IOSR Journal of Dental and Medical Sciences (IOSR-JDMS)
e-ISSN: 2279-0853, p-ISSN: 2279-0861.Volume 16, Issue 8 Ver. I (Aug. 2017), PP 33-37
www.iosrjournals.org

Expectations Of Patients Using Mental Health Services

*Dr Kiran Singuru[1], Dr Ramananda Kishore Kavi[2], Dr S Radharani[3]
Department of Psychiatry, Government Hospital for Mental Care, Visakhapatnam.
[1]Assistant professor, [2]Postgraduate, [3]Professor
*Corresponding author: *Dr Kiran Singuru*

Abstract:
Background: *Treatment in psychiatry is almost always individualized to cater to the needs of the patient. Improvement of quality of life of the patient is the ultimate goal of any psychiatrist. Satisfaction with life is a direct reflection of the quality of care. Thus, assessment of the patient's expectations and their experiences is essential in order to provide complete care to the patient.*
Aims and Objectives: *This study aims to measure experiences and expectations of patients using mental health services. This study also aims to measure the relationship of these expectations with socio-demographic data, psychiatric diagnosis, and duration of the illness.*
Methodology: *Outpatients and inpatients attending Government Hospital for Mental Care, Visakhapatnam were invited to the study. After taking a written informed consent, sociodemographic data was collected. Then they were asked to complete the Carers and Users Expectations of Services, User Version(CUES-U) questionnaire. This is a 16 item self-questionnaire divided into comparison score and service satisfaction score. Statistical analysis was done on the data, with ANOVA and student t-test, between demographic variables and scores obtained on the scale using SPSS software version 22.*
Results: *Patients predominantly belonged to the age group 30 – 45 years (57%) and majority of the sample were males (73.1%). The sample consisted mostly Hindus (78.5%) and majority were employed (75.3%). Illiterates (54.8%) and married patients predominated the sample (47.3%). Satisfaction with the quality of life items ranged from 33.33% (money) to 46.24% (social life) for part A questions and from 34.41% (help with finances) to 44.09% (social life) for part B questions. Satisfaction with health services ranged from 39.78% (Advocacy and medication/drug treatment) to 51.61% (Access to physical health services and relationships with physical health workers) for part A questions and from 27.96% (Access to mental health services) to 43.01% (Access to physical health services) for part B questions.*
Patients' illness diagnosis was significantly related to their total scores for life comparison ($p<0.05$) and service comparison ($p<0.05$) but not to the total service satisfaction ($p>0.05$) or life satisfaction scores ($p>0.05$).
Patients' socioeconomic class and duration of illness were significantly related to their total scores for life comparison ($p<0.05$) and service comparison ($p<0.05$) and also to the total service satisfaction ($p<0.05$) and life satisfaction scores ($p<0.05$).
conclusion: *Patient satisfaction ratings are important as an outcome measure when evaluating the quality of their mental health services. Quality of life also depends on the expectations of the patient and their satisfaction with life and mental health services. Certain factors influencing an individual's satisfaction with the care provided (such as their marital status, religion, socioeconomic status) are not directly under the control of professionals. Thus, assessment must be individualized to cater to the expectations of the patient.*
Keywords: *Expectations, experiences, carers and users, quality of life*

I. Introduction

Patient satisfaction ratings are increasingly being promoted as an indicator of quality of care.[1]Mental health focus groups believe that a reliance on psychiatric symptoms alone as a measure of service satisfaction is too narrow a concept.[2] Quality of life is also a strong predictor of psychological wellbeing.[3]People with mental illness are believed to experience lower life satisfaction than the population as a whole.[4] A Medline literature search 1966 to 2002 revealed that the factors which determine satisfaction with mental health services remain greatly under-researched.[5,6,7] Studies have often been hampered by the quality and validity of the instruments used.[8,9] Some investigators have found that an individual's satisfaction with mental health care is correlated with their age and global subjective quality of life, but not psychotic symptoms, insight, or attitudes to treatment.[10] Others, in contrast, have found no relationship between satisfaction and age or living conditions.[11] Treatment in psychiatry is almost always individualized to cater to the needs of the patient. Improvement of quality of life of the patient is the ultimate goal of any psychiatrist. Satisfaction with life is a direct reflection of the quality of care. Thus, assessment of the patient's expectations and their experiences is essential in order to provide complete care to the patient.

A recently validated satisfaction instrument was chosen, the Carers' and Users' Expectations of Services, User Version (CUES-U).[12] CUES-U is important because it covers the issues of quality of life and satisfaction with mental health services that patients, rather than professionals, have identified as being their priorities.[13]

II. Aims and objectives

This study aims to measure experiences and expectations of patients using mental health services. The purpose of this study was to determine whether patients' satisfaction with their mental health care and general quality of life is related to their age, gender, psychiatric diagnosis, and duration of illness.

III. Methodology

Study design:

A cross sectional study was conducted to assess experiences and expectations of patients using mental health services, with the study population being in-patients and out-patients attending Government Hospital for Mental Care, Visakhapatnam. Prior informed consent was taken from patients who were willing to participate in the study.

A total of 85 patients were involved in the study.

Inclusion and exclusion criteria:

In the sample, those patients were included who gave an informed consent and aged between 18 and 60 years and those who were diagnosed with a mental illness according to ICD – 10, chapter V (F) after excluding those with comorbid medical illness and other common stigmatizing illnesses (HIV, TB, leprosy, epilepsy, vitiligo).

Tools used for the collection of data:

In the current study, following tools were used for collecting the required data:

1. Consent form.
2. General information sheet to collect socio-demographic details.
3. Carers and Users Expectations of Services, User Version(CUES-U) questionnaire.

Carers and users expectations of services, user version (cues-u) questionnaire:

This is a 16 item self-questionnaire divided into comparison score and service satisfaction score. CUES-U is a self-rated 16 item booklet. It assesses seven key quality of life areas ("Where you live", "Money", "Help with Finances", "How you spend your day", "Family and friends", "Social life", and "Stigma and discrimination") and nine areas of mental healthcare delivery ("Information and advice", "Access to mental health services", "Choice of mental health services", "Relationships with mental health workers", "Consultation and control", "Advocacy", "Medication", "Access to physical health services", and "Relationship with physical health workers".

Each area contains two main questions. Part A ("comparison") gives a normative statement describing the situation if there was no problem arising. The respondent is then asked how their situation compares with this (as good as this, worse, or very much worse than this). Part B ("satisfaction") questions represent whether the respondent is satisfied (yes, unsure, or no) with the issue described.

IV. Statistical analysis

Both qualitative and quantitative variables were analyzed with the software SPSS statistics version 22. Various measures such as measures of central location (like mean and median) and measures of dispersion (like standard deviation, standard error) were calculated for the quantitative variables. Four "total CUES-U" scores were calculated by adding together individual groups of responses for quality of life items and service delivery items. For part A questions, this gave a "life comparison score" (seven items, maximum = 14) and a "service comparison score" (nine items, maximum = 18). For part B questions, a "life satisfaction score" (seven items, maximum = 14) and a "service satisfaction score" (nine items, maximum = 18) were obtained. As the CUES-U responses were categorical or ordinal, non-parametric statistical tests were applied. $p<0.05$ was consideredstatistically significant.

IV. Results

Demographic data:

Table 1: Characteristics of patients in the study (n, %):

Illness diagnosis	Schizophrenia	Substance abuse	Mood disorders	Others
	23 (24.7%)	22 (23.7%)	23 (24.7%)	25 (26.9%)
Age	18 - 29 years	30 - 45 years	46 - 60 years	
	27 (29%)	53 (57%)	13 (14%)	

Gender	Male	Female		
	68 (73.1%)	25 (26.9%)		
Geographical area	Urban	Rural		
	38 (40.9%)	55 (59.1%)		
Religion	Hindu	Muslim	Christian	
	73 (78.5%)	12 (12.9%)	8 (8.6%)	
Employment status	Employed	Unemployed	Student/others	
	70 (75.3%)	21 (22.6%)	2 (2.2%)	
Marriage status	Unmarried	Married	Divorced /others	
	34 (36.6%)	54 (58.1%)	5 (5.4%)	
Socioeconomic class	Lower	Middle	Upper	
	44 (47.3%)	44 (47.3%)	5 (5.4%)	
Family type	Nuclear	Joint		
	84 (90.3%)	9 (9.7%)		
Literacy status	Literate	Illiterate		
	42 (45.2%	51 (54.8%)		

The above table describes the characteristics of the patients in the study with schizophrenia patients being 24.7%, substance abuse 23.7%, mood disorders 24.7% and other disorders (anxiety, conversion and personality disorders) being 26.9%. Patients predominantly belonged to the age group 30 – 45 years (57%) and majority of the sample were males (73.1%). The sample consisted mostly Hindus (78.5%) and majority were employed (75.3%). Illiterates (54.8%) and married patients predominated the sample (47.3%).

Response patterns:

Table 2: Satisfaction with quality of life - response patterns:

'Life comparison' subscale (n, %)				'Life satisfaction' subscale (n, %)			
	As good as this	Worse than this	Very much worse than this		Yes	Unsure	No
Q-1	32(34.41)	50(53.76)	11(11.83)	Q-1	38(40.86)	42(45.16)	13(13.98)
Q-2	31(33.33)	48(51.61)	14(15.05)	Q-2	33(35.48)	48(51.61)	12(12.9)
Q-3	32(34.41)	44(47.31)	17(18.28)	Q-3	32(34.41)	45(48.39)	16(17.2)
Q-4	27(29.03)	53(56.99)	13(13.98)	Q-4	34(36.56)	47(50.54)	12(12.9)
Q-5	38(40.86)	42(45.16)	13(13.98)	Q-5	35(37.63)	42(45.16)	16(17.2)
Q-6	43(46.24)	40(43.01)	10(10.75)	Q-6	41(44.09)	38(40.86)	14(15.05)
Q-7	37(39.78)	47(50.54)	9(9.68)	Q-7	36(38.71)	40(43.01)	17(18.28)

Table 3: Satisfaction with health services - response patterns:

'Service comparison' subscale (n, %)					'Service satisfaction' subscale (n, %)			
	As good as this	Worse than this	Very much worse than this			Yes	Unsure	No
Q-8	40(43.01)	42(45.16)	11(11.83)		Q-8	26(27.96)	52(55.91)	15(16.13)
Q-9	43(46.24)	39(41.94)	11(11.83)		Q-9	36(38.71)	47(50.54)	10(10.75)
Q-10	44(47.31)	37(39.78)	12(12.9)		Q-10	34(36.56)	48(51.61)	11(11.83)
Q-11	42(45.16)	41(44.09)	10(10.75)		Q-11	34(36.56)	52(55.91)	7(7.53)
Q-12	37(39.78)	46(49.46)	10(10.75)		Q-12	36(38.71)	49(52.69)	8(8.6)
Q-13	43(46.24)	37(39.78)	13(13.98)		Q-13	38(40.86)	46(49.46)	9(9.68)
Q-14	37(39.78)	46(49.46)	10(10.75)		Q-14	34(36.56)	49(52.69)	10(10.75)
Q-15	48(51.61)	38(40.86)	7(7.53)		Q-15	40(43.01)	43(46.24)	10(10.75)
Q-16	48(51.61)	36(38.71)	9(9.68)		Q-16	37(39.78)	46(49.46)	10(10.75)

Satisfaction with the quality of life items ranged from 33.33% (money) to 46.24% (social life) for part A questions and from 34.41% (help with finances) to 44.09% (social life) for part B questions. Satisfaction with health services ranged from 39.78% (Advocacy and medication/drug treatment) to 51.61% (Access to physical health services and relationships with physical health workers) for part A questions and from 27.96% (Access to mental health services) to 43.01% (Access to physical health services) for part B questions.

Comparison between subscales:

The comparison (part A) responses correlated significantly with the satisfaction (part B) responses ($p<0.001$). Total life comparison scores correlated significantly with total life satisfaction scores (r = 0.664,

$p<0.001$), Total service satisfaction scores correlated significantly with total service comparison scores (r = 0.668, $p<0.001$).

Comparison between subscales and demographic data:

Patients' illness diagnosis was significantly related to their total scores for life comparison ($p<0.05$) and service comparison ($p<0.05$) but not to the total service satisfaction ($p>0.05$) or life satisfaction scores ($p>0.05$). Patients' socioeconomic class and duration of illness were significantly related to their total scores for life comparison ($p<0.05$) and service comparison ($p<0.05$) and also to the total service satisfaction ($p<0.05$) and life satisfaction scores ($p<0.05$). No significant difference was found between the comparison scores and satisfaction scores in relation to the age of the patient, gender, geographical area, employment status, family type, and literacy status of the patient. Significant differences were found in total life comparison scores in relation to their marital status and religion ($p<0.05$).

V. Discussion

This study found that longer the duration of illness and patients belonging to middle socioeconomic class were associated with poor satisfaction with the quality of life items and poor satisfaction with health services. As the illness progressed expectations of the patients might have increased and reduced support from caregivers might have led to poorer satisfaction scores. Family dynamics in the middle-class individuals might have led to poorer scores in satisfaction with life when compared with patients from high socioeconomic status.

Those with a diagnosis of schizophrenia expressed higher levels of satisfaction for their life when compared with other disorders. This may indicate that psychiatric services are being targeted towards those psychotic disorders more than other disorders such mood disorders or substance abuse disorders. The generally low levels of satisfaction expressed in this study are in contrast to those found in previous research using both mental[14] and physical[15] illness populations. However, lower satisfaction scores seen in those with anxiety and personality disorders are consistent with their common clinical presentation, which may include subjective complaints of boredom with aspects of life or dissatisfaction in personal or clinical relationships.

This study showed that satisfaction with the quality of life varied significantly with the marital status where unmarried patients reported higher satisfaction with the quality of life than married patients.

Literature says that, older patients were significantly more satisfied with their mental health care. One possible explanation for this finding is a cohort effect, with younger generations having greater expectations and older patients perceiving a greater sense of duty not to complain about the services offered[16]. In support of this hypothesis, previous research has shown that patients who inappropriately disengage from services are more likely to be younger.[20] It is also possible that some respondents are continuing to engage with services not because of greater satisfaction, but because they are hoping that their workers will eventually find appropriate solutions to their difficulties. However, this study found no significant relationship between the patient's age and their satisfaction and comparison scores.

Satisfaction with mental health services correlated significantly with satisfaction in other areas of patients' lives such as housing, money, social life, and relationships. A study noted that service satisfaction, more than any other health indicator, was linked to relationships, leisure activities, and general wellbeing.[18] This study adds to these research findings by confirming that the general quality of an individual's life circumstances is closely linked to their satisfaction with mental health care.

VI. Conclusion

Patient satisfaction ratings are important as an outcome measure when evaluating the quality of their mental health services. Quality of life also depends on the expectations of the patient and their satisfaction with life and mental health services. Certain factors influencing an individual's satisfaction with the care provided (such as their marital status, religion, socioeconomic status) are not directly under the control of professionals. Thus, assessment must be individualized to cater to the expectations of the patient.

Limitations:

This is a cross sectional study. Longitudinal studies with a control group to compare expectations and satisfaction rates and quality of life will be more target oriented to treat the patients. Severity of illness and treatment details were not taken into account in this study which affects the satisfaction and quality of life. Study is conducted at a tertiary hospital. Community based studies with a larger sample size are needed to generalize the results.

References

[1]. Rea CA, Rea DM. Managing performance and performance management: information strategy and service user involvement. Journalof Management in Medicine 2002;16:78–93.

[2]. Powell RA, Single HM, Lloyd KR. Focus groups in mental health research: enhancing the validity of user and provider questionnaires. Int J Soc Psychiatry 1996;42:193–206.
[3]. Christopher KA. Determinants of psychological well-being in Irish immigrants. West J Nurs Res 2000;22:123–40.
[4]. Holley H. Quality of life measurement in mental health. Introduction and overview of workshop findings. Canadian Journal of Community Mental Health 1998;3(suppl):9–21.
[5]. Holley H. Quality of life measurement in mental health. Introduction and overview of workshop findings. Canadian Journal of Community Mental Health 1998;3(suppl):9–21.
[6]. Lovell K. User satisfaction with in-patient mental health services. Journal of Psychiatric Mental Health Nursing 1995; 2:143–50.
[7]. Blenkiron P. Referral to a psychiatric clinic: what do patients expect? International Journal of Health Care Quality Assurance 1998;11:188–92.
[8]. Noble LM, Douglas BC, Newman SP. What do patients expect of psychiatric services? A systematic and critical review of empirical studies. Soc Sci Med 2001;52:985–98.
[9]. Barker DA, Orrell MW. The psychiatric care satisfaction questionnaire: a reliability and validity study. Soc Psychiatry Psychiatr Epidemiol 1999;34:111–16
[10]. Holloway F, Carson J. Subjective quality of life, psychopathology, satisfaction with care and insight: an exploratory study. Int J Soc Psychiatry 1999;45:259–67.
[11]. Eklund E, Hansson L. Determinants of satisfaction with community-based psychiatric services: a cross-sectional study among schizophrenia outpatients. Nordic Journal of Psychiatry 2001;55:413–8.
[12]. Lelliott P, Beevor A, Hogman G, et al. Carers' and users' expectations of services—user version (CUES-U): a new instrument to measure the experience of users of mental health services. Br J Psychiatry 2001;179:67–72.
[13]. Lelliot P. What do people want from specialist mental health services and can this be measured in routine settings? Behavioural and Cognitive Psychotherapy 2000;28:361–8.
[14]. Perera H, Perera R. User satisfaction with child psychiatry outpatient care: implications for practice. Ceylon Med J 1998;43:185–90.
[15]. Bidaut-Russell M, Gabriel SE, Scott CG, et al. Determinants of patient satisfaction in chronic illness. Arthritis Rheum 2002;47:494–500.
[16]. P Blenkiron, C A Hammill. What determines patients' satisfaction with their mental health care and quality of life? Postgrad Med J 2003;79:337–340
[17]. Barr W, Huxley P. The impact of community mental health reform on service users: a cohort study. Health and Social Care in the Community 1999;7:129–39.
[18]. Ruggeri M, Gater R, Bisoffi G, et al. Determinants of subjective quality of life in patients attending community-based mental health services. The South-Verona Outcome Project 5. Acta Psychiatr Scand 2002;105:131–40.

*Dr Kiran Singur. " Intractable Psychogenic Nonepileptic Seizur Expectations Of Patients Using Mental Health Services es. " IOSR Journal of Dental and Medical Sciences (IOSR-JDMS) 16.8 (2017): 33-37