Workbook 6

Client Satisfaction Evaluations

WHO
World Health Organization

UNDCP
United Nations International Drug Control Programme

EMCDDA
European Monitoring Center on Drugs and Drug Addiction

Acknowledgements

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Overview of workbook series

This workbook is part of a series intended to educate programme planners, managers, staff and other decision-makers about the evaluation of services and systems for the treatment of psychoactive substance use disorders. The objective of the series is to enhance their capacity for carrying out evaluation activities. The broader goal of the workbooks is to enhance treatment efficiency and cost-effectiveness using the information that comes from these evaluation activities.

This workbook discusses the assessment of client satisfaction. It focuses on:

- reasons for assessing client satisfaction
- the use of client satisfaction measures for programme improvement
- measures of client satisfaction

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What is a client satisfaction evaluation?

Client satisfaction evaluations are an excellent opportunity to involve clients or patients in the process of evaluating your programme.

Client satisfaction evaluations can address

1. the reliability of services, or the assurance that services are provided in a consistent and dependable manner;
2. the responsiveness of services or the willingness of providers to meet clients/customer needs;
3. the courtesy of providers; and
4. the security of services, including the security of records.

Specific questions may assess clients' views about :

- the physical setting of services
- the helpfulness of support staff
- information resources
- the competence of counsellors
- the costs of service
- the relevance of services to their needs
- the accessibility of services
- waiting times for service components
- frequency of appointments
- time spent with counsellor
- the 'humanness' of services
- the effectiveness of services in ameliorating their problems

Client satisfaction occupies an 'intermediate' step in establishing a healthy culture for evaluation within a programme or a setting. It often follows process evaluation and cost analysis, and precedes outcome and economic evaluations. Accordingly, measures of client satisfaction lie somewhere between 'process' and 'outcome' measures. When the concern is with the extent to which clients are satisfied with the context, processes, and perhaps the costs of a treatment service or network, the relevant measures of satisfaction can be viewed as process measures. However, when the concern is with the extent to which clients view the programme as having been helpful in resolving their problems, client satisfaction becomes a proxy outcome measure.

It is worth keeping in mind that satisfaction with the treatment processes, treatment compliance, and positive treatment outcomes are inter-related.

Client satisfaction with treatment processes may both influence, and be influenced by, treatment outcomes. Clients who are not satisfied with a service may have worse outcomes than others because they miss more appointments, leave against advice or fail to follow through on treatment plans. On the other hand, clients who do not do well after treatment may have less than favourable attitudes towards a treatment service, even if it was of high quality by other criteria. In practice, these mutual influences may be difficult to disentangle. It is worth keeping in mind that satisfaction with the treatment processes, treatment compliance, and positive treatment outcomes are inter-related.

Ratings of different dimensions of satisfaction have been highly correlated in some studies, and scores on these dimensions have been added to yield overall satisfaction ratings. However, responses to specific items are of interest to service providers who want to find out how a particular aspect of the service could be improved.

Client satisfaction surveys may provide the only means for clients to express concerns about the services received.'

Why do a client satisfaction evaluation?

The assessment of client satisfaction adds an important 'consumer'perspective to evaluations of PSU treatment services and systems. Client satisfaction evaluations can be viewed as an opportunity to 'consult'with clients about their experiences in your programme. Client satisfaction surveys may provide the only means for clients to express concerns about the services received, and to express their views about new services that are needed.

'... evidence of positive client satisfaction is not, in itself, sufficient to establish the effectiveness of treatment.'

Client satisfaction ratings have been criticised as indicators of the quality of human services because they may reflect unrealistic expectations. While this criticism may be valid in some instances, research with clients of mental health services suggests that they can effectively discriminate between services that are different in quality (Lebour, 1983; Sheppard, 1993). It is, however, important to recognise that evidence of positive client satisfaction is not, in itself, sufficient to establish the effectiveness or accessibility of treatment. Clients with no base for comparison may be satisfied with services that are 'ineffective'as determined by more objective outcome evaluations. On the other hand, clients may be displeased with services that achieve the objective of reducing their PSU but employ rigid or authoritarian approaches.

How to do a client satisfaction evaluation?

The most common method for assessing client satisfaction is with self-administered questionnaires. These may be given to clients as they enter or leave services, or at various times in between. They can also be administered at some point after treatment has been completed, when the outcomes of treatment are more clear to the client. Client satisfaction questionnaires can be completed at the time they are distributed, or at a later date selected by the client or program personnel. Stamped, return envelopes can be provided if questionnaires are to be returned by mail. Satisfaction questionnaires also can be mailed to former clients with stamped, return envelopes. A cover letter should explain why the questions are being asked and how the information will be used. The cover letter should also indicate if individual replies will be considered confidential or anonymous, and what steps will be taken to ensure that this is the case. For ethical reasons, risks to clients should be made clear. It should be stated that their responses will not in any way affect present or future treatment.

Programme managers typically want the questionnaire to identify the respondent so that they can follow-up with these individuals who express concerns about the services received. If this is the case, clear provisions for confidentiality must be made, including, for example, removal of the information identifying the client prior to data analysis by computer or other tabular means. For more information about these ethical issues, see Workbook 2 of this series, Step 1A, entitled 'Manage Ethical Issues.'

Client satisfaction also can be assessed in face-to-face or telephone interviews or focus groups. These strategies are more expensive than self-completed questionnaires. If interviews or focus groups are used, it is preferable to have them conducted by someone who is not connected directly with the service. This may be an independent evaluator, volunteers or former clients themselves trained to take on this role. If interviews or focus groups must be done by a manager or staff member, it is best not to have the individual's principal therapist ask about client satisfaction because clients may be reluctant to comment negatively about their treatment directly to their therapist. Interviews may be highly structured, perhaps guiding the client through the same type of questionnaire used on a self-administered basis in other situations. Other interviews, and certainly focus groups, will be much less structured and the resulting information will be analysed qualitatively. Workbook 1 provides guidance for conducting focus group and semi-structured/unstructured interviews. Workbook 2 offers advice on analysing the resulting information.

The design and conduct of client satisfaction surveys

Client satisfaction surveys are most useful when they are designed to meet specific objectives and when they use appropriate methods and measures. This involves choices of sampling procedures, timing, cultural acceptability, and sensitivity of the questions to various levels of satisfaction.

Choosing samples of clients

There are no right or wrong ways to choose samples in client satisfaction surveys. However, it is important that your sample be consistent with the evaluation objectives.

Your strategy for selecting clients for a satisfaction survey can influence the kinds of results you obtain. If the surveys are limited to clients who complete treatment, the results will probably differ from those obtained in surveys that include people who have dropped out of the programme. There are no right or wrong ways to choose samples in client satisfaction surveys. However, it is important that your sample be consistent with the evaluation objectives. If the objective is to learn about client satisfaction among those who complete treatment then there will be no need to involve treatment drop-outs. However, if the aim is to find how, in general, clients feel about the programme, a representative sample of all clients completing the intake process would be more appropriate. Regardless of the sample chosen, you must be sure to clearly describe the sample in subsequent reports. Limitations to the generalizability of results must be stated. For example, are your results biased due to the exclusion of early drop outs?

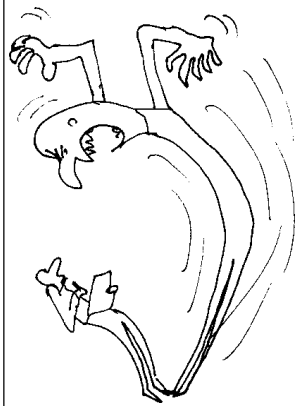
Once you have decided which types of clients will be involved in satisfaction surveys, you have a number of options for choosing particular clients, including a random or systematic sample. These and other options for sampling are discussed in Workbook 2.

Choosing samples of clients

There is no 'best' timing for these surveays, except to ensure consistency with the objectives of the evaluation.

The timing of client satisfaction surveys can influence your results. Clients with positive views during or immediately following treatment may change their minds if they later relapse. On the other hand, clients may gain a greater appreciation of services as their value becomes evident in an increasing number of real life situations. There is no 'best' timing for these surveys, except to ensure consistency with the objectives of the evaluation. If the objective is to find out what clients feel at the time of discharge, then ask clients to complete a satisfaction questionnaire as they are about to leave. However, if the aim is to find out if clients are satisfied as part of an outcome evaluation, wait until some period of time has passed before asking former clients to complete a satisfaction questionnaire. The timing of surveys should be clearly indicated in reports and any associated biases should be discussed. If, for example, clients complete satisfaction questionnaires following an emotional 'graduation' ceremony this could bias attitudes in favour of the programme.

Culture sensituvity



Cultures differ with respect to expectations of feedback on public and private services. In jurisdictions where 'consumerism' is firmly established, frank verbal or written feedback may be freely given. However, direct negative feedback in some cultures may be considered impolite and complaints may only be shared with intimate acquaintances. Direct and challenging questions also may be culturally inappropriate (NIDA, 1993). Experiences with (and attitudes toward) the use of questionnaires, interviews, focus groups and other methods of inquiry also differ between cultures. Methods for soliciting client feedback must take into account the prevailing cultural norms and seek to ensure the use of appropriate methods that assess client beliefs and opinions.

Measures validated in one culture may not be appropriate in others. Simple translation of questionnaire items does not guarantee that the items will have the same meaning across cultures (Attkisson and Greenfield, 1994). Considerable effort may be required to generate new, culturally appropriate questions. Clients, or people advocating on their behalf, should be involved in this process of questionnaire design to ensure that the measures will provide a valid indication of client satisfaction.

Some groups of clients may also find particular methods for assessing client satisfaction more acceptable than others. For example, those with poor cognitive or reading skills may prefer personal interviews over a written questionnaire. However, clients who are shy or have low self-esteem may prefer questionnaires over interviews.

Sensitivity to different levels of satisfaction

...if satisfaction is rated on a five-point scale, the proportions of clients who are 'very satisfied', 'somewhat satisfied' or 'neutral' can be better discriminated...

Many satisfaction surveys of clients of health and social services have shown high levels of satisfaction partly because they have used insensitive measures (Ruggeri, 1994). An example would be using questionnaire items that only have two response options (satisfied/not satisfied). Such items tend to invite a 'satisfied' response, even from those who are neutral of even mildly dissatisfied. However, if satisfaction is rated on a five-point scale, the proportions of clients who are 'very satisfied', 'somewhat satisfied' or 'neutral' can be better discriminated, as can the proportions who are 'somewhat' or 'very' unsatisfied .

Seeking out expressions of dissatisfaction

Clients ... may feel especially obliged to show that they are grateful and satisfied with the services provided.

Clients of human service agencies have a tendency to be grateful for the attention they receive, and to be reluctant to criticise in the event that this leads to negative consequences. Clients with low self-esteem, or who are conscious of status differences between themselves and service providers, may feel especially obliged to show that they are grateful and satisfied with the services provided. These tendencies can be overcome if clients are assured that their honest feedback is being sought and that there will be no consequences for those who criticise the services in question. This can be made clear in verbal or written instructions for completing satisfaction questionnaires or participating in interviews or focus groups. Confidentiality of the results should be assured as strongly as possible. It is desirable to actively seek out sources of discontentment by asking the following kinds of questions:

- Are there any parts of the programme that you liked more than others?
- Have you any suggestions for ways in which the programme can be improved?

Also, look for behavioural indicators of dissatisfaction, for example, high drop-out or no-show rates within specific programmes, or for specific counsellors. While many factors may contribute to low participation, low client satisfaction may be involved.

Established questionnaires for assessing client satisfaction

When choosing a questionnaire for your evaluation, you first need to consider whether all dimensions of client satisfaction are relevant to the service components being evaluated. It is often the case that one treatment agency provides different types of services and activities. You will have to decide whether your client satisfaction questionnaire will provide feedback about individual service components, or whether you will focus on a more global level of programme participation. This will be an issue to resolve in the assessment of satisfaction with services received across a large network of agencies. If the intention is to use the resulting information to suggest highly specific areas for service or system enhancement, you may need to customise your selection of client satisfaction measures to fit particular service or system components. This may ultimately involve a choice between a standardised, global measure of satisfaction available from published literature (see below), and questionnaires tailored to your specific information needs.

If you are going to use a structured, self-administered questionnaire, you may select one from the published literature. Such measures in the public domain will likely have data available on reliability and validity in a particular setting. This is a big advantage, but must be considered in light of cultural variations between the culture in which the questionnaire was validated and the culture in which you intend to use it now . In addition, standardised questionnaires may be too general to give you the kind of detailed feedback you need for making improvements to specific parts of the program. Feedback unique to your program can be derived from a specially-tailored questionnaire, although issues of reliability and validity will be of concern. Open-ended questions can also be added to a self- administered questionnaire and then analysed qualitatively.

A questionnaire which can be used to assess client satisfaction is the Client Satisfaction Questionnaire (CSQ-8). This is a widely used instrument with published data on reliability and validity (Greenfield and Attkisson, 1989). The instrument is available in several languages, including English, Spanish, Dutch and French (de Brey, 1983; Roberts et al., 1984; Sabourin et al., 1987). Case examples of evaluations that used the CSQ-8 also are reported at the end of this workbook.

Workbook 1, Appendix 2 also contains four other examples of questionnaires that can be used to assess client satisfaction. There are no data on the reliability and validity of these other instruments. However, they may be helpful in your situation or stimulate ideas for the development of a questionnaire unique to your needs.

A report from the National Institute on Drug Abuse (1993) entitled 'How Good is Your Drug Abuse Treatment Program?'contains a series of client satisfaction questions used in an AIDS Risk Reduction Project. Two other measures of client satisfaction appropriate for PSU services are the Service Satisfaction Scale (SSS-30) (Attkisson and Greenfield, 1984), and the Verona Service Satisfaction Scale (VSSS) (Tansella, 1991). The SSS-30 is a 30-item multi-dimensional scale developed on the basis of experience with the Client Satisfaction Scale. The first case example at the end of this workbook (Part A: by Thomas Greenfield) describes the SSS-30 in greater detail. The VSSS is an 82-item scale which covers seven dimensions — overall satisfaction, professional skills and behaviours, information, access, efficacy of interventions and relative improvement.

Developing your own client satisfaction questionnaires

A good starting place for the development of a new client satisfaction questionnaire that is tailored to your individual service or treatment system will be your programme logic model and accompanying written descriptions of your programme (see Workbook 1). These will identify the main components, activities and treatment processes for which client satisfaction ratings could be developed. In addition, clients could be asked to rate their satisfaction with the staff, comprehensiveness of the services provided and aspects of the physical environment. It would also be useful to convene small groups of current and former clients to explore issues most relevant to their needs. These groups may be helpful in testing ideas for questionnaire items and response options. The instruments contained in Workbook 1, Appendix 2 also will be useful.

To help validate measures of client satisfaction, the ratings can be compared with verbal reports or satisfaction ratings from family members or others that are familiar with the services received. You can also compare the results using your new questionnaire with the results of an instrument like the CSQ-8 completed by the same people. Client satisfaction ratings can also be compared with actual behaviours that signify satisfaction with services. Comparisons could be made, for example, between client satisfaction ratings and their record of keeping appointments, completing treatment, or returning for further treatment following a relapse.

Using client satisfaction measures during times of change in service delivery

Once reliable client satisfaction measures are available, they can be used for routine or periodic 'check-ups' on the quality of services from the clients' perspective. They also can be used to assess client reactions to changes in service delivery being implemented. For example, changes may be planned to increase the efficiency of a service but there are concerns that these could lead to decreased client satisfaction. Measures of satisfaction taken before or after the changes are introduced will show if this has been the case.

[Clients] could be asked if they feel satisfied with the information that is available on the range of services in the community.

Measuring client satisfaction in evaluations across two or more agencies

It is possible to assess client satisfaction with services received across a network of programmes, rather than focusing on the client's experience with only one service provider. Not all clients will have experience with other services in the treatment network. However, clients of all services may have useful perspectives on system-wide issues. For example, they could be asked if they feel satisfied with the information that is available on the range of services in the community. They could also be asked to rate their satisfaction with recommendations for referral given the options that were presented. Did they like this referral? Was it too far away for them? Do they feel satisfied with being referred to a residential service when they

might have gone to a day treatment or outpatient service (and vice versa)? A review of a logic model for the treatment system may suggest other topics to be included in client satisfaction surveys. For example, waiting times for moving from one service component to another may be of particular concern. The issue of duplication of services is also important to explore, for example, whether agencies in the system duplicate the collection of assessment information when the client moves from one service to another.

Clients who have experienced two or more services in a network may have valuable perspectives on the degree to which these services are co-ordinated. Sample questions concerning client satisfaction with inter-service co-ordination are:

- How satisfied are you with the way that (name of both services) exchanged treatment information about your problems?
- How satisfied are you with the information that (name of both services) provided to you about each other's treatment programmes?
- How satisfied are you with the ways the treatment staff of (name of both services) worked together to help you with your problems?
- Based on your experience, how well do (name of both services) work together?

It's your turn

Put the information from this workbook to use for your own organisation or treatment network. Complete these exercises below.

Remember to use the information from Workbooks 1 and 2 to help you complete an evaluation plan. Review that information now, if you have not already done so.

Exercise 1

Think about your treatment programme or local treatment network. List five general areas in which you want to know the views of clients or patients.

Example:

What do clients think about the helpfulness of our clinicians?

1)
2)
3)
4)
5)

Exercise 2

Using the information provided in this workbook about how to design and conduct a client satisfaction evaluation, make the following decisions:

- Decide what modality you will use to collect the data (questionnaires, interviews, focus groups)
- Choose a sampling procedure for choosing clients to survey
- Decide the timing of the evaluation

- Develop a procedure for ensuring clients' confidentiality and promoting their honesty in answering questions

- Decide who will help you administer the questionnaires/interviews/focus groups.

Example (from above):

- Data will be collected using a self-report questionnaire.

- All clients checking in for appointments during the week of December 10th will be handed the survey to complete while waiting for their appointments.

- Data will be collected over a one week period of time only, from 10-15 December.

- Clients will be given envelopes in which to place their completed questionnaires before returning them to the collection box. The following statement will appear at the top of the questionnaire:

  'Please help us improve our programme by answering some questions about the services you have received. We are interested in your honest opinion, whether it is positive or negative. To ensure your confidentiality, please do not write your name on this form. When you are finished, place the form in the envelope (provided) and seal it closed, then place it in the collection box in the waiting area.'

- Because the questionnaire assesses client satisfaction with staff, it is not feasible for staff to be involved with distributing or collecting questionnaires. A outside research assistant will be hired to hand out the introductory letters, consent forms, and questionnaires. The assistant also will remove the questionnaires from the collection box and keep them in a safe place to ensure their confidentiality from the staff.

Now it's your turn. Follow the same procedure for your evaluation questions.

Exercise 3

You will need to prepare an introductory letter and consent form that explains the purpose of your study. Review **Section 1A** of **Workbook 2**, entitled **Manage Ethical Issues**, for more information about the important topic of participants' rights in evaluation research.

In general, all participants should be asked permission ahead of time before being enrolled in the study. When you do this, your should explain the purpose, nature, and time involved in their participation. No person should be forced or coerced to participate in the study.

A standard practice is to have each participant sign a consent form, which:

- describes the purpose and methods of the study

- explains what they will need to do if they participate

- explains that participation is voluntary

Note that an ethical committee may waive the requirement of a signed consent form if the research contains minimal risk. In these cases, researchers still need to provide full information to participants. A consent form is included in the following example for the sake of completeness.

Example (from above):

Introductory Letter:

We are asking your help in improving our programme by filling out a 2 page questionnaire about the services you have received here. The questions will ask about your views regarding our staff members. They will take about 10 minutes to complete. All information that you provide us will remain strictly private and confidential.

If you agree to participate, please read and sign the consent form (attached) and return it to the research assistant who gave you this packet when you arrived. Thank you for your time.

Sincerely,
Dr. X
Director, Treatment Programme

Consent Form

You agree to participate in a client survey of satisfaction with our staff. You will complete a 2 page questionnaire today, which will take about 10 minutes to complete. Your participation is completely voluntary. You can refuse to answer any questions and/or withdraw from the study at any time without a problem to you or your treatment here. All your responses will remain strictly confidential: programme staff members will not have access to your responses , your name will not appear on your questionnaire, and your responses will not be linked to your identity at any time.

I have read the information above and agree to participate.

Signature:
Date:

Now it's your turn. Using the example above, and the additional information provided in Workbook 2, section 1A, write your own introductory letter and consent form.

Exercise 4

Run a pilot test of your evaluation measurement and procedures to ensure that everything runs smoothly. Review section **IC** of **Workbook 2** entitled **Conduct a Pilot Test** for specific information about how to do this. In general, pilot tests assess these questions:

- Do the questions provide useful information?
- Can the questions be administered properly? For example, is it too long or too complicated to be filled out properly?
- Can the information be easily managed by people responsible for compiling the data?
- Does other information need to be collected?

Example (from above):

A pilot test will be run during one clinic day: 3 November. During this day, 10-15 patients checking in will be given the questionnaire. Afterwards, their responses will be examined to determine whether they seemed to understand the questions and were answering honestly. All persons involved with distributing the forms and compiling the data will be interviewed to determine their views on any improvements that could be made in the process and/or to the forms.

Now it's your turn. Write down how you will pilot test your evaluation study. Don't forget to review Workbook 2 first!

Conclusion and practical recommendation

In this workbook, we have outlined the basic principles and practices in the evaluation of client satisfaction with PSU services and systems. After completing your evaluation, you want to ensure that your results are put to practical use. One way is to report your results in written form (described in Workbook 2, Step 4). It is equally important, however, to explore what the results mean for your programme. Do changes need to happen? If so, what is the best way to accomplish this?

Return to the expected user(s) of the evaluation with specific recommendations based on your results. List your recommendations, link them logically to your results, and suggest a period for implementation of changes. The examples below illustrate how to manage two different kinds of results using this technique.

Unfavourable findings

Based on the finding that over 1/4 of clients were 'very dissatisfied'or 'somewhat dissatisfied'with the friendliness of the clinical staff, we recommend that the programme institute a 2 hour client satisfaction training workshop for all clinicians to attend. The workshop could happen in March, which traditionally is a low-census month for the programme, and be run by Dr. Z, who is well-liked and respected by the staff.

Favourable findings

The results indicate that clients are 'very satisfied' overall with the helpfulness of the clinical staff. Therefore, we recommend that the composition of the clinical staff remain unchanged, and that these favourable findings are publicly acknowledged at the next programme-wide staff meeting.

Remember, clients provide an invaluable perspective on the success of your programme. It is important to use the information that they provide to improve treatment services. Through careful examination of your results, you can develop helpful recommendations for your programme. In this way, you can take important steps to create a 'healthy culture for evaluation' within your organisation.

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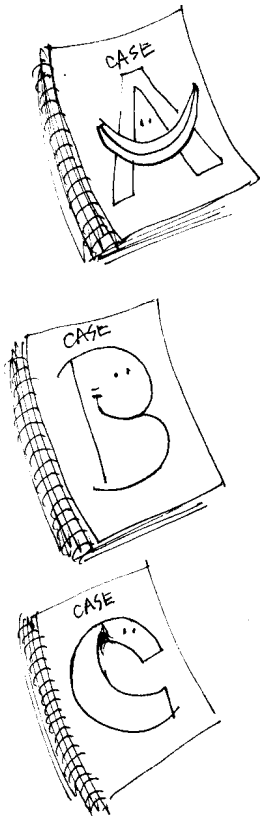
Comments about case examples



Each of the following case examples describes evaluations comparing client satisfaction across sites. The first evaluation (Part A) presents a client satisfaction evaluation of a state-sponsored treatment, primarily for people convicted of drunk driving. Satisfaction was measured using two scales discussed in this workbook: the CSQ-8 and SSS-30. Whereas the CSQ-8 provides a single satisfaction score, the SSS-30 assesses several aspects of client satisfaction. Results were used to guide site procedural improvements.

The second evaluation (Part B) is a good example of how client satisfaction evaluations can be completed with limited resources. In this case, a mental health intern wanted to examine client satisfaction across several residential PSU treatment programmes. With limited assistance, he was able to plan and successfully implement his evaluation. Differences in satisfaction across sites were detected by the multidimensional SSS-30.

The third evaluation examined client satisfaction across three community methadone treatment sites in Australia. Evaluators used the CSQ-8 and two qualitative, open-ended questions to assess satisfaction. They found significant differences in satisfaction across sites. These differences were given to clinic managers to make procedural improvements.

While each of these cases generated useful information about client satisfaction, it is noteworthy that none attempted to provide information about client outcome or treatment effectiveness. As described earlier in this workbook, measurement of client satisfaction is useful yet distinct from measurement of client outcome or treatment effectiveness. On occasion, clients can be satisfied with treatment that is ineffective in reducing PSU. On the other hand, certain treatments can be effective but unpopular with clients. Evaluators must remember that client satisfaction and client outcome are distinct evaluation concepts.

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The second evaluation (Part B) is a good example of how client satisfaction evaluations can be completed with limited resources. In this case, a mental health intern wanted to examine client satisfaction across several residential PSU treatment programmes. With limited assistance, he was able to plan and successfully implement his evaluation. Differences in satisfaction across sites were detected by the multidimensional SSS-30.

The third evaluation examined client satisfaction across three community methadone treatment sites in Australia. Evaluators used the CSQ-8 and two qualitative, open-ended questions to assess satisfaction. They found significant differences in satisfaction across sites. These differences were given to clinic managers to make procedural improvements.

While each of these cases generated useful information about client satisfaction, it is noteworthy that none attempted to provide information about client outcome or treatment effectiveness. As described earlier in this workbook, measurement of client satisfaction is useful yet distinct from measurement of client outcome or treatment effectiveness. On occasion, clients can be satisfied with treatment that is ineffective in reducing PSU. On the other hand, certain treatments can be effective but unpopular with clients. Evaluators must remember that client satisfaction and client outcome are distinct evaluation concepts.

Case examples of client satisfaction evaluations

Part A: An evaluation of satisfaction with a state drinker driver treatment program

The author alone is responsible for the views expressed in this case example.

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Who is asking the questions and why do they want this information?

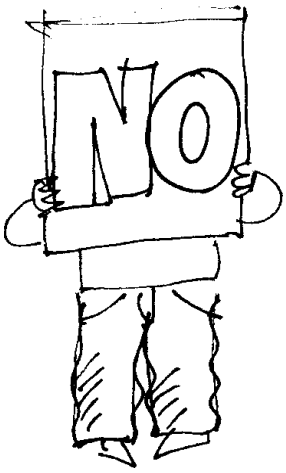
Purposes for the client satisfaction evaluation

There are a number of reasons why clients' satisfaction with services is such a critical variable in an overall substance abuse treatment outcome evaluation effort. First, substance abuse treatment programme directors and managers are often required to justify their programs. They find consumer satisfaction is a concept readily understood by their clients, the public, government bodies, or other funding agencies (Greenfield, 1983). This was the case for a private provider in a small Eastern U.S. state licensed to provide a brief outpatient counselling service to the 'chemically dependent client'. The programme is licensed by the state to provide its services in response to the Driving Under the Influence (DUI) problem. It of course interacts closely with courts, corrections, and the Department of Motor Vehicles (DMV).

Its managers knew that the state and involved agencies would need a positive response from its clientele, in addition to objective outcomes, for continued referrals and relicensing. In addition, the managers wanted data on specific aspects of their programme so that improvement efforts might target areas of greatest concern to clients. The multidimensional SSS-30 questionnaire was selected for this reason based on prior experience in giving useful feedback to student services, primary care, and EAP managers (Attkisson & Greenfield, 1994; Greenfield & Attkisson, 1989a).

Specific programme

In the programme, referrals are primarily (but not exclusively) individuals guilty of a second DUI, and required by law to receive treatment. The programme operates solely on client fees totalling U.S. $495 at the time of the study. After two individual sessions, a treatment plan is developed with suitable, eligible clients. Eligibility requirements include (a) willingness to explore drinking and drug taking, allowing for a 'normal degree of denial', (b) agreement to participate and remain sober and drug free, (c) commitment to be involved and work toward 'reasonable treatment goals', and (d) no overt psychiatric difficulties implying a primary mental health problem. The programme involves approximately 25 contact hours, including four individual sessions, six educationally oriented group sessions, and eight 90 minute group sessions (under 16 members in each group). Additional individual and family counselling may be included if needed. Conditional driving privileges may be restored by the court after 16 hours. The programme has some coercive elements: clients unwilling to participate meaningfully are deemed 'noncompliant', with paperwork indicating this sent back to the referring agency. The court must act to clear this up before the client may again be enrolled in the programme. Upon completion of the treatment, an aftercare plan is developed in the discharge session. The programme's offices are located in various counties and the evaluation focused on three sites to assess their clients' satisfaction. For a more complete description of the programme and the basis for client selection, see Greenfield (1989) and Greenfield (1994).



What resources were needed to collect and interpret the information?

Questionnaires were handed out to clients upon arrival for their final session by programme staff. Completed forms were collected daily during the survey period. Thus, little additional effort was required for administration. A copier was used to duplicate the questionnaires so that the main resource needed was for data entry, accomplished by office staff using the existing dBase software. This was the software package used for maintaining client records (questionnaires were not identified, so no linkage to other client data was possible or attempted). Data entry required approximately two minutes per questionnaire and was done by the office staff responsible for the client information system. Because the programme did not have analysis software or capacity, the dBase files were sent on diskette to the scales' authors for analysis inSPSS. (Scoring keys for in-agency use, and SPSS syntax for reading data from common spredsheet or relational database file formats, are available from the scale's firs author). At each of the two phases, analysis time involved about a day of work with an additional day needed for report writing.

How were the data collected?

The two case studies use direct client satisfaction measures, providing examples of each of the two measurement strategies. Both questionnaires were designed to be broad enough to assess satisfaction with a range of human services including substance abuse treatment. The two are the Client Satisfaction Questionnaire-8 (Nguyen, Attkisson & Stegner, 1983;

Attkisson & Greenfield, 1994; Attkisson & Greenfield, 1995b), a widely-used, brief (8 item), general satisfaction measure, used in the first case study, and the Service Satisfaction Scale-30 (Attkisson & Greenfield, 1994; Attkisson & Greenfield, 1995a, 1995b; Greenfield & Attkisson, 1989a) a 30-item multidimensional version with derivative forms available for case management and residential settings (Greenfield et al., 1996) including a family member version (Greenfield & Attkisson, 1989b). Italian (Ruggeri & Greenfield, 1995) and Spanish translations are available.

There is evidence that these human service measures are suitable for use in substance abuse treatment. The research done suggests good psychometric performance of these two measures (SSS-30 and CSQ-8) (Attkisson & Greenfield, 1994; Greenfield, 1989; Greenfield, 1994; Greenfield & Attkisson, 1989a). The scales are both products of the University of California, San Francisco (UCSF), Department of Psychiatry's research programme on client satisfaction which has extended over a quarter of a century (Attkisson & Greenfield, 1995b). Permission to use these copyright scales may be obtained from Dr. C.C. Attkisson (CSQ-8) at the UCSF Graduate Division, 200 West Milberry Union, 513 Parnassus Avenue, San Francisco, California 94143-0404 USA (FAX+1-415-476-9690) and Dr. Greenfield (SSS-30) at the Alcohol Research Group, 2000 Hearst Ave., Berkeley, California, 94709 USA (FAX+1-510-642-7175).

Both scales can be scored and simply analysed using common statistical programmes such as SPSS or EPI INFO, or spreadsheet or national data base management software such as Lotus 1-2-3, Excel, dBase, or Paradox, among other software programmes. If programming capability is not available in-hours, or more sophisticated analyses are needed, analysis can be done by an evaluator or analyst. SPSS scoring keys and syntax are available from the scale's first author (Thomas Greenfield, INTERNET: tgreenfield@arg.org).

The CSQ has been included in a compendium of instruments assembled by the U.S. National Institute on Alcohol Abuse and Alcoholism (NIAAA), the NIAAA Treatment Handbook Series 2: Alcoholism Treatment Assessment Research Instruments (Attkisson, et al., 1985). Both the CSQ and the SSS have been included in Lloyd Sederer and Barbara Dickeyl 's Outcomes Assessment in Clinical Practice (Attkisson & Greenfield, 1995a) which includes the scales as appendices. Norms and psychometric results for the SSS-30 and CSQ-8 are available in a chapter in Mark Maruish's useful book Psychological Testing: Treatment Planning and Outcome Assessment (Attkisson & Greenfield, 1994). A second edition of this book contains updated chapters on the CSQ-8 (Attkisson & Greenfield, in press) and the SSS-30 (Greenfield & Attkisson, in press).

Because this was a relatively new application to substance abuse treatment, the project involved two phases. In the first, it was decided to conduct factor analyses of the SSS-30 data to confirm the factor-based scales previously developed in mental health and primary care programmes (Attkisson & Greenfield, 1994; Greenfield & Attkisson, 1989a). In the second phase, data were collected from three programme sites in different locations. In both phases, for validation purposes, the CSQ-8 scale was administered at the same time as the SSS-30. The dimensional analyses and comparison of results with the two measures may be considered to be the methodological aims of the study.

For practical reasons, it was only possible to obtain data for people completing the programme. The two questionnaires were to be completed during the last session and left in a box at the door prior to departure. Questionnaires were filled out anonymously. In

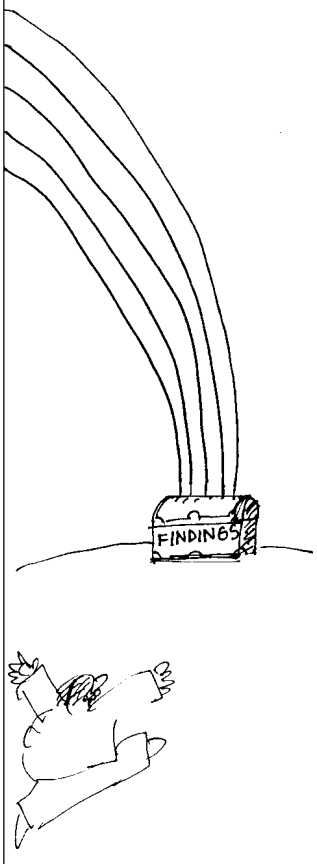
Table 1: Internal reliability of the four SSS-30 subscales.

SSS-30 Subscale	Nº Items	Reliability coefficient (Cronbach' Alpha)	
		Substance Abuse Program	Published norm groups*
Practicioner manner and skill	9	.83	.89
Perceived outcome	8	.83	.83
Office procedures	5	.74	.74
Accessibility	4	.60	.67

* Based on 3 Norm groups - Four health Clinics, a Mental Health Service, and an Employee Assistance Programme (see Attkisson & Greenfield, 1994).

the first phase, demographics were not collected due to an oversight. In the second phase, the SSS-30's standard demographics section was added including gender, age, income, ethnicity, distance from programme, and number of sessions attended.

How were the data analysed?



Analyses were done using SPSS PC and SPSS for Windows7'. Data were read in from dBase7' files provide by the programme (SPSS can read such files directly). Reversed items were recoded 5=1, 4=2, 3=3, 2=4, 1=5 prior to analysis and scoring, based on the published SSS-30 subscales (scoring key and code available from T. K. Greenfield at the Alcohol Research Group, 2000 Hearst Ave., Berkeley, California 94709, USA). In the first psychometric and confirmatory phase (n=1027), item descriptive analyses, factor analyses and reliability analyses (using SPSS factor and reliability routines) of the SSS-30 items were done, comparing similarity of factor solutions using Harmonl 's (1970) coefficient of congruence calculated using a simple spreadsheet. The SSS-30 Total Scale score was correlated (SPSS correlate) with the CSQ-8 score. These preliminary analyses helped assure that the scale functioned well in a substance abuse programme.

In the second evaluation phase (n=720), demographic profiles of clients at each of the three programme sites were first compared. Overall satisfaction was then assessed by examining item and subscale distributions using the SPSS frequencies routine. Subscales were again scored and these scores compared across the three programme sites using SPSS anova (Analysis of Variance) routine. This allowed satisfaction across sites to be compared while controlling for gender differences, since men tend to be more willing to indicate lower satisfaction than women (or are actually less satisfied). Finally, the CSQ-8 and SSS-30 total scores were again correlated.

What did they find out?

Phase 1

The two major SSS-30 factors found earlier in mental health and primary care samples (Attkisson & Greenfield,1994) were confirmed. Practitioner Manner and Skill and Perceived Outcome factors were highly congruent with equivalent ones from earlier studies (Harmon coefficients .88 - .93). These two standard factor-based subscales were, therefore, useful for assessing client satisfaction in this substance

abuse programme. There was also some confirmation for the earlier established Accessibility and Office Procedures factors, so these subscales too were constructed. Internal reliabilities for the four scales were acceptable (see Table 1).

Finally, the SSS-30 Total score and the CSQ-8 score correlated .70, which provides some added validity to the newer scale. When all items are combined to assess general satisfaction, the total scale score may be used as a general satisfaction measure.

Substantive findings indicated that these substance abuse programme's court mandated treatment clients were quite satisfied with both their counsellor's Manner and Skill (programme level = 38.0 + 5.4 versus the norm of 38.4 + 5.0 in mental health counselling) and a bit less so for Perceived outcome (program level = 29.6 + 5.6 versus the norm of 32.4 + 4.0 in mental health counselling). Although lower by half a standard deviation, the mean satisfaction was high (mean-item-mean=4.1), equivalent to a l 'Mostly Satisfied' response. Item-level results showed that many programme completers (41%) were dissatisfied ('Mostly Dissatisfied'or 'Terrible'responses) with cost. It will be recalled that this coerced group of people charged with driving while intoxicated were required by the courts to pay for their substance abuse treatment programme. Facility location and accessibility were also sources of dissatisfaction to 17% and it will be recalled that many had their drivers licenses suspended. Otherwise few clients (under 10%) were dissatisfied with remaining programme aspects although somewhat more were l 'Mixed'in their responses.

It was important to demonstrate congruence between the factors found for substance abuse treatment and those in earlier primary care and mental health norm groups. Although not unexpected, this comparative dimensional analysis confirmed the appropriateness of retaining the original subscale composition, making comparison with findings and norms from other human services realistic and appropriate. In addition, the correlation between the widely used and well validated CSQ-8 general satisfaction measure and the SSS-30 composite scale lends construct validity to the newer instrument as a measure of client satisfaction. The SSS-30 being a multidimensional measure adds to its value to programme managers who find its subscales provide relevant feedback on programme strengths and weaknesses. In addition, its scaling results in less skewed item distributions, leading to more normally distributed scale scores than with the CSQ-8 (Greenfield & Attkisson, in press). It also makes the use of this outcome measure as a dependent variable in multivariate analyses controlling for demographics and other variables more appropriate, increasing its sensitivity to differences in programme performance.

Phase 2

Clientele were mostly male (84%) with modal age 26-35 years old (46%). They were predominantly of Caucasian origin (77%) with African Americans making up 10%, typically high school graduates (48%) with modal income US $20-40,000 (39%) and tended to live 6-10 miles from the programme site. Some clientele differences were seen across sites with women under-represented at one of them. In the cross-site analyses, controlling for gender (which was a significant predictor), Manner and Skill satisfaction did vary significantly ($p<.05$), though not strongly, between sites (together, gender and site accounted for only 3% of the variance, so programme managers were cautioned not to over interpret the statistically significant difference). For Perceived Outcome gender was again significant, but only a trend toward significance ($p=.06$) was seen by site. Contrasting these minimal differences, stronger differences were found for

Office Procedures subscale satisfaction scores. One site had markedly higher satisfaction with office personnel, procedures, referrals, collaboration between staff, and record handling, suggesting support staff were functioning well from the service consumers' viewpoint. Accessibility satisfaction, though not significantly different, favoured the same site. However, one of the other two sites had clients who lived further away.

How were the results used?

It is important to assure that data provided by clients are actually used to improve services, so that the commitment to the client to use her or his input for this purpose is carried through, justifying the small burden of completing the measure.

Results were provided to programme managers in a graphic form, showing overall subscale and item means, as well as cross site comparisons on the subscales for men and women client separately. Subscale score distributions, shown as averaged item means, were given so that the relative number of dissatisfied of 'mixed'responses could readily be seen. Managers can easily share such results with staff. In this case, most of the feedback was positive, allowing for reinforcement of 'a job well done', much needed in substance abuse services where staff burnout tends to be high. In addition, positive office personnel and procedures in the one site could be identified and emulated across sites via cross-site training and selective procedural 'tune-ups.' Results were also used in presenting findings to referring agencies, the courts, Department of Motor Vehicles and accreditation bodies. The methodological results from phase 1 were used to assure the managers and evaluators that the Service Satisfaction Scale was a reliable and valid tool for assessing satisfaction with substance abuse services.

Part B: Client satisfaction with residential substance treatment programmes

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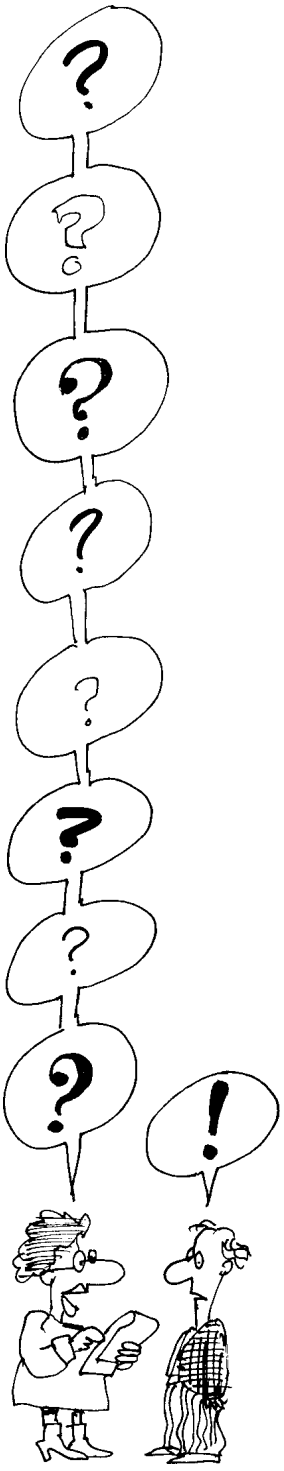
The author alone is responsible for the views expressed in this case example.



Who is asking the questions and why do they want this information?

An intern in a county's umbrella organisation responsible for funding and supervising the management of publicly funded drug and alcohol treatment programmes had concerns about how to measure client satisfaction given an earlier experience with a general satisfaction scale in the county's community mental health centers (CMHCs). In the earlier study, the vast majority of clients in a range of CMHCs, both those thought by the county to be excellent and those deemed weaker, had indicated *mostly satisfied*. The client satisfaction measure was seen as *insensitive*. In fact, the Research Director *had given up on satisfaction questionnaires as a means of obtaining valid client feedback* (Nebeker, 1992, p.2). The intern knew of the newly developed, multidimensional scale, the SSS-30 (Greenfield & Attkisson, 1989a) and approached its first author to consult with him on its use in assessing client satisfaction in residential substance abuse problems. He had hopes that the multidimensional measure, unlike global measures that the county had given up on, might *produce sufficient variation in the data to be able to differentiate one facility from another* Nebeker (1992, p.1). The intern wanted to find a way to reduce Areactivity@ which Lebow (1983, 1983a; 1983b) has discussed as biasing satisfaction responses upward when therapists collect data, or questions are read to clients rather than answered by paper-and-pencil. He wanted to achieve high response rates and potentially study the effect of response rate on satisfaction levels. Substantively, he wished to see if there were measurable differences in satisfaction between samples of active residents in four different residential programmes.

What resources were needed to collect and interpret the information?

The intern reproduced the SSS-30 instrument himself and served as the administrator. First, he secured county agreement for the pilot study. Then he obtained agreement from programme directors to administer the scale himself. He used the sampling and administration method described in the next section which required a medium sized

cardboard box. Once obtained, he entered the data in a word processor, saving the final file as an ASCII text file, which can be read by SPSS (or other statistical programmes). Lastly, he secured the services of the evaluator to assist him with data analysis using an IBM compatible microcomputer version SPSS and wrote up the results as a Masters Thesis (Nebeker, 1992). Considerable independent effort was required of him over the course of a year to accomplish this research project.

How were the data collected?

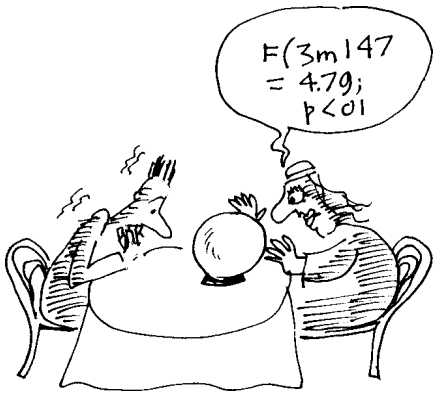
The intern developed what he called a Agroup momentum@ method of data collection which he described as follows: AThrough trial and error [in pilot work] the following method emerged: (1) the staff called a meeting [of residents] for the explicit purpose of filling out the questionnaire; (2) I explained that participation in the study was anonymous and voluntary; (3) the clients were instructed to place the completed forms in a cardboard box with a slit cut into the top of the box; (4) I left the room so that the clients filled out the questionnaire without the presence of staff or a test administrator; (5) I removed the box as soon as the last client had completed the questionnaire (Nebeker, 1992, pp.27-28). The intern comments further that AInstances where the clients filled out the questionnaire individually, outside the group, produced a lower response rate@ (p.28).

How were the data analysed?

Data were analysed in the same way as described in Phase 2 of the previous case study. The standard subscale scores were computed and used to compare the mean scores for each subscale across the four residential programmes, using ANOVA, with post-hoc tests to indicate the source of any difference if found.

What did they find?

Client satisfaction with the programmes differed between facilities on some but not other subscales. One dimension Office Procedures and Personnel showed a significant overall difference between sites ($F(3m\ 147)= 4.79$; $p<.01$). In post-hoc comparisons, one specific programme was found to differ from another on this dimension (Mean-item-mean 3.8 vs 3.3). Perceived Outcome showed an overall trend toward a difference ($p=.11$) and again post-hoc analysis showed the same two residential programmes differed ($M = 3.8$ vs 3.4) significantly ($p<.05$). In terms of Accessibility, the same level of trend toward overall difference was observed. This time the post-hoc pairwise comparisons showed a different programme provided highest satisfaction, statistically ($p<.05$) higher (Mean-item-mean = 3.7) than the residence that had shown lower satisfaction on the other two subscales as well ($M = 3.3$). Only Coun-



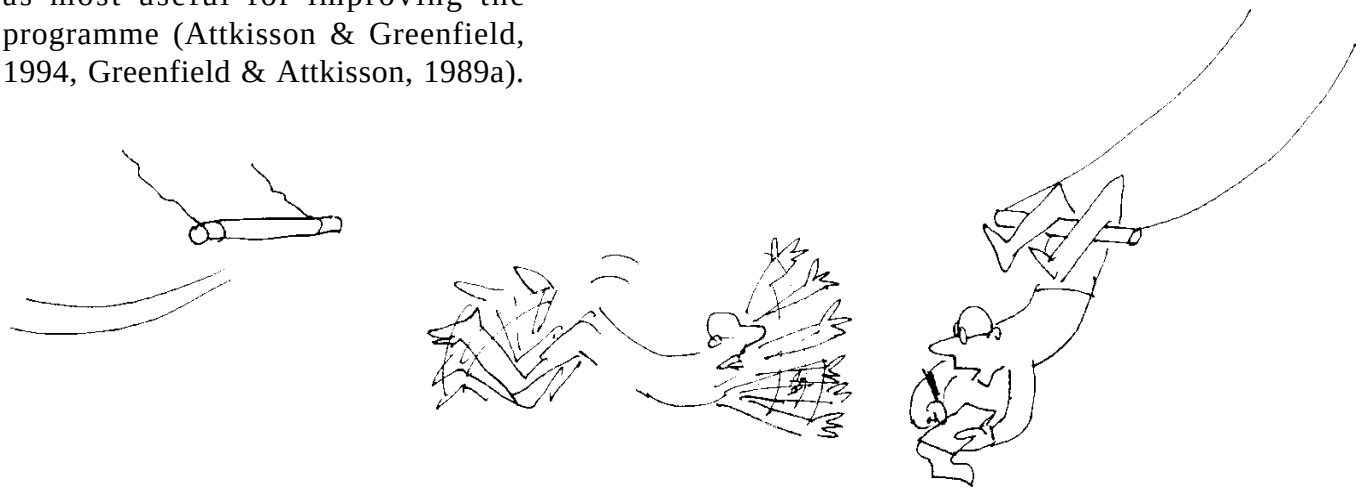
sellor Manner and Skill showed no significant differences between the facilities. Samples obtained during the pilot phase at two facilities had lower response rates than those obtained at each using the Agroup momentum@ approach, which achieved 90-97% response rates. As hypothesised, the samples involving low response rates (20-41%) showed higher satisfaction levels, significantly so for two subscales: Counsellor Manner and Skill ($p<.01$) and Accessibility ($p<.05$). At one of the facilities the low-response-rate sample gave a Manner and Skill mean value of 4.1, or .5 higher than the mean from the more complete sample.

An important finding from this small study was the illustration of the fact that when insufficient efforts are made to assure the highest possible response rates in a nonreactive climate, or when data collection is haphazard and possibly left in the hands of staff, results are likely to be seriously biased toward greater satisfaction. From an ethical view point, it is essential for evaluators, whether internal or external, to help assure a neutral setting for completion of questionnaires where there is minimal programme staff involvement and influence. In other studies that have achieved excellent response rates, a volunteer has served as the individual approaching waiting room clients in an open, friendly manner, explaining the purpose of the study and encouraging candid feedback as most useful for improving the programme (Attkisson & Greenfield, 1994, Greenfield & Attkisson, 1989a).

It is also important to select a scale that has the sensitivity needed to assess real difference in degree of client satisfaction (Greenfield & Attkisson, in press). Global scales in widespread use are brief and attractive to programme administrators, but seldom have the requisite psychometric qualities to allow genuine differences in satisfaction to be detected, except with extremely large samples, sometimes gathered in years of routine monitoring (Greenfield, 1983). For small sample studies a sensitive instrument is absolutely essential.

How were the results used?

The results were provided to programme managers and to the county umbrella group's staff. Anecdotal evidence suggests the county personnel were not surprised by the differences observed which confirmed informal observations of the programme sites. However, the main result of the study was to demonstrate the feasibility of using a multidimensional satisfaction scale designed to have greater sensitivity than global scales in more widespread use, and to show the importance of obtaining high response rates for unbiased estimates of client satisfaction, especially so if the intent is cross-programme comparison.



It's your turn

What are the strengths and the weaknesses of the presented case example? List three positive aspect and three negative aspects:

Strengths of the case study

1

2

3

Weaknesses of the case study

1

2

3

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Part C: The case of community methadons treatment programs

The author alone is responsible for the views expressed in this case example.

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Who is asking the questions and why do they want this information?

Three publicly funded methadone maintenance clinics located in Sydney, Australia participated in an evaluation conducted by the Australian National Drug and Alcohol Research Center (NDARC). The purpose of the study was to examine relationships between treatment received, client characteristics, client satisfaction and treatment outcome in terms of heroin use, crime and HIV risk-taking behaviour. In this case study, the outcome of interest is how satisfied clients are with the treatment they have been receiving and what, if any, variables are related to their level of satisfaction.

The questions were being asked by researchers at NDARC as part of a larger research effort into the clinical aspects of methadone maintenance treatment. Client satisfaction with treatment was investigated, because it has become an important outcome of interest to policy makers and treatment providers (Stallard, 1996). Furthermore, previous research has found client satisfaction to be associated with client characteristics, service utilisation and better treatment outcome in other areas of health care (Pascoe, 1983; Tanner 1981).

What resources were needed to collect and interpret the data?

As the data collected were to be used in statistical analyses, an interview questionnaire was required that preferably would provide a single quantitative estimate of client satisfaction. It was also desirable that the questionnaire be quick to administer and have established validity and reliability (i.e. that it has been demonstrated that the questionnaire measures what it claims to measure and that it does so consistently with different populations and over different situations). Such a questionnaire is the 8-item version of the Client Satisfaction Questionnaire (CSQ-8; (Attkisson & Zwick, 1982). The questionnaire was incorporated in a much larger interview schedule that included questions and questionnaires assessing a range of other variables related to clients' histories, current functioning and recent treatment experiences.

Approximately 350 interview schedules were printed and 348 clients attending the three methadone clinics were interviewed by trained interviewers from NDARC.

How were the data collected?

Trained interviewers from NDARC visited each of the three clinics and interviewed clients on-site for the evaluation project. Clients were told that the information collected would not be communicated to clinical staff in any way that would identify individuals. This was to ensure that they would not modify their answers to questions in order to either please staff or avoid retribution.

The CSQ-8 was filled out by the clients themselves and took approximately 5 minutes to complete. Each of the eight items that make up the CSQ-8 has five responses to choose from ranging from being very dissatisfied to very satisfied to which a score of between 0 and 4 is attached. A higher score indicates more satisfaction with treatment, and the eight scores are summed to yield a single overall measure of satisfaction. The CSQ-8 score for each client interviewed was entered into a computer using SPSS for Windows software. Scoring and data entry for the CSQ-8 took approximately 6 hours. As well as the 8 individual items that make up the CSQ-8, there are two questions that allow for a more open-ended response. These two items ask respondents to complete the sentences: 'The thing I like best about this agency is•'..'and 'If I could change one thing about this agency, it would be•'..'These items were scanned for consistent responses specific to the clinic concerned and recorded for feedback to the clinic staff. This took an additional 10 hours.

How were the data analysed?

The data was entered and analysed using **SPSS for Windows** Version 6.0. When the questionnaires were scored, it was found that 6 of the clients had not completed the forms properly. The responses of these 6 clients were not included in the analysis; this left 342 scores on the CSQ-8 for the analysis.

The data analysis proceeded through four steps, each designed to answer a different question. The four basic questions that informed this analysis were:

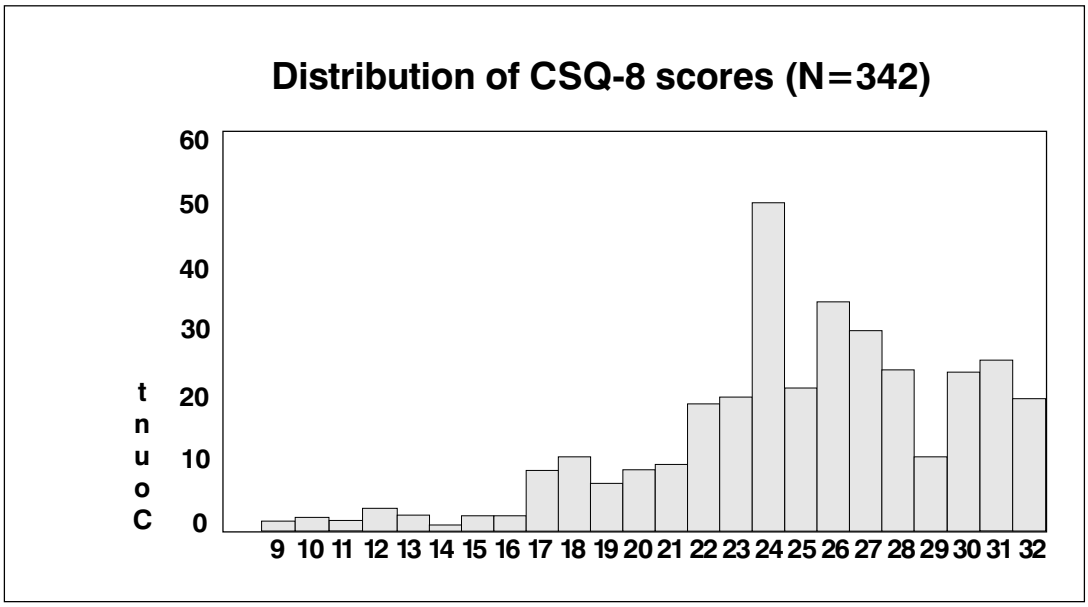
- What form does the distribution of CSQ-8 scores take?
- Is there a difference in client satisfaction at each of the three clinics?
- If the three clinics differ in level of client satisfaction, why and how do they differ?
- What aspects of the treatment program were identified as being in need of change in the clients' responses to the open-ended questions?

What form does the distribution of scores take?

A preliminary step in analysing the data was to inspect the distribution of the CSQ-8 scores to see if the pattern followed that observed in other studies, where a majority of study participants indicate more, rather than less, satisfaction with the treatment they receive (Stallard, 1996). The distribution of the CSQ-8 scores for the study of the public methadone clinics is set out below in Figure 1. Figure 1 is a histogram which represents graphically the number of clients who returned each of the scores on the CSQ-8.

As Figure 1 (on next page) shows, the shape of the distribution suggests that, as in previous studies, clients tended to express more, rather than less, satisfaction with the treatment they received.

Figure 1



Do clients attending the three methadone clinics differ in their level of satisfaction with treatment?

Having determined that clients attending the three methadone clinics tended to be more rather than less satisfied with the treatment they were receiving, an important subsequent question was whether there were any differences in satisfaction with treatment across the three clinics. In order to answer this question the means on the CSQ-8 for each of the three clinics were calculated and can be found in Table 1.

Table 1: Mean CSQ-8 scores for the three methadone clinics

Clinic	Mean CSQ-8 Score
A	22.8
B	24.9
C	26.3

As can be seen from Table 1, the mean CSQ-8 scores for the clients attending the three methadone clinics were different from each other, with the clinic indicated by A having the lowest score and the clinic indicated by C having the highest. To determine whether these differences were simply due to chance or not, the next step was to subject them to a statistical test.

The appropriate statistical test for assessing whether the differences in the scores on the CSQ-8 were due to chance or not is a one-way analysis of variance (ANOVA). The F-ratio, which assesses the statistical significance of the ANOVA was found to be equal to 15.18, which was statistically significant with p set at 0.05 ($F = 15.18$; $df = 2,340$; $p = .000$). This means that the differences observed were not simply due to chance.

To determine which clinics differed from each other, the least significant difference test was employed with adjustment for multiple tests. This revealed that clients attending clinic C were more satisfied than those attending clinics B and A and that those attending clinic B were more satisfied than those attending clinic A.

If the three clinics differ in level of client satisfaction, why and how do they differ?

Having found out that there were statistically significant differences between the three clinics in satisfaction with treatment, as measured by the CSQ-8, the question arose as to why these differences were observed.

In order to answer this question and to examine whether the previously observed relationships between age, service utilisation, treatment outcome and satisfaction would be found with the methadone clients, a multiple linear regression model was developed. In a regression model, an outcome (in this case the scores on the CSQ-8) is predicted by a set of variables often referred to as predictor variables. The model allows us to estimate to what extent any given predictor variable in the model is related to the outcome after taking into account the contribution of all of the other variables in the model. In this case study, a simple model is developed as an example. The procedure followed in developing the model is the one recommended by Kleinbaum (Kleinbaum, Kupper, & Muller, 1988).

As noted at the beginning, client characteristics and treatment outcome have been found in previous research to be related to client satisfaction. In this case study, we will use gender and reported crime in the past month as examples. Typically, previous research has shown women to be more satisfied with health care services than men (Pascoe, 1983; Tanner, 1981), while one of the major outcomes expected of methadone maintenance treatment is that it will reduce crime (Ward, Mattick, & Hall, 1994).

The regression model is set out below in Table 2. In Table 2, variables marked Clinic B and Clinic C are known as 'dummy'variables and indicate the extent of the relationship between these two clinics and the CSQ-8 when compared with Clinic A which is used as a reference category.

The F statistic at the bottom of the table indicates that the model, as a whole, is associated with client satisfaction as measured by the CSQ-8. Looking at the variables in the model, it can be seen that there appears to be no difference between men and women in their level of satisfaction. Similarly, the outcome from treatment indicated by whether the client reported committing a crime in the month prior to interview, is also unrelated to satisfaction with treatment. However, in the case of crime, the p value (.059) is close to the significance level (.05) and suggests a closer look at this relationship

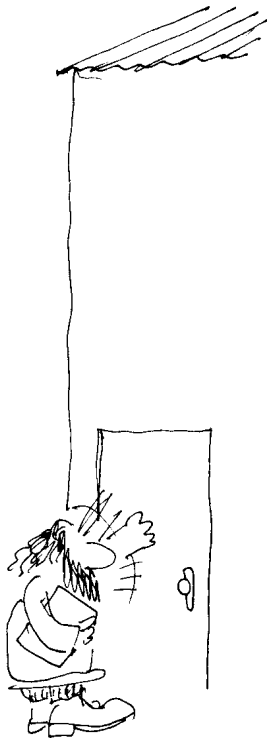
Table 2: Multiple regression model for predicting client satisfaction with methadone treatment

Variables in model	Regression coefficient	Standard error	t	P
(Constant)	22.83	.58	39.36	.000
Clinic B	3.59	3.59	5.60	.000
Clinic C	2.24	2.24	3.45	.001
Crime reported in past month	-0.99	-0.99	-1.90	.059
Gender (1=male)	0.37	0.37	0.75	.455

F=8.663, p=.000

might be warranted. After adjusting for gender and crime, we find that there are still significant differences between the three clinics. The meaning of the statistically significant relationships for the clinics is that when compared with Clinic A as a reference category, clients attending both Clinic B and Clinic C are more satisfied with the treatment they have been receiving.

What aspects of the treatment program were identified as being in need of change in the clients' responses to the open-ended questions?



The clients' responses to the questions concerning what they liked and what they thought needed changing concerning their treatment were read and sorted into major thematic groups. There is insufficient space in this context to elaborate fully on these responses. However, an example will suffice. One of the main client concerns were the restricted hours that the clinics were open for methadone dosing. By far the most common thing that clients would change if they could was the times at which the clinics were open.

What did the study find out?

In terms of the variables selected for investigation in this case study, it has been shown that while clients attending three public methadone clinics in Sydney, Australia tend to be satisfied with the treatment they have been receiving, there are statistically significant differences between the level of satisfaction at these three clinics. Unlike studies in other areas of health care, gender and treatment outcome were not found to be related to level of satisfaction, although the treatment outcome selected (crime) was very close to being statistically significant, suggesting that further investigation may be warranted to determine if and under what circumstances it may be related to satisfaction with treatment. It is important to note, however, that this analysis has intentionally been restricted to a small number of variables for the purposes of this cases study and that the relationships investigated may be different when placed in the context of the larger number of variables included in the study.

How where the results used?

In the first instance, the results were communicated to staff at the participating clinics. As an example of the way in which the results were used by the clinic managers, one aspect of the survey's use by the manager of Clinic A will be discussed. The manager of Clinic A, which had the least satisfied clientele was not surprised by the results. A recent change in the clinic's location and changes to staffing levels were thought to be the cause of the client's unhappiness. This was reflected in the clients answers to the open-ended questions at the end of the CSQ-8. The manager requested a copy of the data set which was made available so that future surveys conducted by clinic staff could be compared with the results of this first survey. In this way, the manager would be able to assess whether changes that were being planned would improve clients' satisfaction with their methadone treatment.

The results of the study will also be published in an appropriate journal and will contribute to the scientific literature on methadone maintenance clinics and on client satisfaction in general.

It's your turn

What are the strengths and the weaknesses of the presented case example? List three positive aspect and three negative aspects:

Strengths of the case study

1

2

3

Weaknesses of the case study

1

2

3

References for case example Part C

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