

ASSESSING CLIENT SATISFACTION WITH TREATMENT FOR SUBSTANCE USE PROBLEMS AND THE DEVELOPMENT OF THE TREATMENT PERCEPTIONS QUESTIONNAIRE (TPQ)

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This report describes the development of a brief 10-item scale to measure client satisfaction with treatment for substance use problems. The Treatment Perceptions Questionnaire (TPQ) was developed from two independent studies. The first field study recruited 123 subjects from inpatient and community treatment programmes. Each respondent completed an interviewer-administered questionnaire comprising the TPQ and other measures of personal/social functioning and treatment processes and perceptions. A sub-sample (n = 38) participated in a three-day re-test administration of the instrument with two interviewers. In a second study of outcomes from oral and injectable methadone maintenance treatment, the TPQ was administered to a further 33 patients as part of a six-month outcome evaluation. Results from these studies show that the instrument has good construct and discriminant validity, good internal reliability and acceptable test-retest reliability. The TPQ can be used in research studies of treatment process and outcome and routine programme audit activities.

Keywords: Drug and alcohol treatment; client satisfaction; treatment perceptions

INTRODUCTION

In the general mental health field, a sizable body of research has investigated clients' satisfaction with treatment services (e.g. Koltuv, Ahmed & Meyer, 1978; Larsen et al., 1979; Macdonald, Sibbald, & Hoare, 1988).

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Common to this work is a definition of client satisfaction as the extent to which a programme is perceived to have met an individual's treatment wants and needs. A range of issues have been examined including the accessibility, adequacy, content and impact of services received. In addition to serving a simple monitoring function for treatment service providers and funders, treatment satisfaction is argued to be a valuable indicator of treatment experience. Treatment satisfaction can act as a moderator of treatment outcome, since it is reasonable to assume that less satisfied clients may leave treatment prematurely or have different responses to interventions (Atkisson & Pascoe, 1983).

Several instruments have been developed for measuring treatment satisfaction in the general mental health service arena (e.g. Love, Caid & Davis, 1979; Slater, Linn & Harris, 1982). The most notable is the Client Satisfaction Questionnaire (CSQ) which has been developed in several forms and has been widely used in health services research (Larsen *et al.*, 1979; Greenfield and Atkisson, 1989). However, in spite of the prevalence of client satisfaction surveys, several methodological shortcomings have been identified (see reviews by Lebow, 1982 and Ruggeri, 1994). In particular, the ability of satisfaction measures to address issues which are of concern to specific client populations has been questioned in several studies (Lehman & Zastowny, 1983; Lebow, 1982; Lyke & Zyzanski, 1987). Also, satisfaction measures which have been validated in one culture, may not be appropriate in another (Atkisson & Greenfield, 1994).

In contrast to the general mental health field, there is a sparse literature on client treatment satisfaction issues in the substance use treatment arena. Outcome research from the United States, which has administered the CSQ and other instruments, has reported high levels of service satisfaction amongst clients in methadone maintenance, therapeutic community and outpatient drug-free programmes (e.g. Simpson & Lloyd 1979). Studies which have looked for associations between satisfaction ratings and treatment process and outcome have produced mixed results. For example, Chan *et al.* (1997) observed that greater pre-treatment problem severity and duration of the index treatment assessed were positively correlated with treatment satisfaction. In contrast, in a study of methadone maintenance, Joe & Friend (1989) found only modest associations between satisfaction, length of treatment and favourable outcome.

In the United Kingdom, gathering information about clients' satisfaction with treatment services is considered to be a valuable adjunct to the collec-

tion of primary outcome measures (Task Force to Review Services for Drug Misusers, 1996; Marsden et al., 1998). Many providers have undertaken surveys of their clients' satisfaction with treatment as part of audit and quality assurance initiatives. However, to date, a specific research instrument to assess treatment satisfaction amongst the substance misuse treatment population has not been developed.

General satisfaction instruments could be selected for use in addiction treatment research but these may not be sensitive to the key issues of concern for clients with drug and alcohol misuse problems. Qualitative studies have provided several insights into the perceptions of clients in substance use treatment (Jones, Power & Dale, 1994; Hunt & Rosenbaum, 1998; Neale, 1998; Bacchus et al., 1998) and these studies suggest that there are several specific issues which are related to satisfaction with treatment services, including: therapeutic relationships with staff; personal treatment goals; the operation of treatment services; and having enough time in treatment to deal with problems. These issues are not covered by existing instruments. Consequently, as a complement to developmental work at our centre on measuring primary treatment outcomes in addiction treatment programmes (see Marsden et al., 1998), we sought to develop a brief research measure of treatment satisfaction – the Treatment Perceptions Questionnaire (TPQ) – which could be used for treatment programme evaluation and other research applications. Our primary concern was to develop a set of items which would cover specific areas of concern expressed by people in addiction treatment, whilst also being sufficiently generic for application in a variety of treatment modalities and settings. The instrument was designed to meet the following requirements: (i) good content and face validity for the adult treatment-seeking substance misuse population; (ii) minimal overlap of items with existing instruments; (iii) brief administration; (iv) acceptable reliability and discriminant validity; (v) and simple scoring with clear interpretation. The specific objectives of the studies were: (i) to establish a brief set of items which have high face validity and capture important aspects of treatment satisfaction for clients with substance use disorders; (ii) to assess the structure; internal consistency, test-retest reliability; discriminant validity of these items, and (iii) explore predictors of client treatment satisfaction. This report describes the development and field testing of the TPQ in two independent studies.

METHOD

Study 1

In the primary instrument development study, four treatment services in South London (two residential programmes and two community programmes) were approached and invited to participate. These were: (i) a 30-day, hospital in-patient detoxification and relapse-prevention treatment programme; (ii) a 14-day, hospital in-patient rapid admission detoxification and assessment programme; (iii) a community methadone maintenance treatment programme; and (iv) a community drug and alcohol team providing methadone reduction treatment for dependent opioid users and focussed counselling and referral for problem alcohol users.

Study 2

Following the initial development of the TPQ, the instrument was incorporated as part of the subject assessment battery for a clinical trial of injectable and oral methadone maintenance conducted at our specialist community treatment centre in South London (Strang *et al.*, submitted for publication). The design of the study, which incorporated a distinct design factor (formulation of methadone) provided an opportunity to explore the discriminant validity of the instrument amongst subjects receiving oral or injectable methadone maintenance.

Initial item pool

We first established an initial pool of 14 items for the TPQ from a review of existing instruments and research literature, and from semi-structured interviews with eight subjects (four in in-patient treatment and four attending community treatment). During the interview, each client was invited to talk freely about their impressions of the service and their treatment and what they found satisfying and dissatisfying about it. A content analysis of the client interviews indicated that two broad areas were central influences on the extent of satisfaction with the treatment received. The first area concerned the perception of clients towards the nature and extent of contact with the programme staff. The second area concerned aspects of the treat-

ment service and its operation and rules and regulations. We compiled the comments from clients and translated these into fourteen belief statements, using both positively and negatively worded items to minimise the likelihood of response set, as follows:

Staff perceptions

1. The staff have not always understood the kind of help I want.
2. The staff and I have had different ideas about my treatment objectives.
3. There has always been a member of staff available when I have wanted to talk.
4. The staff have helped to motivate me to sort out my problems.
5. I think the staff have been good at their jobs.

Programme perceptions

1. I have had problems travelling to this treatment programme.
2. I have been well informed about decisions made about my treatment.
3. I have received the help that I was looking for.
4. I have not liked all of the treatment sessions I have attended.
5. I have not had enough time to sort out my problems.
6. I have not liked some of the treatment rules or regulations.
7. My treatment has not been flexible enough for me.
8. I have received useful feedback about my progress and achievements during my treatment.
9. The atmosphere in the programme is welcoming and friendly.

These items were included in the field-tested version of the TPQ, and were scored on a five-point scale (strongly disagree – strongly agree; weighted 0–4). Score weights for negatively worded items were reversed (ie. strongly agree = 0 and strongly disagree = 4). Higher scores reflect greater satisfaction with treatment. These items differ substantially from – the CSQ-8 – arguably the most widely used existing client treatment satisfaction measure. They also focus on distinct issues of importance to the study population. Item 8 from the TPQ pool is similar to the CSQ-8 item 2 – “Did you get the kind of service you wanted” but the remaining items from the CSQ-8 concern different areas (overall service quality; programme had met needs; recommendation of programme to a friend; satisfaction with amount of help received; effectiveness of help received;

overall satisfaction with service and whether client will come back to programme again).

Study measures

Data for study 1 were gathered from a brief, structured, researcher-administered questionnaire of approximately 25 minutes duration. The interview contained the following measures: (i) an indicator measure of whether the client had a positive or negative perception of the programme at intake; (ii) a rating scale of the perceptions of current treatment need across physical and psychological health problems, relationship problems, accommodation problems, and education/training and employment issues (scored on a five-point scale, ranging from none to extreme); and (iii) the frequency and intensity of substance use using the Maudsley Addiction Profile (MAP; Marsden *et al.*, 1998), a multidimensional instrument for treatment outcome research. For subjects treated in the community the recall period for substance use was the 30 days prior to interview. For the residential subjects, the 30 days preceding admission to treatment were used. Data for study 2 were gathered from a structured, researcher-administered interview of 40 minutes duration which was conducted six-months after intake to treatment. We elected to not include an existing treatment satisfaction instrument measure in the interview due to time constraints on administration in treatment services and because of the extent of separation between the items of the TPQ and other satisfaction measures.

Subjects and procedure

Study 1

In study 1, the sample consisted of 123 clients. All were adult drug users who entered treatment with opiate or alcohol dependence and were interviewed in either a community methadone prescribing programme or hospital in-patient programme. To be eligible for participation in the study, clients had to have been in the community methadone treatment programme for a minimum of 30 days or in in-patient treatment for a minimum of 10 days. Lists of eligible subjects were drawn from programme case-records. Subjects were invited to participate by an independent research interviewer (authors LB and AR) and all interviews were con-

ducted in a private room at the treatment centre. Participants were assured that their comments about their treatment were both anonymous and confidential to the study. Refusal rates were low in each programme: six subjects in the in-patient programmes and eight subjects in the community programmes declined the invitation to participate. The most common reason cited in the former setting was that the client was feeling unwell because of withdrawal symptoms; in the latter, most refusing clients stated that they did not have sufficient time available.

To assess the reliability of the TPQ, 38 subjects were randomly selected to participate in a retest interview. Two researchers each interviewed 19 subjects. A random sample of 20 problem drug users and 20 problem alcohol users was intended, but one subject in each group elected to withdraw from the study prior to the retest. On each occasion, interviews were readministered after approximately three days.

Study 2

The second sample consisted of 33 clients (18 in the injectable methadone maintenance condition and 15 in the oral methadone condition) who participated in a personal, researcher-administered interview six months after intake to treatment. The TPQ was administered as a self-completion questionnaire which was then sealed in an envelope and only seen by researchers who were independent of the clinical study. All interviews were conducted between November 1997 and August 1998.

Data analysis

The structure of the instrument was examined using exploratory principle components analysis and the internal consistency of the instrument was assessed using Chronbach's alpha. Test-retest reliability was assessed using intra-class correlation coefficients (ICC). In terms of evaluating the strength of the ICC, it has been suggested that a coefficient above .75 indicates excellent agreement; .65-.74 reflects a good agreement and .40-.64 fair agreement (Fleiss, 1991). Predictors of treatment satisfaction as measured by the TPQ, were explored using multiple regression analysis with backwards elimination of covariates. Discriminant validity assessments between subjects receiving different treatments were undertaken using multiple correlation analysis one-way analysis of variance and t-tests.

RESULTS

Sample characteristics

Eighty-eight of the 123 participants in study one, were dependent on opiates and 35 were dependent alcohol users. Those in the community treatment programmes had been in treatment for an average of 273 days (s.d. = 62.1). Subjects in the in-patient programmes had been in treatment for an average of 16 days (s.d. = 5.5). The personal/demographic profile of the subjects is shown in Table I. These and subsequent results are presented as pooled data across the community and in-patient treatment settings. The scale used to measure current "treatment need" had acceptable internally reliability ($\alpha = .67$). Overall, there were no differences in perceived treatment need between the two treatment settings among the alcohol clients. Drug users treated in in-patient settings reported higher treatment need scores than those who were treated in the community ($F_{[1,119]} = 4.30, p < 0.05$).

TABLE I Personal/demographic characteristics of the sample (n = 123)

	<i>Community Drug and Alcohol Teams (n = 81)</i>	<i>In-patient programmes (n = 42)</i>
% drug clients	76.5	61.9
% male	72.8	71.4
Average age (s.d.)	37.4 (8.3)	35.9(7.0)
% non-white UK ethnic group	9.9	23.8
% unemployed in past month	84.0	95.2
% in relationship	46.9	50.0
% in trouble with law	25.9	23.8
Mean days in treatment (s.d.)	503.3 (517.6)	10.8 (5.5)

Instrument structure

Some 30% of the correlations between the TPQ items were at .30 or above (correlation between no pair of items exceeded .49 in absolute value). Only 7% of the sample agreed with the item concerning service access ("I have had problems travelling to this treatment programme") and we elected to remove this item from the scale. Exploratory principle compo-

nents analysis with oblimin rotation was then performed to assess the structure and factorial validity of the remaining 13 items. An initial principle components analysis isolated three factors (with eigenvalues > 1) which accounted for 53.1% of the variance in scores. Interpretation of the initial solution was hampered by three items. The first, ("*my treatment has not been flexible enough for my needs*") failed to load highly on one of the three factors (with an average loading of .23) and we elected to remove it. The other two items, ("*I have received useful feedback about my progress and achievements during my treatment*" and "*The atmosphere in the programme is welcoming and friendly*") were not correlated with the first two factors and were the sole components of the third factor. As these items did not form a coherent factor in their own right we also elected to remove them from the scale.

A second principle components analysis of the 10-item TPQ, extracted two factors which we labelled "staff perceptions" and "programme perceptions" and which accounted for 51.6% of the variance. The staff perceptions factor accounted for 38.7% of the variance while the programme perceptions factor accounted for a further 12.9% of the variance. As noted in Table II, loadings for one item ("*I have received the kind of help I was looking for*") were split across the two factors. Since this item was more closely concerned with programme perceptions rather than staff issues, *per se*, we chose to include the item on the second factor. The items comprising Factor 1 and Factor 2 were internally reliable ($\alpha = .76$ and $\alpha = .71$, respectively), as was the total scale ($\alpha = .83$). Table II shows the item means, the item factor loadings and item test-retest coefficients. The scores on the final 10-item instrument can range from 0–40. Scores were approximately normally distributed (mean = 27.7; s.d. = 5.5; median = 28.0; mode = 26.0; range = 14 – 40).

Test-retest reliability

The results of the retest reliability study were satisfactory (see Table II). The overall ICC for the scale total for responses from 38 subjects was .57 (falling within the range judged to indicate fair retest-reliability by Fleiss 1991). All ICCs for the Individual scale items fall within the .40-.60 range and are all judged to have fair test-retest reliability. There were no statistically differences in TPQ responses attributable to the two interviewers.

TABLE II Items, means (standard deviations), principal components and test-retest intraclass correlation coefficients (95% confidence intervals) for the Treatment Perceptions Questionnaire (n = 123)

	Mean (s.d.)	Factor 1: Staff perceptions	Factor 2: Programme perceptions	ICC ^a
The staff have not always understood the kind of help I want.	2.9 (0.8)	-0.59	0.23	.52 (.25 – .73)
The staff and I have had different ideas about my treatment objectives.	2.8 (1.0)	-0.58	0.19	.47 (.18 – .66)
There has always been a member of staff available when I have wanted to talk.	2.8 (1.0)	0.86	-0.24	.52 (.23 – .73)
The staff have helped to motivate me to sort out my problems.	3.1 (0.8)	0.74	-0.00	.49 (.21 – .70)
I think the staff have been good at their jobs	3.2 (0.7)	0.63	0.02	.47 (.18 – .70)
I have been well informed about decisions made about my treatment.	2.7 (1.0)	0.26	0.57	.45 (.14 – .67)
I have received the help that I was looking for ^b	2.8 (0.8)	0.43	0.37	.51 (.23 – .72)
I have not liked all of the counselling sessions I have attended.	2.6 (0.9)	0.17	-0.64	.42 (.10 – .66)
I have not had enough time to sort out my problems	2.7 (0.9)	-0.13	-0.92	.56 (.28 – .66)
I have not liked some of the treatment rules or regulations.	2.2 (1.1)	-.14	-0.55	.60 (.43 – .76)

a. Based on test-retest responses from 38 subjects.

b. Loadings for this variable are split across the two factors, the item is included in factor 2 to increase the consistency of the two factor solution.

Predictors of treatment satisfaction

Turning to the second objective of the study, we sought to identify predictors of variability in TPQ scores from personal and treatment related measures gathered in study one. Multiple regression analysis was performed using the TPQ total score as the dependent variable and nine covariates: age, gender, primary treatment problem (opiate or alcohol dependence), treatment setting, length of time of waiting list before intake, initial perception of treatment, duration on current treatment, current perception of treatment needs, and heroin use in the past month during treatment (community clients only). Fifty-one percent ($n = 41$) of the opiate users in the community sample reported using heroin on at least one occasion during the month preceding the interview. The covariates to cases ratio was 1:14. This exceeds an acceptable minimum for multiple regression analysis (Tabachnik & Fidell, 1993). Model generation was achieved sequentially with backwards elimination of covariates. Results of the final model are shown in Table III.

TABLE III Univariate correlations and multiple regression analysis (with backward elimination) of treatment variables on scores on the Treatment Perceptions Questionnaire ($n = 123$)

Variables	TPQ (DV)	Setting	Wait	Initial	Community	B	β
Setting ^a	.26**					4.963	0.43***
Wait ^b	-.33***	-.28**				-0.021	-0.25**
Initial ^c	.41***	0.09	-.00			4.075	0.34***
Community ^d	-0.15	.84***	-.07	-.08		-0.003	-0.25**
Heroin ^e	-0.08	.50***	-.15	-.02	.39***	-3.314	-0.29**
<i>Intercept = 24.355</i>							
							$R^2 = .42$
							Adjusted $R^2 = .39$
							$R = .65$

** $p < .01$; *** $p < .001$;

- Treatment setting (0 = residential; 1 = community).
- Time on waiting list before intake (days).
- Initial perception of treatment programme (0 = negative and 1 = positive).
- Weeks in current treatment (for community programmes).
- Heroin use in past month for community clients (0 = no; 1 = yes).

Scores on the TPQ were not predicted by subjects' age, gender, or perception of current treatment needs. Some 42% of the variance in scores in the final model (39% adjusted; $F_{[5,117]} = 16.85$; $p < 0.0001$) was predicted by the remaining five covariates. Higher scores on the dependent variable were associated with treatment in a community programme ($\beta = .43$) and favourable initial perceptions of treatment across both settings ($\beta = .34$). Longer waiting times for treatment were predictive of lower satisfaction scores ($\beta = -.25$). For subjects treated in the community, duration of treatment was negatively associated with the TPQ ($\beta = -.25$). Finally, clients who had used heroin during treatment were more likely to report lower satisfaction scores ($\beta = -.29$).

Discriminant validity

A first assessment of the discriminant validity of the TPQ was obtained from the multiple regression analysis. A more favourable perception of treatment was reported by community versus in-patient subjects. We then assessed the ability of the TPQ to detect differences between community treatments in study two. At six month follow-up, the average total scores were 27.9 (s.d. = 5.2) for subjects receiving injectable methadone maintenance and 22.6 (s.d. = 7.7) for the subjects receiving oral methadone maintenance treatment ($t_{[38]} = 2.06$; $p = .051$). Scores on the two component sub-scales on the TPQ revealed that the groups did not differ in their ratings of satisfaction with the staff in the programme ($t_{[23]} = 0.62$, $p = 0.54$) but that subjects in the injectable MMT group had significantly higher satisfaction ratings of the programme operation (treatment decisions; overall perception of treatment utility; counselling sessions; time in treatment and programme regulations and rules; (mean = 13.93 [s.d. = 2.13] versus mean = 9.55 [s.d. = 4.3]; ($t_{[38]} = 3.32$; $p = .003$).

Discussion

This paper describes the development and initial assessment of the Treatment Perceptions Questionnaire (TPQ). The TPQ is a 10-item questionnaire designed to assess critical issues which influence the treatment satisfaction of people in addiction treatment programmes. The TPQ is the first questionnaire for assessing this response measure in the addiction treatment population to be developed in the UK.

The instrument contains two five-item sub-scales concerning perceptions of staff and perceptions of the treatment programme. The former concerns beliefs about staff's understanding about the client's problems, agreement about treatment objectives, availability for talking to, ability to motivate, and professional competence. These items emerged as a main dimension in our exploratory factor analysis. The second five items assess a client's perceptions of various aspects of the operation of the treatment programme as follows: communication about treatment decision-making, treatment expectations, therapeutic content, time in treatment, and programme rules and regulations. The instrument contains a mix of five positively and five negatively worded items to minimise response bias. Scoring of the TPQ is straightforward and achieved by summing the item weights across the 10 items. If desired, the two sub-scales can be scored individually to examine response patterns on the staff and programme items separately.

Studies of the internal and test-retest reliability of the TPQ were satisfactory. The test interview conducted with 123 subjects, produced internal reliability coefficients for the staff perceptions sub-scale of .76 (.71 for the staff perceptions, and .83 for the total score). It would now be useful to conduct confirmatory factor analyses with further samples of subjects in addiction treatment programmes. We plan to include the TPQ in further treatment evaluation research activities for this purpose.

In terms of test-retest reliability, the TPQ achieved low but acceptable ICC estimates. This result, although endorsing the reliability of the measure, does suggest that treatment perceptions are likely to fluctuate to some extent across short periods of time. A response discrepancy analysis between the test and retest interviews was not conducted in the present study and a further exploration of whether response variation is attributed by the client to events occurring during the retest interval or a different overall evaluation, would be of interest.

Much of the literature from the general mental health field has suggested that there may be little variability in satisfaction scores both within client samples and across treatment settings (see Lebow, 1982). In part, this may reflect a reluctance of dissatisfied clients to express their feelings. Whilst our findings suggested that subjects with substance use problems were broadly satisfied with their current treatment, satisfaction scores were associated with several individual and treatment-related factors. The results of multiple regression analysis suggested that longer waiting times

before intake resulted in a lower satisfaction rating at interview across both settings, while favourable initial perceptions of treatment at intake translated into higher satisfaction ratings at interview. The importance of minimising access time for clients assessed for a residential treatment programme has been recognised by researchers and policy makers (Love & Gossop, 1985; Tackling Drugs To Build A Better Britain, 1998). Some clients undoubtedly find it difficult to maintain their commitment to enter treatment and drop-out is a serious problem during waiting periods. Overall, our findings support attempts to reduce waiting time as long waiting lists may lead to lower levels of subsequent treatment satisfaction. In the development of the instrument, concerns about access to treatment (specifically about problems travelling to the services) were identified as a problem by only 7% of the subjects in the study. Researchers and programme staff wishing to use the TPQ may wish to incorporate open ended questioning to their assessment procedures about treatment access if this is considered to be an issue in the local area.

Our analysis also established the discriminant validity of the TPQ. There were treatment setting differences in satisfaction ratings, with higher TPQ scores observed for the community treated clients. A formal test of the utility of the TPQ for outcome research purposes showed that clients receiving injectable methadone maintenance treatment reported higher TPQ scores in comparison to clients receiving standard maintenance treatment with oral methadone. We have described elsewhere that clients receiving in-patient treatment may be critical of various aspects of a programme's rules and regulations and this may account for the observed differences (Bacchus *et al.*, 1999). For the community treatment clients, the duration of the current episode was negatively associated with treatment satisfaction. This association stands in contrast to previous research which has found either no or a modest positive association between treatment duration and satisfaction (Joe & Friend, 1989; Chan *et al.*, 1997). In addition, clients who reported using heroin during treatment were more likely to report lower satisfaction ratings. Overall, the findings presented in this paper raise important issues about the need for further research on the nature, experience and response of clients in methadone and other longer-term treatment programmes. How treatment regulations and other factors are perceived by clients and how these perceptions influence treatment participation and treatment outcomes also warrant closer investigation.

The results of the TPQ development study suggest that it may be a valuable component of both formal studies of treatment process and outcome and routine programme audit. For outcome monitoring applications, the TPQ could be used alongside follow-up administration of the Maudsley Addiction Profile (Marsden et al. 1998) as a moderator of primary treatment outcomes. Although the TPQ was developed as an independent interviewer-administered instrument, we foresee few problems in using the instrument in an anonymous self-completion format. In this context, the addition of a brief section for clients to record basic personal demographic information would be valuable as would the addition of an open question inviting respondents to record specific dissatisfying issues encountered and/or their suggestions about ways in which the programme can be improved.

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