

## REFERRER SATISFACTION WITH A COMMUNITY TEAM FOR PEOPLE WITH LEARNING DISABILITIES

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### Introduction

There is increasing interest in involving the 'consumer' in the evaluation and planning of human services (e.g. Kelman, 1976; Morrison, 1978; Martin, 1986). One of the reasons for this is the recognition that there are some aspects of service quality for which the consumer is the only valid judge (Donabedian, 1982). Consequently consumer satisfaction with services is now an important index of service quality (e.g. Donabedian, 1982; Justice and McBee, 1978; Ovretveit, 1990). There have been a small number of detailed studies of consumer satisfaction with services to people with learning disabilities (Lowe, 1992; Lowe and De Paiva, 1988; Takahashi and Ooshima, 1990; Thomas *et al.*, 1980). For example Lowe (1992) interviewed 31 families of clients who received NIMROD services.

She found high levels of satisfaction with these services, although there was some suggestion that as families became more familiar with the service they began to expect more from it and so became more critical. However, most of this work concerns special projects to measure consumer opinion of specially resourced services. Although the work of Community Teams for People with Learning Disabilities (CTPLDs) is reasonably well documented (e.g. Grant *et al.*, 1986; Pollitt and Cooke, 1989; Cooper and Bonham, 1987) there are no published accounts of routine satisfaction surveys of referrers to such teams as part of a regular quality assurance process.

Satisfaction surveys of referrers are made difficult by a number of factors (Shaw, 1976; 1984). Referrers may suspect

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that if they criticize a service this may affect the future or current treatment of the client and they may not have the experience of alternative services needed to make useful comparisons (Shaw, 1976; 1984; Gutek, 1978). Thus changes in satisfaction over time may reflect changes in the referrers' knowledge of alternatives and increased confidence in the service rather than simple changes in satisfaction (e.g. Lowe, 1992). There are also a number of methodological difficulties in satisfaction surveying. For example face-to-face interviewing may provide useful information (e.g. Lowe, 1992) but is time consuming. Postal questionnaires take less time but suffer from low response rates (Moser and Kalton, 1971) and may only provide global statements of satisfaction and dissatisfaction from which it may be difficult to identify and prioritize areas for service improvement (Larsen *et al.*, 1979). Lebow (1982) notes that little attention has been paid to the psychometric properties of satisfaction measures. The Client Satisfaction Questionnaire (CSQ; Larsen *et al.*, 1979) is one of the few well researched such questionnaires. However, the CSQ is concerned with global satisfaction and uses forced-choice questions and so does not offer a solution to the problem of how to recommend specific service changes on the basis of such responses. An adaptation of the CSQ for child and adolescent psychology services (Dagnan and Fish, 1991) used a number of open-ended questions to supplement the forced-choice items. They found that 75% of respondents gave information in response to the open-ended items that was useful in recommending changes to the service.

This paper describes the adaptation of the CSQ for use in routine satisfaction surveying of referrers to a Community Team for People with Learning Disabilities in Solihull, a borough to the south of Birmingham, UK. We present the form of the satisfaction questionnaire, data concerning the nature of referrals and responses to the questionnaire. This study forms part of an annual evaluation of the activity of the team. Solihull has a population of 200,000 people. It encompasses a wide variety of communities ranging from small villages to larger, suburban housing developments. The community team works from two bases which serve the north and south of the borough. The core team members are community nurses, social workers, direct care workers, psychiatrists, psychologists and psychology assistants. Other professionals attend the meetings on a regular basis. The team aims to enable people with a learning disability to lead an ordinary life by working in partnership with parents, professional carers and people with learning disabilities themselves. The team has an open referral system by which any person may refer to it although the team only accepts referrals for people aged 17 and over.

## **Method**

### *The characteristics of referrals to the team*

A Social Services Department Referral Form is completed for every referral to the Community Team. This provides brief demographic and referral data including who the person lives with, date

of birth, whether they are aware of the referral and whether they are already known to the team. Fifty-seven people were referred to the team in 1991; all referral forms were examined and the information coded. Other information recorded at the time of referral was also coded, specifically the reason for referral as identified at the time of referral and the team decisions regarding action on the case. In addition the date of the referral and the date of the next entry into case notes following the date of referral were recorded.

### *The satisfaction survey*

The CSQ was adapted for use with referrers to the Community Team. A copy is available from the authors. The questionnaire consists of eight forced-choice questions and two open-ended questions; it covers two sides of A4 paper. Questions are concerned with general satisfaction and not aimed at specific aspects of services. An example is 'If a colleague or a friend were in need of similar help would you recommend the CMHT to them?' The open ended questions each followed a related forced-choice question. For example following the forced-choice question, 'To what extent has the CMHT met the needs of the person you asked for help with?', the open ended question was 'Could the CMHT have done more to help you with the person you contacted them about?' Care was taken that terms used would be understandable both to professional referrers and families; for example 'a referral' was described as 'asking for

help'. The case with which the questionnaire could be read was assessed using the Flesch formula (Ley, 1973). The questionnaire has Flesch reading ease score of 83 which means it will be easily read by most people.

Exploratory psychometric analysis was carried out using the 20 full replies received in the present study. Larsen *et al.* (1979) reported a single factor structure for the CSQ, with the factor accounting for 43% of the total variance. The adapted version of the scale reported here also has a single factor structure with the main factor accounting for 75% of the total variance. Similarly Larsen *et al.* (1979) report an alpha coefficient of 0.93; the alpha coefficient for the adapted scale is 0.95. Thus the adapted scale seems to be measuring a single construct of general satisfaction and is highly internally consistent. However, the analysis needs to be repeated with a larger data set to confirm the robustness of these psychometric data.

A full list of referrer names and addresses was taken from the referral forms. Satisfaction questionnaires were sent to the referrers of 43 (75%) clients. Fourteen referrers were not sent a questionnaire. Of these six were people with learning disabilities who had referred themselves and who need a different approach to satisfaction surveying; two were people who had moved and for whom there was no forwarding address; one was a professional who was known not to be working in the area; and five were referrers for whom there were insufficient data to enable a questionnaire to be sent. The satisfaction survey was

sent with a covering letter and a stamped and addressed return envelope in February 1992.

## Results

### *Characteristics of the referrals*

The 57 people who were referred to the team had an average age of 31 years (SD = 16). TABLE I shows other characteristics of the people referred and people making referrals to the team in 1991. TABLE II shows the main reason for referral; these data were available for 44 referrals. The four most common reasons for referral are for general advice, housing advice, benefit advice and challenging behaviour. This table illustrates the broad range of health, behavioural and social problems addressed in the work of the community team. TABLE III shows the decisions taken regarding involvement with referrals. In this table 'no further action' refers to cases which were judged inappropriate for the team and who were referred onto other services; 'limited action' refers to cases which only required brief involvement such as telephone advice, attendance at single review meetings, enabling access to respite care services; 'ongoing involvement' refers to cases which required further worker involvement. Eighty-two percent of known responses involve at least limited action. The median number of working days from referral to the first entry in case notes was 4.0 (Semi-Interquartile Range 0.5 - 10.0).

### *The satisfaction survey*

Forty-three satisfaction questionnaires were sent in February of 1992. The 43 to whom the questionnaire was sent differed significantly from the 14 to whom it was not sent on one variable, that of referral agent. Questionnaires were sent to 52% of family and self referrers and to 93% of professional referrers (Chi-Square = 11.66,  $df = 2$ ,  $p > 0.01$ ). However, this difference is accounted for by the decision not to send the postal questionnaire to the 6 people who had referred themselves.

Responses were received from 23 (53%) of surveyed referrers; three of these respondents returned a blank questionnaire as they had simply referred on a client with whom they had had no contact. As postal questionnaires rarely achieve very high responses (Moser and Kalton, 1971) it is important to establish whether those who respond are representative of the total population to whom the questionnaire was sent. A series of chi-square tests demonstrated that the people who returned questionnaires and those who did not do not differ significantly on any of the client, referrer or referral characteristics discussed above.

The item responses were summed to gain an overall 'score' for satisfaction. Whilst this is not very informative by itself it does provide information that can be used to compare satisfaction with a service over time and to identify those referrers who are most and least satisfied with the service they received. The median score for the 20 completed questionnaires was 25.5 (Semi-Interquartile

**TABLE I**  
**Characteristics of clients and referrers**

<b>CLIENT CHARACTERISTICS</b>	<b>Number</b>	<b>Percent</b>
<b>Sex</b>		
Female	19	33
Male	38	67
<b>Client told of referral</b>		
Yes	38	67
No	13	23
Not recorded	6	10
<b>Client already known to team</b>		
Yes	33	58
No	14	25
Not recorded	10	17
<b>Occupation</b>		
Employed	3	5
Not employed	38	66
School	10	17
Not known	4	7
Not recorded	2	3
<b>Marital status</b>		
Single	43	75
Other	7	12
Not known	3	5
Not recorded	4	7
<b>Ethnic origin</b>		
UK European	45	79
Afro/Caribbean	2	3
Not known	7	12
Not recorded	3	5
<b>Client lives with</b>		
Alone	1	2
With family	36	63
In residential services	12	21
Not known	6	10
Not recorded	2	3
<b>REFERRER CHARACTERISTICS</b>		
<b>Referrer agent</b>		
Self	6	10
Relative	17	30
Professional agency	29	51
Not recorded	5	9
<b>Referral method</b>		
Interview	15	26
Telephone	37	65
Not recorded	5	8

**TABLE II**  
Reasons for referral

Reasons for Referral	Number	Percent
Advice	10	27
Accommodation	7	19
Challenging behaviour	6	16
Benefits	6	16
Skills training	4	11
Other placement	3	8
Psychological therapy/counselling	3	8
Sexual abuse	2	5
Respite care	2	5
Medical	1	3
Aids and adaptations	1	3

**TABLE III**  
Decisions for action on 1991 referrals

Action	Number	Percent
No further action	6	11
Limited action	11	20
Ongoing involvement	17	30
No information	22	39

Range 20.5 - 29.0). This is a similar median and range to that reported by Larsen *et al.* (1979). Open-ended responses were given in 16 (80%) of the questionnaires.

The open-ended responses were coded into broad categories of positive, negative and neutral comments.

### *Positive Responses*

There were 2 broad categories of positive response:

1. General positive statements or compliments. Six respondents made com-

ments in this category. Examples include *'They did a good job with (name) at the right speed and balance'*; *'The CMHT has helped in every way with all of our clients'*.

2. Acknowledging the reliability of the service. Three respondents made comments in this category. For example one respondent noted that *'The response was quick and friendly, visits were made when they said they would be'*; *'They found the information I wanted very quickly . . . and followed up their assistance the following day by offering further guidance and support'*.

## Negative Responses

There were 2 broad categories of negative response:

1. Professionals who felt that they should have been given more information about the CTPLD's work with clients they had referred. Three respondents made comments like this. For example, *'... frequently feel that I am playing guessing games to gain full information about some individuals'*.
2. Families who felt that they needed further involvement from the team. Five people made comments in this category. For example, *'You never see anyone, hear off anyone to see how you are coping, and when you do need help they don't seem to want to know.'*

## Neutral Responses

There were 3 broad categories of response that were neither positive or negative.

1. Two people felt that the team had not helped with a referred client but noted particular difficulties that the case had presented. For example one respondent noted that the family situation of a referred client made resolution of a problem difficult.
2. Two people stated that the CTPLD's involvement in a case was ongoing and therefore they could not comment on the service.
3. Five respondents noted that a service they required was not available. For example, *'I found the team leaders attitude most helpful and friendly. He gave me information to pass to the family, but*

*unfortunately was unable to help with their particular problem . (I am sure he would have helped if he could.)'*

The satisfaction scores were used to identify cases of extreme satisfaction and dissatisfaction with the CTPLD's services. The questionnaires with the top 25% of scores and those with the bottom 25% of scores were identified and the comments made on these responses were examined. The questionnaires with the bottom five scores (those scoring 20 or less) contained comments as follows: 2 negative responses, both felt they had needed more involvement than had been offered by the team; 2 non-judgemental responses, 1 acknowledged special difficulties in working with a referred client, the other recognised that the CTPLD was not the appropriate team for the referral; 1 contained no written comments. The questionnaires with the top six scores (those scoring 29 or above) contained comments as follows: 4 positive compliments on the service; 1 acknowledged specific difficulties with the referred client but also considered they should have been told more about the work that had been carried out; 1 made no comment.

## Discussion

This report has presented the results of a satisfaction survey of referrers to the community team for people with learning disabilities in Solihull in the West Midlands. A response rate of 53% for a postal survey can be considered

adequate (Moser and Kalton, 1971) and responses concerned a representative sample of referrers and those being referred to the team in 1991. The majority of referrers to the team express satisfaction with some aspects of the services they received. Two areas of dissatisfaction were identified. First a number of professional referrers felt that they would have liked to know more about the work of the team with the clients they referred. The second major area of dissatisfaction relates to non-professional referrers who felt that the team could have been more involved with their referrals. It is not possible to comment on the appropriateness of the level of involvement and communication given by the team. In these cases, however, the comments may reflect a need for collaborative goal setting with clients and referrers so that it is clear from the outset the amount and type of work being agreed and the level of communication that will occur concerning this work. Such agreements could be renegotiated periodically. These areas have been targeted for improvement within the quality assurance process.

The satisfaction questionnaire was easily readable and the adaptation does not seem to have altered its psychometric properties. Further adaptation is also possible. For example Larsen *et al.* (1979) indicate three of the questions are a good representation of the full questionnaire. Thus the questionnaire can be further developed to reflect the concerns of consumers in Solihull whilst retaining a minimum of these three questions to allow comparison over time and between services.

The only group who were not represented in the satisfaction survey were people with learning disabilities who referred themselves. Techniques to interview a sample of people with learning disabilities to establish their satisfaction with the services they receive have been described (Lowe and De Paiva, 1988; Atkinson, 1988; Flynn, 1986). We hope to pilot these in relation to the CTPLD in the next year. It is important that the clients' view is taken into account as it indicates that their views are valued and they have a unique perspective of the services provided. However, Ovretveit (1990) cautions against considering consumer satisfaction the only measure of quality; professional standards of quality should also be considered.

The satisfaction questionnaire reported here has provided useful information giving a total score to use both for comparison purposes and to identify those people who are most and least satisfied with services. Eighty percent of respondents gave open-ended responses which have identified specific areas which have been targeted for improvement within the quality assurance process. The questionnaire is brief and has elicited responses from a representative sample of referrers.

## References

- Atkinson, D. (1988). Research interviews with people with a mental handicap. *Mental Handicap Research*, 1, 75-90.
- Cooper, D. A. and Bonham, K. G. (1987). A study of two community mental handicap teams in Scotland. *British Journal of Mental Subnormality*, 33, 117-130.

- Dagnan, D. J. and Fish, A. J. (1991). A pilot satisfaction questionnaire for use in a child and adolescent psychology service. *Clinical Psychology Forum*, Number 35, 21-24.
- Donabedian, A. (1982). *Exploration in Quality Assessments and Monitoring. Volume II. The Criteria and Standards of Quality*. Ann Arbor, Michigan, Health Administration Press.
- Flynn, M. C. (1986). Adults who are mentally handicapped as consumers: Issues and guidelines for interviewing. *Journal of Mental Deficiency Research*, 30, 369-377.
- Grant, G., Humphreys, S. and McGraith, M. (1986). *Community Mental Handicap Teams: Theory and Practice*. Kidderminster: British Institute of Mental Handicap.
- Gutek, B. A. (1978). Strategies for studying client satisfaction. *Journal of Social Issues*, 34, 44-56.
- Justice, B. and McBee, G. (1978). A client satisfaction survey as one element in evaluation. *Community Mental Health Journal*, 14, 248-252.
- Kelman, H. R. (1976). Evaluation of health care quality by consumers. *International Journal of Health Services*, 6, 431-442.
- Larsen, D. L., Attkisson, C. C., Hargreaves, W. A. and Nguyen, T. D. (1979). Assessment of client/patient satisfaction: Development of a general scale. *Evaluation and Programme Planning*, 2, 197-207.
- Lebow, J. L. (1982). Consumer satisfaction with mental health treatment. *Psychological Bulletin*, 91, 244-259.
- Ley, P. (1973). The measurement of comprehensibility. *Journal of the Institute of Health Education*, 11, 17-20.
- Lowe, K. (1992). Community-based service - what consumers think. *The British Journal of Mental Subnormality*, 38, 6-14.
- Lowe, K. and De Paiva, S. (1988). Canvassing the views of people with a mental handicap. *The Irish Journal of Psychology*, 9, 220-234.
- Martin, E. (1986). Consumer evaluation of human services. *Social Policy and Administration*, 20, 185-200.
- Morrison, J. K. (1978). The client as a consumer and evaluator of community health services. *American Journal of Community Psychology*, 2, 147-153.
- Moser, C. A. and Kalton, G. (1971). *Survey Methods in Social Investigation*. London, Heinemann Educational Books.
- Ovretveit, J. (1990). *Quality Health Services*. Brunel University: Health Services Centre.
- Pollitt, A. and Cooke, L. (1989). Reflections of a community mental handicap team. *Mental Handicap*, 17, 154-155.
- Shaw, I. F. (1976). Consumer opinion and social policy. *Journal of Social Policy*.
- Shaw, I. F. (1984). Consumer evaluation of personal social services. *British Journal of Social Work*, 14, 277-284.
- Takahashi, A. and Ooshima, M. (1990). Consumers' view of a community care program. In Fraser, W. I. (Ed.). *Key Issues in Mental Retardation Research*. London: Routledge.
- Thomas, D. A., Smith, P. S. and Smith, L. J. (1980). Consulting the consumer. *Health and Social Services Journal*, February, 225-226.