

# **Assessing Clients' Satisfaction with Mental HealthCare Services in Accra, Ghana.**

**BY**

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**DECLARATION**

This is to certify that this thesis is the result of research carried out by DRAMANI YAKUBU towards the award of the MPhil Clinical Psychology in the Department of Psychology, University of Ghana.

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## ABSTRACT

*This study examined clients' satisfaction with mental healthcare services in Accra by sampling 205 adult mental health patients from the Pantang and Accra Psychiatric hospitals as its participants. The study adopted cross-sectional survey method and used systematic sampling techniques to administer a modified version of the Patients Satisfaction Questionnaire-18 by Marshall and Hays (1994), Multidimensional Scale of Perceived Social Support by Zimet et al. (1988), the Satisfaction with Life Scale by Diener et al. (1985) and a modified version of the WHO Encounter Form. The research data were analysed using Multivariate Analysis of variance, independent t-test, Pearson correlation and multiple regression analyses. Results from the study showed no significant satisfactions difference between outpatients and inpatients but female patients were significantly more satisfied with mental healthcare services across all the domains of satisfaction than male patients. Similarly, significant positive linear relationships were observed among clients' satisfaction, perceived social support and satisfaction with other life domains. Both perceived social support and satisfaction with other life domains significantly predicted patients' satisfaction with mental healthcare services with perceived social support accounting for more of the satisfaction variance. Clients' demographic characteristics age, sex and level of education also significantly predicted satisfaction with services. As a recommendation, clinicians should actively involve trusted relatives and friends of patients in the treatment process. Their involvement has the potential to increase patients' perceived social support and satisfaction with other aspects of life which will in turn improve satisfaction with services and mental healthcare outcomes*

## **DEDICATION**

This thesis is dedicated to my entire family particularly my wife Nafisatu Yussif who has been my rock and my son Dramani Abdul-Hakeem Kangre.



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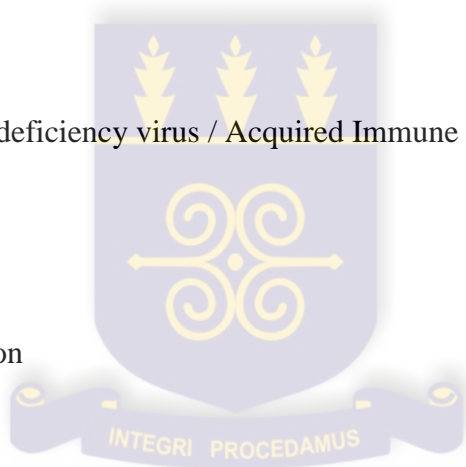
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## List of Abbreviations

PSQ-18	Patient Satisfaction Questionnaire-18
SWLS	Satisfaction with Life Scale
MSPSS	Multidimensional Scale of Perceived Social Support
WHO	World Health Organization
SPSS	Statistical Package for Social Scientists
SSA	Sub-Sahara Africa
NHS	National Health Service
IV	Independent Variable
DV	Depended Variable
HIV/AIDs.	Human immunodeficiency virus / Acquired Immune Deficiency Syndrome
Comm.	Communication
TQual.	Technical Quality
GSat.	General Satisfaction
FASpe.	Financial Aspect
AccCon.	Accessibility and Convenience
InterP.	Interpersonal Manner
Clini.	Time spent with clinician
SS.	Perceived Social Support
Fam.	Family
Frie.	Friend
Sig O.	Significant Other



*For the purposes of this study patient and client are used interchangeably.*

## **CHAPTER ONE:**

### **INTRODUCTION**

#### **1.1. Background of the Study**

Across all sectors, service users' opinions in the appraisal of service quality have gained prominence over the past few decades in many parts of the world (Sitzia, 1997; Hawthorne, 2006). The significance of clients' assessment of their experiences and satisfaction with mental healthcare services in particular is attributed to its frequent use as an indicator of service quality (Powell, Holloway, Lee, & Sitzia, 2004). This study examines patients'/clients' satisfaction with mental healthcare services in a developing country context, Ghana.

Compared with other measures, client satisfaction emphasizes the uniqueness of individual patient's experience of the total package of service delivery. The World Health Organisation for instance, defines client satisfaction as a measurement obtained from patients' reports about services received from a hospital, clinician or healthcare provider (WHO, 2003). Client satisfaction has also been defined as an attitudinal response to value judgments that consumers of healthcare services make about their clinical encounter (Kane, Maciejewski, & Finch, 1997). As such, clients' satisfaction with mental healthcare is the degree to which their desired expectations, goals and or preferences are met by the mental healthcare provider.

A common theme in all these understandings of clients' satisfaction above is that, client satisfaction is a subjective measure with no definite association to outside realities. For example, two patients who receive exactly the same treatment at a healthcare facility may not

perceive these services as being exactly similar. Therefore, exploring clients' satisfaction and the various factors that influences it would be helpful in improving healthcare outcomes as would be seen in the following paragraphs.

Refreshingly, there has been tremendous research interest in clients' satisfaction with healthcare services over the past few decades, especially in the field of mainstream health psychology (Hawthorne, 2006). This is mainly explained by the understanding of satisfaction as an important indicator of the quality of healthcare (Jackson, Chamberlin, & Kroenke, 2001; Powell, Holloway, Lee et al., 2004). Similarly, Hawthorne (2006) argued that three key reasons account for the rising research interest in patient satisfaction over the years. Firstly, the role of clinicians has changed from one of helping clients through their illness to where the clinician is expected to either cure the patient or at least lessen his/her chronic symptoms. Secondly, the rise of the patients' rights movements, present patients as consumers of healthcare, and has led to their views being taken into account during therapeutic decision-making. Finally, clients' views are increasingly being sought for the purposes of monitoring healthcare delivery and the legitimization of health policies (Hawthorne, 2006).

Outcomes of satisfaction surveys have also been used to identify aspects of healthcare service delivery that need to be changed to improve clients' experiences Jackson and Kroenke (1997) and to assist healthcare institutions in identifying patients likely to disenroll (Fan, Burman, McDonnell, & Fihn, 2005a). When patients are particularly dissatisfied with a specific aspect of mental healthcare, it presents service providers an opportunity to institute measures to improve on that aspect of care while enhancing patients' experiences in the process.

In addition, the positive relationship between client satisfaction and adherence to treatment has also been credited as contributing to interest in satisfaction studies (Evance, Elwyn, & Edwards, 2004). For instance, evidence suggests that patients are more likely to adhere to treatment regimes if they are satisfied with the services they received at the healthcare facility (Ogden, 2006). In any case, healthcare treatment regimes will only be effective if patients adhere to them in the first place. Hence, satisfaction with treatment regimes has both implications for the effectiveness of the professionals' treatments and economic implications in terms of wasted medicines and high absence from work due to illness.

However, despite consensus in the literature on the vital role clients' satisfaction research could play in improving healthcare outcomes, and the resultant interest in researching patients' satisfaction in general healthcare practice, interest in clients' satisfaction with mental healthcare services has been lacking Daniel, Bill, Dominic and Douglas (2011); especially in low and middle income countries (WHO, 2011). This is partly due to the concern that mental illness may affect the quality of data collected from this patient group.

Negative attitudes (stigmatisation) of mental illness have also been implicated for the dearth of satisfaction research among mental health clients. For instance, Barke, Nyarko and Klecha (2011) identified stigmatisation as a serious problem affecting patients and their relations as well as institutions and healthcare employees working with persons with mental illness. Thus, negative societal attitudes, with cultural undertones, toward mentally ill individuals have direct implications not only for the quality of life of affected persons but also efforts to research and determine whether available services meet clients' needs.

Clients' satisfaction with mental healthcare services is predominantly assessed using cross-sectional surveys, but the myriad of determinants and domains of satisfaction with mental healthcare makes its measure complex and problematic. A measure of clients' satisfaction with mental healthcare services is seen as an attempt to capture elements of the quality of healthcare against the patients' expectations (Linder-Pelz's, 1985). These elements of quality of care include: technical quality of care; accessibility of services and convenience of accessing available services; affordability (ability to pay for services); interpersonal manner / rapport (the manner in which healthcare providers interact with service users); communication, physical environment and time spent with clinician (Ron et al., 1987; Marshall, & Hays, 1994). As such, clients' satisfaction survey data frequently aimed at appreciating elements of healthcare service delivery particularly from the clients' perspective to improve service quality.

Understanding patients' perspectives on the quality of mental healthcare service delivery and adequately providing for services that meet their expectations is crucial if we are to improve service quality and more importantly mental healthcare outcomes. Yet, the construct of 'satisfaction' remains complex and difficult to compartmentalise. While numerous satisfaction surveys have been developed, some with acceptable psychometric properties, the factors individual patients use to judge themselves as satisfied remain largely unidentified (Jackson & Kroenke, 1997; Baker, 1997). As a result, studies measuring clients' satisfaction with healthcare service in general and mental healthcare services in particular have explained only a small portion of satisfaction's variance (Jackson, & Kroenke, 1997).

One of the main concerns in clients' satisfaction studies is the fact that patients reported satisfaction with services received from a healthcare facility may be influenced by variables

outside the control of healthcare system. Patients' characteristics such as level of education, age and gender Nguyen, Briancon and Empereur (2002) and ethnicity or race Garson, Yong, Yock and McClellan (2006) have been identified in the literature as influencing client's satisfaction. Others are; previous healthcare experience Burroughs, Davies, Cira and Dunagan (1999), perceived social support Coulter and Cleary (2001) and satisfaction with other life domains (Porter et al., 2012).

Older age, female gender and social support are consistent predictors of patients' satisfaction with socio-demographic characteristics accounting for more of the variance in satisfaction than did facility characteristics (Rosenheck, Wilson, & Meterko, 1997). Similarly, perceive social support Coulter and Cleary (2001), pathways to care and satisfaction with other life domains Porter et al. (2012) have also been identified to account for a significant variance in clients' satisfaction with mental healthcare services. For instance, evidence suggests that perceived social support is associated with positive mental health and leads to improved general wellbeing (Haber, Cohen, Lucas, & Baltes, 2007; McDowell, & Serovich, 2007).

Psychologists generally agree that the lack of a good social support system makes it harder for mental health clients to succeed in treatment (Comer, 2010). As such, one way to make it less likely that a person develops a mental illness is to make sure that person has a strong social support system (Karel, 1997). Mental health clients with high perceived social support from their family, friends, and partners have higher self-efficacy for coping which in turn, predicts better adjustment. Additionally, when patients are satisfied with other aspects of their life, they are also likely to appraise the healthcare services they encounter positively (Porter et al., 2012).

From this trajectory, regardless of the concerns in the literature on the complexity of capturing a measure of clients' satisfaction that accurately inform quality mental healthcare improvement processes, it is essential to adopt measures that overcome many of these challenges. The very complexity and difficulties in measuring clients' satisfaction among mental healthcare patients should generate interest in this subject rather than become a disincentive and a hindrance in the quest to understanding this important and growing population.

## **1.2. Statement of the Problem**

Clients' satisfaction with mental healthcare services is important not only as a measure of quality of care in terms of acceptability to individual clients or populations, but also as a predictor of important mental healthcare outcomes. As such, data obtained from patients' satisfaction surveys can be useful in improving mental healthcare outcomes (Ogden, Baig, Earnshaw, Elkington, Henderson, et al., 2001; Fan, Burman, McDonnell, & Fin, 2005a; Adeoti, & Lawal, 2012).

However, there is a significant attribute of mental healthcare which effectively restrict adequate research into services provided for mental health service users. There is the concern that features of the illness experienced by mental health clients may interfere with the processes of comprehension. This applies equally to both the questions asked mental health clients and their responses. Similarly, there is the concern that the variables that shape clients' satisfaction with mental healthcare services may be beyond the control of the healthcare system (Hawthorne, 2006). The effect is that little research is entered into with this client group and research that does occur suffers from reliability and validity concerns.

Regrettably, this low interest in satisfaction research among the mentally ill persists even though, mental health conditions are a growing concern across most countries of the world. For instance, 1,222,400 adults in England were in contact with mental health services in 2008-2009 representing an increase of 2.7% since 2007-2008 (NHS, 2009). Out of this figure, 8.4% spent time during the year as psychiatric inpatients. It has also been suggested that one in four people in the world will experience mental health problem at some point in their lives (WHO, 2005). Similarly, the WHO estimates that about 2.17 million persons in Ghana suffer from moderate to mild mental disorders and approximately 650,000 suffer from a severe mental disorder with a treatment gap of 98% of the affected population (WHO, 2007).

From this background, one would be right to argue that the prevalence of mental health conditions in Ghana is so high for patients of these illnesses to be excluded from an important quality of healthcare indicator as clients' satisfaction. In any case, an understanding of clients' perspective on what they want in service delivery is essential if we are to understand the intricacies of clients' satisfaction and improve on it for enhanced healthcare outcomes. Additionally, knowledge of clients' satisfaction with the different aspects and or spheres of mental healthcare is pertinent in any comprehensive effort to improve mental healthcare delivery in Ghana and elsewhere.

### **1.3. Aims and Objectives of the Study**

Specifically, the study will;

1. Determine whether outpatients and inpatients have different levels of satisfaction with mental healthcare services.

2. Assess mental healthcare services that clients are satisfied with and those they are dissatisfied with.
3. Evaluate the impact of clients' experiences with other care domains (clients who sought treatment from pastors, mallams or traditional priest before coming to the psychiatric hospital) on their satisfaction with orthodox mental healthcare services. This would be done by comparing the satisfaction scores of patients who experienced other care domains with those who did not.
4. Determine whether the levels of clients' satisfaction with mental healthcare services at the Accra Psychiatric and Pantang hospitals differ.
5. Assess the relationship between psychiatric patients' satisfaction with services and their satisfaction with other aspects of life.
6. Assess the variance of patient's satisfaction with mental healthcare services accounted for by perceived social support and satisfaction with other life domains.
7. Measure the impact of client characteristics on their reported satisfaction with mental healthcare services.

#### **1.4. Relevance of the study**

The primary reason for conducting this study is to provide clinicians and mental healthcare providers in general with information on patients' satisfaction with mental healthcare services in Accra Ghana, so that problematic aspects of care can be identified and improved.

Moreover, most of the current researches on patients' satisfaction with mental healthcare services were conducted in the developed world. Very few data exists on countries in Sub Sahara Africa (SSA). This dearth of data on satisfaction with mental health clients becomes

even more prominent when one narrows down on Ghana. In fact, the researcher has not come across any published study of client's satisfaction with mental healthcare services on Ghana. This study will therefore add to the global literature while serving as a baseline for future satisfaction research among mental health clients in Ghana. The study will highlight on the levels of clients' satisfaction with mental healthcare services in Accra, Ghana and examine the variance of satisfaction with mental healthcare services accounted for by clients' characteristics, perceived social support, satisfaction with other life domains and pathways to care.

Hopefully the outcome of this study will improve healthcare professionals' (Medical Doctors, Nurses, Psychiatrists, Health Educator and Promoters and Policy Makers) understanding of client's satisfaction with mental healthcare services in the Ghanaian context. It will also help Psychologists, particularly Clinical Psychologists who want to go into private practice, to appreciate the importance of clients' satisfaction with mental healthcare services as a measure of quality of care and give them a competitive edge.

## **CHAPTER TWO: LITERATURE REVIEW**

### **2.1. Introduction**

There have been various efforts from different fields including: Health Psychology, Medical Sociology, Consumer Science, Nursing and Clinical Psychology to theorise clients' satisfaction. While some progress has been made in this regard, there is yet to be an agreed or generally accepted theory for this complex construct (Brannan, Elizabeth, & Heflinger, 1996). This chapter presents the theoretical framework within which this study is located. The intricate ways in which clients' socio-demographic characteristics, perceived social support, and experiences of other care modalities account for satisfaction variance would also be explored. Lastly, the literature gaps this study hopes to contribute to filling would be explicated.

### **2.2. Theoretical Framework**

#### **2.2.1. Donabedian's Theory of Quality of Healthcare**

The foundational work of Donabedian in the early 1980s identified the importance of client satisfaction as well as provided much of the basis for research in the area of quality assurance in healthcare. The importance of measuring patient satisfaction is further well articulated (Lin, & Kelly, 1995) with client satisfaction having been studied and measured extensively both as a standalone construct, and in quality of healthcare assessment studies (Sofaer, & Firminger, 2005).

Donabedian's theory emerged from evaluation research, with quality being the overriding construct. According to his theory, quality of healthcare consists of three key dimensions

including: health, subjects of care and providers of care. Health is envisioned to consist of physiological, psychological and social functions and the manner in which we conceive health influence the methods used to assess and assure quality healthcare. Subjects of care and providers of care on the other hand relate to the patients and the healthcare workers respectively.

The theory further asserted that there are three main objects of evaluation in appraising quality: structures, process, and outcome; where he defined structures of care as the elements of organization and administration that guide the processes of care. Process and outcome on the other hand refer to the operation and course of care and the result of care respectively. The theory advocates that a complete quality assessment program requires the simultaneous use of all three concepts as well as an assessment of the linkages among them. However, researchers have had little success in achieving this theoretical objective (Lewis, 1995).

Studies designed to examine all three concepts would require very large samples of various structures, each with the various processes being compared and large samples of subjects who have experienced the outcomes of those processes. This theoretical goal would also require huge funding and cooperation of various stakeholders involved in healthcare delivery which is a major challenge. The theory has also been criticised for not defining quality even though it is its key concept (Mark, 1995). There were several attempts to modify Donabedian's theory of Quality of Healthcare. Loegering, Reiter and Gambone (1994) proposed the inclusion of the family, social context, providers of care as well as recipients of care. Access to care has also been suggested as one of the dimension healthcare that needs consideration in assessing quality of healthcare.

Despite these early efforts, the concept of satisfaction remains intricate Heidegger, Saal and Nuebling (2006) irrespective of the area in which it is studied. Furthermore, satisfaction is a multidimensional concept; not yet tightly defined; and probably part of a yet to be determined complex model (Hawthorne, 2006). As a result, the many attempts, especially in the 1980s, to develop a theory for the study and explanation of client satisfaction with healthcare services have failed to reach a consensus. However, Liz and White (2009) summarized some of the common theories of client satisfaction with healthcare as follows:

### **2.2.2. The Discrepancy and Transgression Theory**

This theory by Fox and Storms (1981) advocates that patients' healthcare orientations may differ from provider's conditions of care (Liz, & White, 2009; Adeoti, & Lawal, 2012). Accordingly, if patient's healthcare orientations and providers' conditions of care were congruent then patients were satisfied, if it is not, they were dissatisfied.

The theory assumed that cultural influences (described by Fox & Storms as person's orientation) would affect individuals' appraisal of healthcare services. Where patient orientation reflect three key dimensions including: Knowledge about the health condition of interest (disease aetiology, symptoms etc); beliefs about care (world view of the condition's aetiology and how it should be treated), and the expected conditions of care (Hawthorne, 2008). Thus, dissatisfaction with healthcare services is caused by contravention of clients' expectations largely informed by a discrepancy in clients' and providers' world views.

While this theory recognises the important role health beliefs play in determining satisfaction with care, it seems to overlook the significant part played by socio-demographic characteristics

such as gender, age and other psychosocial factors as social support. The theory also fails to adequately appreciate the vital role played by actual occurrences (what actually happened during the patient's encounter with healthcare service) including: information provision, rapport and cost of care among others. Subsequent theories attempted to overcome these weaknesses and acknowledged the value client-professional encounter play in improving satisfaction among patients.

### **2.2.3. Expectancy-value Theory**

Linder-Pelz's (1985) Expectancy-value theory argued that patient satisfaction is a function of expectancy and discrepancy mediated by social evaluation. Like Fox and Storms, Linder-Pelz posits that high satisfaction would be reported when positive expectations and experiences coincided, and where experiences were as good as or better than those of others.

Therefore, the determinants of client's satisfaction with healthcare services are: client's expectations (i.e. beliefs about a service); value (i.e. a person's attitude towards the service); and entitlement {i.e. the belief held by an individual that he/she has proper and accepted grounds for claiming a particular outcome} (Hawthorne, 2008). The rest include: Occurrences (i.e. the perception of what actually occurred during an encounter with the healthcare system, at whatever level); and interpersonal comparisons (i.e. with others or with other service users). Consequently, Dissatisfaction would occur where expectations were not met.

But, this theory is able to explain only a limited proportion of observed differences in satisfaction (Linder-Pelz, 1982). The theory also fails to account for the variance of satisfaction attributed to patient characteristics and perception of availability of social support. These

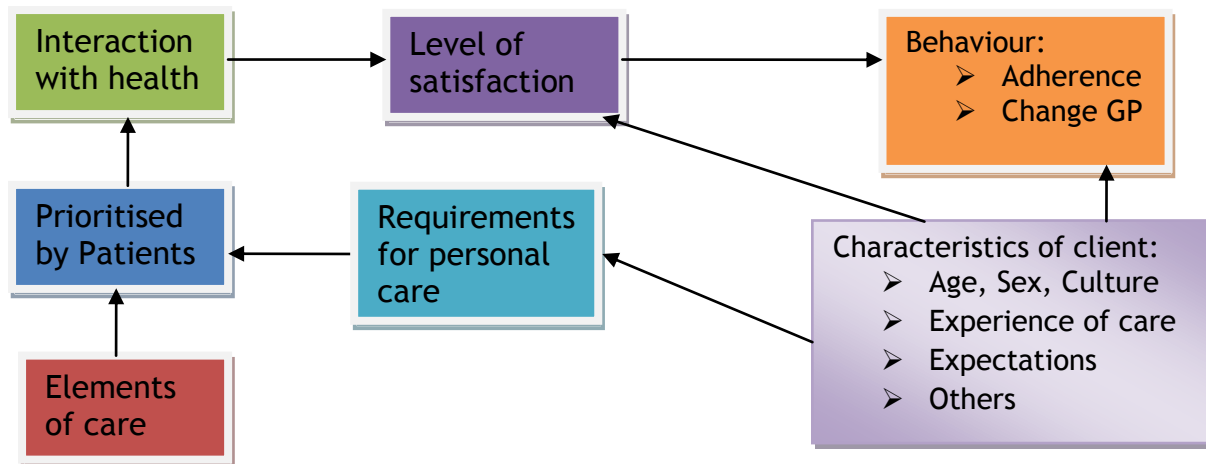
deficits particularly the failure to account for clients' socio-demographic characteristics was answered by other theories.

#### **2.2.4. Pragmatic Model of Client's Satisfaction**

Baker (1997) pragmatic model hold that patients' characteristics influence both the priorities they assign to different elements of care and their attitudes or level of satisfaction after an interaction with the healthcare system (Baker, 1997). For instance, some clients may assign the highest priority to cost of healthcare due to their socio-economic status; while others may prefer short waiting time and or adequate information provision owing to the importance they ascribe to different elements of healthcare.

According to this theory, patients' characteristics like: age, sex and past experience of care do not only account for a significant amount of satisfaction variance, but also influence patients' future behaviour such as adherence to medical advice or treatment; change of therapist or clinician and or seek alternative treatment (eg. from traditional priests, mallams and pastors etc).

The figure below is a graphical representation of the Pragmatic model of client satisfaction:

**Figure 1****Pragmatic model of patient satisfaction in general practice****Source: Baker 1997**

In brief, the Pragmatic model of satisfaction propounded that patients' satisfaction is affected by multivariate determinants including: access to the healthcare facilities providing the needed care (eg. location, opening hours, transportation etc), issues of cost-carrying and insurance (i.e. who pays, are there gaps in payment), service availability (eg. the range of treatments available) and staff interface (eg. friendliness, responsiveness and respectfulness) (Hawthorne, 2008).

Baker described his theory as pragmatic for three key reasons. Firstly, it does not rely on more general social or psychological theories of behaviour, but rather link together available empirical evidence about patient satisfaction without recourse to existing social and psychological theories other than to define satisfaction as an attitude (Baker, 1997). Where attitude is described as an evaluative judgement (or reaction to) care received. As with other attitudes, it is learned from experience, it's relatively enduring in comparison with emotional states-such as anger or amusement and exerts some influence on behaviour (O'Keefe, 1990).

Secondly, satisfaction is regarded in Baker's theory as a continuous rather than dichotomous variable.

Thirdly, it is multidimensional with different elements of care each causing differences in satisfaction. Therefore, a client may be satisfied with one element of healthcare (eg. Waiting time) but dissatisfied with another (eg. information provision) as observed by Summers and Happell (2003). Consequently, a measure of overall satisfaction should be a summary of the competing evaluations of the client and should be sensitive to differences in levels of satisfaction with individual elements of care.

Furthermore, different elements of care may be more or less important for different clinical conditions. For instance, among chronic mental health patients continuity and confidentiality of care may be viewed as particularly important, but clients with acute mental health conditions may prioritise the provision of comprehensive information about treatment choices. As such, measures of client's satisfaction should assess all relevant elements of care and be designed with participants' socio-cultural context in mind. However, Baker's theory seems to over emphasize the effect of patients' socio-demographic characteristics on satisfaction with healthcare and generally ignored psychosocial variable such as perceived social support and satisfaction with other aspects of life.

It is evident from the above trajectory that several theories and models have been used to study and explain client satisfaction even though there is yet to be a consensus on its theorisation. This study draws mainly on the Pragmatic Model of Client Satisfaction by Baker (1997) because it

treats client satisfaction as a complex concept influenced by a myriad of factors pertinent to the client characteristics, elements of care and the context of service delivery.

## **2.3. Related Studies**

This part of the study elaborates on measuring clients' satisfaction with mental healthcare services and reviewed the literature on patients' satisfaction with care in relation to the variables of interest.

### **2.3.1. Measuring Clients' Satisfaction with Mental Healthcare Services**

Researchers predominantly rely on cross-sectional surveys to appraise patients' satisfaction with mental healthcare services even though the complex myriad of determinants and domains of satisfaction with mental healthcare makes this endeavour intricate and problematic. However, this difficulty is not necessarily due to a limitation of cross-sectional surveys since the many domains of satisfaction have been clearly identified with adequate survey tools to measure them, but rather a difficulty in identifying the factors individual patients use to judge themselves as satisfied (Baker, 1997). As a result, studies measuring clients' satisfaction with healthcare service in general and mental healthcare services in particular have explained only a small portion of satisfaction's variance (Jackson, & Kroenke, 1997).

Additionally, client's satisfaction surveys have often been criticized for underestimating dissatisfaction and hiding poor experiences, due mainly to patients desire not to appear ungrateful, and their willingness to accept the limitations of providers of healthcare services (Crawford, & Kessel, 1999; Fitzpatrick, 2002). There are also concerns in the literature that the

variables that shape clients' satisfaction with services may be outside the control of the healthcare system. Where this is the case, of what relevance are the findings of satisfaction with mental healthcare studies?

The answer to this pertinent question lies in the study design; whether it accounts for the identified variables outside the healthcare systems control with the possibility of affecting clients' reported satisfaction. Some of these variables identified in the literature include: patient characteristics such as level of education, age and gender Briancon and Empereur (2002) and ethnicity or race (Garson, Yong, Yock, & McClellan, 2006). Others are: perceived social support Coulter and Cleary (2001) and satisfaction with other life domains (Porter et al., 2012).

Further, in analysing the validities and reliabilities of different instruments used to assess satisfaction in 195 published papers, Sitzia (1997) found that most studies did not demonstrate much evidence of reliability and validity of the instruments employed. Based on his findings, he recommended that future research should adopt instruments with established reliability and validity as indicated by previous studies or test their instrument for their statistical rigour before using them. There is however a difficulty adopting instruments with established reliability in the assessing clients' satisfaction.

As Sitzia (1997) acknowledged, there is no common agreement about what instrument to use for measuring patient satisfaction with mental health services. Additionally, many of the current instruments are based on previous instruments that have been adjusted to local needs Hoff, Rosenheck, Meterko and Wilson (1999) since many aspects of patient satisfaction cannot be assessed or interpreted without considering the unique milieu in which the services have been

received. An alternative approach involves adopting assessment tools with established reliability and validity and adjusting them to fit the distinctive environment for which they are to be used. Such tools are then pilot tested for their statistical rigour before they are used.

It is also worth noting that despite these methodological challenges in studying satisfaction with mental healthcare, previous studies have not only enriched our understanding of clients' satisfaction with care and its impact on future behaviour Odgen (2006), but also outcomes of such studies have been used to improve healthcare delivery across many parts of the world (Hawthorne, 2008).

### **2.3.2. Patients' Socio-demographic Characteristics**

Most studies on client satisfaction report that clients' socio-demographic characteristics accounted for a significant difference in satisfaction among patients irrespective of the diagnoses. Socio-demographic factors generally refer to how people are classified into groups using common characteristics such as: race, level of education, marital status, gender, age among others. These distinguishing features have been found to influence patients' preferences as well as their satisfaction with healthcare services. In their study entitled patient socio-demographic characteristics as predictors of satisfaction with medical care, Hall and Dornan (1990) conducted a meta-analysis of literature to find out the relationship between patients' characteristics and their satisfaction with medical services.

The socio-demographic characteristics of interest in their study were age, ethnicity, sex, socioeconomic status, marital status, and family size. The study outcome showed that greater

satisfaction with medical care was significantly associated with older age and less education, and marginally significantly associated with being married and having higher social status. Thus, age was the strongest correlate of satisfaction. No statistically significant relationship was found for ethnicity, gender, income, or family size with satisfaction with medical care.

Similarly, Cho and Kim (2007) in their study "Trends in patient satisfaction from 1989-2003; using repeated cross-sectional surveys found that older age, being female, married, and less-educated people were more likely to be satisfied. Age was also found to be significantly and independently related to patients' satisfaction among a Swedish population (Al-Windi, 2005). But these studies examined the effects of patients' characteristics on satisfaction among general health patients rather than mental health patients. The studies also predominantly probed the relationship between patients' satisfaction and their demographic characteristics and neglected other satisfaction covariates.

Also, Rosenheck, Wilson and Meterko (1997) randomly sampled veterans discharged from inpatient units with primary diagnoses of a psychiatric or substance use disorder to respond to a questionnaire on their recent hospital experience. They found that older age and better self-reported health status were the strongest and most consistent predictors of satisfaction. In fact, further analysis of their data showed that patient characteristics accounted for more of the variance in satisfaction than did facility characteristics. However, in their study, the respondents were older than non-respondents, were more likely to be white, married and to have non-psychotic disorders limiting the extent to which their findings can be generalised. Other studies explored race/ethnicity and satisfaction with mental healthcare services.

Racial/ethnic differences in access to and experience of mental health services have been a long standing issue and concern (Ghuloum, Bener, & Tuna-Burgut, 2010). The relevance of ethnicity in access to and experience of healthcare service delivery lies in the fact that, when socio-cultural and or ethno-religious differences between client and clinician are not well appreciated, explored or communicated during the clinical encounter; patient may be dissatisfied with the service delivery which could ultimately poorer health outcomes. Numerous studies in the United States Lillie-Blanton and Alfaró-Correa (1995) and Great Britain Wilkinson (1996) have demonstrated racial inequalities in healthcare. Ethnic minorities and those lower on the socio-economic ladder, in particular, have less access to healthcare, use fewer healthcare resources and are less satisfied with healthcare than the relatively well-off.

For example, in examining the impact of patients' ethnic diversity on satisfaction with psychiatric care using a cross sectional study in Qatar, Ghuloum, Bener and Tuna-Burgut (2010) found no significant differences in the satisfaction scores among Qatari psychiatric patients. However a statistically significant difference was observed between Arab expatriate patients and Qatari patients. Arab expatriate patients (480; 55.9%) were more satisfied with psychiatric care than Qatari patients (378; 44.1%) and an even higher difference was observed between Spanish psychiatric patients and Qatari patients. In fact, they found that satisfaction score was significantly higher in the Spanish population in all domains of satisfaction compared to the Qatari and other Arab expatriate patients working in Qatar. These findings point to the fact that a patient's socio-economic status may be more important in determining his/her access to and satisfaction with care than his/her ethnicity.

However, not all studies established socio-demographic characteristics of clients' as having statistically significant influence on satisfaction. Demir and Celik (2002) researched the effect of patients' demographic characteristics on overall satisfaction with healthcare and found only lower education level to be statistically significant determinant of satisfaction.

Similarly, Hakon, Helle, Solveig and Ketil (2008) examine the facility's service unit effect on parent satisfaction with outpatient treatment among Norwegian outpatient child and adolescent mental health service; and found among other things that waiting time was negatively associated with treatment outcome satisfaction. But adjustments for patient characteristics did not substantially change the relative effect on satisfaction ratings. Yet, their study focused on parents of mental health clients rather than the mental healthcare service users themselves even though mental health patients' own experiences play a vital role in making them satisfied with services or not (Linder-Pelz's, 1985).

Generally speaking, expectations are ideals or beliefs that people have about the way things should be. Patients, irrespective of their illness condition, attend treatment facility with predetermined ideal outcome of such an encounter, and where there is discrepancy between patients' experiences and their expectation dissatisfaction will occur (Linder-Pelz's, 1985). As (Hawthorne, 2006) puts it, patients attend mental healthcare facilities basically to get cured or at least have their symptoms lessened. Where these expectations of a patient are not met alternative treatment modalities are likely to be considered based on the clients' orientation.

Awara and Fasey (2008) established in their study that, even though 85% of their participants were satisfied with the psychiatry service they received, a sizable proportion expressed

dissatisfaction with the type of therapy, likelihood of obtaining appointments, degree of therapists' omnipotence and availability of information. Women and those who are unemployed were also found to be less satisfied than their counterparts. Thus, clients' have wide-ranging expectations of the healthcare system and services would better serve the interest of patients if they are informed by patients' needs and expectations. Their study however focused exclusively on patients' expectations without accounting for the possible effects of patients' characteristics on such expectations Baker (1997) and ultimately their satisfaction with care.

### **2.3.3. Elements of Care**

Besides clients' characteristics, which are in fact outside clinicians sphere of influence in mental healthcare service delivery, the actual client-clinician encounter is important in their appraisal of services as satisfactory or not. For instance, studies point to the quality of interpersonal care as one of the most important determinant of clients' satisfaction, and their perception of service quality (Liz, & White, 2009). Campbell et al. (2000) described interpersonal care as the social and psychological interactions that happen between the patient and the clinician or other caregivers in the course of service delivery. Others such as Ogden (2004) referred to interpersonal care as rapport, which generally are the relationships of mutual understanding or trust and agreement developed between patients and clinicians in the course of their therapeutic engagement(s).

Evidence from satisfaction studies in Nigeria show: greetings, complementary remark, personal communication, listening, hand shake and jokes as the most important occurrences in the line of care found to influence satisfaction (Adeoti, & Lawal, 2012). As a result, a combination of these

factors could go a long way to improve patients' satisfaction with healthcare if healthcare providers incorporate them in treatment regimes. Achieving this however requires appreciating the ethno-cultural context of service delivery. This is so because the effectiveness of interpersonal care is dependent on whether the interactions were importantly appropriate in the specific environment or situation (Flood et al., 2000). In any case, the delivery of mental healthcare services is a complex endeavour Sheffield (2008) and establishing good rapport with patients, especially those on compulsory admission, would be demanding for even the most experienced clinicians.

This is even more challenging in Ghana where the quality of service delivery in the health sector has been a major issue and was identified as one of the key themes of the first Medium Term Health Strategy (MoH, 2009). With the passage of the Mental Health Act, 2012 (ACT 846), it is envisaged that mental healthcare service delivery would improve over the medium to long term. Yet, a considerable amount of money and hard work would be needed to turn the Act's vision into reality.

A clear case of the enormous challenge in actualising the vision of the Mental Health Act, 2012 (Act 846) lies in the attitudes of many healthcare workers in Ghana. For example, respect is a very important value in the social structure of Ghana and people get offended if they feel disrespected (Sjaak van der Geest, 1997). Nonetheless, studies have reported several cases of poor treatment meted out to service users by healthcare providers, many of whom have been described as authoritarian, insensitive, discourteous and disrespectful (Andersen, 2004). The stigma surrounding mental health illness in Ghana and the relative neglect of mental healthcare in the country make the experiences of mental health patients even more precarious. Helpful

attitudes towards service users will thus lead to satisfaction with healthcare and result in not only positive experiences but also desired mental healthcare outcomes.

Yet, aside rapport, clinicians' competence in providing quality care is just as important. In analysing the relationship between satisfaction and technical quality of care for common mental disorders Edlund, Young, Kung, Sherbourne and Wells (2003) conducted a nationally representative telephone survey of 9,585 individuals. They investigated the association between satisfaction with mental healthcare services available for personal or emotional problems and two quality indicators using regression techniques. Appropriate technical quality of care (use of either appropriate counselling or psychotropic medications) during the prior year for a probable depressive or anxiety disorder was the first measure; while the second was active treatment (ie. whether the respondent received treatment) for a psychiatric disorder in the past year at all.

The outcome of their study after controlling for covariates like severity of mental health and socio-demographics showed that, appropriate technical quality of care was significantly associated with higher levels of satisfaction even though the strength of the association was moderate. Thus, the content of care mental health clients experience in their search for relief has a direct and positive relationship with their satisfaction with service delivery. But the study employed a telephone survey technique and could only recruit clients with access to telephone to participate.

Similarly, Druss, Rosenheck and Stolar (1999) measured the association between patients' satisfaction with mental healthcare and the quality of care at both an individual and hospital

levels by mailing a satisfaction questionnaire to veterans discharged during a three-month period from an inpatient psychiatric unit. Using regression analysis they established that, at the patient level, satisfaction with several aspects of service delivery was associated with both fewer readmissions and fewer days of readmission. Additionally, better rapport with inpatient staff was associated with higher adherence which is an indication of satisfaction with care. At the hospital level, patients who expressed greater rapport with facility staff were more satisfied with care. Perhaps, the associations between clients' satisfaction and quality of care at the individual level support the idea that these measures address a common underlying construct (Druss, Rosenheck, & Stolar, 1999).

The argument one can make from these evidence is that, even though some of the variables that influence clients' satisfaction are outside the control of the healthcare system the content of care plays an essential role in patients' judging their experiences as satisfactory or not. In support of this argument are studies on the impact of quality improvement programs have on satisfaction with care.

Isenberg and Stewart (1998) set out to quantitatively measure the effect of quality improvement-based intervention on improvement in patient satisfaction with care; using convenient sampling to select new and returning patients seen at a multiple-site community-based medical and surgical office practices. One group of patients (control group) were surveyed on two separate occasions with no intervention between the two occasions, while a second group (intervention group) were also surveyed on their satisfaction with office visits on two separate occasions, but had their clinicians went through a quality improvement programme between surveys.

Analyses of the results showed changes in patient satisfaction between control and the intervention groups. In fact, the control group demonstrated little and non-significant changes in patient satisfaction between the two survey periods while the intervention group demonstrated statistically significant improvements in patient satisfaction between the two survey periods. This finding points to the fact that irrespective of the covariates that may influence clients satisfaction, the content of care in itself is a major determinant of satisfaction with healthcare. It is worth noting however that this study adopted a convenience sampling strategy limiting its external validity.

Further, the intricacy of the construct of satisfaction means that clients' overall satisfaction with mental healthcare alone is inadequate since it doesn't elucidate clients' assessment of different spheres of care. More often than not, clients' satisfaction varies across the different aspects of service provision. Prado et al. (2009) studied users' satisfaction with mental healthcare services in Brazil involving 1,162 healthcare users and found a positive overall evaluation of services even though satisfaction varied across the different domains assessed. For example, while the overall satisfaction mean was 4.4 (SD=0.4), Communication and relationship with clinicians 4.5 (SD=0.5), and information provision 4.8, satisfaction with general service infrastructure had a lower mean of 3.9.

However, the study neither investigated the role of patients' characteristics in their reported satisfaction, nor the effects of social support which have been found to influence clients' evaluation or care. Nevertheless, an important lesson in this study is that, clients' overall satisfaction with mental healthcare may differ from their satisfaction with the different elements

of care. Data on clients' satisfaction with mental healthcare would thus be more useful if they go beyond overall satisfaction to measure satisfaction with different spheres of care.

#### **2.3.4. Perceived Social Support**

The hassles of life that confront humans, as social beings, like unemployment, meeting tight deadlines, loss of loved ones, divorce among others extort a lot of demand on us. As individuals, our assessment of these life's challenges and the resources at hand to deal with them affect the coping strategies we adopt which has implications for our mental health and well-being. Thus, the way an individual interprets a challenge as well as his/her assessment of the resources available to deal with it influences how he/she is affected by the challenge. Theoretically, the stress-buffering hypothesis posits that, stress is associated with several negative health effects particularly mental health and social support can be effective in shielding individuals from stress (Cassel, 1976; Cohen, & Willis, 1985).

Social support in its varied forms has been recognised as an essential ingredient for the collective functioning of every society no matter its level of development. It is also generally accepted in the literature as a crucial element that ensures the wellbeing of individuals. Gottlieb (2000) defined social support as the "process of interaction in relationships which improves coping, esteem, belonging, and competence through actual or perceived exchanges of physical or psychosocial resources" (MacGeorge, 2011, p. 183). This definition appreciates the complexity of the construct of social support and covers key features of social support including: Interaction, Coping, Esteem, Belonging, Competence and Exchange.

Yet, in conceptualising social support we need to differentiate actual from perceived social support. Actual support is the support that an individual receives in terms of what is said, what is given, and what is done for that individual (MacGeorge, 2011). Perceived support on the other hand refers to an individual's belief that social support is available. In essence, social support as a fundamental part of our well-being lies not only in the fact that it helps us feel better, but also equip us with the needed resources to enable us cope with challenges.

Having access to sufficient social support leads to improved health and overall well-being (Lyyra, & Heikkinen, 2006; Motl, McAuley, Snook, & Gliottoni, 2009). If people have a support network, they have access to the tangible and intangible support needed to stay healthy or recover from illness. For instance, patients with chronic mental illness in Ghana may need support to access reliable transportation to and from treatment centres. Mental health patients, depending on their individual circumstances may also need assistance in taking care of basic tasks, including: housework (cooking, house cleaning, taking care of children etc) and personal hygiene. Additionally, some mental health patients may lack insight, without access to social support such clients may not be able to fully adhere to medical recommendations regarding treatment and follow ups. This support networks where available does not only allow patients to get the rest and assistance they need for recuperation, but also influences their life's satisfaction.

Studies have generally found a positive relationship between social support and positive healthcare outcomes. However, the helpfulness of social support to enhance an individual's mental health and well-being depended on the individual's feeling that the support was adequate or that the support was what was needed in the given situation. In this case the perception of available social support becomes more pertinent. Accordingly, perceived support has been

found to be more significant than actual support in enhancing individual's mental health and their general well-being (Haber, Cohen, Lucas, & Baltes, 2007). In their study comparing the effects of perceived and actual social support on mental health of men and women living with HIV/AIDS, McDowell and Serovich (2007) established that perceived social support predicted positive mental healthcare outcomes, while the effect of actual social support on mental healthcare was minimal. Thus, both actual and perceived support has effect on clients' mental health albeit the later has a stronger effect.

Again, Mortimore et al. (2008) studied elderly patients recovering from a hip fracture and found that those with less social contact and support were five times more likely to die within five years of fracture than those with more social contact and support. They also found that, the support network of friends and family gave elderly patients with social support both information about eating healthy and the confidence that they could choose healthy over unhealthy foods (Anderson, Winett, & Wojcik, 2007).

In examining the factors associated with satisfaction among HIV infected patients treated with long term antiretroviral therapy in France using cross-sectional survey, Préau, Protopopescu, Raffi et al. (2012) found that aside patients' socio-demographic characteristics, strong social support from friends and family were positively associated with complete satisfaction with care. In fact, they recommended for more attention to be given to patient satisfaction, especially for socially vulnerable patients, in order to avoid potentially detrimental consequences such as poor adherence to treatment regimes. Though this study and the preceding one did not deal specifically with patients with mental health illnesses, they undoubtedly demonstrate a positive relationship between patient satisfaction and social support.

Lippens and Mackenzie (2011) studied the rates and correlates of treatment satisfaction, perceived treatment effectiveness, and dropout among older users of mental health services using logistic regression in Manitoba, Canada. They established that over 88% of the respondents who had used mental healthcare services during the past years were satisfied with services. Just like previous studies, they found that social support was significantly and positively associated with treatment satisfaction. According to their findings older adult mental health patients in Manitoba, Canada had very good self-reported treatment outcomes and that individual patient characteristics and social support had significant effect on patients' reported satisfaction. But this study was carried out in Canada and sampled only elderly patients. It did not also consider other covariates of satisfaction with mental healthcare such as experiences with other care modalities.

Moreover, the relation between post-stroke satisfaction with time use, perceived social support and depressive symptoms was assessed by Susan, Shearer, Julie and Stan in (2009). They analyzed data of 54 patients grouped by yes/no responses to 'Are you satisfied with how you spend your time?' and found that dissatisfied subjects reported lower affectionate support and fewer positive social interactions as well as higher levels of depression. The implication of their finding is that depressed post-stroke patients who are dissatisfied with their time use may benefit from social support and participation in meaningful social activity. Nonetheless, while this study demonstrate a positive relationship between perceived social support and satisfaction with time use, and life in general, single item questionnaires have not proven to be an adequate measure of a complex construct like satisfaction.

Clients' satisfaction with mental healthcare services is not influenced only by their perceived support from family and friends but also the climate within which services are delivered. Good patient-clinician rapport and or good therapeutic relationship with key-workers create the perception of supportive climate in the care environment. This is important since mental healthcare service users' perceptions about the social climate of their treatment have been found to have a significant positive relationship with satisfaction with care (Daniel, Bill, Dominic, & Douglas, 2011). This observation emphasized the importance of forming and maintaining effective therapeutic relationships with clients and reinforces the need to sustain a therapeutic environment of trust free of tension and threats. Beside the above, patients' pathways to orthodox psychiatry care may expose them to experience different mental healthcare modalities which in turn affect their evaluation of each care they experience.

### **2.3.5. Pathways to Care**

Pathways to mental healthcare, broadly called health-seeking behaviour, generally refer to the route(s) clients take to access mental healthcare services. Numerous studies have demonstrated that clients' belief system about illness aetiology De-Graft (2005), nature of service delivery, accessibility and cost influenced not only clients' choice of psychiatry care James et al. (2011), but also satisfaction with experienced care (Weijun, Xuemei, Yan, Xiulan, & Zhiyong, 2013).

The traditional belief system and ethno-cultural explanation of mental illness aetiology are influential in mental health clients' choices of whether to seek help at all and where (Ajzen, 1980). Supernatural theories of disease aetiology often dominate the understanding of mental illness in most developing countries. Studies in Uganda highlight that, in most Sub-Saharan

African (SSA) countries mental health is perceived to be due to witchcraft, curses and evil or ancestral spirits (James et al., 2011).

Given such world view about the causes of mental illness, spiritual solutions (traditional healers, pastors/prophets etc) were often seen by many as the most appropriate source of care. It is also not uncommon for people with this world view to lack faith in the ability of conventional psychiatric treatment to treat and cure mental illness; rather they see traditional healers as targeting the root cause of the illness, and thus possessing much more potential for success.

Yet, belief systems are not the sole determinant of pathway to psychiatry care as James et al. (2011) appear to portray. For example, healer-shopping<sup>1</sup> does not depend exclusively on (ethno-cultural and other) theories of illness aetiology, or commitment to particular healthcare systems (ethno-medical, biomedical etc) on the basis of unique areas of healthcare expertise. Rather, and more crucially, cost, availability, and accessibility of pluralistic medical services also affect mental health clients' health-seeking decisions (Rekdal, 1999; Nyamwaya, 1987).

In fact, research findings show healer-shopping to be common among many chronically ill patients in SSA (Kirby, 1993; Nkwi, 1994; De-Graft, 2005). Accordingly, even though supernatural explanations of mental illness aetiology dominate in most parts of SSA, such understandings coexist with biomedical theories. Patients appear to have a very sophisticated and pluralistic view of illness causation and treatment. Thus, while traditional religious healers are seen as experts in treating and curing spiritually caused conditions, biomedicine is also

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<sup>1</sup> The use of a second healer without referral from the first for a single episode of illness (Kroeger, 1983; De-Graft, 2005).

accommodated as having a role to play in treating the physical cause of the same illness episode.

Similarly, the manner of healthcare delivery is a major influencing factor in patient's help-seeking behaviour. The prevalent choice of traditional healing as a mode of treatment is the consequence of the way in which traditional healers deal with clients. Such practitioners were felt to listen to clients' complaints with empathy and unconditional positive regard James et al. (2011) contrary to the unkind, disrespectful and busy-like manner clients are often dealt with by conventional mental health practitioners (Anderson, 2004). As mentioned earlier, accessibility to mental healthcare facilities and financial costs associated with care in the form of high transport costs, expensive drugs and other financial implications frustrate patients and their caregivers, may make them resort to the more readily available and affordable traditional healers within their localities.

Likewise, the care patients encounter in search of solutions for their problems at one healthcare facility or provider affect their evaluation of subsequent experiences. For instance, evidence in the literature suggests that black patients take different pathways to mental healthcare in South London and these pathways are influenced by both previous experiences with services as well as clinical diagnosis (Bhugra, Harding, & Lippett, 2004). Black patients were found to be more likely to encounter psychiatry care via the police or the justice system rather than referral through primary care services and were also more likely to be dissatisfied with primary care compared with white patients (ibid).

Earlier, Commander, Cochrane, Sashidharan, Akilu et al. (1999) compared the pathways to psychiatric hospital and the provision of in-patient and after-care for Asian, black and white patients with non-affective psychoses in the United Kingdom by sampling 120 patients, 40 from each ethnic group. Their findings showed that Asian and especially Black patients had different pathways to psychiatry care from their white counterparts. Asians and Blacks were less likely to perceive themselves as having a psychiatric problem or as needing to go into hospital and had higher levels of both involvement with the police and compulsory detention than Whites. They also expressed less satisfaction with the admission process.

Black patients, as compared to Asian but especially White patients, were more often detained in the hospital against their will, confined to the ward and treated within a secure environment. The implications of these findings are that, clients' previous care experiences affect their future decisions of whether to seek care at all and where. Accordingly, early intervention programmes and home treatment services to address the ethnic differentials identified in this study merit consideration (Morgan, Mallett, Hutchinson, & Leff, 2004).

Steel, McDonald, Silove, Bauman, Sandford et al. (2006) examined the routes to mental healthcare followed by clients presenting for the first time to community and hospital based mental healthcare services and the degree to which individual characteristics, cultural background and social support influence the time and pathways taken to reach care. They sampled 146 Australian-born, Asian and Arabic-speaking patients making their first contact with mental healthcare services and found that an average of three professional consultations were made by patients prior to first contact with public mental healthcare services with the average time taken to reach mental healthcare services being 6 months. Moreover, patients'

characteristics such as gender, age, English fluency and social support were not associated with delays in receiving public mental healthcare.

However, ethnicity was associated with lower utilization of mental healthcare services and clients satisfaction with care (Steel, et al., 2006). This study findings suggest that socio-cultural factors influence pathways to mental healthcare but do not delay mental health clients' first contact with public mental healthcare facility. Yet, studies that only enumerate differences in sources of referral to psychiatric services and rates of compulsory admission are not very helpful, as no recommendations for policy or service reform have been developed from such researches (Morgan, Mallett, Hutchinson, & Leff, 2004).

For example, it has been consistently reported that the African-Caribbean population in the United Kingdom are more likely than their White counterparts to access mental healthcare services via the police and under compulsion. Yet, the reasons for these differences are poorly understood as the issue of ethnic variations in pathways to psychiatric care has been studied almost exclusively within a medical epidemiological framework, neglecting the potential insights offered by social research in illness behaviour (Morgan et al., 2004).

Data from pathway to care studies would be more useful if it is studied as a social process subject to a wide range of influences, including the cultural context within which the mental illness is experienced. In any case, it is only through gaining a better understanding of the processes at work in shaping different responses to mental illness and interactions with mental healthcare services that the patterns observed in research can be fully understood. Meanwhile, the scope of this aspect of the study is on how patients' experiences with different care

modalities affect their satisfaction with orthodox psychiatry care rather than the myriad of factors that influence patients' healthcare decision making.

Aside the above, the context within which mental health is experienced is closely interwoven with not only physical health Koivumaa-Honkanen et al. (2011), but also individual's interpersonal and socio-economic life circumstances. This assertion is reinforced by the very definition of health (see below) by the WHO and points the need to preserved and promote mental health across different sectors of society.

### **2.3.6. Satisfaction with other Life Domains**

The WHO defined health as a state of complete physical, mental and social well-being and not merely absence of disease or infirmity. Good health, mental health in particular, is thus an objectively desirable mental state indicating progress and subjective psychosocial well-being (Vaillant, 2003). From this perspective, people's subjective measure of life satisfaction is not only an indicator of their well-being, but also a dimension of mental health (Vaillant, 2003; Gunnell, 2006). Among the general population, life satisfaction has been shown to protect against adverse health outcomes, including premature work disability and mortality Koivumaa-Honkanen et al. (2004), suicides Koivumaa-Honkanen, Honkanen, Viinamaki et al. (2001), fatal injuries and mental health (Gunnell, 2006).

As such, life satisfaction should be an important goal for treatment outcome (Zimmerman, McGlinchey, Posternak, Friedman, Boerescu et al., 2008). In support of this argument is a study that showed that patients with major depression frequently mentioned: optimism, vigour, self-confidence and general well-being (the features of positive mental health) in defining important

features for remission (Koivumaa-Honkanen, Rissanen, Hintikka, Honkalampi, Haatainen et al., 2011). Only after these were the absence of symptoms of depression mentioned (Zimmerman, McGlinchey, Posternak, Friedman, Attiullah et al., 2006).

Moreover, a sample of psychiatric outpatients in a recent study defined meaningfulness in life, peaceful and positive feelings, and hope for the future as the most important issues for health Jormfeldt (2010) rather than the absence of symptoms. These examples establish satisfaction with life in general as an important issue among psychiatric patients. What is the relationship between patients' satisfaction with life and their assessment of psychiatry services they encounter then?

Blenkiron and Hammill (2003) investigated whether clients' satisfaction with mental healthcare and quality of life is related to their age, gender, psychiatric diagnosis, and duration of mental disorder. They surveyed adults receiving care from a community mental health team in North Yorkshire in the United Kingdom using the Carers' and User's Expectations of Services, User Version (CUES-U) questionnaire. The outcome of their study showed that satisfaction with mental healthcare services correlated significantly with patients' age and their satisfaction in other areas of their lives such as housing, money, and relationships. But gender and duration of disorder were unrelated to service satisfaction. Thus, different variables ranging from client's socio-demographic characteristics, routes to psychiatry care, perceived social support account for some patients' satisfaction variance.

#### **2.4. Rationale for the Present Study**

Patients' satisfaction has generally been studied using surveys Gonzales et al. (2005), but some of these surveys have been criticised for using single item questionnaires which are incapable of measuring satisfaction with the different aspects of care. The lack of an adequate theory for studying clients' satisfaction with mental healthcare services and the use of unreliable survey instruments are also concerns. Linder-Pelz (1982) for example argued that the low power to explain satisfaction is due to lack of good models of satisfaction, with most studies relying on post-hoc correlation analysis rather than model driven research.

Similarly, receptionists and other staff in most hospitals often receive grumbles from patients (Baker, 1997). Yet, satisfaction measures at these facilities generally record high client satisfaction (ibid). This is partly due to the technical difficulties in measuring clients' satisfaction as Hawthorne (2008) observed. In addition, there are very few studies that have looked at patients' satisfaction with mental health services across the world and the few existing data were the result of research conducted mostly in western developed countries. Also, clients' satisfaction studies rarely assess patients' satisfaction together with the covariates of patients' characteristics, perceived social support, satisfaction with other life domains and routes to psychiatric care as the reviewed literature above demonstrate.

Additionally, studies in mental healthcare measuring satisfaction multidimensionally have only recently begun to examine satisfaction with the actual occurrences in the process of care, especially information provision or communication (Perreault et al., 2006). Nonetheless, researches examining the importance mental health patients attribute to treatment characteristics

have revealed that receiving clarification on treatment Glass (1995), rapport, accessibility and affordability of care are important issues.

Moreover, while interest in clients' satisfaction with medical healthcare services has increased over the past decade Hawthorne (2008), studies on satisfaction among mental healthcare patients are still scanty. Similarly, the review literature revealed a complete lack of studies on clients' satisfaction with mental healthcare services in Ghana. Furthermore, studies examining clients' satisfaction with mental healthcare services have generally not considered the impact of experiencing other care modalities prior to coming to the psychiatric hospital (pathways to care), social support and satisfaction with other life spheres. This study aims to contribute to the literature by delving into these deficits.

## **2.5. Statement of Hypotheses**

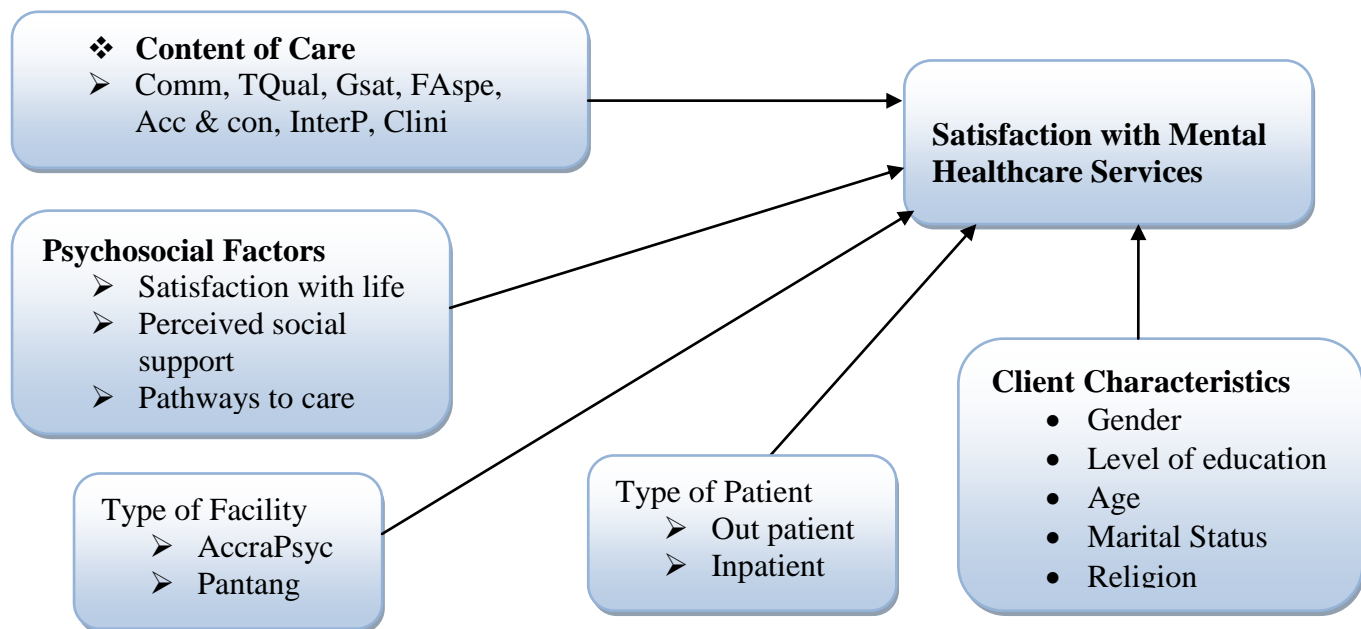
Informed by the reviewed literature, the following hypotheses would be tested.

1. There is likely to be a statistically significant difference in outpatients and inpatients satisfaction with mental healthcare services.
2. Female psychiatric patients are likely to be significantly more satisfied with psychiatric care than their male counterparts.
3. Clients who have experienced other modes of care (sought treatment from pastors, traditional priest etc) prior to coming for orthodox psychiatric care are likely to be less satisfied with mental healthcare than those who have not.
4. There is likely to be a significant difference in the levels of clients' satisfaction with mental healthcare services at the Accra Psychiatric and Pantang hospitals.

5. There is likely to be a significant positive relationship between patients' satisfaction with mental healthcare services and their satisfaction with other life domains.
6. Patients' perceived social support is likely to account for more variance in their satisfaction with mental healthcare services than their satisfaction with other aspects of life.
7. Clients' demographic characteristics (age, gender and level of education) will account for a significant variance of patients' satisfaction with mental healthcare services.

**Figure 2**

**Proposed Model for Understanding Clients' Satisfaction with Mental Healthcare Services**



## 2.6. Operational Definitions

**Patients' Satisfaction with Mental Healthcare Services:** the degree to which patients' desired expectations and preferences have been met by the mental healthcare provider(s) as measured by the Patients Satisfaction Questionnaire -18 (PSQ-18). The domains of satisfaction measured by PSQ-18 are: communication, technical quality, general satisfaction, financial aspect, accessibility and convenience, interpersonal manner and time spent with clinician.

**Satisfaction with other Domains of Life:** this refers to patients' satisfaction with other aspects of life aside mental healthcare as measured by the Satisfaction with Life Scale (SWLS).

**Pathways to Care:** the route(s) patients take in search for a cure as measured by the WHO Encounter Form

**Experience of other care modalities:** patients who sought treatment from other care providers like Pastors, Mallams and Traditional Priests as measured by the WHO Encounter Form.

**Perceived Social Support:** refers to an individual's belief that social support is available as measured by the Multidimensional Scale of Perceived Social Support (MSPSS).

## **CHAPTER THREE:**

### **METHODOLOGY**

#### **3.1. Introduction**

This chapter covers the methodology of the study and explains in detail the various techniques, procedures and processes used to gather information from the sampled population. It also explained the sampling procedures employed to ensure that adequate and unbiased information is obtained. This segment also provides information on how the collected data was analysed as well as some ethical issues that were addressed to meet the objectives of the study.

#### **3.2. Study Sites**

The two main government psychiatric hospitals in Accra, the Accra Psychiatric and the Pantang Hospitals were the sites for the conduct of this study. These two hospitals were chosen for both their strategic location and the services they provide for clients. Firstly, both hospitals are located in Accra making them convenient sites for data collection for the researcher. Secondly, the hospitals provide numerous services including: Outpatient & Inpatient Management, Pharmacy Services, Clinical Psychology Services among other services. These two psychiatric hospitals also serve as referral sites for patient coming from different parts of the country. The wide range of services rendered by these two psychiatric hospitals, their referral status together with their proximity make them the obvious choice for this study.

#### **3.3. Population, Inclusion and Exclusion Criteria**

The population of interest for this study were all adult (male and female) mental health clients, both outpatients and inpatients visiting the Accra Psychiatric and the Pantang Hospitals at the

time of the data collection. This population was chosen because Accra (the capital of Ghana) is very cosmopolitan and comprises of people from all parts of the country. As a result, the mental healthcare patients at the hospitals come from different parts of the country.

Adult mental health clients, between the ages of 18 and 60 years, at these two psychiatric hospitals at the time of data collection qualify to participate in this study. Clients who are below 18 or above 60 years old and or lack insight as a result of their mental health illness/condition were excluded from the study to ensure that clients' responses reflect their experiences. Studies have generally shown that, as patients' illness condition improves, especially when they are in remission their insight regarding objective experiences improves as well (Simon & Anthony, 1999). In this case, recruiting patients on remission and about to be discharged from the psychiatric hospitals is appropriate.

### **3.4. Sampling Technique and Sample Size**

In research, while it is ideal to work with the whole population, it is almost always nearly impossible to do so (Prashant, & Supriya, 2010). As a result, researchers choose to work with samples. Sample selection when done properly, enable researchers to draw strong robust conclusions from the limited amount of information and also permit generalization of results (Gogtay, 2010).

In this regard, systematic sampling procedure was used to select the research sample. A list of inpatients who do not present psychotic symptoms and those who have such symptoms but are on remission and either waiting to see the psychologist or their relatives before discharge at the two study sites was developed and used to select every 2<sup>th</sup> patient on the list to participate in the

study. Where the 2<sup>th</sup> patient is not qualified to participate because of age or refuses to participate the nearest qualified patient is recruited to participate. Similarly, every 5<sup>th</sup> outpatient who visited the Accra Psychiatry and the Pantang Hospitals during the data collection period was sampled to participate in the study. The outpatients usually seat in queues on first-come-first-serve bases making random selection of every 5<sup>th</sup> patient to participate in the study after seeing the clinician possible.

Systematic sampling was chosen because it is a probability sampling technique which gives everyone in the study population a none zero chance of being included in the research. Moreover, this sampling technique allows for strong conclusions to be drawn from the limited data and permit generalisation of research result to the study population.

The sample for this study was made up of two hundred and five (205) mental health patients representing ninety nine (99, 48.3%) and one hundred and six (106, 51.7%) from Pantang and Accra Psychiatric hospitals respectively. This sample size selection was based on the minimum sample size determination offered by Field (2009) taking into consideration the effect size as well as the statistical power at which the effects size would be detectable. This particularly applies to performance of multiple regression analysis and the minimum sample sizes are listed below:

For a medium effect size and high level of statistical power (.80) with 10 predictors, a minimum of 150 sample size is required. For a medium effect size and high level of statistical power (.80) with 20 predictors, a minimum of 200 sample size is required. From this sample size determination therefore, the sample size of 205 is sufficient for multiple regression analysis to

be performed in order to obtain a medium effect size and a high statistical power in this study. Additionally, Tabachnick and Fidell (1996) hold that a sample size of 74 ( $N = > 50 = 8m$  ( $m =$  number of IVs) is adequate to be tested using multiple regression analysis if the study only has three IVs; as long as the data meet the other criteria for inferential statistical analysis.

**Table 1**

**Demographic Characteristics of the Mental Healthcare Patients in the Study**

<b>Gender</b>	<b>N (%)</b>
Male	92 (44.9%)
Female	113 (55.1%)
<b>Age Categories</b>	
18-30 years	91 (44.4%)
31-45 years	80(39%)
46-60 years	34(16.6%)
<b>Marital Status</b>	
Single	91(44.6%)
Married	70(34.3%)
Separated/divorced,	33(16.2%)
Widowed	10(4.9%)
<b>Education</b>	
No Formal Education	42(20.5%)
Basic	113(55.3%)
Secondary	40(19.5%)
Tertiary	10(4.9%)
<b>Religion</b>	
Christianity	158 (78.2%)
Islam	41 (20.3%)
Others	3 (1.5%)
<b>Type of Patient</b>	
Inpatient	96 (46.6%)
Outpatient	110 (53.4%)

### 3.5. Instrumentation

Choosing a questionnaire to assess clients' satisfaction with mental healthcare is a challenging adventure in the Ghanaian setting because of the dearth of literature in this field. This study however adopted and modified four questionnaires to collect data from respondents after pilot testing them for participants' understanding and statistical rigour. These are: the Patient Satisfaction Questionnaire-18 (PSQ-18), the Satisfaction with Life Scale (SWLS), the Multidimensional Scale of Perceived Social Support (MSPSS) and the WHO Encounter Form.

The primary questionnaire for this study was the **Patient Satisfaction Questionnaire-18 (PSQ-18)** by Marshall and Hays (1994). This questionnaire is a short version of the original 50 item (PSQ-III) developed by Ron et al. (1987) and has very good psychometric properties and shown on the table below. The PSQ-18 contains 18 items and taps into all the seven domains of satisfaction with healthcare measured by PSQ-III: General satisfaction, Technical Quality, Interpersonal manner, Communication, Financial aspect, Time spent with clinician, Accessibility and convenience. PSQ-18 subscale scores are substantially correlated with the original PSQ-III and possess adequate reliability and internal consistency. The table below shows the internal consistency reliabilities and correlations of PSQ-III and PSQ-18.

**Table 2****Reliability Scales and Correlation Coefficients between PSQ-111 and PSQ-18**

Subscale	PSQ-111	PSQ-18	<i>r</i>
General satisfaction	0.88 (6)	0.75 (2)	0.92
Technical Quality	0.85 (10)	0.74 (4)	0.92
Interpersonal manner	0.82 (7)	0.66 (2)	0.83
Communication	0.82 (5)	0.64 (2)	0.92
Financial aspect	0.89 (8)	0.73 (2)	0.90
Time spent with clinician	0.77 (2)	0.77 (2)	1.00
Accessibility and convenience	0.86 (12)	0.75 (4)	0.91

*Source: Marshall and Hays, 1994.*

*r* = Pearson Product Moment Correlation Coefficient

( ) = Number of items on the questionnaire

From the table above we see that the reliability values of the PSQ-18 and the correlation of its subscales with the original version makes it an adequate replacement. This scale has a Likert response format of 5-points including; 1 = strongly disagree, 2 = disagree, 3 = Uncertain, 4 = agree, 5 = strongly agree. PSQ-18 which has a (total score range from 18 – 90) is scored such that higher scores represent high satisfaction. The questionnaire yields an overall score as well as separate scores for each of the seven different subscales: General Satisfaction (Items 3, 17); Technical Quality (Items 2, 4, 6, 14); Interpersonal Manner (Items 10, 11); Communication (Items 1, 13); Financial Aspects (Items 5, 7); Time Spent with Doctor (Items 12, 15); and Accessibility and Convenience (Items 8, 9, 16, 18).

Some examples of items in the scale are: I am dissatisfied with some things about the mental healthcare I receive (General Satisfaction); sometimes mental health professionals make me wonder if their diagnosis is correct (Technical Quality); the mental healthcare professionals treat me in a very friendly manner (Interpersonal Manner); the mental healthcare professionals sometimes ignore what I tell them (Communication); I have to pay more for my mental healthcare than I can afford (Financial Aspects); professionals usually spend plenty of time with me when treating me (Time Spent with Clinician); where I get mental healthcare people have to wait too long for treatment (Accessibility and Convenience).

Also, the **Satisfaction with Life Scale (SWLS)** developed by Diener, Emmons, Larsen and Griffin (1985) was used to measure clients' satisfaction with other life domains. This scale has a Likert response format of 5-points including; 1 = strongly disagree, 2 = disagree, 3 = Neither agree nor disagree, 4 = agree, 5 = strongly agree. Some examples of items in the scale are: 'In most ways, my life is close to ideal', 'I am satisfied with my life' and 'If I could live my life over, I would change almost nothing.'

The SWLS is a five item scale designed to assess a person's global judgment of life satisfaction which has been found to be related to satisfaction with specific life domains. The total scores on the SWLS range from 5 to 25, with higher scores indicating greater well-being (Kowal, Swenson, Aubry, Marchand, & Macphee, 2011). Moreover, the brief format of the SWLS means that it can be incorporated into an assessment battery with minimal cost in time. SWLS has good psychometric properties as well with a reported coefficient alpha of .87 for the scale and a two month-test –retest stability coefficient of 0.82 (Diener et al., 1985).

Additionally, the **Multidimensional Scale of Perceived Social Support (MSPSS)** developed by Zimet, Dahlem, Zimet and Farley (1988) was used to measure clients' perceived social support. It is a twelve-item scale that taps into 3 domains of social support: family, friends and significant others. This scale has a Likert response format of 5-points including; 1 = strongly disagree, 2 = disagree, 3 = Neutral, 4 = agree, 5 = strongly agree. It has good reliability with a Cronbach's alpha between 0.83 and 0.91. Cronbach's values for the subscales range from 0.82, 0.80, and 0.79 for Family, Friends, and Significant Other respectively (Nakigudde, Musisi, Ehnvall, Airaksinen, & Agren, 2009). Some examples of items in the scale are: 'I have a special person who is a real source of comfort to me' (Significant Other); 'I get the emotional help and support I need from my family' (Family) and 'I can count on my friends when things go wrong' (Friends).

"Significant Other" in MSPSS is understood as any person with great importance to an individual's well-being as well as self evaluation (Nakigudde et al., 2009). In the cultural context of Ghana, this could be any person ranging from spouse, partner, parent, uncle grandparent or even one's supervisor at the work place. Studies generally show a positive relationship among social support, especially perceived social support, and mental health, well-being and satisfaction with life (Cohen, & Willis, 1985).

Lastly, **WHO Encounter Form** was used mainly to assess clients' route to orthodox psychiatric care as well as the prominent symptoms that informed the decision to seek help. The WHO Encounter Form is mostly used to conduct pathway studies which highlight the help-seeking behaviours of patients with both physical and mental health illnesses. The aim of using the Encounter Form in this study is to explore how experiences with other care domains affect their

satisfaction with orthodox psychiatric care. The item used to distinguish patients who experienced other care domains from those who have not was: ‘Who was first seen? 0 = traditional healer/herbalist, 1 = pastor/ malam, 3 = medical practitioner/general hospital, 4 = psychiatric hospital and 5 = any other, state.....’ The item was scored such that patients who sought treatment elsewhere before coming to the psychiatric hospital = 1 and those who sought remedy straight from the psychiatric hospital = 2.

### **3.6. Pilot Study**

A pilot study was conducted prior to the main study to determine the suitability and reliability of the scales employed in the study in the Ghanaian context. This pilot study was conducted by administering the scales to 20 mental health patients (10 inpatients and 10 outpatients) at the Accra Psychiatric Hospital. Patients demonstrated understanding of the items on the scales per the completion rate. The scales also had good internal consistencies with Cronbach’s Alpha coefficient of .72 for the PSQ-18 while the SWLS and the MSPSS had Cronbach’s Alphas .84 and .82 respectively.

### **3.7. Design**

Since the study sought to obtain self-reports of clients’ satisfaction with mental healthcare services where data is captured at one point in time, the most appropriate design is cross-sectional survey (Atindanbila, 2013).

### **3.8. Procedure**

A letter of introduction from the Department of Psychology introducing the researcher to the two hospitals was obtained. The introductory letter was supported with the research protocol

together with a certificate of ethical approval for the conduct of the study from the Institutional Review Board of the Noguchi Memorial Institute for Medical Research and submitted to the two hospitals to secure permission to undertake the research. Further, there were preliminary visits to the two psychiatry hospitals and during those visits the objectives of the research was discussed with the authorities in charge to facilitate the process.

Two psychology students were recruited and trained as research assistants to help in data collection. Additionally, the questionnaires were piloted to ensure their statistical rigour as well as the suitability of the questions to the research population or to guarantee participants understand the items on the questionnaires.

Also, all those involved in the data collection had not been involved in the assessment or treatment of any of the patients. Evidence points that not involving providers of healthcare in the data collection allows patients to provide honest feedback regarding the service they had received at their respective facility without fear of offending a person involved in the provision of that service (Summers, & Happell, 2003).

### **3.9. Ethical Considerations**

The ethical issues identified in this study include: informed consent, confidentiality, and respect for persons' privacy, rights and dignity. The measures put in place to resolve these ethical issues to limit any potential negative effects the study might have on participants are explained below.

Firstly, the aims, benefits and potential harm of the study were explained to each participant. Participants were then requested to sign a written consent form indicating they have understood

the nature of the research and agreed to participate. Each respondent was guaranteed anonymity since his/her consent form is not matched with his/her questionnaire. Again, participants' were assured their responses would be used for academic purposes only. In summary all possible means were used to protect respondents' anonymity and confidentiality including shredding the questionnaires once the data has been processed.

Moreover, the study protected the autonomy of all participants by not coercing any client to participate in the study. Thus, it was made clear to participants that they have a choice to participate or not participate in this study at no cost to them and can rescind their decision to participate at any stage of the study if they do not feel comfortable to continue.

The benefits of this study are enormous. Upon completion the study will increase our understanding of clients' satisfaction with mental healthcare services in our psychiatry hospitals in Accra. It will inform mental healthcare professionals and policy makers, from the clients' perspective, the mental healthcare services that need improvement. The study will also improve our understanding of the relationship among clients' satisfaction with mental healthcare, satisfaction with other life domains and experience with other care modalities.

Finally, this study did not expose any client to risk higher than he/she would usually face in the course of seeking mental healthcare treatment. These measures coupled with the potential benefits of this study make the researcher confident that the study is worth undertaking.

## **CHAPTER FOUR:**

### **RESULTS**

#### **4.1. Introduction**

This chapter presents the results from the analyses of the collected data and used summary tables where appropriate to explicate the key findings. The aspects of the study covered in this chapter include; data analyses, presentation of result, hypotheses testing, and summary of findings. A number of statistical analyses were performed including: Multivariate Analysis of Variance (MANOVA), Independent t test, Pearson Product Moment Correlation and Regression analyses to test the study hypotheses using the Statistical Package for Social Scientists (SPSS) version 16.00. Also, the statistical test that was used to analyse each hypothesis and reasons for using that test are discussed below. Additional findings that are not part of the main hypotheses are also highlighted.

#### **4.2. Data Analyses**

Hypotheses one and two were analysed using Multivariate Analysis of Variance (MANOVA) because they compared type of patient and sex (gender) across seven dependent variables (Communication, Interpersonal manner, Technical quality, Cost, Accessibility and convenience, General satisfaction and Time spent with clinician) respectively. Hypothesis three and four were analysed using independent t test because both compared the satisfaction mean scores of two independent samples. These independent samples were patients who experienced other care modalities and those who did not on one hand and patients from the Pantang and Accra psychiatric hospitals on the other. In addition, the dependent variable (patients' satisfaction with mental healthcare services) was measured on an interval scale making this test appropriate for these hypotheses.

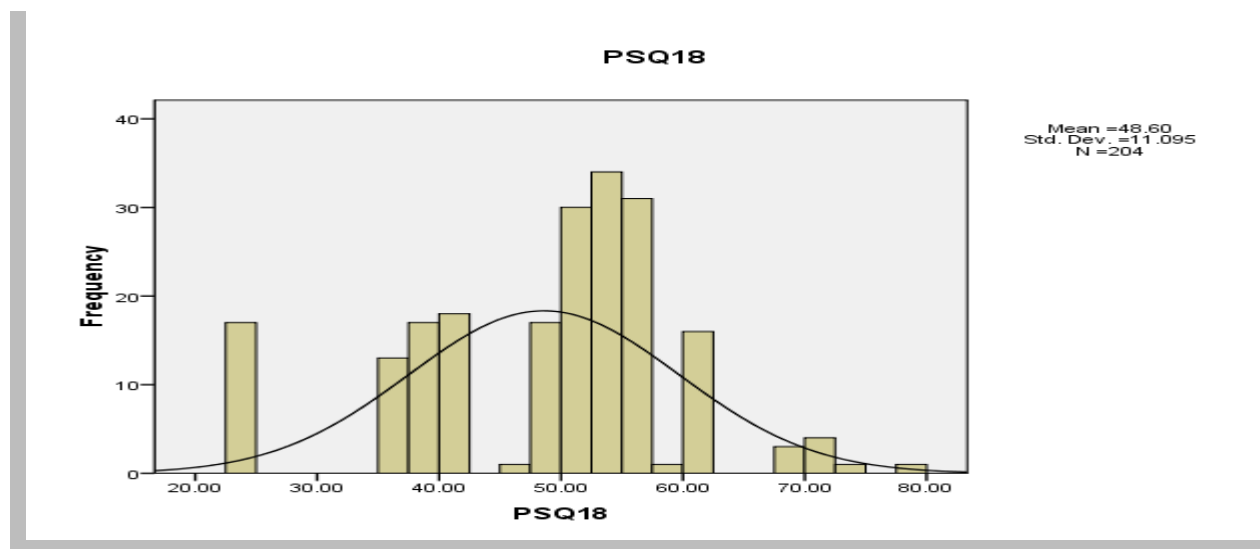
Hypothesis five was tested using Pearson correlation because the variables (patients' satisfaction with mental healthcare services and their satisfaction with other life domains) were measured at least on an interval scale and assumed to be linearly related. Hypotheses six and seven were tested using multiple regression analysis because (perceived social support, satisfaction with other aspects of life, age, gender and level of education) were regressed on patients' satisfaction with mental healthcare services.

### 4.3. Preliminary Analyses

A preliminary analysis to test the assumption that the data is normally distributed was done. The means, standard deviation, skewness and kurtosis of the variables are displayed in table 3 below. From the table we find that the data is normally distributed since the absolute numbers for the positive kurtosis and skewness as well as negative skewness and kurtosis are not very high to point otherwise. A visual inspection of the shapes of the variables' distribution using histograms also showed the data to be normally distributed as the example figure 3 shows.

**Figure 3**

**A Histogram with normal curve of PSQ-18 data as measured in this study**



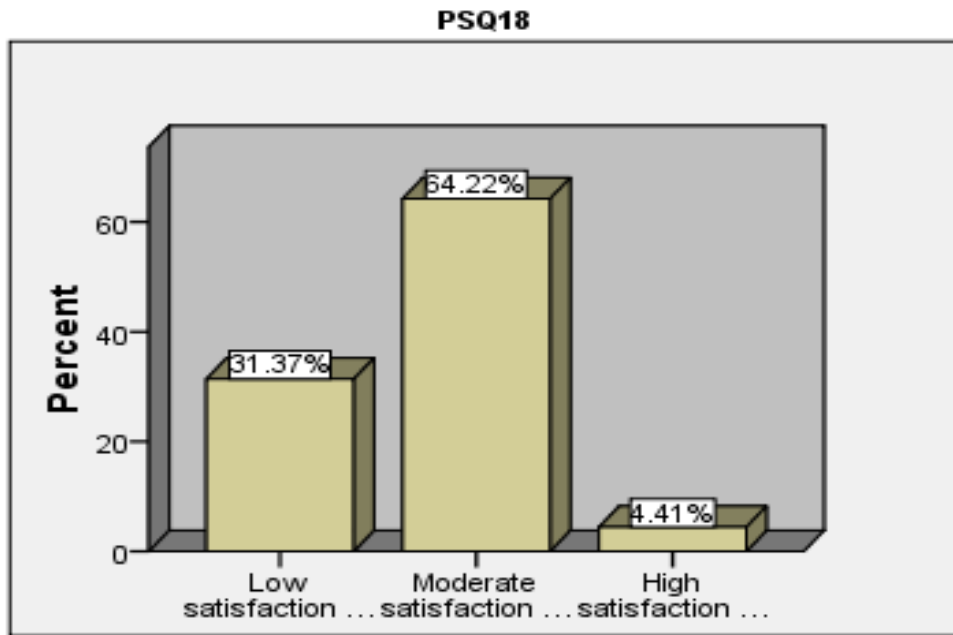
**Table 3****Preliminary Analyses (Means, Standard Deviation, Skewness and Kurtosis)**

<b>Variables</b>	<b>Means (M)</b>	<b>Standard Deviation (SD)</b>	<b>Reliability (<math>\alpha</math>)</b>	<b>Skewness</b>	<b>Kurtosis</b>
<b>A. PSQ-18</b>	<b>48.60</b>	<b>11.10</b>	<b>.82</b>	<b>-.49</b>	<b>.28</b>
<b>Subscales</b>					
1. Communication	5.22	1.93	.29	-.28	-.84
2. Technical Quality	10.73	3.05	.67	-.21	-.42
3. General Satisfaction	5.13	1.97	.25	-.04	-.77
4. Financial Aspect	6.15	2.00	.43	-.53	-.33
5. Acc & Convenience	10.48	2.85	.39	-.65	.26
6. Interpersonal Manner	5.31	1.24	-.86	-.32	1.05
7. Time with Clinician	5.66	1.15	-.23	.34	-.12
<b>B. MSPSS</b>	<b>47.04</b>	<b>7.55</b>	<b>.88</b>	<b>.38</b>	<b>-1.29</b>
<b>Subscales</b>					
1. Significant Others	16.20	2.95	<b>.68</b>	-.24	-1.10
2. Family	15.26	2.92	<b>.90</b>	.35	-1.32
3. Friends	15.60	2.75	<b>.77</b>	-.40	-.49
<b>C. SWLS</b>	<b>15.43</b>	<b>4.23</b>	<b>.79</b>	<b>-.01</b>	<b>-1.27</b>

Similarly, figure 4 below shows the Levels of Clients’ Satisfaction with mental healthcare services as measured by PSQ-18 in this study.

**Figure 4**

**Levels of Clients’ Satisfaction with mental healthcare services as measured by PSQ-18 in this study**



#### 4.4. Testing of Hypotheses

**Hypothesis 1:** *There is likely to be a statistically significant difference in outpatients and inpatients satisfaction with mental healthcare services.*

The results of this test are presented in table 4 below;

**Table 4: Summary of MANOVA test, Means of scores of type of patient**

Mean Scores	Outpatients	Inpatients	<i>df</i>	<i>F</i>	<i>p</i>	$\eta^2$
<b>PSQ-18</b>	<b>65.50(<i>SD</i>=12.67)</b>	<b>61.39(<i>SD</i>=11.67)</b>	<b>1, 205</b>	<b>5.79</b>	<b>.017</b>	<b>.028</b>
Communication	7.59( <i>SD</i> =1.94)	7.10( <i>SD</i> =1.59)	1, 205	3.75	.054	.018
Technical quality	15.08( <i>SD</i> =3.11)	13.47(3.31)		12.94	.000	.060
General satisfaction	6.99( <i>SD</i> =1.54)	6.10( <i>SD</i> =1.95)		13.18	.000	.061
Financial aspect	7.72( <i>SD</i> =1.67)	7.70( <i>SD</i> =1.23)		.017	.897	.000
Acc & Convenience	13.8( <i>SD</i> =3.04)	13.26( <i>SD</i> =2.60)		1.84	.176	.009
Interpersonal manner	7.13( <i>SD</i> =1.80)	6.99( <i>SD</i> =1.52)		.352	.554	.002
Time with Clinician	7.31( <i>SD</i> =1.43)	6.76( <i>SD</i> = 1.63)		6.64	.011	.032

*Bonferroni Adjustment = .007. Since there are seven dependent variables, the Bonferroni adjustment was done to reduce type- 1 error by dividing the .05 alpha level by seven in order to adopt a more stringent alpha level. Thus, the new alpha level for these F- ratios is .007.*

A One-way MANOVA was used to find out the differences in satisfaction with regards to type of patient as measured by the PSQ-18. The independent variable was type of patient while the seven dependent variables are the subscales on the PSQ-18 as seen on table 3 above. Preliminary assumptions testing were done to check for normality, outliers, homogeneity of variance; covariance and no serious violations were noted.

### **Interpretation**

An examination of the result displayed on the MANOVA table above indicates that, there was no statistically significant difference at the  $p < .007$  level between outpatients ( $M = 65.50$ ,  $SD =$

12.67) and inpatients ( $M = 61.39$ ,  $SD = 11.67$ ) levels of satisfaction with mental healthcare services [ $F(1, 205) = 5.79$ ,  $p = .017$  and a small effect size of  $\eta^2 = .028$ .

For the specific satisfaction domains, a significant difference was observed in the level of patients' satisfaction with mental healthcare services with regard to Technical Quality of care; with outpatients reporting higher satisfaction, [ $F(1, 205) = 12.94$ ,  $p < .001$ , and a moderate effect size of  $\eta^2 = .060$ . Similarly, a significant difference was found between outpatients ( $M = 6.99$ ,  $SD = 1.54$ ) and inpatients ( $M = 6.10$ ,  $SD = 1.95$ ) in their general satisfaction, with outpatients more satisfied than inpatients [ $F(1, 205) = 13.18$ ,  $p < .001$  and a moderate effect size of  $\eta^2 = .061$ .

However, no significant differences were observed between outpatients and inpatients in their levels of satisfaction with mental healthcare in relation to the domains of: Communication, Interpersonal Manner, Financial Aspect, Accessibility and Convenience and Time spent with clinician at the,  $p < .007$  level as figures in table 3 above demonstrate. Therefore, the hypothesis that there is likely to be a statistically significant difference in outpatients and inpatients satisfaction with mental healthcare services is not supported.

**Hypothesis 2:** *Female psychiatric patients are likely to be significantly more satisfied with psychiatric care than their male counterparts.*

This hypothesis was analysed using the MANOVA because gender are being compared on their satisfaction on the PSQ-18 which has seven continuous DVs. The results of this test are presented in table 5 below;

**Table 5: Summary of MANOVA test, Means of score of Gender**

Mean Scores	Female	Male	<i>df</i>	<i>F</i>	<i>p</i>	$\eta^2$
<b>PSQ-18</b>	<b>67.44(<i>SD</i>=12.12)</b>	<b>58.83(<i>SD</i>=10.97)</b>	<b>1, 205</b>	<b>27.87</b>	<b>.000</b>	<b>.121</b>
Communication	7.89( <i>SD</i> =1.72)	6.72( <i>SD</i> =1.68)		23.86	.000	.105
Technical quality	15.23( <i>SD</i> =3.07)	13.17( <i>SD</i> =3.22)		22.55	.000	.100
General satisfaction	7.14( <i>SD</i> =1.68)	5.88( <i>SD</i> =1.70)		28.36	.000	.123
Financial aspect	7.98( <i>SD</i> =1.50)	7.38( <i>SD</i> =1.39)		8.72	.004	.041
Acc & Convenience	14.29( <i>SD</i> =2.94)	12.63( <i>SD</i> =2.45)		18.83	.000	.085
Interpersonal manner	7.56( <i>SD</i> =1.52)	6.46( <i>SD</i> =1.65)		24.63	.000	.108
Time with Clinician	7.43( <i>SD</i> =1.53)	7.59( <i>SD</i> =1.44)		16.25	.000	.074

*Bonferroni Adjustment = .007. Since there are seven dependent variables, the Bonferroni adjustment was done to reduce type- 1 error by dividing the .05 alpha level by seven in order to adopt a more stringent alpha level. Thus, the new alpha level for these F- ratios is .007.*

A One-way MANOVA was used to find out the differences in satisfaction with regards to gender of patients as measured by the PSQ-18. The independent variable was gender while the seven dependent variables are the subscales on the PSQ-18 as seen on table 4 above.

### **Interpretation**

An examination of the MANOVA table above shows that, there was a statistically significant difference at the  $p < .007$  level for the two groups [ $F(1,205) = 27.87, p < .001$ ] and a small effect size of  $\eta^2 = .121$ . An examination of the mean scores show that females ( $M = 67.44, SD = 1.09$ ) reported higher levels of satisfaction than males ( $M = 58.83, SD = 1.21$ ).

For the specific satisfaction domains, statistically significant differences were observed at the  $p < .007$  level between the two groups on all the domains of satisfaction measured by the PS-18. Thus, the means scores of females ( $M = 7.89$ ,  $SD = 1.72$ ) and males ( $M = 6.72$ ,  $SD = 1.68$ ) on patients' satisfaction with mental healthcare services with regards to Communication shows that females were more satisfied than males [ $F(1, 205) = 23.86$ ,  $p < .001$  with moderate effect size of  $\eta^2 = .105$ ].

In fact, a look at the mean scores show that females were more satisfied than males on Technical Quality of care [ $F(1, 205) = 22.55$ ,  $p < .001$  with a moderate effect size of  $\eta^2 = .100$ ]; General Satisfaction [ $F(1, 205) = 28.36$ ,  $p < .001$  with a moderate effect size of  $\eta^2 = .123$ ]; Financial Aspect [ $F(1, 205) = 8.72$ ,  $p = .004$  with a small effect size of  $\eta^2 = .041$  and Accessibility & Convenience [ $F(1, 205) = 18.83$ ,  $p < .001$  with a moderate effect size of  $\eta^2 = .085$ ]. The rest are: Interpersonal Manner [ $F(1, 205) = 24.63$ ,  $p < .001$  with a moderate effect size of  $\eta^2 = .108$  and Time spent with clinician [ $F(1, 205) = 16.21$ ,  $p < .001$  and a moderate effect size of  $\eta^2 = .074$ ]. Therefore, hypothesis two that female psychiatric patients would be significantly more satisfied with psychiatric care than their male counterparts is supported.

**Hypothesis 3:** *Clients who have experienced other modes of care (sought treatment from pastors/mallams, traditional priests etc) prior to their contact with orthodox psychiatric care are likely to be less satisfied with mental healthcare than those who have not.*

The results of this test are presented in table 6 below;

**Table 6: Summary of t test, Means, SD of scores on patients who experienced other care modalities and those who did not.**

Care Experience(s)	<i>N</i>	Mean	<i>SD</i>	<i>df</i>	<i>t</i>	<i>p</i>	$\eta^2$
<b>EOCD</b>	158	61.79	11.87	204	3.91	.000	.122
<b>NEOCD</b>	47	69.55	12.18				

*EW OCD = experience of other care domains. NEOCD = no experience of other care domains.*

### **Interpretation**

The result above show that the mean difference between patients who experienced other care modalities ( $M = 61.79$ ,  $SD = 11.87$ ) and patients who did not experienced other care modalities ( $M = 69.55$ ,  $SD = 12.18$ ) on their satisfaction with mental healthcare as measured by the PSQ-18 was found to be statistically significant ( $t = 3.91$ ,  $df = 204$ ,  $p < .001$ , one tail). A comparison of the two mean scores show that patients who sought treatment elsewhere before coming to the psychiatric hospitals were less satisfied with services than those who did not seek care elsewhere and the magnitude of the difference in the means was moderate  $\eta^2 = .122$ . Therefore, hypothesis three that clients who have experienced other modes of care (sought treatment from pastors/mallams, traditional priests etc) prior to their contact with orthodox psychiatric care are likely to be less satisfied with mental healthcare than those who have not was supported.

**Hypothesis 4:** *There is likely to be a significant difference in the levels of clients' satisfaction with mental healthcare services at the Accra Psychiatric and Pantang hospitals.*

The results of this test are presented in table 7 below;

**Table 7: Summary of t test, Means, SD of scores on type of hospital**

Care Experience(s)	<i>N</i>	Mean	<i>SD</i>	<i>df</i>	<i>t</i>	<i>p</i>	$\eta^2$
Accra Psyc	106	64.59	11.48	203	-1.22	.223	.085
Pantang	99	62.48	13.20				

*Accra Psyc = Accra psychiatric Hospital = experience of other care domains. Pantang = Pantang Psychiatric Hospital.*

### Interpretation

The results in table 7 above show that the mean difference between patients from Pantang ( $M = 62.48$ ,  $SD = 13.20$ ) and patients from Accra Psyc ( $M = 64.48$ ,  $SD = 11.48$ ) on their satisfaction with mental healthcare as measured by the PSQ-18 was found to be statistically not significant ( $t = -1.22$ ,  $df = 203$ ,  $p = .223$ , two tail). The magnitude of the difference in the means was moderate  $\eta^2 = .085$ . Therefore, the hypothesis that there is likely to be a significant difference in the levels of clients' satisfaction with mental healthcare services at the Accra Psychiatric and Pantang hospitals was not supported.

**Hypothesis 5:** *There is likely to be a significant positive relationship between patients' satisfaction with mental healthcare services and their satisfaction with other life domains.*

Pearson Correlation was performed to test hypothesis five because the hypothesis seeks to determine a relationship between clients' satisfaction with mental healthcare services and their satisfaction with other aspects of life. The results are summarised in Table 8 below;

**Table 8: Summary of Pearson r test, Means, SD of scores of patients**

<b>Variable</b>	<b>N</b>	<b>Mean</b>	<b>SD</b>	<b>r</b>	<b>p</b>
PSQ-18	205	63.57	12.36	.591	.000
SWLS	203	17.40	3.84		

**Interpretation**

The results from table 8 above indicate that there is a statistically significant positive correlation between patients' satisfaction with mental healthcare services and their satisfaction with other aspects of life ( $r = .591$ ,  $N = 205$ ,  $p < .001$ , one tail). It is a moderately strong correlation and 35% of variance explained. As such, the hypothesis that there would be a significant positive relationship between patients' satisfaction with mental healthcare services and their satisfaction with other life domains is supported.

Further analysis showed a statistically significant positive relationship between clients' satisfaction with services and their perceived social support ( $r = .656$ ,  $N = 205$ ,  $p < .001$  as presented in table 9 below;

**Table 9: Summary of Pearson r test, Means, SD of scores of patients**

<b>Variable</b>	<b>N</b>	<b>Mean</b>	<b>SD</b>	<b>r</b>	<b>p</b>
PSQ-18	205	63.57	12.36	.656	.000
MSPSS	205	47.21	6.78		

Table 9 above indicates that, there is a moderately strong positive correlation between patients' satisfaction with services and their perceived social support and 43% of variance explained.

**Hypothesis 6:** *Patients' perceived social support is likely to account for more variance in their satisfaction with mental healthcare services than their satisfaction with other life domains.*

This hypothesis aimed at finding out the effect of perceived social support and satisfaction with other life domains on patients' satisfaction with mental healthcare services. The standard multiple regression was used to analyse the data. This is because two IVs (perceived social support and satisfaction with other life domains) are used to predict their effect on one DV (patients' satisfaction). The results are seen below in table 10 and 11 below;

**Table 10: Summary of ANOVA Results of Perceived Social Support and Satisfaction with other Life Domains as Predictors of Patients' Satisfaction.**

<b>Model</b>	<b>Sum of squares</b>	<b>df</b>	<b>Mean Squares</b>	<b>F</b>	<b>P</b>	<b>R<sup>2</sup></b>
Regression	15080.82	2,200	7540.41	95.78	.000	.489
Residual	15745.20		78.73			

***Predictors:** Perceived social support, satisfaction with other life domains.*

***Dependent Variable:** Patients' satisfaction with mental healthcare*

### **Interpretation**

As shown in table 10 above, when the predictors were regressed onto the dependent variable (PSQ-18 scores), a significant model emerged at the .001 level of significance [ $F(2,200) = 95.78, p < .001$ ]. That is, the entire model explained 49% in the levels of patients' satisfaction with mental healthcare services. As a follow up, multiple regression was performed to find out the contribution of each variable in explaining patients satisfaction with services. The results are shown in table 11 below;

**Table 11: Multiple Regression Results of Perceived Social Support and Satisfaction with other Life Domains as Predictors of Patients' Satisfaction with Mental Healthcare Services.**

Predictor	B	SEB	$\beta$	$t$	$P$
Perceived Social Support	.859	.115	.472	7.45	.000
Satisfaction with life	.983	.204	.305	4.82	.000

**Predictors:** *Perceived social support, satisfaction with other life domains.*

**Dependent Variable:** *Patients' satisfaction with mental healthcare*

The results in table 11 above show that the most significant predictor of patients' satisfaction in this model is Perceived Social Support. Thus, perceived social support significantly predicted patients' satisfaction with mental healthcare services [ $\beta = .47$ ,  $t = 7.45$ ,  $\rho < .01$ ], accounting for 47% patients satisfaction variance. Satisfaction with other Life Domains also significantly predicted patients' satisfaction, contributing 31% of the satisfaction variance [ $\beta = .31$ ,  $t = 4.82$ ,  $\rho < .01$ ]. Therefore, the sixth hypothesis that perceived social support will significantly predict satisfaction with mental healthcare services more than satisfaction with other life domains is supported.

**Hypothesis 7:** *Clients' demographic characteristics (age, sex and level of education) will account for a significant variance of patients' satisfaction with mental healthcare services.*

Multiple regression using dummy variables was performed to test this hypothesis. The variables (sex and level of education) which are categorical variables were transformed into dummy variables to meet the requirement for regression analyses. Sex was transformed into one dummy variable because it has only two levels (male and female, with female as the baseline). Level of education on the other hand was transformed into three dummy variables (no education vs all else, secondary education vs all else, and tertiary education vs all else) because it has four categories. The results of the regression analyses are presented in table 12 below;

**Table 12: Regression Analysis of Demographic Characteristics as Predictors of Satisfaction with Mental Health Care**

Model	B	SEB	$\beta$	<i>t</i>	<i>P</i>
<b>Step 1. Constant</b>	67.4	1.09		61.7	.000
Sex1	-8.61	1.63	-.347	5.28	.000
<b>Step 2. Constant</b>	52.3	2.82		18.5	.000
Sex1	-6.54	1.56	-.264	-4.20	.000
Age	.417	.072	.362	5.76	.000
<b>Step 3 Constant</b>	51.3	3.46		14.8	.000
Sex1	-6.50	1.56	-.263	-4.17	.000
Age	.439	.073	.380	5.95	.000
Basicedu vs all else	-1.29	1.96	-.042	-.656	.513
Secondedu vs all else	4.15	1.98	.133	2.20	.037
Tertiaryedu vs all else	9.96	3.52	.174	2.83	.005

*Predictors: Age, Sex, and Level of Education.*

*Dependent Variable: Patients' satisfaction with mental healthcare services*

### Interpretation

From table 12 above we find that sex significantly contributed to clients' satisfaction variance with being male contributing negatively to about 35% of the satisfaction variance. That is, a change from male to female increases satisfaction with care to about 35% [ $\beta = -.35$ ,  $t = 5.28$ ,  $\rho < .001$ ]. Age also significantly contributed to clients' satisfaction [ $\beta = .36$ ,  $t = 5.76$ ,  $\rho < .001$ ], accounting for 36% of satisfaction variance among mental health patients. The results also show that the contribution of level of education to clients' satisfaction vary according to patients' level of education. For instance, as compared to patients with no tertiary education, those with

tertiary education are 17% more satisfied with care [ $\beta = .17, t = 2.83, \rho = .005$ ]. That is, a move from none tertiary to tertiary level of education increases clients' satisfaction with care by 17%. Having secondary education also increased clients' satisfaction by 13% compared to other levels of education or no education at all. Therefore, the hypothesis seven that Clients' demographic characteristics (age, sex and level of education) will account for a significant variance of patients' satisfaction with mental healthcare services is supported at the .01 level of significance.

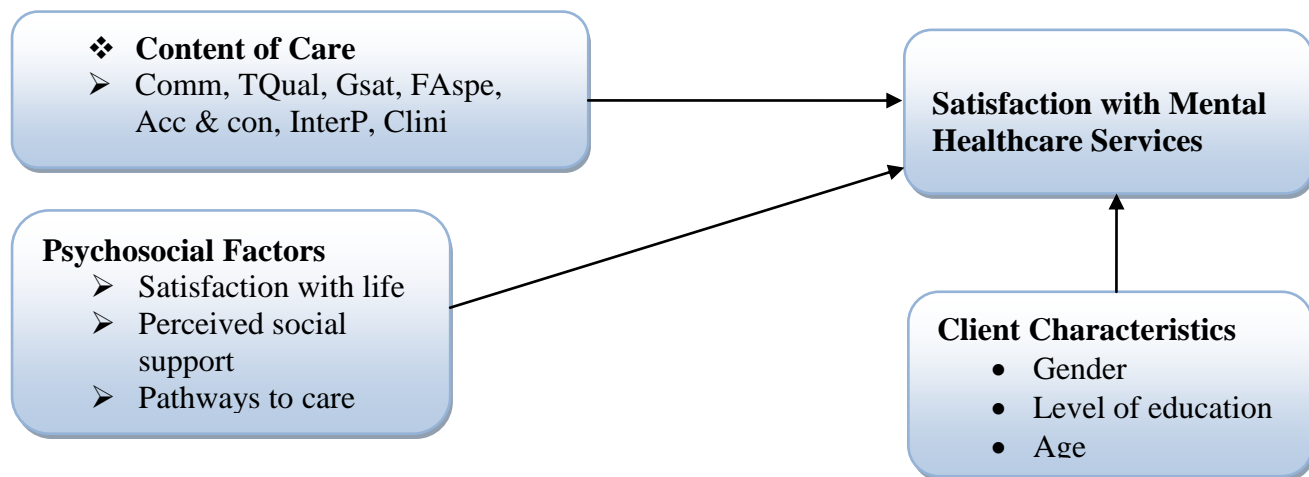
#### **4.5. Summary of Findings:**

- I. There was no statistically significant difference between outpatients and inpatients in their levels of satisfaction with mental healthcare services.
- II. Female mental health patients were significantly more satisfied with mental healthcare services than male mental health patients.
- III. Patients who sought other modes of care prior to coming to the psychiatric hospital were significantly less satisfied with care than patients who did not.
- IV. There was no statistically significant difference in the levels of patients' satisfaction with mental healthcare services at the Pantang and the Accra Psychiatric Hospitals.
- V. There was a statistically significant positive relationship between patients' satisfaction with mental healthcare and (a) their satisfaction with other life domains and (b) perceived social support.
- VI. Perceived social support and satisfaction with other care domains both accounted for a statistically significant patients' satisfaction variance with perceived social support accounting for more of the satisfaction variance.

VII. Clients' age, sex and level of education accounted for a significant clients' satisfaction variance, with being female, older age and higher education associated with higher levels of satisfaction.

**Figure 5**

**Observed Model for Understanding Clients' Satisfaction with Mental Healthcare Services**



The model showed that interaction with the healthcare system, perceived social support, pathways to care as well as the demographic characteristics of gender, age and level of education are not only related to but influenced patients satisfaction with mental healthcare services.

## **CHAPTER FIVE:**

### **DISCUSSION**

#### **5.1. Introduction**

This chapter presents the findings from the study and discusses them with reference to previous studies and the theories of clients' satisfaction that guided this study. Further, the findings are explained to put the outcomes of this study into perspective, taking cognisance of ethno-cultural arrangements and the context within which services are delivered and received. The implications of the study findings as well as recommendations for future studies are also outlined. Lastly, the limitations of this study and conclusions are spelt out.

#### **5.2 Discussion**

Hypothesis 1 examined whether patients' satisfaction levels differ by type of patient (outpatients and inpatients). To test this hypothesis, MANOVA was performed and the result showed no statistically significant satisfaction difference by type of patient. However, a significant difference was observed in the level of patients' satisfaction with mental healthcare services with regard to the domains Technical Quality of care and General Satisfaction. The lack of significant difference in the levels of satisfaction between outpatients and inpatients could be due to the fact that patients were generally satisfied with the mental healthcare services they received at these two psychiatric facilities as measured by this study. The levels of clients' satisfaction with mental healthcare services as measured by the PSQ-18 in this study are presented in figure 4 at page 57.

The observation that patients were generally satisfied with mental healthcare services agrees with trends in the literature that patients generally report high levels of satisfaction with care (Hawthorne, 2006; Ogden, 2006; Adeoti, & Lawal, 2012).

This finding could also be due to the fact that some aspects of care, especially those pertaining to only inpatients (feeding, bedding, ward overcrowding etc) were not measured to establish their effect on patients' satisfaction with services. The indications of this finding also point that, the quality of mental healthcare services provided for outpatients and inpatients at these two psychiatric hospitals could be very similar and do not lead to variations in their satisfaction with services.

For instance, Anderson (2004) in his study 'Villager: Differential treatment in a Ghanaian hospital' observed that, healthcare workers in Ghana profile patients and either treat them with respect or disregard according to their perceived social status. Patients perceived to be from high social status are treated with respect and kindness while those perceived to be from low social status are treated with disrespect and insensitivity.

Hypothesis 2 in this study found statistically significant sex differences in clients' satisfaction with mental healthcare services. Specifically, female clients were found to be more satisfied with the services they encounter than their male counterparts. In fact, the scale of this satisfaction difference between males and females is further explained by the fact that female psychiatric patients were significantly more satisfied with care than male psychiatric patients on all the domains of clients' satisfaction measured by the study.

This observation is largely supported in the literature where females are generally more satisfied with healthcare than males (Cho & Kim, 2007). Even though Awara and Fasey (2008) and other studies did not find any significant satisfaction difference by gender. Yet, in Ghana's ethno-religious structural arrangements, women are generally lower in the social hierarchy than men. These cultural arrangements coupled with the social expectation to respect people in authority may in fact be contributing to female psychiatry patients reporting higher levels of satisfaction with care and not necessarily because they received better care than males.

Aside these two reasons (females receiving better care than males and cultural arrangements limiting their willingness to express their opinions freely), it may also be that female psychiatric patients have lower expectations of the mental healthcare delivery system. As Linder-Pelz's (1985) Expectancy-value theory asserts, patients' assessment of service delivery is informed by their expectations mediated by the social context of service delivery. Thus, high satisfaction would be reported when positive expectations and experiences coincided, and where experiences were as good as or better than what was expected. This means that, if the wider context (Ghana) within which mental healthcare services are delivered confines a section to having low expectations, they would report high levels of satisfaction since those expectations are easily met.

In the same light, it could be argued that male psychiatry patients have unreasonable expectations of the healthcare system thereby making even high quality care unsatisfactory to them. For example, patients generally attend healthcare facility expecting to be cured of their illnesses (Hawthorne, 2008). Yet, in reality some mental health conditions are incurable but can only be managed. There could be other explanations why female psychiatry patients reported

higher levels of satisfaction than their male counterpart, but not all female respondents in this study reported higher levels of satisfaction with care than their male counterparts.

As such, this result is a trend and does not reflect every individual case. Mental healthcare professionals should therefore not rely on the outcome of this finding and not treat each female mental health patient as a special case deserving of unique services tailored to her needs.

Further, results from testing for hypothesis 3 found that patients' experience of other care domains prior to accessing orthodox psychiatry care significantly affected their satisfaction with mental healthcare services. This finding is very important in the Ghanaian context where ethno-cultural explanation of mental illness aetiology are influential in mental health clients' choices of whether to seek help at all and where (Ajzen, 1980).

Studies have shown that clients' belief system about illness aetiology De-Graft (2005), nature of service delivery, accessibility and cost influenced both clients' choice of psychiatry care James, Dorothy, Fred, Joshua, Sheila et al. (2011) and also their satisfaction with experienced care (Weijun, Xuemei, Yan, Xiulan, & Zhiyong, 2013). Given that supernatural world view about the causes of mental illness dominate among many mental patients in Ghana, spiritual solutions (traditional healers, pastors/prophets etc) are usually seen by many as the most appropriate source of care. It is also not uncommon for people with this world view to lack faith in the ability of conventional psychiatric treatment to treat and cure mental illness; leading to their low satisfaction with the care they receive.

The observation by Andersen (2004) that clients are profiled according to their perceived social status and treated with respect and or contempt depending on their perceived social status may also be contributing to this finding. Patients' perceived to be of low social status are often treated by healthcare professionals in unkind, disrespectful and busy-like manner; whilst those seen as coming from high social class are treated in courteous, respectful and dignified manner. Conversely, traditional healers spend time with their clients and listen to their concerns.

Conversely, test results for hypothesis 4 showed no statistically significant satisfaction difference by type of hospital. Thus, patients' levels of satisfaction at the two psychiatric facilities are not significantly different. The reason for this finding may be that healthcare facilities in Ghana face very similar challenges including inadequate staff and equipment for the few available staff to work with. There are not enough facilities as well leading to congestion at the few available facilities. These Challenges are even more precarious when one narrow down to mental healthcare facilities as there are no mental healthcare facilities available in the northern half of Ghana.

Cost of care has also been streamlined by the Ghana Health Service such that prices charged at public healthcare facilities are very similar. Additionally, poor staff attitudes leading to differential treatment of patients also cuts across many healthcare facilities and has been identified by the Ministry of Health as a problem dating back to 2009. Similarly, patients from different parts of Ghana and socioeconomic backgrounds attend both facilities which may have cancelled out the levels of satisfaction and dissatisfaction at both facilities. As such, this finding is consistent with the policy framework as well as the socio-cultural context of mental healthcare delivery in Ghana.

Similarly, test result for hypothesis 5 showed patients' satisfaction with other life domains as a statistically significant predictor of patients' satisfaction with mental healthcare services and accounted for 31% of clients' satisfaction variance. That is to say that, 31% of clients' satisfaction with mental healthcare services is explained by their satisfaction with other life domains. Evidence in the literature corroborates with this finding. For example, satisfaction with life has been shown to protect against adverse health outcomes, including premature work disability and mortality among the general population Koivumaa-Honkanen et al. (2004), fatal injuries and mental health (Gunnell, 2006). In addition, earlier studies have shown satisfaction with mental healthcare services to be positively and significantly correlated with patients' satisfaction in other areas of their lives such as housing, money, and relationships (Blenkiron, & Hammill, 2003).

If satisfaction with life influences clients' satisfaction with mental healthcare as established by this study and others before it Koivumaa-Honkanen et al. (2011); then, it would be helpful to view life satisfaction as an important goal for treatment outcome as noted by Zimmerman, et al. (2008) rather than concentrating mainly on symptom reduction. This is in line with the WHO's definition of health as a state of complete physical, mental and social well-being and not merely absence of disease or infirmity.

In addition, test results for hypothesis 6 found both Perceived Social Support and Satisfaction with other Life Domains as significant predictors of patients' satisfaction with mental healthcare services with the former accounting for more of the satisfaction variance than the latter. These two variables together accounted for 49% of patients' satisfaction variance. Findings using multiple regression analyses show that Perceived Social Support significantly predicted

patients' satisfaction with mental healthcare services and accounted for 47% patients' satisfaction variance. That is, 47% of the variance in patients' satisfaction with mental healthcare services can be explained by their perceived social support. This finding also agrees with earlier studies in that social support enables people to cope better with their life challenges.

For instance, Préau et al. (2012) found social support from friends and family to be significantly and positively associated with complete satisfaction with care among HIV/AIDS patients. In fact, they recommended for more attention to be given to patient satisfaction, especially for socially vulnerable patients (which include mental healthcare patients), in order to avoid potentially detrimental consequences such as poor adherence to treatment regimes.

When individuals believe that the support they require is available and adequate, they feel better able to cope with their illness which enhances their well-being as well as satisfaction with care. This claim is supported by an earlier study finding that, the support network of friends and family gave elderly patients with social support both information about eating healthy and the confidence that they could choose healthy over unhealthy foods (Anderson, Winett, & Wojcik, 2007). That is, a good social support network could provide patients with information on adhering to medication, keeping appointments and other measures to avoid relapse. Similarly, mental health clients may need support for housework (cooking, house cleaning, taking care of children etc) and personal hygiene that may be stressful to the patient.

This finding is particularly relevant in Ghana which is gradually shifting from being a pluralistic society to an individualist one. The study finding therefore indicates that when patients perceive that they have adequate social support from friends, family and significant others like their

primary caregivers; they would be satisfied with the healthcare services they receive. The lesson mental healthcare providers could learn from this finding is to explore mental health patients' support networks as part of the treatment process and engage their family and friends on ways they could explore the patients' needs and provide the needed support in ways that are acceptable to the patient.

Lastly, test results for hypothesis 7 using multiple regressions analysis found that, patients' demographic characteristics including age, sex and level of education significantly predicted satisfaction with mental healthcare services. The higher one's level of education the more satisfied with care he/she is. We found in the previous chapter that moving from no education to basic education did not result in any statistically significant increase in satisfaction with care. However, having tertiary education for example increases patients' satisfaction by about 17% compared to not having tertiary level education.

This finding contradicted studies that showed higher satisfaction for clients' with less education compared to those with higher education (Hall, & Dornan, 1990; Cho, & Kim, 2007; Al-Windi, 2005). Perhaps, patients with low levels of education have lower expectations which are easily met by the healthcare system; in a well structured care environment where all patients are treated equally according to their needs.

This finding however, supported Anderson's (2004) assertion that, patients in Ghana seem to be profiled and treated according to their perceived social status. Since higher education is generally associated to higher socioeconomic status in a developing country context like Ghana, such patients are likely to receive better care and thus be satisfied with their care. This claim

also agrees with the theorists who posit that high satisfaction would be reported where experiences were as good as or better than those of others (Fox, & Storms, 1981; Linder-Pelz, 1985). Thus, when patients know that the mental healthcare services they receive are relatively better than the services other clients receive they would report higher levels of satisfaction.

### **5.3. Limitations of the Study**

This study has some limitations that are worth sharing. The study relied on client's self-reports which in some instances has been found to be influenced by social desirability bias as reporting satisfaction with care might be considered a sensitive topic for some clients. Secondly, the study sampled only adult mental health patients, as such this findings do not reflect the experiences of none adult populations. Similarly, the questionnaires that were adopted for this study were all developed in the developed West and may not adequately capture all the variables patients in the Ghanaian context used to judge themselves as satisfied.

### **5.4. Recommendations**

The recommendations following the outcomes of this study are categorized under two main headings of Practical Recommendation and Future Studies.

#### **5.4.1. Practical Recommendations**

The results from this study present real and practical implications for mental healthcare service providers in Ghana and similar contexts. Patients' experiences affect their satisfaction with care which in turn has been found to affect their future behaviour and mental healthcare outcomes. Every individual patient should be treated as a unique case and needs tailor-made services according to his/her circumstances. Clinical Psychologists in private practice in particular need

to take clients' satisfaction particularly seriously if they are to become very competitive since their direct competitors in the form of traditional priest and prophets/pastors' modes of treatment fit well in the current predominant world view of mental illness aetiology. As such, perceived cause(s) of mental illness is worth exploring for every patient, especially during the assessment stage of the treatment process, to determine whether psychoeducation needs to be incorporated in the patient's treatment.

Further, this study showed that patients who sought treatment elsewhere before seeking treatment at the psychiatric hospitals are less satisfied with care than patients who did not. As such, mental healthcare providers need to be cognisance of this and make extra effort to meet the expectations of such patients if they are to be satisfied with care. This could be done by exploring patients' treatment expectations and integrating it into the treatment regime. Knowing a patient's expectation in advance of commencing treatment will allow for unrealistic expectations to be dealt with as part of the treatment process.

Additionally, since females were significantly more satisfied with care than males, varying treatment procedures for male clients to allow them more active participation in the treatment decision making process might help. This is so because evidence points that the masculine male identity of some African men makes them want to be in charge of decision making and guiding them to be in charge of treatment decision making could improve satisfaction with care. Lastly, there is the need for a referral system to be instituted to reduce the amount of time patients' spend waiting in long queues to be attended to by professionals. Patients also need to be more assertive and demand their rights rather than being passive recipients of whatever care is available.

There is a need to organise refresher courses, on ethics in particular, for healthcare providers to train them to treat patients according to their illness needs and not based on social status. Similarly, patients need to be educated on their rights to help strengthen the healthcare delivery system. The patient charter of 2005 is a good step, but having the charter is one thing and patients knowing about it and demanding for their rights is a completely different thing.

#### **5.4.2. Future Studies**

As a recommendation for future studies, it would be advisable to examine the contribution of hospital residential facilities to the satisfaction variance, so that the inpatient exclusive services like (meals, beddings among others) could be controlled for to allow a more rigorous comparison of inpatients and outpatients. A comparison could also be made between mental health and medical health patients in a facility like the Pantang hospital which provides both services to see if their satisfaction rates vary. Also, future studies should explore other possible domains of care paying particular attention to ethno-cultural nuances like respect, greeting and others that may be relevant in the Ghanaian context.

#### **5.5. Conclusion**

Mental illnesses are a growing concern in most countries including Ghana. It is estimated that one in four people in the world would suffer from mental illness at some point in their live. Evidence in the literature points that clients' satisfaction with mental healthcare services serves both as a measure of quality of care and predictor of important mental health outcomes such as adherence to clinician advice, keeping appointments and seeking alternative care. As such, data obtained from patients' satisfaction surveys can be useful in improving mental healthcare outcomes and identifying patients likely to disenroll.

Satisfaction with healthcare studies are mostly conducted using surveys, but satisfaction studies on mental health clients are scanty and almost none existent on mental health patients in Ghana. This study examined clients' satisfaction with mental healthcare services in the Ghanaian context and established no statistically significant satisfaction difference between outpatient and inpatients. The study also found that female mental health patients were significantly more satisfied with care than male patients across all the domains of satisfaction measured. There was no satisfaction difference by type of hospital (Pantang and Accra Psychiatric Hospital), but patients were generally satisfied with mental healthcare services.

Perceived social support and satisfaction with other life domains were all found to be positively correlated with satisfaction with mental healthcare services. Additionally, perceived social support and satisfaction with other life domains significantly predicted satisfaction with services with perceived social support accounting for more of the satisfaction variance. The demographic variables of age, sex and level of education also significantly predicted clients' satisfaction with services.

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## APPENDICES

Department of Psychology  
University of Ghana-Legon

### Appendix A: QUESTIONNAIRE

I am a student of Legon and undertaking this project in partial fulfillment in the award of the MPhil degree in clinical psychology at department of psychology. The questionnaire is to collect data on your satisfaction with mental healthcare services you received at this facility. The data collected is for academic purposes and all information provided shall be treated as confidential.

#### **Section 1: Biodata**

1. Age .....
2. Sex F ( ) M ( )
3. Marital Status: Single ( ) Married ( ) Divorce ( ) Widowed ( )
4. Educational Level: None( ) Primary( ) JSS/Middle( ) SSS/O' Level( ) Tertiary ( )
5. Religion: Christian( ) Islam( ) Traditional Religion( ) other, please specify .....

#### **Satisfaction with Life Scale**

**Instructions:** Below are five statements that you may agree or disagree with. Using the 1-5 scale below, indicate your agreement with each item by placing the appropriate number in the box to the right of the statement. Please be open and honest in your responding.

- 5 – Strongly agree
- 4 – Agree
- 3 – Neither agree nor disagree
- 2 – Disagree
- 1 – Strongly Disagree

1. In most ways, my life is close to ideal.
2. The conditions of my life are excellent.
3. I am satisfied with my life.
4. So far, I have gotten the important things I want in life.
5. If I could live my life over, I would change almost nothing.

**PATIENT SATISFACTION QUESTIONNAIRE (PSQ-18)**

These next questions are about how you feel about the mental healthcare you receive.

On the following pages are some things people say about mental healthcare. Please read each one carefully, keeping in mind the mental healthcare you are receiving now. (If you have not received care recently, think about what you would expect if you needed care today.) We are interested in your feelings good and bad about the mental healthcare you have received.

How strongly do you AGREE or DISAGREE with each of the following statements?

(Circle One Number on Each Line)

	Strongly Agree	Agree ...	Strongly Uncertain	Disagree	Disagree
1. Mental healthcare professionals are good at explaining the reason for my treatment.	1	2	3	4	5
2. I think my doctor's office has everything needed to provide complete mental healthcare .....	1	2	3	4	5
3. The mental healthcare I have been receiving is just about perfect .....	1	2	3	4	5
4. Sometimes mental health professional make me wonder if their diagnosis is correct .	1	2	3	4	5
5. I feel confident that I can get the mental healthcare I need without being set back financially .....	1	2	3	4	5
6. When I go for mental healthcare, they are careful to check everything when treating and examining me .	1	2	3	4	5
7. I have to pay for more of my mental healthcare than I can afford .	1	2	3	4	5
8. I have easy access to the mental healthcare specialists I need ..	1	2	3	4	5

	Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree
9. Where I get mental healthcare people have to wait too long for treatment .....	1	2	3	4	5
10. The mental healthcare workers act too businesslike and impersonal toward me ...	1	2	3	4	5
11. The mental healthcare professionals treat me in a very friendly manner.....	1	2	3	4	5
12. Those who provide my mental healthcare sometimes hurry too much when they treat me .....	1	2	3	4	5
13. The mental healthcare professionals sometimes ignore what I tell them.....	1	2	3	4	5
14. I have some doubts about the ability of the professionals who treat me .....	1	2	3	4	5
15. Professionals usually spend plenty of time with me when treating me	1	2	3	4	5
16. I find it hard to get an appointment for mental healthcare right away.....	1	2	3	4	5
17. I am dissatisfied with some things about the mental healthcare I receive	1	2	3	4	5
18. I am able to get mental healthcare whenever I need it .....	1	2	3	4	5

### Multidimensional Scale of Perceived Social Support

**Instructions:** We are interested in how you feel about the following statements. Read each statement carefully. Indicate how you feel about each statement.

Circle the “1” if you **Strongly Disagree**

Circle the “2” if you **Disagree**

Circle the “3” if you **Neutral**

Circle the “4” if you are **Agree**

Circle the “5” if you **Strongly Agree**

1.	There is a special person who is around when I am in need.	1	2	3	4	5	SO
2.	There is a special person with whom I can share my joys and sorrows.	1	2	3	4	5	SO
3.	My family really tries to help me.	1	2	3	4	5	Fam
4.	I get the emotional help and support I need from my family.	1	2	3	4	5	Fam
5.	I have a special person who is a real source of comfort to me.	1	2	3	4	5	SO
6.	My friends really try to help me.	1	2	3	4	5	Fri
7.	I can count on my friends when things go wrong.	1	2	3	4	5	Fri
8.	I can talk about my problems with my family.	1	2	3	4	5	Fam
9.	I have friends with whom I can share my joys and sorrows.	1	2	3	4	5	Fri
10.	There is a special person in my life who cares about my feelings.	1	2	3	4	5	SO
11.	My family is willing to help me make decisions.	1	2	3	4	5	Fam
12.	I can talk about my problems with my friends.	1	2	3	4	5	Fri

## WHO Encounter Form

### 1. Basic Information

a) Name of facility at which the form is filled  
in \_\_\_\_\_

b) Date: \_\_\_\_\_

c) Patient's code: \_\_\_\_\_

d) Date first seen by mental health service: \_\_\_\_\_

e) What was the first symptom developed by patient?  
\_\_\_\_\_  
\_\_\_\_\_

f) How long ago? (Number of months)  
\_\_\_\_\_

g) Patient's diagnosis: \_\_\_\_\_

### 2. The Decision To First Seek Help

a) Who was first seen?

0 = traditional healer/herbalist

1 = pastor/ malam

3 = medical practitioner/general hospital

4 = psychiatric hospital

5 = any other, state \_\_\_\_\_

b) How long ago? (number in months): \_\_\_\_\_

c) Who initiated first contact?

0 = patient himself/herself

1 = family relative

(specify \_\_\_\_\_)

2 = friend/neighbors

3 = workmates/schoolmates

4 = employers

5 = other, specify \_\_\_\_\_

d) What symptoms caused  
decision to seek treatment? (specify):  
\_\_\_\_\_

e) What treatment(s) was offered?  
\_\_\_\_\_

### 3. The First Referral

a) Who was next seen?

0 = traditional healer/herbalist

- 1 = pastor/mallm
- 3 = medical practitioner/general hospital
- 4 = psychiatric hospital
- 5 = any other, state\_\_\_\_\_

b) How long ago? (number in months): \_\_\_\_\_

- c) Decision taken by whom?
- 0 = patient himself/herself
  - 1 = family relative  
(specify\_\_\_\_\_)
  - 2 = friend/neighbors
  - 3 = workmates/schoolmates
  - 4 = employers
  - 5 = other, specify\_\_\_\_\_

d) What symptoms caused  
decision to seek first referral? (specify):  
\_\_\_\_\_

e) What treatment(s) was offered?  
\_\_\_\_\_

**Thank you.**

## Appendix B: CONSENT FORM

### NMIMR-IRB CONSENT FORM TEMPLATE

**Title:** Assessing Clients' Satisfaction with Mental Healthcare Services in Accra, Ghana.

**Principal Investigator:** Dramani Yakubu

**Address:** [Department of Psychology, University of Ghana-Legon, P. O. Box LG 84, Accra]

#### General Information about Research

This study aims to explore clients' satisfaction with mental healthcare services in Accra, as well as the variance of satisfaction accounted for by clients' characteristics, their satisfaction with other life domains, perceived social support and pathways to care. Respondents are expected to fill four questionnaires to illicit information for this study. Each participant will spend approximately 15 minutes in filling these questionnaires.

#### Possible Risks and Discomforts

This study would not expose participants to risk higher than they would normally face in the course of seeking mental healthcare since they would not be exposed to any physical or experimental activities. However, the researcher would be available to provide help for any participants who may experience distress as a result of their participation in this study.

#### Possible Benefits

The possible benefits of this study would be enormous. Upon completion, the study would increase our understanding of clients' satisfaction with mental healthcare services in our psychiatry hospitals in Accra, as well as the variance of satisfaction accounted for by clients' characteristics, satisfaction with other life domains and experience of other care modalities. It would inform mental healthcare professionals and policy makers, from the user's perspective, about the mental healthcare services that need improvement.

#### Confidentiality

You are assured of confidentiality in this study since your name would not be requested and matched with responses given. Additionally, confidentiality of the information you provide would be ensured by securing a location where you will fill the questionnaire privately or with the help of the researcher. Again, your responses would be treated as confidential information and used for academic purposes only. In summary, all possible means would be used to ensure that the information you provide is confidential including shredding the questionnaires and destroying tapes once the data has been processed.



**Compensation**

If you agree to participate in this study you would be given GH¢ 2 after filling the questionnaire as compensation for your time and effort in completing the questionnaire.

**Voluntary Participation and Right to Leave the Research**

Your participation in this study is voluntary (not compulsory). The researcher would respect your right to ask questions to clear any doubt you may have about any aspect of the study before agreeing to participate. You have the right not to participate in this study or to complete it should you desire with no repercussions to you.

**Contacts for Additional Information**

In case of any questions or issues about this study please contact:

The principal investigator: Dramani Yakubu, Tel: 054 3670500, Email: [ydkangrek@yahoo.com](mailto:ydkangrek@yahoo.com)

**Your rights as a Participant**

This research has been reviewed and approved by the Institutional Review Board of Noguchi Memorial Institute for Medical Research (NMIMR-IRB). If you have any questions about your rights as a research participant you can contact the IRB Office between the hours of 8am-5pm through the landline 0302916438 or email addresses: [nirb@noguchi.mimcom.org](mailto:nirb@noguchi.mimcom.org) or [HBaidoo@noguchi.mimcom.org](mailto:HBaidoo@noguchi.mimcom.org) . You may also contact the chairman, Rev. Dr. Ayete-Nyampong through mobile number 0208152360 when necessary.



**VOLUNTEER AGREEMENT**

The above document describing the benefits, risks and procedures for the research titled, **Assessing Clients' Satisfaction with Mental Healthcare Services in Accra, Ghana**, has been read and explained to me. I have been given an opportunity to have any questions about the research answered to my satisfaction. I agree to participate as a volunteer.

\_\_\_\_\_  
Date  
\_\_\_\_\_  
Name and signature or mark of volunteer

**If volunteers cannot read the form themselves, a witness must sign here:**

I was present while the benefits, risks and procedures were read to the volunteer. All questions were answered and the volunteer has agreed to take part in the research.

\_\_\_\_\_  
Date  
\_\_\_\_\_  
Name and signature of witness

I certify that the nature and purpose, the potential benefits, and possible risks associated with participating in this research have been explained to the above individual.

\_\_\_\_\_  
Date  
\_\_\_\_\_  
Name Signature of Person Who Obtained Consent



## Appendices C: ETHICAL CLEARANCE

**NOGUCHI MEMORIAL INSTITUTE FOR MEDICAL RESEARCH**  
*Established 1979* *A Constituent of the College of Health Sciences*  
**University of Ghana**

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+233-289-522574  
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Telex No: 2556 UGL GH

**INSTITUTIONAL REVIEW BOARD**



Post Office Box LG 581  
Legon, Accra  
Ghana

My Ref. No: DF.22  
Your Ref. No:

8<sup>th</sup> May, 2013

**ETHICAL CLEARANCE**

**FEDERALWIDE ASSURANCE FWA 00001824**

**IRB 00001276**

**NMIMR-IRB CPN 098/12-13**

**IORG 0000908**

On 8<sup>th</sup> May, 2013, the Noguchi Memorial Institute for Medical Research (NMIMR) Institutional Review Board (IRB) at a full board meeting reviewed and approved your protocol titled:

**TITLE OF PROTOCOL** : **Assessing Clients' Satisfaction with Mental HealthCare Services in Accra, Ghana**

**PRINCIPAL INVESTIGATOR** : **Dramani Yakubu, MPhil Candidate**

Please note that a final review report must be submitted to the Board at the completion of the study. Your research records may be audited at any time during or after the implementation.

Any modification of this research project must be submitted to the IRB for review and approval prior to implementation.

Please report all serious adverse events related to this study to NMIMR-IRB within seven days verbally and fourteen days in writing.

This certificate is valid till 7<sup>th</sup> May, 2014. You are to submit annual reports for continuing review.

Signature of Chairman: .....  
  
Rev. Dr. Samuel Ayete-Nyampong  
(NMIMR – IRB, Chairman)

cc: Professor Kwadwo Koram  
Director, Noguchi Memorial Institute  
for Medical Research, University of Ghana, Legon


**Appendix D: Permission Note from Accra Psychiatric Hospital**

27-02-14

Permission Note

Please permit the bearer of this note the necessary assistance on the ward to complete his project.

Thank you.

for 

ACCRA PSYCHIATRIC HOSPITAL  
NURSING ADMINISTRATION  
RECEIVED  
DATE 27/02/14 @ 10<sup>46</sup> am

## Appendix E: Permission Letter from Pantang Psychiatric Hospital

Pantang Psychiatric Hospital

4<sup>rd</sup> June 2013

*To: In-charges –Psycho OPD, Wards, etc.*

Dear Sir/Madam,

**Letter of Introduction**

**RE: Dramani Yakubu**

The above is an M.Phil student of the Department of Psychology, University of Ghana undertaking a research entitled: "*Assessing Clients' Satisfaction with Mental Healthcare Services in Accra, Ghana*".

He has chosen Pantang Hospital as the focus of his study. Ethical clearance has been acquired from the Ethics Committee of Pantang Psychiatric Hospital.

We will be very grateful if you could let him have access to outpatients and inpatients for his data collection. The location for the interviews will be negotiated between the researcher and the participants. Please ensure that the participants sign or thumbprint the consent forms. Copies of each consent form should be given to Dr. Wozuame by the researcher as evidence.

Attached are copies of his application and ethical clearance from the appropriate agencies.

Thanks for your cooperation.

Yours sincerely,



**Dr. Benedictus Wozuame**

**Chairman, Ethics Committee.**

## Appendix F: Introduction Letter from Ghana Health Service

PSYC 2/33/01

20th May, 2013

The Regional Director of Health Services  
Ghana Health Service  
Greater Accra Region

Dear Sir/Madam,

**LETTER OF INTRODUCTION  
MR. DRAMANI YAKUBU**

The above-named is an M.Phil Clinical Psychology student at the University of Ghana, Legon.

In partial fulfillment of the requirement for the awards of the M.Phil degree Mr. Dramami Yakubu has to write and submit an original thesis. He has selected the topic: **"Assessing Clients' Satisfaction With Mental Healthcare Services in Accra, Ghana"**.

To enable him collect data for his work he would need to administer questionnaires and/or conduct interviews. He has selected Pantang Hospital and Accra Psychiatry Hospital as suitable for his data collection.

Any assistance you may give him would be greatly appreciated.

Yours faithfully,

  
(Dr. B. Amponsah)  
HEAD OF DEPARTMENT

**Appendix G: Patients Demographic Characteristics**

<b>Gender</b>	<b>N (%)</b>
Male	92 (44.9%)
Female	113 (55.1%)
<b>Age Categories</b>	
18-30 years	91 (44.4%)
31-45 years	80(39%)
46-60 years	34(16.6%)
<b>Marital Status</b>	
Single	91(44.6%)
Married	70(34.3%)
Separated/divorced,	33(16.2%)
Widowed	10(4.9%)
<b>Education</b>	
No Formal Education	42(20.5%)
Basic	113(55.3%)
Secondary	40(19.5%)
Tertiary	10(4.9%)
<b>Religion</b>	
Christianity	158 (78.2%)
Islam	41 (20.3%)
Others	3 (1.5%)
<b>Type of Patient</b>	
Inpatient	96 (46.6%)
Outpatient	110 (53.4%)

**Appendix H: Chi-Square, T-tests and Multiple Regression Tables****Summary of Chi-Square of Satisfaction and Dissatisfaction among Psychiatric Patients**

Variable	Satisfied	Dissatisfied	Expected Frequency	df	$\chi^2$	P
PSQ-18	147	58	102.5	1	38.64	.00
Communication	140	65	102.5	1	27.24	.00
Technical	139	66	102.5	1	26.00	.00
General	103	102	102.5	1	.01	.94
Financial	154	51	102.5	1	51.57	.00
Acc	127	78	102.5	1	11.71	.00
interpersonal	120	85	102.5	1	5.98	.02
Clinician	128	77	102.5	1	2.69	.00

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interpersonal	120	85	102.5	1	5.98	.02
Clinician	128	77	102.5	1	2.69	.00

**Table 4: Summary of MANOVA test, Means of scores of type of patient**

Mean Scores	Outpatients	Inpatients	df	F	p	$\eta^2$
<b>PSQ-18</b>	<b>65.50(SD=12.67)</b>	<b>61.39(SD=11.67)</b>	<b>1, 205</b>	<b>5.79</b>	<b>.017</b>	<b>.028</b>
Communication	7.59(SD=1.94)	7.10(SD=1.59)	1, 205	3.75	.054	.018
Technical quality	15.08(SD=3.11)	13.47(3.31)		12.94	.000	.060
General satisfaction	6.99(SD=1.54)	6.10(SD=1.95)		13.18	.000	.061
Financial aspect	7.72(SD=1.67)	7.70(SD=1.23)		.017	.897	.000
Acc & Convenience	13.8(SD=3.04)	13.26(SD=2.60)		1.84	.176	.009
Interpersonal manner	7.13(SD=1.80)	6.99(SD=1.52)		.352	.554	.002
Time with Clinician	7.31(SD=1.43)	6.76(SD= 1.63)		6.64	.011	.032

**Table 5: Summary of MANOVA test, Means of score of Gender**

Mean Scores	Female	Male	<i>df</i>	<i>F</i>	<i>p</i>	$\eta^2$
<b>PSQ-18</b>	<b>67.44(SD=12.12)</b>	<b>58.83(SD=10.97)</b>	<b>1, 205</b>	<b>27.87</b>	<b>.000</b>	<b>.121</b>
Communication	7.89(SD=1.72)	6.72(SD=1.68)		23.86	.000	.105
Technical quality	15.23(SD=3.07)	13.17(SD=3.22)		22.55	.000	.100
General satisfaction	7.14(SD=1.68)	5.88(SD=1.70)		28.36	.000	.123
Financial aspect	7.98(SD=1.50)	7.38(SD=1.39)		8.72	.004	.041
Acc & Convenience	14.29(SD=2.94)	12.63(SD=2.45)		18.83	.000	.085
Interpersonal manner	7.56(SD=1.52)	6.46(SD=1.65)		24.63	.000	.108
Time with Clinician	7.43(SD=1.53)	7.59(SD=1.44)		16.25	.000	.074

**Summary of t test, Means, SD of scores on patients who experienced other care modalities and those who did not.**

Care Experience(s)	<i>N</i>	Mean	<i>SD</i>	<i>df</i>	<i>t</i>	<i>p</i>	$\eta^2$
<b>EOCD</b>	158	61.79	11.87	204	3.91	.000	.122
<b>NEOCD</b>	47	69.55	12.18				

*EW OCD*= experience of other care domains. *NEOCD* = no experience of other care domains.

**Multiple regression results for Demographic characteristics as predictors of clients' satisfaction**

<b>Model</b>	<b>B</b>	<b>SEB</b>	<b>B</b>	<b>t</b>	<b>P</b>
<b>Step 1. Constant</b>	67.4	1.09		61.7	.000
Sex1	-8.61	1.63	-.347	5.28	.000
<b>Step2. Constant</b>	52.3	2.82		18.5	.000
Sex1	-6.54	1.56	-.264	-4.20	.000
Age	.417	.072	.362	5.76	.000
<b>Step 3 Constant</b>	51.3	3.46		14.8	.000
Sex1	-6.50	1.56	-.263	-4.17	.000
Age	.439	.073	.380	5.95	.000
Basicedu vs all else	-1.29	1.96	-.042	-.656	.513
Secondedu vs all else	4.15	1.98	.133	2.20	.037
Tertiaryedu vs all else	9.96	3.52	.174	2.83	.005

**Hierarchical regression of the moderation effects of demographic characteristics on perceived social support and satisfaction with other life domains**

<b>Model</b>	<b>B</b>	<b>SEB</b>	<b>B</b>	<b>T</b>	<b>P</b>
<b>Step 1. Constant</b>	67.4	1.09		61.7	.000
Sex1	-8.61	1.63	-.347	5.28	.000
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