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# Patient satisfaction with outpatient mental health services – the influence of organizational factors

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## Pasienttilfredshet med polikliniske tilbud i det psykiske helsevernet – betydningen av organisatoriske faktorer

Pasientenes opplevelse og tilfredshet med behandlingstilbudet har i økende grad blitt vektlagt ved evaluering av tjenester til mennesker med psykiske lidelser. Systematiske målinger av brukererfaringer i det psykiske helsevernet skal inngå som en av flere kvalitetsindikatorer for spesialisttjenesten. Dette skal blant annet gi brukerne beslutningsgrunnlag for å kunne velge hvor man ønsker å behandles, fagfolkene innspill til egen kvalitetsutvikling og staten nødvendig styringsinformasjon. Hensikten med avhandlingen var å undersøke i hvilken grad organisatoriske forhold har betydning for pasientenes tilfredshet med behandlingstilbudet. Resultatene i avhandlingen bygger på analyser av data fra flere større undersøkelser med spørreskjema til pasienter om deres erfaringer med det psykiske helsevernet.

Samlet sett viser resultatene at misnøye eller tilfredshet med tjenestetilbudet i liten grad var avhengig av hvor behandlingen fant sted. Det vil si at pasientene var fornøyd eller misfornøyd relativt uavhengig av hvor de ble behandlet. For eksempel blant pasienter i poliklinikker for voksne kunne bare om lag to prosent av variansen i tilfredshet knyttes til hvilken behandlingsenhet som sto for behandlingen. Resultatene viste også at ulike mål på den psykiske lidelsens alvorlighet var assosiert med pasienttilfredshet, noe som vil ha betydning ved sammenlikning av behandlingsenheter med til dels ulike behandlingsoppgaver.

Avhandlingen viser at aggregerte mål for pasienttilfredshet har klare begrensninger som indikator på organisatorisk kvalitet. Det er grunn til å tvile på om gjennomsnittlig tilfredshet ved for eksempel en poliklinikk er egnet som styringsinformasjon. Det synes som om metoden i liten grad er egnet til å identifisere poliklinikker med dårlig kvalitet og det er også usikkert om de poliklinikkene som metoden beskriver som dårlige, faktisk er dårlige.

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***Veiledere: Jon Magnussen, Torleif Ruud og Svein Friis***
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# Content

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## List of papers

Paper I:

Patients' experiences and clinicians' ratings of the quality of outpatient teams in psychiatric care units in Norway. Bjørngaard JH, Ruud T, Garratt A, & Hatling T. Psychiatric Services; 58: 1102-1107, 2007.

Paper II:

Patient experiences with treatment in private practice compared with public mental health services (Online ahead of print). Bjørngaard JH, Garratt A, Gråwe R, Bjertnæs ØA, & Ruud T. Scandinavian Journal of Psychology, 2008.

Paper III:

User satisfaction with child and adolescent mental health services – impact of the service unit level (Online ahead of print). Bjørngaard JH, Andersson HW, Ose SO, & Hanssen-Bauer K. Social Psychiatry and Psychiatric Epidemiology, 2008.

Paper IV:

The impact of mental illness on patient satisfaction with the therapeutic relationship. Bjørngaard JH, Ruud T, & Friis S. Social Psychiatry and Psychiatric Epidemiology; 42: 803-809, 2007.

# 1. Introduction

Over the past few decades, patients' opinions regarding the assessment of services has gained prominence (1). Also, patients' ratings of their experiences and satisfaction with mental health services has been a frequently used indicator of service quality (2). It has been suggested that patient satisfaction is associated with compliance and health outcome (3) and that its measurement may raise issues that service providers often fail to identify (4). However, there is a limited understanding of the extent to which psychiatric units contribute to patients' perceptions of quality. The aim of this dissertation is to investigate the extent to which organizational factors are reflected in user satisfaction ratings, in order to contribute significant information about the utility of satisfaction measures as an indicator of organizational and system quality. The emphasis will be on outpatient services.

There has been a growing acceptance, over the past few decades, of monitoring health care organizations in order to give feedback to providers about important aspects of their resource utilization and performance. Health care organizations' performance, however, cannot be defined without considering the explicit goals that reflect the values of various stakeholders, such as patients, professionals and regulators. However, very few performance measurement systems focus on health outcomes valued by users of the services. In response to this lack of user input, measurement of patient satisfaction has gained importance, along with an increased emphasis on patient empowerment within health services (1,2). Quantitative surveys have been viewed as potentially effective, fairly cheap and easy to conduct in order to monitor performance among health care providers.

As noted by Wykes (5), there is no consensus regarding what should be appropriate terminology for describing a person who has been in contact with mental health services. Many terms are used, such as “patient”, “consumer”, “client” and “user”, or even “survivor” (6). Although the research is not conclusive (7), surveys have indicated that, to some extent, the people concerned prefer the label “patient” (8-10). For the most part, I have used the label “patient” in this dissertation when referring to persons receiving treatment for their mental illness. However, when referring to the parents of patients in Child and Adolescent Mental Health Services (CAMHS), I have used the label “user”. Beyond that, I have not emphasized any particular terminology.

Donabedian (11,12), who has been credited with a considerable number of theoretical contributions that define the quality of health services, has suggested that patient satisfaction is a key care outcome measure. Furthermore, he called attention to the need for investigations of the causal linkages between structural attributes of the settings in which care occurs, the processes of care, and the outcomes of care (13). Moreover, he emphasized the question of whether individual or social preferences define the optimum quality of services. Furthermore, he defined the patient–practitioner interaction within the core concept of quality (11).

# 2. Norwegian outpatient mental health services

## 2.1 Organization of Norwegian outpatient mental health services

Mental health services in Norway have undergone major changes over the past few decades, with substantial growth of locally based outpatient services (14). This development is in line with changes in other European countries, going from inpatient to outpatient care as the preferred modality for most patients (15).

In 1998, a national programme for improvement in services for the mentally ill was initiated. As a part of this comprehensive program for the development and enhancement of Norwegian mental health services, a major increase in the capacity of outpatient clinics and other community mental health services was proposed.

In Norway, the state is responsible for specialized health services, which are delivered through four regional health authorities. Within each regional health authority, mental health services, such as community mental health centres and hospital-based services, are provided by health trusts. Outpatient clinics with various teams are part of these community mental health centres. The outpatient clinics provide psychiatric services for a given population, and their teams can be defined as the lowest administrative organizational level of care. In addition to the main provision of outpatient public mental health care services, there is a substantial supply of outpatient treatment given by psychiatrists and clinical psychologists in private practice.

## 2.2 Organizational contributions to the quality of outpatient mental health services

Research has indicated that treatment outcome is closely related to relational factors between the patient and the practitioner (16-19). Within Norwegian mental health outpatient clinics, most patients have contact with only one therapist. The patients have little contact with other patients seen by the same clinic. Nevertheless, from a quality improvement perspective, it is also important to investigate the extent to which the clinical work of therapists is influenced by the context within which they work. If there are large quality differences between care units, this may indicate a potential for improvement.

Administrative units, such as clinics, are suggested as important units for the measurement of the quality of mental health services, from both national government and regional health authority points of view. This is reflected in the national guidelines for the management of Norwegian outpatient clinics (20), as well as in political signals to increase productivity and reduce waiting times (21). Furthermore, national performance indicators are currently presented to support the government's goal of facilitating patients' rights to choose where they receive treatment (22).

Modern multidisciplinary community mental health care is supposed to reflect the idea that the care of people with a mental illness cannot be met by one person or discipline alone. Following Burns (23), community mental health treatment requires doctors, psychologists, nurses and social workers who work closely together to organize care outside of the hospitals. Patients attending treatment at a clinic are supposed to take advantage of the competence provided by the clinic as a whole, not just from the therapist who is responsible for their treatment. Other clinicians may be involved in specific assessments or additional treatments, or the treatment provided by the therapist may be influenced by supervisors or team discussions. This implies considerable interdisciplinary cooperation when treating a particular patient.

The outpatient clinic, as an organizational unit, is responsible for the education and supervision of health professionals, as well as collaboration with other specialized health services. Admission procedures and managerial decisions will determine when and how treatment is started. Furthermore, structural service characteristics, such as waiting times, professional background of staff, productivity, stability, learning environment and leadership, are factors that may influence the work of professionals. However, the extent to which outpatient clinics actually are an important contextual factor affecting patients' treatment outcomes has been scarcely investigated (24).

In the case of outpatient treatment, it is not unequivocal whether organizational factors play a substantial role in determining the outcomes from mental health services. The question is whether the quality of care is just a matter of the personal relationship between provider and patient, independent of structural and cultural aspects of the organizational environment. Health service organizations may be interpreted as what Mintzberg (25) defined as professional bureaucracies. The various tasks in such organizations are taken care of by highly specialized and autonomous professionals who are given legitimacy to carry out actions based on their affiliation to a profession (26). An extreme variant would be clinicians who share premises but who do not interact with one another.

## 3. Patient satisfaction with mental health services

A vast literature has included some type of patient satisfaction measurement. A search in Medline on January 10, 2008 using the subject "consumer satisfaction (exp)" returned a total of 48,045 entries. Most of the literature is thematically related to health areas other than mental health. A combined search with "consumer satisfaction (exp)" and "mental disorders (exp)" provided a total of 3170 entries. In the past decade, the literature on patient satisfaction has proliferated, with a higher rate of growth for papers being concerned with topics related to mental disorders (see Figure 3.1).

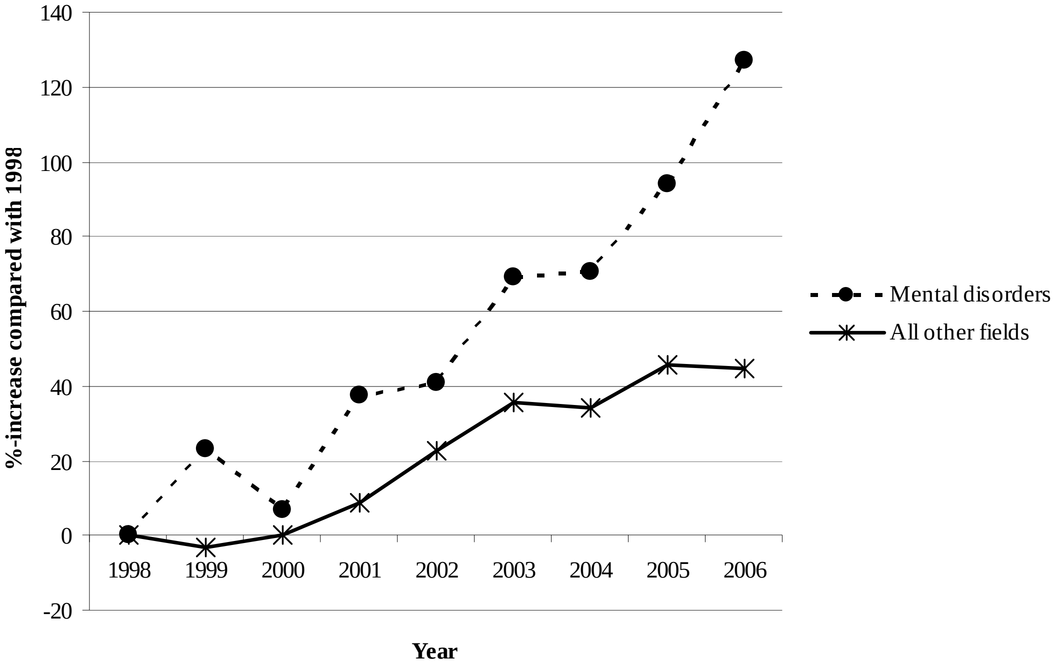

Figure 3.1 – Number of entries in the Medline database for the subject "consumer satisfaction (exp)" from 1999 to 2006 as a percentage of the number obtained for 1998.

Despite a large literature on patient satisfaction with health services in general, and mental health services specifically, there remains uncertainty about the usefulness of patient satisfaction measurement (27). A US survey of mental health care providers, however, showed a positive attitude towards patient satisfaction as an indicator of the quality of health services (28).

## 3.1 The concept of patient satisfaction

Compared with other outcome measures, patient-defined outcomes emphasize the importance and uniqueness of the individual experience (29). Hence, the credibility of patient evaluations does not necessarily rely on any agreement about professionally defined outcome measures. For instance, it is not clear how satisfaction is related to technical quality, which is defined by Donabedian (12) as the extent to which health care services meet predefined standards of acceptable or adequate care. Different studies have reported moderate to no association between patient satisfaction and technical quality of care (30,31). Other studies have maintained that providers and patients view quality differently (32), and that both views must be considered in quality assessment.

Patient satisfaction is a subjective measure with no definite relationship to external realities. Two persons given exactly the same treatment and stimuli will not perceive these services as being exactly similar. Several researchers have called attention to the lack of conceptual agreement in the field of patient satisfaction research (33,34).

As pointed out by Thompson and Sunol (33), patients' expectations prior to care delivery appear to be taken for granted as an important factor in most studies of patient satisfaction. Researchers have viewed satisfaction as the degree of discrepancy between expectations and experience. Satisfaction has been proposed to occur when experiences are equal to, or better than, expectations. Parasuraman *et al.* (35) suggested a comprehensive model of service quality derived from the size and directions of five possible gaps between expectations and experiences, as well as empirical solutions to operationalize these gaps. On the other hand, others have criticized the nature of gap theories as static, simplistic and mechanistic (36). It is also questionable whether the concept of satisfaction is clarified by introducing expectations as a key element of patients' evaluations of their services. One could argue that the nature and concept of people's expectations are no clearer than the concept of satisfaction. For instance, the extent to which patients have realistic expectations is likely to be uncertain if they have no, or limited, knowledge about health services (37). Furthermore, expectations are difficult to separate from experience, because it is likely that experiences influence expectations and vice versa.

Another approach to conceptualizing patient satisfaction has been empirical rather than theoretical. By emphasizing patients' evaluations and views of health service attributes, lists of critical health care features from a patient's point of view have been established. For instance, in Ware *et al.* (38), satisfaction ratings were considered to be subjective evaluations of care that could not become known from observing the care directly, as opposed to reports reflecting more objective and factual accounts of care, such as waiting time. According to Ware *et al*., satisfaction rating is a measure of characteristics of both the care provided and the patient.

When appraising satisfaction, it is not unequivocally clear what aspects of care are being considered. Furthermore, the patients' preferences, expectations, values and desires will play a role irrespective of whatever care is provided. In addition, the use of ordinal scales, by which each patient rates his or her level of satisfaction, is an abstraction that cannot be claimed to be the same for all respondents. Hence, patients will have different response styles when appraising their satisfaction with health services. It is difficult to reveal the extent to which satisfaction results are due to subjective psychological factors that are not amenable to change by health services. That is, what is characterized as satisfactory may vary considerably among people. Patient satisfaction measurement is susceptible to the effects of cognitive biases. Patients are surrounded by a multitude of information and stimuli, which may influence their perceptions of services (39). In addition, fluctuations in mood have been suggested as influencing evaluations of different aspects of individuals' lives (40). Although there seems to be agreement in the literature that satisfaction results do reflect care characteristics, they also reflect patient characteristics that are beyond the control of health service providers. The magnitudes of these different aspects of satisfaction remain unknown.

While subjective and psychological factors are likely to be important mechanisms operating at the individual level, the reliability of patient-rated outcomes has been shown to improve when mean scores that have been aggregated over wards, for instance, have been used (41,42). If a group of patients share an environment, such as treatment within a care unit, all other variables being equal, the concurrence in satisfaction ratings between patients sharing this environment can be understood as a consensual evaluation of that environment. That is, differences between care units may be less affected by the various psychological factors that influence patients' evaluations. However, there may well be some specific satisfied or dissatisfied patient groups allocated to different care units. For instance, different units may have responsibility for the treatment of specific patient groups who may perceive services differently. Furthermore, aggregated means are not necessarily representative of all patients. There may be subgroups of patients who have different needs and receive different types of treatment.

## 3.2 Components of satisfaction

Given the number of experiences that patients will perceive during mental health treatment, single global scores may disguise divergent judgements on different aspects of care (43). The selection of items to capture the nature and number of important dimensions of care is thus of crucial importance when assessing patients' perception of health services. There is evidence that more detailed and specific questions reveal greater levels of dissatisfaction than more general questions (1). Hence, there seems to be a growing understanding that dissatisfaction with specific aspects of care may be concealed by general ratings of overall satisfaction. Different classifications of the essential dimensions of patient satisfaction have been proposed. Others have called attention to a need for user involvement in instrument design and research (27,44,45). Satisfaction instruments are often designed on the basis of what is assumed to be important from a provider's point of view, and important patient views may be overlooked. Hence, it has been proposed that information from qualitative in-depth interviews with patients provides vital information about what is important from a patient's point of view.

In qualitative interviews, patients have emphasized that the interpersonal relationship between patients and staff is a key factor, in addition to effective responses to frequent long-standing problems (46,47). Furthermore, the patients' perception of being understood, trust and a good personal relationship with clinicians have been proposed as key elements from a patient's point of view (48-50).

It follows that those aspects of satisfaction that are valued by patients are associated with the core of the therapeutic process, such as the therapeutic alliance and obtaining help for their problems. This also concurs with the conclusions of Wampold (16), who suggested that factors common to different psychotherapies, such as a positive working alliance between the therapist and the patient, account for a substantial part of the variability in outcomes.

Nevertheless, it is important to take into account the possible multidimensional nature of the concept of satisfaction (51). Hence, several items may be necessary to cover critical aspects of satisfaction with health care. Using factor analysis (52), items are combined to measure important dimensions that provide a smaller number of measures that are both detailed enough to capture satisfaction and manageable from an analytical point of view.

### 3.3 Measurement of patient satisfaction

Sitzia (53) analysed the validities and reliabilities of different instruments used to assess satisfaction in 195 published papers. His review revealed that most studies did not demonstrate much evidence of reliability and validity. He suggested that further research should be based on instruments with established reliability and validity as indicated by previous studies.

However, there is no common agreement about what instrument to use for measuring patient satisfaction with mental health services. Different instruments have been developed for users of mental health services. In Europe, the Verona Satisfaction Scale (54,55), and a Swedish questionnaire from the University of Lund/SPRI have had some dissemination (56). However, many instruments are based on prior instruments that have been adjusted to local needs (57-59). One reason for this may be that many aspects of patient satisfaction cannot be measured or interpreted without considering the specific context in which the services have been received.

Patient satisfaction surveys have been criticized for underestimating dissatisfaction and hiding poor experiences, due to a desire on the part of patients not to appear ungrateful, as well as their acceptance of the limitations of health care delivery (27,60). An alternative approach involves asking patients to rate their experiences of those aspects of health care that assess more concrete experiences with care, including whether important events have taken place (51). This form of measurement involves the collection of more objective information relating to whether specific health care events have occurred. There is an implicit assumption that the various aspects of experience covered by such instruments are related to patient satisfaction. This approach rests heavily on the selection of experiences that are to be rated. Therefore, it is important to select items of high relevance for the patients. Following the discussion in chapter 3.2, such items can be combined in scales that capture the underlying dimensions of patient experiences.

# 4. What influences patient satisfaction?

In a comprehensive review of the patient satisfaction literature, Crow *et al.* (51) distinguished between determinants of satisfaction related to patient characteristics and to health services. They identified three main types of individual factors, namely expectations, health status, and the socio-economic and demographic characteristics of the respondents. Furthermore, they concluded that the research on expectations as determinants of satisfaction was important but problematic. They highlighted a lack of definition of expectations, a problem also mentioned in chapter 3.1.

## 4.1 Health status and patient satisfaction

There is evidence that poorer health status is associated with lower levels of reported satisfaction (51). Studies have consistently found a clear correlation between self-perceived health status and patient satisfaction (61,62). However, when patients themselves respond to questions about their health status and satisfaction in the same questionnaire, the results may be influenced by a generalized response bias (63). Nevertheless, studies have found lower satisfaction ratings among patients with clinician-rated poor health (39). It is, however, difficult to discriminate between the effects of the mental illness and lack of improvement on patient satisfaction.

Studies have found a relationship between symptom relief and satisfaction (64). One could speculate on the extent to which satisfaction levels are due to symptom improvement following care, or whether satisfaction levels follow mood fluctuations independent of care delivery. A longitudinal study in the US (65) assessed parental satisfaction with the same inpatient stay at 3, 6, and 12 months after discharge. This study found a statistically significant decline in satisfaction from discharge to follow-up, especially for those reporting more behavioural problems. This finding suggests that users’ perceptions of a care episode are subject to change.

## 4.2 Socio-demographic variables and patient satisfaction

In general, the findings from the literature on the impact of socio-economic status on satisfaction have been inconclusive (51). The impact of such variables may be influenced to some extent by the health care system, for instance, if health care services are provided by governmental funding, insurance or out-of-pocket payment.

There are no consistent findings about the relationships between satisfaction and the patient's sex (66,67). The small differences between men and women may reflect different patterns of service utilization, differences in experiences, as well as differing needs and expectations (68).

There is a consistent finding in the literature that older adult patients are more satisfied than younger patients (51,69), although the absence of such differences has also been reported (39). Crow *et al.* (51) suggested various explanations for why older people generally report higher satisfaction. For instance, it may reflect that older patients may be more accepting than younger patients. Moreover, older patients may also have lower expectations based on previous experiences when the standards were lower. Alternatively, old age may engender more care and respect from the providers.

There is some evidence that ethnicity is weakly associated with satisfaction, but the results are not conclusive (51). Studies of patients receiving mental health services in the UK found either small differences between different ethnic groups (62) or no differences at all (70).

There are no consistent findings regarding the effects of level of education and income on patient satisfaction (51).

### 4.3 Organizational contributions to patient satisfaction

There is an inbuilt assumption that expressed dissatisfaction reflects not only individual patient characteristics but also deficiencies within the services. For instance, if patients are dissatisfied with the provided information, health service organizations should try to improve their information procedures. However, this assumption has been hardly investigated. While it has been almost taken for granted that patient satisfaction is related to the quality of services at different organizational levels, few studies have analysed the extent to which satisfaction ratings depend on the organizational environment of which the patients are a part.

Furthermore, patients may be influenced by different environmental factors when receiving treatment. Such contexts can be observed as different hierarchical levels. For instance, in Norway, health services are provided at large health trusts. Each health trust consists of a number of clinics, each of which consists of teams and patients within each team. Explanatory variables may be defined at each of these hierarchical levels.

Multilevel analysis is an analytical approach that has been used increasingly to investigate the relative effects of different organizational levels (71). Studies of inpatient somatic treatment have found only marginal organizational contributions to patient satisfaction variance at the levels of wards and hospitals (72-74). Studies of patient satisfaction with general practitioners have reported a 2–10% practice/practitioner level contribution to satisfaction variance (75-77).

Within mental health services, one US study found a 10–25% contribution to the variance in adult patient satisfaction from psychosocial rehabilitation teams (78). However, psychosocial rehabilitation teams have a particular cooperative work method. The extent to which user satisfaction ratings are reflected by organizational factors in other health areas of mental health services has not been resolved.

Administrative/structural measures have been associated with patient satisfaction. For instance, some studies have found hospital size to be negatively correlated with aggregated levels of satisfaction with somatic care (74,79), while others have not found such an association (73).

Characteristics of the clinical work environment may influence patient satisfaction (73,80). A study by Friis (42) indicated that case mix may influence the treatment environment in such a way that a negative ward atmosphere was associated with a higher percentage of psychotic patients on the ward.

Freidson (81) suggested that patients are more likely to be satisfied in private solo practices than in public practices where the clinicians also have obligations to a work organization. When alternative ways of financing care and the implications for patient satisfaction were assessed as part of a systematic review, there was evidence that patient satisfaction varied according to the way in which health care was financed (51). In Norway, outpatient mental health treatment is provided by public outpatient clinics, as well as by private specialists in psychiatry and clinical psychology who have contracts with the health authorities. However, the difference in satisfaction between patients of private practitioners versus public outpatients is not well understood.

# 5. This dissertation's objectives

## 5.1 Analytical considerations

The main aim of this dissertation was to investigate the extent to which organizational factors are reflected in patient satisfaction ratings. Organizational contributions to the perceived quality of mental health services were measured as differences in patient satisfaction between the various organizational levels of care, such as between health trusts, between outpatient clinics and/or between teams. Furthermore, patient satisfaction with outpatient treatment was investigated by comparing their experiences with those of patients who were treated in private practice, as inpatients or in day-patient care.

Although the analyses are concentrated mainly on services for adults, child and adolescent services are addressed in one of the four papers. Thematically, patients' experiences and satisfaction will be defined by their experiences with the therapeutic relationship, information and treatment outcomes.

Following the causal diagram in Figure 5.1, organizational factors (O) are hypothesized to influence patient satisfaction (PS) by means of either a direct effect (*a*) or an indirect effect through the clinical work of therapists (T). The following causal diagrams are used to identify sources of possible bias in the analyses. The arrows in the causal paths link descendant effects to their ancestor causes. It is thus an assumption that an effect follows its cause in time.

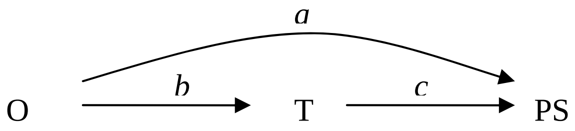

Figure 5.1

Assuming no random error and randomly distributed patients to different organizations, differences between organizations could be interpreted as organizational contributions to patient satisfaction. That is, we can investigate the crude effect of organizational influence, without information being available about each of the causal paths (*a, b, c*).

However, patients are not randomly distributed to different organizations. It is thus possible that organizational contributions to patient satisfaction may be influenced by confounding factors. Following Figure 5.2, there is confounding if there is an unobserved common cause (C) between the effects of organizational factors (O) and patient satisfaction (PS). If both causal paths, *e* and *d*, are different from zero, the associations between *a*, *b* and *c* would be influenced by confounding factors. In care units, the most obvious confounding factor would be the patient's health status. Outpatient clinics provide psychiatric services for a given population and thus will have similar treatment responsibilities. Nevertheless, it is likely that there are differences between the clinics in their mental health case mix. Furthermore, teams within clinics are organized to care for patients with specific conditions and problems. Hence, confounding may be a larger problem when comparing teams than when comparing clinics. Other variables causing patient satisfaction do not introduce any bias in the organizational effect as long as they do not also have a causal link with O.

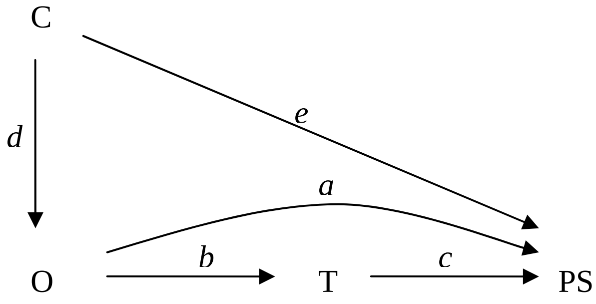

Figure 5.2

The causal diagram in Figure 5.2 does not take into account the possibility that individual characteristics may interact with organizational effects. For instance, it is possible that some organizational contexts are better for some patients than others. Hence, there is a possibility of conditional organizational effects that depend on certain patient characteristics.

This dissertation is based on the results from questionnaires completed by patients. Response rates in surveys of patient satisfaction with psychiatric services are usually low (3). If there is a different association between the organizational level effects and patient satisfaction among those responding to a study compared with those who did not respond, the results would be affected by selection bias. Referring to the causal diagram in Figure 5.3, the results would be biased if satisfaction influenced response probability (R), that is, if satisfied patients had a different response probability than dissatisfied patients and there was an unmeasured common causal link between the response probability (R) and the organizational effect (O).

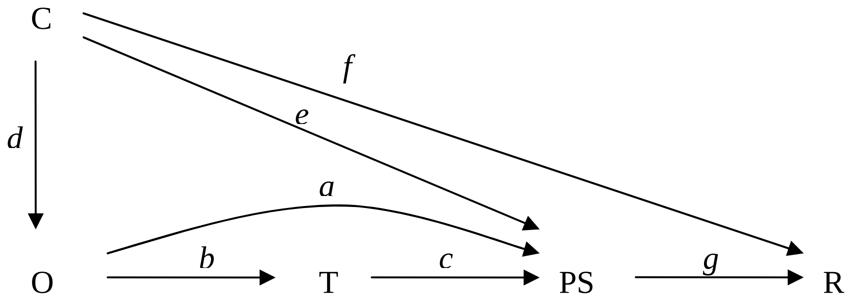

Figure 5.3

Finally, the results depend on the instruments used for patient satisfaction measurement. It is assumed that there is a close relationship between each patient's satisfaction and his or her response to a question in a questionnaire. Following Figure 5.4, patient satisfaction measurement ($PS_m$) should be caused by the patient's "true" satisfaction and not by some type of measurement error. Hence, a weak association between PS and $PS_m$ might reduce the effect of the other variables in the causal diagram.

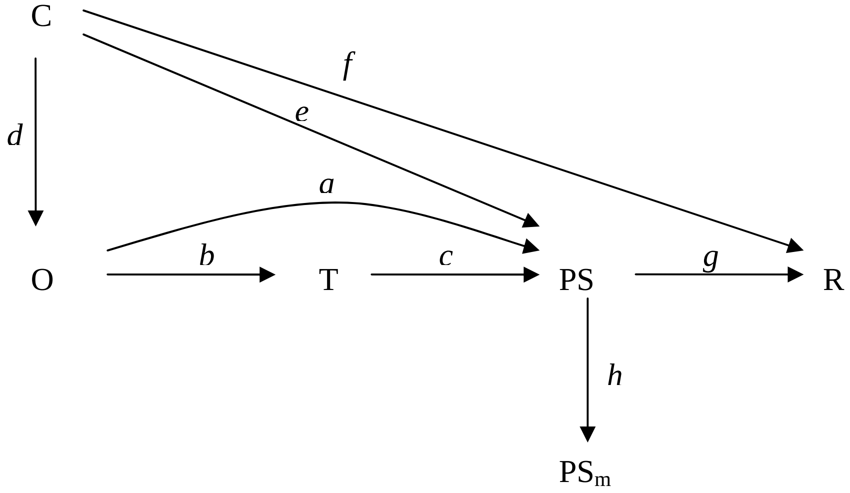

Figure 5.4

## 5.2 Aims of this dissertation

The dissertation comprises four empirical papers that investigate different aspects of organizational contributions to patient satisfaction. Following the preceding discussion, four major sources of possible analytical problems can be derived:

1. possible confounding factors;
2. possible interactions between individual characteristics and organizational factors;
3. possible selection effects; and
4. possible measurement error.

The patients' health status was analysed as a possibly important confounding factor. Depending on available indicators of health status contained in the materials used in these different papers, both self-perceived and clinician-rated health status was operationalized. In addition, adjustments were made for variables such as age, sex and use of services. In two of the papers, the possible interaction effects between organizational effects and patient characteristics were investigated. A thorough investigation of possible selection effects was performed in paper IV. To reduce the effect of possible measurement error, the papers were based on several different materials, instruments and items. In addition, in paper III we used parents, rather than patients, as informants. In paper I, the results were compared with clinicians' perceptions of quality.

The study described in paper I assessed patient satisfaction variance attributable to outpatient teams, clinics and health trusts, as well as the extent to which clinician evaluations of quality were related to patients' satisfaction. In other words, what is the organizational contribution to variance in patient satisfaction obtained from different hierarchical organizational levels, and what is the association between the clinicians' perceptions of quality and the patients' experiences? Patient-level variables such as age and sex, self-reported mental and physical health, duration of treatment, former inpatient history, number of visits in the past three months and perceived waiting time, were included to control for differences in patient characteristics across the various care settings.

Paper II investigated satisfaction among patients of private practitioners in Norway, when compared with the satisfaction of patients who attended public outpatient clinics. Patient-level variables such as age and sex, self-reported mental health, duration of treatment and number of visits in the past three months were included to control for differences in patient characteristics between the two care settings. Furthermore, each of the independent variables was tested for possible different effects on the dependent variable among the private patients compared with the public patients (interaction effects).

In paper III, parent satisfaction with outpatient Child and Adolescent Mental Health Service units (CAMHS) was investigated. The purpose of this study was to examine the amount of satisfaction variance attributable to the organizational level of the CAMHS unit. Patient-level variables such as age and sex, episode length, referral status, and waiting time were included to control for differences in patient characteristics across the care settings.

Paper IV reported a study that investigated the relationship between psychopathology and its effect on patient satisfaction with the therapeutic relationship. The study investigated the extent to which psychopathology, as a characteristic of both the individual patient and of teams, influences satisfaction with the therapeutic relationship. Furthermore, an investigation of possible interaction effects between psychopathology at the individual level and the organizational variables was performed. Also, an analysis was made of the differences between responders and non-responders.

# 6. Materials and methods

The empirical material in this dissertation comprises data from different studies in the various papers. Satisfaction and experiences data from four different measurement materials were used.

Paper I used data from a postal questionnaire sent to all patients aged 18 years or older who received services from mental health outpatient clinics in Norway in September 2004. The survey was carried out by the Norwegian Knowledge Centre for the Health Services (82).

Data for paper II arose from two Norwegian studies that collected information on the experiences of adult patients aged 18 years and over. The first study was a survey of patients receiving treatment by private practitioners in central Norway during a two-week period in September 2004. The second data set arose from the same study as was described in paper I. The survey of patients receiving treatment by private practitioners was part of an investigation of the treatment provided by private practitioners in central Norway (83).

Paper III used data obtained from a study undertaken during 19 days in May 2004 in 49 of 72 Norwegian outpatient CAMHS units. Parents whose children had received at least one previous consultation at the service were asked to fill in a questionnaire when they arrived for an appointment. The survey was part of a large-scale investigation of patients in Norwegian CAMHS units (84).

Data for paper IV were collected from eight community mental health centres, representing a cross-section of urban and rural settings, over a four-week census period in February–March 2005. The sample comprised patients in outpatient, inpatient, and day-patient treatment. Data were collected as part of a large-scale study designed to examine the impact of the development of community mental health centres on various mental health outcomes (85,86).

## 6.1 Procedures used in instrument development

The instruments used in this dissertation were developed to capture concrete experiences with various aspects of health care. As discussed in chapter 3.3, there is an inbuilt assumption that aspects of experience are related to patient satisfaction.

The development of the patient experiences questionnaire, the POPEQ used in paper I, was based on collaboration between the Norwegian Knowledge Centre for the Health Services and SINTEF Health Research (87). Instrument development followed a rigorous procedure. Item generation was based on a literature review, qualitative interviews with patients, pilot testing and discussions within a network comprising clinical staff, researchers and a user organization. From this questionnaire, 11 items, selected with broad applicability to respondents, covered the quality of interaction with the clinician, outcomes and the quality of information provision. Factor analysis and tests of item discriminant validity provided empirical support for an index of overall experiences, as well as three subscales that also have a theoretical basis. The outcome scale comprised three items: "outcome from conversations with the professional", "overall treatment outcome" and "change in psychological problems". The interaction with clinician scale comprised six items: "enough time for contact/dialogue", "understanding", "therapy/treatment suitability", "follow-up actions carried out", "communication" and "say in treatment package". The information scale comprised two items: information about "treatment options" and "psychological problems".

In paper II, data were obtained from patients in private practice and in public outpatient clinics. Data from outpatient clinics were the same as in paper I. The survey of patients' receiving treatment from private practitioners included six questions relating to patient experiences. These questions were derived from the longer questionnaire used in paper I: "overall treatment outcome", "enough time for contact/dialogue", "understanding", "therapy/treatment suitability", "follow-up actions carried out", and "say in treatment package". The six items was combined in a summated scale.

The instrument used in paper III was designed to provide information on parents' experiences and satisfaction with child and adolescent mental health services. A pool of potential questions covering important areas was derived from existing satisfaction questionnaires reported in the literature and from available satisfaction questionnaires used locally at some of the outpatient services. An expert group of clinicians and researchers selected the final items using criteria of clarity and utility. Based on the results from a factor analysis and internal consistency reliability estimates, two summary scales were constructed. The outcome scale comprised four items measuring "reduced problems", "treatment helps the child", "treatment helps the family" and "treatment help parent". The clinician interaction/information scale comprised six items: "clinician shows care and understanding", "trust in clinician", "clinician has good knowledge", "good information about clinical examination", "good information about child's problem" and "good information about treatment".

Paper IV used data collected from eight community mental health centres. The questionnaire was designed to provide information on several aspects of care in collaboration with the user organization, Mental Health Norway. The instrument was tested in an earlier study at the same centres (85). Six items representing different aspects of the therapeutic relationship were selected for further analyses: "sufficient time for contact/dialogue", "clinicians' ability to listen and understand", "follow-up of planned interventions", "respect for patient's views/opinions", "cooperation among clinicians", and "influence on treatment".

## 6.2 Organizational variables

Paper I reported an investigation of the amount of variance in patient experiences that could be explained by outpatient teams, clinics and health trusts. We also used survey data from a study assessing clinicians' views about various aspects of care in all Norwegian mental health outpatient clinics at the beginning of September 2004 (88). Four scales were used, the mean team-level clinician scores on the four scales being linked to the patient experience data.

In paper II, patient experiences with psychiatric treatment provided by private practitioners and public outpatient clinics were analysed. In paper III, differences in parent satisfaction between the various outpatient CAMHS were analysed.

In paper IV, we analysed the amount of satisfaction variance that could be explained by teams. Team function was categorized into outpatient, day-patient and inpatient treatment teams. The teams' mean scores on the summated Health of the Nation Outcome Scales (HoNOS) (89) and the Global Assessment of Functioning (GAF) (90) scale for patients treated by the team were used as measures of mental illness severity within each team.

## 6.3 Patient-level variables

In paper I, independent variables at the patient level included age and sex, self-reported mental and physical health, duration of treatment episode, former inpatient history, number of visits in the past three months and perceived waiting time. The independent patient-level variables in paper II comprised age and sex, self-reported mental health, duration of treatment episode, and number of visits in the past three months.

In paper III, independent variables included patients' age and sex, episode length, main reason for referral, and waiting time. The main reason for referral was categorized in terms of externalizing symptoms (hyperkinetic symptoms, conduct symptoms, antisocial behaviour/crime and drug use), internalizing symptoms (anxiety, suicidal symptoms, phobias, avoidant symptoms, compulsory features and depressive symptoms), or other symptoms (psychosis, autistic symptoms, school refusal, learning difficulties, eating disorder symptoms and other symptoms).

In paper IV, psychiatric disorders were recoded into two main categories: schizophrenia spectrum disorders (F2, ICD-10) and other disorders, based on the International Statistical Classification of Diseases and Related Health Problems, 10th revision (ICD-10) (91). Problems with substance abuse were assessed with combined information from the ICD-10, and two scales that assessed the use of alcohol and drugs (92). Patients receiving diagnoses of mental and behavioural disorders due to psychoactive substance use (F10–19, ICD-10) and/or having a score of 3 or more on the two scales (abuse/addiction/institutionalized) were rated as abusing.

Symptom severity, level of functioning and treatment outcome were assessed by the clinician treating the patient. The HoNOS (89) and the GAF scale scores (split symptom and function scores from 1 to 100, where 1 is the most severe problem level) (90) were based on an evaluation of the most severe conditions observed during the previous week. The two GAF scales were combined to produce an average score. The HoNOS comprises 12 different scales: “aggression”, “self-harm”, “drug/alcohol problems”, “cognitive impairment”, “physical problems”, “hallucinations and/or delusions”, “depression”, “other psychological problems”, “social relationships”, “activities of daily living”, “accommodation problems”, and “employment/leisure problems”. The sum of the scores on scales 1 to 7 and 9 to 10 was used as an index of the severity of the patient's problems. In data collected earlier, clinicians' ratings of case vignettes had shown satisfactory reliability on all HoNOS scales, with the exception of scale 8 (85). Scales 11 and 12 were excluded because they do not measure aspects of the patients’ condition. The HoNOS score was rated from 0 (no problems) to 4 (severe problems). The sum score was transferred to a 0–100 score, where 100 was the most severe problem level.

The clinicians rated seven items that involved changes in clinical state since the start of the treatment, each being scored on a seven-point ordinal scale where 1 equals “much poorer” and 7 equals “considerable improvement”. A rating of 3 indicated “no change”. The seven items were “psychiatric symptoms”, “psychological problems”, “close relations”, “social functioning”, “practical functioning”, “work ability” and “behavioural problems”. The summed score was used as a measure of treatment outcome and was transformed to a 0–100 value, where 100 represented the best possible treatment outcome. In addition, length of treatment episode, and patients’ age and sex were included as control variables.

### 6.4 Statistical analyses

Several different statistical techniques were used for data analyses, including factor analysis, multivariate regression analysis and descriptive statistics.

In all four papers, factor analysis (52) was used for the construction of dependent variables. To establish subscales, we carried out a factor analysis with varimax rotation (52). A summated scale score was made for items with loadings greater than 0.50, the difference between the loading on the corresponding factor and the highest loading on a non-corresponding factor was > 0.1, and Chronbach’s alpha exceeded 0.7. The internal consistency of the resulting scales was assessed using a corrected item–total score correlation and Cronbach’s alpha. The former measures the strength of association between an item and other items in the same scale. The latter assesses the overall correlation between items within a scale and produces a reliability estimate for that scale.

In paper I, factor analysis and tests of item-discriminant validity provided empirical support for a scale of overall experiences, as well as for three subscales, which also have a theoretical basis. In paper II and IV, factor analysis and internal consistency reliability estimates supported the construction of one summated scale in each of the papers. In paper III, factor analysis and internal consistency reliability estimates provided empirical support for the construction of two summated scales.

### 6.4.1 Assessment of organizational contributions to patient satisfaction

Multilevel regression analysis, computed using the MLwiN software, was used to partition the variance attributed to organizational factors and patient factors (93). In multilevel regression analysis, the residuals can be partitioned between the various hierarchical levels of interest. For instance, in a two-level model with patients within clinics, the residuals are partitioned as $u_j$ (clinic-level variance) and $e_{ij}$ (patient-level variance), which form the random part of the model. The proportion of clinic-level variance is estimated by dividing the service-level variance ($u_j$) by the total variance ($u_j + e_{ij}$), which is defined as the intraclass correlation coefficient (ICC). When the ICC is multiplied by 100, it can be interpreted as the percentage of variance attributed to service level.

$$Y_{ij} = \beta_0 + \beta x_{ij} + \beta z_i + u_j + e_{ij} \qquad [1]$$

In the multilevel multivariate regression model, explanatory variables may be defined at both the patient level and the hierarchical level of interest. For instance, equation [1] shows an example of a two-level model with a vector of individual patient level characteristics ($x$) and organizational characteristics ($z$).

The significance level of the predictor variables was achieved by dividing the estimated coefficients by their standard errors that resulted in estimated $t$-values. The significance level of the variance estimates was achieved with a one-sided $t$-test since the variance can not be less than zero, with the estimate divided by the standard error. However, MLwiN variance estimates and their standard errors are not very accurate (71). Hence, as a test of robustness, a 95% confidence interval of the variance estimates was achieved with a MCMC estimation procedure (94). The results of this robustness analyses did not deviate substantially from those reported in the papers.

In paper II, it was not possible to link patients to the private practitioners, given the anonymity of the data. Therefore, ordinary regression analysis was performed.

# 7. Results

## 7.1 Sample properties

In the survey used in paper I, all 15,422 persons aged 18 years or older who received services from mental health outpatient clinics in Norway in September 2004 were mailed a questionnaire within the following month. When patients receiving outpatient treatment within an inpatient setting were excluded from the analyses, respondents for this study consisted of 6570 (43% response rate) patients from 222 outpatient teams across 89 outpatient clinics from 33 health trusts.

Table 7.1 Response rates

| Respondents | Paper | Response rate | Administration procedure | Return method |
|---|---|---|---|---|
| Patients in outpatient clinics | I and II | 43% | Postal | Postal |
| Patients in private practice | II | 56% | Handed out at clinic | Postal |
| Parents in outpatient CAMHS | III | 87% | Handed out at clinic | At clinic |
| Patients in Community Mental Health Centres | IV | 39% | Handed out at clinic | Postal/at clinic |

In the survey of private practice patients used in paper II, 642 respondents returned questionnaires, giving a 56% response rate. In the survey used in paper III, a total of 2588 parents were invited to participate in the study, of whom 2253 (87%) filled in the questionnaire. We were able to match questionnaire information to service information for a total of 2164 parents. The 49 (70%) CAMHS in the sample treated 68% of the total number of outpatients in 2003.

In the survey used in paper IV, 1194 (39%) of the 3040 patients returned the questionnaire. We were able to link 969 of these 1194 respondents to clinical data provided by the responsible clinician, as some patients had not given consent for such linkage.

The dependent variables used in the four papers are presented in Table 7.2. Cronbach’s alpha values in a range from 0.75 to 0.91 met the criterion, suggested in the literature, of a minimum value of 0.7 being required for assessing differences between individual patients (95,96). Test–retest reliability, which was only assessed for the scales used in paper I, ranged from 0.8 to 0.9 (97).

All scale scores were transformed to a 0–100 score, where 100 is the best possible score. All mean scale scores were skewed towards positive experiences, a result that is consistent with those that are widely documented in the literature (2,3,51).

Table 7.2 Dependent variables

| Scales | Paper | Number of items | Respondents | Cronbach's alpha | Mean (SD) |
|---|---|---|---|---|---|
| POPEQ Total | I | 11 | Outpatients | 0.91 | 68.7 (18.3) |
| POPEQ Outcome | I | 3 | Outpatients | 0.83 | 70.2 (20.8) |
| POPEQ Clinician interaction | I | 6 | Outpatients | 0.89 | 69.9 (18.6) |
| POPEQ Information | I | 2 | Outpatients | 0.75 | 62.3 (27.4) |
| Sum of patient experiences scale | II | 6 | Outpatients/private practice patients | 0.88 | 68.9 (19.2) |
| Clinician interaction/information scale | III | 6 | Parents in CAMHS | 0.85 | 78.3 (17.4) |
| Experience of outcome scale | III | 4 | Parents in CAMHS | 0.86 | 65.6 (21.3) |
| Therapeutic relationship scale | IV | 6 | Inpatients, day-patients and outpatients | 0.85 | 75.1 (18.0) |

## 7.2 Summary of paper I

**Patients' experiences and clinicians' ratings of the quality of outpatient teams in psychiatric care units in Norway.** Bjørngaard JH, Ruud T, Garratt A, & Hatling T. Psychiatric Services; 58:1102–1107, 2007.

*Objective:* Patients' experiences and satisfaction ratings are increasingly used to evaluate quality of care. This study assessed the extent to which outpatient teams, clinics, and health trusts contributed to patients' experiences, and to what extent clinicians' evaluations of quality were related to patients' experiences. *Methods:* A questionnaire was mailed to 15,422 outpatients who attended Norwegian clinics in September 2004; 43% responded. Patients' experiences were measured on an 11-item index and three subscales: outcomes, interaction with clinicians, and information. Aggregated responses from clinicians were linked to the data on patients' experiences. Multilevel analyses were used to divide the variance between the different organizational levels and to assess the relationship with clinicians' opinions and individual level factors. *Results:* Data were analysed for 6570 outpatients within 222 teams derived from 89 outpatient clinics within 33 health trusts. Differences in patients' scores were determined largely at the patient level, with teams accounting for 2% of the total variance and organizational levels of clinics and health trusts not contributing to patients’ experiences. Team-level clinician quality scores were not significantly associated with patients’ experiences. Better experiences were significantly associated with patients’ female sex, older age, better self-perceived health, absence of an inpatient history, longer treatment episodes, frequent consultations, and waiting times perceived as acceptable. *Conclusions:* The organizational contributions to patients’ experience scores were minimal. Although clinicians’ ratings of quality are not a substitute for patients’ perceptions of quality, surveys of outpatients’ experiences and satisfaction may not be appropriate for cross-sectional comparisons of health care providers.

## 7.3 Summary of paper II

**Patient experiences with treatment in private practice compared with public mental health services** (Online ahead of print). Bjørngaard JH, Garratt A, Gråwe R, Bjertnæs ØA, & Ruud T. Scandinavian Journal of Psychology, 2008.

The study compared patient experiences with psychiatric treatment provided by private practitioners and public outpatient clinics. Questionnaires were completed by 642 outpatients in private practice and 6677 outpatients in public clinics. The questionnaire included a measure of patient experiences comprising six items: treatment outcome, enough time for contact and dialogue with clinician, clinicians’ understanding of patient’s situation, suitability of therapy and treatment, clinician follow-up of planned actions, and influence on treatment. Patients in private practice had generally better experiences than patients in public outpatient treatment. The difference between private and public patients was largest for patients with poor self-evaluated mental health or those who had just one consultation in the previous three months. Private practitioners appear to have an important role in mental health services delivery, and patients have relatively good experiences with services. Further studies that assess the patient–clinician interaction in different mental health services may give further insights into potential service improvements.

## 7.4 Summary of paper III

**User satisfaction with child and adolescent mental health services — impact of the service unit level** (Online ahead of print). Bjørngaard JH, Andersson HW, Ose SO, & Hanssen-Bauer K. Social Psychiatry and Psychiatric Epidemiology, 2008.

*Background:* Child and adolescent mental health service units (CAMHS) play an important role in the supply of services to children and adolescents with mental illness. The purpose of this study was to examine the service unit effect on parent satisfaction with outpatient treatment. *Method:* The study was undertaken in 49 of 72 Norwegian outpatient CAMHS in 2004. A total of 2253 parents (87%) responded. Parent satisfaction was measured using two summated scales: clinician interaction/information and treatment outcome. Multilevel analyses were used to assess the contribution of the service units to satisfaction and to investigate patient level predictors of parent satisfaction. *Results:* About 96-98% of the parent satisfaction variance could be attributed to factors within CAMHS, leaving only 2–4% of the variance attributable to the CAMHS level. Parents of patients aged 0–6 years were more satisfied than older patients’ parents. Longer treatment episodes were positively associated with satisfaction. Parents whose children had been referred with externalizing symptoms were less satisfied with treatment outcome than those referred for internalizing symptoms. Waiting time was negatively associated with treatment outcome satisfaction. Adjustments for patient characteristics did not substantially change the relative effect of CAMHS on satisfaction ratings. *Conclusion:* The results indicate that information from user satisfaction surveys has clear limitations as an indicator of CAMHS quality. From a quality improvement perspective, the factors affecting the variance within CAMHS are of dominating importance compared to factors affecting between CAMHS variance.

## 7.5 Summary of paper IV

**The impact of mental illness on patient satisfaction with the therapeutic relationship.** Bjørngaard JH, Ruud T, & Friis S. Social Psychiatry and Psychiatric Epidemiology; 42:803–809, 2007.

*Background:* The relationship between patients and their clinicians is an essential factor in psychiatric treatment. The purpose of this study was to analyse the influence of psychopathology on patient satisfaction with the therapeutic relationship. *Methods:*

Data from 969 patients from 40 different treatment teams collected from eight Norwegian community mental health centres were analysed. Patient satisfaction with the therapeutic relationship was assessed with a six-item scale: sufficient time for contact/dialogue, clinicians' ability to listen and understand, follow-up of planned interventions, respect for patients' views/opinions, cooperation among clinicians, and patients' influence on treatment. Mental illness was assessed using the Health of the Nation Outcome Scales (HoNOS) and the Global Assessment of Functioning (GAF) scale. Diagnoses were established using the International Statistical Classification of Diseases and Related Health Problems–10th revision (ICD-10). Treatment outcomes were clinically assessed retrospectively by rating changes from start of treatment on seven items. Multilevel regression analysis was used for a simultaneous analysis of the contribution of patient and team variables. *Results:* Satisfaction was associated with treatment outcome, better health as assessed using HoNOS, being female, of older age, and having less psychiatric team severity indicated by the teams' mean GAF score. Patients with a schizophrenia spectrum disorder were more satisfied when treated as in- and day-patients, compared with outpatient treatment. Patients in other diagnostic categories were less satisfied with day treatment. *Conclusions:* Patients' perceptions of the therapeutic relationship may be influenced by psychopathology. Teams comprising many patients with severe mental illness may constrain the therapeutic relationship. Hence, resources and organizational measures should be carefully considered in such care units.

### 7.6 Summary of organizational contributions to patient satisfaction

Taken together, the results from this dissertation showed that the different organizational levels contributed little to the explanation of patient satisfaction variance. Table 7.3 summarizes the results of organizational contributions in the various studies (papers I, III and IV). Among adult outpatients (paper I), most of the differences in patient experiences could be attributed to differences between patients rather than to the care unit in which they where treated. About 2–4% of the variance in parent satisfaction could be attributed to the outpatient CAMHS level (paper III), a result consistent with the results from the study reported in paper I. In paper IV, 12% of the variance, when unadjusted for any of the independent variables, could be attributed to the team level. When adjusting for variables such as psychopathology and treatment setting, the between-team variance was reduced from 12% to 2%.

Table 7.3 Organizational contributions to satisfaction with mental health services

| Organizational levels | Paper | ICC% – unadjusted |
|---|---|---|
| Adult outpatient teams | I | 1–2% |
| Adult outpatient clinics | I | 0 |
| Adult health trust | I | 0 |
| Parents in CAMHS | III | 2–4% |
| Adult inpatient, outpatient and day-patient treatment teams | IV | 12% |

Team-level clinician quality scores were not significantly associated with patient experiences in paper I. The results of paper II suggested that patients in private practice have better experiences compared with public outpatients and that this difference in experience varies considerably between patient groups.

Table 7.4 Independent organizational variables and patient satisfaction

| Organizational variables | Paper | P<.05 |
|---|---|---|
| Mean clinician team score, patient treatment scale | I | |
| Mean clinician team score, professional competence scale | I | |
| Mean clinician team score, time adequacy scale | I | |
| Mean clinician team score, work environment scale | I | |
| GAF team mean | IV | IV |
| HoNOS team mean | IV | |
| Outpatient, day-patient, or inpatient treatment | IV | IV[a] |
| Private practice vs outpatient treatment | II | II[b] |

[a] Modified by diagnoses of Schizophrenia spectrum disorders

[b] Modified by self-perceived mental health status and number of visits

The results reported in paper IV suggested higher satisfaction with the therapeutic relationship during inpatient and outpatient treatment than during day-patient treatment, except for patients with Schizophrenia spectrum disorders, who were more satisfied with inpatient and day-patient care. Furthermore, less satisfaction was associated with more severe psychiatric symptomatology in each team.

### 7.7 Summary of individual characteristics and patient satisfaction

These various papers have investigated several possible individual characteristics as determinants of satisfaction (table 7.5). In papers I and II, better patient experiences were significantly associated with female sex, older age, better self-perceived health, longer treatment episodes, and frequent consultations. In addition, in paper I better experiences were significantly associated with no inpatient history and with waiting times being perceived as acceptable.

Table 7.5 Independent variables and patient/parent satisfaction

| Individual variables | Informant | Paper | P<.05 |
|---|---|---|---|
| Socio-demographic characteristics*:* | | | |
| Age | Patient/clinicians | I,II,III,IV | I,II,III,IV |
| Sex | Patient/clinicians | I,II,III,IV | I,II,IV |
| Health status | | | |
| Self-perceived mental health | Patient | I,II | I,II[a] |
| Self-perceived physical health | Patient | I | I |
| Drugs/alcohol abuse | Clinicians | IV | |
| GAF | Clinicians | IV | IV[b] |
| HoNOS | Clinicians | IV | IV |
| Outcome from treatment | Clinicians | IV | IV |
| Schizophrenia spectrum disorders | Clinicians | IV | IV[c] |
| Episode characteristics | | | |
| Episode length | Patient/Clinicians | I,II,III,IV | I,II,III,IV[b] |
| Perceived waiting time | Patient | I | I |
| Actual waiting time | Clinicians | III | III[d] |
| Number of visits | Patient | I,II | I,II[a] |
| Referral status | Clinicians | III | III[d] |

[a] Modified by treatment setting (private practice vs outpatient treatment)

[b] Not statistically significant in the full model

[c] Modified by treatment setting (outpatient vs inpatient, day-patient treatment)

[d] Associated with parent satisfaction with the outcome

In paper II, public patients with more than one consultation in the previous three months had better experiences compared with patients with only one consultation, this difference being significantly smaller for the private patients. Better experiences were clearly associated with better self-perceived mental health for both private and public patients. However, the difference in the total scores for patients’ experiences as private and public patients depended upon the level of self-perceived mental health status. For public patients, there was a clear relationship between self-perceived mental health and the total scores. This relationship was somewhat weaker for patients treated in private practice.

The results from paper III revealed that parents of patients aged 0–6 years were more satisfied than older patients’ parents. Longer treatment periods were positively associated with satisfaction. Parents whose children had been referred with externalizing symptoms were less satisfied with the treatment outcome than those referred for internalizing symptoms. Waiting time was negatively associated with treatment outcome satisfaction.

In paper IV, satisfaction was associated with clinician rated treatment outcome, better health as assessed using HoNOS, being female and being older. Patients with a schizophrenia spectrum disorder were more satisfied when treated as inpatients and day-patients, compared with outpatient treatment. Patients in other diagnostic categories were less satisfied with day treatment.

# 8. Discussion

The main aim of this dissertation was to investigate the extent to which organizational factors are reflected in patient satisfaction ratings, by evaluating the utility of satisfaction measures as indicators of organizational and system quality. The dissertation was based on four empirical papers, which addressed different aspects of patient satisfaction and experiences with mental health services.

Satisfaction scores were skewed towards positive experiences, a result that is consistent with most patient satisfaction studies (2,3,51). However, scale scores ranging from 62 to 78, where 100 was the best possible score, also indicated substantial levels of dissatisfaction among the adult patients and the parents in the CAMHS.

Multilevel regression analyses revealed that patient satisfaction did not vary substantially among outpatient service units. That is, many patients were dissatisfied with the services provided, this dissatisfaction being fairly similar across care units.

Despite small organizational contributions to patient satisfaction, the results presented in this dissertation showed that satisfaction ratings differed systematically between several service characteristics.

## 8.1 Discussion of methodology

### 8.1.1 General comments

Given that patient satisfaction is a subjective measure, ratings will be influenced by differences in both expectations and response style. For instance, Wampold (98) maintained a possible lower patient-level variance in trials because of selection prior to the trial that was based on patient characteristics. Hence, we might have found somewhat higher relative organizational contributions if we had controlled for unmeasured psychological variables at the patient level. On the other hand, the POPEQ scale of information in paper I did not have any significant variance between care units, which indicates that any differences between teams were no greater than would be expected by chance alone.

In paper IV, patients with a diagnosis of schizophrenia were more satisfied with day-patient or inpatient status when compared with outpatient care. In paper II, the difference between private and public patients was largest for patients with poor self-evaluated mental health and those who had received just one consultation in the previous three months. These results indicate that the treatment context is of greater importance for some patients than others. Hence, we can not rule out that there may be unmeasured subgroups of patients for whom the organizational context is of greater importance.

### 8.1.2 Reliability and validity

Reliability refers to the quality of measurement in terms of its ability to reflect a “true score” that is free from random error. Any factor that randomly affects the measurement of a variable will contribute to this random error. In survey research, respondents’ misinterpretations of questions, and respondents’ mood and errors during data recording are sources of such random errors. A random error will have a zero mean and will not produce bias across the entire sample. Reliability is often considered in terms of a measure’s stability and consistency. A measure’s stability refers to the extent to which the same results are obtained when a phenomenon is measured at different time points. A measure’s consistency refers to how similar the results are when different items measure the same construct.

All the scales used as dependent variables showed good internal consistency reliability. Test–retest reliability, which was only assessed for the scales used in paper I, ranged from 0.8 to 0.9. Together with other research (54), this result indicates acceptable to very good stability reliability for patient satisfaction and experiences. Hence, there is no reason to believe that, in general, users of mental health services are any different in their measurement stability than other patient groups.

Validity refers to the quality of measurement in terms of its being free from both random and non-random, or systematic, errors. In other words, does the scale measure what we want it to measure? Validity is of several different types, each with its own meaning (99). Face validity involves a subjective judgement made by the users of the instrument about whether the individual items represent an appropriate range of problems. Content validity refers to the extent to which a measure represents all facets of a given topic, while consensual validity refers to the opinions of experts. Face, content, and consensual validity where established during a rigorous process of instrument development, which included contributions from people with expert knowledge. The construction of the items used in papers I and II also included patients as experts in instrument development, which was not the case for the instruments used in papers III and IV. These instruments were developed and used for the first time in this dissertation. None of the instruments had been assessed for reliability and validity in previous studies.

Criterion-related validity assesses whether instrument scores behave as predicted, according to existing knowledge. This involves comparisons with other variables, such as testing associations with variables known to be correlated with patient satisfaction. Construct validity refers to the psychological meaning of the test scores. The instrument used in paper I, the POPEQ, showed evidence of criterion validity. The scales were extensively tested in association with variables that have been identified as having a consistent association with patient experiences and satisfaction (97). The scales used in paper III and IV, clearly differentiated between satisfied and dissatisfied parents. Furthermore, the scales also distinguished between variables that are known to correlate with user satisfaction.

The process of instrument development, following publication of a validation article (97), is stronger evidence for the reliability and validity of the instrument used in paper I when compared with instruments used in the other papers. Paper II was based on a shorter version of the questionnaire using items selected from the instrument used in paper I.

### 8.1.3 Selection bias

Following the discussion in chapter 5.1 (Figure 5.3), the low response rates in several of the surveys reported in this dissertation could induce bias. Usually, surveys of patient satisfaction with psychiatric services have a low response rate (3). Because a low participation rate is a major concern in patient experience and patient satisfaction research, the results cannot be claimed unequivocally to be representative of all patients. For instance, it has been suggested that patients with more severe mental illness are less likely to participate in patient satisfaction surveys (100). However, in general, the literature has not been conclusive about the consequences of low response rates (101-103).

The highest response rate was achieved for parents in the CAMHS (87%). This high response rate may be explained by a more personalized delivery and collection of the questionnaire at the clinic. Hence, the response rate did not rely on the parents' willingness to spend time and effort returning the questionnaire by post, because they delivered it to the clinic. However, personal contact and interview methods may give less critical answers (51). Because the questionnaires were distributed by the CAMHS, we cannot rule out the possibility of selection bias. For example, in acute or severe situations, it could be interpreted as insensitive to hand out a questionnaire. Furthermore, the respondents were parents who accompanied their children to the clinic. Hence, parents of patients attending the clinic alone were not included.

The response rate was also substantially higher in the private practice sample than in both the national public outpatient sample and the sample from the eight Community Mental Health Centres (56% vs 43% and 39%, respectively). This difference may be explained partly by a more personalized delivery of the questionnaire, which was handed out by the therapist (private patients) instead of being sent by mail (public outpatients). However, the questionnaires were also handed out at the clinic for the patients in the Community Mental Health Centres, where the response rates were fairly similar to those for the public outpatient clinics. It is difficult to interpret the consequences of these differences in response rates, because the clinical information about the non-responders was poor, with the exception of the sample from the Community Mental Health Centres. To some extent, non-responders appeared to represent greater symptom severity and decreased functioning, characterized by lower GAF and HoNOS scores, as well as a greater proportion of patients with a diagnosis of schizophrenia. It is therefore possible that the differences in response rates among private practice patients and the two public samples were, to some extent, due to differences in case mix. If this is the case, one could assume that this would have made the three samples more alike, if there was a selection towards healthier patients responding to the questionnaires. In any case, the low response rates constitute an important limitation of the materials used in this research.

### 8.1.4 Measurement error

It may be that the organizational context of outpatient care delivery is significantly important but that our measures have not been able to capture this possible outcome, as discussed in chapter 5.1 (Figure 5.4). A major problem relates to the fact that questionnaire surveys may underestimate dissatisfaction because patients are unwilling to appear ungrateful or because they accept the limitations of health care delivery (68). The high satisfaction ratings have often been contradicted by the descriptions given by service users in qualitative studies (27). A study by Williams *et al.* (104) revealed that patients frequently described their experiences in positive or negative terms during in-depth interviews. However, many of these differences were not captured using a formally validated and structured patient satisfaction instrument, suggesting that expressions of "satisfaction" hid a variety of reportable negative experiences. Forced alternatives may also constrain the possibility of patients expressing what is most important for them. Qualitative research designs have proved to be more sensitive to patients' elaborative statements (49,105).

Because different instruments were used in this dissertation, the results are less sensitive to the potential weakness of one instrument. Furthermore, the results are also similar to those contained in the literature. Nevertheless, when there is low consensual agreement between patients in their ratings of the same environment, this may indicate that patient satisfaction instruments have limited ability to detect quality deficiencies in a clinical environment. On the other hand, this result may also be due to real within-setting differences. In paper I, it was interesting to note, however, that there were no significant associations between the clinicians' and patients' evaluations of quality.

## 8.2 Discussion of the results

### 8.2.1 Patient satisfaction as an indicator of organizational and system quality

Taken together, the results from this dissertation showed that organizational contributions to user experiences and satisfaction scores are fairly small. Among adult outpatients, most of the differences in patient experiences (98%) could be attributed to differences between patients rather than to the care unit in which they where treated. About 2–4% of the variance in parent satisfaction could be attributed to the outpatient CAMHS level, a result consistent with the study described in paper I.

Among inpatient, day-patient and outpatient teams in community mental health centres, 12% of the variance, when not adjusted for any independent variables, could be attributed to the team level (paper IV), a value that is considerably greater than those found in paper I (about 2%) and paper III (about 2–4%). Teams in community mental health centres provide services with considerable diversity, offering individual therapy, day/group treatment, ambulatory care and some inpatient services, such as short-term crisis intervention units and longer-term rehabilitation units. This may be a reason for the high team-level contribution to satisfaction variance, uncorrected for other variables. When adjusting for variables such as psychopathology and treatment setting, the between-team variance was reduced from 12% to 2%.

Thornicroft and Tansella (99) introduced the “matrix model” as a relevant tool for analysing mental health services. Their analytical framework tried to bridge the gap between different levels of analysis. They maintained that incidents and outcomes are often described primarily at the patient level, but consequences seldom remain at that level. For instance, the catalysts of adverse events may be revealed at different actor levels, such as the patient level, the local level or the regional level. Thornicroft and Tansella indicated that a comprehensive analysis of mental health services must take into account the services’ multicausal and multilevel framework. The results obtained in this dissertation require that attention be focused on an important empirical aspect of this argument. Taken together, administrative units may be meaningful categories for clinicians and health service administrators, but they are not necessarily important contexts for patients. Thus, it is crucially important to determine important contextual levels from a patient’s point of view.

Despite the fairly low impact of organizational factors on patient satisfaction ratings, there is evidence that certain factors contribute to this effect. This dissertation showed that satisfaction ratings were systematically related to service characteristics. The results in papers I, III and IV revealed statistically significant organizational contributions to satisfaction. Hence, the differences between outpatient teams, outpatient CAMHS, and inpatient, outpatient and day-patient teams in community mental health centres are not totally random. From a quality improvement point of view, satisfaction data may be an adequate quality indicator for evaluating alternative approaches to care delivery, including clinical trials. However, when planning an intervention, it is probably better to altering the behaviour within a context of real influence for the outpatients, for instance at the clinician level, rather than the team or clinic level.

In summary, these results indicate a need to analyse further organizational contributions to patient satisfaction and other outcome measures, even if the influence of organizational factors is small. However, cross-sectional comparisons for benchmarking purposes are problematic. As pointed out by Freeman (106), feasible performance indicators must be able to identify poorly performing units (sensitivity), and any units identified as performing poorly must truly be performing poorly (specificity).

Finally, to a large extent, the quality and satisfaction with treatment outcomes may be a consequence of patient factors. For example, research has suggested that highly motivated patients show measurable improvement before their first session with the therapist (107), suggesting that the first step towards behaviour change may lie in just making the appointment. Silber *et al.* (108) found that, to a large extent, treatment outcome from simple surgical procedures was a matter of who is being treated rather than of any of the characteristics of the services providing treatment.

### 8.2.2 The impact of health status on patient satisfaction

Because patients are not randomly allocated to the various care units, differences between units may be influenced by confounding variables, as mentioned in chapter 5.1 (Figure 5.2). The four different papers have investigated several possible individual characteristics as determinants of satisfaction. The most obvious factor for creating bias due to confounding would be the patients' health status and psychopathology.

Following previous findings, the results from papers I and II showed that patients' self-perceived health status was positively associated with patient satisfaction. This association was stronger among patients in public outpatient clinics than patients in private practice (paper II). However, there is reason to be cautious about making causal interpretations of the association between self-perceived mental health status and patient satisfaction. Firstly, good self-perceived mental health may be an indicator of improvement. Hence, the association may be due to treatment outcome rather than to the severity of the illness. Secondly, the validity of the association between self-reported measures of health status and patient satisfaction has been questioned, as the association may be largely due to a generalized response bias (63). That is, response style and daily mood fluctuations may imply that a negative rating on one item in a questionnaire will be followed by a negative response on another item.

However, in paper IV, the association between clinician ratings of patients' health status and patient satisfaction with the therapeutic relationship was assessed. In the multivariate regression model in paper IV, satisfaction was associated with better health as assessed by HoNOS, even when adjusting for the clinician's assessment of treatment outcome. This result suggests that the patients' mood could be affected by the severity of their illness, so that, to some extent, experiences could be coloured by the mental illness itself.

The significant relationship between clinical assessment of treatment outcome and patient satisfaction supports the use of patient-rated outcomes as measures of the clinical utility of treatment. However, further longitudinal studies are required to assess how satisfaction varies with changes in the severity of the mental illness.

The results reported in paper IV suggested that satisfaction with the therapeutic relationship, when controlled for patients' individual levels of mental illness, was negatively associated with more severe psychiatric symptomatology in each team, as measured by the teams' mean GAF score. Therefore, mental health status may influence patient satisfaction, as a characteristic of both the individual patient and the team as an organizational unit. Teams with many severely ill patients may receive poor aggregate ratings for two reasons. Firstly, more severely ill patients tend to be less satisfied. Secondly, a high percentage of severely ill patients may comprise the function of the team.

Furthermore, the analysis in paper IV indicated that people with a diagnosis of schizophrenia were more satisfied with day-patient or inpatient care than outpatient care. This may indicate that patients with a chronic disorder benefit from the close follow-up that occurs in day-patient and inpatient treatment. It is also possible that inpatient and day-patient care provides a social network for people with schizophrenia, which may prevent loneliness, for example. Further studies are required to assess the quality of care in different settings for patients with chronic psychiatric disorders.

However, the measurement of psychopathology in paper IV was performed by the responsible clinician, and not by experts outside the institution. We cannot rule out the possibility that this may have influenced the validity of the psychopathology measures. It is also possible that there could be specific scoring cultures within the teams.

### 8.3 Further research

The growing recognition of patient empowerment is likely to prevail in both mental health provision and research on mental health services (45). Patients, as experts on their own mental illness, are likely to provide information that mental health providers may overlook (5,6,44). However, it is important that the methods used for obtaining patients' views and contributions do not undermine efforts to elicit patient input and involvement in providing mental health research and services. This is particularly important in order to prevent patient empowerment from becoming a buzzword without real influence.

Measurement of patient satisfaction has been criticized from a conceptual viewpoint (34). It has been suggested that its measurement may diminish other approaches to enhancing patient empowerment (63). This dissertation's results indicate that the relevance of patient satisfaction studies is likely to increase if the studies are conducted at meaningful contextual levels. For patients receiving individual therapy, the relationship with the clinician is more likely to be important than the organization in which the care has been provided. Hence, patient satisfaction data are likely to have greater applicability at the clinician level.

The studies in this dissertation did not provide data that permitted an assessment of any change in patient satisfaction during the treatment period. A longitudinal design measuring patient satisfaction at each appointment would have been advantageous, making it possible to analyse individual trajectory curves. One study found considerable intrapatient variance (109), suggesting that patient experiences and satisfaction vary between each care episode. Given the potential impact of the different response styles among patients, future research should assess intrapatient change in satisfaction during a treatment episode; for instance, in order to evaluate alternative approaches to care delivery, including clinical trials.

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# Paper I

Patients' experiences and clinicians' ratings of the quality of outpatient teams in psychiatric care units in Norway.  Bjørngaard JH, Ruud T, Garratt A, & Hatling T. Psychiatric Services; 58: 1102-1107, 2007.

# Patients' Experiences and Clinicians' Ratings of the Quality of Outpatient Teams in Psychiatric Care Units in Norway

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***Objective:*** **Patients' experiences and satisfaction ratings are increasingly used to evaluate quality of care. This study assessed the extent to which outpatient teams, clinics, and health trusts contributed to patients' experiences and to what extent clinicians' evaluations of quality were related to patients' experiences.** ***Methods:*** **A questionnaire was mailed to 15,422 outpatients who attended Norwegian clinics in September 2004; 43% responded. Patients' experiences were measured on an 11-item index and three subscales: outcomes, interaction with clinicians, and information. Aggregated responses from clinicians were linked to the data on patients' experiences. Multilevel analyses were used to divide the variance between the different organizational levels and to assess the relationship with clinicians' opinions and individual-level factors.** ***Results:*** **Data were analyzed for 6,570 outpatients within 222 teams derived from 89 outpatient clinics within 33 health trusts. Differences in patients' scores were determined largely at the patient level, with teams accounting for 2% of the total variance and organizational levels of clinics and health trusts not contributing to patients' experiences. Team-level clinician quality scores were not significantly associated with patients' experiences. Better experiences were significantly associated with patients' female gender, older age, better self-perceived health, absence of an inpatient history, longer treatment episodes, frequent consultations, and waiting times perceived as acceptable.** ***Conclusions:*** **The organizational contributions to patients' experience scores were minimal. Although clinicians' ratings of quality are not a substitute for patients' perceptions of quality, surveys of outpatients' experiences and satisfaction may not be appropriate for cross-sectional comparisons of health care providers. (*Psychiatric Services* 58:1102–1107, 2007)**

Patients' ratings of their experiences and satisfaction with health services are a frequently used indicator of service quality (1). However, there is a limited understanding of how psychiatric units contribute to patients' perceptions of quality (2). It has been suggested that patients' satisfaction is associated with compliance and health outcome (1,3) and that its measurement may raise issues that the providers of services often fail to identify (4). Others have maintained that providers and patients view quality differently (5) and that both views must be considered for quality assessment. However, there is a limited understanding of the relationship between clinicians' and patients' perceptions of quality. Studies of patient satisfaction have been criticized for providing a limited picture of user views (6). Other researchers have maintained that conclusions from patient satisfaction studies are often based on weak methodological premises (7).

Several studies have linked differences in patients' experiences and satisfaction to expectations, health status, and other patient characteristics (8). The link between patient satisfaction and organizational attributes is less well understood (2,9). Although it has been suggested that patient satisfaction is related to the quality of services at different organizational levels, few studies have used a multilevel framework where the variance is partitioned among different levels. Multilevel analysis is an an-

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alytical approach increasingly used to investigate the relative effect of different organizational levels (10).

Findings from the United States suggest that satisfaction in somatic general medical and surgery units is primarily determined at both the patient and episode-of-care levels, with the care unit or department level accounting for less than 1% of the total variance (11). A Norwegian somatic study found significant ward-level variance (approximately 1%) in inpatients' experience of information provided (9). An Italian study of patients receiving diabetes care from either general practitioners or diabetes outpatient clinics found that approximately 4% of the variance in satisfaction was due to the setting of care or care at the physician level (12). An English study of patient satisfaction within 14 general practices found that 2%–7% of the variance occurred at the practice and physician levels of care, with the remainder due to differences between patients (13). A Dutch study found that between 5% and 10% of the variation in patient satisfaction was due to the practice or general practitioner (14).

Within mental health, a U.S. study found that differences across group-based psychosocial rehabilitation teams accounted for 10%–25% of the variance across four satisfaction scales (15), a result substantially different from the other studies cited above. It remains equivocal, however, as to whether the results from the U.S. study are due to the mental health context or to the specific profile of psychosocial rehabilitation teams. We are not aware of other studies within mental health that have assessed the specific contribution of organization level to patients' experiences. Psychiatric services are widely provided as outpatient treatment, and their impact on patients' experiences requires further study.

This study addressed the feasibility of using patients' experience ratings as a measure of organizational quality by using data from a national survey of outpatients and clinicians from Norwegian mental health services. In Norway, the state is responsible for specialized health services, which are delivered through five regional health authorities. Within each regional health authority, mental health services, such as community mental health centers and hospital-based services, are provided by health trusts. Outpatient clinics with various teams are a part of the community mental health centers. The outpatient clinics provide psychiatric services for a given population, and their teams can be defined as the lowest organizational care unit.

This study addressed two questions. The first relates to the amount of variance in patients' experiences that the different levels of care—outpatient teams, clinics, and health trusts—are able to explain. The second compares clinicians' assessment of quality with patients' experiences.

## Methods

### *Data collection*

All 15,422 persons aged 18 years or older who received services from mental health outpatient clinics in Norway in September 2004 were mailed a questionnaire within the following month. Patients were asked to rate their experience with regard to their most recent treatment episode.

The procedure regarding informed consent, study design, and collection of data was approved by the Norwegian Regional Committee for Medical Research Ethics, the Data Inspectorate, and the Norwegian Board of Health.

Patients' assessments of quality of care were collected via the Psychiatric Out-Patient Experiences Questionnaire (POPEQ). The POPEQ was developed after a literature review, interviews with patients, and pretesting of questionnaire items (16). Factor analysis and tests of item-discriminant validity provided empirical support for an index of overall experiences, as well as for three subscales, which also have a theoretical basis. The outcome scale comprises three items: outcome from conversations with the professional, overall treatment outcome, and change in psychological problems. The scale for assessing interaction with clinicians comprises six items: enough time for contact and dialogue, understanding, therapy and treatment suitability, follow-up actions carried out, communication, and say in treatment. The information scale comprises two items: information about treatment options and psychological problems.

The POPEQ has good evidence for reliability and validity. Item-versus-total correlations ranged from .5 to .8. Cronbach's alpha and test-retest reliability estimates exceeded the criterion of .7, with most being over .8 and POPEQ total scores over .9. Construct validity was supported by the results of 128 tests (16). The POPEQ scales, which are scored 0–100, where 100 is the best possible experience of care, are the dependent variables in the analyses that follow.

A questionnaire assessing clinicians' view of care was mailed to the clinicians via all mental health outpatient clinics in Norway in the beginning of September 2004. The questionnaire comprises four scales. Patient treatment has a Cronbach's alpha of .79 and six items: patient assessment, content of patient records, content of the discharge reports, closure of treatment episodes, the patient's influence in treatment, and overall evaluation of patient treatment. Professional competence has an alpha of .60 and two items: professional justifiable treatment and adequate competence in patient treatment. Time adequacy has an alpha of .66 and three items: the clinician's evaluation of having adequate time for each patient and for skills upgrading and ability to prioritize between important tasks. Work environment has an alpha of .90 and includes eight items: work environment, admission policy, collaboration between therapists, meetings, professional management, administrative management, personnel management, and job satisfaction. The scales are scored 0–100, where 100 is the best possible score.

### *Statistical analyses*

The material was divided into four hierarchical levels: health trusts, outpatient clinics, teams, and patients. For outpatient clinics not divided into teams, the clinic and team level are the same. In accordance with previous studies, we hypothesized that most of the variance in patients' experiences would be between patients but that there would also be a significant contribution of the care unit to patients' experiences (9,11–15). Mean team-level clinician index scores on the four scales were linked to the patients' experiences data.

The team-level mean clinician scores formed the independent variables. To control for differences in patient characteristics across the care settings, patient-level variables known to be related to patients' experiences and satisfaction were included in the analysis (8,16,17). These included age and gender, self-reported mental and physical health, duration of treatment, former inpatient history, number of visits in the past three months, and perceived waiting time.

Patients rated their experiences on the basis of shared environments, such as teams, outpatient clinics, and health trusts; therefore, analyses were performed using multilevel regression analyses (18), with the statistical program MlWin. The dependent variables were treated as continuous variables, and linear regression analyses were performed.

The regression intercepts were allowed to vary randomly across higher-level units, such as teams, outpatient clinics, and health trusts, thus making it possible to estimate the variance attributed at different levels (18). It is possible to test whether the variance at a given level is significantly larger than what could be expected by chance alone. The intraclass correlation coefficient (ICC) is a measure of the degree of agreement between, for example, patients who received treatment at the same clinical unit (18). If, for instance, there is no concordance between patients within care units, then the ICC is zero, whereas if all patients score the same value at each care unit, then the ICC equals one. When the ICC is multiplied by 100, it can be interpreted as the percentage of variance attributed to the unit level of care.

***Table 1***

Characteristics of patients surveyed about their experiences in a psychiatric care unit in Norway

| Variable | N | % | M | SD |
|---|---|---|---|---|
| Age | 6,570 | 100 | 39.5 | 12.3 |
| Self-evaluated mental health[a] | 6,442 | 98 | 1.1 | .9 |
| Self-evaluated physical health[a] | 6,462 | 98 | 1.7 | 1.1 |
| Gender | | | | |
| Male | 2,104 | 32 | | |
| Female | 4,466 | 68 | | |
| Duration of treatment episode | | | | |
| <1 month | 201 | 3 | | |
| 1–6 months | 2,076 | 32 | | |
| >6 months | 4,155 | 65 | | |
| Former inpatient history | | | | |
| No | 4,077 | 63 | | |
| Yes | 2,370 | 37 | | |
| More than 1 consultation in the past 3 months | | | | |
| No | 483 | 8 | | |
| Yes | 5,891 | 92 | | |
| Had to wait to see the physician | | | | |
| No | 4,763 | 74 | | |
| Yes | 1,663 | 26 | | |
| Psychiatric Out-Patient Experiences Questionnaire scores[b] | | | | |
| Total | 6,555 | 100 | 68.7 | 18.3 |
| Outcome | 6,544 | 100 | 70.2 | 20.8 |
| Clinician interaction | 6,516 | 99 | 69.9 | 18.6 |
| Information | 6,227 | 95 | 62.3 | 27.4 |
| Clinician team scores[b] | | | | |
| Patient treatment | 158 | 71 | 73.2 | 7.2 |
| Professional competence | 158 | 71 | 80.1 | 8.2 |
| Time adequacy | 158 | 71 | 45.5 | 11.8 |
| Work environment | 158 | 71 | 75.0 | 12.2 |

[a] Possible scores range from 0, poor, to 4, excellent.

[b] Possible scores range from 0, worst possible, to 100, best possible.

## Results

Patients receiving outpatient treatment within an inpatient setting were excluded from the analyses, which gave 6,570 (43% response rate) patients from 222 outpatient teams across 89 outpatient clinics of the 33 health trusts as respondents for this study. Compared with nonrespondents, respondents were more likely to be older and female (16). Questionnaires were returned by 1,688 clinicians. The anonymous method of data collection did not permit the calculation of the response rate for the entire sample, but in a subsample of outpatient clinics, 906 out of 973 (93%) responded to the questionnaire. It was possible to link aggregated information at the team level for 158 outpatient teams with the experiences of 5,542 patients.

Table 1 shows that the mean±SD age of patients was 39.5±12.3 years and that 68% of the sample were female. POPEQ total, outcome, and clinicians' interaction scores were close to 70, whereas the information score was about 62. The team mean clinician score ranged from 45 to 80.

Table 2 shows the variance in patients' experiences that were attributable to each of the four levels of analysis, without any other explanatory variables. The POPEQ scores were partitioned into patient level, team level, clinic level, and health trust level of care. There was significant variance between teams but not between outpatient clinics or between health trusts. However, two-level models including the patients and clinics, or the patients and health trust levels separately, showed small but significant variance at both the clinic and health trust levels.

Just 2% of the differences in the POPEQ total, outcome, and clinician interaction subscale scores were attributable to the team level, with 98% attributed to the patients' variance within teams. POPEQ scores for the information scale did not vary significantly between any of the care unit levels; that is, there was no organiza-

**Table 2**

Intraclass correlation coefficients (ICCs, in percentages) of Psychiatric Out-Patient Experiences Questionnaire (POPEQ) scores at the patient, team, outpatient clinic, and health trust levels

| | Patients | | Team | | Outpatient clinic | | Health trust | |
|---|---|---|---|---|---|---|---|---|
| POPEQ scale | ICC | p | ICC | p | ICC | p | ICC | p |
| Total score | 98 | <.001 | 2 | .009 | 0 | .295 | 0 | .316 |
| Outcome | 98 | <.001 | 2 | .01 | 0 | .496 | 0 | .309 |
| Clinician interaction | 97 | <.001 | 2 | .006 | 0 | .276 | 0 | .259 |
| Information | 99 | <.001 | 1 | .076 | 0 | .494 | 0 | .212 |

tional contribution to the variance in this scale.

Table 3 shows parameter estimates and p values for the independent variables. With this analysis no additional variance remained between clinics or health trusts; therefore, we used two-level models, namely patients within teams. The models in Table 3 comprise patient- and team-level variables. There was a significant team-level variance, hence independent variables for care unit were used at the team level. The teams contributed 1%–2% of the variance in POPEQ scores after the analyses controlled for patient- and team-level characteristics. There were no significant associations between any of the clinician indices and the POPEQ scales.

There was a significant concave, curvilinear association between age and POPEQ scores, with older patients having better experiences. Women reported significantly better experiences than men for all POPEQ scores, with the exception of the information scale. Higher self-reported mental and physical health were significantly associated with better experiences, the former association being concave curvilinear and the latter being linear.

There was a significant correlation between duration of the current treatment episode and POPEQ scores. This was strongest for the outcome scale, where patients whose

**Table 3**

Multilevel regression analyses of the Psychiatric Out-Patient Experiences Questionnaire's total, outcome, clinician interaction, and information scales

| | Total score (N=5,182) | | Outcome (N=5,182) | | Clinician interaction (N=5,159) | | Information (N=4,936) | |
|---|---|---|---|---|---|---|---|---|
| Variable | B | p | B | p | B | p | B | p |
| Clinician team score | | | | | | | | |
| Patient treatment scale | .06 | .333 | .07 | .31 | .08 | .235 | –.03 | .742 |
| Professional competence scale | –.02 | .668 | –.08 | .17 | –.02 | .743 | .06 | .433 |
| Time adequacy scale | .01 | .851 | .01 | .775 | .00 | .977 | .03 | .537 |
| Work environment scale | .00 | .952 | .02 | .71 | –.01 | .766 | .03 | .58 |
| Patient-level variable | | | | | | | | |
| Age/10 | 2.39 | <.001 | 1.83 | <.001 | 1.73 | <.001 | 5.56 | <.001 |
| Age/$10^2$ | –.50 | <.001 | –.50 | <.001 | –.44 | <.001 | –.75 | <.001 |
| Women compared with men | 3.08 | <.001 | 3.79 | <.001 | 3.11 | <.001 | 1.31 | .096 |
| Self-evaluated mental health | 7.76 | <.001 | 12.17 | <.001 | 5.31 | <.001 | 8.51 | <.001 |
| (Self-evaluated mental health)$^2$ | –1.11 | <.001 | –2.17 | <.001 | –.55 | .012 | –1.32 | <.001 |
| Self-evaluated physical health | 1.53 | <.001 | 1.74 | <.001 | 1.41 | <.001 | 1.43 | <.001 |
| Treatment episode, 1–6 months versus <1 month | 6.78 | <.001 | 8.92 | <.001 | 6.17 | <.001 | 3.93 | .085 |
| Treatment episode, >6 months versus <1 month | 11.97 | <.001 | 17.25 | <.001 | 10.72 | <.001 | 6.41 | .004 |
| Former inpatient history versus none | –3.20 | <.001 | –1.95 | <.001 | –3.31 | <.001 | –4.86 | <.001 |
| >1 visit versus 1 visit in the past 3 months | 9.62 | <.001 | 9.95 | <.001 | 9.78 | <.001 | 7.27 | <.001 |
| Did not wait for treatment versus had to wait | 4.09 | <.001 | 3.67 | <.001 | 3.77 | <.001 | 6.18 | <.001 |
| Variance estimate | | | | | | | | |
| Team-level variance | 3.79 | .002 | 3.38 | .012 | 5.60 | <.001 | 3.33 | .085 |
| Patient-level variance | 256.03 | <.001 | 320.74 | <.001 | 278.48 | <.001 | 646.69 | <.001 |
| Intraclass correlation coefficient, team (%) | 1 | | 1 | | 2 | | 1 | |

treatment was longer than six months had better experiences compared with those in treatment for less than one month, with a difference of approximately 17 scale points. Former inpatients reported significantly poorer POPEQ scores than patients who had not been inpatients. Patients with more than one visit over the past three months had better experiences for all POPEQ scores. Patients who felt that they had to wait for treatment reported poorer POPEQ scores.

## Discussion

We found that most of the differences in patients' experiences, as measured by the POPEQ, could be attributed to differences between patients rather than the care unit in which they were treated. There was some significant variance between teams but no independent variance between outpatient clinics or between trusts.

The marginal difference that was found between care units might lead to the suggestion that measures of patients' experiences and satisfaction lack the discriminatory power necessary for comparison at the organizational level, including mental health institutions. However, it is also possible that the care provided at this level is fairly uniform across organizations. Policies or guidelines that are being followed by trusts and outpatient clinics may lead to small quality differences at the organizational level. Studies of outpatient treatment have, however, found considerable variation between clinicians in their response to clinical guidelines (19).

It has been argued that many patient satisfaction studies lack reliability and validity, which casts doubt on the credibility of the findings (20). The questionnaire used in this study, the POPEQ, has good reliability and validity in terms of its power to discriminate between different groups of patients (16). However, the POPEQ did not measure substantial differences at the organizational level, even if there was a large total variance in the scale scores. In fact, the POPEQ scale of information had the largest total variance but did not have any significant variance between care units. That is, many patients were dissatisfied with the information provided, but this dissatisfaction was similar across care units. It follows that the large total variance in scores was not necessarily measuring quality differences in the environment that provided the treatment.

The results from this study draw attention to what may be defined as a substantial environmental context for patients. Administrative units, such as clinics, may be meaningful categories for clinicians and health service administrators in organizing services but not for assessing differences in patients' experiences. Within Norwegian mental health outpatient clinics, most patients receive individual therapy with only one clinician, and the patients have little contact with other patients in the same care units. These factors may explain why we found only minor differences between teams, whereas a study of psychosocial rehabilitation teams found 10%–25% contextual variance (15), indicating teams that work more coherently than our general outpatient teams. The low variance at the care unit level could be due to large individual practice differences within each unit and across all units. The therapist effect on treatment outcome is shown to be of high importance, as is the patient-clinician alliance (21). We were not able to assess patients' experiences for individual clinicians. Further studies are needed to determine the variance in patient satisfaction between clinicians compared with that between teams.

The results showed that almost all of the variance in patients' experiences could be attributed to differences between patients. However, we did not have data that allowed us to assess any change in patients' experiences during the treatment period. One study found considerable within-patient variance (11), which suggests that patients' experiences and satisfaction vary between each episode of care. Given that most mental health outpatients have several consultations, further analyses are needed to understand more about changes in patients' experiences during the treatment period.

Our study found low concordance between the quality perceived by the clinicians in teams and by the patients receiving care from the same teams, which may be a consequence of the low team-level variance in patients' ratings. This finding is in contrast to other findings of clinicians' confidence in the results of patients' experiences and satisfaction studies (22). On the other hand, the low concordance may indicate that patients' and clinicians' evaluations are different and that both may contribute to the understanding of quality differences from separate viewpoints (5). This result could also indicate that clinicians buffer problems in their work environment in order to secure adequate treatment for their patients. That is, clinicians do not let their perceptions of the professional quality, competence, time adequacy, and work environment influence treatment quality, as perceived by the patients. Other studies have also reported weak or nonexistent associations between average levels of provider ratings and patients' experiences (23). One found a weak but significant association for one of several different items and scales that measured the average level of nurses' job satisfaction at the ward level and patients' experience with information (9). Another showed a significant relationship with team burnout as experienced by the clinicians and patients' satisfaction (15).

Similar to previous findings, age was positively associated with patients' experiences, and women reported better experiences than men (8,16). Health status was positively associated with patients' experiences (8,24,25). Both the frequency and duration of the current treatment episode were related to higher POPEQ scores. Former inpatients reported poorer experiences. Perceived longer waiting times were negatively related to patients' experiences (17).

The modest response rate from patients should be taken into consideration. Low response rates are a problem in mental health user surveys (26–28), and the response rate for the POPEQ was consistent with previous findings. The literature in general is not conclusive on the consequences of low response rates (29–31).

## Conclusions

Aggregated results from surveys of patients' experiences and satisfaction of outpatients have limitations as a single indicator of organizational quality. Administrative units, such as teams and clinics, may not represent important environmental contexts for patients receiving care. For patients receiving individual therapy, the relationship with the clinician is likely to be more important than the organization in which the care has been provided. The results of this study suggest that patients' experiences and satisfaction data are likely to have greater applicability at the clinician level. Future research should assess intrapatient change in satisfaction during a treatment episode, for instance, for purposes of evaluating alternative approaches to care delivery, including clinical trials. Provider ratings of quality cannot be substituted for patients' perceptions of quality but should also be considered when service quality is measured.

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# Paper II

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## Paper IV

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## Appendixes

I. **Questionnaire to patients aged 18 years or older who received services from outpatient clinics in Norway in September 2004.**
II. **Questionnaire to patients receiving treatment by private practitioners in the central part of Norway during a two-week period in September 2004.**
III. **Questionnaire to parents whose children had received at least one previous consultation in Child and Adolescent Mental health Services. Delivered at appointment during 19 days in May 2004 in 49 service units.**
IV. **Questionnaire to patients in eight Community Mental Health Centres over a four week period in February–Mars 2005.**

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# Hva er erfaringene dine som bruker av poliklinikk i psykisk helsevern?

Hensikten med denne undersøkelsen er at tjenestene skal bli bedre for brukere av poliklinikker i det psykiske helsevernet. Vi vil derfor gjerne høre om *erfaringene dine med den poliklinikken du for tiden går til*.

Sett kun ett kryss på hvert spørsmål. Det er fint om du kan krysse av midt i rutene. Spørreskjemaet sender du tilbake til Nasjonalt kunnskapssenter for helsetjenesten. Returkonvolutten er ferdig adressert og Kunnskapssenteret betaler portoen. Alle svar blir behandlet fortrolig.

**VIKTIG**: Dersom du samtykker til å delta i undersøkelsen, er det viktig at du krysser av i ruten under.

☐ JA, jeg samtykker i å delta i undersøkelsen slik den er beskrevet i følgebrevet fra Kunnskapssenteret.

**1. Alt i alt, hvor fornøyd eller misfornøyd er du med tilbudet du har mottatt ved poliklinikken?**

| Svært misfornøyd | Ganske misfornøyd | Både og | Ganske fornøyd | Svært fornøyd |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

**2. Alt i alt, hvordan er erfaringene dine med tilbudet ved poliklinikken?**

| Mye dårligere enn forventet | Noe dårligere enn forventet | Som forventet | Noe bedre enn forventet | Mye bedre enn forventet |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

## Erfaringer med poliklinikken

3. **Måtte du vente for å få tilbud ved poliklinikken?**

| Nei | Ja, men ikke lenge | Ja, ganske lenge | Ja, altfor lenge |
|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ |

4. **Hvor lenge har du hatt tilbud ved denne poliklinikken?**

| Under 1 måned | Fra 1 til 6 måneder | Fra 7 til 12 måneder | Fra 13 måneder til 3 år | Mer enn 3 år |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

5. **Hvor mange ganger i løpet av de siste 3 månedene har du hatt poliklinikktime? (Svar også hvis du har gått til poliklinikken kortere enn 3 måneder.)**

| Bare én gang | 2-5 ganger | 6-12 ganger | Mer enn 12 ganger |
|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ |

6. **Hva synes du om antall behandlingstimer du har fått ved poliklinikken?** (Sett kun ett kryss.)

| Passe antall timer | Litt for få timer | Altfor få timer | Har ikke ønsket konsultasjoner |
|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ |

7. **Har det vært vanskelig eller lett å få kontakt med ansatte ved poliklinikken på telefon?**

| Svært vanskelig | Ganske vanskelig | Både/ og | Ganske lett | Svært lett | Har ikke forsøkt å ringe |
|---|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

8. **Har du blitt møtt med høflighet og respekt ved poliklinikken?**

| Ikke i det hele tatt | I liten grad | I noen grad | I stor grad | I svært stor grad |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

**9. Hvilken behandling mener du at du har behov for ved poliklinikken? (**Du kan sette flere kryss.)

| Behandling med medisiner | Samtaler med én behandler | Samtaler i gruppe | Samtaler hvor dine nærmeste deltar | Treningsopplegg for å mestre plagene dine |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

**10. Hvilken behandling har du mottatt ved poliklinikken? (**Du kan sette flere kryss.)

| Behandling med medisiner | Samtaler med en behandler | Samtaler i gruppe | Samtaler hvor dine nærmeste deltar | Treningsopplegg for å mestre plagene dine |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

**11. Hvilket utbytte har du hatt av følgende behandlingsformer ved poliklinikken? (**Sett kun ett kryss per linje.)

| | Ikke noe utbytte | Lite utbytte | En del utbytte | Stort utbytte | Svært stort utbytte | **Ikke mottatt** |
|---|---|---|---|---|---|---|
| **Behandling med medisiner** | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| **Samtaler med en behandler** | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| **Samtaler i gruppe** | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| **Samtaler hvor dine nærmeste deltar** | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| **Treningsopplegg for å mestre plagene dine** | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

**12. Hvilket utbytte har du hatt, alt i alt, av behandlingen ved poliklinikken?**

| Ikke noe utbytte | Lite utbytte | En del utbytte | Stort utbytte | Svært stort utbytte |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

**13. Er dine psykiske plager blitt bedre eller verre nå, sammenlignet med før behandlingen startet ved poliklinikken?**

| Mye bedre | Litt bedre | Verken bedre eller verre | Litt verre | Mye verre |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

**14. Spørsmålene nedenfor gjelder den behandleren du vanligvis går til:**
**(**Sett kun ett kryss per linje.)

| | Ikke i det hele tatt | I liten grad | I noen grad | I stor grad | I svært stor grad |
|---|---|---|---|---|---|
| **Får du nok tid til samtaler og kontakt med behandleren din?** | ☐ | ☐ | ☐ | ☐ | ☐ |
| **Opplever du at behandleren din forstår din situasjon?** | ☐ | ☐ | ☐ | ☐ | ☐ |
| **Opplever du at behandlingen din er tilpasset din situasjon?** | ☐ | ☐ | ☐ | ☐ | ☐ |
| **Følger behandleren din opp tiltak som planlagt?** | ☐ | ☐ | ☐ | ☐ | ☐ |

**15. Har du fått fortalt behandleren det som er viktig for deg om tilstanden din?**

| Ikke i det hele tatt | I liten grad | I noen grad | I stor grad | I svært stor grad |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

**16. I hvilken grad har du hatt innflytelse på valg av behandlingsopplegg?**

| Ikke i det hele tatt | I liten grad | I noen grad | I stor grad | I svært stor grad |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

**17. I hvilken grad har du ønsket innflytelse på valg av behandlingsopplegg?**

| Ikke i det hele tatt | I liten grad | I noen grad | I stor grad | I svært stor grad |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

**18. Hvordan har behandleren samarbeidet med dine pårørende?**

| | | | | | |
|---|---|---|---|---|---|
| Svært dårlig | Ganske dårlig | Både/ og | Ganske bra | Svært bra | Ikke aktuelt |
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

**19. Har du hatt den behandleren du ønsker deg?**

| | | |
|---|---|---|
| Ja | Nei | Har ikke noen spesielle ønsker |
| ☐ | ☐ | ☐ |

**20. Hva synes du om informasjonen du har fått om de behandlingsmulighetene som finnes for deg?**

| | | | | | |
|---|---|---|---|---|---|
| Svært dårlig | Ganske dårlig | Både/ og | Ganske bra | Svært bra | Ingen mening |
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

**21. Hva synes du om informasjonen du har fått om dine psykiske plager/din diagnose?**

| | | | | | |
|---|---|---|---|---|---|
| Svært dårlig | Ganske dårlig | Både/ og | Ganske bra | Svært bra | Ingen mening |
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

| | Ja | Nei |
|---|---|---|
| **22. Har du fått informasjon om klagemuligheter på behandlingen (fylkeslege, kontrollkommisjon og pasientombud)?** | ☐ | ☐ |
| **23. Har du fått informasjon om din rett til innsyn i journalen din?** | ☐ | ☐ |

**24. Har medisinene mot dine psykiske plager blitt skrevet ut av lege på poliklinikken eller av andre leger?**

| Lege på poliklinikken | Av andre leger | Bruker ikke medisiner mot psykiske plager |
|---|---|---|
| ☐ | ☐ | ☐ |

**25. Har du hatt innflytelse på medisineringen din?**

| Ikke i det hele tatt | I liten grad | I noen grad | I stor grad | I svært stor grad | Bruker ikke medisiner mot psykiske plager |
|---|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

**26. Har du ønsket å ha innflytelse på medisineringen din?**

| Ikke i det hele tatt | I liten grad | I noen grad | I stor grad | I svært stor grad | Bruker ikke medisiner mot psykiske plager |
|---|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

**27. Hva synes du om informasjonen du har fått om bivirkninger av medisiner som du har begynt å bruke på poliklinikken?**

| Svært dårlig | Ganske dårlig | Både/ og | Ganske bra | Svært bra | Bruker ikke medisiner mot psykiske plager |
|---|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

**28. Hvordan synes du poliklinikken har samarbeidet med ulike offentlige etater for å hjelpe deg med dine praktiske problemer (økonomiske problemer, bosted, praktiske løsninger osv.)?**

| Svært dårlig | Ganske dårlig | Både/ og | Ganske bra | Svært bra | Vet ikke/ Ikke aktuelt |
|---|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

**29. Har behandlingen ved poliklinikken skjedd frivillig, eller har du følt deg tvunget til å delta?**

| | | | | |
|---|---|---|---|---|
| Helt frivillig | Ganske frivillig | Både/ og | Ganske tvunget | Helt tvunget |
| ☐ | ☐ | ☐ | ☐ | ☐ |

**30. Har du blitt behandlet nedlatende eller krenkende ved poliklinikken?**

| | | | |
|---|---|---|---|
| Nei, aldri | Ja, én gang | Ja, noen ganger | Ja, ofte |
| ☐ | ☐ | ☐ | ☐ |

## Tidligere erfaringer med helsetjenesten og bakgrunnsspørsmål

**31. Har du noen gang vært innlagt på en psykiatrisk døgninstitusjon?**

| | | |
|---|---|---|
| Nei, aldri | Ja, én gang | Ja, mer enn én gang |
| ☐ | ☐ | ☐ |

**32. Alt i alt, hva synes du om den hjelpen du har fått fra helsetjenesten med dine psykiske plager?**

| | | | | |
|---|---|---|---|---|
| Svært dårlig | Ganske dårlig | Både/ og | Ganske bra | Svært bra |
| ☐ | ☐ | ☐ | ☐ | ☐ |

**33. Stort sett, vil du si din *fysiske* helse er:**

| | | | | |
|---|---|---|---|---|
| Utmerket | Meget god | God | Nokså god | Dårlig |
| ☐ | ☐ | ☐ | ☐ | ☐ |

**34. Stort sett, vil du si din *psykiske* helse er:**

| | | | | |
|---|---|---|---|---|
| Utmerket | Meget god | God | Nokså god | Dårlig |
| ☐ | ☐ | ☐ | ☐ | ☐ |

**35. Er du mann eller kvinne?**

| | |
|---|---|
| Kvinne | Mann |
| ☐ | ☐ |

**36. Hva er din alder?** (Antall år)

☐☐

**37. Er du gift eller samboende?**

| | |
|---|---|
| Ja | Nei |
| ☐ | ☐ |

**38. Hva er din høyeste fullførte utdanning?**

| | | | |
|---|---|---|---|
| Grunnskole | Videregående skole | Høyskole eller universitet inntil 4 år | Høyskole eller universitet 4 år eller mer |
| ☐ | ☐ | ☐ | ☐ |

**39. Hva er det første språket du lærte?**

| | | | | |
|---|---|---|---|---|
| Norsk | Samisk | Annet nordisk språk | Annet europeisk språk | Ikke-europeisk språk |
| ☐ | ☐ | ☐ | ☐ | ☐ |

**40. Hvordan er din nåværende bosituasjon?** (Sett kryss ved ett eller flere alternativer.)

| | | | | | |
|---|---|---|---|---|---|
| Bor alene | Bor sammen med barn | Bor sammen med ektefelle/ samboer | Bor sammen med foreldre/ søsken/andre | Bor i omsorgsbolig, sykehjem, bofellesskap eller lignende | Annet |
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

**41. Hva gjør du til daglig? (**Sett kun ett kryss.)

| | | | | | | |
|---|---|---|---|---|---|---|
| Yrkesaktiv | Sykemeldt | Uføretrygdet | På attføring/ rehabiliteringspenger | Under utdanning | Arbeidsledig | Annet |
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

**42. Kunne du tenke deg å svare på et nytt spørreskjema om kort tid, dersom det blir aktuelt? Sett kryss i ruten under dersom du kunne tenke deg det.**

| |
|---|
| Ja, jeg kunne tenke meg å svare på et nytt spørreskjema |
| ☐ |

**Skriv gjerne ned kommentarer til skjemaet eller utdypninger av dine erfaringer her:**

*Tusen takk for at du tok deg tid til å svare!*

HELSE MIDT-NORGE

SINTEF

# Undersøkelse om pasienters erfaringer med henvising og behandling hos privatpraktiserende spesialister

Hensikten med denne undersøkelsen er at tjenestene skal bli bedre for brukere av privatpraktiserende spesialister (psykologer og psykiatere) i Midt-Norge. Vi vil derfor gjerne høre **din** erfaring med å bli henvist til slik behandling. Undersøkelsen utføres av SINTEF Helse på oppdrag fra Helse Midt-Norge. Alle svar er anonyme. Det betyr at du ikke skal oppgi personidentifiserbare opplysninger.
Din behandler vil ikke få tilgang på de utfylte skjemaene.

## VIKTIG

Dersom du samtykker til å delta i undersøkelsen, er det viktig at du krysser av i ruten under.

☐ **JA, jeg samtykker i å delta i undersøkelsen.**

## INFORMASJON

Svarene leses inn maskinelt. Det er derfor viktig at du krysser av **inne** i ruten.
Det er fint om du kan svare på spørreskjemaet og returnere det til SINTEF i løpet av en uke.
Svaret legges i returkonvolutten, som er ferdig adressert og med porto betalt.

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## ERFARING MED HENVISNING

**1. Hvem henviste deg til privatpraktiserende spesialist?** *(Sett ett kryss)*

☐ Fastlegen
☐ Annen lege
☐ Behandler ved poliklinikk
☐ Behandler ved psykiatrisk sykehusavdeling/klinikk
☐ Andre *(spesifiser)*: ..................................................................................................

**2 a. Hvorfor ble du henvist til privatpraktiserende spesialist og ikke til offentlig poliklinikk?**
*(Sett ett eller flere kryss)*

☐ Etter eget ønske
☐ Etter fastlegens/legens ønske eller anbefaling
☐ Poliklinikken hadde ikke kapasitet
☐ Andre

**2 b. Hvis du er henvist etter eget ønske - hva var grunnene til dette?** *(Sett ett eller flere kryss)*

☐ Behandling hos privat spesialist er mer anonymt enn på offentlig poliklinikk
☐ Jeg tror at jeg får bedre behandling
☐ Det er mer fleksibelt mht samtaletidspunkt (f.eks. på ettermiddag eller kveld)
☐ Det passer meg bedre fordi det er kort vei å reise
☐ Jeg har fått det anbefalt av andre (slekt, venner eller andre)
☐ Jeg synes ikke at jeg er så syk at jeg trenger å gå til offentlig poliklinikk
☐ Andre grunner *(spesifiser)*: ..................................................................................................

**3 a. Var det du selv som fant frem til en spesialist som du kunne henvises til (f eks ved å kontakte spesialistene)?** *(Sett ett kryss)*

☐ Ja ☐ Nei

**3 b. Hvis ja – kryss av for hva du måtte gjøre for å finne frem til spesialisten:** *(Sett ett eller flere kryss)*

☐ Jeg skaffet meg lister/oversikt over avtalespesialister i området
☐ Jeg ringte rundt til spesialister og spurte om ventelistetid og om de kunne hjelpe meg
☐ Jeg sendte forespørsel om behandling via brev eller e-post
☐ Annet *(spesifiser)*: ..................................................................................................

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**4. Hvor lang tid gikk det fra du ble henvist og til du fikk svar fra spesialisten (enten per brev eller telefon)?** *(Sett ett kryss)*

☐ Mindre enn 14 dager
☐ Mellom 14 dager og 1 måned
☐ Mellom 1 og 2 måneder
☐ Mellom 3 og 6 måneder
☐ Mer enn 6 måneder

**5 a. Fikk du informasjon fra spesialisten om ventetid?** *(Sett ett kryss)*

☐ Ja
☐ Nei

**5 b. Hvis JA – var det overensstemmelse mellom den opplyste ventetiden og den virkelige ventetiden?** *(Sett ett kryss)*

☐ Ja, i stor grad
☐ Nei, i liten grad
☐ Vet ikke

**6. Fikk du tilbud om forhåndssamtale/undersøkelse hos den privatpraktiserende spesialisten i ventetiden (det vil si mellom henvisning og behandlingsoppstart)?** *(Sett ett kryss)*

☐ Ja
☐ Nei
☐ Uaktuelt

**7. Hvor lenge måtte du faktisk vente fra henvisning til behandlingsoppstart?** *(Sett ett kryss)*

☐ Mindre enn 14 dager
☐ Mellom 14 dager og 1 måned
☐ Mellom 1 og 2 måneder
☐ Mellom 3 og 6 måneder
☐ Mellom 6 og 9 måneder
☐ Mer enn 9 måneder

**8. Hvor fornøyd eller misfornøyd har du vært med den faktiske ventetiden (fra henvisning til behandlingsoppstart)?** *(Sett ett kryss)*

| Svært misfornøyd | Misfornøyd | Både og | Fornøyd | Svært fornøyd |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

**9. Hva synes du om den informasjon om behandlingsmuligheter og ventetid som du fikk av din henvisende lege?** *(Sett ett kryss)*

| Svært dårlig | Dårlig | Både og | Bra | Svært bra |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

**10. Hva synes du om den informasjon om behandlingsmuligheter og ventetid som du har fått av den privatpraktiserende spesialisten?** *(Sett ett kryss)*

| Svært dårlig | Dårlig | Både og | Bra | Svært bra |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

## ERFARING MED BEHANDLINGSTILBUDET

**11. Alt i alt, hvor fornøyd eller misfornøyd er du med det behandlingstilbudet du har fått?** *(Sett ett kryss)*

| Svært misfornøyd | Misfornøyd | Både og | Fornøyd | Svært fornøyd |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

**12. Har du fått den behandleren du ønsket deg?** *(Sett ett kryss)*

☐ Ja
☐ Nei
☐ Har ikke ønsket noen spesiell behandler

**13. Hvor lenge har du hatt tilbud hos din privatpraktiserende spesialist?** *(Sett ett kryss)*

☐ Under 1 måned
☐ Fra 1 til 6 måneder
☐ Fra 7-12 måneder
☐ Fra 13 måneder til 3 år
☐ Mer enn 3 år

**14. Hvor mange ganger i løpet av de siste 3 månedene har du hatt time hos din privatpraktiserende spesialist? (Svar også om det er mindre enn 3 måneder siden du startet behandlingen.)** *(Sett ett kryss)*

☐ Bare én gang
☐ 2-5 ganger
☐ 6-12 ganger
☐ Mer enn 12 ganger

**15. Hva synes du om antall behandlingstimer du har fått hos din privatpraktiserende spesialist?** *(Sett ett kryss)*

☐ Passe antall timer
☐ Litt for få timer
☐ Altfor få timer
☐ Vet ikke

**16. Er du fornøyd med det initiativet din behandler har vist med hensyn til å samarbeide/ha kontakt med andre for å hjelpe deg?** *(Sett ett kryss på hver linje)*

| | Tilfreds med behandlerens initiativ | Skulle ønske det var et bedre samarbeid | Uaktuelt |
|---|---|---|---|
| Støttekontakt | ☐ | ☐ | ☐ |
| Fastlege / annen primærlege | ☐ | ☐ | ☐ |
| Sykepleier / annen fagperson i kommunen | ☐ | ☐ | ☐ |
| Sosialkontor | ☐ | ☐ | ☐ |
| Barnevernet og/eller barne- og ungdomspsykiatri | ☐ | ☐ | ☐ |
| Psykiatrisk sykehusavdeling | ☐ | ☐ | ☐ |
| Distriktspsykiatrisk senter / poliklinikk | ☐ | ☐ | ☐ |
| Somatisk sykehusavdeling / poliklinikk | ☐ | ☐ | ☐ |
| Rusteam, rusavdeling | ☐ | ☐ | ☐ |
| Arbeidsgiver | ☐ | ☐ | ☐ |
| Skole / utdanningssted | ☐ | ☐ | ☐ |
| A-etat | ☐ | ☐ | ☐ |
| Trygdekontor | ☐ | ☐ | ☐ |
| Politi, fengsel, kriminalomsorg i frihet | ☐ | ☐ | ☐ |

**17. Hvordan har behandleren samarbeidet med dine pårørende?** *(Sett ett kryss)*

| Svært dårlig | Dårlig | Både og | Bra | Svært bra | Ikke aktuelt |
|---|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

**18. Hvilket utbytte har du hatt, alt i alt, av behandlingen hos din privatpraktiserende spesialist?** *(Sett ett kryss)*

| Ikke noe utbytte | Lite utbytte | En del utbytte | Stort utbytte | Svært stort utbytte |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

**19. I hvilken grad har du hatt innflytelse på valg av behandlingsopplegg?** *(Sett ett kryss)*

| Ikke i det hele tatt | I liten grad | I noen grad | I stor grad | I svært stor grad |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

**20. I hvilken grad har du ønsket innflytelse på valg av behandlingsopplegg?** *(Sett ett kryss)*

| Ikke i det hele tatt | I liten grad | I noen grad | I stor grad | I svært stor grad |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

**21. Spørsmålene nedenfor gjelder den behandleren du nå går til:** *(Sett ett kryss per linje)*

| | Ikke i det hele tatt | I liten grad | I noen grad | I stor grad | I svært stor grad |
|---|---|---|---|---|---|
| Får du nok tid til samtaler og kontakt med behandleren din? .............. | ☐ | ☐ | ☐ | ☐ | ☐ |
| Opplever du at behandleren forstår din situasjon? .............................. | ☐ | ☐ | ☐ | ☐ | ☐ |
| Opplever du at behandlingen din er tilpasset din situasjon? ............... | ☐ | ☐ | ☐ | ☐ | ☐ |
| Følger behandleren din opp tiltak som planlagt? ................................ | ☐ | ☐ | ☐ | ☐ | ☐ |

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## TIDLIGERE BEHANDLING OG BAKGRUNNSSPØRSMÅL

**22. Har du mottatt annen behandling tidligere for samme problem/lidelse?** *(Sett ett kryss)*

☐ Ja
☐ Nei

**23. Stort sett, vil du si at din psykiske helse er**: *(Sett ett kryss)*

| Utmerket | Meget god | God | Nokså god | Dårlig |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

**24. Er du kvinne eller mann?** *(Sett ett kryss)*

☐ Kvinne
☐ Mann

**25. Hva er din alder?** *(Sett ett kryss)*

☐ Under 18 år
☐ 18-29 år
☐ 30-39 år
☐ 40-49 år
☐ 50-59 år
☐ 60-69 år
☐ 70-79 år
☐ 80 år eller mer

**26. Hvilket fylke bor du i?** *(Sett ett kryss)*

☐ Møre- og Romsdal
☐ Sør-Trøndelag
☐ Nord-Trøndelag

***Takk for at du tok deg tid til å svare!***

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# Spørreskjema for ungdommer og foresatte om erfaringer med poliklinikken

For å gjøre tilbudet til barn og ungdom med psykiske problemer bedre, vil man nå undersøke hva familier, barn og ungdom selv synes om det tilbudet de mottar ved de ulike poliklinikkene i landet. Med dette får du utlevert et kort spørreskjema, der du skal svare på noen spørsmål om hva du synes om det tilbudet dere får her.

Det er frivillig å delta. Vi håper imidlertid at du vil være med. Ved å fylle ut skjemaet kan du fortelle oss hva du mener om hjelpetilbudet ved poliklinikken. Det er SINTEF Helse som har ansvar for gjennomføringen av denne undersøkelsen, etter ønske fra Sosial- og helsedirektoratet.

Det er ett spørreskjema til foreldre/ foresatte, og ett til ungdom som er fylt 11 år. Etter at dere har fylt ut skjemaene skal de legges i den vedlagte svarkonvolutten og leveres til kontoransatt, evt. via behandleren.

Det er bare kontorpersonell ved denne poliklinikken som vil kunne se hva dere svarer. De vil ta i mot spørreskjemaene fra dere og legge svarene inn på data. De svarene dere gir blir på denne måte koblet til noen av de opplysningene som ligger i pasientjounalen. Opplysninger fra dere vil bli koblet mot opplysninger om kjønn, alder, henvisningsgrunn og evt. diagnose, samt ventetid ved poliklinikken.

En datafil med disse opplysningene blir sendt til en forsker ved SINTEF Helse. I datafilen ligger det ikke opplysninger om navn eller fødselsnummer, og det vil ikke være mulig å gjenkjenne noen av de som deltar i undersøkelsen. Når prosjektet avsluttes i desember 2004, vil alle de innsamlede opplysningene bli fjernet og slettet.

### Samtykkeerklæring for deltakelse i spørreskjemaundersøkelsen ved poliklinikken

Før dere fyller ut spørreskjemaet ber vi om at dere signerer en samtykkeerklæring.
Ved å underskrive her gir dere oss mulighet til å bruke svarene dere gir i vår undersøkelse.

For utfylling av skjema til foresatt.
☐ JA, jeg samtykker i å delta i undersøkelsen slik den er beskrevet av SINTEF Helse *(sett kryss)*

*Underskrift av foreldre/fortsatt:*

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VIKTIG! Foresatte til barn mellom 11 og 18 år skal samtykke i at barna fyller ut et eget skjema. Dette gjøres ved at du signerer samtykkeerklæringen som er heftet ved ungdomsskjemaet

**Utfylte spørreskjema legges i vedlagte svarkonvolutt sammen med dette arket.**
**Konvolutten skal leveres til en kontoransatt, eventuelt til behandleren.**

**Takk for samarbeidet!**

☐ Saknr. (fylles ut av BUP)

**Til foresatte**

# Erfaringer med BUP-klinikken

For å gjøre tilbudet til barn og ungdom bedre, ønsker vi å få vite hvor fornøyd dere er med det tilbudet dere mottar her. I dette skjemaet kan du lese noen påstander. Vi ønsker at du svarer på om du synes de stemmer eller ikke. Dette gjør du ved å sette *kryss* for det svaret som passer best. Ikke bruk for lang tid på hvert spørsmål, men svar gjerne det som først faller deg inn. Husk å tenke på **hele** behandlingsperioden når du fyller ut, ikke bare den siste tiden.

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Skjemaet fylles ut av:
☐ Mor/foresatt
☐ Far/foresatt
☐ Begge foresatte
☐ Andre:.......................................

Dato: .............................

**Utsagnet stemmer:**

| | **Uaktuelt** | **Ikke/ Aldri** | **Ikke i særlig grad/ Sjelden** | **Delvis/ Av og til** | **I stor grad/ Ofte** | **Helt/ Alltid** |
|---|---|---|---|---|---|---|
| 1. Ventetiden fra henvisning til første samtale var altfor lang. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 2. Jeg kan få kontakt med behandler utenom avtalt tid hvis det er behov for det. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 3. Fordi vi ikke snakker samme språk, forstår behandler og jeg hverandre dårlig. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 4. Forskjeller i kulturell bakgrunn gjør at behandler og jeg forstår hverandre dårlig. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 5. Personalet viser omtanke og forståelse for min/vår situasjon. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 6. Behandler har ofte for lite tid når vi møtes. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 7. Jeg har tillit til behandler. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 8. Jeg synes behandleren vet mye om slike problemer vi ønsker hjelp for. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Jeg har fått god informasjon om: | | | | | | |
| 9. – de undersøkelser som har blitt gjort eller skal gjøres. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 10. – slike problemer som barnet mitt har. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 11. – hvordan problemene kan behandles. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 12. – virkninger av medisiner som barnet mitt får eller har fått. *(Uaktuelt = ikke fått medisiner)* | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 13. – hvor jeg kan henvende meg hvis jeg vil klage. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 14. Jeg har fått bestemme for lite når undersøkelser eller behandlingsopplegg har blitt planlagt. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 15. Kritikk mot behandlingsopplegget eller personalet har blitt taklet på en dårlig måte. *(Uaktuelt = ikke kommet med kritikk)* | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 16. Det virker som behandlerne ved BUP (f.eks. psykolog, lege, sosionom, pedagog eller andre) samarbeider for lite om opplegget. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 17. Behandlerne ved BUP samarbeider for lite med andre fagpersoner utenom BUP, som også har kontakt med barnet. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 18. Etter at vi kom til klinikken har barnets/ungdommens problemer blitt mindre. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 19. Samtalene ved klinikken hjelper meg. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 20. Medisiner hjelper barnet mitt. *(Uaktuelt = bruker ikke medisiner)* | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 21. Behandlingen hjelper barnet mitt. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 22. Behandlingen hjelper familien. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 23. Jeg har blitt behandlet nedlatende eller respektløst. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 24. Jeg er fornøyd med hjelpen fra klinikken totalt sett. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 25. Jeg kan tenke meg å anbefale andre å søke hjelp ved denne klinikken. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

Skjemaet er utviklet av Ketil Hanssen-Bauer, Regionsenter for barn og unges psykiske helse Øst og Sør,
i samarbeid med SINTEF Helse og representanter fra BUP og R-BUP.

SINTEF

Prosjekt for evaluering av DPS-utbyggingen
SINTEF Helse, Postboks 124 Blindern, 0314 Oslo
Prosjektleder Torleif Ruud. Tlf. 9136 2750. E-post: torleif.ruud@sintef.no

Oslo 14.februar 2005

## Forespørsel om samtykke til en vitenskapelig undersøkelse om: Bidrar utbyggingen av distriktspsykiatriske sentre til bedre tjenestetilbud og høyere brukertilfredshet?

### Hva undersøkelsen gjelder

Undersøkelsen gjelder om utbygging av distriktspsykiatriske sentre fører til bedre behandling og hjelp. Utbyggingen er en del av Opptrappingsplan for psykisk helse som Stortinget har vedtatt.

Norges forskningsråd skal evaluere resultatene av opptrappingsplanen, og dette prosjektet er en del av denne evalueringen. Det samles inn opplysninger i 2005 som sammenlignes med opplysninger fra 2002. Siste datainnsamling blir i 2007 med ny forespørsel til dem som har kontakt med tjenestene da.

Undersøkelsen er godkjent av Regional etisk komite for medisinsk forskning i Midt-Norge. Den er meldt til Datatilsynet via Norsk samfunnsvitenskapelig datatjeneste (NSD), og brukerorganisasjonene Mental helse Norge og Landsforeningen for pårørende i psykiatri (LPP) har også vært positive til den.

Ved å gi ditt samtykke til de ulike deler av denne undersøkelsen, kan du bidra til at myndighetene og helsetjenestene får informasjon som kan bidra til å gjøre helsetjenesten bedre. Det er bare du som kan fortelle om de erfaringene du har.

### Samtykke til bruk av anonymt kodenummer

1. Vi ber deg om samtykke til at opplysninger om din tilstand og den hjelpen du mottar vinteren 2005 blir utlevert merket med et anonymt kodenummer. Opplysningene blir gitt uten personidentifiserbare opplysninger, og bare ledelsen ved institusjonen vet hvem kodenummeret gjelder. Vi trenger dette kodenummeret til å sammenholde de ulike opplysningene for samme person uten å vite hvem vedkommende er. Om du ikke gir samtykke, vil de avidentifiserte opplysningene ikke bli merket med et kodenummer som noen kjenner. Prosjektet vil bli avsluttet 31.desember 2008, og kodenøkkelen vil da bli slettet slik at datamaterialet forblir anonymt.

2. Vi ber deg også om samtykke til å gi deg et spørreskjemaet om hvordan du har det og hva du synes om den hjelpen du har fått. Du kan selv avgjøre om du vil svare på spørreskjemaet når du får det.

3. Vi ber deg om samtykke til å gi din nærmeste pårørende et spørreskjema om tilbudene du har fått.

### Informasjon om undersøkelsen

Den hjelp du får fra institusjonen, er den samme enten du gir samtykke til undersøkelsen eller ikke. Du kan når som helst trekke ditt samtykke tilbake, og kodenummeret vil da bli slettet.

Dersom du ønsker informasjon om resultatene av undersøkelsen (høsten 2005), kan du gi beskjed til prosjektleder via brev, telefon eller elektronisk post (se øverst på dette arket) - eller til din behandler. Du er også velkommen til å ta kontakt med meg med spørsmål du har om undersøkelsen.

Med vennlig hilsen

Torleif Ruud

Torleif Ruud
Prosjektleder

| | |
|---|---|
| SINTEF | Prosjekt for evaluering av DPS-utbyggingen<br>SINTEF Helse, Postboks 124 Blindern, 0314 Oslo<br>Prosjektleder Torleif Ruud. Tlf. 9136 2750. E-post: torleif.ruud@sintef.no |

## Samtykke til en vitenskapelig undersøkelse om:

## Bidrar utbyggingen av distriktspsykiatriske sentre til bedre tjenestetilbud og høyere brukertilfredshet?

Undertegnede har lest om undersøkelsen i brev av 14.februar 2005 fra prosjektleder Torleif Ruud.

Jeg er kjent med at jeg når som helst kan trekke mitt samtykke tilbake.

1. Jeg samtykker i at SINTEF Helse får utlevert opplysninger om min tilstand og behandling merket med et anonymt kodenummer. Opplysningene skal ikke være personidentifiserbare.

☐ Ja ☐ Nei

Jeg samtykker i at SINTEF Helse kan gi meg et spørreskjema som ledd i undersøkelsen.

☐ Ja ☐ Nei

Jeg samtykker i at SINTEF Helse kan gi et spørreskjema til min nærmeste pårørende om de tilbud som jeg får, og at dette kan merkes med samme anonyme kodenummer.

☐ Ja ☐ Nei

Min nærmeste pårørende er. ______________________________
Adresse: ______________________________
______________________________

______________________________
(sted og dato)

______________________________
(underskrift)

______________________________
(navn med trykte bokstaver)

Dette skjema med samtykke leveres via behandler til ledelsen ved helseinstitusjonen, som oppbevarer samtykket og sikrer at institusjonen handler i samsvar med samtykket som er gitt. Prosjektleder vil ikke motta samtykket eller kopi av det, og vil derfor ikke vite hvem du er.

| | | |
|---|---|---|
| SINTEF | SINTEF Helse. Prosjektleder Torleif Ruud Telefon 9136 2750.<br>Postboks 124 Blindern, 0314 Oslo. (Faks 2206 7909) | **Skjema P-2005** |

Institusjon

Utfylt dato (dag/måned) 2005

Kodenummer bare om samtykke til det

Kodenr. pasient

# Spørreskjema til pasienter vinteren 2005

Ved å svare på spørreskjemaet bidrar du til en evaluering av tilbudene til mennesker med psykiske plager. Resultatene vil bli brukt av helsemyndigheter og helsetjenester for å forbedre tilbudene om behandling og hjelp.

**Kjønn** ☐ Kvinne ☐ Mann

**Fødselsår**

**Hvilke tilbud har du hatt vinter 2005?**

☐ Poliklinisk tilbud
☐ Dagtilbud
☐ Døgnopphold
☐ Hjelp fra team som kom til deg

1.Er kontakten avsluttet? ☐ Ja ☐ Nei

2.Har du vært tvangsinnlagt denne vinteren (2005)? ☐ Ja ☐ Nei

3.Har du fått medisiner etter vedtak om tvangsbehandling? ☐ Ja ☐ Nei

## Først er det noen spørsmål om hvor fornøyd du er med ulike områder i livet slik det er nå

For hvert område i livet som er nevnt nedenfor setter du kryss i den boksen som best beskriver hvordan du har det nå med denne delen av livet. Skalaen for hver av de sju ulike svarene (boksene) står øverst under tallene. Du kan sende oss det utfylte spørreskjemaet i den vedlagte svarkonvolutten eller levere det til senteret i konvolutten.

| | **Sett ett kryss på hver linje.** | **1 Kunne ikke ha vært verre** | **2 Misfornøyd** | **3 For det meste misfornøyd** | **4 Blandet-både fornøyd og misfornøyd** | **5 For det meste fornøyd** | **6 Fornøyd** | **7 Kunne ikke ha vært bedre** |
|---|---|---|---|---|---|---|---|---|
| 1 | Hvor fornøyd er du med livet ditt samlet sett? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 2 | Hvor fornøyd er du med arbeidet ditt eller din daglige virksomhet (arbeid, opplæring, studier o.l.) - eller hvor fornøyd er du med å være uten arbeid eller pensjonert? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 3 | Hvor fornøyd er du med utdanningen din? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 4 | Hvor fornøyd er du med økonomien din? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 7 | Hvor fornøyd er du med hvor mange venner du har? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 8 | Hvor fornøyd er du med forholdet til vennene dine? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 9 | Hvor fornøyd er du med fritiden din? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 10 | Hvor fornøyd er du med boligen din? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 11 | Hvor fornøyd er du med området/ nabolaget der du bor? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 12 | Hvor fornøyd er du med din personlige trygghet? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 13 | Hvor fornøyd er du med dem du bor sammen med? - eller hvor fornøyd er du med å bo alene? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 14 | Hvor fornøyd er du med ditt forhold til ektefelle/ samboer/ partner? - eller hvor fornøyd er du med å ikke ha noen ektefelle/samboer/ partner? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 15 | Hvor fornøyd er du med ditt seksualliv? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 16 | Hvor fornøyd er du med forholdet til familien din? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 17 | Hvor fornøyd er du med din fysiske helse? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 18 | Hvor fornøyd er du med din psykiske helse? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

## Så følger noen spørsmål om problem eller plager de siste to ukene

| Angi hvor mye hvert enkelt problem har plaget deg eller vært til besvær i løpet av <u>de siste 14 dagene</u>.<br>Sett ett kryss på hver linje. | | Ikke plaget | Litt plaget | Ganske mye plaget | Veldig mye plaget |
|---|---|---|---|---|---|
| 1 | Matthet eller svimmmelhet | ☐ | ☐ | ☐ | ☐ |
| 2 | Plutselig frykt uten grunn | ☐ | ☐ | ☐ | ☐ |
| 3 | Stadig redd eller engstelig | ☐ | ☐ | ☐ | ☐ |
| 4 | Følelse av å være anspent, oppjaget | ☐ | ☐ | ☐ | ☐ |
| 5 | Lett å klandre seg selv | ☐ | ☐ | ☐ | ☐ |
| 6 | Søvnproblemer | ☐ | ☐ | ☐ | ☐ |
| 7 | Føle håpløshet med tanke på framtiden | ☐ | ☐ | ☐ | ☐ |
| 8 | Nedtrykt, tungsindig | ☐ | ☐ | ☐ | ☐ |
| 9 | Følelse av at alt er et slit | ☐ | ☐ | ☐ | ☐ |
| 10 | Følelse av å være unyttig | ☐ | ☐ | ☐ | ☐ |

## Resten gjelder din vurdering av de tilbud du har fått ved denne institusjonen vinteren 2005

| Hva synes du om den informasjonen du har fått fra dine behandlere om de ulike forhold nedenfor? | 1 Svært dårlig | 2 Ganske dårlig | 3 Blandet, både-og | 4 Ganske bra | 5 Svært bra |
|---|---|---|---|---|---|
| 1. Om diagnose og de plagene du har | ☐ | ☐ | ☐ | ☐ | ☐ |
| 2. Om de behandlingsmuligheter som finnes for deg | ☐ | ☐ | ☐ | ☐ | ☐ |
| 3. Om medikamenter (virkninger, bivirkninger og hvor lenge du måtte regne med å bruke dem)? | ☐ | ☐ | ☐ | ☐ | ☐ |
| 4. Om din rett til å få innsyn in journalen din | ☐ | ☐ | ☐ | ☐ | ☐ |
| 5. Om din rett til å få journalført egne ønsker/synspunkt | ☐ | ☐ | ☐ | ☐ | ☐ |
| 6. Om hvor du kunne klage på det tilbudet du fikk (fylkeslege, kontrollkommisjon, pasientombud) | ☐ | ☐ | ☐ | ☐ | ☐ |

| Hvordan har behandlerne vært når det gjelder . . . | 1 Svært dårlig | 2 Ganske dårlig | 3 Blandet, både-og | 4 Ganske bra | 5 Svært bra |
|---|---|---|---|---|---|
| 1. Å gi seg nok tid til samtaler og kontakt | ☐ | ☐ | ☐ | ☐ | ☐ |
| 2. Evne til å lytte og forstå | ☐ | ☐ | ☐ | ☐ | ☐ |
| 3. Oppfølging av tiltak som er planlagt eller avtalt | ☐ | ☐ | ☐ | ☐ | ☐ |
| 4. Respekt for dine synspunkter og meninger | ☐ | ☐ | ☐ | ☐ | ☐ |
| 5. Samarbeid innbyrdes med hverandre | ☐ | ☐ | ☐ | ☐ | ☐ |
| 6. Din mulighet til å påvirke hvem du fikk som behandler | ☐ | ☐ | ☐ | ☐ | ☐ |

| Om du har hatt behandlingskontakt over lengre tid eller med flere poster eller polikliniske team | 0 Ikke vært aktuelt | 1 I svært liten grad | 2 I liten grad | 3 I noen grad | 4 I stor grad | 5 I svært stor grad |
|---|---|---|---|---|---|---|
| 1. Har fått beholde samme hovedbehandler eller terapeut over lengre tid | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 2. Hvor godt primærhelsetjenesten og psykiatrien samarbeider om mine tilbud | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 3. Har fått beholde samme behandler ved overføring til en annen post / annet team | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 4. Hvor godt samarbeidet har vært mellom enhetene ved overføring til annet team | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

| **Hvor mye hjelp har du har fått med . . .** | **0**<br>**Hadde ikke slikt problem** | **1**<br>**Svært lite** | **2**<br>**Ganske lite** | **3**<br>**Hverken lite eller mye** | **4**<br>**Ganske mye** | **5**<br>**Svært mye** |
|---|---|---|---|---|---|---|
| 1. Forholdet til deg selv og ditt selvbilde | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 2. Kunnskap om sykdommen din | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 3. Å redusere symptomer og plager | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 4. Å lære å mestre symptomer og plager | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 5. Forholdet til dine nærmeste | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 6. Forholdet til andre mennesker | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 7. Å fungere bedre praktisk i det daglige | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 8. Å bedre din arbeidsevne | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 9. Å bedre din fysiske form og fysiske helse | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

| **Hvilket utbytte synes du at du har hatt av de formene for behandling eller hjep som er nevnt nedenfor?** | **Om du har mottatt slik behandling** | | | | **Om du ikke har mottatt slik behandling** | |
|---|---|---|---|---|---|---|
| **Sett bare ett kryss på hver linje** | **1**<br>**Ikke noe utbytte** | **2**<br>**Lite utbytte** | **3**<br>**Stort utbyte** | **4**<br>**Svært stort utbytte** | **0**<br>**Har ikke ønsket det** | **5**<br>**Hadde ønsket å få det** |
| 1. Undersøkelse og utredning | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 2. Råd om spørsmål jeg har hatt | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 3. Behandlng med medikamenter | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 4. Samtalebehandling, psykoterapi | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 5. Gruppesamtaler, gruppeterapi | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 6. Familiesamtaler, parsamtaler | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 7. Krisehjelp, akutt hjelp | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 8. Trening i å omgås andre mennesker | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 9. Trening i å klare meg selv praktisk | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 10. Delta i fysiske aktiviteter | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 11. Musikkterapi, billedterapi og lignende | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 12. Hjelp og støtte til mine pårørende | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

| **Noen spørsmål om individuell plan** | **Ja** | **Nei** | **Noen andre spørsmål** | **Ja** | **Nei** |
|---|---|---|---|---|---|
| 1. Har du hørt om retten til å ha en individuell plan? | ☐ | ☐ | 1. Var det akseptabel ventetid for å få tilbud her? | ☐ | ☐ |
| 2. Har du gitt samtykke til å ha en plan? | ☐ | ☐ | 2. Har du vært utsatt for krenkende uttalelser fra behandlere / personale? | ☐ | ☐ |
| 4. Har du en skriftlig individuell plan? | ☐ | ☐ | 3. Har du vært utsatt for krenkende handlinger fra behandlere / personale? | ☐ | ☐ |

| **Noen spørsmål om individuell plan. Disse besvares bare dersom du har en individuell plan.** Bruk skalaen til høyre og sett ett kryss på hver linje | **1**<br>**I svært liten grad** | **2**<br>**I liten grad** | **3**<br>**I noen grad** | **4**<br>**I stor grad** | **5**<br>**I svært stor grad** |
|---|---|---|---|---|---|
| 1. Hvor mye innflytelse hadde du på innholdet i planen? | ☐ | ☐ | ☐ | ☐ | ☐ |
| 2. Har planen gitt deg bedre oversikt over tilbudene? | ☐ | ☐ | ☐ | ☐ | ☐ |
| 3. Er du fornøyd med hva planen inneholder? | ☐ | ☐ | ☐ | ☐ | ☐ |
| 4. Blir planen gjennomført som planlagt? | ☐ | ☐ | ☐ | ☐ | ☐ |
| 5. Har planen ført til bedre tilbud og hjelp? | ☐ | ☐ | ☐ | ☐ | ☐ |

SINTEF Helse februar 2005

| Om du var innlagt som døgnpasient, hvordan var . . | 1 Svært dårlig | 2 Ganske dårlig | 3 Blandet, både-og | 4 Ganske bra | 5 Svært bra |
|---|---|---|---|---|---|
| 1. Din mulighet til å være for deg selv | ☐ | ☐ | ☐ | ☐ | ☐ |
| 2. Din bevegelsesfrihet i posten eller avdelingen | ☐ | ☐ | ☐ | ☐ | ☐ |
| 3. Din mulighet for meningsfylte aktiviteter | ☐ | ☐ | ☐ | ☐ | ☐ |
| 4. Tilstrekkelig mulighet for samtaler med personalet | ☐ | ☐ | ☐ | ☐ | ☐ |
| 5. Din mulighet til å ha kontakt med andre pasienter | ☐ | ☐ | ☐ | ☐ | ☐ |

## Her er noen få oppsummerende spørsmål til slutt

**Alt i alt, hvor fornøyd eller misfornøyd er du med tilbudet du har mottatt ved senteret?**
☐ 1 Svært misfornøyd
☐ 2 Ganske misfornøyd
☐ 3 Både og
☐ 4 Ganske fornøyd
☐ 5 Svært fornøyd

**Alt i alt, hvordan er erfaringene dine med tilbudet ved senteret?**
☐ 1 Mye dårligere enn forventet
☐ 2 Noe fårligere enn forventet
☐ 3 Som forventet
☐ 4 Noe bedre enn forventet
☐ 5 Mye bedre enn forventet

**Hvilket utbytte har du hatt, alt i alt, av behandlingen ved senteret?**
☐ 1 Ikke noe utbytte
☐ 2 Lite utbytte
☐ 3 En del utbytte
☐ 4 Stort utbytte
☐ 5 Svært stort utbytte

**I hvilken grad har du hatt innflytelse på valg av behandlingsopplegg?**
☐ 1 Ikke i det hele tatt
☐ 2 I liten grad
☐ 3 I noen grad
☐ 4 I stor grad
☐ 5 I svært stor grad

**I hvilken grad har du ønsket innflytelse på valg av behandlingsopplegg?**
☐ 1 Ikke i det hele tatt
☐ 2 I liten grad
☐ 3 I noen grad
☐ 4 I stor grad
☐ 5 I svært stor grad

**Har behandlingen skjedd frivillig, eller har du følt deg tvunget til å delta?**
☐ 1 Helt frivillig
☐ 2 Ganske frivillig
☐ 3 Både og
☐ 4 Ganske tvungent
☐ 5 Helt tvungent

**Om du vil skrive noe med egne ord om erfaringene dine med tilbudet, kan du gjøre det her:**

**Vennligst se etter om du har svart på alle spørsmålene før du legger skjemaet i komvolutten.**

**Takk for at du har formidlet dine erfaringer og synspunkter ved å fylle ut spørreskjemaet!**

## Dissertations at the Faculty of Medicine, NTNU

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1. Knut Joachim Berg: EFFECT OF ACETYLSALICYLIC ACID ON RENAL FUNCTION
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