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An Evaluation of the Silver Chain Grief Support Service

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Abstract

Client satisfaction is recognized as an important indicator in performance monitoring and evaluation. The Silver Chain Grief Support Service was evaluated using client satisfaction as a performance indicator. Data were collected via mailed, telephone and personal interviews utilizing the Client Satisfaction Questionnaire-8, dimensions of the Evaluation Ranking Scale, and open-ended questions. Results indicate high levels of satisfaction with the service. Findings and limitations of the evaluation are discussed. Recommendations for improvement of the service are presented.

In recent years program evaluation has developed into a respected scientific discipline, and as a consequence has become increasingly important in social and organizational policy formation (Patton, 1982). Therefore evaluating how well services/programs are being delivered has become central to program planning and implementation.

A program is a set of related activities representing a major result area, with identified outputs and/or outcomes, directed toward the achievement of an objective (The Treasury, 1989). Program evaluation may be defined as a periodic or cyclic process in which data on the performance and impact of a program and the activities and work units which make up the program elements, are systematically collected, analyzed and used by stakeholders to make decisions about the future of that or similar programs (Department of Treasury and Finance, 1995).

Program evaluation literature frequently characterizes evaluations according to two types:

- Formative (developmental, process): Aimed at providing information for program improvement, modification, and management.

- Impact (summative, outcome, effectiveness): Aimed at determining program results and effects,

> especially for the purpose of making major decisions about program continuation, expansion, reduction, and funding (Patton, 1982. p.44).

The present evaluation is a formative evaluation, undertaken to obtain the perceptions and experience of clients of the Silver Chain Grief Support Service (GSS) with a view to program improvement. While the program activities include telephone counselling, group counselling and individual counselling, only the last mentioned activity has been evaluated.

Performance Indicators. In order to continuously measure, monitor, evaluate and improve program performance, managers require information which relates required outputs to inputs. Outputs are the goods or services produced, while inputs are the resources expended when producing an output (The Treasury, 1989). This information can be provided by measurements of actual performance, such as actual/budget expenditure and output/workload; expected net appropriation revenues and actual receipts; and/or performance indicators. Performance indicators may be defined as objective quantitative and/or qualitative, verifiable measures which provide information on the extent to which a program has achieved its objectives (Armstrong, 1994).

Client Satisfaction has been adopted by Home And Community Care (HACC), Silver Chain's major funding body, as a

performance indicator in performance monitoring and evaluation. Thus the concept of client satisfaction has been used as a performance indicator in this evaluation.

Operational definition of satisfaction. Satisfaction may be defined as the extent to which the service fulfills the clients' treatment expectations (Lebow, 1982a). Operationalization of satisfaction is generally possible through client self-report and behavioural indices (for example, utilization or discontinuation of utilization of the service).

Dimensions of care that were assessed in this evaluation. When measuring patient/client satisfaction it is important to be cognizant of the dimensions of service delivery that have been found to influence satisfaction judgements. A content analysis by Ware, Snyder, & Wright (1976) of 900 published evaluation of health care services questionnaire items identified the following dimensions of a service which potentially affect clients' evaluations: Accessibility/convenience, "art" of care, availability, continuity, efficacy/outcome, finances, physical environment, and technical quality of care.

In their development of the Evaluation Ranking Scale, Pascoe and Attkisson (1983) identified similar dimensions. Satisfaction with these dimensions has therefore been measured in this evaluation. These are as follows:

- Location and appointments
- Building, rooms, and waiting time
- Assistants and helpers
- Counsellors
- Clients' needs vs services
- Service results

The Service. The Silver Chain Nursing Association was established in 1905 as a non political, non sectarian and not for profit organization. It offers a wide range of services, including home nursing, personal care, home help, respite, etc., the goal of which is to assist the sick and terminally ill to receive the care that they require in the comfort of their own homes, should they so wish. In a 1993 review of the Hospice Care Service it was recommended that resources be made available to extend the existing bereavement counselling service to people in the community in need of bereavement support or counselling. The Silver Chain Grief Support Service (GSS) was thus established in October 1994 to provide counselling, education, resources, and information on loss and grief to the community of Western Australia.

On 1st September 1995 the GSS established its main office in West Perth, bringing its clinical, administrative and support staff together. Counselling by appointment is provided on these premises as well as in several satellite rooms in the metropolitan area. The service is provided by paid and voluntary counsellors, all of whom have undertaken

the GSS training program, and receive regular professional supervision. In a 1995 pilot evaluation of the individual counselling aspect of the program, a high level of client satisfaction was reported.

Objectives of this evaluation: (a) To measure client satisfaction with the GSS individual counselling service. (b) To provide both positive and negative feedback to GSS staff, when indicated. (c) To make recommendations on the ongoing functioning of the GSS.

Method

Participants

As a pilot evaluation of client satisfaction had been done during the last quarter of 1995, it was decided that the first half of 1996 would afford the participation of a different and larger group of clients than in that evaluation. Furthermore it was decided to request the participation of only those clients who had completed counselling to ensure that the same type of satisfaction would be measured across the sample. Therefore clients who presented for counselling in the first

five months of 1996 and who were no longer receiving counselling were asked to participate in the evaluation.

One hundred and thirty six clients met the above criteria and were invited to participate in this evaluation. Of these, 43 (32%) consented and participated. Of the 43 participants, 38 (88%) were female, and 5 (12%) were male. Participants ranged in age from 20 to 80 years.

Measures

The measures chosen for this evaluation were the Client Satisfaction Questionnaire-8 (Attkisson & Zwick, 1982), the Evaluation Ranking Scale (Pascoe & Attkisson, 1983), and open-ended questions (Appendix A).

The Client Satisfaction Questionnaire-8 (CSQ-8) is a shortened version of the Client Satisfaction Questionnaire-18 (CSQ-18) (Attkisson & Zwick, 1982). As the CSQ-8 can easily be supplemented by open-ended questions and/or items pertaining to areas of special interest (Nguyen, Attkisson, & Stegner, 1983), open-ended questions and items regarding the following dimensions of the Evaluation Ranking Scale (Pascoe & Attkisson, 1983) were added to the instrument for the purpose of this evaluation: (a) GSS location and appointments, (b) Building, rooms, and waiting time, (c) GSS assistants and

helpers, (d) Counsellors, (e) Clients' needs vs GSS services, and (f) Service results.

The CSQ-8 is one of the most carefully psychometrically constructed and widely used health care evaluation scales (Lebow, 1983). The 8 items of this standardized instrument provide a homogeneous estimate of general satisfaction with services. There are four response choices for each of the items, from "1" indicating the lowest degree of satisfaction through to "4" indicating the highest degree of satisfaction. There is therefore no neutral position, thus enabling elicitation of a positive or negative response. Coefficient alpha for this questionnaire is .93 (Perreault & Leichner, 1993).

To counteract the CSQ-8's lack of attention to the importance of the six dimensions of care identified in the Evaluation Ranking Scale (GSS location and appointments, building and waiting time, GSS assistants and helpers, counsellors, clients' needs vs GSS services, and service results), items regarding these were added to the CSQ-8 and clients were asked to rate each in the same way that they rated the CSQ-8 questions (i.e. from "1" indicating the lowest degree of satisfaction through to "4" indicating the highest degree of satisfaction).

To further improve the content validity of the CSQ-8 it also was decided to use a qualitative approach to document

participants' feedback of their experience of the service. According to Williams (1994) quantitative measures tend to elicit high levels of satisfaction while qualitative reports reveal greater levels of dissatisfaction. Open-ended questions were therefore added to the instrument as it was hoped that important information would be obtained by this means.

Procedure

A letter (Appendix B) was sent by Silver Chain to all the clients who were selected to participate in this evaluation. It explained the purpose of the evaluation and requested their participation. The letter also explained that although Silver Chain had requested the evaluation, the person conducting it was not a Silver Chain employee but an independent researcher which would guarantee that their responses would remain confidential.

The letter seeking consent to participate specified for each participant his/her method of participation (i.e. mailed interview, telephone interview, or personal interview). Clients were selected for each group through random selection procedures. It was requested that if they agreed to participate, they should sign and return the included letter of consent (Appendix C) in the enclosed postage paid envelope by a stipulated date. If they did not do this, the

assumption would be made that they did not wish to participate. It was made explicit in the letter that their non-participation in the evaluation would in no way affect any service which they may have been receiving from Silver Chain. When it was clear which clients were willing to participate, a list of their names, addresses, and telephone numbers were given by Silver Chain to the researcher. Of the 136 clients who were approached, 21 consented to a mailed interview, 14 to a telephone interview, and 8 to a personal interview.

The researcher then sent the questionnaire with a covering letter (Appendix D) and a postage paid envelope to the participants who had agreed to being interviewed by mail. The remaining participants were contacted by telephone to arrange for a time convenient to them for their nominated method of interview (that is, telephone or personal). All personal interviews were conducted in the participants' homes. Although the interviews were standardized, they ranged in length from 30 to 60 minutes as some participants spent more time than others on the open-ended questions.

Results

The majority of participants (93%) reported that in an overall general sense they were satisfied with the service they had received. As may be seen in Figure 1, 72% were "very satisfied" and 21% were "mostly satisfied".

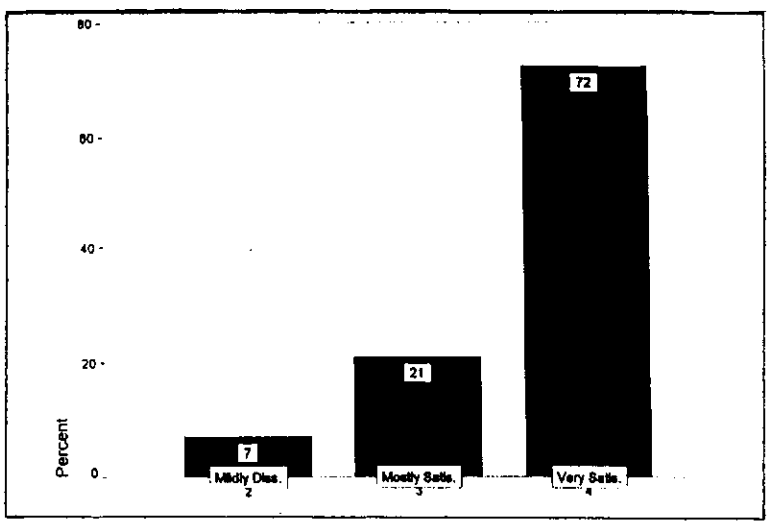

Figure 1. Overall satisfaction with service

Furthermore the majority of participants (98%) were satisfied with the quality of service that they had received. As is shown in Figure 2, 72% of participants rated the quality of the service that they received as "excellent" and 26% rated it as "good".

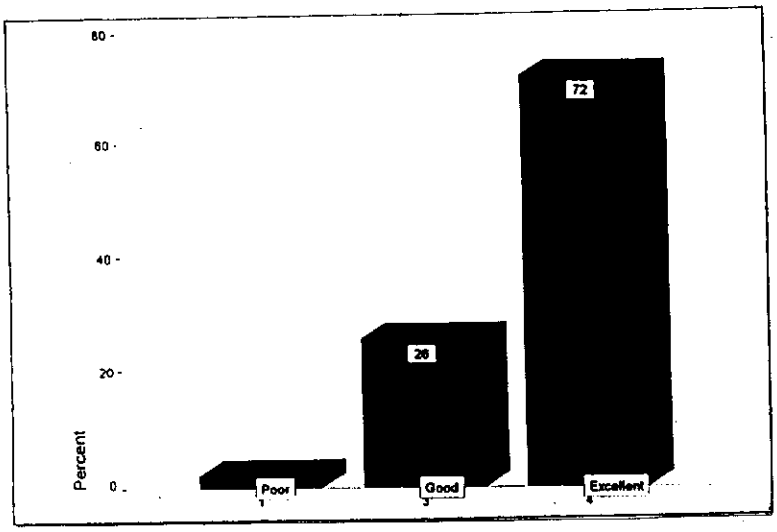

Figure 2. Quality of service received

To assess outcome, participants were asked whether the service had met their needs, and whether it had helped them to deal more effectively with their problems.

As may be seen in Figure 3, 40% of the participants felt that "almost all" of their needs had been met and 47% felt that "most" of their needs had been met.

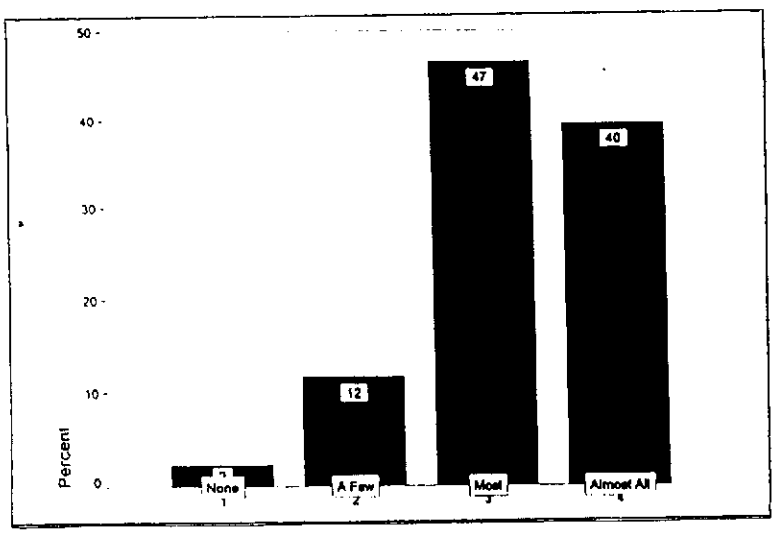

Figure 3. Service met needs?

Similarly, as may be seen in Figure 4, in assessing whether the service had helped them to deal with their problems, 53% responded that it had helped "a great deal" and 44% responded that it had helped "somewhat".

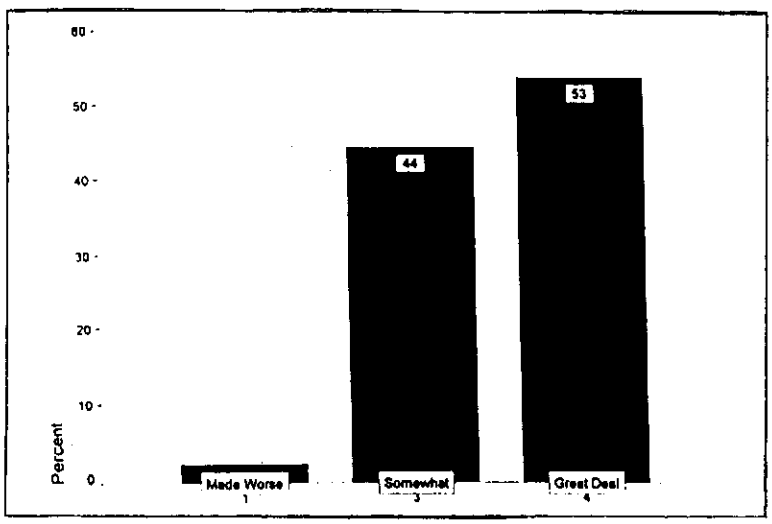

Figure 4. Service helped with problems

To further assess outcome, participants were asked to rate their level of distress before and after counselling on a scale of 1 to 10. Eighty six percent of participants reported that counselling had reduced their level of distress. The mode level of reduction was 4 points.

As behavioural indices can be used to ascertain satisfaction, participants were asked whether, if in a similar situation, they would use the service again, and whether they would recommend the service to others.

As may be seen in Figure 5, the majority of participants

responded that they would use the service again (79% "definitely yes" and 14% "yes").

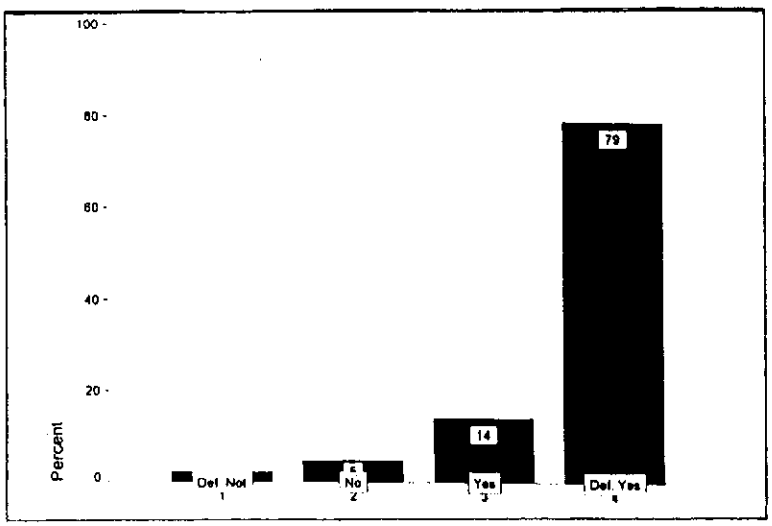

Figure 5. Would use service again?

Similarly, as is shown in Figure 6, 86% responded "definitely yes" and 12% responded "yes" when asked whether they would recommend the service to others.

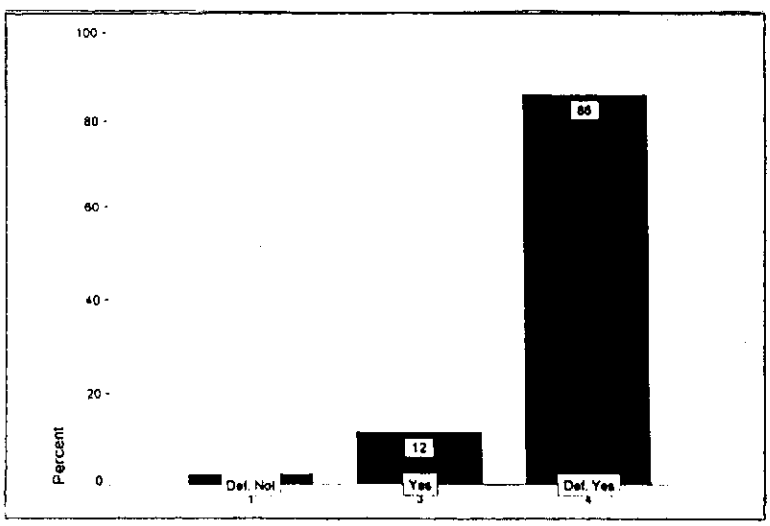

Figure 6. Recommend service?

To ascertain whether the service had met the participants' treatment expectations, they were asked whether they had received the kind of service that they had wanted, and how well the service and the counsellors had met their expectations.

As is shown in Figure 7 the majority of participants responded that they had received the kind of service that they had wanted (53% "definitely yes", and 40% "yes")

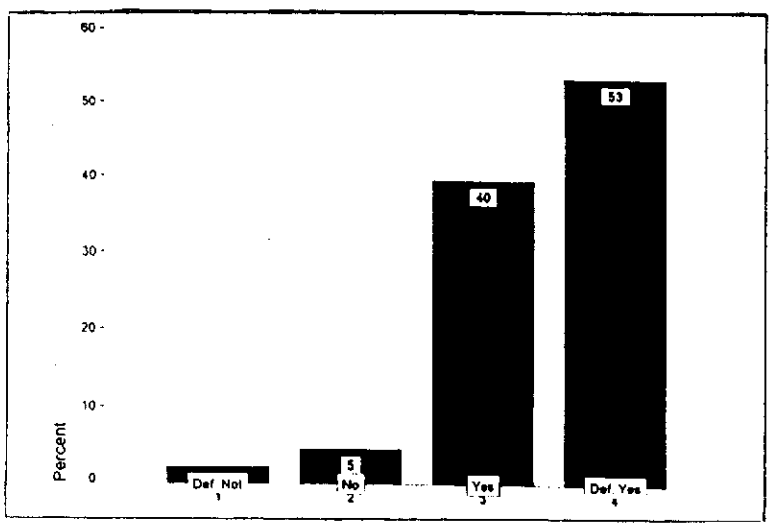

Figure 7. Received kind of service that had wanted?

A similar result was obtained for the questions pertaining to expectations about the service and counsellors. As may be seen in Table 1, the majority of participants reported that the service and counsellors had met their expectations satisfactorily.

Table 1

Service and Counsellor met Expectations

	% Dissatisfied	% Satisfied
Service	7.0	93.0
Counsellor	9.3	90.7

Analysis of the data also revealed that the majority of participants were satisfied with the amount of help that they had received. Sixty seven percent reported being "very satisfied" and 21% "mostly satisfied". However, 54% of participants indicated that on completing individual counselling they would have been interested in participating in group counselling.

As may be seen in Table 2 the majority of participants were satisfied with the location of the counselling service, the parking, hours of operation, and the appointment times that they were offered.

Table 2

Satisfaction with Location, Parking, Hours of Operation and Appointment Times

	% Dissatisfied	% Satisfied
Location	4.7	95.3
Parking	14.0	86.0
Hours of Operation	23.3	76.7
Appointment Times	2.3	97.7

Similarly, as is shown in Table 3, the majority of participants reported satisfaction with the physical facilities of the counselling service.

Table 3

Satisfaction with Signposting, Building, Waiting Area, and Counselling Room

	% Dissatisfied	% Satisfied
Signposting	20.9	79.1
Building	7.0	93.0
Waiting Area	7.0	93.0
Counselling Room	4.7	95.3

Ninety seven point seven percent of participants reported that they were satisfied with the way that they had been treated by the Grief Support Service receptionist and other staff members.

In assessing satisfaction with counsellors, the vast majority of participants expressed satisfaction with level of skill, friendliness, and ability to understand.

Table 4

Satisfaction with Counsellors' Skill, Friendliness, Ability to Understand

	% Dissatisfied	% Satisfied
Skill	7.0	93.0
Friendliness	0	100.0
Understanding	7.0	93.0

The majority of participants reported that they were satisfied with the fee that they had been charged for the service (42% "most satisfied" and 49% "satisfied") When asked whether they would have preferred to pay for each counselling session instead of the current system of no fee for Hospice clients or a once-off administration fee for community clients, the majority of participants responded in the negative.

The qualitative data were analyzed firstly by transcribing the verbatim reports of each participant. The data were then categorized at two (and in some instances, three) separate

times by the researcher. When agreement between the results was unequivocal, the categories were accepted. Themes within each of the categories were then identified using the same procedure as described for identifying the categories. When there was agreement between the results of each analysis, the themes were accepted.

The qualitative data will be described as they pertain to the individual open-ended questions. In response to the question regarding how much the counselling had helped, several themes emerged.

A major theme was that the relationship with the counsellor was helpful because counsellors were non family members and as such they were able to hear what family and friends were unwilling or unable to hear. Counsellors were seen to be highly skilled, non judgmental, understanding, supportive and objective, and thus had provided them with the safe place in which they were able to experience what they were feeling, to focus on their grief, to cry, to unburden, to say what they were unable to say to family and friends.

Participants also reported that the counselling had helped them to put thoughts into words, to come to terms with their grief, to see a way out, to overcome depression, to talk about the deceased person, to deal with anger, and to make decisions about the future. They also expressed the relief that was felt in being believed and understood, and the relief

of being reassured that what they were experiencing was "normal".

Finally they reported that counselling had facilitated an understanding of what they were experiencing, and that it had facilitated coping, and "moving on".

When asked to describe the counselling in terms of how quickly it had helped them, answers ranged from having being helped right from the first session to some participants feeling that they were still in need of counselling. Participants' responses consistently reflected their recognition that grieving is a slow process.

In describing the usefulness of the counselling that they had received, participants stated that it was useful because it was help that nobody else had been able to provide. Participants also described the counselling as emergency/crisis support.

On the other hand, others stated that the counselling had not been useful in helping them to "reconstruct" their lives, that they would have liked the counsellors to give advice on how to "rebuild" their lives.

When invited to make comments and give ideas for improvements to the service participants made several suggestions. (a) The sessions could be longer (one and a half hours) and more frequent than once a week. (b) It should be made explicit that it is possible to have more than 6 sessions. (c) There should be 6 free sessions and thereafter a fee for service so that clients do not feel that they are taking advantage of the system. (d) There should be better advertising of the service because so many people are unaware of its existence. (e) There should be routine assessment (for example, a paper and pencil test) of every client at the first interview for depression or other complicating factors. (f) Counsellors should be more long term. (g) There should be follow-up interviews after counselling has ended.

Discussion

The results of this evaluation indicate high levels of satisfaction with the quality and effectiveness of the service, as well as with the amount of help which was received by the participants. Similarly, participants reported high levels of satisfaction with each of the dimensions of the service, namely (a) The GSS location and appointments, (b) Building, rooms and waiting time, (c) GSS assistants and helpers, (d) Counsellors, (e) Clients' needs vs GSS services,

and (f) Service results. The majority of participants reported that their expectations of the service had been satisfactorily met and that if necessary they would be prepared to use it again, or recommend it to others. The majority of participants also reported being satisfied with the current fee system.

Satisfaction rates ranged from 86% to 100%. The only two aspects of the service which attracted less than an 86% satisfaction rating were the signposting outside the building and the hours of operation. Similar reports of high satisfaction were obtained in the 1995 pilot evaluation of the GSS.

The high levels of satisfaction that were obtained in this evaluation are consistent with the findings of similar studies in health care settings. The elevated rates that are generally obtained in such studies are regarded by LeVois, Nguyen, & Attkisson (1981) as one of the most perplexing aspects of the client satisfaction literature. It has been suggested that these rates may arise as a result of the artifacts of social desirability or response bias, that is, giving either all positive or all negative responses without properly considering the questions (LeVois, et al., 1981), or methodological factors such as sampling procedures (Blais, 1990).

While it was not possible to control for the artifact of

social desirability, it was hoped that by adding qualitative questions to the questionnaire, response bias would be reduced through the process of requiring participants to give considered opinions in their own words about the service that they had received rather than just choosing negative or positive responses.

It was also not possible to control for the effect of sampling bias. Although it was hoped that the majority of approached clients would consent to participate, this did not happen. As their consent was sought through the mail, the 32% response rate was consistent with previous research findings which indicate approximately a 30% response rate (Shaughnessy & Zechmeister, 1985). It is thus possible that the results of this evaluation reflect the effect of self selection of participants. In other words, it is possible that only satisfied clients participated and that dissatisfied clients were excluded from giving feedback by their decision not to participate. It has been suggested by Lebow (1982b) that non-respondents may differ from respondents, and that those who do not return a follow-up questionnaire may be less satisfied than those who do. Nevertheless, the ratings and information obtained from those clients who did participate still represent a valid perspective of the appropriateness, adequacy, and quality of the services received. Assessment of their satisfaction with the GSS was done by comparing their expectations of care with their perceptions of the care that they actually received.

Over 90% of the participants felt that their expectations had been met and that they had received the kind of service they had wanted. Williams (1994) argues, however, that even though satisfaction and expectations are often positively correlated, there is little research evidence to suggest that satisfaction is largely the result of fulfilled expectations. He suggests that the expression of satisfaction may not be the result of a critical evaluation having taken place, but rather a reflection of limited prior expectations about the service. However, participants' responses about the usefulness of counselling indicates that they were evaluating the service and comparing it with other available help. The salient theme in their responses was that they had received help that nobody else had been able to provide. This is congruent with the satisfaction rates obtained by the quantitative measures.

Similarly, there is concurrence in the results of the qualitative and quantitative data in assessing the participants' satisfaction with the counsellors. In the qualitative data, counsellors were described as highly skilled, non judgmental, understanding, supportive and objective. In the quantitative data participants reported high levels of satisfaction with the counsellors' skill levels, friendliness, and understanding. The importance of assessing these factors as measures of satisfaction is supported by the findings of studies linking satisfaction to

provider competence (Lewis, 1994), friendliness and understanding (Conte, Ratto, Clutz, & Karasu, 1995).

The other dimensions of care identified by Pascoe & Attkisson (1983) similarly attracted high ratings of satisfaction. These included: The GSS location and appointments; the building, rooms, and waiting time; and the GSS assistants and helpers. Within these dimensions there were only two aspects of the service which received less than an 86% satisfaction rating. These were the hours of operation, and the signposting outside the building/s. With regard to the former, a theme in the qualitative data regarding the usefulness of counselling was that it had provided participants with emergency/crisis support. Within that framework it is understandable that some participants would have preferred access to a 24 hour counselling service.

The effectiveness of the service is indicated by the assessment of the majority of participants that the service had met their needs, had helped them to deal more effectively with their problems, and that their levels of distress had been reduced. The qualitative data support these results. The themes in participants' responses to questions about how much counselling had helped and how useful it had been to them, were that the service helped them to deal with their losses, their reactions, and coping with the future. However, it is important to note that although the majority of participants were satisfied with the amount of help that they

had received in individual counselling, 54% indicated that on completion they would have been interested in participating in group counselling. It would therefore seem appropriate for counsellors to routinely suggest group counselling to each client as his/her individual counselling nears completion.

As satisfaction can be operationalized by behavioural indices (Lebow, 1982a) participants were asked whether, if in a similar situation, they would use the service again, and whether they would recommend the service to others. The majority of participants responded that they would use the service again, and indicated that they would recommend the service to others. While intended behaviour is an important indication of satisfaction (Gotlieb, Grewal, & Brown, 1994), it is recognized that actual behaviour would provide a better measurement of satisfaction. That is, whether participants had used the service before, whether they had recommended it to others, etc. While there were some reports of actual behaviour in the qualitative data, there was no quantitative support for this aspect of satisfaction measurement.

On examining the participants' responses with regard to payment, it was found that the majority were satisfied with what they had been charged (that is, no fee, or a once-off access fee), and that they would have been unwilling to pay for the services they received. The question therefore arises whether financial constraints dictated the participants' choice of counselling service and consequent

satisfaction. According to Pascoe (1983) lower income patients/clients often prefer a "clinic" to a private practice, finding that their psychosocial needs are more adequately met in such a setting, hence their high satisfaction ratings of such services. While on the one hand it is possible that their satisfaction judgments may have been influenced by such personal factors, research indicates that despite having few alternatives for receiving services elsewhere, dissatisfaction with a service actually results in lower satisfaction scores (Williams, 1994). Therefore it would seem that the obtained ratings do reflect satisfaction with the service and not a resignation to being unable to access alternative and perhaps more expensive services.

To further assess the influence of personal factors on satisfaction, age and gender of participants were taken into account. Research has shown that increased service satisfaction is significantly associated with being elderly and being female (Fox & Storms, 1981). However, although 88% of the participants in this evaluation were female, 71% were aged between 20 and 59 years. This group therefore cannot be considered elderly. Thus it is possible that in this evaluation only the gender, but not the ages, of the participants may have influenced their satisfaction judgments.

Limitations of this evaluation. One of the main limitations of this evaluation is that the sample cannot be considered large enough to be representative of all clients presenting

for counselling during the first five months of 1996, and similarly the findings cannot be generalized to clients presenting for counselling after that period.

A further limitation is that owing to the possible self selection of participants, the findings may represent only the evaluations of satisfied clients, as dissatisfied clients may have chosen not to participate. It is therefore suggested that in future when completing counselling, all clients routinely should be asked to complete some evaluation measures of the service. If procedures are implemented to assure clients of confidentiality and anonymity, better participation rates in such evaluations may result.

Another limitation of the present evaluation is that although participants' expectations have been used as determinants of satisfaction, there were no baseline measures of the existence, or level of their expectations. Satisfaction was thus measured after treatment had been completed, using the participants' self-reports of their prior treatment expectations as the baseline measure. Owing to the inherent inaccuracies of post event self-report, it is recommended that when using expectations as determinants of satisfaction in health care studies, some baseline measurements be made at the initial stages of treatment. This could be done utilizing paper and pencil measures (questionnaires), or by means of structured interviews.

In conclusion it may be said that the obtained satisfaction rates are comparable with results of similar health care studies. While it is possible that only satisfied clients participated in this evaluation, their perceptions and experiences of the service have nevertheless provided important information on how well the service was delivered to them, and how it may possibly be further improved. It is suggested, however, that baseline measurements of clients' expectations be made when service provision is commenced, and that the service should be routinely evaluated by all clients when they complete counselling. Participants' suggestions for improvement of the service focused on the length, frequency and number of counselling sessions, assessment of clients for complicating factors, follow-up interviews after completion of counselling, and better advertising of the service.

References

Armstrong, R. (1994). Preparing performance indicators: A practical guide. Public Sector Management Office. Perth: Government Printers.

Attkisson, C.C. & Zwick, R. (1982). The Client Satisfaction Questionnaire: Psychometric properties and correlations with service utilization and psychotherapy outcome. Evaluation and Program Planning, 5, 233-237.

Blais, R. (1990). Assessing patient satisfaction with health care: Did you drop somebody? Canadian Journal of Program Evaluation, 5, 1-13.

Conte, H.R., Ratto, R., Clutz, K., & Karasu, R.B. (1995). Determinants of outpatients' satisfaction with therapists: Relation to outcome. Journal of Psychotherapy Practice and Research, 4 (1), 43-51.

Department of Treasury and Finance (1995). A guide to output specification and performance measurement (interim guidelines - 20 December 1995). Victoria: Government Printers.

Fox, J.G., & Storms, D.M.A. (1981). A different approach to sociodemographic predictors of satisfaction with health care. Social Science and Medicine, 15A, 557-564.

Gotlieb, J.B., Grewal, D., & Brown, S.W. (1994). Consumer satisfaction and perceived quality: Complementary or divergent constructs? Journal of Applied Psychology, 79 (6), 875-885.

Lebow, J.L. (1982a). Consumer satisfaction with mental health treatment. Psychological Bulletin, 91, 331-342.

Lebow, J.L. (1982b). Pragmatic decisions in the evaluation of consumer satisfaction with mental health treatment. Evaluation and Program Planning, 5, 349-356.

Lebow, J.L. (1983). Research assessing consumer satisfaction with mental health treatment: A review of the findings. Evaluation and Program Planning, 6, 211-236.

LeVois, M., Nguyen, T.D., & Attkisson, C.C. (1981). Artifact in client satisfaction assessment: Experience in community mental health settings. Evaluation and Program Planning, 4, 139-150.

Lewis, J.R. (1994). Patient views on quality care in general practice: Literature review. Social Science and Medicine, 39 (5), 655-670.

Nguyen, T.D., Attkisson, C.C., & Stegner, B.L. (1983). Assessment of patient satisfaction: Development and refinement

of a service evaluation questionnaire. Evaluation and Program Planning, 6, 299-314.

Pascoe, G.C. (1983). Patient satisfaction in primary health care: A literature review and analysis. Evaluation and Program Planning, 6, 185-210.

Pascoe, G.C., & Attkisson, C.C. (1983). The Evaluation Ranking Scale: A new methodology for assessing satisfaction. Evaluation and Program Planning, 6, 335-347.

Patton, M.Q. (1982). Practical evaluation. California: Sage Publications, Inc.

Schainblatt, A.H. (1980). What happens to the clients? Community Mental Health Journal, 16, 331-342.

Shaughnessy, J.J., & Zechmeister, E.B. (1985). Research methods in psychology. New York: Alfred A. Knopf, Inc.

The Treasury. (1989). Program management: An introduction. Perth: Government Printers.

Ware, J.E., JR., Snyder, J.K., & Wright, W.R. (1976). Development and validation of scales to measure patient satisfaction with health care services: Volume 1 of a final report. Part B: Results regarding scales constructed from the Patient Satisfaction Questionnaire and measures of other

health care perceptions. Springfield, VA: National Technical Information Service.

Williams, B. (1994). Patient satisfaction: A valid concept? Social Science and Medicine, 38 (4), 509-516.

APPENDIX A

The Client Satisfaction Questionnaire-8

Please help us improve the Grief Support Service program by answering some questions about the services you have received. We are interested in your honest opinion, whether it is positive or negative. Please answer all of the questions. We also welcome your comments and suggestions. Thank you very much, we really appreciate your help.

CIRCLE YOUR ANSWER

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

1	2	3	4
Poor	Fair	Good	Excellent

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

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

3. To what extent has our service met your needs?

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

4. If a friend were in need of similar help, would you recommend the service to him or her?

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

2/.....

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

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

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

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

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

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

8. If you were to seek help again, would you come back to the service?

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

9. How satisfied were you with the location (suburb) of the Grief Support Service?

1	2	3	4
Most dissatisfied	dissatisfied	satisfied	Very satisfied

10. How satisfied were you with the Grief Support Service parking?

1	2	3	4
Most dissatisfied	Dissatisfied	Satisfied	Very satisfied

11. How satisfied were you with the Grief Support Service hours of operation?

1	2	3	4
Most dissatisfied	Dissatisfied	Satisfied	Very satisfied

12. How satisfied were you with the appointment times that were offered to you?

1	2	3	4
Most dissatisfied	Dissatisfied	Satisfied	Very satisfied

13. How satisfactory was the signposting outside the Grief Support Service building?

1	2	3	4
Highly unsatisfactory	Unsatisfactory	Satisfactory	Most satisfactory

14. How satisfactory was the Grief Support Service building?

1	2	3	4
Highly unsatisfactory	Unsatisfactory	Satisfactory	Most satisfactory

15. How satisfactory was the waiting area?

1	2	3	4
Highly unsatisfactory	Unsatisfactory	Satisfactory	Most satisfactory

16. How satisfactory was the counselling room?

1	2	3	4
Highly unsatisfactory	Unsatisfactory	Satisfactory	Most satisfactory

17. How would you rate the courtesy and helpfulness of the Grief Support Service receptionist?

1	2	3	4
Highly unsatisfactory	Unsatisfactory	Satisfactory	Most satisfactory

18. How would you rate the courtesy and helpfulness of the Grief Support Service staff?

1	2	3	4
Highly unsatisfactory	Unsatisfactory	Satisfactory	Most satisfactory

19. How satisfied were you with your counsellor's level of skill?

1	2	3	4
Highly dissatisfied	Dissatisfied	Satisfied	Most satisfied

20. How satisfied were you with your counsellor's level of friendliness?

1	2	3	4
Highly dissatisfied	Dissatisfied	Satisfied	Most satisfied

21. How well did you feel your counsellor understood you?

1	2	3	4
Not at all	Not too well	Fairly well	Very well

22. How well did the service match your expectations?

1	2	3	4
Not at all	Not too well	Fairly Well	Very well

23. How well did your counsellor match your expectations?

1	2	3	4
Not at all	Not too well	Fairly Well	Very well

24. Are you satisfied with the fee (if any) that was charged for the services you received?

No fee

1	2	3	4
Most dissatisfied	Dissatisfied	Satisfied	Most satisfied

25. Would you have preferred to pay for each session?

1	2	3	4
Definitely not	No	Yes	Definitely yes

26. On a scale of 1-10, how distressed did you feel before having counselling at the Grief Support Service?

1 2 3 4 5 6 7 8 9 10

27. On a scale of 1-10, how distressed did you feel after completing counselling at the Grief Support Service

1 2 3 4 5 6 7 8 9 10

28. After completing individual counselling, would you have liked to participate in group counselling?

1	2	3	4
Definitely not	No	Yes	Definitely yes

29. How would you describe the counselling you received in terms of how much it helped you?

30. How would you describe the counselling you received in terms of how quickly it helped you?

31. How would you describe the counselling you received in terms of how useful it was to you?

32. Please use the space below for any comments and ideas that you have on how the Grief Support Service can be improved to better meet your needs.

APPENDIX B

Dear.....

We are writing to ask for your help in reviewing the Silver Chain Grief Support Service. As you have recently used the service, we would value your feedback, be it positive or negative, in order to assist us to plan for the future.

We realise that this has been a difficult time for you and that you may not want to relive your experiences. But we hope that Silver Chain has been of some help to you and that you in turn will help us to provide a better service for others by giving us your feedback.

The review will be conducted by an independent researcher from Curtin University who is a Psychologist trained to deal with grief issues and with confidential information.

Your participation will take approximately 30 minutes of your time and will be in the form of:

- a questionnaire to be completed and returned by mail/ or
- a telephone interview/ or
- a personal interview

The researcher will ensure that your input is kept totally confidential and anonymous. Silver Chain will have no access to your detailed information or comments and will be provided with a general report on the service only.

If you are prepared to participate in this review, please sign the attached consent form and return it in the provided envelope by .....

If you do not wish to participate, we shall respect this. Please be assured that this will in no way affect any current or future services that you receive from Silver Chain.

Should you have any questions about this review, you can contact Dr Lyndall Steed at Curtin University on telephone number (09) 351 7182.

Thank you in anticipation for your assistance.

Yours faithfully,

Manager

APPENDIX C

LETTER OF CONSENT

I, the undersigned, hereby consent to participate in the review of the Silver Chain Grief Support Service.

I have read the letter explaining the reason for the review and am aware that my participation is voluntary.

I am aware that I can withdraw from participating in this review at any stage and that no service that I receive from Silver Chain will be affected.

.....(signature)

(Participant's name will be typed below this line to assist in correctly identifying who is willing to participate)

APPENDIX D

Dear

Thank you for agreeing to participate in the Silver Chain Grief Support Service Review.

As the independent researcher conducting the review I would like to ask you to complete the attached questionnaire and return it in the enclosed envelope as soon as possible, but by not later than.....

Please be assured that all the information you give will remain anonymous and confidential. Your individual responses will not be forwarded to Silver Chain and will only be used to compile the overall report and recommendations.

Thank you again for participating. Without your feedback this review and future improvement of the service would not be possible.

Yours sincerely,

J. Schutze
Department of Psychology
Curtin University

APPENDIX E

Defining, Considering, and Measuring Patient/Client Satisfaction: A Literature Review

CONTENTS

Models of Satisfaction

Satisfaction is defined in the psychological literature by several conflicting models. While some researchers define satisfaction as an affective response (Linder-Pelz, 1982; Cadotte, Woodruff, & Jenkins, 1987), others, for example, Hunt (1977) and Bagozzi (1992) propose a cognitive model of satisfaction. For the purpose of this review, the Linder-Pelz (1982) and the Bagozzi (1992) models will be described.

Linder-Pelz (1982) has developed her model of satisfaction using the attitude theory framework of Fishbein & Ajzen (1975). The latter define attitudes as people's relatively enduring sets of thoughts (or beliefs) and feelings about particular people, objects, or issues, and their willingness/unwillingness to act in consistent ways with those thoughts and feelings. Thus attitudes are posited as having three strongly inter-related components: Cognitive, affective and behavioural.

In Linder-Pelz's formulation, however, attitudes are regarded as affective and affect is equated with evaluation. She does not regard cognitions as being part of the attitude, although she does include them as the expectations in her model of satisfaction. She posits that satisfaction is a positive attitude "based on two distinct pieces of information: Belief strength and attribute evaluations.

Specifically, measures of belief strength about attitudes and measures of evaluation of those attributes are multiplied and the products summed" (1982 p. 578-579). The attributes referred to in this model are the dimensions of the service/product being evaluated.

It would seem, however, that while satisfaction may be partially determined by prior expectations and general values, Linder-Pelz has overlooked the influence on satisfaction of the individual's reaction to his/her immediate experience. Furthermore, it is possible that contrary to Linder-Pelz's formulation, rather than being interactive, cognitions and affective responses may instead be quasi-independent predictors of satisfaction.

An alternative model of satisfaction has been proposed by Bagozzi (1992). Extending Lazarus' (1991) theoretical framework of appraisal, followed by emotional response, followed by coping, Bagozzi (1992) has developed a cognitive framework of satisfaction. Using the idea of an "outcome-desire unit", he suggests that individuals engage in activities because of a desire to achieve certain outcomes. If an individual's appraisal of an activity indicates that he/she has achieved the planned outcome, then "desire-outcome fulfillment" exists, which is followed by an affective response (for example, satisfaction). On the other hand if the individual's appraisal of the outcome indicates that the desired outcome was not achieved, then "outcome-desire

conflict" exists, which will be followed by an affective response (for example, dissatisfaction). The appraisal followed by affect sequence has also been suggested by other researchers, for example, Carver & Scheier (1990).

Bagozzi's theoretical framework further suggests that the affective response will then be followed by a coping response (for example, a behavioural response) in an effort to maintain or increase/decrease the level of affect. It would seem, however, that the weakness of this model is the assumption that objective outcomes alone determine satisfaction.

Although conflicting, both the Linder-Pelz (1982) and the Bagozzi (1992) models plausibly define satisfaction. Elements of each of these models are found in other formulations of satisfaction. Hulin, Roznowski, & Hachiya's (1985) model of job satisfaction posited that satisfaction is a function of the difference between performance, that is, what the individual contributes to the work role (for example time and effort) compared with outcomes or what is received (for example pay, status, and intrinsic factors). As outcomes received relative to inputs invested increase, satisfaction is hypothesized to increase. Hulin et al. (1985) hypothesized that the individual's frame of reference, which they defined as past experience with relevant outcomes, is expected to influence how the individual perceives current outcomes that are received. In other words, individuals become accustomed to a certain level of outcomes, and those

experiences influence how they evaluate their outcomes.

The theoretical underpinnings of Hulin et al's (1985) model can be traced to March & Simon (1958) who hypothesized that affective responses to work-role memberships are a function of the discrepancy between contributions and inducements. The more inducements that employees receive relative to the contributions they invest, the more satisfied they are expected to be with their jobs. Hulin et al's (1985) model of satisfaction is based on discrepancy theory. Discrepancy theories define satisfaction as the result of the perceived discrepancy between actual outcome and expected outcome, using the individual's perception of what is expected or valued as the baseline for comparing actual outcomes. Although this model allows for the comparison of outcomes to some psychological standard, its weakness is the assumption that any deviation from expectations will produce dissatisfaction.

This theoretical model based on discrepancy theory has been the most frequently used model in patient satisfaction studies. When patient satisfaction has been defined, researchers have generally referred to a matching of expected care with the perception of the care actually received (e.g. Byalin, 1993; Lebow, 1982; Nguyen, Attkisson, & Stegner, 1984; Perreault & Leichner, 1993; Vuori, 1991).

Measurement Issues

Several measurement issues require consideration when assessing patient/client satisfaction. These include the expectations which are used as a standard; the domain of the system about which to inquire; the dimensions of the domain on which to focus; and other influences.

(a) Expectations

As expectations are used in this model as determinants of satisfaction, it becomes necessary when assessing and measuring satisfaction to identify which type of expectation is being used as a psychological standard. Miller (1977) described four different expectations: Ideal, minimum, expected, and deserved. "Ideal" represents a maximum level, "minimum" the least acceptable level, "expected" represents past average experience, and "deserved" represents the individual's subjective sense of what should be, based on his/her investments and costs.

The three models most frequently used to conceptualize the role of expectations in the satisfaction process are the contrast model, the assimilation model, and the assimilation-contrast model.

The contrast model is based on Helson's (1964)

adaptation-level theory of judging stimuli. According to Helson (1964) standards of comparison can also be called adaptation levels. For any given stimulus, the adaptation level is the level of stimulation perceived as average or normal. Stimuli that fall within the average or expected range are not likely to capture the individual's attention, but stimuli that fall outside the average range or are exceptional, probably will. When applied to the contrast model, stimuli (performance) higher than expectations will be judged as satisfactory, while stimuli (performance) less than expected will be judged as unsatisfactory. It would seem that when attributes are not ambiguous contrast effects will result.

The assimilation model is based on evaluative consistency approaches (Festinger, 1957). According to Festinger's (1957) cognitive dissonance theory when cognitions are inconsistent, that is, when one cognition contradicts another, a dissonant relationship exists between the two. Festinger hypothesized that this state of cognitive dissonance produces a psychological tension that the individual is motivated to reduce. One way of doing this is to change one or both cognitions to make them less dissonant. When applied to the assimilation model, the individual can reduce the psychological tension by adjusting his/her perceptions of performance to match his/her expectations. It is furthermore possible that assimilation effects may occur in reaction to ambiguous attributes as the latitude of acceptance may be

fairly broad around the subjective standard, which would lead to assimilation of the experience and in most instances, to a sense of satisfaction.

The assimilation-contrast model is based on the work of Sheriff & Hovland (1961). According to this approach expectations serve as a standard for judging a service or a product, but there is a latitude of acceptance surrounding this standard. Assimilation of discrepancies within this latitude occur as follows: Decreased performance evaluations and concomitant lessened satisfaction result when expectations are lower than outcome. Increased performance evaluations and concomitant greater satisfaction result if performance and expectations are matched. Contrast effects occur when discrepancies between performance and expectations are relatively large.

In summarizing the role of expectations in judging satisfaction, it is argued that experiences that fall within the latitude of acceptance relative to the expectation will be assimilated, leading in most instances to satisfaction. Experiences that are more positive or more negative will produce a contrast effect, leading to satisfaction or dissatisfaction.

On the other hand, however, while there are aspects of service provision for which patients/clients have expectations on which they can base their evaluations, in some situations

they may not have any expectations. According to West (1976) service users coming into contact with a service for the first time may not have expectations formed through past experience on which to base their evaluations. In other words, prior experience of a service will give service users some idea of what to expect, but the lack of such experience may mean that they have not formed expectations and that their expectations may still need to be formed through the process of experience.

Furthermore, the greater the perceived technical nature of treatment, the more likely it is that some service recipients will not believe in the legitimacy of holding their own expectations, and concomitantly, their evaluations (Cleary & McNeil, 1988). Therefore reported satisfaction with technical aspects of care may actually be an expression of confidence in the ability of the health care providers rather than an active and critical evaluation.

(b) The Domain

When measuring patient/client satisfaction it also becomes necessary to distinguish between the macro and the micro domains of the system that is being measured, and the dimensions within each domain (Pascoe, 1983). In health care the macro level is represented by health care providers and health care delivery in general, while the micro level is

represented by the actual care the individual receives for his/her health needs. It therefore becomes possible that the satisfaction that the patient/client has with the broader domain of a service may not match satisfaction resulting from a particular service experience. It is thus important to explicitly define which domain is under consideration.

(c) The Dimensions within the Domain

Furthermore, as has been shown by Andrews & Withey (1976), there are multiple dimensions to be judged within each domain and individuals may use multiple criteria when making those judgments. A content analysis by Ware, Snyder, & Wright (1978) of 900 published questionnaire items identified the following dimensions that potentially affect health care recipients' evaluations. These are: Accessibility/convenience, "art" of care, availability, continuity, efficacy/outcome of care, finances, physical environment, and technical quality of care.

Similarly, in constructing the Client Satisfaction Questionnaire, Nguyen, Attkisson, & Stegner (1984) consulted published and unpublished sources to identify the dimensions of service delivery that influence satisfaction judgments. They were able to identify nine dimensions: Physical surroundings; support staff; kind/type of service; treatment staff; quality of service; amount, length, or quantity of service; outcome of service; general satisfaction; and

procedures.

Pascoe & Attkisson (1983) used concepts from evaluation theory and from the literature on dimensions of health care when developing the Evaluation Ranking Scale. They identified six dimensions which represent the service environment: Location and appointments; building, offices and waiting time; assistants and helpers; health care providers (nurses, doctors, therapists); client/patient needs vs clinic services; service results.

In summary, the advantage of differential evaluation of multiple program dimensions is that it becomes possible to pinpoint the dimensions responsible for satisfaction or dissatisfaction.

(d) Other influences

Other influences on satisfaction judgments have also been reported in the literature. Diener's (1984) review of past research on subjective wellbeing suggested a number of demographic influences on satisfaction judgments. These include age, gender, ethnicity, socioeconomic status, marital status, and health status. Typically increased service satisfaction is significantly associated with being older and being female (Fox & Storms, 1981). Minority groups and lower socioeconomic status groups have been found to have lower life satisfaction (Diener, 1984) which in turn may possibly

influence other satisfaction judgments. Diener (1984) also reports a positive relationship between marital status, health status and life satisfaction, which similarly may influence other satisfaction judgments. Patient/client ratings of outcome of treatment and life satisfaction have been found to correlate highly with service satisfaction (Lebow, 1982).

Social-psychological artifacts which have been found to influence satisfaction judgments include: social desirability, response bias, cognitive consistency (LeVois, Nguyen, & Attkisson, 1981), and the Hawthorn effect (Roethlisberger, 1977). Similarly, methodological factors such as sampling procedures (Blais, 1990) and the effect of response anonymity (Soelling & Newell, 1983) may influence the expression of satisfaction/dissatisfaction.

Measurement Instruments

In developing instruments to measure patient/client satisfaction researchers have used an indirect approach (for example Ware, Snyder, Wright, & Davis, 1983) or a direct approach (for example Nguyen, Attkisson & Stegner, 1983).
The indirect approach (for example "Doctors always do their best to keep the patient from worrying") assesses macro domain satisfaction, while the direct approach (for example "The doctor has relieved my worries about my illness") assesses micro domain satisfaction.

Research findings indicate that each approach measures a different type of satisfaction (Pascoe, 1983) and that there is not a strong relationship between the two types (Gutek, 1978). It has been found that direct measures tend to elicit higher satisfaction scores (Roberts, Pascoe, & Attkisson, 1983) and that overall satisfaction is only related to direct measures (Wilson & McNamara, 1982).

Macro measures have been developed to assess domains such as value of physicians, value of health care, etc. While the early measurement instruments used Guttman scaling (Andersen, 1968), Thurstone scaling (Hulka, Zyzanski, Cassel, & Thompson, 1970), subsequent instruments (for example Zyzanski, Hulka Cassel's 1974 Scale for the Measurement of Satisfaction with Medical Care) have used Likert-type scales.

Micro measures have been developed by standard scale construction methods using summated ratings (Likert, 1932), descriptive analyses of correlations, and factor analysis of Likert-type items and originally-generated micro items. For example Linder-Pelz (1982) conducted a factor analysis on her data which resulted in Likert-type scales measuring physician conduct, convenience, and general satisfaction with one's health. Similarly, a principal components factor analysis was used by Larsen, Attkisson, Hargreaves & Nguyen (1979) to develop a Likert-type general scale that can be used by health care service consumers.

Although scales have often been constructed using information from literature searches or under the guidance of a panel (for example, Larsen, Attkisson, Hargreaves, & Nguyen, (1979), for the Client Satisfaction Questionnaire; and Attkisson, Roberts, & Pascoe, (1983) for the Evaluation Ranking Scale), there are also reports of qualitative approaches being used in scale development. Elbeck & Fecteau (1990) used focus groups in which patients were asked their opinions about the characteristics of ideal health care, and Holcomb, Adams, Ponder, & Reitz (1989) used brainstorming sessions with groups of patients to guide the development of their scales.

Reliability

Most reliability estimates of patient satisfaction measures are generally at or above .50. Pascoe (1983) therefore suggests that most scales, although reliable enough for making group comparisons, are not suitable for comparing individuals given the recommended minimum reliability level of .90 for the comparison of individuals.

Validity

Ideally, patient satisfaction measures should be valid with respect to both external and internal (criterion, content

and construct) validity. Externally valid measures should reflect the qualitative differences in the outcome of care as well as accurately predict subsequent health related behaviours (for example utilization, selection of services, etc.). Internally valid measures should enable accurate measurement of satisfaction with the different domains and dimensions of the service.

However, according to Perreault & Leichner (1993) there are no macro or micro measures that appear to be fully validated.

Choice of Instrument

The importance of using psychometrically sound measures when evaluating satisfaction is stated by Whitfield & Baker (1992) as follows: "Poor questionnaires act as a form of censorship imposed on patients. They give misleading results, limit the opportunity of patients to express their concerns about different aspects of care, and can encourage professionals to believe that patients are satisfied when they are in reality highly discontented" (p. 152).

Of the instruments that are currently available, the Client Satisfaction Questionnaire (Attkisson & Zwick, 1982) and the Evaluation Ranking Scale (Pascoe & Attkisson, 1983) appear

to be the most carefully psychometrically constructed (Lebow, 1983) and widely used scales.

The Client Satisfaction Questionnaire (Attkisson & Zwick, 1982) is a paper and pencil measure which has been successfully used in a variety of studies as a global, or general measure of patient satisfaction. It has three forms: An eight item version (CSQ-8) and two 18 item versions (CSQ-18). The scales are standardized, the items providing a homogeneous estimate of general satisfaction with services. There are four response choices for each of the items, from "1" indicating the lowest degree of satisfaction through to "4" indicating the highest degree of satisfaction. There is therefore no neutral position, thus enabling elicitation of a positive or negative response. Coefficient alpha for these scales is .93.

The Evaluation Ranking Scale (Pascoe & Attkisson, 1983) features the rating of satisfaction along six dimensions which represent the service environment, coupled with a rank ordering of the importance of each. The Evaluation Ranking Scale thus counteracts the problem which is inherent in most satisfaction scales, namely, that the importance of the various dimensions is neglected. The dimensions of health care service as identified in the Evaluation Ranking Scale are: Location and appointments; building and waiting time;

assistants and helpers; health care providers (nurses, doctors, therapists); client/patient needs vs clinic services; service results.

Why measure satisfaction?

It is now recognized that in order to continuously measure, monitor, evaluate and improve program performance, managers require information which relates required outputs to inputs. Outputs are the goods or services produced, while inputs are the resources expended when producing an output (The Treasury, 1989). This information can be provided by measurements of actual performance, such as actual/budget expenditure and output/workload; expected net appropriation revenues and actual receipts; and or performance indicators. Performance indicators may be defined as objective, quantitative and/or qualitative, verifiable measures which provide information on the extent to which a program has achieved its objectives (Armstrong, 1994).

Over recent years consumer satisfaction has gained widespread recognition as a measure of quality, and has consequently been adopted as a Performance Indicator in many public sector services.

The Grief Support Service Evaluation

In a 1993 review of the Silver Chain Hospice Care Service it was recommended that resources be made available to extend the existing bereavement counselling service to people in the community in need of bereavement support or counselling. The Silver Chain Grief Support Service (GSS) was thus established in October 1994 to provide counselling, education, resources, and information on loss and grief to the community of Western Australia.

On 1st September 1995 the GSS established its main office in West Perth, bringing its clinical, administrative and support staff together. Counselling by appointment is provided on these premises, as well as in several satellite rooms in the metropolitan area. The service is provided by paid and voluntary counsellors, all of whom have undertaken the GSS training program, and receive regular professional supervision. In a 1995 pilot evaluation of the individual counselling aspect of the program, a high level of client satisfaction was reported. The present evaluation has been undertaken to evaluate the same aspect of the program, using Client Satisfaction as a performance indicator.

In conclusion it is argued that as client/patient satisfaction continues to gain recognition as a measure of quality in health care settings, it will become increasingly important in ascertaining how well services are being delivered. However, although satisfaction is recognized as an important indicator in performance monitoring, agreement has not yet been reached on how to define and measure it. Furthermore satisfaction judgments have been found to be influenced by complex issues such as client/patient expectations, the domain being measured, the dimensions within the domain, as well as other factors such as demographic influences and social-psychological artifacts. The goal of future research should therefore be to continue to identify the meaning of satisfaction and the ways and terms in which clients/patients perceive and evaluate it.

References

Andersen, R. (1968). A behavioural model of families' use of health services (Research Series No. 25). Chicago, IL: Center for Health Administration Studies.

Andrews, F.M., & Withey, S.B. (1974). Social indicators of wellbeing. New York: Plenum Press.

Armstrong, R. (1994). Preparing performance indicators: A practical guide. Public Sector Management Office. Perth: Government Printers.

Attkisson, C.C. & Zwick, R. (1982). The client satisfaction questionnaire. Psychometric properties and correlations with service utilization and psychotherapy outcome. Evaluation and Program Planning, 5, 233-237.

Attkisson, C.C., Roberts, R.E., & Pascoe, G.C. (1983). The Evaluation Ranking Scale: Clarification of methodological and procedural issues. Evaluation and Program Planning, 6, 349-358.

Bagozzi, R.P. (1992). The self-regulation of attitudes, intentions, and behaviour. Social Psychology Quarterly, 55, 178-204.

Blais, R. (1990). Assessing patient satisfaction with

health care: did you drop somebody? Canadian Journal of Program Evaluation, 5, 1-13.

Byalin, K. (1993). Assessing parental satisfaction with children's mental health services. Evaluation and Program Planning, 16, 69-77.

Cadotte, E.R., Woodruff, R.B, & Jenkins, R.L. (1987). Expectations and norms in models of consumer satisfaction. Journal of Marketing Research, 24, 305-314.

Carver, C.S., & Scheier, M.F. (1990). Origins and functions of positive and negative affect: A control-process view. Psychological Review, 97, 19-35.

Cleary, P.D. & McNeil, B.J. (1988). Patient satisfaction as an indicator of quality care. Inquiry 25(25)

Diener, E. (1984). Subjective wellbeing. Psychological Bulletin, 95, 542-575.

Elbeck, M., & Fecteau, G. (1990). Improving the validity of measures of patient satisfaction with psychiatric care and treatment. Hospital and Community Psychiatry, 41, 998-1001.

Festinger, L.A. (1957). A theory of cognitive dissonance. Evanston, Ill.: Row, Peterson.

Fishbein, M., & Ajzen, I. (1975). Belief, attitude, intention and behaviour: An introduction to theory and research. Reading, MA: Addison-Wesley.

Fox, J.G., & Storms, D.M. (1981). A different approach to sociodemographic predictors of satisfaction with health care. Social Science and Medicine, 15(A), 557-564.

Gutek, B. (1978). Strategies for studying client satisfaction. The Journal of Social Issues, 34, 44-56.

Helson, H. (1964). Adaptation-level theory. New York: Harper & Row.

Holcomb, W.R., Adams, N.A., Ponder, H.M., & Reitz, R. (1989). The development and construct validation of a consumer satisfaction questionnaire for psychiatric inpatients. Evaluation and Program Planning, 12, 189-194.

Hulka, B.S., Zyzanski, S.J., Cassel, J.C., Thompson, S.J. (1970). Scale for the measurement of attitudes toward physicians and primary medical care. Medical Care, 8, 429-436.

Hulin, C.L., Roznowski, M., & Hachiya, D. (1985). Alternative opportunities and withdrawal decisions: Empirical and theoretical discrepancies and an integration. Psychological Bulletin, 97, 233-250.

Hunt, H.K. (1977). CS/D - Overview and future research directions. In H.K. Hunt (Ed.), Conceptualization and measurement of consumer satisfaction and dissatisfaction. Cambridge, MA: Marketing Science Institute.

Larsen, D.L., Attkisson, C.C., Hargreaves, W.A., & Nguyen, T.D. (1979). Assessment of client/patient satisfaction in human service programs: Development of a general scale. Evaluation and Program Planning, 2, 197-207.

Lebow, J. (1983) Pragmatic decisions in the evaluation of consumer satisfaction with mental health treatment. Evaluation and Program Planning, 5, 349-356.

Levois, M., Nguyen, T.D., & Attkisson, C.C. (1981). Artifact in client satisfaction assessment: Experience in community mental health settings. Evaluation and Program Planning, 4, 1-12.

Likert, R.A. (1932). A technique for the measurement of attitudes. Archives of Psychology, 1-55.

Linder-Pelz, S. (1982). Toward a theory of patient satisfaction. Social Science and Medicine, 16, 577-582.

March, J.G., & Simon, H.A. (1958). Organizations. New York: Wiley.

Miller, J.A. (1977). Studying satisfaction, modifying models, eliciting expectations, posing problems, and making meaningful measurements. In H.K. Hunt (Ed.), Conceptualization and measurement of consumer satisfaction and dissatisfaction. Cambridge, MA: Marketing Science Institute.

Nguyen, T.D., Attkisson, C.C., & Stegner, B.L. (1983). Assessment of patient satisfaction: Development and refinement of a service evaluation questionnaire. Evaluation and Program Planning, 6, 299-314.

Pascoe, G.C. (1983). Patient satisfaction in primary health care: A literature review and analysis. Evaluation and Program Planning, 6, 185-210.

Pascoe, G.C., & Attkisson, C.C. (1983). The Evaluation Ranking Scale: A new methodology for assessing satisfaction. Evaluation and Program Planning, 6, 335-347.

Perreault, M. & Leichner, P. (1993). Patient Satisfaction with outpatient psychiatric services. Qualitative and quantitative assessments. Evaluation and Program Planning, 16, 109-118.

Roberts, R.E., Pascoe, G.C., & Attkisson, C.C. (1983). Relationship of service satisfaction to life satisfaction and perceived wellbeing. Evaluation and Program Planning, 6, 373-383.

Roethlisberger, F.J. (1977). The elusive phenomena: An autobiographical account of my work in the field of organized behaviour at the Harvard Business School. Cambridge, Mass.:Harvard University Press.

Sheriff, M. & Hovland, C.I. (1961). Social judgments: Assimilation and contrast effects in communications and attitude change. New Haven, CT: Yale University Press.

Soelling, M.E., & Newell, T.G. (1983). Effects of anonymity and experimenter demand on client satisfaction with mental health services. Evaluation and Program Planning, 6, 329-333.

The Treasury, (1989). Program management: An introduction. Perth: Government Printers.

Vuori, H. (1991). Patient satisfaction - does it matter? Quality Assurance in Health Care, 3(3), 183-189.

Ware, J.E., JR., Snyder, M.K., & Wright, W.R. (1978). Some issues in the measurement of patient satisfaction with health care services. Santa Monica, CA: The Rand Corporation.

Ware, J.E., JR., Snyder, M.K., Wright, W.R., & Davies, A.R. (1983). Defining and measuring patient satisfaction with medical care. Evaluation and Program Planning, 6, 247-

263.

West, P. (1976). The physician and management of childhood epilepsy. In M. Wadsworth & D. Robinson (Eds.), Studies in everyday medical life. London.

Whitfield, M., & Baker, R. (1992). Measuring patient satisfaction for audit in general practice. Quality Health Care, 3, 151.

Wilson, P., & McNamara, F.R. (1982). How perceptions of a simulated physician-patient interaction influence intended satisfaction and compliance. Social Science and Medicine, 16, 1699-1704.

Zyzanski, S.J., Hulka, B.S., & Cassel, J.C. (1974). Scale for the measurement of 'satisfaction' with medical care: Modification in content, format, and scoring. Medical Care, 13, 611-620.