Quality management in health care: empirical studies in addiction treatment services aligned to the EFQM excellence model

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Consumer satisfaction as a quality indicator for mental health and addiction treatment services in the Netherlands

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Abstract

OBJECTIVE To give an overview of the possibilities and limitations of consumer satisfaction as a quality indicator of mental health care and addiction treatment services.

METHOD Based on a review of the Dutch literature, three representative studies were selected, summarized and discussed.

RESULTS Study 1. The national cross-sectional consumer satisfaction survey with a multidimensional questionnaire shows that more than two-thirds of the consumers are satisfied with mental health and addiction treatment services. The report card score is satisfactory to good. Patients are especially positive about the expertise and the respectful approach by health care professionals. Study 2. The longitudinal patient satisfaction study, in which mental health and addiction services are compared, demonstrates the complexity of satisfaction as a process and an outcome indicator. Patients of addiction treatment services are generally more positive about the communication, the therapist and the results than patients of mental health services. However, comparisons between these settings with regard to consumer satisfaction are hampered by the fact that satisfaction is associated with the level of psychopathology. The report card score is satisfactory to good. Study 3. As potential consumers of mental health and addiction treatment services, Dutch citizens are more confident in medical-, than in mental health professionals and services. Only 50% of the citizens have confidence in mental health and addiction treatment services. The report card score is not satisfactory.

CONCLUSION Consumer satisfaction is an important but complex quality indicator dependent on assessment procedure, setting and target population. Simple comparisons between different services in benchmark procedures might result in misleading conclusions. More fundamental research is needed about the concept, the measures and the samples in order to responsibly use the satisfaction data.
Consumer satisfaction

Introduction

In the Netherlands, as in other European countries, quality of health care became a popular theme for policy makers, services and professionals at the end of the 1980s (Shaw, 2000). The starting point in the Netherlands is marked by the so-called Leidschendam Conferences in 1988 and 1989. Eight years later, The Care Institution Quality Act was introduced. This law gives the patient the role of a consumer and obliges all health care services to deliver consumer-centered, effective and efficient cure and care (Casparie, 1993). As a consequence, all health care services, including mental health care and addiction treatment services, started quality assurance programs. There are more than one hundred regional mental health and addiction treatment services delivering a broad diversity of care and cure for patients with mental health and addiction problems.

The implementation of the quality law in the services was monitored by the Netherlands Institute for Health Service Research (NIVEL). In a recent study by NIVEL (Sluis & Wagner, 2003; Sluis & Wagner, 2000) conducted among 144 mental health and addiction treatment services, findings show that 88% of the mental health services have drawn up mission and vision documents; 79% have an annual quality report; 63% employ at least one quality coordinator; 72% of the services use protocols for specific procedures and; 58% of the services have protocols for critical aspects of the care process. In addition, 50% of the mental health services are engaged in institutional peer reviews; 56% use the Dutch version of the European Foundation for Quality Management (EFQM); and 28% have started with a certification program. Furthermore, 68% of the services have conducted consumer satisfaction surveys. Comparing these findings with previous studies (Sluis & Wagner, 2000) shows that there is an increase in quality instruments and projects.

These findings indicate that mental health and addiction treatment services in the Netherlands have succeeded in implementing quality instruments over the last few years. However, the findings do not address how consumers experience improvements or appreciate the quality of the services. Consumer satisfaction has always been a central theme in the service industry (Zeithaml, Parasuraman, & Berry, 1990) and somatic health care. Numerous publications (Cleary et al., 1991; Jenkins, Coulter, Bruster, Richards, & Cleary, 2002; Sitzia, 1999; Sitzia & Wood, 1998) and methodological reviews (Sitzia & Wood, 1997) are available and it is seen as an important concept (Institute of Medicine, 2002). Consumer satisfaction is also gaining attention (Carlson & Gabriel, 2001) in mental health and addiction treatment centres, (Pukies, 2001), but there are a number of specific conceptual and methodological problems to overcome: The multi-dimensional character of satisfaction; the longitudinal and dynamic aspect of treatment; and the question of
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specifying the consumer of mental health services (Sitzia, 1999).

In the Netherlands, several consumer satisfaction surveys in mental health and addiction services have been carried out and show interesting findings. However, as they are mostly written in Dutch, they are not readily available to the international scientific community. Based on methodological criteria such as design, sample, reliability, and validity of the instruments as well as appropriateness of the statistical procedures, three studies were selected for this overview (Aarsse, Nabitz, & Brink van den, 2005): The cross-sectional national study, which used the multi-dimensional self-report questionnaire Mental Health Care Thermometer (Mulder, 2003), and addresses the question: How do consumers evaluate their mental health and addiction treatment? The longitudinal treatment effect study, in which patient satisfaction is studied both as a process and an outcome indicator of mental health and addiction treatment (Aarsse, 2003), and addresses the question: What is the function of satisfaction in the course of the treatment process? A study based on population surveys among Dutch citizens about their confidence in the various health care services and professions (Friele, Verhaak, & Andela, 2000; Nabitz & Oudejans, 2002) and addresses the question: How do Dutch citizens, as potential consumers, judge the quality of mental health and addiction treatment services? All three studies were carried out in the same year, applied satisfaction questionnaires and used the Dutch school report card scores for a global evaluation.

Study 1: National satisfaction survey for mental health and addiction services

In medical health care, there is a large knowledge-base concerning consumer satisfaction (Cleary, 1999). In the Netherlands, the main consumer satisfaction studies were conducted in academic settings and collected data on 40 687 patients (Winters, Kleefstra, Kool, & Steenbeek, 2004) and in home care services among 54 897 consumers (PricewaterhouseCoopers, 2005). Furthermore, a recent study was conducted with the Dutch version of the Consumer Assessment of Health Plan Survey (Arah et al., 2006). Consumer satisfaction surveys were also initiated as a national project in the mental health and addiction treatment services (GGZ Nederland, 2003) to improve insight into consumer satisfaction and open the possibility of benchmarking between the services.

Method study 1

In 2002, twelve mental health and addiction treatment services participated in a large-scale survey in which 7 888 patients were asked to fill out a satisfaction questionnaire after treatment ended. 4 071 questionnaires were returned for data processing (response rate: 52%). The patient satisfaction questionnaire used was called
The Mental Health Care Thermometer for Appreciation of Clients (GGZ Nederland en Trimbos Instituut, 2003), which was developed and validated for in- and outpatient mental health and addiction treatment services (Jongerius, Hull, & Derks, 1994). It comprises sixteen true-false questions, a Dutch school report card score, and one open question. The following dimensions were specified in subscales: a) Appreciation of Information; b) Appreciation of Decision Making; c) Appreciation of the Health Care Worker; and d) Treatment Results. The internal consistency of the subscales was moderate to good (Cronbach alpha ranges between 0.70 and 0.86).

Results study I
Table 1 shows the findings for outpatient services (N = 2,423), inpatient services (N = 893), and addiction treatment services (N = 172). All subscales and items show positive scores in all three types of treatment services. The answers regarding the satisfaction with health care professionals are the most positive. At least 90% of the consumers said that their worker was knowledgeable, respectful, open, and trustworthy. Satisfaction with information and decision making was rated less positively. Item five (Documented treatment plan) has the lowest ratings. Satisfaction with treatment results shows interesting variations between mental health, and addiction treatment services. Overall, the ratings of the addiction services are better, especially for items 14 (Progress through treatment) and 16 (Improvement in coping with people and situations) with variations of more than 20% between the settings. Based on the Dutch school report card scoring system, the average score was satisfactory (7.1) for the mental health services, and good (7.8) for the addiction treatment services.

Discussion study I
The consumers of mental health and addiction treatment are highly satisfied with the services concerning information, decision making, professionals and results. It is apparent that the quality improvement projects do have some impact, although there are no specific relations to instruments and projects. Before relating the scores to quality actions of the services, the consumer's decision-making process after treatment has to be studied. Analysis of confounders such as expectancy level, role definition of patients and professionals, mechanisms of cognitive dissonance, personality traits and severity of symptoms is needed to clarify the components of these high satisfaction ratings (Williams, Coyle, & Healy, 1998). In-depth interviews, open questions, and variations in the wording of the questions can be used to improve our understanding of the underlying mechanisms of satisfaction ratings and the results of these investigations can be used to correct and standardize the ratings.

The highest scores are given for the appreciation of the health care professional, a finding that is typical in mental health settings (Pukies, 2001). The strong position of the professional and the role definition in a treatment setting is confirmed, which
### Table 1: Results of the three services regarding the 16 items on the Mental Health Care Thermometer

<table>
<thead>
<tr>
<th>Groups and questions</th>
<th>Outpatient mental health services</th>
<th>Inpatient mental health services</th>
<th>Addiction treatment services</th>
</tr>
</thead>
<tbody>
<tr>
<td>N = 2423</td>
<td>N = 893</td>
<td>N = 172</td>
<td></td>
</tr>
<tr>
<td>Appreciation of Information (item 1 to 3)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Sufficient information about possible treatment methods?</td>
<td>76%</td>
<td>77%</td>
<td>88%</td>
</tr>
<tr>
<td>2 Sufficient information about the practical aspects of your treatment or support?</td>
<td>79%</td>
<td>81%</td>
<td>92%</td>
</tr>
<tr>
<td>3 Sufficient information about the expected treatment results?</td>
<td>79%</td>
<td>80%</td>
<td>90%</td>
</tr>
<tr>
<td>Appreciation of Decision Making (item 4 to 6)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 Decision making about the treatment?</td>
<td>78%</td>
<td>80%</td>
<td>86%</td>
</tr>
<tr>
<td>5 Documented treatment plan?</td>
<td>81%</td>
<td>72%</td>
<td>91%</td>
</tr>
<tr>
<td>6 Agreement to the available treatment plan?</td>
<td>69%</td>
<td>83%</td>
<td>73%</td>
</tr>
<tr>
<td>Appreciation of the Health Care Worker (item 7 to 10)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7 The expertise of your health care worker?</td>
<td>93%</td>
<td>92%</td>
<td>96%</td>
</tr>
<tr>
<td>8 Confidence in your health care worker?</td>
<td>92%</td>
<td>90%</td>
<td>93%</td>
</tr>
<tr>
<td>9 Respectfully approached by the health care worker?</td>
<td>94%</td>
<td>94%</td>
<td>98%</td>
</tr>
<tr>
<td>10 Interest of the health care worker in you?</td>
<td>91%</td>
<td>91%</td>
<td>95%</td>
</tr>
<tr>
<td>Treatment Results (item 11 to 16)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11 Treatment plan was carried out conform your wishes?</td>
<td>77%</td>
<td>78%</td>
<td>94%</td>
</tr>
<tr>
<td>12 Good approach for your problems?</td>
<td>81%</td>
<td>83%</td>
<td>90%</td>
</tr>
<tr>
<td>13 More control over your problems?</td>
<td>80%</td>
<td>82%</td>
<td>92%</td>
</tr>
<tr>
<td>14 Progress through treatment?</td>
<td>78%</td>
<td>76%</td>
<td>97%</td>
</tr>
<tr>
<td>15 Capable to live your life as you want?</td>
<td>75%</td>
<td>78%</td>
<td>97%</td>
</tr>
<tr>
<td>16 Improvement in coping with people and situations?</td>
<td>73%</td>
<td>76%</td>
<td>91%</td>
</tr>
</tbody>
</table>

Dutch School Report Card Score

1 = very bad, 2 = bad, 3 = not at all sufficient, 4 = not sufficient, 5 = not satisfactory, 6 = passed, 7 = satisfactory, 8 = good, 9 = very good, 10 = excellent

<table>
<thead>
<tr>
<th></th>
<th>7.1</th>
<th>7.3</th>
<th>7.8</th>
</tr>
</thead>
</table>

12 Mental Health Services and 4 Addiction Treatment Services. The confidential interval (5% level) is for N = 2423: +/- 2%, for N = 893: +/- 3% and for N = 172: +/- 7%.

has to be considered for quality improvement projects. It can be postulated that quality improvement has to go through the health care professional in order to effect the satisfaction of the consumer.

The lowest score is given to documentation of the treatment plan and decision making, which is an administrative or organizational task. The Dutch quality law states that consumers should be fully informed, and have to agree to the treatment plan. However, this is not carried out or very poorly handled. Thus, there is a gap between the quality requirements and the evaluation by the patients.
Comparison of the satisfaction score of the three treatment services shows that addiction treatment services rank first. This could be related to the more structured and protocol supported addiction treatment. However, a systematic analysis of the score in a national benchmark approach to identify predictors and adjust the score is needed in order to confirm this finding.

In the Netherlands, there are currently no defined norms for the *Mental Health Care Thermometer*. Often the norm is arbitrarily set at an eighty-percent yes answer to a particular scale or item. In this case, that norm would be easily achieved (see Table 1). The norm could also be that all items are mandatory, and that each consumer must answer yes to all of the items but such a norm would be difficult to achieve. A final answer is not yet available, but the current data can be used as a starting point for a discussion about norms and targets (Lehman & Zastowny, 1983). In turn, this discussion between professionals, teams, and managers would challenge the development of performance management necessary for the process of continuous learning and improving (Walburg, 2005).

The cross-sectional national satisfaction survey has provided initial results and established an infrastructure to carry out the survey. However, only ten percent of the services currently participate in standardized national surveys. The other services still use their own instruments and procedures, which makes benchmarking difficult. The participation in the national survey is voluntary and has no incentives or sanctions. As a result, the response rate of the participating services is around fifty percent. These methodological problems have to be resolved before consumer satisfaction becomes a strong measure that reflects the quality of a service.

**Study 2: Patient satisfaction as a quality indicator of treatment**

In the surveys with the *Mental Health Care Thermometer*, satisfaction is measured as an outcome indicator for the quality of inpatient and outpatient mental health and addiction treatment services. However, the treatment process in mental health is complex and often stretches over a longer period of time. To understand consumer satisfaction, it has to be seen as part of that process.

The aim of this longitudinal study was to determine the level of patient satisfaction during the process of relatively brief treatments for relatively mild mental health or addiction problems (Aarsse, 2003). Furthermore, the study tried to clarify determinants of consumer satisfaction such as patient characteristics at baseline, quality of the treatment process and treatment outcome.
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Method study 2

This prospective study had four measurement points: a) before the start of treatment (T1 - baseline); b) at the end of treatment (T2 - exit); c) one month after treatment (T3 - Follow up 1); and d) three months after treatment (T4 - Follow up 2). The study was carried out in four mental health (MH) and addiction treatment (AT) services where brief protocol based treatments were delivered. The group comprised 240 patients: 157 AT and 83 MH. The response rates ranged from 48% to 70% depending on the measurement point.

The following aspects were measured: personality traits, interpersonal style, social desirability, severity of psychological complaints and alcohol problems (T1); treatment preference and work alliance (T1, T2); patient satisfaction, clinically significant improvement of psychological complaints and alcohol problems (T2, T3, T4).

Patient satisfaction was measured with a revised version of the Consumer Satisfaction Monitor (CSM-R) (Aarsse & Brink van den, 2002) including three subscales: satisfaction with the communication process (information and decision making); satisfaction with the therapist (expertise and respect); and satisfaction with treatment outcome. The CSM-R has a six-point Likert scale, which ranges from fully agree (6) to completely disagree (1). The internal consistency of the scales was good (Cronbach alpha between 0.85 and 0.96). Patients were defined as satisfied if all questions of a subscale were rated 5 or 6, and less satisfied when at least one question was rated 4 or lower. Furthermore, patients were asked to give a global school reporting card score (1 means very bad –10 means excellent).

Results study 2

The findings of the three consumer satisfaction subscales for the mental health and the addiction treatment group are shown in Figure 1. Both groups differ significantly. The addiction treatment services’ patients were more satisfied than patients in mental health services. Satisfaction with time periods varied somewhat, but generally showed little change. The Dutch school report card scores varied for the addiction treatment group from 7.5 to 7.8 good, and for the mental health group from 6.8 to 7.0 satisfactory. There were no statistically significant variations in report card scores between the different treatment settings.

Further analysis showed that patients in addiction treatment services differed from patients in mental health services in a series of demographic factors (age, sex, marital status). However, these factors were not related to consumer satisfaction and therefore, comparisons between settings were not confounded by these demographic differences. More important, mental health patients reported more psychological complaints, higher levels of neuroticism, and more distrust than addicted patients. These variables had a significantly negative effect on consumer satisfaction and sub-
Figure 1: Patient satisfaction during treatment - divided into the addiction treatment (AT) group and the mental health (MH) group.

Patient satisfaction in addiction treatment (AT) and mental health treatment (MH): percentage of satisfied patients at four points in time and on three scales: T1 = after 2nd/3rd session, N = 108; T2-exit = final session after treatment, N = 93; Follow up 1 = one month after end of therapy, N = 108; Follow up 2 = three months after the end of therapy, N = 108. N of T2 is lower because of the missing values of the dropouts.

Subsequently confused the comparisons of consumer satisfaction between treatment settings. Therefore, satisfaction levels should be adjusted for psychopathology when used as a benchmark between mental health and addiction treatment services.

The consumers' treatment preferences were generally met, and no differences were found between mental health and addiction treatment. However, when treatment preferences were not met, satisfaction scores on communication and therapist were considerably lower.
On average, the working alliance between patient and therapist (rated by the patient) was stronger in addiction treatment than in mental health care. Working alliance was positively related to satisfaction with communication and therapist during the treatment, but it did not predict satisfaction with outcome. The treatment alliances scored by the therapist did not predict the satisfaction of the consumer.

A final analysis showed that clinically improved patients reported higher satisfaction with outcome, but there was no relation between clinical outcome and consumer satisfaction with communication and therapist. The overall dropout was 30% in the AT group and 32% in the MH group. There was no relation between dropout and consumer satisfaction, and dissatisfaction did not predict dropout.

**Discussion study 2**

This longitudinal study illustrates a number of fundamental issues and complexities of consumer satisfaction as a quality indicator and shows that satisfaction is a multidimensional concept (Moller-Leimkuhler et al., 2002). Satisfaction is directly related to different treatment factors and indirectly to the quality assurance program of the service. This study also shows that satisfaction is an independent outcome indicator: clinical outcome was not associated with consumer satisfaction regarding communication and therapist.

The Dutch school report card score shows that the overall scores are satisfactory and good for MH and AT respectively, which is in general agreement with the results of study 1. This study also shows that consumers are more satisfied with communication and the interaction with the therapist and less with treatment outcome, which can be related to quality assurance policy of the treatment services. However, the scoring cannot be directly related to specific quality improvement projects and instruments that were introduced by the services.

Patient psychopathology at baseline is predictive for satisfaction. As a consequence, baseline patient characteristics should be taken into account in benchmark projects directed at the comparison of treatment services in terms of consumer satisfaction.

Finally, consumer satisfaction is often used as an outcome indicator, but more research is needed to clarify the meaning of consumer satisfaction as an indicator of the quality of the treatment process (Hser, Evans, Huang, & Anglin, 2004). Answers to basic questions regarding the process characteristics of consumer satisfaction and treatment intensity and outcome would contribute to develop a theory on consumer satisfaction in mental health and addiction treatment.
Study 3: The opinion of the Dutch citizen

One of the complications in mental health and addiction treatment services is the definition and segmentation of the consumers. More often, segmentation is made between patient, client or consumer; the caretaker or the family; the referral agency such as the family doctor; and the citizen as a potential patient (Schramade & Nabit, 2005). Epidemiological studies show that the lifetime prevalence of psychiatric problems including addiction in the Netherlands and in the US is around 40%, indicating that almost every other citizen is liable to become a consumer of the mental health and addiction treatment services (Bijl, Ravelli & Zessen van, 1998). However, about one in every 10 people with a mental health or addiction problem uses the services. This is probably related to the unfavourable opinion of the citizen about the quality and effectiveness of these services. Two studies (NIVEL study and AIAR study) were carried out concerning the confidence of Dutch citizens in their medical and somatic health services (Friele, Verhaak & Andela, 2000; Nabitz & Oudejans, 2002).

Method study 3

Two representative panels (N = 1500 and N = 2300) of the Dutch general population were used to carry out a postal and an internet survey. The response rates were 68% and 83% respectively. Non-response analyses did not signal a systematic bias. In both studies, a large variety of questions were asked and the potential consumer gave a school report card score. The items regarding the confidence in health care professionals and in treatment services were presented with a four-point scale ranging from very much to very little.

Results study 3

Figure 2 shows the results of eight professional groups and eight services. In general, about 50% of the citizens had (very) much confidence in the services. Almost 70% of the potential consumers had (very) much confidence in general hospitals, psychiatric hospitals and consultation offices for alcohol and drugs. All other services were less valued and the percentage of (very) much confidence of these services was approximately 50% or lower with the nursing homes rating lowest (42%).

The results are more positive for the professionals. More than 70% of all citizens had (very) much confidence in the professionals, although there was a clear distinction between the medical and the psychological, psychiatric and social workers. Mental health workers’ ratings showed less confidence than medical professionals, e.g. 24% of the citizens had very much confidence in the general practitioner and 6% had very much confidence in the psychiatrist.
On the school report card scores (1-10) somatic services scored 6.8 satisfactory, but the scores for the mental health and the addiction services were much lower: 5.4 not satisfactory.

Additional analyses showed that neither the Dutch school report card scores nor the confidence scores were related to the demographic variables of the respondents, implying that they represented the general opinion of Dutch citizens. The personal experience with mental health services showed a small but statistically significant positive influence on the opinion of the citizens.
Discussion study 3

The major finding of the survey is that about 50% of the potential consumers expressed confidence in the services and that 70% percent showed confidence in the health care workers. These findings can best be summarized by the quote from the Dutch Consumer Federation: “There is no doubt that many professionals have the best of intentions, and that they deliver excellent cure and care, but it is clear that the mental health services as a whole need to be improved” (Consumentenbond, 1998). In other words, the Dutch citizen has little idea about the quality improvements carried out. The positive opinion about the professionals could be the basis to improve the organizational aspects – waiting time, information about treatment, courtesy and support – of the services. Professional pride could be a motivator to engage health care workers to increase the service and organizational quality and therefore, the confidence in the services. Practical changes can be easily approached through quality projects, which have proven to be successful.

Although many quality assurance programs have been carried out in mental health and addiction treatment services over the last few years, the mental health services clearly rank below the somatic services. One explanation might be that the services have spent too much time focusing on internal affairs and have neglected external contacts. An active public relations programme could be quite effective in improving the image and demonstrating what has been achieved. Most of the time, publicity in the media is focused on negative incidents involving psychotic and aggressive individuals. A public relations campaign for mental health and addiction services in the Netherlands could also provide a more realistic picture of mental health and addiction services and the successes of these services in terms of successfully treated patients.

Low confidence in mental health and addiction treatment services is probably also one of the main reasons for the treatment gap, i.e. the fact that only about 10% of all people with a mental health or addiction problem seek treatment. In its recent action plan, the World Health Organisation European Regional Office proposed a series of actions to reduce the gap in treatment, which included increasing the awareness for mental well-being, fighting against stigmatisation, implementing comprehensive mental health systems, building a competent workforce and using the experience and knowledge of the consumers (WHO, 2005). The realisation of the action plan in combination with a variety of consumer satisfaction surveys to monitor and demonstrate progress would be propitious.
General conclusion

Mental health and addiction treatment services in the Netherlands have taken a step towards establishing quality assurance programs and assessing the satisfaction of its consumers. The quality assurance programs are a first step towards quality improvement and the customer satisfaction is high. However, further analyses shows that the measurement of consumer satisfaction is a complex task (Carr-Hill, 1992). There is research and organizational infrastructure to support the satisfaction surveys of the various services, but several methodological problems have to be solved to prevent the dissemination of non-information, which can lead to misleading conclusions. The findings of the three studies are preliminary, but should be discussed in the scientific community and taken seriously by the practitioners.

The three studies, carried out in the Netherlands in 2002, provide an insight into consumer satisfaction. A high percentage of consumers are fairly satisfied with the information, the decision making, the health care professional and the treatment effect. These consumers are most positive about the health care professional. The exit measures also show that addicts and mental health patients are typically more positive about specific aspects of the services, than about the overall services, which were rated satisfactory to good on the Dutch school report card score.

An important finding of the longitudinal study is the predictive value of psychopathology for the level of satisfaction. Direct comparisons cannot be made between patient groups, services or teams, if there are differences in the psychopathology between groups of patients. Satisfaction scores have to be adjusted for differences in psychopathology, if they are to be used for benchmarking between treatment services.

The studies also show that the concept of satisfaction in the process of treatment is complex. It is apparent that consumer satisfaction as a process variable does not directly predict treatment outcome and that consumer satisfaction as an outcome indicator is relatively independent of treatment success. More research is needed to develop an evidence-based model for consumer satisfaction and its role in quality improvement in health care services (Linder-Pelz, 1982).

The satisfaction of Dutch citizens as potential consumers clearly deviates from patients who have utilized the services. Although many citizens show some confidence in the professionals, only 50% have confidence in the services: the school report card score of the citizens is not satisfactory. These results show that the services have to continue their quality improvement programmes and improve the communication of the results so that mental health and addiction services reach the quality level of hospitals.

It should be noted that the studies presented here refer to two types of con-
Consumer satisfaction

consumers, the patient and the citizen, but mental health and addiction treatment services have many other consumers, such as relatives and referral agencies. Instruments to measure their opinion and satisfaction with the services (Jong de, 2005; Obertop, 2005) are currently being developed and initial results show a broader representation (Kulla, 2004). Eventually, a broad consumer or stakeholder approach will be necessary to obtain true representation of consumer satisfaction.

The three satisfaction studies presented were carried out through the internet, interviews and questionnaires. The questionnaire _Mental Health Care Thermometer_ has recently been transferred to a telephone survey and is being used in the follow-up evaluation, which is carried out by a call-centre. The findings of the survey are regularly available for the treatment centre and can be used as feedback for the teams. Furthermore, the contact by the call centre provides more opportunities to stay in contact with patients and effectively manage aftercare (McKay, Lynch, Shepard, & Pettinatie, 2005).

Consumer satisfaction in mental health and addiction treatment services is an important and relevant quality indicator. There are several research questions, which have to be answered. There are also many opportunities for improvements when the professionals and the management of the services use the findings systematically. Perhaps the topic remains challenging and promising because it can be reduced to one simple question: Would I appreciate this service or treatment if I was the consumer or patient?

**Reference list**


Consumer satisfaction


