Patient satisfaction with psychiatric outpatient care in Geneva: a survey in different treatment settings

Bernard Davy[a, b], Ineke Keizer[a], Patrice Croquette[a], Gilles Bertschy[a], François Ferrero[a], Marianne Gex-Fabry[a], Guido Bondolfi[a]

[a] Division of Adult Psychiatry, Department of Psychiatry, Geneva University Hospitals, Geneva, Switzerland
[b] Clinique La Lignière, Gland, Switzerland

No conflict of interest to declare.

Summary

Objectives: This study examined client satisfaction in different types of psychiatric outpatient care facilities and its association with treatment setting, patient socio-demographic and clinical variables.

Methods: The twelve public outpatient psychiatric clinics for adults in Geneva, Switzerland, offer a rich variety of settings including general psychiatry clinics, crisis centres and specialised programmes for specific disorders (depressive disorders, bipolar disorder, borderline personality disorder, early psychotic disorders and family and marital counselling). A consecutive sample of 918 patients agreed to answer three self-administered satisfaction questionnaires (the CSQ-8 Client Satisfaction Questionnaire measuring global satisfaction, the CIC questionnaire examining various components of service and a qualitative questionnaire with open-ended questions). These forms were adequately completed by 707 subjects, who constituted our study group. Their clinical and socio-demographic characteristics were obtained from their attending psychiatrists.

Results: The global satisfaction rate was high (38.5% satisfied and 54.6% very satisfied). Reasons for greater satisfaction were therapeutic interventions, relationship with staff and confidentiality, while a lower satisfaction was related to information on disease and medication, adjustment of the program to patient expectations, clinic organisation and environment. Socio-demographic and clinical characteristics were not homogeneously distributed across the three types of treatment settings. A significantly larger proportion of male, single, pensioned, chronically-ill patients with minimum education were followed at the general psychiatric consultation centers, where diagnosis of schizophrenia was the most frequent. In the crisis centres, non-chronically disabled patients with a short psychiatric history (<1 year) and diagnosis of depression were more prevalent. Logistic regression showed a significant association between high satisfaction and gender (female), civil status (not single), financial resources (not receiving a disability pension or other social aid), main diagnosis (not presenting a psychotic disorder), and setting (attending a specialised programme). A multivariate model including these five variables showed that setting (odds ratio = 1.84 for specialised programmes) and civil status (OR = 0.57 for single subjects) remained significant predictors of satisfaction.

Conclusions: The satisfaction of psychiatric outpatients could be improved by adjusting the programme content or setting according to these findings (systematic clarification of patient expectations, more information about disease and medication, appropriate frequency and length of appointments, specialised care and medical follow-up, greater attention to physical environment), but it should be taken into account that client appreciation is also influenced by socio-demographic and clinical characteristics.

Keywords: satisfaction; psychiatry; outpatient; socio-demographics; diagnosis; treatment setting

Correspondence:
Dr Bernard Davy
Clinique La Lignière
CH-1196 Gland
e-mail: bernard.davy@la-ligniere.ch

Introduction

Over the past years, the Division of Adult Psychiatry at the Geneva University Hospitals has been restructured in response to an increasing demand for psychiatric consultations and hospitalisations [1]. Since 2002 four districts corresponding to four geographical areas have received comparable resources for inpatient and outpatient services. A general psychiatric outpatient consultation centre is found in each district, while five specialised outpatient units (for depressive disorders, bipolar disorder, borderline personality disorder, early psychotic disorders and family and marital counselling) provide services for patients from all districts. Additionally, three "Brief Therapy Centers" can provide unstable patients with 24-hour crisis interventions and accommodation for a few nights. The general psychiatric consultation centres and crisis centres constitute the front-line community care in Geneva. Patients are treated at their own request or referred by general practitioners and private psychiatrists.

The five specialised outpatient units constitute the second-line care. Physicians send the most severe and treatment-resistant patients to the appropriate specialised clinic. As "expertise centres", these units also conduct evaluations in order to provide treatment recommendations to clinicians. Two clinics are devoted to mood disorders (unipolar and bipolar) and provide specific psychopharmacological expertise, psychosocial and psycho-educational interventions for patients and families [2], cognitive-behavioural group and individual therapies [3], light therapy and transcranial magnetic stimulation. Patients with a diagnosis of borderline personality disorder and severe parasuicidal behaviours are referred to the borderline personality disorder unit, where interventions are mainly based on Dialectical Behaviour Therapy [4]. The early psychotic disorders unit aims at reducing the time interval between onset of psychosis and introduction of effective treatment (drug and psychosocial). Patients benefit from early diagnosis and treatment of schizophrenia and related psychoses [5], including day-hos-

pital and individual care. The family and marital counselling unit offers specific psychotherapeutic interventions based on the systemic model. It should be pointed out that other specialised structures, which are not part of the Division of Adult Psychiatry in Geneva, were not considered in the present study (for example outpatient facilities for patients with substance abuse, eating and somatoform disorders).

Patients' satisfaction with care has been examined since the early 1970s to evaluate the quality of psychiatric programs with the goal of enhancing treatment outcomes. Various instruments have been developed: quantitative questionnaires, qualitative questionnaires using open-ended questions, and behaviour markers such as number of drop-outs or missed appointments [6–9]. The short, 8-item version of Larsen's Questionnaire (CSQ-8) seems to be the most widely used instrument. Several problems have been identified when satisfaction is evaluated with quantitative global scales [6, 7], most notably high levels (ranging from 70 to 90%) of reported satisfaction with any programme [10]. Various tools have been developed to deal with this "ceiling effect" or ubiquitously high rate of satisfaction: asking patients to rank the various aspects of the programme (such as environment, location, non-clinical personnel, medical staff, interventions) in terms of importance and level of satisfaction [6]; focusing on dissatisfaction, for example the clients who are most dissatisfied or the components of the service that provide the least satisfaction [7]; analysing satisfaction with the same instrument at consecutive time intervals, especially after changes have been introduced; using qualitative instruments with open-ended questions ("What do you like most at the clinic?" or "Which services could be improved at the clinic?") making it easier to highlight problem areas [8]; and comparing satisfaction rates between different treatment settings.

Attempts to identify the determinants of patients' satisfaction with mental health care have often led to conflicting results. Studies of socio-demographic variables have generally shown negative results or only weak associations between female gender, older age and higher satisfaction [9, 11, 12]. Better quality of life, living with a spouse and having a job also correlated with higher satisfaction [9, 13, 14]. When a significant association was found with diagnosis, satisfaction was higher for anxiety, adjustment and mood disorders than for psychotic, personality, somatoform and eating disorders [15, 16]. Increased satisfaction has generally been associated with better psychological functioning, better one-year prognosis and longer follow-up [13, 12, 17].

The objective of the present study was to investigate patients' satisfaction five years after an important restructuration of psychiatric services in Geneva and to determine whether satisfaction was related with treatment setting, after taking into account sociodemographic and clinical variables. It was hypothesized that despite higher severity, patients followed in specialised programmes would display higher satisfaction rates as a consequence of more intensive and specific treatment interventions. The present survey integrated validated quantitative instruments as well as qualitative assessment of satisfaction. To current knowledge, no study has previously assessed satisfaction in different types of outpatient psychiatric care facilities, using a uniform methodology.

Participants and methods

Study design and procedure

The present survey was designed to provide a snapshot of patients' satisfaction, within a 2-month recruitment period, that would minimally interfere with clinicians' everyday practice and be simple enough to allow for a high response rate among outpatients. It included all outpatient facilities (four general psychiatric consultation centres, three crisis clinics, five specialised outpatient units) of the Division of Adult Psychiatry in Geneva. All attending psychiatrists were invited to ask their first 50 clients to fill out self-administered satisfaction questionnaires, starting on May 1st 2006. Eligible participants were 18 to 65 years old, had been seen at least three times at the clinic, were sufficiently fluent in French and had no severe cognitive deficiencies. Written informed consent was obtained from all participants. The study was approved by the Ethics Committee of the Department of Psychiatry. For each patient, the psychiatrist collected information about socio-demographic characteristics and diagnoses from the medical file. Disorder duration was classified into three categories: less than one year, 1–5 years and more than five years. Disorder severity was rated from 0 (very light) to 10 (very severe).

Patients were asked to fill out the satisfaction questionnaires on their own and return them in sealed envelopes, into specific boxes at the reception desks. They were assured that their doctor or nurse would not have access to their questionnaires so that they could freely express their opinions. Medical forms and patient questionnaires were coded to ensure anonymity. The data collection period lasted for two months.

Instruments

Satisfaction was assessed with two short quantitative questionnaires and two open-ended questions, in order to minimise non-response rate.

- The Client Satisfaction Questionnaire (CSQ-8) was developed by Larsen et al. [7] to provide a quantitative estimate of global satisfaction. It is a Likert-type scale including 8 items (listed in table 1) rated from 1 (lowest satisfaction) to 4 (highest). The French translation was validated by Sabourin and Perreault [11, 18]. Total scores vary from 8 to 32. They can be used as such in data analysis or, as Larsen proposed, according to three levels: low (total score 8–20), medium (21–26), and high (27–32) [7].
- A *modified version of the CIC questionnaire* ("Evaluation de la satisfaction des usagers des CIC – Centres de Santé et de Services sociaux de l'Energie"), used in Quebec [19], included 9 questions examining satisfaction with various components of services (listed in table 1). For each item, possible responses were very satisfied, satisfied, moderately satisfied or dissatisfied.
- The *two open-ended questions,* used and tested by Perreault et al. [8], were added in order to obtain a qualitative evaluation: "What do you like the most at the clinic?" and "Which services could be improved at the clinic?" These questions are simple and easy to understand, allowing

participants to express both satisfaction and dissatisfaction. To analyse the qualitative data, Perreault et al. have proposed classifying answers into five categories according to content: clinic environment, clinicians, interventions, clinic organisation and general comments about the clinic [8].

Study sample

A sample of 1139 patients was considered for participation in the study. Psychiatrists excluded 112 subjects due to cognitive deficiency or inability to understand the questionnaires in French. 109 patients refused to take part. From 918 patients who agreed to participate, 733 patients returned the questionnaires. Raw response rate was 64.4% (733/1139) and assessment response rate was 79.8% (733/918). A comparison of patients who did and did not participate (excluded or refusals) showed a higher participation rate in specialised programmes (73.5% participating versus 26.5% not participating) than in consultation centres (58.8% participating) or crisis centres (60.3% participating; chi-square test, $p = 0.0003$). Data analysis was performed in subjects who had all CSQ-8 items completed (n = 707). Distribution across treatment settings was the following: consultation centres: n = 406, crisis clinics: n = 129, specialised programmes: n = 172 (unit for early psychotic disorders: n = 27; bipolar disorders: n = 47; depressive disorders: n = 30; borderline personality disorders: n = 30; family and marital counselling: n = 38).

A comparison of patients who returned complete CSQ-8 questionnaires (n = 707) with those who did not return the questionnaires (n = 185) or had incomplete data (n = 26) did not reveal any significant difference for socio-demographic and diagnostic variables (gender, age, civil status, origin, financial resources, main diagnosis or chronicity), except for education. Subjects with minimal education were over-represented in the group that agreed to participate but did not return the questionnaire, or returned it with incomplete data (42.8 vs 32.7%, chi-square test, $p = 0.027$).

Data analysis

Statistics were computed using SPSS for Windows version 11.0 (SPSS Inc., Chicago, IL, USA). Pearson's chi-square test and Fisher's exact test (2 × 2 tables) were used for comparing frequencies. A one-way analysis of variance (ANOVA) was used to compare age (a normally distributed continuous variable) across settings. As CSQ-8 scores showed large deviations from normal distributions, they were used to define a dichotomous variable (high satisfaction with scores in the 27–32 range vs scores <27). That variable was used as the dependent variable in logistic regression analyses. Univariate models were considered first, with odds ratios estimated and tested (Wald's test) for each individual predictor. A multivariate logistic regression model was then considered in order to assess the combined influence of the variables identified as significant in univariate analyses. All tests were two-tailed with significance levels set at 0.05.

Results

Socio-demographics, clinical variables and treatment settings

For the 707 participants, mean ± SD age was 41 ± 11, and 54% were female. The country of origin was Switzerland (51%), other European countries (31%), Africa (9%), America (5%) or other (4%); although 95% of the sample had been living in Switzerland for more than five years. The results for civil status showed that 42% of patients were single, 31% were married and 27% were divorced or widowed. From the sample, 36% lived alone, 54% lived with their spouse or family, 10% with friends or other, and 89% of the participants lived in a private apartment while 11% stayed in collective-type housing facilities. Financial resources included work (22%), unemployment benefits (14%), disability pensions (38%), welfare (12%) and other funds (14%). Main diagnoses were mood disorder (49%), psychotic disorder (27%), personality disorder (11%), anxiety or adjustment disorder (7%), substance abuse (2%) or other (4%) (table 2).

Socio-demographic and clinical characteristics were not homogeneously distributed across the three types of treatment settings. A significantly larger proportion of male ($p < 0.01$), single, pensioned, chronically-ill ($p < 0.001$) patients, with minimum education ($p < 0.01$) were followed at general psychiatric consultation centres. The diagnosis of schizophrenia was also more prevalent in this setting ($p < 0.001$) and patients were significantly older than in crisis centres or specialised programs ($p < 0.001$). In crisis centres, non-chronically disabled patients with a short psychiatric history (<1 year) and a diagnosis of depression were more prevalent ($p < 0.001$). The clinical condition was rated as significantly more severe in crisis clinics and specialised programs where more intensive care is provided ($p < 0.001$).

Satisfaction

Global satisfaction was examined with the CSQ-8, and specific reasons for satisfaction or dissatisfaction were studied using the CSQ-8 and modified CIC questionnaires. On both instruments, distributions of responses indicated a very small proportion of dissatisfied or less satisfied patients. Only 6.8% of patients scored in the CSQ-8 "low" satisfaction category (total score 8–20), whereas 38.5% were satisfied (21–26) and 54.6% very satisfied (27–32).

CSQ-8 and CIC items were ranked from highest to lowest satisfaction rates in order to illustrate the features patients were more or less satisfied with (table 1). For CIC items, highest rates were found for confidentiality and quality of the relationship between health care staff and patients (>60% of patients very satisfied). Lowest rates were observed for time before first appointment and information about health status and medication (<45%). For CSQ-8 items, highest rates were observed for coming back to the programme and recommending it to friends (>55% of patients very satisfied), while lowest rates were obtained for patients getting the type of service they wanted and the program meeting their needs (<35%).

Table 1
Ranked satisfaction rates for the items of Larsen's CSQ-8 Satisfaction Questionnaire* and the Modified CIC Satisfaction Questionnaire.

CSQ-8 (n = 707)	% very satisfied**
If you were to seek help again, would you come back to our programme?	58%
If a friend were in need of similar help, would you recommend our program to him or her?	57%
Have the services you received helped you to deal more effectively with your problems?	51%
How satisfied are you with the amount of help you have received?	41%
How would you rate the quality of service you have received?	40%
Overall, how satisfied are you with the service you have received?	36%
Did you get the kind of service you wanted?	34%
To what extent has our programme met your needs?	34%
modified CIC	**% very satisfied*** **
Are you satisfied with …	
… confidentiality and discretion? (n = 695)	68%
… your relationship with health care staff members? (n = 703)	63%
… staff members' availability? (n = 702)	54%
… the opening hours of this treatment centre? (n = 698)	46%
… the length of appointments? (n = 700)	47%
… the frequency of appointments? (n = 699)	46%
… the information received about your treatment (medication)? (n = 670)	44%
… the time you waited before your first appointment? (n = 695)	43%
… the information received about your health status? (n = 693)	37%

* http://www.tchcoalition.org/PM/Questionnaire.doc
** CSQ-8 item score of 4 = highest satisfaction
*** CIC item score of 1 = very satisfied

Open-ended questions

A majority of positive comments was obtained with respect to the quality of the relationship between patients and staff (557 positive versus 68 negative comments about being listened to, understood, respected and professionalism of the therapeutic relationship), available interventions (209 positive comments, mainly about interviews or individual/group therapies, versus 62 negative, mainly about information) and therapeutic effects of the interventions (131 positive versus 9 negative comments about ability to cope with mental health problems and sense of security). A majority of negative comments was recorded for organisation of the unit (166 complaints about frequency of appointments, delays, changing or insufficient staff, versus 40 positive) and its environment (78 negative comments about decoration and impossibility to have a drink, versus 52 positive).

Relationship between satisfaction and socio-demographic characteristics, clinical variables and setting

Binary logistic regression analyses were performed to investigate the relationship between high satisfaction (CSQ-8 score ≥27) and possible explanatory variables. Gender (female), civil status (not single), financial resources (not on a disability pension or other social aid), main diagnosis (not schizophrenia or psychosis), and setting (specialised programmes) were all significantly associated with higher satisfaction when considered independently (see table 2, univariate analysis). A multivariate model including these five variables showed that setting and civil status remained significant satisfaction predictors after adjusting for gender, diagnosis and financial resources (table 2). This result also emphasises that explanatory variables did not contribute independently to satisfaction, in keeping with differences between settings with respect to gender, civil status, financial resources and diagnosis (see above).

On the modified CIC, satisfaction was significantly higher in specialised programs for all items (chi-square tests, $p<0.01$) except the 2 items about organisational issues (opening hours, waiting time).

Discussion

This survey examined satisfaction in various outpatient settings with quantitative and qualitative assessments. Overall, a small proportion of participants were dissatisfied while the majority were satisfied or very satisfied, no matter which type of facility they evaluated.

In line with earlier studies that documented weak associations between higher satisfaction and female gender, living with a spouse and having a job [9, 11–14], the present study showed significantly lower satisfaction in male, single, and unemployed patients. Civil status remained a significant determinant of satisfaction, after adjusting for gender, financial resources, diagnosis and treatment setting. Thus, living conditions and family environment might have a significant impact on patients' evaluations of psychiatric services. Similarly to previous research, our study found a decrease in satisfaction rates in patients diagnosed with schizophrenia and psychosis [15, 16].

These results illustrate the complexity of analysing the multifactorial nature of satisfaction and emphasise that comparison of different studies can be difficult due to methodological differences (for example diversity of variables, instruments, settings, treatment intensity). The present

Table 2
Relationship between high satisfaction (CSQ-8 total score ≥27), socio-demographic variables, clinical characteristics and outpatient setting (n = 707).

		N	%	univariate logistic regression		multivariate logistic regression[a]	
				odds ratio[g]	p value	odds ratio[g]	p value
Gender	male	327	46.3	1	–	1	–
	female	380	53.7	1.50	0.008	1.26	0.17
Age	17–35	225	31.8	1	–	–	–
	36–45	219	31.0	0.99	0.94	–	–
	>45	263	37.2	1.22	0.28	–	–
Civil status	married	223	31.5	1	–	1	–
	divorced/widowed	190	26.9	0.96	0.84	0.99	0.96
	single	294	41.6	0.55	0.001	0.57	0.008
Country of origin	Switzerland	363	51.3	1	–	–	–
	other	344	48.7	1.26	0.12	–	–
Education[b]	primary school only	227	32.7	1	–	–	–
	secondary or apprenticeship	213	30.7	0.80	0.23	–	–
	higher or university	254	36.6	1.05	0.80	–	–
Financial resources[c]	working or unemployment benefits	248	36.3	1	–	1	–
	disability pension or other social aid	341	49.9	0.66	0.01	0.78	0.20
	other	94	13.8	1.04	0.87	0.99	0.98
Main diagnosis[d]	schizophrenia or psychotic disorder	187	26.5	1	–	1	–
	mood disorder: manic or bipolar	104	14.7	2.37	0.001	1.28	0.39
	mood disorder: depression	243	34.4	1.64	0.01	1.03	0.90
	personality or behaviour disorder	78	11.0	2.09	0.007	1.33	0.34
	other	94	13.3	1.85	0.02	1.11	0.72
Diagnosis since[e]	>5 years	94	16.4	1	–	–	–
	1–5 years	228	39.9	1.24	0.24	–	–
	<1 year	250	43.7	1.25	0.36	–	–
Severity[f]	high (7–10)	143	21.5	1	–	–	–
	medium (3–7)	287	43.2	1.05	0.81	–	–
	low (0–3)	234	35.2	1.19	0.41	–	–
Setting	general consultation	406	57.4	1	–	1	–
	crisis clinic	129	18.2	1.27	0.23	0.99	0.99
	specialised programme	172	24.3	2.12	0.0001	1.84	0.005

[a] The 5 variables that were significant in univariate analyses were entered together in a multivariate model.
Missing data: [b] n = 13; [c] n = 24; [d] n = 1; [e] n = 135; [f] n = 43.
[g] For each predictor an odds ratio of 1 indicates the reference subgroup.

study used the same methodology to compare several settings. Satisfaction was higher in specialised programmes rather than general consultation centres and differences remained significant after adjusting for socio-demographic and clinical variables. However, patients attending specialised units and crisis centres presented more severe clinical conditions than those at the general consultation centres and usually had more frequent appointments. This may have influenced satisfaction, especially as insufficient frequency of interviews was cited as a reason for dissatisfaction. Treatment provided in these programmes is also adapted to specific diagnostic groups, and patients may appreciate these programs, usually after the frontline facilities have provided less specific interventions. Most studies [20–22] have found that patients appreciate information about disease and treatment options, psycho-education, help to strengthen self-confidence and self-efficacy, appropriate frequency and length of appointments, group support and group therapy. These components are emphasised in specialised units and may have contributed to higher satisfaction.

Expectations about treatment may differ between patients and professionals. Perreault et al. [11] concluded that "the greater dissatisfaction expressed by patients with schizophrenia and other psychotic disorders may be related to their therapists' undervaluing the non-biological aspects of treatment such as social support". Lelliott [23] also discussed the fact that attaining full remission of symptoms was more important to health care workers than to psychiatric patients, who placed greater emphasis on improving quality of life, especially returning to work, finding suitable accommodation, and establishing and maintaining significant relationships. Our results may reflect such an attitude, with lower satisfaction for CSQ-8 questions about whether patients' needs were met and whether they received the

kind of service they wanted. Patients ranked "coming back" and "recommending the program to a friend" first, which seemed to confirm that quality of care was not questioned.

The present study has several strengths and limitations. Strengths include a large sample size and good response rate. Selection bias was minimised by stating to psychiatrists that satisfaction would not be compared between recruiting physicians and informing patients that doctors and nurses would not have access to data. Thus, patients were expected to feel at ease to freely express their opinions. The use of standardised and validated instruments combined with a more qualitative approach was an additional strength. However, as the recruitment procedure did not consider random sampling, it cannot be ascertained that the study sample was actually representative of the population attending outpatient services. Moreover, some patients' subgroups were deliberately excluded from the present study (for example patients not fluent in French) or under-represented among responders to the survey (for example patients with lower education). Limitations also include the fact that collected information might have been partly biased towards higher satisfaction as a consequence of ongoing treatment in our services. The risk that some questions of the self-administered questionnaires might have been misunderstood was another limitation. Finally, more rigorous control of possible explanatory variables might have allowed complementing the present multifactorial picture of the relationship between setting and satisfaction rate.

Conclusion

Future investigations should evaluate how satisfaction of psychiatric outpatients might be enhanced by adjusting program content according to the following factors, outlined by the present study: systematic clarification of patient expectations, additional information about disease and medication, appropriate frequency and length of appointments, specialised care such as group support, group therapy, help to strengthen self-confidence and self-efficacy, and specialised medical follow-ups. When comparing satisfaction at different psychiatric clinics, the influence of socio-demographic and clinical characteristics should be taken into account.

Acknowledgments: The authors wish to thank all the physicians and patients from the Division of Adult Psychiatry for their contribution and support.

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