

**CHILDREN AND FAMILY  
RESEARCH CENTER**

# **Measurement of Client Satisfaction**

**Gardenia Harris, M.S.W.**

**John Poertner, D.S.W.**

**School of Social Work**

**University of Illinois at Urbana-Champaign**

**SCHOOL OF SOCIAL WORK  
UNIVERSITY OF ILLINOIS AT  
URBANA-CHAMPAIGN**

1207 West Oregon Street

Urbana, Illinois 61801

1998, John Poertner

# **MEASUREMENT OF CLIENT SATISFACTION: THE STATE OF THE ART**

Gardenia Harris, MSW  
John Poertner, DSW  
Children and Family Research Center  
School of Social Work  
University of Illinois at Urbana-Champaign  
1207 W. Oregon  
Urbana, IL 61801

# EXECUTIVE SUMMARY

## Measurement of Client Satisfaction: The State of the Art

The measurement of client satisfaction is becoming increasingly popular because of its role in quality assurance and continuous quality improvement systems. Clients have a wealth of information regarding the functioning of social service programs, and gathering their views can provide insight and information useful for improving services. This literature review focuses on the identification of recent measures of client satisfaction and examines them in terms of their ability to reflect clients' experiences with service systems, the dimensions of satisfaction they are intended to measure, and their ability to obtain quality data from clients. Thirty-nine studies published between 1990-1997 that included descriptions of the data collection instruments are reviewed. The studies examined client satisfaction in the following areas: mental health services (19), with health services (5), family mediation services (4), child welfare/protection services (4), services for disabled children (4), and self-help groups (2). If client satisfaction is generally defined as clients' perspectives on aspects of the service transaction important to them, then it is the items used in a satisfaction measure that define satisfaction for a particular service. In other words, the questions asked of clients indicate how client satisfaction is defined. This review organizes client satisfaction instruments according to the source of the items. Items contained in client satisfaction measures come primarily from three sources: clients, professionals, and professional literature. The majority of authors defined client satisfaction according to what other authors had discovered (21) or on the views of professionals (4). Fewer studies relied primarily on clients (2) and clients and professionals (5) as their major source of items. The source of items in five of the studies reviewed was not specified. Common themes identified across all service areas included attention to the interaction between service providers and consumers, and consumers' perceptions of service outcomes. Examples of a selection of the instruments presented in the review are included in the appendix.

The usefulness of client satisfaction measures can be qualified by several methodological problems. Low response rates and response bias are just two of those problems. Client satisfaction data is plagued by low response rates, which casts doubt on the representativeness of satisfaction results. The potential for response bias to affect the

usefulness of satisfaction evaluations is also of concern. How the instrument is administered, and the format and wording of items has been found to significantly influence the results of client satisfaction studies.

## **Measurement of Client Satisfaction: The State of the Art**

Measurement of client satisfaction is becoming increasingly popular because of its role in quality assurance and continuous quality improvement systems. Clients have a wealth of information regarding the functioning of social service programs and gathering their views provides valuable insights about how they experience services. With this information, service providers can continue practices to which clients are responding favorably and change those aspects of services that clients feel are not helpful.

This review focuses on recent literature and measures of client satisfaction. These measures are examined in terms of their ability to reflect clients' actual experiences, the dimensions of satisfaction they are intended to measure, and their ability to obtain quality data from clients. The following computerized data bases were used for this review: ERIC, PsychLit, Sociofile, HSTAR medical index, and the Psychological and Behavioral and PschInfo portions of the Wilson Indexes. References were also identified from information gathered at conferences and publications designed to help users evaluate consumer satisfaction measurement instruments, including [A Guide for Evaluating Consumer Satisfaction with Child and Adolescent Mental Health Services](#) (Nicholson, J. and Robinson, G., 1996). Since there has been a great deal of recent interest in client satisfaction, this review is limited to the empirical studies published between 1990-1997 in which descriptions of the data collection instruments are included.

### **Definitions of Client Satisfaction**

Client satisfaction is defined as clients' perspectives on aspects of the service transaction important to them. Consequently, the items used in a satisfaction measure define satisfaction for a particular service. This review examines the range of definitions of client satisfaction as indicated by the items and dimensions used for its assessment. Thirty-nine studies were identified that included information on a client satisfaction instrument. They were related to services in the following areas: mental health services (20), health services (5), family mediation services (4), child welfare/protection services (4), services for disabled children (4), and self-help groups (2). Items contained in client satisfaction measures come primarily from three sources: clients, professionals, and professional literature. This review

organizes client satisfaction instruments according to the source of items. Methodological issues important to assessment of client satisfaction are also discussed.

### **Instruments where clients were the primary source of items**

If client satisfaction is defined as clients' perspectives on aspects of the service transaction important to them, perhaps the most important sources for identifying these service features are clients. Developing instruments in this way typically involves engaging clients in focus groups or interviews. Two instruments in this review were developed in this way.

McComas, Kosseim, and Macintosh (1995) utilized a client-centered approach to develop an instrument to assess parent and caregiver satisfaction with services at a seating clinic, which prescribes seating and mobility devices for children with physical disabilities. Respondents were allowed to choose either a focus group or individual interview format. Data obtained from clients was coded into themes relating to the process, which refers to events leading up to the creation of the seating insert and the quality of the end product, the seating insert. Themes relating to the service process included communication, waiting and evaluation time, persons in the clinic, process choice, responsibility, and organization. Themes related to the product included quality, cost and value, and product choices. The resulting Likert-type questionnaire was designed to reflect the chronological sequence of events typical of a clinic of this type, as well as the themes uncovered.

The items were validated by requesting feedback on clarity, content, and design from program participants and health professionals. During the validation process, participants tended to focus more on the content and wording of questions and possible omissions than did professionals.

Weaver, Ow, Walker, and Degenhardt (1993) developed a 25-item Physicians' Humanistic Behaviors Questionnaire (PHBQ) to assess the humanistic behaviors of physicians. Structured interviews and questionnaires were used to define important humanistic qualities such as integrity, respect, and compassion. Patients were asked to describe a behavior that would indicate that a physician had this quality, as well as a behavior that would demonstrate that a physician did not have this quality. The humanistic qualities that the instrument measured were not specified. The PHBQ directed respondents to rate professionals on a 5-point Likert-type scale ranging from strongly disagree to strongly agree.

Testing of a pilot version of the instrument resulted in the elimination of items that did not discriminate between respondents. The PHBQ and the Medical Interview Satisfaction Scale (MISS), a standardized questionnaire that measures patient satisfaction with a specific physician, were found to be highly correlated in both the hospital and the clinic ( $r=.87$  and  $.87$   $p<0.001$ , respectively). This provides support for the validity of the PHBQ. The correlation between the PHBQ and attending physicians' evaluations of six medical residents was  $r=0.57$ ,  $p=0.23$ . This relative lack of agreement between patients and physicians suggests different observations, criteria, or standards between the two groups.

### **Instruments where professionals and clients were the sources of items**

Five of the thirty-nine studies reviewed used both clients and professionals to develop the satisfaction instrument. These studies developed items from separate focus groups of clients and professionals and by combining information developed by a committee of professionals with that gathered from a pilot study of client views. Drake (1996) generated items from data gained from focus groups with child welfare consumers and child welfare workers. Eight key child welfare competencies were identified: (a) development of worker-consumer relationship, (b) diversity skills, (c) special population skills, (d) inter-organizational skills, (e) intra-organizational skills, (f) self-management skills, (g) assessment skills, and (h) intervention skills. Drake found a high congruence between the competencies identified by consumers and those identified by workers.

McWilliam, Lang, Vandiviere, Angell, Collins, and Underdown (1995) employed both quantitative and qualitative methods, (a mail survey and in-depth semi-structured interviews, respectively) to assess parents' satisfaction with early intervention services for children biologically or environmentally at risk for developmental delays or who exhibit atypical development. The instrument reflected the combined concerns of clients who participated in a pilot study and the concerns of a multi-disciplinary committee comprised of service providers, parents, local program administrators, state agency representatives, and a university researcher. The resulting survey data were grouped conceptually into the following categories: inclusion, service delivery, payment, comprehensiveness, families, and overall satisfaction.

Greenley and Robitschek (1991) measured caregivers' satisfaction with a community-based pilot program for youth with severe emotional disorders. Caregivers reported on the

services they were currently receiving as well as those they had received before entering the pilot program. The majority of items in the survey were derived from interviews with program conceptualizers and implementers, as well as leaders of organizations for parents of children with severe emotional disturbances. Some items were also taken from previous literature in the field. The survey instrument contained items on pre- and post-program needs, prior and current treatment experiences, services needed and used, difficulty obtaining services, level of caregiver involvement, and satisfaction with specific services.

Gerkenmeyer, Barron McBride, Finke, and Austin (1996) developed the Parent Satisfaction with Staff Interaction Instruments to measure parents' perceptions of mental health staff providing services to their children. The two primary scales are the (a) Parent Satisfaction Scale (PSS) which is made up of direct measures of patients satisfaction with staff interactions, and (b) the Parent-Staff Interaction Scales (P-SIS) that measures parents' perceptions of staff interactions. The PSS was developed independently from the P-SIS to collect direct measures of satisfaction since it cannot be assumed that measures of parents' perceptions equate with their level of satisfaction. The PSS, is made up of seven direct satisfaction items. This scale also contains two items measuring general satisfaction: a) If I needed services for my child again, I would go back to these staff; and b) I would recommend these staff to friends and neighbors with similar problems. The P-SIS has thirteen items measuring parents' perceptions of staff interactions. All items are rated on a 5-point Likert scale ranging from "strongly agree" to "strongly disagree."

Gerkenmeyer et al. (1996) report a high inter-item correlation alpha of .98 (N=68) indicating high internal consistency and evidence for the reliability of the P-SIS and PSS scales. Evidence for criterion validity of the P-SIS is the high correlation of the P-SIS to two general satisfaction items expected to be positively related to the P-SIS. The correlations between the P-SIS and the independent items were .88 and .87, respectively (N=68). The P-SIS was also strongly correlated with the PSS ( $r=.98$ ).

Gerkenmeyer et al. (1996) suggest that because the items were drawn from a large pool, the resulting instruments provide information about parents' perceptions of staff interactions that is specific enough to be meaningful. Also, the clustering of the item means around the midpoint of the 5-point Likert scale and large standard deviations indicate that the scales capture variability between subjects and do not have the positively skewed results typical of most satisfaction measures.



Shapiro, Welker, and Jacobson (1997) generated items for the Youth Client Satisfaction Questionnaire (YCSQ) on the basis of a literature review, focus groups with clinicians, and individual exploratory interviews with ten young clients and their parents. A pilot test of the resulting 17 items conducted with 20 respondents indicated that the items were readily understandable. Three criteria for retaining items for the final measure were used- (a) a test-re-test reliability correlation greater than or equal to .50, (b) a part-,whole correlation greater than or equal to .40, and (c) a correlation with a validation item that inquired about overall satisfaction that was greater than or equal to .30. Fourteen of the 17 original items met the criteria. The correlations were all significant at  $<.0001$ , and average correlation for the 14 items were .67 for test-re-test reliability, and .65 for part,whole correlation. A test-re-test reliability coefficient of .92 (Cronbach's  $\alpha=.90$ ) was obtained for total scores.

The Youth Client Satisfaction Questionnaire (YCSQ) includes fourteen close-ended questions with wording, sentence structure, and response format that is readily comprehensible to the vast majority of youth 11 years old and older. The directions and wording are intended to minimize the influence of social desirability response bias. The instrument includes open-ended items that ask for information on the best and worst aspects of counseling, and any additional comments the respondent might have. The questionnaire provides space for the recording of interviewer's comments. The YCSQ was developed to be administered as a telephone interview rather than as a written instrument to maximize the measure's practicability of use in community clinical settings in which low response rates from mailed questionnaires, premature termination of therapy, youths' privacy, and the fact that dissatisfied clients are less likely to reply by mail may be an issue. According to the authors a telephone interview procedure: (a) is unaffected by whether termination of therapy was planned, (b) provides respondents with privacy, and (c) eliminates reading ability as a potential obstacle to valid responding (Shapiro, Welker, & Jacobson, 1997). Responses are given in terms of a 4-point Likert-type scale. Due to the difficulty that respondents have remembering all four-scale points, the items are administered as brief, one-step or two-step exchanges between the interviewer and the respondent. Initially, a response that is either globally positive or negative is requested. A follow-up question, based on the respondent's first answer, asks for a more precise specification of the degree to which the respondent is positive or negative about services. For example, "Did you have a bad time in counseling, or

did you have a good time?". If the response was bad, the youth is then asked, "Was it mostly bad, or was it all bad?"

A factor analysis yielded two principle components of youth consumer satisfaction. The Relationship with Therapist factor indicates the youth's perception of the therapist as understanding, caring, helpful and culturally sensitive, and enjoyment of therapy. The Benefits of Therapy factor refers to therapy-caused changes and beneficial learning and understanding of therapeutic goals. The factors explained 34% and 33% of the variance, respectively. Correlation between factors of .61 ( $p < .0001$ ) and data on cross-loading indicates that the two factors were only semi-independent and that they were strongly related.

### **Instruments where professionals were the primary source of items**

Instruments from four of the thirty-nine studies were generated primarily from professionals. These authors typically used agency or professional documents to generate items. Begley, Ross, Austin, Casey, Collins, Hennings, Agriesti, and Marshall (1994) developed an inventory to measure client satisfaction with results of HIV counseling. Items were written by examining program objectives. The resulting Albion Center Scale (ACS), a 19-item scale measuring client satisfaction with HIV counseling, obtains client ratings on a 5-point Likert scale ranging from "strongly agree," "agree," "uncertain," "disagree," and "strongly disagree." Begley et al. uncovered four client satisfaction dimensions: (a) perception of progress and improved mood; (b) recognition of a specific need for counseling; (c) behavior change from counseling; and (d) counseling climate. The reliability of the four scales was: .85, .70, .73, and .50 respectively.

Cournoyer and Johnson (1991) developed the Helping Behavior Checklist (HBCL) to measure parents' perceptions of behaviors of the mental health professionals who serve them. Professional codes of ethics were used to identify 31 helping behaviors. The questionnaire used four responses: almost always true, often true, seldom true, and almost never true. The authors used a panel of expert judges to determine the content validity of the HBCL. Nineteen of the items -were matched to the same ethical principle by 90% of the experts. Seven other items were matched to the same principle by more than 70% of the judges, four more were matched by 70%, and the remaining item was matched to the same

principle by more than 60% of the judges. Twenty-two of the 28 items retained in the final instrument had significant test-re-test correlations ranging from .30 to .86. Only one HMCL item, professional helpers' refusal to provide reasonable access to records that were requested, was found to be significantly correlated with parents' belief that the child was doing as well as expected. The authors cited this finding as evidence that parents' ratings of a particular professional are not influenced by experience with other helpers or by parental hopes and aspirations. This was cited as evidence for the discriminant validity of the instrument.

The Consumer Satisfaction Survey was created for the Consumer Oriented Mental Health Report Card project by the Mental Health Statistics Improvement Program (MHSIP) Task Force, a collaborative effort of consumers, the MHSIP community, and the Center for Mental Health Services. The 40-item instrument contains four questions related to general satisfaction, seven questions related to access to services, fifteen questions related to appropriateness of treatment, and fourteen items related to outcome of care. Respondents are asked to respond to a 5-point Likert-type scale ranging from "strongly agree" to "strongly disagree" with one "not applicable" choice (MHSIP, 1996).

A pilot test of 101 respondents revealed that inter-item correlations ranged from .50 to .60 for items in the same domain. Typical correlations between items measuring different domains ranged from .20 to .40. The instrument demonstrated an alpha reliability of .95. The results of the pilot test revealed five factors: (a) outcomes, (b) access, (c) appropriateness of staff behaviors, (d) appropriateness of consumer behaviors, and (e) financial barriers to services. The general satisfaction dimension was not confirmed. Seventy-six percent of respondents felt that the instrument was not too long and 80% felt that it was not too short. Sixty-percent of respondents felt that the instrument did not omit any important issues, 97% felt it did not include any irrelevant items, and 96% felt that it did not include any difficult or unclear items. The pilot version of the instrument was modified based on consumers' indications of confusion associated with the reverse questions. The reverse questions were changed into direct questions in the version of the survey included in the Report Card MSIP, 1996).

The American Managed Behavioral Healthcare Association (AMBHA) is comprised of the nation's leading managed behavioral healthcare organizations. AMBHA member

organizations collectively manage mental health and substance abuse care for well over 80 million U.S. residents. The AMBHA (1995) work group on consumer-based measures developed a set of core questions to be included in member companies' standard patient satisfaction surveys. The survey contains performance-based measures related to satisfaction in the following areas: (a) time interval to the first appointment, (b) intake clinician or worker, (c) therapist, (d) service outcome, and overall satisfaction. The survey is intended to target a random sample of adults who received services in a given year (American Managed Behavioral Healthcare Association, 1995).

Guidelines for survey methodology were created to insure reliable and comparable results. In order to be aggregated as part of the organization's report card, data collected by telephone or mail survey must meet the following guidelines: (a) a minimum response rate of 70%, (b) a minimum of 500 responses per company (the number may be reduced for companies with multiple products), (c) results must be reported as both percents and frequencies, (d) the sample size and response rate must be stated, (e) they must use a random sample of all adults receiving the service through the company, (f) respondents should be contacted 2-6 months after intake to insure that they have enough experience with the company to form an opinion, as well as a good recall of the experience, (g) patients who would be put at a significant and eminent risks of harm by being contacted may be exempted from the random sample, and finally, and (h) AMBHA guidelines must be followed in determining the final sample size and in calculating the response rate (American Managed Behavioral Healthcare Association, 1995).

### **Instruments where professional literature was the primary source of items**

The majority of authors, twenty-one, defined client satisfaction according to what other authors had reported. Some authors gathered data using the instruments employed by other professionals, however, the majority of authors modified these instruments to fit their purposes and/or augmented the instruments with additional items designed to measure specific aspects of the service under question. Many of the scales in this section were derived from the Client Satisfaction Questionnaire (CSQ) developed by Larsen, Attkisson,

Hargreaves, and Nguyen (1979). The CSQ is a self-report measure designed to assess consumer satisfaction with mental health services and includes the following dimensions of consumer satisfaction: (a) physical surroundings, (b) kind/type of treatment, (c) treatment staff, (d) quality of service, (e) amount, length, or quantity of service, (f) outcome of service, (g) general satisfaction, and (h) procedures (Gaston & Sabourin, 1992). The CSQ utilizes a 4-point response format including "very satisfied," "satisfied," "dissatisfied," and "quite dissatisfied" (Byalin 1993), with scores ranging from 0-4. Byalin (1993) used the CSQ-18, an 18- item version of the instrument to measure consumer satisfaction with children's mental health services. Several authors used a shorter, 8-item version of the instrument, the CSQ-8 (Gaston Sabourin, 1992; Kurtz, 1990; Vandiver, Jordan, Keopraseuth, & Yu, 1995).

The internal consistency of the CSQ-8 was high, with alpha coefficients ranging from .84 to .93 (Gaston & Sabourin, 1992). Gaston and Sabourin found a lack of relationship between client satisfaction and social desirability, and suggest that this provides support for the discriminant validity of client satisfaction measures. These authors also stated that the lack of difference in levels of CSQ-8 scores across clients undergoing different forms of psychotherapy suggests that the measurement of client satisfaction could be useful to assess the outcome of diverse psychotherapy approaches.

Other work involving the CSQ-8 includes; Gaston and Sabourin (1992) measured consumer satisfaction with psychotherapy in a private practice setting, Kurtz (1990) measured satisfaction with a self-help group for depressed clients, and Vandiver et al. (1995) measured satisfaction with outpatient psychiatric services. Perreault, Leichner, Pierre Sabourin, and Gendreau (1993) used the French version of the CSQ-8 to measure consumer satisfaction with out-patient psychiatric services. Perreault et al. found a high alpha coefficient of .92 using the French version of the CSQ-8 administered to 236 patients.

In measuring client satisfaction with a self-help group for depressed clients, Kurtz (1990) combined a modified version of the CSQ-8 with additional items that asked for satisfaction and ranking of specific activities in which self-help group members were likely to engage. The instrument also asked subjects to rank possible benefits received as a result of participation. Subjects were asked to supply outcome and demographic data. The author analyzed correlations of satisfaction ratings and demographic items including age, marital status, gender, employment status, educational level, and income. Only income correlated significantly with satisfaction ratings ( $r=.18, P<.01$ ). The author asserted that the lack of

correlation between demographics and satisfaction helped support the construct validity of the instrument.

Krahn, Eisert, and Fifield (1990) combined the CSQ-8 with fourteen items that addressed the specific concerns of an evaluation and case management service for families of children with developmentally disabilities. Additional narrative items were also included. Krahn et al. uncovered four dimensions of satisfaction: (a) general satisfaction, (b) clarity of communication, (c) pre-appointment wait and information, and (d) efficiency. All eight CSQ-8 items -were included in the General Satisfaction dimension. A separate principal components analysis with varimax rotation conducted on these 8 items confirmed the unidimensionality of the CSQ-8. This was seen as providing support for the use of the instrument with families of children with developmental disabilities. Narrative comments by respondents reflected the themes of the four factors. There was a 96% inter-rater agreement across all responses. An analysis of narrative responses identified the following service dimensions: (a) physical environment, (b) atmosphere, (c) personnel, (d) intervention characteristics, and (e) clients, functioning.

Pickett Lyons, Polonus, Seymour, and Miller (1995) developed an 11 -item questionnaire to measure consumer satisfaction with managed mental health care that -was based on the CSQ developed by Atkisson and Zwick (1982). Components measured included: (a) helpfulness of the primary care physician in facilitating therapy, (b) promptness of response for a request for treatment, (c) staff understanding of patient's presenting problem (d) staff helpfulness, (e) therapist skill, (f) convenience of location, (g) ratings of current psychological health, (h) current distress level, (i) reason for termination of therapy, (j) and number of sessions attended.

The Client Satisfaction Questionnaire (CSQ) is a slightly modified version of the Larsen et al instrument. This version of the CSQ is required by states participating in the Comprehensive Community Mental Health Service Program for Children with Serious Emotional Disturbances (Cross & McDonald, 1995). The CSQ is designed to assess parents' and caregivers' satisfaction with services received by their children over the preceding six months. The instrument consists of eight simple questions measured on a four-point scale ranging from 'great satisfaction' to "great dissatisfaction." The authors assert that one or two items might be useful for assessing areas for improvement (e.g. "If you were asked to seek

help again, would you come back to this program?"). These authors also discuss the lack of information regarding the validity and reliability of the instrument.

Clare (1995) developed the Huntingdon Portage Client Feedback Questionnaire to serve as a standard measure of parent satisfaction with pre-school home teaching services for children with special needs. The services are based on behavioral principles with an emphasis on partnerships between parents and professionals. The instrument includes questions adapted from the CSQ to assess general satisfaction and satisfaction related to specific services. The format of the questionnaire was adapted in part from the Client Feedback Questionnaire (Barker & Pistrang, 1991). Items were revised based on pilot interviews with two families.

This scale asks parents to rate their satisfaction with services, the perceived quality of services, the extent to which the service has helped them as a parent, and their ideas regarding actual or planned use of the Portage method. Responses are rated on a 4-point Likert-type scale. Respondents are also asked open-ended questions regarding the most and least helpful aspects of services, and areas that could be changed or improved. The author suggests that the measure may be considered to have adequate face and content validity because it appears to be acceptable to parents, is easy to complete, provides both quantitative and qualitative data on general satisfaction, and contains questions related to Portage services.

Stuntzner-Gibson, Koren, and DeChillo (1995) adapted items from the CSQ to develop the Youth Satisfaction Questionnaire (YSQ), a brief self-report measure designed for children 9 years of age and older. The authors rephrased CSQ items to make them more understandable to children and minimized the number of items used to measure general satisfaction. Items measure children's perception of the helpfulness of services, the degree to which they like services, and whether they are receiving the appropriate amount of services. Children respond to items based on a yes, somewhat, or no format. Opinions regarding distinct services and activities are assessed by directing children to assign grades (A through F) to each specific service or activity. Data obtained from the questionnaire indicated that caregivers' and children's ratings of day treatment and medication management evidenced strong levels of agreement ( $r=.81$  and  $.60$ , respectively,  $p<.001$ ), while their ratings of case management, family activities, education, and counseling showed moderate to low levels of

agreement ( $r < .042$ ,  $p < .001$ ). The authors suggested that these findings underscore the need to evaluate children's attitudes toward services independently from those of adults.

Researchers for the Casey Family Program (1994) in Seattle, Washington utilized their personal experience and a literature review by Le Prohn (1993), and Reid and Gundlach (1983) to develop a measure of foster parents' perceptions of agency services and support. General and specific items were employed to identify program strengths and areas in need of improvement. Foster parent agency satisfaction was measured by the Foster Parent Agency Satisfaction Scale administered by mail and by two open-ended questions about areas of satisfaction and dissatisfaction with the social worker that were administered via telephone. Seven of the items were related to foster home developers and the remaining 36 items were related to the agency and the social worker.

Factor analysis was used to create sub-scales reflecting the following aspects of satisfaction: (a) worker effectiveness, which contains items reflecting the social worker's ability to help the foster parent and/or the foster child, (b) worker availability, which consists of items reflecting the social worker's availability and helpfulness, (c) communication, which contains items pertaining to the social worker's ability to communicate with the foster parent, and (d) interviewing performance, which reflects the social worker's ability to get information in an honest and non-judgmental manner. Subjects are also asked to rate their satisfaction with agency help and support.

Davies, Ralph, Hawton, and Craig (1995) developed their Client Satisfaction Questionnaire (CSQ) by modifying a previously developed instrument by Kelly and Gigy to reflect specific aspects of family court counseling. The questionnaire contained seven sub-scales: (a) professional skills, (b) fairness, (c) impact of fairness, (d) adequacy of information given, (e) child specific issues, (f) outcomes, and (g) the management of abuse issues.

In a measure of client satisfaction with AIDS case management services, Fleishman, Mor, and Piette (1991) directed interviewees to rate their case manager by "strongly agreeing," "agreeing," "disagreeing," or "strongly disagreeing", with eight evaluative statements. Examples of the statements include: the case manager can be reached easily in an emergency ... has helped you a lot to get your benefits and services ... seems to be too busy to spend enough time with you ... can be counted on when things get tough.



Glajchen and Magen (1995) developed a Group Evaluation Questionnaire to gauge satisfaction with the cancer support group experience. Items were rated on 5-point Likert scale ranging from "not at all satisfied" to "very much satisfied." Open-ended questions about what clients liked and disliked about group sessions were also included in the instrument.

Harkness and Hensley (1991) collected data via the Client Satisfaction Scales (CSS), an instrument used previously by Poertner (1986) to measure consumer satisfaction with community mental health services. This instrument measures three dimensions of client satisfaction: worker helpfulness, goal attainment, and worker-client partnership. Subjects are asked to rate their agreement with each item on a 4-point scale. Harkness and Hensley (1991) reported that the CSS had good alpha reliability and good face validity.

In a measurement of patient satisfaction with health care services, Hseih and Kagle (1991) obtained data via a modified version of the Patient Satisfaction Scale which is a standardized questionnaire developed and tested by Ware, Snyder, and Wright (1976). Clients responded to items on a 5-point Likert scale. Factor analysis identified four client satisfaction factors: (a) satisfaction with physician's conduct, (b) availability of health resources, (c) satisfaction with accessibility, (d) and satisfaction with financial coverage of care. The instrument's alpha reliability was reported as .91.

In measuring the satisfaction of substance abuse clients, Mavis & Stoffelmayr (1994) modified existing satisfaction surveys previously utilized by Damkot, Pandiani, & Gordon (1983), and Linn & Greenfield (1982). The authors used four scales developed by Mavis & Stoffelmayr (1990): (a) counselor quality which is comprised of nine items related to perceptions of the counselor's experience, thoroughness, competence, and training, (b) program improvement which contains four items assessing perceived improvement as a result of treatment, (c) counselor attention which is a 3 item scale related to counselor's interest in the client, friendliness, and concern for the client's comfort, and (d) overall program satisfaction based on five items assessing the cost of services, satisfaction with services, and willingness to recommend the program to others.

Miller (1992) developed a questionnaire to measure patient satisfaction with a group practice HMO based on a model that conceptualizes a clinic visit as composed of a series of encounters and interactions. Thus, the survey gathered data on patient satisfaction with each point of interaction between the patient and the system during a clinic visit. The

questionnaire relied heavily on the service qualities of courtesy, information giving, and the time it took to render and receive services. Satisfaction was measured on a 5-point Likert scale which ranged from 'very satisfied' to 'very dissatisfied' and included an additional "not applicable" choice. Four sub-scales of satisfaction were identified: (a) provider interaction, (b) access, (c) ancillary services, and (d) exit.

In the measurement of consumer satisfaction with child welfare services, Olsen (1995) patterned questions after the Homebuilders Client Feedback Survey by Whittaker, Kinney, Tracy, and Booth (1990), and the Parent Outcome Interview developed by Magura and Moses (1986). Parents were asked about their substance abuse problem, satisfaction with services and their worker, and their expectations for service.

Perreault, Leichner, Sabourin, and Gendreau (1993) measured satisfaction with outpatient psychiatric services using the SHARP-V instrument consisting of a scale of 25 dichotomous yes/no items covering the following aspects of client satisfaction: (a) satisfaction, (b) helpfulness, (c) accessibility, (d) respect, and (e) partnership. The authors reported that a factor analysis with a varimax rotation of the French version of the SHARP-V gave a one-factor solution with only one factor having an Eigenvalue higher than 1.

Pyke and Apa (1994) drafted a questionnaire to measure client satisfaction with community mental health services. The questionnaire was based on the research findings of the studies of family satisfaction with mental health conducted by Francell Conn, and Gray; Holden and Lewine (1982); Tessler, Gamache, and Fisher (1991); and the 1991 Ontario Friends of Schizophrenia survey. A panel of six consumers and five program staff members modified the basic questionnaire to ensure that questions were: (a) clear and understandable, (b) brief and easy to respond to, (c) allowed room for respondents to make comments, (d) consistent with program objectives, and (e) focused on the services provided to the family. Satisfaction was measured by whether respondents would recommend the program to others and a general satisfaction question. The questionnaire also contained open-ended questions about what families liked the most and least about services, what clients thought might improve those services, and a space for general comments. Issues of meeting times and places, as well as financial compensation were established to support the attendance and participation of consumers. The meeting milieu encouraged open and free discussion of beliefs of consumers and family members who were not always in agreement.

Rosen, Heckman, Carro, and Burchard (1994) reported utilizing a 5-point Likert scale ranging from "extremely satisfied" to "extremely dissatisfied" to measure youths' satisfaction with wraparound services. The instrument has youth assess the following factors: (a) treatment team (b) residential placement, (c) caseworker, (d) case manager, (e) school program (f) vocational program, (g) respite, and (h) general satisfaction.

Solomon and Draine (1994; 1995) measured client satisfaction with case management services based in a community mental health center and a consumer self-help organization. To assess satisfaction with treatment, the authors utilized a 16-item measure developed by Hoult, Reynolds, Charbonneau-Powis, Weekes, and Briggs (1983) for assessing a community treatment team approach conceived by Stein and Test (1980). Each item described a service which subjects were asked to rate on a 4-point scale: very helpful, helpful, somewhat helpful, and not at all helpful. Items were grouped conceptually into three subscales: (a) case manager's personal characteristics ( $\alpha=0.92$ ,  $N=79$ ), (b) case manager's problem-solving characteristics ( $\alpha=0.82$ ,  $N=79$ ), and (c) case manager's ability to serve as a resource ( $\alpha=0.86$ ,  $N=79$ ). Solomon and Draine reported the reliability coefficient for clients who completed all measures on the Hoult et al. instrument was acceptable ( $N=21$ ,  $\alpha=.99$ ).

Winefield and Barlow (1995) adapted questions from instruments previously used by Fryer, Bross, Krugman, Denson (1990), and Baird, Shireman, Grossnickle, Hinsey, and White (1990); and other health client satisfaction measures to measure client satisfaction with child protection services. Clients were asked to rate staff members for attentiveness, warmth, knowledge, availability, and helpfulness on a 4-point scale of "strongly disagree," "disagree a little," "agree a little," and "strongly agree." The authors reported that their adapted measure showed acceptable internal consistency as shown by alpha coefficients of .69 and .87 for the two workers evaluated.

### **Instruments where the source of items was unspecified**

Six studies did not explicitly specify the source of their items. These authors seemed to imply that they developed the questionnaire specifically for the current study. Depner, Cannata, and Ricci (1994) obtained data on parents' views of court mediation services using the Parent Viewpoint questionnaire, which measured: helpfulness of services, sufficient opportunity to discuss the issues, and general satisfaction. Slater, Shaw, and Duquesnel

(1992) developed a survey questionnaire to obtain client feedback for a family court mediation program. This instrument included feedback on the parenting plan, satisfaction with mediation and investigative services, and parent ratings of positive and problem behaviors perceived in their children. Survey respondents were asked to rate the overall quality and the helpfulness of the services they received.

Teare, Peterson, Furst, Authier, Baker, and Daly (1994) obtained satisfaction ratings from youth clients of a short-term emergency shelter during a confidential termination interview with a shelter administrator. During the interview, youth rated the shelter staff as a whole on fairness, communication, concern, pleasantness, and helpfulness. Ratings were on a 7-point Likert-type scale, where "1" indicated complete dissatisfaction and "7" indicated complete satisfaction. Youth were also asked whether they had been abused by shelter staff during their stay.

Van Slyck, Stern, and Newland (1992) measured families' satisfaction with a state sponsored parent-child mediation service via a mailed questionnaire. Families evaluated mediator performance on several dimensions, including understanding, neutrality, fairness, and listening.

The Vanderbilt Satisfaction Scales were developed by the Vanderbilt Institute Center for Mental Health Policy research team for use in the Fort Bragg Evaluation Project. The Vanderbilt Satisfaction Scales are self-report measures designed to assess parents' and adolescents' general and specific satisfaction with services (Cross & McDonald, 1995). Both the Parent Satisfaction Scales (PSS) and the Adolescent Satisfaction Scales (ASS) are included in the Vanderbilt Satisfaction Scales.

Each version of the test consists of nine scales that target different service areas. Target services include: (a) intake and assessment services, (b) after school services, (c) day treatment services, (d) the therapeutic foster home program (e) case management services, (f) in-home services, (g) the therapeutic home program (h) group home services, and (i) inpatient and residential services. All of the scales, except the intake and the assessment scales, asked respondents to refer to experiences they have had within the previous six months. Respondents are asked to circle a response from 1 to 5 (1 indicating "not satisfied" and 5 indicating "very satisfied"). An overall satisfaction score is determined for each specific service. Separate ratings of satisfaction can also

be generated in the following content areas: (a) access and convenience, (b) child's treatment, (c) parent services, (d) family services, (e) relationship with therapist, (f) staff responsiveness, (g) financial charges, and (h) discharge and transition (Cross & McDonald, 1995).

According to Cross and McDonald (1995), a content analysis provides preliminary support for the scale's construct validity. A four-factor model yielded the following factors and fit indices: (a) access and convenience (.88), (b) child's treatment process (.96), (c) parent and family services (.98), and (d) global satisfaction (.98). These authors report that the content area of the scales for the parent module demonstrated good internal consistency as assessed by Cronbach's alpha coefficient ranging from .76 to .98. Values of reliability for parents' services (.57) and family services (.68), scales were considerably lower. Cronbach's alpha for intake assessment, outpatient, and inpatient scales ranged from .71 to .91. Lower values were obtained for the therapist relationship content area (.68), discharge and transition (.61), and access and convenience (.63) (Cross & McDonald, 1995).

The Parent Satisfaction Scale (PSS) is a self-administered scale that assesses satisfaction with mental health services and covers: (a) intake and assessment, (b) outpatient therapy, (c) inpatient hospital/residential treatment, (d) case management, (e) day treatment, (f) therapeutic group home, (g) therapeutic family home, (h) after-school services, and (i) in-home counseling. Within each module, several aspects of the treatment process are measured. Although the content areas vary across modules, they generally include: (a) access and convenience, (b) child's treatment, (c) parent services, (d) family services, (e) relationship with therapist, (f) staff responsiveness, (g) financial charges, (h) discharge/transition services, and (i) global satisfaction. Two content areas in the day treatment module had an alpha coefficient of less than .70 (parent services = .57, and family services = .68). A limited sample size prohibited assessment of the after school module. A confirmatory factor analysis (CFA) using data from the outpatient module indicated the existence of four dimensions of satisfaction: (a) access and convenience, (b) child's treatment process and relationship with therapist, (c) parent and family services, and (d) global satisfaction. The fit index for the four factor model was .974, with a chi-square of 82.50 (df = 29,  $p < .001$ ). Factor loading ranged from .82 to .98, with error terms ranging from .20 to .54 (Anderson, Rivera, & Kutash, 1996).

The Adolescent Satisfaction Survey (ASS) is a self-administered questionnaire designed to measure adolescents' satisfaction with mental health services (Anderson, Rivera, & Kutash). The instrument is designed to be used with parents and caregivers of children ranging from age 5 to 18, and adolescents from ages 12 to 18 (Cross & McDonald, 1995). The ASS, a parallel version of the previously mentioned Parent Satisfaction Survey, contains the same nine service-specific modules as the parent version. Each module contains content areas similar to the parent version, however, several areas considered inappropriate for adolescents, such as satisfaction with explanation of financial charges/payments were deleted from the adolescent version (Anderson, Rivera, & Kutash, 1996).

Coefficient alphas for three of the nine modules (intake & assessment, outpatient therapy, and inpatient hospital/residential treatment) demonstrated high internal consistency, with most alpha coefficients equaling .70 or greater. Only three content areas had alpha coefficients lower than .70. In the outpatient module, the area of satisfaction with discharge/transition services yielded an alpha coefficient of ( $r=.61$ ) and satisfaction with therapist relationship ( $r=.68$ ). The inpatient hospital/residential treatment center module, satisfaction with access and convenience yielded a coefficient alpha of .63. Thus, these three modules have acceptable internal consistency alphas ranging from .61 to .91 (Anderson, Rivera, & Kutash, 1996).

Rouse, MacCabe, and Toprac (1994) devised the Family Satisfaction Questionnaire and the Child/Adolescent Satisfaction Questionnaire to measure parents' and children's satisfaction with mental health services. These almost identical self-administered instruments are comprised of 12 Likert questions, one multiple choice question about treatment obstacles, and an open-ended question asking for additional comments. A factor analysis isolated three distinct domains of satisfaction: (a) treatment effectiveness, (b) satisfaction with services, and (c) child/provider relationship. These scales have been found to be significantly correlated. Both instruments have also been found to be internally reliable: the Parent Satisfaction Questionnaire coefficient alpha equaled 0.89 and the Child/Adolescent Satisfaction Questionnaire coefficient alpha equaled .88 (Rouse, MacCabe, & Toprac, 1994).

## **Dimensions of Client Satisfaction**

The studies of client satisfaction that are the focus of this review are wide ranging in the areas studied: child welfare, mental health, health, mediation services, services to families of children with disabilities, and self help groups. The literature is also diverse in the number of dimensions of client satisfaction. In an effort to identify common elements of satisfaction, the authors examined the dimensions identified in each general service area.

### **Child Welfare or Protection**

The four studies in this category focused predominately on worker effectiveness, worker skills, and the quality of the helping relationship. Three of the four articles also considered the quality of workers' assessment skills to be an important aspect of consumer satisfaction. Dimensions that were mentioned infrequently include clients' expectations for services, diversity skills or skills with special populations, and worker ability to function outside the public welfare agency.

### **Mental Health Services**

Most of the client satisfaction literature is in the area of mental health services. Twenty articles specified dimensions that were important in the measurement of consumer satisfaction with mental health services. Most authors considered clients' perceptions of mental health professionals to be an important aspect of client satisfaction. Service quality, the worker-client relationship, service outcome, and general satisfaction were also frequently mentioned dimensions of satisfaction. Less frequently mentioned dimensions include physical surroundings, procedures, the type of treatment, access to services, financial barriers to services, and interval to first appointment.

### **Services for Children with Disabilities**

Each of the four articles that explicated dimensions related to consumer satisfaction with services for children with disabilities focused on the quality or structure of the service delivery process. General satisfaction, the quality of communication, clients' perceptions of waiting time in terms of their initial appointment or receipt of the end product, and the degree that clients felt they were offered a sufficient array of services or options in receiving

services were considered important dimensions of consumer satisfaction in two of the articles. Most dimensions that were mentioned in only one study tended to reflect idiosyncratic aspects of the particular service under question, early childhood intervention as opposed to fitting of mobility devices for physically disabled children. Examples of these dimensions include the quality of the final product, satisfaction with the degree of mainstreaming, and the extent to which service providers pursued the family's stated priorities. The perceived helpfulness of the service, as well as intent to continue using the model of services presented were mentioned by one author.

### **Self-Help Groups**

Two studies specified the dimensions that were used to measure consumer satisfaction with self-help groups. Dimensions common to both studies included quantity of services received and possible benefits from group participation (i.e. emotional support and universalization of circumstances). One study dealt exclusively with dimensions related to current service delivery such as physical surroundings, procedures, service outcomes, etc. The other study was also concerned with gathering information related to environmental factors and past history. Examples of these dimensions include clients' additional sources of social support and their experiences prior to entering the group. The articles also differed in their measurement of overall satisfaction. One author measured only global satisfaction while the other measured satisfaction with specific elements such as satisfaction with the group leader and factors that clients specifically liked and disliked about the group.

### **Family Mediation Services**

All four articles that delineated dimensions related to consumer satisfaction with family mediation considered general satisfaction to be an important dimension of satisfaction. Three of the articles contained measurements of the mediator's skills and service outcome or symptom reduction. Clients' perceptions of the fairness of the mediator and the impact on family relationships were mentioned twice. Examples of items that were idiosyncratic include items such as client feedback about themselves, child specific issues, and a parenting plan.



## **Health Services**

Each of the five authors that measured consumer satisfaction with health services measured clients' satisfaction with service providers' ability to make clients feel comfortable. Qualities such as accessibility, helpfulness, and humanism are representative of this dimension. Availability of services was mentioned on two occasions. Dimensions mentioned infrequently included financial coverage, staff knowledge, and the quality of ancillary laboratory and pharmaceutical services, and the perception of progress and improved mood.

There seem to be two overall approaches embedded in the client satisfaction literature. One approach is that satisfaction is considered to be the consumer's response to a question of the type: How satisfied are you with service x? Another approach is that there are specific features of the service to which the consumer reacts. The diversity of dimensions of satisfaction with the second approach is understandable and potentially more useful. When a program has feedback from clients that says they have a level of satisfaction of 4 on a 5-point scale, it is difficult to know what to do to improve. However, when a program has feedback from clients that says they felt their worker listened to them most of the time, it is possible to take action on this specific aspect of the service transaction. This type of information can be used to reward workers doing well and to problem solve when the information shows there is room for improvement.

While there are a wide number of dimensions of client satisfaction that are specific to the service type, there seems to be a few overarching themes. In nearly every study there is substantial attention to the interaction between workers and consumers. This may be identified explicitly as the worker-client relationship, or less directly as the consumer's perception of worker effectiveness or the provider's ability to make the consumer comfortable. A second theme seems to be the consumer's perceptions of the results or outcomes of services. As additional consumer satisfaction studies are conducted, it is clear that these are important dimensions.

## **Methodological Issues**

While there has been considerable attention to consumer satisfaction, there are also many difficulties in obtaining meaningful results. The usefulness of client satisfaction measures might be qualified by several methodological problems. Some of these issues are

low response rates, response bias, client involvement, and lack of psychometric testing of the instruments.

## **Response rates**

Client satisfaction data is plagued by low response rates. Response rates ranged from 28% to 83.3 %, with the median being 64%. The following authors reported fairly low response rates: Byalin (1993) 28%, Perreault et al. (1993) 30%, Kurtz (1990) 33%, McWilliam et al. (1995) 35%, Cournoyer and Johnson (1991) and Johnson et.al. 39%, Slater et al. (1992) 40%, and Clare(1995) 46% of past recipients and 78% of present recipients. Researchers reporting more desirable return rates included: Shapiro, Welker, and Jacobson (1997) 57%, Krahn et al. (1990) 62%, Greenley and Robitschek (1991) 63%, Hseih and Kagle (1991) 63.5%, Gaston and Sabourin (1992) 65%, Pyke and Apa (1994) 67%, Depner et al.. (1994) 72%, Perreault et al. (1993) 74.5%, Solomon and Draine (1994, 1995) 75%, and Mavis and Stoffelmayr (1994) 79%. A few authors reported high response rates. Fleishman et al. (1991) reported a 81% participation rate and Rosen et al. (1994) obtained a 83.3% response rate.

Low response rates cast doubt on the representativeness of satisfaction results. The few researchers reporting high participation rates obtained these rates by using convenience samples and/or very small sample sizes. For client satisfaction results to truly represent the perspective of the clients served a high response rate from a random sample of clients is required. This ideal is difficult to achieve for several reasons. For example, few services have client tracking systems that allow selection of a random sample. In addition, obtaining a high response rate is expensive. Multiple contacts of non-respondents is required and frequently personal contact through phone or face to face is required. Some clients may simply not see a reason to respond. They may be skeptical that the information will really be used or they may simply not be interested.

Low response rates has spurred a few researchers to explore the degree of similarity between respondents and non-respondents. Several authors found that respondents and non-respondents did not differ significantly. Krahn et al. (1990) found that respondents and non-respondents did not differ in terms of the age of the child served, proximity to the clinic site, and financial status. Stallard, Hudson, and Davis (1992) reported no statistically significant differences between respondents and non-respondents in terms of referral source, sex, or age of the child, number of times seen or outcome of treatment for users of

community child and adolescent mental health services. In contrast, in a later study, Stallard (1995) reported that postal questionnaire non-respondents were more often therapy dropouts ( $\chi^2(1)=4.24, p<.05$ ) than respondents with no significant difference in professional ratings of outcome. Ross et al. (1995) found that subjects found ineligible for the study (due to illness, death, and receipt of care at another facility) on contact were 4.9 years older, but did not differ on other socio-demographic characteristics. The subjects who refused to be interviewed or could not be located were considerably younger, and had significantly fewer hospital discharges and clinical appointments.

## **Response Bias**

The potential for response bias to affect the usefulness of satisfaction evaluations is of concern. For example, acquiescence bias may significantly influence levels of satisfaction in the direction of the wording. That is, negatively worded items may evoke a negative response and positively worded items may tend to evoke a positive response. Agreement with positively and negatively worded items may result in an overestimation or underestimation of measured satisfaction (Ross et al., 1995). Even the most carefully worded items may inadvertently communicate a positive or negative bias.

A comparison of satisfaction scores by Perreault et al. (1993) from open-ended and closed-ended questions suggests a tendency for a high proportion of dissatisfied subjects to express satisfaction when given an opportunity. Even if dissatisfaction questions did not elicit as many answers as the satisfaction questions, they seemed to tap dissatisfaction successfully compared to other open-ended questions and standardized scales. Almost half of the subjects that gave a satisfaction answer to the satisfaction open-ended question also gave a dissatisfaction answer for the dissatisfaction open-ended question. A large proportion of subjects expressed dissatisfaction only in response to dissatisfaction questions.

Ross et al. (1995) also uncovered substantial response bias. These authors found that 85% of responses were favorable for the positive scale items and only 40% were favorable for the negative items. For physician attitude measures, 76.8% were favorable for positive items, compared to 51% for negative items. Measures with similar response formats were more highly correlated than those with dissimilar response formats.

In addition Ross et al. (1995) discovered a substantial acquiescence bias when using paired items. Only 35% of respondents answered the 5 paired items in a completely logical

manner, 48% of respondents gave illogical answers on 1 or 2 items, and the remaining 18% of respondents gave illogical answers to 3-5 pairs. On oppositional response items, only 12% of respondents answered more than 1 pair of items in an illogical manner. However, no significant difference was found between non-acquiescent subjects and highly acquiescent subjects on measures of global satisfaction, overall evaluation ratings, behavior intention, or willingness to pay.

Ross et al. (1995) also found that the multidimensional evaluation rating scale yielded higher levels of satisfaction for non-acquiescent subjects than for highly acquiescent subjects. The difference between the mean scores was 1/3 of a standard deviation, which would not have been significant had a more stringent criterion of significance been used. Highly acquiescent subjects were less educated, older, evidenced greater levels of sickness-related dysfunction, but scored higher than non-acquiescent subjects on psychological functioning. The difference between the two groups on the summary physical dysfunction scale was small.

Perreault et al. (1993) found that oral administration appears to make formulation to open-ended questions easier than self-administered questionnaires. Dissatisfaction comments are expressed most readily in a qualitative context and only when the data gathering procedure is highly acceptable to subjects. These results suggest the possibility that satisfaction and dissatisfaction are perceived as two different concepts and that two different measurement instruments should be developed.

Stallard, Hudson, and Davis (1992) reported no statistically significant relationship between overall level of satisfaction and the initiation of open-ended comments ( $\chi^2=6.9$ ,  $df=3$ , ns), although those less satisfied were more likely to comment. Six of seven mildly or very dissatisfied respondents made open-ended comments, compared with only 46 of 80 very or mostly satisfied respondents. An analysis of the comments revealed that 77% of the comments could be construed as negative, referring to things the service had done wrong, not provided, or which could be improved. Fourteen percent of the comments were positive and the content of 9% of the comments was unclear. Stallard (1995) also found that postal non-respondents tended to evaluate services more negatively than respondents and that the groups differed in their specific areas of dissatisfaction. Stallard (1995) found that of the 268 ratings made by postal questionnaire non-respondents, 81 were negative in comparison to 101 negative ratings made by 446 respondents ( $\chi^2(1)=5.12$ ,  $p<.05$ ). Postal non-respondents

expressed more dissatisfaction with the meeting place and with the combination of family members seen by the psychologist. In contrast, respondents were less satisfied with other areas of services, particularly the wait for the first appointment and the total number of appointments offered. Stallard concluded that sole reliance upon postal questionnaires results in positively skewed results and fails to identify important sources of dissatisfaction specific to non-respondents.

Ross et al. (1995) suggest that substantial unreliability exists for respondents found to be acquiescent in their responses. However, this problem may go undetected because the levels of reliability were acceptable across all measures when the full sample was analyzed. However, the authors noted that this study may exaggerate the extent of response bias found in the general population because it relied on senior citizens, who tend to be more acquiescent in their responses. Although this problem may not be as extensive in other populations it is important for researchers to control for acquiescence.

## **Client Involvement**

Adopting the notion of client empowerment supports the notion that clients have decision-making power. It also means adopting client-centered and client-driven methods of program evaluation. Yet study designers rarely ask consumers what they think are important elements in consumer satisfaction (McComas, Kosseim, & Macintosh 1995; Young, Nicholson, & Davis, 1995). In the past, researchers have heavily relied on previously developed questionnaires or items developed from professionals or professional literature to generate data. Previous questionnaires have been developed without widespread client involvement (McComas, Kosseim, & Macintosh, 1995). The instruments presented in this literature review also seem to reflect this tendency. Of the thirty-nine instruments reviewed, clients were the primary source of items in only two studies, and served as the source of items along with professionals in only five additional studies. In contrast, items from four of the studies were generated primarily from professionals, and the majority of the authors, twenty-three, defined client satisfaction according to what other authors had discovered. It must also be noted that in the remainder of the studies the source of items was not specified. Therefore, it is likely that many studies of client satisfaction assess dimensions of satisfaction that may not be important to consumers of services (Young, Nicholson, & Davis, 1995).

If clients are involved in the initial development of the questionnaire, it is more likely to reflect issues that are important to them. Professionals can only guess about which service components are important to clients (McComas, Kosseim, & Macintosh, 1995). In their assessment of the lack of client involvement in the development of client satisfaction measures, Young, Nicholson, and Davis (1995) conclude that: "Demonstrating that consumers believe a program is doing an excellent job on an activity that they consider irrelevant is not useful to anyone."

### **Lack of Psychometric Analysis**

Psychometric analysis has too often been neglected in the field of client satisfaction (Ruggeri, 1994). Very few standardized instruments have been adequately tested, thus it is not easy to find measurement technology that will provide valid and reliable data (Young, Nicholson, & Davis, 1995). However, in the last few years, many researchers have begun to consider the establishment of an instrument's psychometric principles to be a priority. Yet, in spite of this, very few validated instruments for the measurement of consumer satisfaction are currently available (Ruggeri, 1994). The lack of valid and reliable measures may mean that studies may not be measuring client satisfaction well or may not even be measuring the factors they believe they are measuring (Young, Nicholson, & Davis, 1995). Also, because client satisfaction instruments rely heavily on standards generated by professionals, the content validity of such instruments in measuring satisfaction according to the views of clients has seldom been studied (Ruggeri, 1994).

### **Conclusion**

The emergence of managed care and a renewed emphasis on quality management have spurred interest in the area of client satisfaction with services. Researchers are collecting client satisfaction data utilizing a variety of instruments that frequently are not well validated or well designed. Much of the data collected is representative of only a small portion of the population. While the studies reviewed here suggest there is little difference in terms of demographic characteristics between individuals who respond to satisfaction surveys and those who do not, a distinct possibility exists that these populations differ in

terms of their service experiences. Byalin (1993) argues that since dissatisfied consumers are more likely to drop out of treatment more quickly than satisfied consumers, cross-sectional surveys are likely to over represent the opinions of satisfied clients. There is little discussion in the client satisfaction literature regarding response bias. Important work is yet to be done on assessing response bias. Even more important may be development of methods to control for response bias.

The limitation of client satisfaction measurement is most likely due to its status as an emerging issue. Much of the measurement has been at an exploratory level. Many populations are yet to be heard from. To obtain data that is useful in improving programs, both response rates and questionnaire quality must be improved, particularly the role of consumers in the development of measures.

McComas et al. (1995) reported that client involvement in the development of a client satisfaction instrument resulted in a questionnaire that differed from other client satisfaction measures. They attributed this difference to the fact that the questionnaire reflected issues that were most salient to clients. The authors asserted that in the absence of client input, professionals can only guess which service components are most salient to clients. Only four of the studies reviewed relied heavily on consumer input in developing items. Drake (1996) and McWilliam et al. (1995) utilized both professionals and consumers to generate items, while Weaver et al. (1993) and McComas et al. (1995) used clients as their sole source of items. The overwhelming majority of researchers relied on professional literature as their major source of items. This strategy is most likely to result in measures that may not accurately reflect the concerns of consumers.

## References

- American Managed Behavioral Health Care Association (ANMHA). (1995). *Performance measures for managed behavioral healthcare programs*. Washington, D.C.: Author.
- Anderson, J.A., Rivera, V.R., & Kutash, K. (1996). Measuring consumer satisfaction with children's mental health services. Expected to appear in the book - *Outcomes for children and youth, with emotional and behavioral disorders and their families: Programs and evaluation best practices*. M.H. Epstein, K. Kutash, and A.J. Duchonowski (Eds.). Austin, TX.: Pro-Ed. (Expected publication October 1997).
- Attkinson, 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.
- Barker, C., & Pistrang, N. (1991). *Client feedback questionnaire*. Bloombury and Islington District Psychology Department. (Unpublished).
- Begley, K., Ross, M., Austin, P., Casey, K., Collins, P., Hennings, G., Agriestri, L, & Marshall, K. (1994). Development and evaluation of an inventory for rating client satisfaction with outcome in HW counseling: The Albion Center Scale. *Patient Education and Counseling*, 24, 341- 345.
- Byalin K. (1993). Assessing parental satisfaction with children's mental health services. *Evaluation and Program Planning*, 16, 69-72.
- Casey Family Program. (1994). *The Casey Foster Parent Study Research Program*. Seattle, WA.: Casey Family Program.
- Clare, L. (1995). Parents' perceptions of portage: Towards a standard measure of parent satisfaction. *British Journal of Learning Disabilities*, 23, 110-117.



Cournoyer, D.E., & Johnson, HC. (1991). Measuring parents' perceptions of mental health professionals. *Research on Social Work Practice, 1*, 399-415

Dankot, D.K., Pandiani, J. A-, & Grodon, LK (1983). Development, implementation, and findings from a continuing client satisfaction survey. *Community Mental Health Journal. 19*, 265- 278.

Davies, B, Ralph S., Hawton, M., & Craig, L. (1995). A study of client satisfaction with family court counseling in cases involving domestic violence. *Family and Conciliation Courts Review, 33*, 324-331

Depner, C.E., Cannata, K., & Ricci, I. (1994). Client evaluations of mediation services: The impact of case characteristics and mediation service models. *Family and Conciliation Courts Review 32*, 306-325.

Drake, B. (1996). Consumer and worker perceptions of key child welfare components. *Children and Youth Services Review, 18*, 268-279.

Fleishman, J.A., Mor, V., & Piette, J. (1991). AIDS case management: The client's perspective. *Health Services Research, 26*, 447-470.

Fryer, G.E., Bross, D.C., Krugman, R.D., Denson, D/B., & Baird, D. (1990). Good news for CPS workers. *Public Welfare*. Winter, 38-41.

Gaston, L., & Sabourin, S. (1992). Client satisfaction and social desirability in psychotherapy. *Evaluation and Program Planning, 15*, 227-231.

Gerkenmeyer, J., Barron McBride, A., Finke, L., & Austin, J. (1996). Parent satisfaction with mental health staff interactions: The development, validity, and reliability of the Parent Satisfaction Scale and the Parent-Staff Interaction Scale. In C. Liberton, K. Kutash, & Friedman (Eds.). *The 8th Annual Research Conference Proceedings, A System of Care for Children's Mental Health: Expanding the Research Base* (March 6 to March 8, 1995) (pp. 101-

103). Tampa, FL: University of South Florida Mental Health Institute, Research, and Training Center for Children's Mental Health.

Glajchen, M., & Magen, R. (1995). Evaluating process, outcome, and satisfaction in community-based cancer support groups. *Social Work with Groups, 18*, 27-40.

Greenley, J.R., & Robitschek, C.G. (1991). Evaluation of a comprehensive program for youth, with severe emotional disorders: An analysis of family experiences and satisfaction. *American Journal of Orthopsychiatry, 61*, 291-297.

Harkness, D., & Hensely, H (1991). Changing the focus of social work supervision: Effects on client satisfaction and generalized contentment. *Social Work, 36*, 506-512

Hoult, J., Reynolds, I., Charbonneau-Powis, M., Weekes, P., & Briggs, J. (1983). Psychiatric hospital versus community treatment: The results of a random trial. *Australian and New Zealand Journal of Psychiatry, 17*, 160-167.

Hsieh, M., & Kagle, J.D. (1991). Understanding patient satisfaction and dissatisfaction with health care. *Health and Social Work, 16*, 281-290.

Johnson, H.C., Cournoyer, D.E., & Bond, B.M. (1995). Professional ethics and parents as consumers: How well are we doing? *Families in Society, 76*, 408-420.

Krahn, G.L., Eisert, D., & Fifield, B. (1990). Obtaining parental perceptions of the quality of services for children with special health needs. *Journal of Pediatric Psychology, 15*, 761-774.

Kurtz, L.F. (1990). Measuring member satisfaction with a self-help association. *Evaluation and Program Planning, 13*, 119-124.

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

Le Prohn, N. (1993). *Relative foster parents: Role perceptions, motivation, and agency satisfaction*. A dissertation submitted in partial fulfillment of the requirements for the degree of Doctor of Philosophy, University of Washington School of Social Work, Seattle, Washington.

Linn, L. S., & Greenfield, S. (1982). Patient suffering and patient satisfaction among the chronically ill. *Medical Care*, 20, 425-431.

Magura, S., & Moses, B.S. (1986). *The parent outcome interview*. Washington, D.C.: Child Welfare League of America.

Mavis, B.E., & Stoffelmayr, B.E. (1990). Success and satisfaction: Are they the same in alcohol treatment? Paper presented at the meeting of the American Psychological Association, Boston, MA.

Mavis, B.E., & Stoffelmayr, B.E. (1994). Program factors influencing client satisfaction in alcohol treatment. *Journal of Substance Abuse*, 6, 345-354.

McComas, J., Kosseim, M., & Macintosh, D. (1995). Client-centered approach to develop a seating clinic satisfaction questionnaire: A qualitative study. *The American Journal of Occupational Therapy*, 49, 980-985.

McWilliam, R-A., Lang, L., Vandiviere, P., Angell, R., Collins, L., & Underdown, G. (1995). Satisfaction and struggles: Family perceptions of early intervention services. *Journal of Early Intervention*, 19, 43-60.

Mental Health Statistics Improvement Program Task Force on a Consumer-Oriented Mental Health Report Card. (1996). The consumer-oriented mental health report card: The

final task report of the Mental Health Statistics Improvement Program (MHSIP) Task Force on a Consumer-Oriented Mental Health Report Card.

Miller, R.R (1992). Dimensions of service satisfaction with clinic visits in a group practice HMO. *Evaluation and Program Planning, 15*, 395-401.

Nicholson, J., & Robinson, G. (1996). *A Guide for Evaluating Consumer Satisfaction with Child and Adolescent Mental Health Services*. Boston, MA: Judge Baker Children's Center.

O'Donnell J., & Poertner, J. (unpublished). *Assessing the satisfaction of parents of children in substitute care*. A plan and report. Urbana, IL: School of Social Work of the University of Illinois at Urbana-Champaign

Olsen, L. J. (1995). Services for substance abuse-affected families: The Project Connect experience. *Children and Adolescent Social Work Journal, 12*, 183-196

Perreault, M., Leichner, P., Sabourin, S., & Gendreau, P. (1993). Patient satisfaction with outpatient psychiatric services: Qualitative and quantitative assessments. *Evaluation and Program Planning, 16*, 109-118.

Pickett, S.A., Lyons, J.S., Polonus, T., Seymour, T., & Miller, S.I. (1995). Factors predicting patients' satisfaction, with managed mental health care. *Psychiatric Services, 46*, 722-723.

Pyke, J., & Apa, J. (1994). Evaluating a case management service: A family perspective. *Journal of Case Management, 3*, 21-26.

Reid, P. N., & Gundlach, J.H. (1983). A scale for the measurement of consumer satisfaction with social services. *Journal of Social Service Research, 7*, 37-54.

Rosen, L.D., Heckman, T., Carro, M.G., & Burchard, J.D. (1994). Satisfaction, involvement, and unconditional care: The perceptions of children and adolescents receiving wraparound services. *Journal of Child and Family Studies*, 3, 55-67.

Ross, C.K., Steward, C.A., & Sinacore, J.M. (1995). A comparative study of seven measures of patient satisfaction. *Medical Care*, 33, 392-406.

Slater, A., Shaw, J.A., & Duquesnel, J. (1992). Client satisfaction survey. A consumer evaluation of mediation and investigative services: Executive summary. *Family and Conciliation Courts Review*, 30, 252-259.

Rouse, L.W., MacCabe, N., & Toprac, M.G. (1994). *Measuring satisfaction with community-based services for severely emotionally disturbed children and parents*. Paper presented at the Seventh Annual Research Conference for a System of Care for Children's Mental Health: Expanding the Research Base, Tampa, Florida.

Ruggeri, M. (1994). Patients' and relatives' satisfaction with psychiatric services: The state of the art of its measurement. *Social Psychiatry and Psychiatric Epidemiology*, 29, 212-227.

Shapiro, J.P., Welker, C.J., and Jacobson, B.J. (1997). The Youth Client Satisfaction Questionnaire: Development, construct validation, and factor structure. *Journal of Child Clinical Psychology*, 26, 87-98.

Shireman, J.F., Grossnickle, P., Hinsey, C. & White, J. (1990) Outcome study of protective services: Comparison of interviews and records as data sources. *Child Welfare*, 69, 167-179.

Solomon, P., & Draine, J. (1994). Satisfaction with mental health treatment in a randomized trial of consumer case management. *The Journal of Nervous and Mental Disease*, 182, 179-184.

Solomon, P., & Draine, J. (1995). One-year outcomes of a randomized trial of consumer case management. *Evaluation and Program Planning, 18*, 117-127.

Stallard, P., Hudson, J., and Davis, B. (1992). Consumer evaluation in practice. *Journal of Community and Applied Social Psychology, 2*, 291-295

Stein, L., & Test, M. A. (1980). Alternatives to mental hospital treatment; A conceptual model treatment program and clinical evaluation. *Archives of General Psychiatry, 37*, 392-397

Stuntzner-Gibson, D., Koren, P.E., & DeChillo, N. (1995). The Youth Satisfaction Questionnaire (YSQ): What kids think of services. *Families in Society, 76*, 616-624.

Teare, J.F., Peterson, R.W., Furst, D., Authier, K., Baker, G., & Daly. (1994). Treatment implementation in a short-term emergency shelter program. *Child Welfare, LXXIII*, 271-281

Tessler, R.G., Gamache, G.M., & Fisher, G.A. (1991). Patterns of contact of patients' families with mental health professionals and attitudes toward professionals. *Hospital and Community Psychiatry, 42*, 929-935.

Van Slyck M.R., Stern, M., & Newland, L.M. (1992). Parent-child mediation: An empirical assessment. *Mediation Quarterly, 10*, 75-88.

Vandiver, V.L., Jordan, C., Keopraseuth, K., & Yu, M. (1995). Family empowerment and service satisfaction: An exploratory study of Laotian families who care for a family member with mental illness. *Psychiatric Rehabilitation Journal, 19*, 47-54.

Ware, J.E., Snyder, M.K., & Wright, W.R. (1976). *Development and validation of scales to measure patient satisfaction with medical care services: Vol. I of a final report: Part A. Review of literature, overview of methods, and results regarding construction of the scales* (NTIS Publication No. PB 288-329). Springfield, VA: National Technical Information Service.

Weaver, M.J., Ow, C.L., Walker, D.J., & Degenhardt, E.F. (1993). A questionnaire for patients' evaluations of their physicians' humanistic behaviors. *Journal of General Internal Medicine*, 8 135-139.

Whittaker, J.K., Kinney, J., Tracey, E.K & Booth, C. (1990). *Reaching high-risk families: Intensive intervention in human services*. New York: Aldine de Gruyter.

Winefield, H.Y., & Barlow, J.A. (1995). Client and work satisfaction in a child protection agency. *Child Abuse and Neglect*, 19, 897-905.

Young, S., Nicholson, J., & Davis, M. (1995). An overview of issues in research on consumer satisfaction with child and adolescent mental health services. *Journal of Child and Family Studies*, 4, 219-238.

Available upon request:

## **Measurement of Client satisfaction: The State of the Art– Appendix.**

This appendix lists the items contained in many of the client satisfaction scales described in this paper.