness of the Psychology Clinic	3	1	4	2.80	.91	67.50
Did things about the building detract from the services received	6	1	4	2.85	1.05	57.50
Convenience of location of building	12	1	4	2.34	1.03	35.00
SUPPORT STAFF						
Receptionist generally seemed friendly and made client comfortable	14	3	4	3.88	.33	100.00
Receptionist seemed friendly and made client comfortable on first visit	24	3	4	3.88	.33	100.00
Receptionist interested in helping client	28	3	4	3.63	.49	100.00
TYPE OF SERVICE						
Did client get the kind of help they wanted	7	2	4	3.47	.60	95.00
Service appropriate for their particular need	9	1	4	3.33	.83	87.50
Was client satisfied with the kind of service they received	13	1	4	3.50	.72	92.50
People at the clinic understood the kind of help wanted	25	2	4	3.30	.52	97.50
QUANTITY OF SERVICE						
Quantity of service	4	2	4	3.48	.60	95.00
Received all the services they needed	15	2	4	2.97	.62	80.00
Received as much help as they wanted	26	2	4	3.05	.68	80.00

Table 6.5. contd.....

VARIABLE /item	Item no.	Min	Max	Mean	S.D	Percent satisfied
TREATMENT STAFF						
Person with whom they worked most closely listened to them	11	3	4	3.90	.30	100.00
Person with whom they worked most closely understood clients problems and how they felt about them	17	2	4	3.60	.63	92.50
Person with whom they worked most closely was knowledgeable and competent	19	2	4	3.63	.54	97.50
Person they worked most closely with was interested in helping	30	2	4	97.5	3.70	97.50
QUALITY OF SERVICE						
Satisfaction with quality of service	5	1	4	3.60	.71	92.50
Rating of quality of service	21	2	4	3.63	.59	95.00
Had their rights as an individual respected	29	2	4	3.83	.45	97.50
OUTCOME						
How are the problems you came to the clinic with	8	1	4	3.15	.80	85.00
Extent to which services helped client deal more effectively with their problems	10	2	4	3.43	.71	87.50
Extent to which services have led to any changes in either yourself or your problems	16	2	4	2.95	.68	75.00
GENERAL SATISFACTION						
Satisfaction with the service in an overall general sense	20	2	4	3.60	.63	92.50
Would client recommend service to a friend in need of similar help	23	2	4	3.67	.57	95.00
Extent to which clinic met client's needs	27	2	4	3.10	.71	80.00
If sought help again client would come back to the Psychology Clinic	31	3.48	.68	3.48	.68	95.00
EXTRA QUESTIONS						
Extent problem explained to therapist prior to first visit	32	2.70	.65	2.70	.65	60.00
Ability to contact clinic when necessary	33	3.15	.70	3.15	.70	87.50
Client's understanding of reason for coming to the Psychology Clinic.	34	3.20	.94	3.20	.94	80.00
Specific arrangements necessary, eg, child care	35	3.13	.88	3.13	.88	72.50

Percent of Clients Satisfied With Each Item. A clearer indication of what the clients liked about the Psychology Clinic can be gained by looking at the proportion of clients satisfied with each item, that is, rating "3" or "4". For example, item 1 addresses whether clients were seen as promptly as they felt necessary and Table 6.5 shows that 82.5% of clients were satisfied with this aspect of the service. The findings showed that 100% of clients were satisfied with the fee that was charged, clinic confidentiality, thought the receptionist was friendly and helpful, thought their therapist listened, was knowledgeable, competent, and interested in helping them. Overall most items had a high percentage of satisfied clients.

Percent of Clients Satisfied With Each Service Dimension. By collapsing the above results it is possible to determine the percentage of clients who were satisfied with each dimension measured by the CSQ-31 (see Table 6.6). Because "3" is the criteria used to separate satisfied from dissatisfied clients for each item, satisfaction with each dimension was calculated using a criteria three times the number of items for that variable. An example is treatment staff, which is made up of four items. Mean scores more than 12 (4 items x scores of 3) were considered to represent satisfied clients.

High levels of satisfaction were found overall. Table 6.6 shows that 100% of clients were satisfied with the Treatment staff, and the Support staff and 95% with both the Quality of service and Office procedures.

It should be noted that using "3" as a cut off score reflects those clients who were at least **moderately** satisfied with the service they received. To identify clients who were **very** satisfied, a stricter criteria is required. Also included in Table 6.6 are those clients who scored "4" on all the items in each dimension, reflecting a response of optimal satisfaction. Not surprisingly satisfaction ratings are considerably lower using "4" as the criteria to separate satisfied from dissatisfied

clients. Quality of service, Support staff and Treatment staff are the three dimensions clients are most satisfied with.

Table 6.6
Percent Satisfied, Means, and Standard Deviations for the Nine Dimensions of Satisfaction Measured by the CSQ-31. N = 40.

Variable	Percent satisfied (cutoff=3)	Percent very satisfied (cutoff=4)	Mean satisfaction rating per variable	S.D	Mean satisfaction rating per item
Treatment staff	100.00	47.50	14.83	1.62	3.70
Support staff	100.00	55.00	11.37	0.88	3.79
Quality of service	95.00	57.50	11.05	1.40	3.70
Office procedures	95.00	2.50	13.70	1.30	3.40
Quantity of service	82.50	15.00	9.50	1.56	3.17
Type of service	77.50	22.50	13.60	1.90	3.40
Outcome	72.50	17.50	9.52	2.00	3.20
Physical surroundings	42.50	2.50	8.05	2.32	2.70
General satisfaction	87.5	27.5	13.85	2.35	3.46

Dissatisfaction With the Psychology Clinic

Client satisfaction surveys often result in high ratings of satisfaction and Lebow (1983c) suggests then that the focus should be on dissatisfaction. The aspects of the service which clients dislike can be identified by looking at the items with a low percentage of satisfied clients. For example, because only 35% of clients were satisfied with the convenience and location of the building (Q.12), it can be directly inferred that 65% were dissatisfied with this aspect of the clinic. Further

examination of Table 6.4 reveals that 42.5% of clients thought that things about the building detracted from the service they received (Q.6), 32.5% were dissatisfied with the comfort and attractiveness of the clinic (Q.3), 40% were dissatisfied with the extent to which their problem had been explained to the therapist prior to their first visit (Q.32), and 20% of clients didn't receive all the services they needed (Q15).

Four dimensions of satisfaction had satisfaction ratings off less than 95%: 58% were not satisfied with the Physical surroundings, 27.5% were not satisfied with the Outcome, 17.5% were not satisfied with the Quantity of service and 11% were not satisfied with the Type of service.

The Outcome figure however should be reconsidered as a large percent of the clients attended the clinic for assessment only. While some of the clients attending for neuropsychological assessment received some treatment, other clients attended the clinic predominantly for treatment or psychotherapy.

Clients who attended the clinic for neuropsychological assessment only received no treatment thus would not be expected to score highly on Outcome. Furthermore the clients with neuropsychological problems who did receive some treatment (for example, a memory notebook or cognitive retraining) may not score highly on Outcome, as many of their 'problems' , such as physical disability, are permanent. A one-way analysis of variance (ANOVA) was conducted to examine differences in satisfaction with Outcome between clients attending for assessment only (n=15), assessment and some treatment (n=12), and psychotherapy (n=13). As expected a significant difference in satisfaction with Outcome was found between the 'assessment only' clients (M =8.60) and the treatment clients (M=10.84) , $F(2,37) = 5.93$, $p < .05$. Removing the clients that attended the clinic for assessment only from the analysis reveals that 84% were satisfied with the outcome, thus improving the Outcome proportion by 11.5%. Further, removing all clients attending the clinic with neuropsychological problems and leaving only the

clients attending for psychotherapy reveals that all 13 clients were satisfied with the Outcome of therapy.

Using the stricter criteria of "4", causes the proportion of dissatisfied clients to increase. While Physical surroundings remains the dimension with the greatest proportion of dissatisfied clients, dissatisfaction with Office procedure increased significantly.

Global Satisfaction/Dissatisfaction (CSQ-8)

All previous analysis has concentrated on the percentage of satisfied and dissatisfied clients for the 35 items and nine dimensions measured by the CSQ-31. The following analysis uses the CSQ-8 which is embedded in the CSQ-31. The CSQ-8 is used in favour of the variable General Satisfaction as an indicator of global satisfaction because of its sounder psychometric properties .

In accordance with a previous study be Deane (in press) clients were considered satisfied if they scored "3" on at least seven of the eight items measured by the CSQ-8. This method was adopted in the present study as it seemed reasonable that clients could be dissatisfied with one question of the CSQ-8 before being classified as dissatisfied.

Results showed that seven clients from this study fell into this category (17.5% of the sample), however it was noticed that one of the questions in the CSQ-8 was an outcome measure (Q.10), and this seemed inappropriate, as already stated, for the clients attending the clinic for neuropsychological or sexual abuse assessments. Removing question 10 from the CSQ-8 just for those clients attending for assessment only (making it a 7 item measure) reveals that 90% of total number of clients sampled were globally satisfied with the Psychology Clinic.

Identifying Service Dimensions which Predict Global Satisfaction

It was predicted that some service dimensions would be more crucial in determining whether a client was globally satisfied or not. To examine which dimensions predict global satisfaction an all-in multiple regression analysis was conducted. Global satisfaction (CSQ-8) was the dependent variable, and the dimensions of satisfaction measured by the CSQ-31 were the independent variables.

Because the eight items forming the CSQ-8 were extracted from the CSQ-31, they were common to both measures. This means that perfect correlations exist between some items of the independent and dependent variables making the regression analysis inaccurate, and it was thus necessary to drop the common items from the independent variables. Having done this General satisfaction and Quality of service were not included in the analysis as they had too few remaining items. Type of service lost one item making it to a three item variable. Although Outcome of treatment became a 2-item variable it was left in the analysis due to the predicted importance of this variable to global satisfaction. The variables Physical surroundings, Support staff, Treatment staff, Quantity of service and Office procedure were unchanged. Life satisfaction was included in the regression and was discussed under hypothesis 3, as was the screening of the data.

Table 6.7
Multiple Regression of Type of Service, Support staff, Physical Surroundings, Outcome, Office Procedures, Quantity of Service and Life Satisfaction on Global Satisfaction (N=40).

	Global satisfaction	
Variable	BETA	t
Type of service	.237	.038
Support staff	-.003	.971
Physical surroundings	.052	.496
Outcome	.269	.003
Office procedures	-.174	.061
Treatment staff	.570	.000
Quantity of service	.123	.227
Life satisfaction	.017	.805
Adjusted R^2 = .84	F = 26.71	

As shown in Table 6.7, Type of treatment, Outcome of treatment and Treatment staff were all significant predictors of global satisfaction with the service.

Additional Comments and Suggestions

Seventeen of the forty respondents wrote in the space provided for "comments and suggestions" at the end of the Client Satisfaction Questionnaire. These have been grouped under the headings treatment staff, secretary, treatment, physical surroundings and procedure.

Treatment Staff. Five clients made positive comments about the therapist they saw. These were that the therapist was unjudgemental, caring, sincere, helpful, and had a good interviewing style.

Secretary. Five clients said that the secretary/receptionist was friendly and helpful.

Treatment. One person commented that therapy saved their marriage, but two clients commented that the type of treatment was wrong, and that the therapist's constant note taking was off putting.

Physical Surroundings. Seven clients made negative comments about the physical surroundings. These included that the parking was difficult, the building hard to find, that there was no sun, that the rooms were awkward for left handed people, that the waiting room was unattractive and that the lazyboy chair was like a "hotseat".

Procedure. Five negative comments were made about the procedures used. Two clients wanted their results sent directly to them in writing and not via G.P or physician. One thought the waiting list was too long, one would have liked a phone call reminding them of their next appointment because of their bad memory, and one client said they were not sure what to expect and that a pamphlet would have been helpful.

Differences Between Fee Paying and Non Fee Paying Clients.

Only three of the 40 clients surveyed payed the fee themselves, hence it was not possible to statistically test the difference between fee and non fee paying clients. Two of the fee paying clients were satisfied with the fee that were charged while the other client was not. It appears that satisfaction with the fee is related to global satisfaction as those clients satisfied with the fee were also satisfied with the service, whereas the client who was dissatisfied with the fee was also dissatisfied with the service overall.

Differences Between Clients with Neuropsychological Disorders and all Other Clients

A T-test was conducted to examine any differences in global satisfaction between these two groups of clients. Results showed that clients attending the clinic with neuropsychological disorders (n=26, *M*=26.89) were significantly less satisfied that all other clients (n=14, *M* = 30.23), t(38) = 2.57 p = .05.

It was noticed however that one of the questions in the CSQ-8, (Q10) addressed whether the services clients received had helped them deal more effectively with their problems. As the majority of clients with neuropsychological disorders attended the clinic for assessment only, it is not surprising that they were dissatisfied with this question which relates to outcome. Removing question 10 from the CSQ-8, and making it a seven item measure reveals no significant differences between the clients with neuropsychological problems (*M*=24.77) and all other clients (*M*=26.15), t(38) = -2.04, p>.05.

Differences Between Clients Seen by Senior Psychologists, Assistant Clinical Psychologists or Clients seen by Senior and Assistant Clinical Psychologists in Combination.

One way analysis of variance (ANOVA) showed no significant differences in global satisfaction between those clients seen solely by a senior psychologist (M=29.20) by an assistant psychologist (*M* = 28.50) or in senior and assistant psychologist in combination (*M* = 26.27), F(2,37) = 2.84, p > .05.

However clients were more dissatisfied with the Treatment staff when they were seen by senior and assistant clinical psychologists in combination (*M* = 13.37) than when they were seen solely by a senior psychologist (*M* = 15.37), F(2,37) = 6.50, p < .05.

Comparing the Psychology Clinic to Other Similar Services

No New Zealand study has used the CSQ-31 and only one has used the CSQ-8. Deane (in press) used the CSQ-8 to assess client satisfaction at the psychology departments of two New Zealand hospitals as part of a wider research project. Approximately 90% of clients in Deane's study were satisfied with the treatment they received. Using this criteria in the present study shows that 82.5% of clients were satisfied.

However, differences in the methods used to collect data between these two studies present difficulties in comparing the two studies. This study uses specific techniques to decrease reactivity to the rating situation, one of which was having clients fill out the questionnaire away from the treatment facility. In contrast most of Deane's sample filled out the questionnaires at the facility. Responses have been shown to be higher when questionnaires are filled out of the premises.

CHAPTER SEVEN
DISCUSSION:
FEEDBACK TO THE PSYCHOLOGY CLINIC

The present study used a client satisfaction survey to evaluate a university based outpatient psychology clinic. It sought to both investigate client satisfaction as a psychological construct and the measurement of this construct, and provide feedback to the Psychology Clinic. It was thought that a consumers perspective would provide a useful adjunct to the existing annual evaluation which examined the adequacy of resources from the service providers perspective. This chapter presents the findings of the study to the Psychology Clinic, and a discussion of the broader issues relevant to client satisfaction and its measurement will follow in chapter eight.

It should be remembered throughout this discussion that the clients who attended the clinic with chronic back pain were not included in the sample. Accordingly the results cannot be generalised to all clients attending the Psychology Clinic.

The initial emphasis of the current evaluation was on determining what clients liked about the service they received at the Psychology Clinic. It emerged that the majority of clients were satisfied with the treatment staff, the secretary/receptionist and the office procedures. Specifically, all clients responded favourably to the three questions regarding the secretary/receptionist, felt that the therapist they had worked with most closely listened to them, and were satisfied with clinic confidentiality. All but one thought their psychologist was knowledgeable, competent and interested in helping them. Ratings of satisfaction were also high for the quality of the service, and most clients thought that their rights as an individual had been respected. As a general guide to satisfaction, most clients thought they would come back to the Psychology Clinic if they were to seek help again.

Dissatisfaction mostly centred around the physical surroundings of the Psychology Clinic. The convenience of its location was most dissatisfying and in some way detracted from the services they received and a third of respondents thought that the clinic was uncomfortable and unattractive. Also there was some concern from clients

that they were not seen as promptly as they felt necessary. Although gross figures revealed that a quarter of clients didn't think treatment had led to any changes in themselves or their problems, closer examination showed that a large proportion of clients were attending the clinic for assessment only. It is not surprising that these clients attending for assessment or with neuropsychological problems may not rate the **outcome** of their visits highly. All clients attending for psychotherapy were satisfied with the outcome.

Although nearly a fifth of clients were globally dissatisfied with the service this figure is again inflated, as an outcome item is included in the measure of global satisfaction. Removing the question relating to outcome for those clients attending for assessment only revealed that only a tenth of clients were globally dissatisfied.

Statistical analysis indicated that global satisfaction is predicted by satisfaction with **outcome**, **type of treatment**, and **treatment staff**. That is, if a client is satisfied with these three service dimensions they will be satisfied with the service as a whole. Due to problems with the measurement of some variables (for example Outcome was made up of only two items), this can only be a tentative conclusion. However, because the outcome, type of treatment and treatment staff are so closely related to the reasons why clients attend the clinic in the first place, rather that the more peripheral aspects of the service such as office procedures, this conclusion has face validity.

Four additional questions relating specifically to the Psychology Clinic were added to the CSQ-31. These arose from discussions with the clinic director, and related to the specific aspects of treatment that she thought were likely areas of dissatisfaction with clients.

Questions 32 and 34 concerned the clients view of the extent to which their problem had been explained to their psychologist prior to their first visit, and how much the clients themselves knew about their reasons for attending the Psychology Clinic. These questions arose out of two concerns, the first of which was the amount of information provided in the referral letters which varied enormously. While some

would be a short note, others provided a great deal of information. The second concern related to whether the clients themselves really knew why they had been referred to the clinic. While it would be hoped that all referral letters provided the necessary information and that clients knew the reason for their referral, all to often it appeared that little information was provided to the clinic and that clients had little understanding of why they were attending.

Results showed that close to half the clients thought their problems had been explained to the psychologist somewhat unclearly. This needs further investigation and consultation with the individual psychologists would be useful to determine whether they too think this is a problem. A fifth of clients were unclear of their reasons for being referred to the Psychology Clinic. These clients had been referred from a variety of sources, including ACC, GP's, neurologists and through the EAP schemes. One client commented that they didn't know what to expect and that an information leaflet would have been helpful. In considering possible reasons why clients would not understand the reason for being referred, it was wondered whether the clients with physical problems associated with neuropsychological disorders might not understand the reason for seeing a psychologist, as these clients would typically see a medical specialist. The clients attending with chronic back pain who were not included in the sample may also be unclear about their reasons for attending a psychological service.

About seventeen percent of clients were dissatisfied with both these items, that is, the extent to which the psychologist had been explained their problems and their own knowledge of why they were attending the Psychology Clinic. These problems may be overcome by clearly outlining the necessary information that should be provided to the clinic, and what clients should be told to expect from their visits, to the referral agents.

Because the clinic has only a half time secretary and an answerphone in the afternoon there was a concern that clients might find it difficult to contact the clinic. This was confirmed by the survey as one in eight clients thought the clinic was difficult to contact. This problem would be overcome by employing a full time

secretary, or alternatively all clients could be notified that the secretary is only available to speak with them in the mornings.

Question 35 arose out of a concern that difficulties with childcare might prevent some clients from keeping their appointments or attending at all. While over a quarter of clients had to make special arrangements, unfortunately the item did not tap whether this was a problem for them. Rather than asking whether they had to make special arrangements it would have been better to have asked how much of a problem it was to make these special arrangements.

The separate section for "comments and suggestions" highlighted client dissatisfaction with the physical surroundings and their satisfaction with the secretary's friendly and helpful disposition. In addition, two clients said they would have liked their feedback sent directly to them and not via a G.P or specialist physician, one client felt the therapists note taking was off putting and one client felt that the 'lazyboy' chair (used for relaxation) was like a "hotseat". Another client thought an information pamphlet would have been useful. These extra comments warrant consideration by clinic staff for possible inclusion as separate items in future questionnaires.

Staff at the Psychology Clinic were also interested in whether there were differences between certain groups of clients. As only three of the respondents had paid the fee themselves the differences in satisfaction between fee paying and non fee paying clients was not examined statistically. It is likely that clients who are satisfied rather than dissatisfied with the service will also be satisfied with the fee.

No differences in satisfaction was found between those clients referred because of neuropsychological problems and all other clients. Although, no difference was found in **global satisfaction** between the clients seen by senior qualified psychologists, assistant clinical psychologists, or a combination of the two, differences were found for their satisfaction with the **treatment staff**: Clients were more satisfied with the person with whom they worked most closely when they were seen solely by a senior psychologist, rather than a senior psychologist and assistant

psychologist in conjunction. However, no differences were found between satisfaction with a senior psychologist **or** an assistant psychologist. It could be that the presence of a senior psychologist highlights for clients the differences in skill level between the senior and assistant psychologists. It is also possible that the presence of two psychologists in the room causes clients to feel that they are not being listened to as closely. Further investigation is needed here.

Comparison between services is only possible when standardized scales are used (Lebow, 1987; Tanner, 1989) and unfortunately this has not ben the trend in New Zealand. While outpatient psychological services undoubtedly monitor satisfaction in an ad hoc manner, only one published study was found (Deane, in press). Although Deane too used the CSQ-8, problems still exist in comparing the results of this study due to differences in the methodology used to collect data. The majority of the participants in Deane's study completed questionnaires at the treatment facility, and only those clients who were in a hurry took the questionnaire home to complete. In contrast, the clients in the present study were required to complete the questionnaire away from the treatment facility. Direct comparison to Deane's study reveals that 90% of clients were globally satisfied with the service they received compared to 82.5% in the present study. It is highly probable however, that Deane's result is inflated by reactivity to the rating situation.

The results of this study can be used as a baseline by the Massey University Psychology Clinic in the ongoing evaluation of their service. The results will also contribute to a New Zealand database, and can be used by other services to compare their results against.

In summary, high levels of satisfaction emerged with most aspects of service delivery covered in the questionnaire, especially the individual psychologists, the secretary and the overall quality of the service. Parking and difficulty finding the clinic were two common problems and some clients had difficulty contacting the clinic by telephone.

SUGGESTIONS FOR FUTURE RESEARCH

The present study was successful in identifying specific areas of service delivery with which clients were satisfied, and others with which they were dissatisfied. It is suggested that this data complements the existing annual evaluation which examines the adequacy of resources from the managements perspective. Service evaluation is an ongoing process, and it is necessary to implement a regular system of monitoring client satisfaction. The following is a list of suggestions for future satisfaction surveys.

1. Remove the outcome measure (Q.10) from the CSQ-8, when assessing the global satisfaction of those clients attending the Psychology Clinic for assessment only.

2. As already suggested, question 35 should be altered to assess how much of a problem it was for clients to make any special arrangements necessary to attend the clinic (for example childcare), rather than whether any arrangements were made.

3. To ensure the service is not inappropriate for a particular group of clients, continue to investigate the relationship between client satisfaction and the demographic variables age, sex, and socio-economic status.

4. Future surveys should address how appropriate the service is for Maori clients.

In addition to a client satisfaction survey, it is suggested that a formal record of unsolicited complaints and suggestions be kept.

CHAPTER EIGHT
DISCUSSION:
COLLECTION AND ANALYSIS OF CLIENT SATISFACTION DATA

This study set out to scientifically investigate client satisfaction, and at the same time provide feedback for the Psychology Clinic. The results relevant to the Psychology Clinic in particular were presented in chapter seven and the emphasis in this chapter is on the broader issues of collecting and analysing data.

OBSTACLES IN THE MEASUREMENT OF CLIENT SATISFACTION

This section evaluates the effectiveness of various techniques used to improve the measurement of client satisfaction. While the Psychology Clinic provided the vehicle for evaluating these techniques, many of the issues that were considered are relevant to all client satisfaction surveys. The aim was to design a methodology that would produce reliable and valid results, and yet be inexpensive and easily implemented.

This study systematically addressed the methodological flaws common in much client satisfaction research and a discussion of the effectiveness of these techniques follows.

Sampling Bias

A positive sampling bias is likely to occur for two reasons, each adding to the bias. First, dissatisfied clients dropping out of treatment are not typically included in a study. Second, satisfied clients are much more likely to return their questionnaires. To counteract this, it was decided that all clients who dropped out of treatment would be included in the *by-telephone* group. During the time of data collection, only two clients dropped out of treatment, one of whom completed the questionnaire. As the other client did not respond a small positive bias may still exist.

In an effort to overcome the second cause of sampling bias, a variety of techniques were employed to enhance the response rate. These were developed after extensive research in the early eighties, especially by Lebow (1982a, 1982b, 1983). Those included in this study were explanation of the purpose of the study to the clients (by phone or in person), a guarantee of anonymity, provision of a stamped addressed envelope and attention to other reasons why the clients would not return the questionnaire (for example, writing problems or moving house). It was hypothesised that these techniques would produce a response rate higher than the average rate of 55% for mail and phone contact, reported in a review of 63 community mental health centre's (Lebow, 1983b). The resulting response rate of 83% was considerably higher than the average reported above.

Since these techniques were presented as a package for maximum effect, it was not possible to investigate the effectiveness of the techniques separately. The follow up phone call to non respondents increased the response rate by eight percent. While more than one follow up phone call would likely have increased the response rate further (Lebow 1983), the Massey University Human Ethics Committee thought this would amount to badgering the client.

Although the achieved response rate was a substantial improvement on the studies reviewed by Lebow (1983b) this cannot be attributed directly to the above methods alone. As satisfied clients are more likely to return the questionnaire than dissatisfied clients (Lebow, 1983b) the high response rate could be due to a high degree of satisfaction. Further, since high response rates are not expected in highly transient populations (Lebow 1983b) the response rate in the present study may be due to the clients at the Psychology Clinic coming from a geographically stable community.

It was also hypothesised that seeing the clients in person rather than introducing the study to them over the phone would result in a higher response rate. However this was not the case and no significant difference was found between the *in person* and *by telephone* groups. This finding is an important one because having to be at the clinic for the client's last scheduled appointment is difficult when contact is through

an independent evaluator not otherwise working at the clinic. Further time is wasted when clients do not show up for their last appointment, finish therapy earlier or later than the therapist predicted, and when therapists forget to advise the independent evaluator that a client is due to finish. Contacting the clients by phone by-passes all these pragmatic difficulties and is easily implemented, provided an up-to-date record of client phone numbers is kept. Phone contact also means that the procedure can include all the clients who 'drop out' of treatment

Positive Response Patterns

Previous research suggests that consistently high ratings of client satisfaction may not only be due to a positive sampling bias but also to the demand characteristics of the rating situation. That is, clients may feel unable to say bad things about the service and responses might merely be grateful testimonials. The present study incorporated specific techniques suggested by Lebow (1982a, 1983c) to minimize reactivity. These included a guarantee of anonymity, requiring clients' to complete the questionnaire away from the treatment facility, emphasising an interest in group rather than individual data, asking clients to comment on the bad as well as the good things about the clinic and using an independent evaluator to conduct the study. In a further effort to remove service evaluation from service provision it was decided that questionnaires should be returned to a post office box, rather than to the Psychology Clinic directly.

Although it is not possible to know how successful the attempts to minimise reactivity have been without a control group, the above techniques have previously been effective. For example Deane (in press), found that clients who completed the questionnaires at the treatment facility reported significantly higher rates of satisfaction than clients who completed the questionnaire at home. Similarly, Soelling & Newell (1983) found that asking clients to sign their name on the questionnaire significantly inflated client reports of satisfaction.

Further because clients did report dissatisfaction with some aspects of service delivery (for example, the physical surroundings, length of the waiting list, and the outcome of services) it appears hat they were able to express their negative opinions about the clinic. The knowledge that clients could respond honestly about the aspects of the service they were dissatisfied with adds value to the positive results.

Lack of a Standardized Scale:

Researchers in the area of client satisfaction rarely follow the guidelines for scale development and more commonly make up their own scales in an ad hoc manner. These studies vary so widely that it is impossible to compare rates of satisfaction across different settings. The Client Satisfaction Questionnaire used in the present study, was made up of the CSQ-31, an established questionnaire with the addition of four questions relating specifically to the Psychology Clinic. The CSQ-31 is a multidimensional measure chosen in part because it has as its core the CSQ-8, an increasingly utilized scale with good psychometric properties.

CSQ-31 and CSQ-8 Whether clients' can differentiate between all nine dimensions of satisfaction measured by the CSQ-31 is unclear. Larsen et al., (1979) found only one main dimension and Lebow (1983b) noticed that a general factor is most often found which may be supplemented by specific factors. Because a sample of at least 100 is needed to conduct factor analysis it was not possible to factor analyse the results of the CSQ-31 for our group of clients. However, clearly clients were able to distinguish and differentially evaluate at least some of the nine service dimensions: Physical surroundings, Support staff and Office procedures were three. Further the dimensions which did receive similar ratings seemed logically related. For example responses about the amount of treatment, type of treatment and outcome were related and it is unlikely that someone would be happy with the outcome of treatment if they felt they did not receive enough treatment and/or that the type of treatment was inappropriate.

The global measure of satisfaction (the CSQ-8) embedded within the CSQ-31, has been described by Lebow as "one of the most carefully psychometrically developed and widely used scales" (Lebow, 1984, p.8). Larsen et al., (1979) report an alpha coefficient of .93 for the CSQ-31, and a New Zealand study by Deane (in press) recorded a similarly high alpha coefficient of .92. In the present study an alpha coefficient of .91 was found supporting the demonstrated internal consistency of the CSQ-8.

The search for a multifactorial measure with stronger factors continues, for example, Greenfield and Attkisson (1989) trialed a 30 item measure, the Service Satisfaction Scale. They concluded however that more validation work was needed and until a better scale is established the CSQ-31 remains a useful tool.

THE ANALYSIS OF CLIENT SATISFACTION DATA

In contrast to the substantial amount of research on the methods of data collection, there is very little research to guide data analysis. Most studies report overall means and standard deviations but these do not provide a clear and meaningful distinction between satisfied and dissatisfied clients. Attkisson and Zwick (1982) for example, report a total mean score of 24.16 and a standard deviation of 4.94 on the CSQ-8, which tells service providers very little. While the mean in the present study (27.95) is higher than the mean in Attkisson and Zwick's study, the mean gives no indication of what it was that clients preferred in this setting.

Lebow (1982a, 1984) commenting on the unsatisfactory techniques of data analysis, makes no suggestion to rectify the situation.

In the absence of guidelines for data analysis several methods were employed for this study and the benefits of each will be discussed here.

Proportion of Satisfied and Dissatisfied Clients by Item and Dimension

In addition to the means and standard deviations most commonly generated in client satisfaction studies, the present study separated satisfied and dissatisfied clients and calculated the proportion of each. This was done for individual items as well as the nine service dimensions, which allowed items and dimensions with high and low percentages of satisfied clients to be easily identified. The criteria for separating satisfied from dissatisfied clients is an arbitrary one, although the response sets of the CSQ-31 are such that "1" and "2" are consistently dissatisfied responses while "3" and "4" reflect satisfied responses. It is helpful to separate **satisfied** from **very satisfied** clients and in future studies a distinction should be made between **dissatisfied** and **very dissatisfied** clients.

Identifying Predictors of Global Satisfaction

One of the important reasons to conduct client satisfaction surveys is to attempt to identify aspects of the service that need improving. While service providers could themselves make decisions as to what aspects need improving, they may not be able to accurately predict what aspects of the service are most important to clients. Kaufman (1979) asked both consumers, administrators and board members to rank order items for inclusion in a consumer survey. While all three groups emphasized outcome, only the consumers rated confidentiality and continuity of care as important. The clients and the staff clearly had different priorities as to what is important, thus it is important to monitor the clients perspective.

While satisfaction surveys provide a wealth of information that can be used in planning, resources are seldom endless and it is necessary to prioritise where time and money should be channelled. To identify which aspects of the service determine whether a client is satisfied, multiple regression analysis was used. It emerged that outcome, type of treatment and treatment staff were all predictors of global satisfaction. Although most clients were dissatisfied with the physical surroundings, this did not predict whether clients were globally dissatisfied with the Psychology

Clinic. Thus improving the building would not necessarily improve clients feelings of satisfaction overall, although the management may still decide to improve the building in an effort to provide a better service. Multiple regression analysis gives an indication of the importance that the different aspects of a service, to the clients overall or global satisfaction.

Unfortunately this technique is limited by the absence of a psychometrically sound multidimensional measure of client satisfaction. The dimensions of satisfaction that were inserted into the regression as independent variables come from the subscales of the CSQ-31, however factor analysis of the CSQ-31 did not result in nine discrete factors identified. Most of the independent variable had only three items and Outcome was made up of only two items.

In conclusion, while means are useful to examine satisfaction between the different treatment facilities and to examine the relationship to other variables such as life satisfaction and demographic variables, they do not provide the basic information which is necessary for service providers to identify specific problem areas.

Interpretation of Results

The results were reported in terms of the proportion of satisfied and dissatisfied clients, but to interpret these percentages a context is needed. This context is partly dependent on the particular item or dimension being examined, as well as the goals of each particular service.

Analysis may reveal that 20% of clients were dissatisfied with the outcome of treatment but as research suggests that only 66% of clients receiving psychotherapy will receive a positive outcome (Lambert, Sharpiro & Bergin, 1991), this is actually a positive finding. In contrast, that 12.5% of clients were not able to contact the clinic when they needed to is a concern as it is important for all clients to be able to contact the clinic when they need to. Thus the level of dissatisfaction which will be tolerated will depend on the item/dimension under consideration.

The interpretation of results is also dependent on the goals of each particular psychological service. While one service may aim to achieve the highest possible rate of client satisfaction, another services goal may be to ensure a reasonable or minimum standard is met. An overall satisfaction rating of 70% will be treated quite differently by the above two settings. While the first setting is likely to concentrate on the 30% of dissatisfied clients and ask themselves what it is that these clients were dissatisfied with and how the service can be improved, the second setting is likely to accept the 70% figure and not make any changes.

CLIENT SATISFACTION AS A PSYCHOLOGICAL CONSTRUCT

The Nature of Client Satisfaction

The present study operationalised client satisfaction as both a global (CSQ-8) and multidimensional (CSQ-31) construct. It is clear that clients can differentiate between different aspects of the service delivery and the decision of how to operationalism client satisfaction should be determined by the original purpose for conducting the study. Global measures are helpful to examine relationships between different clients group (for example, fee paying and non fee paying clients) however, to look specifically at what aspects of a service is liked or disliked, multidimensional measures are better. For example, while in the present study there were no significant differences in **global** satisfaction between clients seen solely by senior psychologists, and those seen by assistant clinical psychologists and senior psychologists in combination, differences were found when the variable **treatment staff** was considered: Clients were significantly more satisfied with the treatment staff when they saw them on their own. The CSQ-31 is useful as it provides a lot more information than the CSQ-8, that can incorporated into discussions about how service delivery can be improved.

Client Satisfaction and Demographic Variables

The relationship between service satisfaction and demographic variables has been investigated since the nineteen seventies. The demographic variables commonly examined are age, sex, ethnic origin, marital status, education and socio-economic status. The findings have been inconsistent and demographic variables do not seem to be able to consistently predict client satisfaction. In the present study no relationship was found between global satisfaction with the Psychology Clinic and the demographic variables age, sex and socio-economic status. However, it is useful to examine this relationship to identify whether a service is neglecting the needs of a particular group of clients. For example, it may be catering for white middle class clients and be quite inappropriate for ethnic minorities. Once this has been identified, efforts can be made to adjust the service accordingly.

Treatment groups

Lebow (1983c) suggested that satisfaction studies should concentrate on the different groups of clients, for example, clients attending due to depression, anxiety sexual abuse, rather than processing the data from all the clients together. Because, in the present study there were insufficient clients in each of the different treatment groups it was not possible to examine the relative satisfaction between different treatment modalities. Instead, clients were divided into two groups: those with neuropsychological problems and all others, however no significant differences were found in global satisfaction between these groups.

Client Satisfaction and Life satisfaction

One concern expressed by researchers in the area is that client satisfaction with a service is contaminated by their satisfaction with their life. That is, people who are happy with their life in general will be satisfied with the service they receive. Previous research has suggested that the relationship between these two psychological

constructs (life satisfaction and service satisfaction) depends on the way in which service satisfaction is measured. The present study used the CSQ-8 and hypothesised that life satisfaction and service satisfaction would be unrelated and this was confirmed using correlational analysis. Further evidence for the independence of service and life satisfaction came from the multiple regression analysis as life satisfaction was an insignificant predictor of global service satisfaction. Thus the CSQ-8 appears specific enough to tap client satisfaction with services rather than overall positive and negative orientations.

SUGGESTIONS FOR FUTURE RESEARCH

1. The present study adopted the guidelines suggested in prior research for collecting client satisfaction data. These guidelines proved useful and it is suggested that they be adopted in similar settings so that a New Zealand database can be developed and meaningful comparisons made.

2. Few guidelines exist for analysing client satisfaction data and in this study specific methods were developed. These provided considerable information and it would be useful for other services to use them to verify their utility. In it is suggested that future studies:
   (i) Distinguish between dissatisfied and very dissatisfied clients.
   (ii) Use multiple regression analysis to examine the determinants of satisfaction across different settings to establish whether outcome, type of service and treatment staff consistently predict global satisfaction.
   (iii) Use multiple regression analysis to examine whether the determinants of global satisfaction vary across different treatment groups.

CHAPTER NINE
CONCLUSION

This study began with a discussion of the reasons for, and reservations against, monitoring client satisfaction as a form of service evaluation. It has been argued by some researchers that methodological problems make the results of client satisfaction surveys biased, and thus meaningless. It is true that client satisfaction studies are frequently conducted with no regard to the methodologies used, and because positive results are welcomed by service providers there is little incentive to consider the validity of the results.

Privatisation of the health services and the increasing public demand that health professionals become more accountable to their clients has led to an increased interest in monitoring client satisfaction. The low cost and relative ease of collecting client satisfaction data has added to the attraction. There is a danger, however, that service providers will develop their own scales in an ad hoc manner and not consider the effects that methods of collecting data have on the results.

The biggest threat to the validity of client satisfaction data is the positive response bias which can arise from a poor sampling procedure, and low response rate, as well as the reactivity to the rating situation. However, specific techniques have been designed to overcome these problems, and the results of this study have reinforced the value of incorporating these strategies into the methodology. Any agency considering a similar survey would be well advised to adopt these strategies, firstly to prevent needless time spent time developing the strategies and secondly, to ensure that the results are comparable between the different settings, thus contributing to a New Zealand data base.

There is an anomaly between the abundant guidelines for collecting data, and the dearth of guidelines for analysing it. In the absence of the latter, this study has, in the main, developed its own techniques aimed at answering practical questions about service delivery. A wealth of information is contained within the raw data generated

from satisfaction surveys and it makes good sense to use the data to its fullest extent; otherwise they become merely public relations exercises.

In summary, in addition to validating many of the existing strategies of data collection and providing some suggestions for ways of analysing data, this study has provided feedback for the Psychology Clinic at Massey University in particular. The study has been especially timely as it has coincided with a surge of interest in the health area about Quality Assurance. It appears certain that the current major changes to health services in New Zealand will be require that client opinions are monitored as part of overall service evaluations.

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APPENDICES

APPENDIX I: Client Satisfaction Questionnaire

CLIENT SATISFACTION QUESTIONNAIRE

Instructions

For each question please circle your answer. We also welcome your comments and suggestions.

1. When you first came to the Psychology Clinic, were you seen as promptly as you felt necessary?

4	3	2	1
Yes, very promptly	*Yes, promptly*	*No, there was some delay*	*No, it seemed to take forever*

2. Have you ever felt that our clinic was more concerned with procedures than with helping you?

4	3	2	1
Concerned mostly with helping me	*Concerned more with helping me*	*Concerned more with procedures*	*Concerned mostly with procedures*

3. In general how satisfied are you with the comfort and attractiveness of our clinic?

1	2	3	4
Quite dissatisfied	*Indifferent or mildly satisfied*	*Mostly satisfied*	*Very satisfied*

4. How satisfied are you with the amount of help you have received?

1	2	3	4
Quite dissatisfied	*Indifferent or mildly dissatisfied*	*Mostly satisfied*	*Very satisfied*

5. How satisfied are you with the quality of the service you have received?

4	3	2	1
Very satisfied	*Mostly satisfied*	*Indifferent or mildly dissatisfied*	*Quite dissatisfied*

6. Did things about our building detract from the services you have received?

1	2	3	4
Yes, they detracted very much	*Yes, they detracted somewhat*	*No, they did not detact very much*	*No, they did not detract at all*

7. Did you get the kind of service you wanted?

1	2	3	4
No, definitely not	*No, not really*	*Yes, generally*	*Yes, definitely*

8. You came to our clinic with certain problems. How are those problems now?

1	2	3	4
Worse, or much worse	*No change*	*Somewhat better*	*A great deal better*

9. Considering your particular needs, how appropriate are the services you received?

4	3	2	1
Highly appropriate	*Generally appropriate*	*Generally inappropriate*	*Highly inappropriate*

10. Have the services you received helped you to deal more effectively with your problems?

4	3	2	1
Yes, they helped a great deal	*Yes, they helped somewhat*	*No, they really didn't help*	*No, they seemed to make things worse*

11. When you talked to the person with whom you have worked most closely, how closely did he or she listen to you?

1	2	3	4
Not at all closely	*Not too closely*	*Fairly closely*	*Very closely*

12. How convenient is the location of our building?

4	3	2	1
Very convenient	*Mostly convenient*	*Somewhat inconvenient*	*Very inconvenient*

13. How satisfied are you with the kind of service you have received?

1	2	3	4
Quite dissatisfied	*Indifferent or mildly dissatisfied*	*Mostly satisfied*	*Very satisfied*

14. In general, did the receptionist/secretary seem friendly and make you feel comfortable?

4	3	2	1
Yes, definitely	*Yes, most of the time*	*No, sometimes not*	*No, often not*

15. Are there other services you need but have not received?

1	2	3	4
Yes, there definitely were	*Yes, I think there were*	*No, I don't think there were*	*No, there definitely were not*

16. Have the services you received led to any changes in either your problems or yourself?

1	2	3	4
Yes, but the changes were for the worse	*No there was really no noticeable change*	*Yes, some noticeable changes for the better*	*Yes, a great deal of possible change*

17. How clearly did the person with whom you worked most closely understand your problem and how you felt about it?

4	3	2	1
Very clearly	*Clearly*	*Somewhat unclearly*	*Very unclearly*

18. If you paid a fee at the clinic, are you satisfied with the fee that was charged?

1	2	3	4
Quite dissatisfied	*Indifferent or mildly dissatisfied*	*Mostly satisfied*	*Very satisfied*

19. How competent and knowledgeable was the person with whom you have worked closely?

1	2	3	4
Poor abilities at best	*Only of average ability*	*Competent and knowledgeable*	*Highly competent and knowledgeable*

20. In an overall, general sense, how satisfied are you with the service that you have received?

4	3	2	1
Very satisfied	*Mostly satisfied*	*Indifferent or mildly dissatisfied*	*Quite dissatisfied*

4

21. How would you rate the quality of the service you have received?

4	3	2	1
Excellent	*Good*	*Fair*	*Poor*

22. Do you feel that our clinic has kept your problems confidential?

4	3	2	1
Yes, I feel they definitely have	*Yes, I feel they have*	*No I feel they have not*	*No I feel they definitely have not*

23. If a friend were in need of similar help, would you recommend our clinic to him or her?

1	2	3	4
Definitely not	*No I don't think so*	*Yes, I think so*	*Yes, definitely*

24. When you first came to our clinic, did the receptionist/secretary seem friendly and make you feel comfortable?

4	3	2	1
Yes, they definitely did	*Yes, they generally did*	*No, they generally didn't*	*No, they definitely did not*

25. Have the people in our clinic generally understood the kind of help you wanted?

1	2	3	4
No, they misunderstood almost completely	*No, they seemed to misunderstand*	*Yes, they seemed to generally understand*	*Yes, they understood almost perfectly*

26. Have you received as much help as you wanted?

1	2	3	4
No, definitely not	*No, not really*	*Yes, generally*	*Yes, definitely*

27. To what extent has our clinic met your needs?

4	3	2	1
Almost all my needs have been met	*Most of my needs have been met*	*Only a few of my needs have been met*	*None of my needs have been met*

5

28. How interested has the receptionist/secretary been in helping you?

4	3	2	1
Very interested	*Interested*	*Somewhat uninterested*	*Very uninterested*

29. Have your rights as an individual been respected?

1	2	3	4
No, almost never respected	*No, sometimes respected*	*Yes, generally respected*	*Yes, always respected*

30. How interested in helping you was the person with whom you have worked most closely?

4	3	2	1
Very interested	*Interested*	*Somewhat uninterested*	*Very uninterested*

31. If you were to seek help again, would you come back to our clinic?

1	2	3	4
No, definitely not	*No, I don't think so*	*Yes, I think so*	*Yes, definitely*

32. You came to the psychology clinic with certain problems. How clearly did you feel that these problems had been explained to your therapist prior to your first visit?

4	3	2	1
Very clearly	*Clearly*	*Somewhat unclearly*	*Very unclearly*

33 How easy was the clinic to contact when you wanted to make an enquiry or change any arrangements?

1	2	3	4
Very difficult	*Quite difficult*	*Easy*	*Very easy*

34. How clear was your understanding of the reasons for coming to the clinic?

1	2	3	4
Very unclear	*Unclear*	*Clear*	*Very clear*

35. Did you have to make special arrangements (for example child care, transport) to attend the Psychology Clinic?

1	2	3	4
Yes, it took a lot of organising	*Yes, it took some organising*	*It was easy to organise*	*No, I made no special arrangements*

Comments and suggestions

The following questions concern satisfaction with life. Thereare five statements with which you may disagree or agree. Using a 1-7 scale, please indicate your agreement with each item by circling the appropriate number.

1 Strongly disagree
2. Disagree
3 Slightly disagree
4. Neither agree or disagree
5. Slightly agree
6. Agree
7. Strongly agree

In most ways my life is close to the ideal

1 2 3 4 5 6 7

The conditions of my life are excellent

1 2 3 4 5 6 7

I am satisfied with my life

1 2 3 4 5 6 7

So far I have achieved the important things I want in my life

1 2 3 4 5 6 7

If I could live my life all over again I would change nothing

1 2 3 4 5 6 7

How do you feel about your life as a whole?

Terrible 1
Very dissatisfied 2
Mostly dissatisfied 3
Mixed, about equally
satisfied and dissatisfied 4
Mostly satisfied 5
Very satisfied 6
Delighted 7

SUPPLEMENTARY INFORMATION

INSTRUCTIONS

Now , we would like to know a little more about you. This will help us to know how well the clinic is serving different groups of clients. All information provided by you in this questionnaire will be processed with just a code number, hence is strictly confidential.

BACKGROUND (Please circle appropriate answer or write in space provided).

SEX:

1. Female
2. Male

AGE:

___ Years

CURRENT EMPLOYMENT

1. Employed full time
2. Employed part-time
3. Housewife/househusband
4. Unemployed
5. Full-time student
6. Part-time student
7. Retired

USUAL OCCUPATION (Please specify)

_____

YEARLY INCOME (before tax)

1. Nil
2. Less than $10 000 per year ($192 per week)
3. Between $10 000 and $20 000 per year ($192-$385 per week)
4. Between $20 000 and $35 000 per year ($385-$673 per week)
5. Between $35 000 and $50 000 per year ($673-$962 per week)
6. Over $50 000 per year ($962 per week)

NUMBER OF PEOPLE DEPENDENT ON ABOVE INCOME INCLUDING SELF
(please specify)

_____

EDUCATION

1. Some high school
2. Completed fifth form
3. Completed sixth form
4. Completed seventh form
5. Attended university

WHAT IS YOUR ETHNIC ORIGIN?

1. European
2. Maori
3. Polynesian
4. Other (Please specify)_____

SERVICE (Please circle appropriate answer)

REFERRAL TO THE PSYCHOLOGY CLINIC WAS THROUGH:

1. ACC
2. My G.P.
3. The rehabilitation unit
4. A neurologist
5. Social welfare
6. Myself
7. Other eg, family court
   (please specify)_____

WERE YOU CHARGED AN HOURLY FEE TO ATTEND THE PSYCHOLOGY CLINIC?

1. No
2. Yes
   Please indicate the hourly fee you were charged _____

I USUALLY COME TO THE PSYCHOLOGY CLINIC

1. I came here only once
2. I only came here two or three times
3. Once a week (please specify approximate number of weeks) _____
4. Once or twice a month (please specify approximate number of months) _____

HAVE YOU RECEIVED SERVICES HERE BEFORE?

1. Yes
2. No

HAVE YOU EVER RECEIVED SIMILAR SERVICES ELSEWHERE?

1. No
2. Yes (if so please specify)_____

WAS THERE SOMEONE TO MEET YOU ON ARRIVAL AT THE PSYCHOLOGY CLINIC?

1. Always
2. Most of the time
3. Some of the time
4. Never

ARRANGEMENTS FOR YOUR FIRST VISIT WERE MADE:

1. After initial contact by the clinic director.
2. Appointment time made at first phone call from clinic.
3. Appointment received by mail.
4. Appointment was made by another agency on behalf of the Psychology Clinic.
5. After presenting at clinic in person.

Thank you for filling in this questionnaire.

APPENDIX II: Memo to all clinicians at the Psychology Clinic

MASSEY
UNIVERSITY

Private Bag
Palmerston North
New Zealand
Telephone 0-6-356 9099
Facsimile 0-6-350 5611

FACULTY OF
SOCIAL SCIENCES

MEMORANDUM TO: All clinicians at the Psychology Clinic

Would you please tell your clients on their last visit that a client satisfaction survey is being conducted at the clinic and ask them if they could spare five minutes t talk to me about this. something along the lines of the following:

> "Just before you leave, I have to tell you about a client satisfaction study which is being conducted at the clinic. Would it be alright for someone to come in for a few minutes, just to talk to you about this? You have not met this person before, she does not usually work at the clinic. We have asked her to do this so that the study is done independently of those working here."

In this time Susie would explain the procedure to them and obtain their consent if they wish to take part in the survey.

APPENDIX III: Information sheet

MASSEY
UNIVERSITY

Private Bag
Palmerston North
New Zealand
Telephone 0-6-356 9099
Facsimile 0-6-350 5611

FACULTY OF
SOCIAL SCIENCES

INFORMATION SHEET

A client satisfaction survey is being conducted at the Psychology Clinic. All clients finishing their visits to the clinic are being asked to participate in the study.

The survey is being conducted by Susan Watson, an independent evaluator associated with Massey University who does not otherwise work in the clinic. The survey will go towards the completion of her MA degree.

The Psychology Clinic interested in feedback from clients as this helps us to evaluate the services being provided. Your answers to the survey will be used to make decisions associated with improving aspects of the service offered by the Psychology Clinic. All information given will be confidential. The questionnaire will be labelled with a code number instead of your name and this will be the only form of identification used on any material associated with the study. Your answers will therefore in no way effect the past or any future contact you may have with the clinic.

Participation in this study will involve filling out a questionnaire that will take 15-20 minutes to complete. In order to improve the clinic we need to know the negative as well as the positive things you have to say about the clinic and would like you to answer the questionnaire honestly and openly.

You are under no obligation to take part in the study. If you do fill out the questionnaire and are interested in the results, please indicate on the consent form.

Any questions that you may have about the study should be directed to Susan Watson,
Ph 3569099, ex 8423

APPENDIX IV: Consent form

MASSEY
UNIVERSITY

Private Bag
Palmerston North
New Zealand
Telephone 0-6-356 9099
Facsimile 0-6-350 5611

FACULTY OF
SOCIAL SCIENCES

CONSENT FORM

Clients name: _____

Date: _____

I have read the information sheet and have had an opportunity to have my questions answered. I agree to take part in the study.

CLIENT SIGN HERE: _____

I have discussed the purpose of the study with the client and answered the clients questions about the study.

RESEARCHER SIGN HERE: _____

WITNESS SIGN HERE: _____

I would like the results of the survey to be sent to me

Address for results to be sent:

_____

APPENDIX V: Covering letter (group one)

MASSEY
UNIVERSITY

Private Bag
Palmerston North
New Zealand
Telephone 0-6-356 9099
Facsimile 0-6-350 5611

FACULTY OF
SOCIAL SCIENCES

COVERING LETTER

Dear _____

Enclosed is the client satisfaction survey that we discussed at your last visit to the psychology Clinic.

I must stress again that the answers you give will be anonymous and also, that we are interested in the negative as well as the positive things you have
to say about the clinic. We are constantly trying to improve the service that we offer, and input of clients helps us to determine if any changes are necessary.

It is important that you consider each question separately and state your answer. Some questions may seem repetitive but they are all different. It is expected that it will take you about 15-20 minutes to fill out the questionnaire but work at a comfortable pace that suits you.

Also enclosed is a stamped addressed envelope which you can mail your responses back in. The prompt return of the questionnaire would be appreciated.

Thank you for your time it is greatly appreciated

Yours sincerely

Susan Watson

Susan Watson

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FACULTY OF
SOCIAL SCIENCES

APPENDIX VII: Plan of follow-up telephone conversation

PLAN OF FOLLOW-UP TELEPHONE CONVERSATION

Every telephone call will no doubt be different depending on what the client says but certain things, for example the opening sentence will remain the same for every client. In cases where the client is not home the independent evaluator will try again later rather than leaving a message. If it is necessary to leave a message the independent evaluator will leave her name but will not disclose that she is from Massey University.

The following is a guide as to how the conversations will proceed.

Susan: "Hello, it's Susan Watson here from Massey University. I spoke to you on your last visit to the Psychology Clinic about taking part in a client satisfaction survey we are conducting".

(recognition from client)

Susan "I was just wondering if you had received the questionnaire I sent you to fill out".

If client did not receive the questionnaire another one will be sent out. If the client has received questionnaire but has not filled it out.

Susan: "Of course you are under no obligation to fill out the questionnaire but it is helpful for us to know whether to expect one from you".

If there is any reason why the client would like to fill the form out but is unable to this will be addressed. If they are not planning to send the form back but make a comment regarding satisfaction or dissatisfaction this will be noted and no further contact will be made.

To finish off they will be thanked for their time and the conversation will end.

APPENDIX VI: Covering letter (group two)

MASSEY
UNIVERSITY

Private Bag
Palmerston North
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Telephone 0-6-356 9099
Facsimile 0-6-350 5611

FACULTY OF
SOCIAL SCIENCES

Dear _____

Enclosed is the client satisfaction survey that we discussed on the telephone. As I explained I am an independent evaluator associated with Massey University who does not otherwise work in the clinic.

The Psychology Clinic is interested in feedback from clients about the clinic as this helps to evaluate the services being provided. Your answers to the survey will be used to make decisions associated with improving aspects of the service offered by the Psychology Clinic. In order to improve the clinic we need to know the negative as well as the positive things you have to say about the clinic and would like you to answer the questionnaire honestly and openly.

All information given will be confidential. The questionnaire will be labelled with a code number instead of your name and this will be the only form of identification used on any material associated with the study. Your answers will therefore in no way effect the past or any future contact you may have with the clinic.

It is important that you consider each question separately and state your answer. Some questions may seem repetitive but they are all different.

Also enclosed is a stamped addressed envelope which you can mail your responses back in. The prompt return of the questionnaire would be appreciated. Any questions that you may have about the study should be directed to Susan Watson, Ph. 3569099, ex 8423 .

Thank you for your time, it is greatly appreciated.

Your sincerely

Susan Watson