International Journal of Mental Health Nursing

*International Journal of Mental Health Nursing* (2018) ••, ••–•• doi: 10.1111/inm.12454

SPECIAL ISSUE

# Satisfaction guaranteed? Forensic consumer satisfaction survey

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**ABSTRACT:** *Despite many people being forensically hospitalized worldwide, there is limited research reporting on their views of the care they receive. To describe consumer satisfaction and areas for improvement, we utilized our forensic psychiatric hospital's consumer survey. Eleven years of surveys, including a total of 541 surveys, were analysed both quantitatively and qualitatively. The majority of the forensic inpatients believed that their views were valued in their care and treatment. Most felt physically and emotionally safe at the hospital and believed that staff knew how to support them in times of distress. The majority felt that their culture and spirituality were respected. However, some areas for improvement were also noted, such as regarding staff attitudes. This consumer survey demonstrated a reasonably high level of satisfaction with forensic inpatient care, over the course of eleven years, despite this population of people being subject to lengthy hospitalisations. Satisfaction surveys of people in forensic inpatient units can be a regular part of forensic care and can help guide improvements in their care.*

**KEY WORDS:** *attitude of health personnel, consumer, hospitalisation, personal satisfaction, spirituality.*

## INTRODUCTION

The concept of satisfaction with mental health services is one that is becoming paramount to providing quality care. As such, performing consumer satisfaction surveys with those receiving mental health care is now a well-established practice (Boyer *et al.* 2009; Bressington *et al.* 2011; Woodring *et al.* 2004; Zendjidjian *et al.* 2015). Similarly, focus on consumers' perceived quality of care within a forensic setting is gaining traction; however, there is still a relative dearth of research regarding this unique population (Coffey 2006).

Health practitioners have a duty to provide good quality care, and patient satisfaction is linked to improved health outcomes and recovery (Boyer *et al.* 2009; Roche *et al.* 2014; Svensson & Hansson 1994) for psychiatric patients. Therefore, focussing on improved satisfaction should be essential to the provision of care. Forensic patients have a longer length of stay in inpatient settings compared to those on general mental health inpatient units, which is subsequent to the direction of the court, and takes into account their high and complex needs (Simpson *et al.* 2006). Therefore, given that forensic patients are often subject to inpatient treatment for many years, their perception of this treatment becomes even more important.

Whilst there is some research investigating consumer satisfaction in forensic mental health inpatient units, it is still in its infancy and tends to be cross-sectional. The authors of this study, one of whom was the consumer advisor for the service, therefore aimed to investigate the satisfaction with services that forensic

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**Authorship Statement:** Tracey Cannon conceptualized the study, collected the data, and participated in the write-up. Sigourney Taylor participated in data analysis and write-up. Susan Hatters Friedman conceptualized the research questions and participated in data analysis and write-up. All authors listed meet the authorship criteria per the latest guidelines of the International Committee of Medical Journal Editors. All authors are in agreement with the manuscript.

**Disclosure:** None.

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Accepted February 18 2018.

consumer populations experienced over a decade, and to explore the differences between those who were inpatient in the acute and rehabilitative streams. The study highlights the role the consumer advisors played in the design, implementation, and development of the survey over time.

## METHODS

### Setting

The Mason Clinic serves as one of five regional forensic services in New Zealand. It has a catchment area of 1.5 million and has 111 inpatient beds. The Mason Clinic has traditionally had an acute stream, which cares for people who have usually come via courts or prison and consisting of two inpatient units; and a rehabilitation stream, which cares for people who require longer-term support to address mental health, offending, and risk issues and comprises of six units. The mean length of stay in the acute stream was approximately two months and in the rehabilitation stream around 3 years.

Maori, the indigenous peoples of New Zealand, make up roughly half of the inpatients at the Mason Clinic. The Mason Clinic has a Kaupapa Maori unit, Tane Whakapiripiri (TWP), which opened in 2006 within the rehabilitation stream. TWP combines western psychiatry with a Maori world view and is open to patients who want a Maori values-based pathway. Patients are encouraged to participate in a programme that emphasizes their cultural heritage, the community they are linked to via this heritage, their Mana (a Maori sense of internal and external honour, gravitas, belonging, prestige, and how one relates to the world and oneself) and how this relates to their recovery.

Mason Clinic employs two consumer advisers who liaise with patients, ascertain their experience and views of the service, and ensure these views are represented within all aspects of planning, implementation, and delivery of the service.

### Design

The development of the Mason satisfaction survey was led by the consumer advisors. The survey was designed to be primarily a quality improvement tool. Initial design, analysis, and reporting for the first year were collaborative efforts between service management, quality leads, and the consumer advisors with the consumer advisors taking responsibility for ongoing development and reporting in all subsequent years.

The initial survey questions were developed in 2003. The survey was designed with three key aims: to monitor responsiveness to The Health and Disability Commissioner's (HDC) Code of Rights, to give appropriate attention to cultural responsiveness in line with the Treaty of Waitangi, and to ascertain from patients how 'important' they perceived the topics in the survey to be.

These aims resulted in four measures being considered: Hua Oranga (a Maori measure of mental health outcome), the recovery competencies as described by the Mental Health Commission's report in 2001, the National Mental Health Standards, and the HDC Code of Consumer Rights. The aims and measures were synthesized into ten question topics: rights, participation, information, culture and spirituality, safety, programmes and activities, rehabilitation and recovery, complaints, family or whānau involvement, and staff attitudes and abilities.

The first survey tool included a Likert scale for each question ranging from 'very important to me' to 'not important at all' to ascertain the relative importance of each area to participants. The survey tool was piloted in one acute and one rehabilitation unit before being administered throughout the hospital. Results for the first year indicated all areas asked about were important to the majority of participants.

Throughout the eleven years that the survey was administered, the consumer advisors changed and added some questions in response to developments in mental health and evolving evidence regarding features which participants found important. Therefore, these questions were assessed for utility and consistency, and a final question bank of 50 questions under 14 different subheadings was collaboratively decided upon for analysis. From 2004 to 2009, the scale utilized in the survey was 'yes, some, no', whereas from 2010 to 2014, the Likert scale included 'strongly agree, agree, don't know, disagree, strongly disagree'. For example, a question changed from 'Do you feel that you understand your rights?' in the 2004–2009 group to 'I understand my rights.' for the 2010–2014 group.

For the current study's analysis, 16 questions were chosen of these 50 as being the most pertinent to our study aim. These questions were used across the study years. These questions were chosen to be most in line with the current research internationally, which focuses on safety, involvement in decision-making, environmental factors, and interpersonal relationships

as paramount to good care (Boyer *et al.* 2009; Eggert *et al.* 2014; MacInnes *et al.* 2014; Shiva *et al.* 2009a,b). These consisted of nine quantitative and seven qualitative questions as follows.

### Quantitative

1. Do you feel that you understand your rights?
2. Are you involved in your care/treatment?
3. Would you feel comfortable making a complaint?
4. How safe do you feel physically?
5. How safe do you feel emotionally?
6. Do you feel that your culture is respected?
7. Do you feel that your spiritual beliefs are respected?
8. Are you satisfied with the involvement of your family/whānau in your care and treatment?
   (Whānau is a Māori noun referring to extended family, or family group)
9. Do staff help with your recovery?

### Qualitative

1. What makes you feel safe?
2. What makes you feel unsafe, and how could this be addressed?
3. Which programme/activity has been most benefit and why?
4. What keeps you going in difficult times?
5. What attitudes or input from staff are most helpful to you?
6. What attitudes or input from staff are not helpful?
7. What is most helpful for your recovery?

### Participants

The survey was administered annually from 2004 to 2014. The consumer advisers administered the survey at the individual forensic hospital units and were present to ensure no patient answered the questionnaire twice in the same year. Surveys were explained in unit groups, and all patients in the unit were eligible to participate. Excluded were those patients on leave, those in high care areas, and those in the intellectual disability unit. Participation was voluntary. The surveys were anonymized. After the first couple of years of administration, two $50 gift vouchers were offered as random draw prizes to those who had completed the survey.

### Analysis

The analysis was separated into two groups: the acute group and the rehabilitation group. The acute group consisted of all surveys that were answered whilst the participant was in the acute unit of the hospital, and similarly for the rehabilitation group. Quantitative data were analysed using SPSS (version 22). Quantitative data were analysed in survey year subgroups due to the evolution of the questionnaire. Because the survey evolved over the years, to allow for statistical validity, the differing scales were analysed separately. During the analysis, the 'yes' and 'some' answers were combined in the 2004–2009 scale. The 'strongly agree' and 'agree' answers, and the 'strongly disagree' and 'disagree' answers were combined for analysis of the 2010–2014 data. The 'don't know' answer was omitted from 2010 to 2014.

The survey year subgroup responses were then analysed. The 2004–2009 surveys were analysed using chi-square analysis, and the 2010–2014 surveys were analysed using Wilcoxon and Mann–Whitney tests.

Qualitative data were analysed using content analysis. A theme was considered to be a subject or keyword that participants recurrently identified in their comments. Comments could be considered under more than one theme if they contained multiple subjects. The themes were then analysed for frequency, and illustrative quotes were recorded.

This project was approved by the Awhina Research and Knowledge Centre (Registration # RM13582) which is the research centre of the local district health board.

## RESULTS

Over the 11 years, 541 surveys were returned out of a possible 1034, averaging 49 per year, and yielding a 52% return rate.

### Quantitative results

Overall, the majority of participants responded positively about satisfaction in both the acute and rehabilitation groups. For every question posed, the majority of participants answered either 'yes + some' or 'strongly agree + agree'. This was consistent across both time periods, and in both groups (acute and rehabilitation). The percentage of positive response ranged from 71.2% (for the question 'would you feel comfortable making a complaint?') to 98.2% (for 'Do staff help

with your recovery?'). The breakdown of the results for each question is shown in Table 1.

Within the 2004–2009 time frame, a statistical trend ($P < 0.06$) was noted for two of the questions, with rehabilitation stream participants being more likely to be satisfied than those in the acute stream. Participants in the rehabilitation stream were more likely to answer in the affirmative to the question 'Are you involved in your care/treatment?' when compared to those in the acute stream, with 88.9% answering 'yes + some' in the rehabilitation stream versus 79.8% answering 'yes + some' in the acute stream ($P$ value = 0.054). Similarly, for the question 'Do you feel that your spiritual beliefs are respected?', 87.8% of those in the rehabilitation stream answered in the affirmative, compared to 78.4% in the acute stream ($P$ value = 0.053); however, both streams had a positive response to the similar question 'Do you feel that your culture is respected?' (83.7% and 89.0% answering 'yes + some' for the acute and rehabilitation streams, respectively, with no statistically significant difference).

Within the 2010–2014 time frame, those in the rehabilitation stream were significantly more likely to be satisfied than those in the acute stream, in two areas. More participants noted they would feel comfortable making a complaint in the rehabilitation stream compared to the acute stream with a mean positive rank of 21.52 ($P$ value = 0.001). More rehabilitation group participants felt as though staff helped with their recovery compared to those in the acute stream, with a mean positive rank of 20.00 ($P$ value = 0.018).

When comparing the 2004–2009 subgroup with the 2010–2014 subgroup, the results were more positive with the 2010–2014 surveys across all parameters; however, we were unable to accurately assess whether this was a significant finding over the years due to the different scales of measurement utilized.

Our survey found no significant difference between feeling culture is respected across the acute and rehabilitation groups, but both had positive responses ranging from 84% to 93%. However, when we compared TWP with the other general rehabiliation units, there was no significant difference in response to the questions of spirituality, culture, or whanau involvement. This analysis was likely impacted by the small sample size (TWP has ten beds).

## Qualitative results

The opportunity for participants to provide written comments was an attempt to allow for deeper insight into their experience of living in the forensic hospital. Themes noted in response to qualitative inquiries will be further described in this section.

A common theme running through the qualitative responses was regarding the importance of interpersonal relationships. Friends, family, and other patients were identified numerous times; however, it was patient–staff relationships that were most commonly mentioned. For example, staff attitudes were identified as helping with feelings of safety in 30% of responses, and one-third (33%) of responses to 'what helps in times of intense distress' noted staff attitudes as helpful. One participant commented they found it helpful 'knowing there are always people around you can talk to and seek advice from'.

When asked further what attitudes or input from staff were most helpful, over one quarter (27%) of responses discussed practical help, guidance, and encouragements as being most helpful. One-fifth (20%)

**TABLE 1:** *Consumer satisfaction among acute and rehabilitation stream forensic inpatient service users* (N = *541*)

| | Acute 04-09 Yes + some % (*N*) | Rehab 04-09 Yes + some % (*N*) | *P* value | Acute 10-14 Strongly Agree + agree % (*N*) | Rehab 10-14 Strongly agree + agree % (*N*) | *P* value |
|---|---|---|---|---|---|---|
| Do you feel that you understand your rights? | 74.2% (92) | 78.6% (88) | 0.430 | 81.7% (58) | 89.2% (83) | 0.167 |
| Are you involved in your care/treatment? | 79.8% (99) | 88.9% (104) | 0.054 | 85.2% (75) | 90.8% (99) | 0.224 |
| Would you feel comfortable making a complaint? | 75.4% (92) | 80.0% (92) | 0.397 | 71.2% (74) | 89.9% (71) | 0.001 |
| How safe do you feel physically? | 85.5% (112) | 90.8% (108) | 0.201 | 91.1% (82) | 94.6% (106) | 0.326 |
| How safe do you feel emotionally? | 79.7% (98) | 86.2% (94) | 0.187 | 88.9% (80) | 86.1% (93) | 0.558 |
| Do you feel that your culture is respected? | 83.7% (108) | 89.0% (105) | 0.231 | 92.7% (76) | 88.8% (87) | 0.372 |
| Do you feel that your spiritual beliefs are respected? | 78.4% (98) | 87.8% (101) | 0.053 | 87.0% (67) | 90.4% (85) | 0.480 |
| Are you satisfied with the involvement of your family/ whanau in your care and treatment? | 82.6% (100) | 88.7% (102) | 0.186 | 90.7% (78) | 91.2% (103) | 0.912 |
| Do staff help with your recovery? | 87.5% (70) | 90.4% (66) | 0.567 | 93.1% (81) | 98.2% (110) | 0.018 |

also found discussions with staff – and staff who listened – to be helpful. One participant described how they viewed their position in the system: 'I would like my keyworker to be working on my behalf, not giving most weight to what the service would want'.

When asked what is 'not helpful' to their recovery, most commonly, one quarter (26%) reported it was negative comments from staff. A further fifth (20%) commented on bullying, dishonesty, or manipulation, with one participant describing this a 'We hold the keys' attitude, "you're a nobody" attitude'. Staff attitudes were reported to make participants feel unsafe in 15% of responses. Also, one quarter (26%) commented that they felt unsafe in relation to other patients.

With regard to frequencies of write-in responses, the qualitative questions regarding what programmes or activities were most beneficial were answered by the largest number of participants. A number of inpatient programmes (led by a variety of healthcare professionals) were oft mentioned, but the most popular programmes and activities were related to exercise, with the large majority (89%) of participants mentioning a form of exercise in their responses. Rugby, handball, basketball, and going to the gym were all considered beneficial, but when asked what activity or programme had been of most benefit, the overwhelming response was 'volleyball'. Volleyball is a longstanding tradition in the Mason Clinic.

Several participants noted that the activities that benefited them most were those based in Maori culture; 'Doing Maori Studies and learning about my whakapapa, genealogy of my ancestry roots'. Likewise, one-fifth (21%) identified the inpatient programmes, groups, and therapy as being the most helpful for their recovery. A further 17% stated that staff attitudes and interactions were helpful to their recovery, and 11% identified family, friends, or their faith as being helpful. One participant summarized these points succinctly: 'support from my family, taking medication, and being involved with all the recovery classes and sports'. Another noted that 'having the right support around me at all times and getting helpful advice' was most helpful.

Similarly, when asked 'What keeps you going in difficult times?', 29% identified faith or religion, and 22% identified family and friends, often together in the same comment (e.g. 'by keeping faith with the lord Jesus and my kids'). Participants also demonstrated faith in their own recovery ('My belief that I have a future, and the staff helping me with hard times').

Perhaps the most poetic response to this question was: 'prayer, goal setting, family visits out in the community, appreciation of the moment i.e. blossoms in springtime and new leaves and their depth of colour'. When asked for any final comments, one participant shared a progressive perspective on their recovery: 'I do not see recovery as coming back to the place I was before illness. Recovery is about growth in areas that have been starved of fulfilment'.

## DISCUSSION

Overall, over the eleven years evaluated, forensic inpatient participants were generally satisfied with their care. Results from each of the years and from both the rehabilitation and acute treatment streams were heartening positive, with a majority of participants reflecting positively on their experience at the Mason Clinic across all nine quantitative questions.

Participants in the rehabilitation group reported they felt more involved in their care and treatment, and would feel more comfortable making a complaint than those in the acute group. Staff were more likely to be perceived as being helpful to recovery for those in the rehabilitation group, but over 87% in each group felt that the staff helped in recovery. Feeling more involved in care and treatment could be accounted for by the increased focus on these activities in this longer-term rehabilitation part of the service. Similarly, patients' recovery and staff understanding of their role whilst patients were treated in the rehabilitation stream may account for staff being perceived as more helpful to recovery. Recovery stream participants reporting they would feel more comfortable making a complaint could be explained by more familiarity with these processes as well as acceptance of a longer journey in the service therefore more investment in addressing concerns.

Maori are disproportionately affected by mental illness compared to Pakeha populations in New Zealand (Baxter *et al.* 2006), and resultantly, our study population has a high percentage of Maori. It is crucial that we listen to these voices, as they are most often the silenced ones. A belief that culture is respected, which occurred in over four-fifths of participants, is a positive and important result given Mason Clinic patients are of many ethnicities, including approximately half being Maori. These positive trends could be accounted for by a strong focus within all units on cultural responsiveness, the employment of Maori staff, dedicated cultural advisor roles, and the opportunity for patients to progress through the aforementioned Kaupapa Maori stream. It is difficult to interpret the reasons behind

why those in the rehabilitation group had a trend of their spiritual beliefs to be respected more than the acute group given the lack of difference between regarding whether culture was perceived to be respected. At the Mason Clinic, the two are linked due to the approach towards rehabilitation.

The high satisfaction ratings overall indicate that most participants felt positively towards the Mason Clinic irrespective of whether they were in the acute or rehabilitation streams. This is at odds with the restrictions placed particularly in the acute stream, compared to the increasing autonomy and freedom they have when they have moved along to the rehabilitation stream. Perhaps a component to the lack of difference relates to where persons are admitted from. In the acute stream, some are admitted from a judicial mandate for a period of assessment, some are admitted from other inpatients units in the catchment area where they are struggling to meet their complex needs, and others are admitted from prison, where they have been identified as needing acute care. Possibly, it is this last subset who find the forensic hospital preferable to prison and, as such, rate it well in terms of satisfaction. Another potential reason is a belief they may be adversely affected if they answer negatively.

A number of factors have been previously identified as impacting on how patients rate their satisfaction with hospital services. An English study focusing on cancer patients' satisfaction with treatment highlighted some of these conceptual issues including that patients will generally express satisfaction unless something significant has happened to give them reason to feel otherwise, the impact of patient characteristics such as age and ethnicity, and fear of unfavourable treatment or genuine gratitude (Sitzia & Wood 1998). A discussion of the arguments for and against the use of satisfaction surveys noted a primary criticism of 'disempowerment' wherein patients were regularly uncritical of services received, but that contradictions emerged when a more in-depth analysis of patients' views was performed (Powell *et al.* 2004).

The possible effects of survey administrators were evaluated using a 14-item satisfaction survey developed by the New York State Office of Mental Health. Results indicated that when consumer peers administered surveys, lower satisfaction scores were found than when unit staff administered them, possibly due to more candid responding (Uttaro *et al.* 2004). Given that our surveys were exclusively administered by consumer/peers, one might assume closer alignment to what participants 'really felt'. This then would make the high satisfaction results even more striking. Whatever the reasons behind the quite positive response, it is similar to other consumer satisfaction surveys in closed psychiatric units indicating it is certainly an area for future research (Beate *et al.* 2016; Bressington *et al.* 2011; MacInnes *et al.* 2014; Svensson & Hansson 1994; Woodring *et al.* 2004; Zendjidjian *et al.* 2015).

The prison mental health population in many ways could be considered analogous to our sample population. There are little data on consumer satisfaction of psychiatric services in prison; however, one New York study demonstrated that 79% of responders agreed that they were satisfied (Way *et al.* 2007). A general prison health services satisfaction survey carried out in Norway demonstrated high levels of dissatisfaction, with those who identified as having poorer physical and mental health being less satisfied with their care (Bjorngaard *et al.* 2009). A similar study carried out in Connecticut found that 43% (of 2727) agreed with the statement 'I am satisfied with the healthcare I receive in prison' (Tanguay *et al.* 2014).

The qualitative responses may give some insight into how such a restrictive forensic environment can be seen in a positive light. The most common qualitative response was with regard to what participants felt was helpful with regard to interpersonal relationships. Relationships have similarly been reported as crucial to satisfaction results in previous studies. An English study examined how satisfaction was linked to therapeutic relationships finding that feeling respected and well regarded, beliefs about receiving the right treatment, and feeling understood by clinical staff each had positive impacts on satisfaction, with feeling respected and well regarded being the most important (MacInnes *et al.* 2014). Similarly, another English study of forensic inpatients noted that overall 55% of patients were satisfied with their care, which was strongly associated with therapeutic relationships (Bressington *et al.* 2011). A Pennsylvania study also demonstrated that staff attentiveness and friendliness were among the most helpful in their recovery (Woodring *et al.* 2004).

The reflections and experience of the consumer advisors involved in the service over the survey period also suggest that interpersonal relationships are key. These relationships are one of the hallmarks of being human. We form relationships with everyone we meet, from passing interactions to meaningful connections that last our whole lives. The concept of relationships as crucial to personal growth and development can be seen in attachment theory and social identity theory, among others. Given that inpatients are often detained in forensic hospitals for years, the relationships they

form with staff and other patients have the potential to become a grounding pillar in their lives. On entering the forensic hospital, the previous pillars that form the base of patients' lives such as occupation and activities, home, and ability to connect with others outside the hospital, are severely restricted, leaving them to establish an identity in isolation from these pillars whilst they recover from the challenges and events that brought them into the service. Patients have no control over many of the day-to-day aspects of their lives including limited control about who they interact with. These interactions, therefore, become all the more important. Health professionals have the unique opportunity to influence patients to aid in their recovery and rebuild their lives, and patients have the opportunity to forge a support structure of people who are invested in their recovery, along with other patients who have had similar experiences.

The impact of a restrictive forensic environment and how this impacts satisfaction were seen in a New York study which identified medications, physical environment, telephone access, and unit rules and procedures as critical factors in satisfaction (Shiva *et al.* 2009a,b). Other studies have demonstrated that patients who experienced perceived coercion during their inpatient stay had lower satisfaction with their care (Svensson & Hansson 1994), yet still other studies have demonstrated an inconsistent result with regard to the therapeutic relationship and perceived coercion (Roche *et al.* 2014). Given that coercion could perhaps be considered a marker of negative therapeutic relationship, this merits further exploration.

Finally, another important common factor noted in our survey was the value of physical activity, and particularly volleyball. Volleyball allows one to get outside, engage in a team sport, and hone skills of coordination, concentration, and cooperation, as well as to get a much needed dose of exercise. The exercise component of volleyball is otherwise difficult to attain in a locked inpatient unit. Furthermore, medications used to improve psychotic symptoms often have side effects of weight gain, hypertension, impaired glucose tolerance, metabolic syndrome, and lethargy, a combination that increases cardiovascular risk (Taylor *et al.* 2015). Finally, the positive impact of exercise on mental health has been established (Stanton & Happell 2014). Our findings demonstrate that patients value the opportunity for exercise, and with the multitudinous benefits physical, social, and mental, we hope they will encourage other facilities to build regular team sports into their schedules.

## LIMITATIONS

The change in the response scale over the years unfortunately prevented statistical analysis of how satisfaction may have changed over the years. Similarly, given that many patients stay at Mason Clinic for several years, they may have completed the survey in various years of their hospitalisation. Although efforts were made to ensure all patients were offered the survey, there were a small group of patients who were on leave, or in the seclusion area at the time of the survey administration, thereby preventing participation. The different wording of the questions throughout the years may have impacted how questions were answered, with different emphasis on issues depending on the wording. There have been survey tools created that have been validated within the forensic setting such as the Forensic Inpatient Satisfaction Questionnaire (Shiva *et al.* 2009a,b), which may provide a standardized method of data collection for quantitative research in future studies; however, our study spanned years prior to their development. Finally, the questionnaire did not include data about the participant's ethnicity, although we note that Maori are significantly overrepresented in New Zealand's forensic services.

## CONCLUSION AND RELEVANCE FOR CLINICAL PRACTICE

In line with the primary purpose of their role, the consumer advisors were able to use both the quantitative and qualitative data from the surveys to highlight patient concerns, draw attention to consistent areas of satisfaction and dissatisfaction, and propose changes. Quality improvement activities supported and encouraged by survey data over the 11 years of the survey include in-service educational sessions regarding aspects of low or high satisfaction areas initiated by staff after learning survey results, the production of a patient information pack, the continued highlighting of the importance of programmes and activities to patients which contributed to the development of a programme subservice and structure. Perhaps the most influential 'by-product' of the annual surveys' update and insight into patients' responses to service delivery can be seen in the Mason Clinic's openness to including patients within decision-making structures. This has resulted in an established process for selection and approval of 'consumer representatives (reps)' who are current inpatients who participate in a variety of service decision-making meetings and forums, and more recently the

employment of a former patient of the Mason Clinic to the role of consumer advisor. Along with cultural and family input, patient feedback has significantly increased in prominence when any changes that will impact care and treatment are being considered. This direction does reflect an increased drive for service user input in mental health in general; however, this may be more novel to forensic inpatient services.

## ACKNOWLEDGEMENTS

The authors would like to thank the following people for their contributions: Mason Clinic participants and staff, Jason Kumar, Jason Haitana, Cathy Hotere, Yvonne Parkes, Gareth Edwards, Lucy Dunbar, Audrey Walsh, Dr Brian McKenna, Dr Jeremy Skipworth, Dr Sandy Simpson, Nick Wiki and Iain Nicholson.

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