Consumer Satisfaction with Mental Health Service Delivery in Durban

Submitted by
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DECLARATION

I declare that this dissertation is my own work, which is being submitted for the degree of masters in nursing at the University of Natal Durban.

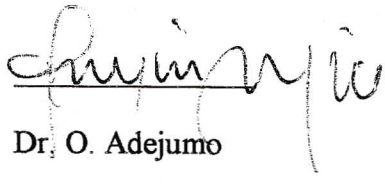
It has not been previously submitted for any other degree or examination in any other university.

Where the author has used the work of others it has been duly acknowledged.

Renée Almeida

January 2002

As the candidate's supervisor I have approved this dissertation for submission



Dr. O. Adejumo

(Supervisor)

Dedication

With Special Appreciation and Dedication

To

My Dear Husband

For Always Being There For Me

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ABSTRACT

This research presents a consumer evaluation of the delivery and aspects of services provided at three community run mental health centres. The purpose of this research is to describe the satisfaction levels of consumers with mental health service delivery in Durban, with a view to using this information to improve the services in future for quality assurance. The current investigation takes a look at how a comprehensive community mental health centre is perceived by its consumers. The subjects totalling one hundred and eleven clients who were attending psychiatric community health clinics during the study period. Using client self report questionnaires, the study investigates clients' perceptions of several aspects of their clinical care in community mental health service. In addition to assessing the clients' level of overall satisfaction and degree of acceptability of the services to the clients, the researcher was also interested in determining the expectation of consumers and how the clients perceived the effectiveness of health care service delivery. Additional information provided was the clients' views of the quality and outcome of therapy. As further measures of the clinic's effectiveness and client satisfaction, questions relative to other help seeking actions, future behaviour in similar situations and recommendations of the clinic to others were asked.

In addition to asking a wide variety of satisfaction-related questions, socio-demographic detail (i.e. age, gender, race, educational level, employment status, length of visits to the clinic) were asked. Most participants were unemployed men. Analysis of findings indicated that most participants were satisfied with the health service provided. Recommendations were, however,

further made for improving quality of care and towards additional studies in other settings to include appropriate proportions of all racial groups in South Africa.

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CHAPTER 1

INTRODUCTION

1.1 BACKGROUND OF THE STUDY

In this era of fiscal restraint and decreased government support for human services, it is essential that community mental health clinics demonstrate their usefulness to the public through careful evaluation of their service. One important component of the evaluation of such public funded delivery systems is an assessment of the satisfaction of the citizens who receive treatment, through their appraisals of both the clinical and the administrative aspects of their care (Lorefice and Borus 1984). The growing emphasis on accountability in Community Mental health centres has increased the need for more effective and innovative program evaluation. The assessment of consumer satisfaction with mental health services was unusual 15 years ago, yet today consumer satisfaction surveys are a standard part of the practice of many health facilities, particularly of community mental health centres (Lebow 1982). There has been a recent proliferation of studies in the United Kingdom assessing satisfaction with mental health services (Stallard 1996a). In the past, patients were expected to be passive recipients of nursing care and were once regarded as being incapable of making decisions about their treatment and health care. In recent years the role of the patient and the imbalance of power that has favoured health care professionals has changed. Greater knowledge of health care issues and the development of bodies created to protect the interests of the consumer all contributed to patients playing a more active role (Biley 1992).

In recent years dealing with the effectiveness of psychotherapy has turned from its initial emphasis on the therapist's evaluation to a more direct and less theoretical measurement of what the patient thinks (Goyne and Ladoux, 1973). Recent years have witnessed growing interest in evaluation of mental health and social service program. Although evaluations of patient satisfaction are in widespread use, research on the topic is still in its early development and has yielded only sparse and frequently conflicting information (Lebow 1982). One perspective for obtaining evaluation information is to solicit reactions from consumers. This procedure provides a personal and unique view of the perceived effectiveness of a clinic's operation (Balch, Ireland, McWilliams and Lewis 1977).

A widely accepted dictum of business is to keep the customer satisfied. Even in situations in which a monopoly exists, such as for public utilities, public concern can influence regulatory bodies and consumer sentiment can no longer be ignored (Damkot, Pandiani, and Gordon 1983). Most mental health centres naturally assume the services they render to clients are the most appropriate ones. However, they pay little attention to getting feedback about what the client thinks of the services and how they could be improved. In an inpatient facility, treatment success can be measured by professional judgement and close observation of behaviour, but in the typical outpatient service, treatment outcome and the clients feelings about treatment are often unknown or at best, obscure. When a client does not keep appointments or schedule further ones, the reasons may range from being dissatisfied with the services to having resolved the problems (Powell, Shaw, and O'Neal, 1971).

The phenomenon of consumerism sparked the patient involvement and participation in care. This movement has given patients an increased knowledge base to make educated health care decisions, placing the patient in a position less dependent on the physician. In the past the health care customer was reluctant to challenge the physician's medical judgement. Now patients are not so quick to agree when the physician speaks but instead question why (Leming 1991).

The emphasis on consumer satisfaction with care appears to have come from either influence of social scientists, humanistic concern in general, the increasing focus on health as a quality of life, and government support for research in this area. A number of techniques have been used to measure patient satisfaction with care such as single items, attitude scales or open-ended questions. Some argue that the average person is not qualified to make judgements about quality of care. Others point that it is usually the patient who seeks care and that that people do evaluate quality in selecting or remaining in care (Slater, Linn, and Harris 1982).

The key to a successful social marketing approach to health care is to continually listening to consumers feedback and being willing to change the health product or service according to their needs and preferences (Bryant, Kent, Lindenberger, Schreiber, Walker, Cole, Uccellani, Brown, Blair, and Bustillo-Hernandez 1998). This approach can increase the likelihood of consumers being satisfied with and continuing to utilise or provide the particular health care.

In the past patients were expected to be passive recipients of nursing care and were once regarded as being incapable of making decisions about their

treatment and health care. The role of the patient and the imbalance of power that has favoured health care professionals has changed. As part of the consumer movement, consumers become more actively involved in the provision of health care. Greater knowledge of health care issues and the development of bodies created to protect the interests of the consumer all contributed to patients playing a more active role (Biley 1992). In the current environment however mental health service delivery has entered an era of accountability in health care that has shifted the balance of powers from supplies to consumers (Granello, Granello, and Lee 1999). According to Larsen, Attkisson, Hargreaves, and Nguyen (1979), until recently, the service consumer's viewpoint has been ignored or under-represented. Even when clients participated in the evaluative process, they are traditionally placed in the role of the ones being evaluated. For example, while many investigations of the outcome or effectiveness of services include client ratings of their functioning or change in functioning, these ratings do not constitute direct evaluation, by the clients, of the program from which they receive services. In recent years there has been a significant shift toward broadening the scope of client participation in the evaluation of human service programs. A notable example of this trend is the proliferation of research on client and patient satisfaction (Larsen et al. 1979).

In addition, changes in the health care system during the last decade resulted in increased pressure on providers to show quality in the delivery of care, largely because of consumer and family demands and escalating costs of care (Campbell in Howard, Clark, Rayens, Hines-Martin, Weaver, and Littrell 2001). There is a proliferation of research on client and patient satisfaction.

The distinguishing feature of satisfaction research is that service recipients are explicitly asked to evaluate the services provided to them (Larsen et al.1979). Patient satisfaction, however, must be seen within the wider context of the health care system.

According to Stallard (1996a), recent trends in health care have brought about many changes. In addition to the traditional tenets of providing care based on the standard of quality of their profession, many health care providers are recognising the importance of viewing the patient as a consumer. Thus, a growing concern of health care facilities is to satisfy this customer, a consumer who comes to expect cost effective, high quality care. The accreditation process reflects this emphasis on patient perceptions as well (Kolb and Race 2000). Recent preoccupation with the measurement and evaluation of mental health services has resulted in growing interest in the assessment of consumer satisfaction. This interest has been fuelled by political moves towards increased consumerism and government pressure to ascertain and use the views of health service consumers to monitor performance and formulate policy. Consumer satisfaction is, therefore, increasingly being highlighted as an important objective of health care, a key determinant of service quality and a useful indicator of outcome (Donabedian1992). This emphasis upon 'putting the patient first' and the relative ease and apparent simplicity of undertaking satisfaction research has proved attractive (Stallard 1996a).

Steele (in Kolodinsky1999) summarised the role of the consumer in shaping health services to meet the needs of both providers and consumers as followers: to provide health services which are responsive to consumers

needs, those organisations whose role it is to purchase, provide or assess health services have a duty to carry out consumer appraisal work. Consumers are referred to as experts on their own priorities, their own needs and their own experiences, and they should be consulted, as should any other expert group. According to Kolodinsky (1999) researchers who empirically examined consumer satisfaction with health care in general have suggested that satisfaction is influenced by aspects of care that are specific to the health care experience and that consumers are able to form summary measures of their satisfaction based on their satisfaction with components of care. Damkot, Pandiani and Gordon (1983) believe that systemic, regular and iterative samples of client and past-client opinions must become one component of community mental health centres self review, program planning and development and evaluative information available to funding sources and the public they serve. Obviously, client opinions are neither sufficient nor adequate as evidence of goodness or poorness of services available, but they are a necessary component of broader review.

In the United States, arguably a more consumer-oriented society, there have been a number of studies examining patients' attitudes. Each study has used its own measures, on different categories of patients in a variety of settings and with differing aims (McIntyre 1989).

Consumer satisfaction has been studied extensively internationally, yet in South Africa studies are in their infancy. In the field of mental health, consumers' views have rarely been sought. This may have something to do with the nature of these problems. In the view of some mental health

professionals, mental illness can deprive an individual of the capacity to make considered and rational judgements.

The views of consumers about the psychiatric services in this country have not been systematically explored and are a neglected component of health service delivery. As consumers, psychiatric patients and their families have, in the past, been a very silent group compared with other patients group. There has been little research on clients' perspective of mental health work. This research therefore contributes to filling the void.

1.1.1 Why measure satisfaction?

Given that the fundamental reason is for the health worker to serve the needs and wishes of the patient and work towards the good of the patient, an understanding of patients concerns and interest is central (Carr-Hill 1992). Just as acceptability greatly determines use and pursuit of mental health services, it also has strong influence on treatment (Kalman 1983).

Satisfaction of care has already been established as an important influence determining whether a person seeks medical advice, complies with treatment and its eventual success and maintains a continuing relationship with a practitioner.

Client satisfaction surveys often attempt a comprehensive assessment by determining the clients' attitude toward all aspects of the service environment. Surveys have obtained the clients' perspective on many different issues, such as overall satisfaction, effectiveness of treatment, access to service, attitude toward the agency's programs and administration, opinions about services received, opinions about the person who worked most with the client, and

responses to general information questions such as by Larsen, Attkisson, Hargreaves, and Nguyen (1979).

It is first necessary to establish consumer's expectations and beliefs about what constitutes effective treatment. In so doing, many evaluators and researchers have advocated the inclusion of client satisfaction ratings as one component of human service program evaluation such as Margolis, Sorenson and Galano (1977); Zusman and Slawson (1972). These writers have advanced several compelling reasons for assessing client satisfaction and more generally, for involving the client in the evaluation of programs (Larsen et al. 1979). First, when the client's perspective is not taken into account, the evaluation of services is incomplete and biased toward the provider's or the evaluator's perspective. Current thinking, however, suggests that client and therapist ratings represent different perspectives, both of which are needed to obtain a more complete assessment of service process and outcome (Attkisson et al. 1978; Strupp and Hadley, as cited in Larsen et al.1979). Waskow and Parloff (cited in Larsen et al. 1979), states that clients ratings, though often at variance with those obtained from other information sources, still represent a potentially valid perspective.

The second reason is that there are legislative mandates to include clients and / or citizens in the evaluative process and a broad-based evaluation of programs is required in order to receive continued funding.

The last and perhaps the most compelling reason to assess clients satisfaction is offered by Marvit and Beck cited in Larsen et al. (1979). It is pointed out that publicly funded health and human services in general are supplier dominated. The poor, the non-mobile, and other disadvantaged citizens have

practically no alternatives to local public service programs. When in need, these citizens often cannot select alternative services based on consideration of cost and quality, for they are unable to go elsewhere for services, even if dissatisfied. Furthermore, publicly funded organisations seldom have a profit motive and have virtually no financial incentive to satisfy the client or to involve the client in the evaluative process. The other reason for assessing patient satisfaction with care is that the patients' view of the medical system is related to their health and illness behaviour (Slater et al. 1982). In addition, satisfaction is related to improvements in health status (Wykes and Carrol 1993). Consumer opinion is therefore particularly needed in ambulatory care settings where providers have less control over adherence to treatments prescribed than they might have in a hospital setting. Certainly a patient is the best judge of a provider's concern, sincerity, compassion and respect. How a patient feels about this part of care, as will as what he or she perceives to be the overall quality seems important to determine. Satisfying patient has always been an implicit goal of human services, and in respect to this objective, patient evaluation is a valid assessment (Slater et al. 1982).
Thus, without explicit client evaluation of services received, the determination of service quality, adequacy and appropriateness is left in the hand of service providers and managers. This situation may affect the quality of service (Larsen et al. 1979). In a study conducted by Macdonald, Sibbald and Hoare (1988), the findings showed that patients can express views about their conditions which should be useful in planning improvements in care. There are also political reasons for the growing interest in the patients' views (Carr-Hill 1992).

Psychiatric care is an expensive service, which is funded mainly by taxpayers. This is an important function of provincial governments in the new South Africa and there is no better time to initiate a regular consumer rating system. The public has very little awareness of the plight of the mentally ill and their families and should be informed and involved (Uys, Thanjekwayo and Volkywan 1997).

1.1.2 Benefits to the profession

Consumer satisfaction instruments can be useful for those who deliver mental health services. Feedback from both trainees and clients can allow a supervisor to assess the impact of supervision on trainees and the impact of trainees on their clients. These measures also can facilitate the professional growth of therapists by providing information about the client's view of the therapy, the therapist, and the client therapist relationship. More broadly, the results of consumer satisfaction measures may be beneficial in creating mental health delivery systems that respond to the needs of relatively neglected client groups (Margolis, Sorenson and Galano 1977).

1.2 PROBLEM STATEMENT

Providers and payers of publicly funded services have traditionally assumed that consumers, especially those with serious mental illness could not speak for themselves, and probably could not recognise or even articulate what they liked and what they thought would be in their best interests. On the other hand Donabedian (1992) believed that patients need to be taught to be less patient, more critical, and more assertive. As consumers, patients need to take an

active part in psychiatric services. Uys et al. (1997) asserted that in order to do this, there need to be a recognised avenue for such inputs and must therefore be empowered to take part in the process. Some of the reasons why the views of consumers of psychiatric services in South Africa have not been given more prominence were provided by Uys et al. (1997) as follows:

- They traditionally have been a hidden population, unorganised and isolated from society by their very condition.
- They were seen by many, especially professionals, as not able to speak for themselves.
- Their extreme and long-term dependence on the health system has made it difficult for them to be assertive about their rights and needs.
- The very serious stigma attached to persons with psychiatric conditions and their families keeps many articulate potential spokespersons quiet.
- There was no clear route for them to make input into service evaluation and planning.

One way of getting the consumers of mental health services to be part of the decision is to obtain their views on the services that they receive. Knowing about their satisfaction or lack of it has often been ignored. It is therefore necessary to get the consumers perspectives and their satisfaction with mental health services received in the community. This study is therefore interested in finding out from the consumers of mental health services in Durban how they perceive the services in terms of their satisfaction with the services received. The question being asked therefore is "What is the level of consumer satisfaction with mental health service delivery in three community health clinics situated in Durban?"

1.3 PURPOSE OF THE STUDY

The purpose of this study is to describe the satisfaction levels of consumers with mental health service delivery in Durban, with a view to using this information to improve the services in future for quality assurance. The views of clients are used, not simply to identify their degree of satisfaction with intervention, but to obtain some idea of the experience of help they have and their complex interaction with professionals during its course. Assessing client satisfaction is an important tool in our evaluation process. This importance is in view that consumers who are satisfied with their care are more likely to stay in treatment, which is a critical factor with people with serious mental illness and are therefore less likely to relapse and need expensive in-patient services. It is also important to take the consumer's perspective into account because satisfaction is defined by the recipient of service (and not by the funder or the provider) and to ensure that the evaluation of services is complete and unbiased. Not only does the process of asking the consumer about his or her satisfaction with the services demonstrate basic respect for the consumer; it also helps to ensure a responsive, innovative and cost-effective service system.

1.4 OBJECTIVES

The study was designed to achieve the following objectives:

1. To identify if the services received meet the expectations of care that consumers have of mental health service delivery.
2. To assess the level of satisfaction that the consumers have with the services.

3. To assess the acceptability of the services consumers receive in the selected clinics.

1.5 RESEARCH QUESTIONS

1. Does the mental health care provided meet the expectations that the consumers have of mental health services in their community clinics?
2. What is the level of satisfaction that clients have of mental health service delivery?
3. How acceptable are the mental health services provided to the consumer?

1.6 SIGNIFICANCE OF THE STUDY

Client satisfaction is a key objective

Huxley and Mohamad (1991) argue that a fundamental requirement of any encounter with a service is to feel satisfied after it. Similarly Lebow (1982), argues that minimal satisfaction is a prerequisite for treatment success since treatment can not occur unless the client is satisfied with it, and attends treatment sessions. The assessment of both therapeutic change and satisfaction with the process by which it has been achieved are therefore important outcomes and dual goals of mental health interventions (Stallard 1994). As Holland (in Stallard 1996a) indicates, if a service is unacceptable to its users it will be under-used, regardless of how effective it might be. The bottom line is that consumers who are satisfied with their care are more likely to stay in treatment and are therefore less likely to relapse and need expensive in-patient service.

An index of outcome

Consumer satisfaction is an important indicator of outcome and is a useful way of assessing services, particularly where therapeutic change is harder to identify and quantify (Fitzpatrick 1991a). Satisfaction has been found to be related to client ratings of general improvement and compliance with treatment as determined by both attendance at appointments and mutually agreed treatment endings (Slater et al.1982). Previous research has shown that the greater the improvement in clinical symptoms, the greater the level of satisfaction reported by patients (Attkissson and Zwick 1982). Consumer involvement in evaluation also leads to improved responsiveness of services.

Quality assurance and service improvement

One of the primary aims of consumer research is to make services more acceptable to users and to encourage better use of services. In this respect the service user offers a unique perspective on the treatment process, particularly the patterns of communication during consultations (Fitzpatrick 1991a). Consumer satisfaction surveys therefore provide a way of assessing and monitoring service quality over time and as a basis for making comparisons with other services. This data can be utilised to change and enhance services by, for example, reducing drop- out rates and improving the health care system (Stallard 1994). Thus, waste can be prevented by consumer participation in evaluation of services. Consumer satisfaction is a component of quality and consumers ultimately define quality. Consumers make an indispensable contribution to defining quality and setting the standards by which it is to be judged. Standards of care can be improved by such

participation. Consumers have a great deal to say about the circumstances under which the task is performed and about the interpersonal exchange with health care workers. In defining what is desirable or undesirable in the interpersonal exchange or the amenities of care, it is consumers who should make the decisive contribution. It is their expectations that should set the standard for what is accessible, convenient, comfortable or timely. It is they who tell us to what extent they have been listened to, informed, allowed to decide and treated with respect. In doing so, consumers express their personal preferences, but they also voice the expectations that particular positions, in particular segments, of particular societies have implanted and nurtured (Donabedian 1992).

Regarding the conducting of technical care, consumers would seem to have almost nothing to say. What do consumes know about the complexities of the technical task or of the resources and skills necessary to perform it? There is reason to believe that consumers are not that ignorant of the processes of good technical care when the situation is familiar and particularly if prior experience of good care has adequately prepared the patient. The quality of technical care is defined not by what is done, but by what is accomplished. Consumers are uniquely able to say what outcomes are to be pursued, what risks to be accepted in return for what prospects of amelioration and at what cost. It can be argued that technical care not congruent with patient preferences has failed in quality. It follows that consumers define the quality of technical care by the simple expedient of specifying the goals it must serve. Only the technical means and the skill by which they are implemented remain for the clinical expert to govern.

Quality assurance is often a time consuming process which removes nurses from their primary task, that of patient care. It can change the 'thrust' of professional subject to this process can be forced to become more concerned about demonstrating to others that they are doing good quality work (Donabedian 1992).

Consumers as evaluators of Quality

Defining quality and evaluating it are a related pair. Therefore, obtaining information about consumer satisfaction or dissatisfaction and the reasons for either, is a necessary component for quality assurance enterprise. Consumer satisfaction plays a tripartite role in health care. It is firstly a judgement on the quality of health care embodying the patient's expectations and perceptions. Secondly, it is an "outcome" of care: one aspect of the patients' psychological wellbeing and also a consequence that health care systems may strive for as a mark of their success. Thirdly, patient satisfaction is a contribution to further care, motivating patients to seek care and to collaborate in enhancing its success (Donabedian 1992).

Attkissson and Zwick (1982) suggested that less satisfied patients attend fewer sessions, drop out earlier and miss more appointments. Premature terminations seem more likely when trust has not been achieved between the therapist and the patient.

Consumers as informants

In addition to defining and evaluating the quality of care, consumers can contribute to the quality assurance effort by providing information concerning

their own experiences in health care. They are not asked to express a judgement on care but merely to report, so others may judge. There are certain kinds of information that only patients can provide, for example, about what happened when they sought care, about their hopes and fears, about being well or unwell, and about function and dysfunction. Other information, mainly concerning the technical process of care, which should have been in the medical record but may have been omitted, can be provided by the patient. In this way patients serve as primary sources of information. At other times they serve what could be called a secondary or confirmatory function. Consequently, consumers can contribute vastly to the quality assurance enterprise (Donebedian 1992).

Donabedian (1992) emphasised that providers of health care services must attain the highest level of consumer satisfaction since it was "an element of psychological health". The bottom line is that consumers who are satisfied with their care are more likely to stay in treatment and are therefore less likely to relapse and need expensive inpatient service. If they were satisfied, they tended to improve.

The thinking has been that mental health clients were unable to rate themselves in the past. This may have something to do with the nature of these problems. In the view of some mental health professionals, mental illness can deprive an individual of the capacity to make considered and rational judgement (Sheppard 1993). Helping services can use consumer satisfaction for training, for professional growth and for promoting a more response delivery system.

This research is also useful for: the paucity of previous research into mental health work, and the growing importance of community mental centres as settings for the provision of community-focused mental health services and the examination of client satisfaction.

Nursing Implications

In general nurses are responding to the consumers' needs and wants by maintaining a close relationship with the customer. This close relationship places the nurse in a strategic position to bridge the service gap between the customer and the health centre. Most important, the nurse must educate patients about their health care and involve patients in establishing their own quality standards. The more clearly and completely patients can state their needs and expectation, the better the nurse can plan, manage and evaluate the quality service process.

To build quality into service and develop service strategies, consumer research must be placed high on the nurse administrator's agenda. Viewing the patient as a customer entails a change of mindset for the health care centre and the health care provider. It is the role of the nurse administrators to act as change agents. The nurse administrator must guide staff to work in a proactive fashion. To be effective and successful in directing these changes, the nurse administrator must establish relationships between nurses and other members of the organisation. It is the nurse administrators' responsibility to design and establish an intensive educational system that reflects the organisation's quality service philosophy.

Consumerism has changed the face of the health care industry and consumers are demanding a higher degree of quality care. To satisfy this demand, nurses must begin to view health care through the eyes of the customers, to understand their need not only for primary services but also for the secondary, comfort and convenience services (Leming 1991).

1.7 DEFINITIONS OF TERMS

Consumer – is a person who has had or currently has a mental illness and has used the public sector psychiatric services.

Satisfaction – is the extent to which treatment gratifies the wants, wishes and desires of clients for services.

Level of satisfaction – extent to which the clients rate aspects of mental health services stated in the Client Satisfaction Questionnaire (CSQ- 8) on a scale of 1- 4.

Acceptability – is the possibility of the patient returning for the same service if he were to seek help again.

Quality – is the degree to which health services increase the likelihood of desired health outcomes.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

This chapter reviews some relevant studies in the area of consumer satisfaction to determine what is already known about the topic and possibly to identify gaps in knowledge. Majority of the research studies accessed pertains to the western world, mainly to the United States of America and the United Kingdom. South African studies on access are very few in this area of satisfaction of clients receiving mental health care.

2.2 CONSUMER SATISFACTION

According to Lazare in McIntyre (1989), viewing the psychiatric patients as a consumer is a relatively modern concept. Weinstein in McIntyre (1989), reviewing the work on the topic, suggested that this was due to the widespread assumption that the mentally ill are unable to give valid opinions.

If what we want is consumer evaluation, rather than evaluation of the consumer, then we should follow a procedure that de-emphasises the sick role and casts the person in the role of a rational person who has purchased something and is now in the position to judge its quality and effectiveness (Denner and Halprin 1974).

Mental health professionals have shown a sustained and growing interest in patient satisfaction with mental health services, despite persistent conceptual ambiguity and problems in the measurement of patient satisfaction (Lehman 1983). The rise in popularity of client satisfaction evaluation is easy to understand. Its appeal comes from the apparent face validity of satisfaction

questionnaire and the seeming ease of implementation of most existing scales administering and analysing a client satisfaction questionnaire is relatively inexpensive (LeVois, Nguyen, and Attkisson 1981).

Most professionals agree that satisfaction with care is important, even though patients view services from a perspective different from that of professionals. For this reason, questions sometimes arise as to whether the patient can be a judge of quality. However, satisfying patients has always been an implicit goal of human services and in respect to meeting this objective, patient evaluation is a valid assessment. Patients have generally been asked to comment on areas such as access, availability, continuity, convenience, cost and perceived quality. Satisfaction has sometimes been seen as a predictor of utilisation and at other times as an indicator of outcome of care, particularly the provider-patient interaction. How a patient feels about this part of care, as well as what he perceives to be the overall quality has much to do with outcome of care (Slater, Linn and Harris 1981).

The views of clients are used, not simply to identify their degree of satisfaction with intervention, but to obtain some idea of the experiences they have of help. Past research has shown that satisfaction with individual service components can be used to meaningfully measure overall satisfaction. Moreover, Frisk, Brown, Cannizzaro, and Naftal (in Kolb 2000) have emphasised that individual service features can differ in their part worth contribution to total service satisfaction, thus all service features should not be given equal importance or weight. They argue that total satisfaction with service is the primary determinant of consumers' intent to reuse or recommend. According to Pekarik (1992), the three studies by Acosta (1980),

Garfield, 1964, Pekarik, (1983), conducted on relationships, clients reasons for dropping out of treatment to outcome and satisfaction obtained similar results: perceived improvement, environmental obstacles and dissatisfaction with services were identified as the most common reasons for dropping out in all the studies. In another study conducted by Pekarik (1992), approximately equal proportions of adults cited problem improvement, environmental obstacles, or dissatisfaction with some aspect of treatment as the reason for dropping out. In a meta-analysis conducted by Lehman and Zastowny (1984), the analysis revealed that chronic patients express less satisfaction with their treatment compared to non-chronic patients. Innovative programs are viewed more positively than conventional ones.

Pablo, (in Kolb and Race 2000) as early as 1975, stated that patient satisfaction can be used as a basis for evaluating whether a given institution has been effective in achieving its goals.

More recently, Frisk et al. (in Kolb and Race 2000), have identified patient surveys as an essential component of a comprehensive and effective patient satisfaction management system. Combined with clinical outcomes and other quality measures such assessments can provide valuable information for decision makers regarding health care services and delivery. Although consumer surveys are a basic building block of any efficient patient satisfaction management system, these surveys need to be accurate, repetitive, useful and highlight priorities. The term accurate is defined here to mean surveys that are reliable and valid (Kolb and Race 2000).

There have been several criticisms of any attempts to obtain the opinions of consumers of psychiatric services. One rather extreme view is that it is not

worth asking this group of patients because their mental illness will prevent them supplying reliable data (Wykes and Carrol 1993). In a study conducted by Wykes and Carrol (1993), on patients who were admitted to an intensive care ward, it was found that these patients are often the most difficult to engage in services and are often thought to provide a stringent test of making an assessment of patients satisfaction with a psychiatric service. The patients were in fact, able to provide detailed views on the service that they had been offered, as well as providing constructive criticism. This was despite the obviously fragile nature of their mental state.

According to Sorenson, Kantor, Margolis and Galano (1979) the bulk of published evaluations assess satisfaction with outpatient therapy such as Denner and Halprin (1974). In short, consumer satisfaction has established a toehold in community mental health (Sorenson et al. 1979). Satisfaction has been positively correlated with therapist's ratings of success (Balch et al. 1977) and measures of treatment outcome (Larsen et al. 1979).

Whatever the underlying conceptual model, consumers do evaluate and make judgements about services. Satisfaction is a derived concept that is likely to be subject to varying definitions both between and within people over time (Carr-Hill 1992). Larsen et al. (1979) identified nine possible determinants of satisfaction with community mental health services. These included the physical surroundings, support staff, type of service provided, treatment staff, quality of service, amount of service, general satisfaction and procedures. Others have identified four factors (Damkot et al., 1983; Slater et al., 1982) and although a number of the specific factors were different, all included a general satisfaction factor. Elbeck and Fecteau (1990), using focus group to

generate attributes of ideal care identified two key factors. Supportive care involving good interpersonal relationships between patient and staff was most important with the maintenance of behavioural autonomy being the second. These studies highlight that the determinants of satisfaction are multi-dimensional and context specific.

These concerns are reasons for consumer research rather than as reasons not to obtain satisfaction data (Damkot, Pandiani, and Gordon 1983). According to Mester and Gonen (1993) one important factor contribution to the financial difficulties of the medical systems is waste of resources due to the non-participation of patients in the evaluation of the services they receive. This assumption is demonstrable in the field of inpatient psychiatry.

Combined with clinical outcomes and other quality measures, such assessments can provide valuable information for decision makers regarding health care services and delivery. Although consumer surveys are a basic building block of any efficient patient satisfaction management system, these surveys need to be accurate, episodic, useful, and highlight priorities (Fisk et al. in Kolb et al. 2000).

After reviewing some of the earlier (pre- 1975) literature in the area of patient satisfaction in general Luft cited in Kolodinsky (1999) characterised satisfaction as being related to access, availability of resources, continuity of care, information transfer, humanness and quality. Higgens et al. in Kolodinsky (1999) suggest ten dimensions of quality that are specific to health maintenance organizations: reliability, responsiveness, competence, access, courtesy, communication, credibility, security, knowing the customer and tangibles such as communications. According to Kolodinsky (1999),

quality of care, access to care, availability of resources and continuity of care accounted for 72 percent of the variance in satisfaction. The results obtained from a study conducted by Kolodinsky (1999) indicated that personal experience, expectations, and judgements about services covered influence overall satisfaction with the plan and that individual differences have little effect on satisfaction. A factor analysis and mean important ratings identified interpersonal relations with staff a key factor of patient satisfaction in a study conducted by Elbeck and Facteau (1990).

In a study conducted by Lorefice and Borus (1984), direct consumer feedback from patients about several aspects of their mental health care in a community based delivery system. The finding that the three most common request for help was for advice, ventilation and an understanding listener. It suggests a need for clinicians to explore a patient's expectations and desires for direct advice early in treatment and not assume that the patient shares self-exploration and independent decision making as the initial therapeutic goals. It highlighted the need for further investigation of the role of advice giving in the care of patients with mental disorders (Lorefice and Borus1984).

Patients' responses to surveys about their satisfaction with treatment have been almost uniformly positive. Lebow's (1982), review article for example, noted that among 26 studies that examined satisfaction in outpatient mental health populations, the degree of satisfaction ranged from 51 percent to 100 percent. The high levels of satisfaction across many studies raises the issue of whether data from these evaluations are so distorted by people wishing to produce information which would please the researcher, usually known as the social desirability effect (Elbeck and Fecteau 1990). It is the view of Wykes

and Carroll (1993) that the validity problems should be seen as a failure in the method of collecting data rather than as sufficient grounds for abandoning their use. In order to reduce the social desirability effects, patients need to be contacted following their discharge by an independent agency (Fitzpatrick 1991a). They need to complete the forms away from the psychiatric services and they need to be assured that the data are confidential and anonymous. However, an important problem in assessing patient satisfaction is how responses are to be interpreted (Conte et al.1989). Assessing the reliability of consumer surveys is difficult since satisfaction changes over time and can be affected by outcome (Stallard 1996b).

Definitions

Lebow (1982) stated that satisfaction was the extent to which treatment gratifies the wants, wishes and desires of clients for services. Pascoe (1983) said that satisfaction was an evaluation of directly received service that involved cognitive and affective reactions to the context, process and result of the health encounter. Patient satisfaction was defined by Pascoe (1983) as "health care recipient's reaction to salient aspects of the context, process, and results of their... experience" (p.189).

Quality assurance was conceived by Donabedian (1992), as an activity aiming to elicit information about clinical performance and based on that information, to readjust the circumstances and processes of health care.

The Preconditions for the basic need satisfaction

According to Maslow (1943), there are certain conditions, which are immediate prerequisites for the basic need satisfactions. Danger to these is reacted to almost as if it were a direct danger to the basic needs themselves. Such conditions as freedom to speak, freedom to do what one wishes so long as no harm is done to others, freedom to express one's self, freedom to investigate and seek for information, freedom to defend one's self, justice, fairness, honesty, orderliness in the group are examples of such pre-conditions for basic need satisfactions. Thwarting in these freedoms will be reacted to with a threat or emergency response. These conditions are not ends in themselves but they are almost so since they are so closely related to the basic needs, which are apparently the only ends in themselves. These conditions are defended because without them the basic satisfactions are quite impossible, or at least, very severely endangered (Maslow 1943). A trusting therapeutic relationship is a necessary prerequisite for helping a chronically ill person develop a satisfactory and satisfying life in the community. Services alone, even when they are integrated and available, simply do not suffice (Bene-Kociemba, Cotton, and Fortgang 1982).

The concept of satisfaction

Satisfaction was defined as acceptability and accessibility in respect to different aspects of clinic treatment facilities; prevention and continuity of care (Slater, Linn, and Harris 1981). Unfortunately it is difficult to quantify patient satisfaction because it is a composite of many variables. An individual's expectations, experiences, personality, attitudes,

psychodynamics, perceptions and philosophy all act in concert to determine the state of mind that researchers label satisfaction. Thus reviews of the satisfaction literature must include a wide variety of patient feedback studies (Kalman 1983).

Human satisfaction is a complex concept that is related to a number of factors including lifestyle, past experiences, future expectations and the values of both individual and society. Satisfaction is a derived concept and any investigation must search for sources of dissatisfaction. Given that the most frequent source of dissatisfaction is the communication of information about the condition and about the appropriate treatment, these clinical issues and the relative expertise, knowledge and therefore power of doctor and patient have to be central to any investigation of dissatisfaction. The sources of dissatisfaction can vary widely, satisfaction is likely to be defined very differently by different people and by the same person at different times (Carr-Hill 1992).

In a study conducted by Edwards, Yarvis, Mueller, and Langsley (1978), it is concluded that patient satisfaction does change over time, as indicated by one significant mean change and the low to moderate test-retest correlation for satisfaction at different time points. This interpersonal and over time variability casts doubt on the value of attempting to define a unitary concept of satisfaction. In addition, patients' expectations will vary according to the presumed success of the intervention and to their experience of health care. By demonstrating a willingness to make services more patient oriented, consumer assessment provides essential information to program planners and administrators (Bene-Kociemba et al.1982).

The theory of consumerism

Consumer theorists argue that there is an imbalance of power between those who provide goods and services and those for whom they are provided. The former possess all the advantages of corporate power and organisation, resources and political influence. The latter, in the market place at least, have the choice of buying or not buying a product or service, and, where competitive markets exist, of choosing according to their own preferences. They carry weight, therefore, only as the sum of their individual choices.

To shift the balance of power in favour of consumers, those representing, their interests have isolated five key factors which provide a structural underpinning of consumerism. These are the principles of access, choice, information, redress and presentation. People must first of all have access to the benefits offered by a product or service. Their choice of products and services must be as wide as possible to establish some measure of consumer sovereignty and they need as much information as possible, both to enable them to make sensible choices and to make the fullest possible use of whatever it is they are seeking. They will also need some means of communicating their grievances when things go wrong and receiving adequate redress. Finally, they need some means of making sure that their interests are adequately represented to those who take decisions affecting their welfare. (Potter 1988).

Transforming public service delivery in South Africa

The department of Health in South Africa has recently introduced the concept of Batho Pele. Batho Pele is the name given to the Government's initiative to improve the delivery of public services. Batho Pele means, in Sesotho, 'People First'. This name was chosen to emphasise that it is the first and foremost duty of the Public Service to serve all the citizens of South Africa.

What has Batho Pele to do with the transformation of the Public Service?

Implementing the basic values and principles governing public administration as set out in the Constitution, 1996, requires, among other things, that the Public Service be transformed. The White Paper on the Transformation of the Public Service sets out a number of transformation priorities of which transforming service delivery is one of them.

How will Batho Pele transform public service delivery?

The new White Paper on Transforming Public Service Delivery (Batho Pele White Paper) lays down eight principles for the transformation of public service delivery. It also lays down norms to ensure that the Public Service puts the principles into practice. The Batho Pele principles are: Consultation. Service standards, access, courtesy, information, openness and transparency redress, and value for money.

Consultation

Citizens should be consulted about the level and quality of the public services they receive and whenever possible should be given a choice about the services that are offered.

Service Standards

Citizens should be told what level and quality of public services they will receive so that they are aware of what to expect.

Access

All citizens should have equal access to the services to which they are entitled

Courtesy

Citizens should be treated with courtesy and consideration.

Information

Citizens should be given full accurate information about the public services, they are entitled to receive.

Openness and Transparency

Citizens should be told how national and provincial departments are run, how much they cost and who is in charge.

Redress

If the promised standard of service is not delivered, citizens should be offered an apology, a full explanation and a speedy and effective remedy and when complaints are made, citizens should receive a sympathetic, positive response.

Value for money

Public services should be provided economically and efficiently in order to give citizens the best possible value for money.

(Batho Pele White Paper on Transforming Public Service Delivery, Government Gazette No. 18340 of 1 October 1997).

Customers in health care

An organisation must satisfy its internal and external customers to compete in the market place. The internal customers being patients, their families, employees, physicians and any others involved in direct patient care. The external customers include the people who have interest in the health care institution but do not provide patient care. Health care centres must understand that agency expectations differ and it is this difference that leads to customer dissatisfaction (Leming 1991).

Client Satisfaction with health care services

Variables affecting client satisfaction with health care can be grouped into four categories. First, socio-emotional factors, are a major determinant of client satisfaction and refer to clients' perception of their providers' communication and interpersonal skills (e.g. caring, empathy and courtesy). Second, system factors refer to the physical or technical aspects of the service encounter, such as: waiting time for appointments, access to services, technical quality of care, costs comfort/convenience of office facilities and length of the visit. Moderating factors that affect a patient's degree of satisfaction include socio-demographic variables and health status. Finally, a patients network of family and friends can be considered influencing factors (Bryant et al.1998).

Justifying consumers' contributory role

No one would argue that the pursuit of each patients welfare is not the chief purpose, and primary obligation, of every health care practitioner. It is

difficult to hold that the patients' views of what constitutes that welfare are of little relevance to that purpose and obligation.

The interpersonal exchange is the vehicle by which technical care is dispensed and acquired. Patients are justified in suspecting that the practitioner who has been cursory, inattentive, uninformative, or even rude has not delivered the full potential of technical skills on their behalf. The interpersonal skill exchange also stands on its own, independent of what other uses it may have. For it is the measure of the humanity and dignity of us all, in every form of intercourse. It is one thing to affirm the right and duty of every patient to define and evaluate the quality of care and quite another to give legitimate, practical expression on that belief. Consumer becomes the judge of the benefits of a service.

As consumers of services they contribute to quality assurance by defining and evaluating quality and by providing information that enables others to evaluate it. Consumers are co-producers of care and as such their behaviour can be changed by increase education or by addressing circumstances that might hinder their ability to act in their own best interests. Also, consumers can influence the health care system by being pro-active and direct in the patient-practitioner exchange. They can also make more active use of available systems such as suggestion boxes, praise and complaints procedures, demonstrate their preference through market mechanisms and finally through political action and lobbying (Stallard 1996).

Stakeholder interest in consumer in consumer satisfaction

Family and consumer stakeholders want access to services that are appropriate and meaningful with options for referral to a range of treatment services, including peer support (Campbell; Chisholm et al. in Howard et al. 2001). In addition to access and treatment options, consumers and family alike have a right to expect quality of care in the services they select. Often they make their choices based on their perceptions of quality and treatment effectiveness of services they received in the past or based on the opinions of others in similar situations. Therefore, these variables, consumer satisfaction and treatment, effectiveness, influence decisions made by consumers, family members, providers and payers (Howard et al. 2001). Both clients and providers are considered consumers, as they both utilise the service entity (Bryant et al.1998).

Consumers appear in many roles on the health care stage: often as patients, at other times as past or future clients' and at all times as citizens. As patients, they can influence the quality of health care, subtly and not so subtly, but always being constrained to maintain a friendly relationship with the doctors on whom so much of their welfare depends. As consumers move further and further away from this position of relative dependency they can become more outspoken, more assertive, even contentious and it is proper that they should become so, provided the purpose is always constructive (Donabedian 1992). It is believed that increased competition between service providers will result in provision of more responsive service in order to gain customers.

The consumers' empowerment lies in being able to choose between competing services. Consumer solutions adopt techniques used in the

commercial world with the aim of increasing the responsiveness of the service to the consumer. For example, a hospital may undertake a customer satisfaction survey to assess the views of patients or introduce complaints' procedures (Hickey and Kipping 1996). Evaluation strategies also entail a focus on various perspectives. Program funders are typically interested in structural variables. Program funders and administrators share avid interest in process measures including measures of productivity, effort, accessibility, cost and service availability. Service providers, community citizens groups, consumers, legislators and program administrators are all advocates of outcome evaluation (LeVois, Nguyen, and Attkisson 1981).

A further, central issue becomes finance. While efficient use of resources (human and material) is important, there is a danger that quality of patient care can become a casualty of this obsession (Sheppard 1993).

Customer service challenges

The challenge to the nurse administrator of achieving quality customer services is crucial for effective high performance in the competitive arena. The challenge begins by changing the corporate culture of the organisation. This means the values and beliefs of an organisation must be redefined in order to deliver new services in a marketplace that is demanding quality care. Management must adopt a philosophy of quality and a serious commitment to quality. Every employee must live the value of quality and become responsible for implementing quality (Leming 1991)

Resistance of professionals

Part of the whole problem is the inevitable resistance of professionals to consumer feedback, with its implications of criticism. However, if the professionals are genuinely concerned about the acceptability and effectiveness of the services they offer, they must be prepared to accept evaluation by the recipients as standard practice. This affects planners of services and of buildings, administrators and front-line mental health workers. Of these, the nurses are probably in the most crucial role with regard to being sensitive to consumer feedback and incorporating the consumer viewpoint into working practices. This additional evaluative strand complements the philosophy of professional evaluation inherent in the nursing process model. Experience has shown, however, that user evaluation is not accorded a high priority by nursing staff perhaps because they find it threatening (Shields, Morrison and Hart 1988).

2.3 METHODOLOGICAL ISSUES

Approaches to assessing satisfaction

Satisfaction is a worthy subject of study in its own right, regardless of its relationship to objective measures. The patient typically comes into a clinic with one major complaint for which he seeks relief. Since relief is very subjective feeling, measures of relief likewise should be subjective and who is in a better position to evaluate relief than the treated patient (Goyne and Ladoux 1973). People live in a subjective world as well as an objective one, and therefore one important part of service effectiveness is clients' subjective reactions to their contacts (Gutek 1978).

A second approach to the study of satisfaction is to view problems associated with satisfaction data predominantly as measurement problems. There is a need to develop better measure of satisfaction than commonly used single-item measures. Satisfaction can be viewed as a discrepancy score between what people expect and what they actually get. The researcher could ask what the person expected when he/she contacted the health centre and how much of that he/she actually received. A satisfied client would be one who received as much as or more than expected.

A third approach to the assessment of satisfaction is to view satisfaction as a global measure with a high proportion of error variance and therefore eschew the global measure for one, which is a combination of more specific facets of satisfaction. There must be other factors contributing to overall assessment of satisfaction than just those that researchers believe to be important. Measures of global satisfaction do seem to be subject to a number of response biases including acquiescence, social desirability and affect or mood.

A fourth possibility is to use terms other than satisfaction in making an evaluation of organisational effectiveness (Gutek 1978).

Consumer satisfaction in different settings

The past decade has witnessed a growing a number of studies assisting consumer satisfaction with mental health services. These have surveyed services located in different settings including inpatient psychiatric services (McIntyre et al. 1989), psychiatric hospitals (Dean, Phillips, Gadd, Joseph and England 1993; Macdonald et al. 1988), day hospital (Granello, Granello and Lee 1999; Milne and Kennedy 1993), psychiatric out-patient clinics (Conte,

Plutchik, Buckley, Spence, and Karasu 1989), community-based services (Lorefice 1982; Dean et al. 1993; Essex, Fox, Groom 1981; Larsen et al. 1977) and primary health care services (Greenfield and Attkisson 1989). They have focused upon varying client groups including the elderly (Damkot, Padiani, Gordon 1983), adults (Granello et al. 1999), children (Pekarik 1992, Essex 1981, Damkot et al. 1983) the relatives and carers of patients (MacDonald, Ochera, Leibowitz and McLean 1990, Ruggeri and Dall'Agnola 1993, Dean et al 1993), mentally retarded clients (Justice and McBee 1978) and staff rating (Milne and Kennedy 1993). Some have evaluated multi-disciplinary services (Wykes and Carroll 1993) whereas others have been uni-disciplinary focusing upon clinical psychology (Powell, Shaw, O'Neal 1971) community psychiatry nurse's (Baradell 1995, Mangen and Griffith 1982) social work (Sheppard 1993) and psychiatry (Conte et al 1989). Some compared the perceptions of clients with those of therapists such as Denner and Halprin (1974) or developed measures of client satisfaction such as Larsen et al. (1979). The vast majority have assessed satisfaction by postal questionnaire although a few have used interviewers (Bene- Kociemba, Cotton, and Fortgang 1982; Macdonald et al. 1988).

Satisfaction Questionnaires

A number of psychometrically evaluated satisfaction questionnaires using a fixed choice format are available for use with adult mental health clients (Stallard 1996a). The Client Satisfaction Questionnaire is available as either an 8 (CSQ-8) or 18 (CSQ-18) item version requiring a fixed choice response from four possible response options (Levois , Nguyen, and Attkisson 1981;

Larsen et al. 1979). The CSQ assesses both general satisfaction and satisfaction with help received, access to and acceptability of the service. Various versions of the CSQ, especially the eight- item form, have been used for research and evaluation in many different health and mental health settings (Greenfield and Attkisson 1989). The CSQ-8 is a simple scale that could be used in a wide variety of settings as a useful measure of general satisfaction. The CSQ-8 was chosen for this study, because a comprehensive review of the literature found them to be well supported in research and commonly used. The instruments were also chosen because of their relation to the research questions of the study, their ease of administration and their overall inexpensive cost.

The Satisfaction with Mental Health Care (SMHC) scale consists of 32 items each rated on a four point scale focusing upon the two dimensions of acceptability and accessibility (Slater, Linn and Harris 1982).

The SHARP is composed of five first order factors: Satisfaction, Helpfulness, Accessibility, Respect and Partnership. It is a 25-item Questionnaire requiring a yes-no response (Tanner 1982). The Client Satisfaction Survey has 10 items, which assess satisfaction with the service, acceptability of the clinician, impact of the service and dignified treatment (Essex et al. 1981).

The Brief Symptom Inventory (BSI) is a 53-item self report inventory of psychopathology and stressors. It is the shortened form of the more widely used Symptom Checklist 90-R (SCL-90) (Granello et al. 1999). Two graphic scales; the Ladder of Life Satisfaction (LLS) and the Ladder of Service Satisfaction (LSS) were used by Levois et al. (1981). Ruggeri and Dall'Agnola (1993), reported parallel scales to measure expectations and

satisfaction of patients and relatives with community based psychiatric services. The Verona Expectations for Care Scale (VECS) requires the client to generate their five most important aspects of receiving satisfactory psychiatric care. It was developed in 3 similar versions: for patients' relatives and staff. The Verona Service Satisfaction Scale (VSSS) then assess the clients view of the service they have received over the past year by rating each item on a 5 point Likert scale. It was developed in two versions: for patients and relatives and in a reduced version for staff. The Patient Satisfaction Questionnaire (PSQ) is one of the few methodologically evaluated questionnaires for assessing parental satisfaction with community and adolescent services (Stallard 1996a). It is a 19-item scale using a mixture of closed and open questions assessing parental satisfaction with parental satisfaction with pro-appointment wait and provision of information, location of appointments, the meetings with the therapist, the amount and timing of contact and outcome. No scales have yet been specifically constructed and evaluated for use with children (Stallard 1996). The Patient Attitude Questionnaire is an open-ended assessment rating the attitudes of psychiatric versions are available which are designed to specifically assess attitudinal change during the transfer of patients from hospital (Thornicroft, Gooch, O'Driscoll and Reda 1993). The KY-CSI was developed to measure consumer satisfaction in the state's psychiatric hospital and incorporates quantitative measures and qualitative questions to triangulate and elucidate the data (Howard et al. 2001). Some researchers choose to develop their own questionnaire for example Damkot et al. (1983), Essex et al. (1981) and Macdonald et al. (1988).

Methodology of satisfaction

There are various modes of administration of the instruments. Some used interviews and self rated questionnaire (Dean et al. 1993). Surveys are at times carried out per telephone or by mail (Essex 1981), letters from patients (Eisen and Grob 1979) or interviewer administered (Macdonald et al. 1988). Levois et al. (1981) used oral, written and graphic modes of collecting data. It was found that the oral administration mode produced significantly fewer unanswered items than did the written mode.

Collecting and using satisfaction data

It is important that the research designed to evaluate the psychometric properties of consumer satisfaction avoid many of the methodological weaknesses of past research efforts. For example, sample size should be sufficiently large to evaluate construct properties of the questionnaire and meet the requirements of complex statistical techniques such as factor or multiple regression analysis. Data gathering should follow methodological protocols that foster frank and honest responses by participants and therefore should avoid or minimise potentially conflicting situations that may be created by in-patient hospital assessments. Thus it may be necessary to use procedures that increase the likelihood of anonymity, such as written questionnaires that are completed anonymously (Kolb and Race 2000). In contrast, past research suggests that interviews are the most common method of gathering this information and has been found to inflate satisfaction scores (LeVois et al. 1981).

Additional criticism of past instruments underscores the focus on health professional's perception rather than the consumer's perception of service areas of importance. In addition, the high level of observed satisfaction has raised concern about social desirability or demand characteristics (Elbeck and Fecteau in Kolb and Race 2000). Bowling (in Kolb and Race 2000), suggests that even in situations where the majority of consumers report that they are satisfied with the health care they received, these same individuals are able to express negative criticism about more specific aspects of their care. Frisk, Brown, Cannizzaro et al. (in Kolb and Race 2000), have argued that extremely high levels of service satisfaction are necessary to sustain consumer loyalty. Added to this, the report by the Technical Assistance Research Programs Institute (in Kolb 2000) suggests that dissatisfied consumers share their dissatisfaction with considerably more friends than do satisfied customers. Thus, Frisk, Brown, Cannizzaro et al. (in Kolb and Race 2000), argue that a near 100% level of satisfaction may be needed if more positive than negative comments are to be heard. The need to include the individual perspective on treatment process and outcome has increasingly been recognised as a useful and necessary component of evaluation in behavioural health (Elbeck and Fecteau 1990). Past research has shown that the perceptions of psychiatric patients regarding their quality of care significantly correlated with the perceptions of treatment staff (Distefano, Pryer, and Garrison in Kolb and Race 2000). Surveys need to incorporate the individual's point of view as well as the professionals, reflect that the patient is not a passive recipient but an active participant in his or her treatment and care and be sensitive to difficult aspects of care. The development of reliable and valid measures, therefore,

may lag behind the demand in a specific care setting. This may partially explain why consumer satisfaction surveys used in mental health settings seems to be a more recent citation in the literature. The empirical investigation of consumer satisfaction assumes, at a minimum, that the measures used to assess it are reliable and valid. Moreover, reasonably large, heterogeneous samples are needed if the measures are intended for general applicability (Kolb and Race 2000).

Questionnaires of patient satisfaction take one of two forms: they may be either episode specific or more general in terms of the focus of the questions. The choice will depend partly on the type of health care setting and partly on the research question. Another broad choice of approach is between questions, which directly ask about level of satisfaction compared with indirect approaches in which satisfaction is inferred from the choice of answer. There is no established advantages to either approach (Fitzpatrick 1991b).

The form of answers offered to the respondent in the questionnaires varies. The simplest form of response is "yes" or "no." The advantages of simplicity of this format are, according to many survey analysts, outweighed by the fact that most respondents will give the favourable answer to any item about health care. This is a major problem given the overall need to maximise the variability of responses in any responses in any survey. Therefore most survey questionnaires now favour more than two alternative responses per question (for example, respondents select from four or five possible answers in a range from "very satisfied" through to "very dissatisfied"). The respondent is given a greater opportunity to express the precise nature of his or her view. More advanced questionnaires tend to be developed from more general principles of

attitude measurement. In particular, several different items may be asked about one issue in the form of Likert scale of items, each of which typically has five responses from "strongly agree" to "strongly disagree" which are given numerical score The summed score of all the items is taken to represent the person's underlying view or attitude (Fitzpatrick 1991b).

A questionnaire survey of patients' satisfaction with clinic services has certain limitations, yet it gives staff one criterion for a broader evaluation of treatment effectiveness. The serious methodological problems in consumer satisfaction research have been widely discussed in the literature. Attention has been drawn to the fact that the concept of satisfaction is rarely defined. Equally problematic is the interpretation of responses which may be coloured by the restricted knowledge patients have of service options, low expectation of standards and a wish not to be seen to complain. Furthermore, investigators must cope with situations where patients have only partly formed or no views at all because the service under review has impinged little on their consciousness. There can also be an inability to verbalise attitudes and a differential capacity to express opinions about personal and technical aspects of treatment (Mangen and Griffith 1982). The challenges to monitor and link quality and outcome measures in any health care venue are formidable. These challenges encompass, at a minimum, what to measure, how to gather and analyse data, as well as how to report, interpret and subsequently use these findings (Kolb and Race 2000). As noted by Teague, Ganji, Hornik, et al. (in Kolb and Race 2000), these measurement systems must be accurate and valid, lead to valid interpretation, achieve their intended purpose whether geared toward quality improvement or consumer awareness, and accomplish this

within acceptable cost parameters. Ultimately, any proposed measurement system must provide demonstrated feasibility and utility to obtain professional and consumer acceptance and must do so within the context of reliable and valid measures (Teague, Ganji, Hornik et al. in Kolb and Race 2000). As an important evaluation strategy, client satisfaction measures must be sensitive to actual client perspectives, be free from distorting response sets such a the "halo"response, and be sufficiently specific so that dissatisfied clients will be reliably distinguished from satisfied clients (Levois, Nguyen and Attkison 1981).

Questionnaire Design

No standard methodology exists for the measurement of patient satisfaction. Thus it is difficult to compare findings from different satisfaction studies (Kalman 1983). A variety of methods have been used to assess satisfaction and elicit the views of service users. The methods vary in terms of their complexity, expense, inclusiveness, specificity and representativeness. The most common method is the satisfaction questionnaire, which is often constructed locally and typically pays little attention to methodological issues. Focus groups whereby consumers meet in order to determine what they consider to be the key qualities of good service have proved useful, particularly in terms of generating items for more structured interviews (Stallard 1996a). A retrospective cross-sectional design with a triangulation of methods guided the study conducted by Howard et al. (2001). Longitudinal case study, including multiple measures at the time of intervention and at 15 month follow up was used by Milne and Kennedy (1993).

Irrespective of the method, the overwhelming bias of many researchers has been towards identifying satisfaction and validating current practice rather than actively seeking out and eradicating areas of dissatisfaction or concern. Complaints and suggestion boxes provide a way of soliciting unstructured comments from service users, although these are limited since they represent only a small proportion of users (Stallard 1996).

In a study conducted by Macdonald, Sibbald and Hoare (1988), the questionnaire proved a simple and effective method of ensuring satisfaction and may be useful to others concerned with improving the quality of the environment of patients.

Elimination of redundant questions from survey form, regarding satisfaction, progress in treatment, or other issues in the services environment, would result in a shorter, less burdensome questionnaire for the client to complete. It would also clarify the separate dimensions that the client does perceive within a service environment. Knowing those dimensions that the client perceives in the service environment would make it easier to investigate correlates of the clients' attitudes (Essex, Fox, and Groom 1981). In a study conducted by Essex at al. (1981), only 19% returned the surveys. Non-respondents were asked why they did not return the survey. Reasons included that the survey was too long (consisted of 33 items), it was misplaced or forgotten and the client had relocated and could not be found. The original survey form was revised to a 10-item questionnaire.

Many of the reasons cited for failure to collect satisfaction information are unsupportable. For example, the assertion that client satisfaction data do not

correlate or correlate negatively with outcome is not confirmed by the literature (Damkot, Pandiani, and Gordon 1983).

Differences in time at which satisfaction is assessed

The time at which satisfaction is assessed has varied and has ranged from consumers still in treatment (Macdonald et al. 1988) to those who have had surveyed patients during a period of three years (Goyne and Ladoux 1973). Some have assessed satisfaction during treatment (Macdonald et al. 1988, Larsen 1979), after discharge (Wykes and Carroll 1993, Baradell 1995, Essex et al. 1981), and patients that were living with their families (Ruggeri and Dall'Agnola 1993). In a study by Granello et al. (1999) participants were evaluated on admission, discharge, and three-month follow up.

Variations between clients, treatments and location of service

Levels of satisfaction may differ among clients in various programs, for clients at different points of time in therapy or at different times after terminating treatment, for various presenting problems, for varied treatment models and so on.

There is evidence to suggest that different client groups have differing levels of satisfaction. Larsen et al. (1979) found that non-white clients were proportionately less satisfied than were white clients. Men tended to respond in the middle ranges, whereas women were more polarised than men do and gave proportionately more very positive and negative responses. Clients who were unemployed were less satisfied with services than either those who were not in the job market. Persons still in treatment were more satisfied than those

who had left treatment. Furthermore satisfaction was not significantly related to years of education, family income, marital status, amount of service, age at admission, social class, or previous treatment at another facility.

Older people maybe more accepting and satisfied with health care services, whereas the better educated and more vocal groups may have higher standards and thus be more critical (Carr- Hill 1992). Chronic patients express less satisfaction with their treatment compared to non-chronic patients and that greater patient satisfaction was expressed with innovative treatment programs as compared to more conventional programs (Lehman and Zastowny 1983). Further research is needed to establish whether this reflects different patterns of service utilisation, difference in experience, differing needs and expectations of men and women and whether this finding is applicable to mental health service (Stallard 1996a).

Some studies have attempted to compare consumer satisfaction with community-based and more traditional hospital-based services such as Dean, Phillips, Gadd, Joseph and England (1993) who found patients in both settings achieved similar outcomes, although the relatives of patients were more satisfied with the community service. Essex et al. (1981) conducted a study at a child guidance centre and community mental health centre. Ruggeri and Dall'Agnola (1993), conducted studies on the relative as main carer for patients and the professional working in the setting.

Rates of patient satisfaction and dissatisfaction

Patients typically express high rates of satisfaction with their mental health care. To address this finding and the lack of well controlled studies on patient satisfaction in the literature, a meta-analysis was undertaken by Lehman and Zastowny (1983) to establish norms on patient satisfaction for various types of mental health programs. The rates of satisfaction and dissatisfaction were 70.6% and 18.9%, respectively.

Repeated versus one-off studies

The significant majority of studies to date tend to be one-off events thereby preventing within-study comparisons. Interpretation of one-off satisfaction results obtained using locally constructed questions is therefore difficult, rendering satisfaction data almost meaningless. Service comparisons are rendered impossible due to immense methodological variations and lack of a consistent common nucleus of questions (Stallard 1996a).

A few studies have reported the repeated use of satisfaction surveys, thereby enabling comparisons within services over time. Dean et al. (1993) reported that satisfaction is continuously assessed and reviewed every six months although no specific data was presented. In this study targets were selected for improvements and service changes implemented. When re-assessed, positive gains in each of the four selected quality improvement targets as determined by increased parental satisfaction were obtained, although only one reached statistical significance. There was a deterioration in satisfaction with other areas of the service, particularly the wait for a first appointment, interval between appointments and the total number of appointments offered, which

reflected increases in overall service quality. Satisfaction surveys should therefore be repeated events and considered part of the on-going process of quality assurance (Stallard 1996a). Granello et al. (1999) studied people within 24 hours after admission and again on the day they were discharged and after 3 months follow-up. Only 21% of the sample participated in the three-month follow up data collection. This is a common and persistent problem in outcome research. The study found that overall study participant's symptom distress was significantly reduced during their partial hospitalisation stays, that the treatment gains were maintained at follow up, and that patients in the program were satisfied with their treatments (Granello et al.1999).

2.4 GOALS OF SATISFACTION STUDIES

The function and value of satisfaction data is largely determined by who commissions the research and their purpose for doing so. Clinicians may want to assess the views of clients about different therapeutic interventions, increase compliance rates or alternatively may wish to produce a positive report to management to validate their service and maintain the status quo. Service managers may undertake satisfaction surveys in order to assess the performance of individual clinicians or to use the data to initiate changes in service delivery. As part of a quality assurance programme they may be used to assess and improve the physical or hotel aspects of care. Alternatively they may be undertaken by radical consumerists to challenge the more traditional professional domination of health care (Stallard 1996a). Investigations of client satisfaction are useful and necessary from the standpoint of offering recipients of services an opportunity to give opinions about service and help

pinpoint areas of dissatisfaction. Additionally, helping services can use consumer satisfaction for training, for professional growth and for promoting a more responsive delivery system. It is important that all staff meet to discuss the importance of the research that is to be conducted. It is also important that everyone "buys into" the program as much as possible, not as something additive or external. Staff are prone to be more open to the project if they see it is a part of the larger system. The demonstration of treatment effectiveness not only can be useful for external marketing but also can have a tremendous morale-boosting effect on often overworked and stressed out mental health professionals and staff.

It must be remembered that patients are passive recipients of a service provided by professionals and deficiencies will continue until the patients are allowed to take more control of their lives within the health care service delivery. Also those people involved in consumer evaluations need to be more than academic researchers. They must also actively campaign for their observations to be acted upon. Client satisfaction is one facet of a growing mandate for consumer and citizen participation in health service planning and evaluation (Margolis, Sorenson and Galano 1977).

2.5 LIMITATIONS IN CONSUMER SATISFACTION RESEARCH

Several reviews of the literature provided a comprehensive picture of the state of research on consumer satisfaction. Patient satisfaction is an area of investigation that suffers from the lack of a standard methodology,

tremendous variability in the work that has been done and the lack of generalizability from one study to another (Kalman1983).

There has been a failure to address the specific outcomes of nursing care and the patients' level of satisfaction with that care (Baradell 1995).

The literature on patient satisfaction with mental health services remains limited in many ways. These limitations include the lack of controlled studies that compare different groups of patients or programmes, the lack of consistency in the instruments used to measure satisfaction, and absence of a clear theoretical framework of patient satisfaction (Lehman 1983). Despite the proliferation of satisfaction surveys methodological issues have been largely ignored sampling bias, uniformly high levels of reported satisfaction and an absence of baseline data upon which to make within-service comparisons (Stallard 1996b).

Problems consistently included lack of attention to study designs and implementation plans, insufficient sample sizes or lack of information about representativeness and instrument limitations. Issues of reliability and validity are seldom considered, response rates are low, and studies are typically one-off events which render comparisons between or within services extremely difficult. Most studies do not have test-retest data on their instrument, and a few instruments have been standardised or have their validity replicated (Kaman 1983).

Most studies theoretical frameworks and study designs lacked methodology or instruments that would yield data on dissatisfaction. Also, data collection procedures often raised questions about confidentiality and anonymity (Larsen, Attkisson, Hargreaves, and Nguyen 1979). Most investigators of

patient satisfaction and attitude have designed their own methods and instruments and their results are not generalisable. Thus it is difficult, if not impossible, to compare one satisfaction study meaningfully with another (Kalman 1983).

In public psychiatric settings problems in acceptability of instruments to clients can easily arise due to the poor education of many subjects, the possible limitation in subjects understanding and patients symptoms such as suspiciousness and passivity. This is fundamental but mostly unexplored methodological issue (Ruggeri 1994).

Another variable that is often not discussed in satisfaction studies is the diagnosis of the subject. Most studies do not sample particular diagnostic group patients' but rather can be assumed to have sampled a cross-section of diagnosis categories. This practice may be a significant contaminant because the presence of psychosis or depression might considerably alter the satisfaction a patient expresses (Kalman 1983). In any survey, there may be an inclination on the part of clients to express satisfaction because of hidden fear that if they do not, services will be withdrawn or fear that treatment will be withheld if needed again. This may be true even though assurances are that all responses will remain anonymous (Blair and McBee 1978). The findings of a study conducted by Baradell (1995) showed that the patients who responded to the mail survey, reported significant reduction in their clinical symptoms and significant improvement in the quality of their lives.

2.6 SERVICE QUALITY

The growing emphasis in mental health on consumer values, community care, and broadened measurements of outcomes has had major significance for the way quality and performance are measured (Campbell 1997).

Over the last few years consumers of behavioural health services and their families have seriously questioned that traditional definition of quality assurance. They have protested that quality of care must also include information about the consumers' satisfaction with services. Specifically, do the services meet the needs and wishes of the people who receive them. The role and influence of consumers and family members in the delivery of mental health services have significantly increased over the last decade, resulting in a more responsive and effective system (Ferry 1996).

Researchers have also noted that a consumer's level of satisfaction with a single service encounter can determine his long-term attitudes about service and what quality means (Bryant et al.1998).

Palmer (1997), sums up quality of care in terms of those health outcomes that can be influenced by health-care processes and those processes of care that can yield desired health outcomes. When measuring health-care quality in terms of processes that can improve health outcomes, many different activities are considered, such as: providing access to care, making accurate diagnosis, implementing treatments and counselling patients concerning self-care that is appropriate to their diagnosis, monitoring persisting disease and adjusting management in response to the patient's needs, providing services and advice for health promotion and disease prevention. For all these activities, safe implementation is an essential component of quality of care because some

services carry risks of harm to patients. Patients' condition can be made worse rather than better by receiving care (Palmer 1997).

In Parasuraman, Zeithaml and Berry's model, published in 1994, consumers have a "zone of tolerance" bounded by adequate and desired service levels. If a service encounter does not meet their minimal performance criteria, then they become dissatisfied and develop a negative image of the service. Researchers and managers of service firms concur that service quality involves a comparison of expectations with performance. Service quality is a measure of how well the service level delivered matches customer expectations. Delivering quality service means conforming to customer expectations on consistent basis (Lewis and Boom in Parasuraman et al. 1985). There is a greater focus on the evaluation of quality in South Africa. Questioning the quality of care has not been part of the ethos of health care in this country, but a deliberate effort is being made to formalise quality improvement in South Africa. A formal Council for Health Service Accreditation of Southern Africa (COHSASA) was registered in November 1995. A project on quality improvements for primary health care services has also been initiated by COHSASA (Booyens 1998).

2.7 ARGUMENTS FOR RESEARCH ON CONSUMER SATISFACTION

In the private sector, dissatisfied health service clients can often seek services elsewhere as an expression of dissatisfaction. In contrast, the public sector client is less likely to have alternative health service options and may not feel free to express dissatisfaction with the only health services available to him or

her. It is necessary, therefore, for public health programs to assume responsibility for establishing accurate ways of obtaining satisfaction feedback from public sector clients (LeVois et al.1981).

The compelling belief that people with mental illness can grow beyond their diagnoses to reach out and share their experiences and learn from each other has led to the growing role of mental health consumers in ensuring quality of care in psychiatric services.

Campbell (1997) noted that consumer satisfaction has implications for mental health services as well as the consumer movement. It was also presented that consumers perspective about satisfaction, quality and effectiveness helps providers understand which treatments are valued and will be used. Additional evidence supporting consumer evaluations of direct service indicates that clients can judge therapy outcome accurately. Thus contrary to traditional wisdom, the client may be a better evaluator of therapy than is the therapist. Client ratings can provide a correction for the bias of therapists' perceptions. In addition, consumers are a valuable source of information about behaviour change across situations. As recipients of direct services, consumers are in a unique position to report on long term benefits that persist or generalise beyond the immediate setting. Furthermore, consumers are a good source of information about such subjective considerations as pre-therapy expectations, therapist-patient relationships, accessibility of health services and needs unmet by available services (Margolis, Sorensen, and Galano 1977).

The essential element of any study, that is, careful assessment, feedback of results, negotiation of change and a follow up evaluation are also

characteristic of our work with the individual client (Milne and Kennedy 1993).

2.8 SOUTH AFRICAN EVALUATIONS

According to Uys et al. (1997), in the past consumers of psychiatric services have had no input in the planning and evaluation of services. The health system has not been organised in a democratic way. This has been changed recently. A national organisation was formed in 1992. Health workers and consumers came together to address the needs of the mentally ill and their families and the National Alliance for Mental Health was formed.

Freeman, Tennyson and William (1994) conducted an evaluation of mental health services in the Orange Free State. Extensive fieldwork was done in seventeen clinics. Semi-structured interviews were held with patients attending the clinics and family members of these patients including people who had defaulted from the clinic and family members of these 'defaulters'. Some of the interview questions pertained to treatment received and satisfaction with the services at the clinic. Half the White patients and 35% of Black patients interviewed said that they felt better after stopping their visits and treatment. Reasons why patients left the clinic included the belief that they no longer needed treatment and side effects of medications. A highly statistically significant ($p< 0.05$) was found between races regarding queues while waiting for treatment. Eighty-two percent of Black patients waited in queues while only 23% of White patients did so. Most patients (88.5%) felt they could talk to the sister or doctor about their problems. However, 51% of

patients (54% Black, 41% White) felt that they needed more time with the staff member seeing them. Forty-eight percent of Black patients and 63% of White patients had received a home visit at some point. Ninety-six percent of patients expressed general satisfaction with the services they received.

Uys et al. (1997), conducted a study in which the expectations of consumers of public sector psychiatric care in South Africa were identified and formulated in the form of 13 standards, each with a set of criteria. The standards are as follows: Community based approach to care; staff attitudes; head office management; consumer participation in management; multi-sectoral, continuity of care approach followed; provincial legislation and procedures acceptable; comprehensive primary psychiatric care offered in nearest clinic: (physical and human resources and policies; optimal assessment, diagnosis and treatment; psycho-social rehabilitation); optimal hospital treatment and care: (physical and human resources and policies; continued care with social network of patient; optimal diagnosis, treatment and management; optimising of functional status and quality of life); forensic psychiatric care available; funding is adequate for the services, regular review and/ or evaluation of services; relevant research encouraged.

During this phase input from the literature was incorporated, and expectations were validated with different groups of consumers, so that rural/urban, ethnicity and regional differences were taken into account.

Based on the comprehensive set of standards and criteria, four instruments were developed to measure attainment of these standards. These included a questionnaire to consumers and one to the Director of Mental Health. It also included two schedules to be filled in by observers during site visits to

hospital units and clinics. The observer teams included community members and consumers. The account validity of the instruments was established by setting out the items measuring each criterion, and validating that with a group of experts. The instruments were then tested in one province. The inter-rater reliability of the site visit schedules was calculated as 0,94, and the coding of the Director questionnaire by different coders was also tested. The average performance on all criteria was calculated, using items from all four data collection instruments. In the process items were revised, coding instructions developed, and criteria adjusted. The level at which this province achieved the standards was 58%. There were two categories in which performances were below 20%, and those were funding and research and development. Management was below 50%, while service provision and the approach category, which included staff attitudes, achieved percentages higher than 50%. There was large variation between the quality of different hospital units (from 22% to 64%) and different clinics (from 27% to 62%) (Uys et al. 1997).

2.9 THEORETICAL FRAMEWORK

Theory of Consumer Satisfaction

The dominant theory of consumer satisfaction is the disconfirmation of the expectancy paradigm. This theory postulates that a consumer's level of satisfaction may be determined by comparing his expectation of what he or she thinks will/should be the benefits and /or costs of a product/service with its performance. If performance surpasses expectations, he experiences positive disconfirmation and is satisfied, strengthening his intention to reuse the product or service. Conversely, if performance falls below expectation,

negative disconfirmation and dissatisfaction occur (Kolodinsky 1999). Smith and Houston (in Parasuraman, Zeithaml and Berry 1985) claimed that satisfaction with services is related to confirmation or disconfirmation of expectations. They based their research on the disconfirmation paradigm, which maintains that satisfaction is related to the size and direction of the disconfirmation experience where disconfirmation is related to the person's initial expectation. Swan in Kolodinsky (1999) has suggested that the formation of patient satisfaction perceptions is based on a reciprocal process that is influenced by both the consumer and provider of medical services. Kolodinsky (1999) further cites that this view of satisfaction is an extension of the expectation / disconfirmation model (Cardozo 1965; Oliver 1980) and is complementary to the work of Woodruff et al. (1983) and Oliver (1989) who asserts that consumers develop a set of experience-based norms on which they judge whether their expectations are confirmed or disconfirmed. In other words, the key to ensuring good service quality is meeting or exceeding what consumers expect from the service.

Service Quality

Researchers have also noted that consumers' level of satisfaction with a single service encounter can determine his long-term attitudes about service quality mean. In Parasuraman, Zeithaml and Berry's newest model, and published in 1994 (cited in Bryant et al. 1998) consumers have a "zone of tolerance" bounded by adequate and desired service levels. If a service encounter does not meet their minimal performance criteria, then they become dissatisfied and develop a negative image of the service.

CHAPTER 3

RESEARCH METHODOLOGY

3.1 INTRODUCTION

This chapter focuses on the research design, the techniques of data collection, the sample and setting, the ethical issues involved and the method of data analysis.

3.2 RESEARCH DESIGN

A descriptive design was chosen because its main objective is the accurate portrayal of the characteristics of individuals, situation, or groups and the frequency with which certain phenomena occur (Polit and Hungler 1995). This design facilitated access to the constructs being studied through participants' portrayal of their opinions, and perceptions of their satisfaction with and acceptance of mental health care received in the community health care. Descriptive designs commonly gather information from a sample of the population of interest with no attempt to manipulate variables or control conditions, in order to gain a clear picture of the way things are (Robson 1993).

Subsequently, by using descriptive design, the researcher is able to observe, describe and classify the phenomenon or construct under study.

A survey is chosen because of the focus on obtaining information regarding the status quo of some situation and will assist the researcher in collecting information on people's knowledge, opinions, attitudes and values. Survey methods are the most widely means of gathering data. Their outstanding advantage is directness and the purpose is clear (Polit and Hungler 1995).

Lebow (1982) added that the responses are straightforward and the tie to satisfaction unequivocal. For those researchers interested in making generalisations, survey research is an ideal method. Survey researchers need to work to go beyond superficiality, to collect information that will yield a better understanding of what respondents actually mean when they answer a questionnaire item (Gutek 1978).

3.3 RESEARCH SETTING

The first setting for this study is situated in central Durban, and for the purpose of this study will be referred to as Clinic 1. Although this clinic serves a mixed population, the consumers, are predominantly White.

The second setting for the study is situated in Durban North, and for the purpose of this study will be referred to as Clinic 2. The consumers in clinic 2 are predominantly of Indian origin.

The third setting is situated in the south of Durban and serves a predominantly Coloured population. For the purpose of this study, this clinic will be referred to as Clinic 3. Unlike clinics 1 and 2 which are open every weekday, clinic 3 operates once a week and the other days are used for different clinics.

The above clinics were chosen in order to establish a distribution of strategic positioning of the services geographically and because they serve different race groups. All three clinics attend to similar mental health conditions.

Permission was obtained from the Assistant Director of community psychiatric services and the heads of the three clinics to conduct this study.

3.4 POPULATION

The population of this study are all eligible consumers of mental health service delivery attending the three clinics during the study period who agreed to participate in the study. This study has covered a cross section of diagnostic categories. The average number of clients seen per month in these clinics are as follows: Clinic 1: 4312; Clinic 2: 2608, Clinic 3: 846.

3.5 SAMPLING

Sampling Approach

The aim is to obtain the views of a sample, in which case the aim is to construct a sample that can represent the entire population while avoiding the many costs that might be expected from gathering every person's views, as in a census (Fitzpatrick 1991b).

The sampling approach used has non-probability components of which the purposive sampling method was utilised because it involves the most readily available or most convenient group of subjects for the sample (Polit and Hungler 1995). Clients were approached in the waiting room or referred by the nursing sisters to a private room.

Sample Size

According to Polit and Hungler (1995), a sample refers to a subset of a population selected to participate in a research study. In this study a sample of one hundred and eleven clients were selected in total. This figure was derived by determining 20% of the average daily clinic attendance by consumers

from the three respective clinics. The average daily clinic attendance are as follows: Clinic 1: 215; Clinic 2: 130; Clinic 3: 211.

The sample consisted of all eligible consumers attending these clinics during the study period and those who agreed to participate in the study.

Inclusion criteria are:

- Consenting adults that is 18 years and older.
- Currently on treatment and attending clinics so were able to evaluate the present situation.
- Identified by the clinic treatment team as symptomatically stable so would be able to produce more valid information. .

Exclusion criteria are:

- Identified by the clinic staff as incapable of providing informed consent.
- Actively psychotic persons.

3.6 INSTRUMENT AND DATA COLLECTION

Instrument

The Client Satisfaction Questionnaire (CSQ-8)

The Client Satisfaction Questionnaire (CSQ-8) is an eight-item questionnaire used to measure client satisfaction. It was developed by Larsen et al. (1979). The adapted version of this questionnaire was used in this study. The wording had to be changed slightly, to make provision for South African service conditions, example, "Program" was changed to "Service". The instrument rates the attitudes of psychiatric patients towards their treatment settings and

staff. It is most important to include a simple, clear statement of the purpose and use of the questionnaire and explanations of why the person has been selected, how the questionnaire is to be completed and what the person is to do with it after its completion. (Fitzpatrick 1991b). Several considerations were taken into account in the choice of instrument. It had to be applicable to a wide range of clinics. It had to cover four areas of concern: general satisfaction; quality of service; amount, length or quantity of service; outcome of service. It had to be simply worded to ensure patient comprehension. It had to be short enough to fit on a single sheet of paper. The questionnaire had to be easy to follow and attractively set out. Finally, it had to be simple to score. The scale also included space for individual written comments and for the patients' description of the best and worst part of the service. The provision for written comments was made in order that the items of the questionnaire should not be defined only by the professional group but also by consumers themselves.

The CSQ-8 was chosen because a comprehensive review of the literature found them to be well supported in research and commonly used. The instruments were also chosen because of their relation to the research questions of the study, their ease of administration and their overall inexpensive cost.

Pascoe, Attkisson and Roberts (1983), found that while other satisfaction instruments tended to measure clients overall satisfaction with health care the CSQ-8 efficiently and effectively measured client satisfaction with a specific treatment program. The excellent performance of the CSQ-8, coupled with the practical advantages of using a shorter questionnaire, suggests that the CSQ-8

is to be preferred as a measure of client satisfaction (Attkisson and Zwick 1982).

The CSQ-8 is a generically written measure of client satisfaction with good psychometric properties. It consists of eight Likert-type items with four response choices, where 1 indicates the lowest rating of quality or degree of satisfaction and 4 indicates the highest (Nguyen, Attikisson, and Stegner, 1983). Patients were asked to rate the quality of the service received in the clinic on a 4 point scale ranging from "excellent" to "poor". Patients were also asked if their needs were met on a 4 point scale ranging from "almost all of my needs have been met" to "none of my needs have been met". The question that asked whether the services helped to deal more effectively with clients problems on a 4 point scale ranged from "yes, they helped a great deal" to "no, they seemed to make things worse". The last item asked if they would come back to the clinic, if they were to seek help on 4 point scale ranging from "no, definitely" to "yes, definitely".

Demographic Questionnaire

A demographic questionnaire was used to obtain a variety of information on the patients in the study including age, education, gender, ethnicity length of visits to the clinic. These variables were selected in an attempt to determine the predictive capacity of the patient demographic variables in forecasting outcome.

According Fitzpatrick (1991b), it is routine in survey research to include what are commonly referred to as "background variables", that is, social and demographic variables. They have particular importance in research of patient

satisfaction because variables such as age, gender, education, social class, marital status may all exert as strong an influence on levels of satisfaction as any direct effect of health services (Fitzpatrick 1991b).

The questionnaire was translated into Zulu and the consumers had an option to choose either English or Zulu as a language medium.

Data Collection

Prior to collection of the data, the purpose of the study and procedure involving data collection of data was discussed with the heads of each of the 3 clinics. Arrangements were then made with regards to suitable times and dates, which were not affected by either staff or type of programmes in the clinics. All data were collected according to the following standardised procedure. Questionnaires as a self-report instrument were used for data collection. Oral interviews were conducted for illiterate consumers. Data was collected over a period of six days. Such data was collected by means of closed-ended questions. During this period, all clients who met the inclusion criteria were asked to complete the questionnaire on site. A private room was used or if this was not available an allocated area in the waiting room was used for this purpose. The nursing sisters referred the clients to the researcher. There was no time limits posed for the completion of the questionnaire by each individual.

In all steps of the study, special care was taken to maintain the neutrality of the interviewer, to stress her independence from the clinical team taking care of the patient and guarantee the confidentiality and the anonymity of the interview. Clients were assured that the outcome of the study would not affect

their receipt of services in any way. Each client was told that criticism of the services would be as helpful as compliments. All instructions appearing in writing made this point as well.

According to Fitzpatrick (1991b), when conducting a survey two broad principles need to be adhered too as far as possible: the anonymity and confidentiality of the respondent's answers and the neutrality of the person gathering the data. Both are primarily designed to maximise the candid expression of views. Statements of confidentiality require a simple explanation how information is to be processed and analysed.

Prevention of sources of distortion in consumer was done with the following:

- Explaining the purpose and procedure to participants.
- Explaining that the analysis will focus on group rather than on individual data.
- The administrator of the questionnaires was not known to the clients and was not part of the staff of the service being evaluated.
- Guaranteeing anonymity
- Consumers were encouraged to be frank and not to feel obliged to praise the program.
- Consumers were informed that criticism of the services with be as helpful as compliments.
- A translated version of the questionnaire was offered to Zulu speaking individuals.

3.7 VALIDITY AND RELIABILITY

Reliability in this context means the ability of the schedule to produce the same data when completed in a repeated fashion.

Validity, which assesses how well the scale measures what it is intended to measure, is much more difficult to assess (Slater et al. 1982).

In a study conducted by Attkisson and Zwick (1982), the internal consistency (coefficient alpha) of the CSQ-8 was 0 .93 and it seemed to be valid in that low scores correlated with early dropouts and numerous missed appointments. This instrument was also used by Granello et al. (1999). Results also demonstrated that the CSQ-8 performed as well as the CSQ-18 and often better. The excellent performance of the CSQ-8, coupled with its brevity, suggests that it may be especially useful as a brief global measure of client satisfaction (Nguyen, Attkisson, and Stegner 1983).

3.8 PILOT STUDY

A pilot study was conducted to test the practical aspects of a research study. According to Brink (1999), the pilot study is a small scale study which is conducted before the main study on a limited number of subjects from the same population as that intended for the eventual project. It is essential that a questionnaire be piloted on a sample of respondents before the full survey. The purpose of the pilot study is to investigate the feasibility of the proposed study and to detect possible flaws in the data-collection instruments.

A pilot study allowed several potential problems to be predicted. Firstly, the clarity and acceptability of questionnaire items can be examined. Also, if respondents are given space for open ended comments additional items or

issues not included in the first draft of a questionnaire may emerge. In addition, the variability of answers may be checked. Other aspects of the survey such as method of explanation and presentational aspects of the questionnaire may also be tested at this stage, and this is also the best opportunity, if possible, to examine formal properties of a questionnaire, such as reliability (Fitzpatrick 1991b).

For this study, a pilot study was conducted on 10 consumers in a selected community psychiatric clinic that is not one of the clinics used in the main study. The questionnaire was piloted on general psychiatric patients and was found to be understandable and acceptable.

The pilot study helped to enhance the planned data collection procedure. The result of the pilot-testing phase was encouraging because a 100% response rate was achieved. There were no modifications made to the questionnaire.

3.9 ETHICAL CONSIDERATION

The following measures were taken to ensure ethical compliance.

- Permission was obtained from the Director of Community Psychiatric Services and clinic managers.
- Permission to use the questionnaire was sought.
- The purpose and procedure of the study was explained to all participants and filled in questionnaires was taken as consent from consumers.
- Participants were assured that the entire questionnaire and the data collected were to be kept anonymous.
- The participation of clients was voluntary and was given freedom to ask questions related to the study.

- The data collected was used by the researcher for the specific use and destroyed once the study was over.
- Participants could quit the study any time they wish without reprisal.
- The languages that were used were English and Zulu.

3.10 LIMITATIONS OF THE STUDY

Given the cognitive limitation characteristic of some mentally ill, it may be questioned whether they consistently report level of satisfaction with treatment components.

The selected 3 clinics may also not be representative of the entire population of mental health clients in the Durban area.

The responses that clients gave may also be influenced by their need to give comments that they felt would not jeopardise the care they are receiving from the clinics. The researcher, nevertheless, had these limitations in mind while collecting and analysing the data from this study.

3.11 DATA ANALYSIS

Descriptive statistics, such as means or frequency distribution, was used to summarise the survey data and demographic characteristics by means of a computer software package called Statistical Package for Social Sciences. Data presentation and analysis will be illustrated in the next chapter.

CHAPTER 4

DATA PRESENTATION AND INTERPRETATION

4.1 INTRODUCTION

This chapter endeavours to give meaning to the data by presenting the data as comprehensively and clearly as possible using schema or tables wherever possible as well as narrative report writing style with no interpretation. The next chapter will be on discussion of findings in which facts shall be interrelated and interpreted. Tables shall be focused enough to permit viewing a full data set in one location and shall be systematically arranged to answer the research questions at hand.

4.2 DEMOGRAPHIC RESULT

SAMPLE CHARACTERISTICS

The sample consisted of one hundred and eleven participants of which 100% completed the questionnaire. The participants were from the various racial groups, that is, Clinic 1 comprised largely of Whites, whilst Clinic 2 was predominantly Indian, and Clinic 3 mainly Coloured. These participants attend the three different community psychiatric clinics within the Durban area. The number of respondents in Clinic 1 (43), Clinic 2 (26), Clinic 3 (42). See table 4.1

AGE

The ages of participants ranged from 18 years to seventy-nine years. In Clinic 1, the age range was between 25-79, Clinic 2 between 18-57 and Clinic 3

between 22-70. The mean age of the respondents was as follows: Clinic 1 (43.90), Clinic 2 (38.1) and Clinic 3 (42.26). See table 4.1

TABLE 4.1: CHARACTERISTICS OF RESPONDING CLIENTS

Description	Clinic 1	Clinic 2	Clinic 3	Total
Total no. of respondents	43	26	42	111(100%)
Age Distribution				
Range	25-79	18-57	22-70	18-79
Mean	43.90	38.1	42.26	41.9459
Standard deviation	12.86	11.24	10.64	11.7951
Gender distribution				
Female	19(44.2)%	7(26.9)%	16(38.1)%	42 (37.8%)
Male	24(55.8)%	19(73.1)%	26(61.9)%	69 (62.2%)
Race				
African	4 (9.3)%	1 (3.8%)	-	5 (4.5%)
Indian	4 (9.3%)	24(92.3%)	2 (4.8%)	30(27.0%)
Coloured	3 (7.0%)	1 (3.8%)	36(85.7%)	40 (36%)
White	32(74.4%)	-	4 (9.5%)	36 (32.4%)
Educational Level				
Primary school	2 (4.7%)	8(30.8%)	9 (21.4%)	19(17.1%)
High school	38(88.4%)	16 (61.5)	30(71.4%)	84 (75.7%)
Diploma	2 (4.7%)	1 (3.8%)	2 (4.8%)	5 (4.5%)
Post graduate	1 (2.3%)	1 (3.8%)	1 (2.4%)	3 (2.7%)
Employment Status				
Employed	9 (20.9%)	4 (15.4%)	3 (7.1%)	16 (14.4%)
Unemployed	34(79.1%)	22(84.6%)	39(92.9%)	95 (85.6%)
Length of visit in years				
Mean	6.27	9.30	8.30	7.7545
Minimum	0.50	2.0	1.0	0.50
Maximum	28.0	29.0	31.0	31.0

GENDER DISTRIBUTION

Generally, there are more males than females. Males were dominant in all the clinics. There were 62.2% males and 37.8% females. See table 4.1

RACE

The sample comprised of Black 5 (4.5%), Indian 30 (27.0%), Coloured 40 (36%), White 36 (32.4%). See table 4.1

LEVEL OF EDUCATION

The majority of consumers, 84 in number (75.7%) had reported receiving high school education. Nineteen, (17.1%) of respondents stopped schooling at primary level. Five, (5%) of respondents received education at diploma level, whilst 3 (2.7%) received post -graduate level of education. See table 4.1

EMPLOYMENT STATUS

The overwhelming majority of the consumers are unemployed, that is 95 (85.6%) and 16 (14.4%) reported being employed.

LENGTH OF VISITS

Consumers have been attending clinics between 6 months and 31 years. Length of visits in Clinic 1 ranged between 6 months and 28 years; Clinic 2, between 2 and 29 years: and in Clinic 3, between one and 31 years.

4.3 CLIENT SATISFACTION RESULT

TABLE 4.2 SERVICE EXPECTATION

Response	Clinic 1	Clinic 2	Clinic 3	Total
No, definitely not	-	-	2 (4.8%)	2 (1.8%)
No, not really	3 (7.o%)	1 (3.8%)	2 (4.8%)	6 (5.4%)
Yes, generally	12 (27.9%)	11 (42.3%)	18 (42.9%)	41 (36.9%)
Yes, definitely	28 (65.1%)	14 (53.8%)	20 (47.6%)	62(55.9%)

In response to the question "Did you get the kind of service you expected?" Most of the consumers 103 (92.8%), responded generally or definitely with "yes", and would therefore appear to have their service expectations met. Those consumers who do not have their expectation met, amount to 8 (7.2%). See table 4.2

TABLE 4.3 HEALTH CARE SATISFACTION

Response	Clinic 1	Clinic2	Clinic 3	Total
Not satisfied	7(16.3%)	7 (26.9%)	11 (26.2%)	25 (22.5%)
Mildly dissatisfied	1 (2.3%)	1 (3.8%)	3 (7.1%)	5 (4.5%)
Mostly satisfied	15 (34.9%)	3 (11.5%)	11 (26.2%)	29 (26.1%)
Very satisfied	20 (46.5%)	15 (57.7%)	17 (40.5%)	52 (46.8%)

With reference to the question "How satisfied are you with the amount of help you have received from the health care provided in this clinic". Thirty (27.0%) appeared to be either not satisfied or mildly dissatisfied, while 81

(72.9%) appeared to be either mostly or very satisfied with the care received. See table 4.3

TABLE 4.4 NEEDS SATISFACTION

Response	Clinic 1	Clinic2	Clinic 3	Total
None of my needs met				
A few needs met	4 (9.3%)	5 (19.2%)	8 (19.0%)	17(15.3%)
Most needs met	20(46.5%)	9 (34.6%)	21(50.0%)	50(45.0%)
Almost all needs met	19(44.2%)	12(46.2%)	13(31.0%)	44(39.6%)

With reference to the question " To what extent has the services received in the clinic met your needs?" Ninety-four (84.6%) expressed that their needs were mostly met, with 17 (15.3%) stating that only a few needs were met. See table 4.4

TABLE 4.5 GENERAL SATISFACTION

Response	Clinic 1	Clinic2	Clinic 3	Total
Quite dissatisfied	-	-	1 (2.4%)	1 (.9%)
Mildly dissatisfied	1 (2.3%)	2 (7.7%)	5 (11.9%)	8 (7.2%)
Mostly satisfied	14 (32.6%)	7 (26.9%)	15 (35.7%)	36 (32.4%)
Very satisfied	28 (65.1%)	17 (65.4)	21 (50%)	66 (59.5%)

The dichotomous satisfaction outcomes for this question indicate a relatively high degree of satisfaction with the service received. As seen in table 4.5, most patients, 102 (91.9%), are generally satisfied with the service they have

received. Only 9 (8.1%) of the respondents appeared to be either quite dissatisfied or mildly dissatisfied.

TABLE 4.6 ACCEPTABILITY

Response	Clinic 1	Clinic 2	Clinic 3	Total
No, definitely not	-	-	1 (2.4%)	1 (.9%)
No, I don't think so	1 (2.3%)	1 (3.8%)	2 (4.8%)	4 (3.6%)
Yes, I think so	13 (30.2%)	4 (15.4%)	13 (31.0%)	30 (27.0%)
Yes, definitely	29 (67.4%)	21 (80.8%)	26 (61.9%)	76(68.5%)

When consumers were asked if they would come back to the same clinic if they were to seek help again, only 5 (4.5%) consumers reported that they would not, whilst 106 (95.5 %) of the respondents said that they would return for help. (See table 4.6)

TABLE 4.7 QUALITY OF MENTAL HEALTH SERVICE

Response	Clinic 1	Clinic 2	Clinic 3	Total
Poor	2 (4.7%)	-	1 (2.4%)	3 (2.7%)
Fair	3 (7.0%)	1 (3.8%)	8 (19.0%)	12 (10.8 %)
Good	11(25.6%)	7 (26.9%)	18 (42.9%)	36 (32.4%)
Excellent	27 (62.8%)	18 (69.2%)	5 (35.7%)	60 (54.1%)

When asked to rate the quality of mental health service received in the clinic, 96 (86.5%) rated this aspect of the service as either good or excellent, while

15 (13.5%) of the respondents considered the quality as either poor or fair. See table 4.7

TABLE 4.8 SERVICE RECOMMENDATION

Response	Clinic 1	Clinic 2	Clinic 3	Total
No, definitely not	-	-	-	-
No, I don't think so	-	-	1 (2.4%)	1 (.9%)
Yes, I think so	15 (34.9%)	6 (23.1%)	18 (42.9%)	39 (35.1%)
Yes, definitely	28 (65.1%)	0 (76.9%)	23 (54.8%)	71 (64.0%)

When asked, "If a friend were in need of similar help, would you recommend our services to him or her?" One hundred and ten (99.1%) responded positively with either a definite or a probable 'yes' whilst 1 (0.9%) responded with either a definite or a probable 'no'. See table 4.8

TABLE 4.9 SERVICE EFFECTIVENESS

Response	Clinic 1	Clinic 2	Clinic 3	Total
No, they made things worse	-	-	1(2.4%)	1 (.9%)
No, they really didn't help	-	1 (3.8%)	2 (4.8%)	3 (2.7%)
Yes, they helped somewhat	10(23.3%)	5 (19.2%)	13 (31.0)	28(25.2%)
Yes, they helped a great deal	33(76.7%)	20(76.9%)	26(61.9%)	79(71.2%)

One hundred and seven (96.4%) of the participants appeared to be positive about the services in terms of how these had helped to deal with their problems, but 4 (3.6%) of the respondents did not seem to feel this way. See table 4.9

4.4 GENERAL COMMENTS FROM THE RESPONDENTS

In the section where free comments were requested from the clients about the services, there were many positive comments complimenting and praising the staff and attributing positive change to the clinical services. In general, consumers liked and respected the clinic staff, despite acknowledgement by the consumers that the clinics were understaffed and providers were overworked. The following are examples of some of the positive comments that were extracted from the respondents.

> *"The staff are very dedicated and sympathetic towards us, although there is a whole lot of pressure from some of the patients."*

> *"The administrator of this clinic must be complimented on the most organised and effective strategies implemented in her programming of work"*

> *"The clinic has given me a chance to lead a normal life and I have a good relationship with various staff."*

> *"The Doctor is very patient, caring, understanding, helpful and accommodating."*

Other comments enlisted that were not on the positive side were as follow:

> *"The waiting period is too long to see the doctor and collect medication. More Doctors are required."*

"The Doctor is very abrupt and rude. He does not listen to me and makes decision without talking to me."

"Sometimes the sisters talk to you disrespectfully and they behave as if you don't know what you are talking about. The patient does not necessarily have to be wrong always."

" The nurses must be more informative to me."

CHAPTER 5

DISCUSSION OF FINDINGS, SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

This chapter discusses the major research findings together with interpretations and relates this to relevant literature studies. The chapter aims to present conclusions drawn from the findings, followed by recommendations.

5.2 DISCUSSION OF FINDINGS

Questionnaires were completed by one hundred and eleven individuals, with a response rate of 100% due to the fact that the respondents completed the questionnaires and handed them over on the spot without taking them away. In this study direct consumer feedback from general psychiatric patients was sought, based on the patients viewpoint of what constitutes ideal service.

Research Questions

For ease of reference, the following research questions were to be answered in this study.

1. What are the expectations of care consumers have of mental health services delivery?
2. What is the level of satisfaction that clients have of mental health service delivery?
3. How acceptable are the mental health services provided to the consumer?

Demographic Data

The first table presented the demographic characteristics of the respondents in order to be able to put the responses in the perspectives of the kind of respondents in this study. The patients in other samples indicate that clients are predominantly females (Baradell 1995, Vincente et al. 1993). The findings in the present study however, as shown in table 4.1, indicate that males, 69 (62.2%), apparently utilised the health services more than the females, 42 (37.8%). This is similar in all three clinics.

Race dominance is clearly demarcated by geographic position of where the respective clinics are situated.

This study covered Black 5 (4.5), Indian 30 (27.0%), Coloured 40 (36%) and White 36 (32.4%) patients. However, the Black patients composed of 4.5% are under-represented in this sample which may be a limitation in this study. This is not intended. It is a result of the sample that was available in the clinics at the time of collecting data. On further investigation it was found that Black patients who attended this clinic either lived or worked around this clinic. Other Black patients attended clinics in their residential areas.

With regard to the educational level of the consumers, most of clients in all three clinics, 84 (75.7%) had achieved secondary level education, 8 (3.2%) had tertiary education and 19 (17.1%) received primary school education.

There is a high rate of unemployment 95 (85.6) involving clients from all three clinics while only 16 (14.4%) were employed in this sample.

As has been widely reported (Denner and Halprin 1974, Lebow 1982, Damkot et al. 1983 and Vincente et al. 1993), the levels of satisfaction, attitudes and opinions were largely unrelated to the personal variables. Past studies have repeatedly found no significant relationships between client perceptions of the service environment and variables such a client age, race sex, marital status, social class and length of treatment including previous psychiatric experience and diagnosis (Lebow 1982; Balch, Ireland, McWilliams and Lewis 1977; Essex et al. 1981)). In a study on client evaluation of community mental health services: relation to demographic and treatment variables, conducted by Balch et al. (1977), of particular interest were the findings that satisfaction and improvement were unrelated to client age, sex, marital status or social class. In this study, no attempt was made to correlate demographic variables with individual questions on the form since it was desired to know only the relationship between demographic variables and major dimensions or the service environment, not individual item. Correlation analyses suggested that all demographic information could be eliminated, therefore demographics details such as age, gender, race, educational level, employment status and length of visits were not correlated to satisfaction in this study.

Client Satisfaction Data

It is clear that the people reached for this study were quite satisfied with the clinic services with most respondents scoring near the upper (satisfied end). The high rate of client satisfaction is consistent with other studies (Stallard 1996, Balch et al. 1977, Larsen et al. 1979, Stallard 1996, Denner and Halprin

1974)) that have found that clients usually report being quite satisfied with services.

Results indicate how consumers perceive the quality, general satisfaction, effectiveness of services acceptability and amount, length or quantity of service and outcome of service covered by the programme. Satisfaction outcomes for each item indicate a relatively high degree of satisfaction for most items. Questionnaires were completed by one hundred and eleven individuals, for a response rate of 100%. Approximately 103 (92.8%) reported that the help they received was consistent with what they expected (Table 4.2) and 102 (91.9%) of the respondents reported satisfaction with their general clinic experience (Table 4.5). The majority of the clients 106 (95.5%) indicated acceptability of the services and expressed that they would return to the clinic if needed (Table 4.6). These findings suggest that those who were satisfied would return to the hospital for mental health services if treatment were needed in the future. Table 4.4, shows that 94 (84.6%) have had their needs met. One hundred and seven clients (96.4%) felt that the service was effective and helped to deal more effectively with problems (Table 4.9) and ninety-six (86.5%) rated the quality of service as acceptable (Table 4.6). One hundred and ten clients (99.1%) indicated recommending the service to others (Table 8). Thirty (27.0%) were dissatisfied with the amount of help received from the health care provided (Table 4.3). This finding suggest what we generally know. We must work to improve the effectiveness of the service we provide.

The problem that was encountered is the difficult and time consuming process of obtaining permission for the research.

Implications for health services

Assessing client satisfaction is important not only for treatment considerations but also to ensure that cost saving measures does not effect client satisfaction with treatment.

The findings in this study have implications for mental health service improvements. Findings indicated that the majority of the participants were satisfied with clinic services. Also findings suggested that those who were satisfied would return to the hospital for mental health services if treatment were needed in the future.

The questionnaire survey gave some indication of the satisfaction or dissatisfaction with which patients regarded the services the clinic offered. In general, patients were satisfied and they believed that the care was often effective. Positive results such as these are easy to accept, but negative results might have had a different impact. A survey of patients' opinions is useful. The value of the study lies in the awareness staff may have gained of patients' assessment of service provided, which becomes one criterion for evaluating treatment effectiveness. However, the more specific findings concerning satisfaction with the care delivery practices provide relevant data for program administrators planning future services. Although investigations of client satisfaction are necessary, it should not be expected that they would provide critical information for evaluation of services. They can, however, help pinpoint areas where the most client dissatisfaction exists (Justice and McBee 1978).

Client satisfaction surveys have also not elicited many suggestions or complaints from patients and former patients when they have been asked to give open-ended comments on services (Justice and McBee 1978).

In the present study there were a few complaints among mental health clients about not enough doctors in attendance, too long waiting periods before being attended to, not given enough information by nurses, staff being rude, disrespectful and not being listened to and included in the decision making process.

5.3 SUMMARY

Patient satisfaction with psychiatric treatment can strongly influence pursuit and use of mental health services as well as treatment compliance and treatment outcome. The evaluation of the success of any service must include patients' views. However, some reservations have been expressed about the value of soliciting the views of psychiatric patients, especially those suffering from severe mental illness. Due to the absence of options for consumers in the public sector it becomes important that they have a say in the evaluation of services directly.

There has been little research on clients' perspectives of mental health work in South Africa.

This study is an attempt to present an appraisal of how a population of psychiatric patients from various racial groups viewed their mental health care in a community setting. A survey was conducted and 111 questionnaires were completed by the respondents, representing a 100% rate of response.

In the sample studied it was found that the vast majority of patients were

satisfied with most aspects of the treatment. Comments were encouraged at the end of the questionnaire. Some of respondents stated that it would be valuable to be given more information, and to have more staff in attendance, to be respected, listened to and included in the decision making process. Furthermore, these findings showed that patients could express views about their conditions, which should be useful in planning improvements in care.

Recommendations were, however, further made for improving quality of care and towards additional studies in other settings to include appropriate proportions of all racial groups in South Africa.

5.4 CONCLUSION

Although the size of the sample is not large in an absolute sense, they represent a substantial sample in comparison to previous-based evaluation of outpatient community mental health centres. Consistent with the findings of previous studies (Lebow 1982, Denner and Halprin 1974), there was a high degree of client satisfaction. Special attention was given to explaining the survey to patients and re-assuring them of their support. This survey has demonstrated that it is feasible to ask psychiatric outpatients about their views of their treatment. It has shown that patients were more satisfied than dissatisfied with their clinic visits. The schedule used here could usefully be modified for patients in other settings. These results suggest that the findings could prove helpful in identifying areas where improvements to patient's quality of life are most needed.

As noted by LeVois, Nguyen and Attkisson (1981) direct feedback from care recipients reflect a legitimate and important perspective on the delivery of quality care. In this sense, the satisfaction data will be of some value to staff. Although the specific findings of this study are limited to the particular treatment setting in which it was undertaken, this study has shown that such consumer evaluation can provide helpful feedback, which can be used to improve the delivery of mental health services at the local level.

Client's statements of satisfaction represent a meaningful assessment of their experience. Their experience provides strong evidence for the importance of ensuring consumer satisfaction in work with clients. Thus, consumer studies provide a direct, systemic channel of communication from service receivers to service providers.

5.5 RECOMMENDATIONS

Reliable and valid consumer satisfaction surveys are recognised as essential components of a comprehensive and effective consumer perception management system. The key issue in future research will be the enhancement of our capacity to detect dissatisfied consumers. For such evaluations to become more useful for planning program policies and services, there is need for a multidimensional examination of patient satisfaction, with specific exploration of the patients views of the clinical and administrative aspects of his or her care. All patients providing feedback with an emphasis on what changes can be achieved so that it is not a sterile exercise, which may later lose all credibility. Feedback from such surveys must be seen as part of user empowerment.

Consumers can influence the implementation of care even more effectively if there are empowered to participate. This can occur either indirectly or directly. The first step is receptiveness to spontaneous suggestions and complaints. Second, consumers can be encouraged to express their opinions by providing suggestion boxes. Third, there should be a systematic canvassing of the feelings, opinions by providing suggestion of clients. Health care workers are expected to be responsive to overt and covert expressions of their patients expectations. It is important that these expectations be properly shaped by prior experience of good service and by continuing education. The best interest of health care practitioners and consumers are congruent and that the political system will be most responsive to quality enhancement when health care professionals and consumers present a united front. Moreover, health care practitioners must, at all time, pursue not selfish, immediate advantage but whatever best serves patient welfare. This is our duty.

Methodology would need to be developed to overcome a tendency on the part of clients to express positive opinions from fear that criticism might result in their being dropped or barred from treatment or given inferior service.

More direct participation of consumers in the quality assurance enterprise should be tried. Consumer representatives should participate in formulating the objectives and policies that concerns quality. Such representation should be part of the quality improvement teams charged with reviewing and reforming many components of the health care system.

The database on community settings is sparse, requiring future studies to survey chronic patients' attitudes. In general, research needs to continue to

investigate these questions of satisfaction, searching for less biased instruments and seeking the opinion of non-responders.

Future surveys could eliminate demographic blocks and substitute other variables of choice that the institution has reason to believe may be related to the clients attitude or could include patient variables to account for a significant part of satisfaction variance. Although this study has its limitations, it can provide meaningful data to administrators concerning the ongoing delivery of care and help them plan patterns of practice for the future.

Satisfaction with care is only one part of patient outcome. One would hope that increased satisfaction would be associated with other types of outcome measured by reduction in symptoms and hospitalisation rates. Future research should be directed toward determining and defining the specific facets that characterise patients' satisfaction with their therapist. Also of interest would be an investigation of whether the strong relation between patients' satisfaction with their therapist and the belief of having received help is maintained when different treatment modalities are compared.

This outcome evaluation could be completed in-house at a mental health facility. It has a variety of benefits including low cost, ease in administration, client confidentiality and greater responsibility in accounting for client outcomes. Results from studies such as this can be used by individual programs to market their services to the community or to improve client treatment through a more detailed analysis intended to measure specific program strengths and weaknesses.

Future research could readily improve on this one, even if only by increasing the sample size. Replication of the current study with different populations

and different tools is needed to enhance the generalisability of the results, especially with Black patients that are under represented in this study. Further study of satisfaction in sites other than community mental health centres is needed, especially in the private sector.

Further efforts should be made to assess the relationship between self-reported satisfaction and maintenance of the minimum acceptability necessary to the client's continuation in treatment to determine whether these consumer responses are affected by the same or by different factors.

Furthermore, it seems likely that patient satisfaction should also be measured by peer review or record audit. Research studies are needed to define this association. Research should also explore the clinical impact of consumer satisfaction evaluation. This may have direct positive effect on the consumer, or it may have indirect effect through orienting health workers toward better practice, or there may be negative impact.

The effects of the purpose, target and use planned for the data on the results require study. The difficulties of implementing recommendations from patient satisfaction surveys point to problems of soliciting their views. If these are not rated, for example, on the grounds of resources availability, then patients' compliance with surveys of this kind will be reduced. Feedback from such surveys must be seen as part of user empowerment. Service providers and purchasers must be willing to supply patients with explanation of what can and cannot be changed. If this is not done, patient satisfaction schedules will provide less and less useful data as the goodwill of patients is lost.

Further improvements in the ability to accurately gauge consumer satisfaction should be a benefit to all stakeholders in health care service delivery. When

we help, consumers help us, that they can make their greatest contribution to enhancing the quality of care.

For consumer satisfaction to be useful and reliable concept in outcomes management programs, additional research is warranted in South Africa.

If the concept of evaluation is to be taken seriously the expressed views need to be acted upon, service changes specified and implemented and consumer opinion re-assessed.

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APPENDIX A

P. O. Box 21091
BLUFF
DURBAN
4020

29 August 2001

Assistant Director: Nursing
Department of Health
Community Psychiatric Services
Private Bag X54318
DURBAN
4000

Madam

REQUEST TO CONDUCT A RESEARCH PROJECT

I am a student at the School of Nursing, University of Natal carrying out a coursework project on Consumer Satisfaction with Mental Health Service Delivery in Durban, in partial fulfilment of the requirements of a Masters Degree in Mental Health Nursing.

I hereby request permission to carry out this study at the following community psychiatric clinics: Escoval House, Phoenix, and Austerville clinics.

I hope that this request receives your favourable consideration.

Yours faithfully

R. ALMEIDA

:NDIX B

PROVINCE OF KWAZULU-NATAL
DEPARTMENT OF HEALTH
DURBAN

ISIFUNDAZWE SAKWAZULU-NATALI
UMNYANGO WEZEMPILO
DURBAN

PROVINSIE KWAZULU-NATAL
DEPARTEMENT VAN GESONDHEID
DURBAN

TEL.: 3374392
FAX.: 3322576

PRIVATE BAG : X54318
ISIKHWAMA SEPOSI : DURBAN
PRIVAATSAK : 4000

Enquiries: R. Ramdutt Imibuzo : Navrae :	Date: 2001.09.07 Usuku: Datum:	Reference: Psy/KZN Imkomba: Verwysing:

Ms R. Almeida
P.O. Box 21091
BLUFF
DURBAN
4020

REQUEST TO CARRY OUT PROJECT AT MENTAL HEALTH CLINICS

Your letter dated 29 August 2001 refers.

Permission is hereby granted for you to carry out a project as requested.

Kindly contact the Sister-in-Charge of the clinics to make the necessary arrangements.

Escoval House / Austerville	(031) 3044635
Phoenix	(031) 5078827

R. Ramdutt AD

R. RAMDUTT
ASSISTANT DIRECTOR: NURSING

APPENDIX C

CLIENT SATISFACTION QUESTIONNAIRE

Please help us to improve our services by answering some questions about the services you have received. We are interested in your honest opinion, about the service you receive in this clinic. Please answer all of the questions. Thank you very much, we really appreciate your help.

PART A – Mark an "X" on the appropriate box.

AGE: ☐

SEX:

FEMALE	☐
Male	☐

RACE:

Black	☐
Indian	☐
Coloured	☐
White	☐

EDUCATION LEVEL

Primary School: Class 1-Standard 5	☐
High School: Standard 6-Standard 10	☐
Diploma Degree	☐
Post Graduate	☐

EMPLOYMENT STATUS

Employed	☐
Unemployed	☐

How long have you been visiting this clinic? ☐

PART B

CIRCLE YOUR ANSWER on a scale of 1-4 as indicated below.

1. How would you rate the quality of mental health service you have received in this clinic?

4	3	2	1
Excellent	**Good**	**Fair**	**Poor**

2. Did you get the kind of service you expected?

1	2	3	4
No, definitely not	**No, not really**	**Yes, generally**	**Yes, definitely**

3. To what extent has the services received in the clinic met your needs?

4	3	2	1
Almost all of my needs have been met	**Most of my needs have been met**	**Only a few of my needs have been met**	**None of my needs have been met**

4. If a friend were in need of similar help, would you recommend our services to him or her?

1	2	3	4
No, definitely not	**No , I don't think so**	**Yes, I think so**	**Yes, definitely**

5. **How satisfied are you with the amount of help you have received from the health care provided in this clinic?**

1	2	3	4
Quite dissatisfied	Indifferent or mildly dissatisfied	Mostly satisfied	Very satisfied

6. **Have the services you received helped you to deal more effectively with your problems?**

4	3	2	1
Yes, they helped a great deal	Yes, they helped somewhat	No, they really didn't help	No, they seem to make things worse

7. **In an overall, general sense, how satisfied are you with the service you have received?**

4	3	2	1
Very satisfied	Mostly satisfied	Indifferent or mildly dissatisfied	Quite dissatisfied

8. **If you were to seek help again , would you come back to this clinic?**

1	2	3	4
No definitely not	No, I don't think so	Yes, I think so	Yes, definitely

Please add any other comments you may have here.

APPENDIX D

IMIBUZO EHLOLA UKUGCULISEKA KUMAKHASIMENDE

Sicela ukuba usisize ngokuphendula imibuzo embalwa ukuze sikwazi ukuthuthukisa izinga lethu lokunikezela ngezidingo ozitholayo. Sifisa ukuthola umbono wakho osuka enhlizweni, ngokunikezela kwethu kwezidingo kulo mtholampilo wethu. Sicela uphendule yonke imibuzo. Sibonga kakhulu, siyaluthakasela ngempela usizo lwakho.

INGXENYE A – FAKA UPHAWU "X"

IMINYAKA YOBUDALA:

UBULILI: OWESIFAZANE
OWESILISA

UBUZWE: OMNYAMA

UMNDIYA

IKHALADI

OMHLOPHE

IZINGA LEMFUNDO: Imfundo YasePhrayimari: Ibanga 1 - 5

Imfundo Yase-High School: Ibanga 6 – 10

Idiploma/Iqhuzu

Izinga elingaphezulu Kweqhuzu

UKUQASHEKA Uqashiwe

Awuqashiwe

Usunesikhathi esingakanani uvakashela lo mtholampilo? ____

INGXENYE B

KOKOLEZELA IMPENDULO YAKHO kusukela esilinganisweni 1 – 4 njengoba kubhaliwe ngezansi.

1. Izinga losizo kwabagula ngokomqondo olutholakala emtholampilo ungalibeka kusiphi isilinganiso?

4	3	2	1
Hamba Phambili	Lihle	Likahle nje	Libi

2. Uthole uhlobo lokunakekelwa obukulindele?

1	2	3	4
Cha neze	Cha, hhayi	Yebo, nje	Yebo impela

3. Luhlangabezane kangakanani usizo olutholile emtholampilo nezidingo zakho?

4	3	2	1
Cishe zonke izidingo zami zihlangatsheziwe	Iningi lezidingo zami zihlanga-tsheziwe	Ezimbalwa kuphela ezihlangatsheziwe	Akukho nesisodwa esihlanga-tsheziwe

4. Uma umngane wakho ubenesidingo esidinga usizo olufanayo, ungamdlulisela kithina?

1	2	3	4
Cha neze	Cha angisho	Yebo, ngicaba-nga kanjalo	Yebo, impela

5. Waneliseke kangakanani ngosizo osulutholile ngokunakekelwa ngokwezempilo okunikezelwa yilo mtholampilo?

1	2	3	4
Anginelisekile ngempela	Angazi kahle noma angenelisekile	Nganelisekile nje	Nganeliseke ngokweqile

6. Usizo olutholile ingabe lukusizile ukubhekana kahle nezinkinga zakho zezempilo?

4	3	2	1
Yebo, lungisize kakhulu	Yebo, lungisizile okungayindawo	Cha, alungisizanga sampela	Cha, lwenze izinto zonakale kakhulu

7. Uma sesibuka ngeso eligcwele, waneliseke kangakanani ngokunakekelwa okutholayo?

4	3	2	1
Nganeliseke Kakhulu	Nganeliseke ngempela	Angazi noma anginelisekile	Anginelisekile ngempela

8. Uma kwenzeka udinga usizo futhi, ungeza kulo mtholampilo?

1	2	3	4
Cha, neze neze	Cha, angisho	Yebo, ngicabanga kanjalo	Yebo, ngempela

Sicela ukuba uphawule lapha ngezansi uma kukhona okunye.

_____

_____

_____

_____

_____

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