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2015-03-26
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PATIENT SATISFACTION SURVEY ON THE QUALITY OF PSYCHIATRIC CARE AT MOHLOMI PSYCHIATRIC OUT-PATIENT CLINIC IN LESOTHO

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A Research Report submitted to the School of Public Health, Faculty of Health Sciences, University of the Witwatersrand, Johannesburg, in partial fulfilment of the requirements for the Degree of Master of Public Health.

October 2014, Johannesburg.

DECLARATION

I declare that this Research Report is my own. It is being submitted for the degree of Master of Public Health at the University of the Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination at any other University.

Pulane Mphats'oe



_____

29th September 2014

ABSTRACT

Background: Patient satisfaction with health services has widely been associated with increased health-seeking behaviour, improved clinical outcomes, and overall quality of health care. Research that has emerged from the developed world has steered the development of both satisfaction measures, as well as research into patient satisfaction at public health facilities. Despite the importance of patient satisfaction to positive health outcomes, few studies exist in the developing world that examine patient satisfaction levels with public health services. Even fewer exist in the field of public mental health services. This study aims to determine adult patients' satisfaction with dimensions of care at a psychiatric out-patient clinic in Maseru, Lesotho.

Design: The study employs a quantitative cross–sectional study design, using interviewer administered paper-pencil questionnaires, which was adapted from the Charleston Psychiatric Out-patient Satisfaction Scale (CPOS) (Pellegrin, Stuart, Maree, Freuh, & Ballenger, 2001). The sample size for the present study was 271, with 194 females, who comprised the majority of the sample and 77 males. The adapted questionnaire elicited information on patient satisfaction within four specific dimensions of care namely, the staff-patient relationship, administrative services, responsiveness to patients' treatment expectations and waiting times. In addition, a qualitative component including two open-ended questions gauged participants' overall experience of satisfaction and self-reported recommendations on how to improve the clinic services.

Statistical analyses: Univariate analyses were conducted on patient socio-demographic variables and patient satisfaction scale. Subscales of patient satisfaction with the quality of services at the psychiatric facility were created. Bivariate analysis was conducted on

the socio-demographic variables, treatment history, referral source and subscales of the patient satisfaction scale using crosstabs and chi- square analysis. The two open-ended questions were analysed using thematic content analysis, hence identifying the themes and sub-themes.

Results: Univariate analyses showed that across all the 12 items measuring patient satisfaction, patients were mostly highly satisfied with the services. Chi-square analysis showed that age was significantly associated with administrative services (*p=.014)* and waiting time (*p=0.05)* and marginally significantly associated with responsiveness to patients' treatment expectations (*p=.063)*. Results from the open-ended component highlighted that most participants were dissatisfied with aspects pertaining to access to service, waiting times and adequacy of services.

Conclusion: Despite the seeming overall satisfaction expressed with the quality of psychiatric care on a scale of patient satisfaction, disaggregation of the results by subscales, as well as exploration of the open-ended responses from patients suggests that our understanding of patient satisfaction with the quality of mental health services may be limited by methodological issues, where patients felt more comfortable with the non-limiting nature of the open-ended section as opposed to the closed-ended nature of the quantitative section of the study tool. Furthermore, patients who are older may be more likely to show higher levels of satisfaction with care in a context where public health care is often challenging to access. This finding highlights a need for management and other stakeholders to pay more attention to the improvement of services for younger patients, who showed lower satisfaction levels with care. Future research employing mixed methods study designs is also suggested.

DEDICATION

In memory of my cousin

Pearl Ocansey

1978-2014

ACKNOWLEDGEMENTS

I would like to thank the following people for their incredible contribution to the completion of this project:

1. My supervisors Ms. Leane Ramsoomar and Dr. Nonhlanhla Nxumalo for their guidance throughout the project. Leane, I have learnt so much from you, you taught me diligence, how to work quickly and efficiently, and you have in numerous occasions gone the 'extra mile' for me. All this you did with incredible warmth. I was truly blessed to have been assigned as your student.
2. My parents and brothers for their support and constant encouragement throughout this journey. I'm truly grateful for all you have done for me. Pops, you have always been there for me and I am forever grateful for your love and conviction in me. Mummy, you are just a pillar of strength.
3. My cousin for her humorous character and encouragement throughout. Cousy, I cherish all the moments with you, Thank you for bringing such joy in my life, your spirit will live on in each of us.
4. This study would not have been possible without the willing participation of the patients of Mohlomi psychiatric outpatient unit, to whom I am greatly indebted.
5. Last but not least I would love to thank my children: Motheo and Tlotla. You are a true 'breath of fresh air'. Your presence in my life, has brought me such happiness, all of which have been vital to me throughout this period.

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CHAPTER 1: INTRODUCTION

1.1 Mental Health in the African context

The developing country contexts lag behind in terms of putting mental health and associated services on the list of priorities for health (Saraceno, Van Ommeren, Batniji, Cohen, Gureje, Mahoney, Sridhar, & Underhill, 2007). Faced with the burden of HIV/AIDS, tuberculosis and malaria, mental health currently receives less attention than it deserves. This, despite the fact that the WHO has shown that 450 million people suffer from mental disorders in both developed and developing countries, and that one in every four people develop one or more mental disorders at some stage in life (WHO, 2002). Furthermore, in many African countries there is a lack of active mental health policies (Fournier, 2011). According to Bird, Omar, Doku, Lund, Nsereko, & Mwanza (2010) seventy percent (70%) of African countries allocate less that 1% of the total health budget to mental health. This is concerning since Modupeloa (2013) has shown that the financial status of people in African countries may predispose them to mental health problems. Given the lack of attention to mental health as a public health priority, as well as the health sector challenges facing the African continent in general, the quality of care received by mental health patients is called into question (Andaleeb, 2001).

1.2 Patient satisfaction with the quality of psychiatric care

Patient satisfaction with the quality of psychiatric care is well researched in developed countries. Research into patient experience is increasingly important to policy and service development process (Stenhouse, 2011). According to Kuosmanen, Hatonen, Jyrkinen & Katajisto (2006) patient satisfaction is a central indicator for health care

quality. In studies from developed contexts, patients had high satisfaction levels with the overall quality of psychiatric care. Another study by Barak, Szor, Kimhi, Kam, Mester & Elizur (2001) in two outpatient settings also showed that patients were satisfied with the quality of psychiatric care provided. Evidence from developed country contexts has shown that quality of care is determined by various factors, including those that exist within the patients immediate environment, the clinic environment, as well as individual factors related to both the patient and the public health worker (Blenkiron & Hammill, 2003; Summers & Happell, 2003; Perreault, Rogers, Leichner, & Sabourin, 1996; Rosenheck, Wilson, & Meterko, 1997; McCabe & Leas, 2008). However, patient satisfaction differs from one context and one dimension of satisfaction to another. In a Finnish study on patient satisfaction with psychiatric outpatients, they showed that patient satisfaction was highest in areas relating to staff and care, and lowest in areas pertaining to information about their mental health (Siponen & Valimaki, 2003). A Danish study by Kessing, Hansen, Ruggeri, & Bech (2006), showed that patient satisfaction was highest in areas of help provided and low for professionals' contact to relatives.

Despite the importance of patient satisfaction to clinical outcomes, few studies exist in the developing world on the quality of psychiatric services. Olusina, Ohaeri, & Olatuwura (2002) argue that the quality of psychiatric care in Africa is neglected, with only a few published studies on patient satisfaction with the quality of psychiatric services in Africa. In many developing countries, health care has been decentralized. This decentralization of care can impact greatly on performance monitoring of health services, therefore necessitating research into patient satisfaction with health service performance.

1.3 Background

1.3.1. The structure of the health system in Lesotho

Lesotho, a very small, landlocked country in Africa functions on a decentralized health care system. The health care system in Lesotho is organised into the primary, secondary and tertiary levels. There is one tertiary hospital, The Queen 'Mamohato Memorial Hospital (QMMH), which recently took over Queen Elizabeth II hospital (QEIIH) in 2011. QMMH offers specialised tertiary services, and is responsible for the management and administration of the peripheral primary health care clinics in the country. Eighteen district hospitals exist in Lesotho, which offer secondary level care, and three specialist hospitals, The Baylor Pediatric College of Medicine, the Bots'abelo Tuberculosis Hospital and Mohlomi Psychiatric Hospital, which are based in the Maseru district.

Efforts towards decentralisation of primary health care in Lesotho have included the development of various primary health care clinics across the ten districts of the country. Primary health care services are provided by several peripheral clinics, however there are a significant number of patients who by-pass primary health centres to seek primary and secondary care at the tertiary hospital, QEIIH (African Development Bank, 1995). This results in the unanticipated consequence of QEIIH, delivering primary, secondary and tertiary health care (African Development Bank, 1995).

Against the backdrop of a context, that faces existing human resource challenges, this inappropriate referral results in high absorptive demands which could potentially impact negatively on the quality of health care services (Daviaud, Engelbrecht & Molefakgotla, 2000).

In Lesotho, where this study was conducted, there have been no satisfaction surveys on the quality of psychiatric care to date. This study aims to fill in this research gap. The purpose of the study is to determine adult patients' satisfaction with the quality of psychiatric care in Mohlomi outpatient psychiatric clinic. Specifically, the study aims to document satisfaction levels and recommendations for improving the quality of psychiatric care at Mohlomi Hospital's psychiatric out-patient clinic from the service users themselves.

1.3.2 Lesotho Mental Health Law

The Lesotho Mental Health Law (1964) was formed in response to the fact that psychiatric patients in Lesotho during the early 1900's were managed and treated under the care of mental institutions in the Union of South Africa, under the Lunacy Act of 1897 of the Cape (Greenlees, 1897). This law was later highly contested, given the human and ethical violations associated with harm to patients, and absence of respect for rights (Lebina, unpublished manuscript, 2010). The Lesotho Mental Health Law (1964) is still operational and governs policies of the Mohlomi psychiatric hospital. The current Lesotho Mental Health law (1964) has been reviewed and a second draft is awaiting approval. The draft includes administrative policy and guidelines suitable for the current operational context of the hospital, which are not contained in the current Lesotho Mental Health Law (1964) (Personal communication, Mohlomi Psychiatric Hospital, 2011). It is therefore imperative that the quality of service is examined.

1.3.3 The health system structure of Mohlomi psychiatric hospital

The Mohlomi Psychiatric Hospital, located in the Maseru district, is a national referral hospital for psychiatric services, and also serves as the Maseru Mental Observation and Treatment Units (MOTUs). The MOTUs were developed as a strategy for decentralisation of psychiatric services in all the nine districts of Lesotho. The management, supervision and administrative role for MOTUs are assumed by the District hospital management team, while Mohlomi Psychiatric Hospital is responsible for providing technical assistance for the MOTUs. The Hospital does not have written Standard Operating Procedures (SOPs), but is governed by the Lesotho Mental Health Law (1964) on aspects that involve inpatient admission, management and discharge of inpatients. The absence of SOPs for both inpatients and notably for outpatients is concerning and could have serious implications for the management and care of patients accessing services at Mohlomi.

Being the only referral psychiatric hospital in the country, Mohlomi Psychiatric hospital serves a large population of psychiatric patients. As such, service performance challenges, such as staff motivation, administrative load and waiting times must be evaluated as part of psychiatric care experience. Collectively, these factors could potentially compromise the quality of psychiatric care, and ultimately lead to patient dissatisfaction. Any attempts to explore patient satisfaction with the quality of psychiatric care at the Mohlomi Psychiatric clinic are a first step to identifying opportunities for improvement of psychiatric care. In addition, evidence-based research can assist in leveraging larger budget allocations from the MOH to continuously improve services. This study anticipates that improvement in the quality of psychiatric

care is likely to impact positively on treatment compliance and consequently, better treatment outcomes.

CHAPTER 2: LITERATURE REVIEW

2.1 Importance of quality of care in health services

There is a growing interest in the measurement of patient ratings of satisfaction as one marker of quality in psychiatric care (Barak et al, 2001). Patient satisfaction has become a frequently used tool for evaluating programmes and treatment outcomes, as well as an important factor in relation to adherence to treatment and continued psychiatric care (Siponen & Valimaki, 2003; Kessing et al, 2006). According to Daviaud et al, (2000) the quality of care in health facilities is a critical determinant of the utilization of health facilities globally, and without satisfactory quality, service users are likely to become disillusioned. This is likely to impact negatively on mental health seeking behaviour, treatment compliance and overall care (Daviaud et al, 2000). There is growing evidence that the perceived quality of health care services has a greater influence on patient behaviours (satisfaction, referrals, choice, usage) when compared to issues of access and costs (Daviaud et al, 2000; Funk, Lund, Freeman and Drew, 2009; Andaleeb, 2001).

Good quality services help build people's confidence in mental health treatment, ensuring that they are more likely to seek the care they need (Funk et al, 2009). Studies on quality of care have shown that poor quality is a barrier to access and would result in a lower health utilisation rate in the public sector (Daviaud et al, 2000). Due to affordability, the poor are usually more affected by poor quality than wealthy service users, who have the option of seeking private health care (Andaleeb, 2001). According to Funk et al. (2009) improving the quality of mental health care involves respecting the rights of people with mental disorders and provision of the best care possible. This can be achieved by the alignment of policy and commitment of key partners, alignment of

funding, accreditation procedures for services, development and application of service standards, and ongoing routine quality improvement (Funk et al, 2009)

2.2 Patient satisfaction and socio-demographic variables

The influence of socio-demographic characteristics on patient satisfaction is evident in many studies (Blenkiron and Hammil, 2003; Perreault et al, 1996); Rosenheck et al, 1997; Burnett-Zeigler, Ziven, Ilgen, Islam & Bohnert, 2011). A meta-analysis by Hall & Dornan (1990) on patient socio-demographic characteristics as predictors of satisfaction with medical care showed that greater satisfaction was associated with increased age and less education. The same study revealed no association between ethnicity, gender, income and family size with satisfaction. Still some studies show no significant correlations between socio-demographic variables and patient satisfaction (Barak et al, 2001).

Patient age has been reported to be a crucial determinant of satisfaction in psychiatric settings, with evidence showing a positive relationship between increased age and satisfaction. According to Blenkiron and Hammil (2003) **older** patients are more satisfied with psychiatric care than **younger** patients. Some evidence has shown an association between patient satisfaction and gender, with females having reported to have higher satisfaction levels with psychiatric care than men (Perreault et al, 1996). In another study, males were reported to have higher satisfaction with psychiatric care than females (Rosenheck et al, 1997). Regarding marital status and patient satisfaction, the study by Rosenheck et al. (1997) showed that married patients reported more satisfaction than those of other marital statuses. While in another study, married patients reported dissatisfaction with the quality of their care (Burnett-Zeigler et al. (2011).

2.3 Patient satisfaction and treatment history

Studies have shown that treatment history is another factor associated with patient satisfaction, with satisfaction increasing with a longer treatment history (Berghofer, Lang, Henkel, Schmidi, Rudas, & Schmitz, 2001; Kuosmanen et al, 2006). According to Berghofer et al. (2001) long term patients have a significantly more positive impression of care than first time visitors. The relationship between patient satisfaction and socio-demographic variables namely age, gender and marital status in psychiatric settings has been discussed in detail in the above section. The following sections will cover the relationship between patient satisfaction and the four dimensions of care namely staff friendliness, administrative services, waiting time and responsiveness to patients' treatment expectations.

2.4 Patient satisfaction and staff friendliness

According to Hamdan-Mansour & Wardam (2009) patient's perception of staffs' degree of friendliness is related to good quality of psychiatric care. Furthermore poor staff attitudes are a source of dissatisfaction for psychiatric patients and have been reported to hamper effective patient care (McCabe & Leas, 2008). Some international surveys show high patient satisfaction with staff friendliness (e.g. Burnett-Zeigler et al, 2011) while other studies have shown that patients perceived staff to be unfriendly, thereby lowering patient satisfaction (McCabe & Leas, 2008).

The study by Burnett-Zeigler et al. (2011) showed that 96% of patients showed satisfaction with their providers' ability to listen, thereby showing that staffs' ability to listen to patients is an important determinant of patient satisfaction. In contrast patients

in another study complained that doctors were uncaring, distant and did not listen to them, resulting in patients finding it difficult to communicate their health concerns (McCabe & Leas, 2008).

2.5 Patient satisfaction and administrative services

Administrative services refer to the administrative and environmental factors unique to the out-patient setting (Pellegrin et al.,2001). Environmental factors which form administrative services would include location and appearance of the facility. Administrative services form the backbone of any health care facility, thus, their efficiency and patients' experience of the quality of services in this area is of utmost concern. Accessibility of the treatment facility is an important administrative factor in psychiatric care and treatment continuity. An American study by Pickett, Lyons, Seymour, & Miller (1995) showed that patients who do not travel great distances to the psychiatric facility may be more likely to continue treatment, than those who travel long distances. In a study by Rosenheck et al. (1997) patients showed dissatisfaction with administrative services, indicating that factors such as the impersonal and confusing atmosphere of large institutions, timeliness, coordination of care and accessibility of services contributed to the low levels of satisfaction with administrative services. This finding was attributed to the fact that large, more complex facilities and those that specialise in mental health care are less satisfying than others (Rosenheck et al, 1997). This finding is relevant to the current study context, where large numbers of out-patients are seen at a clinic which essentially serves the entire country.

2.6 Patient satisfaction and responsiveness to patients' treatment expectations

According to De Silva & Valentine (2000) responsiveness to patients' treatment expectations refers to an outcome that can be achieved when institutions are mindful of and respond appropriately to the commonly valid expectations of patients. Some factors which would define a facilities' responsiveness to patients treatment expectations would include the extent to which the facilities treatment plan matches the patient's individual needs, and also the amount of information given to the patient by their provider. Satisfaction has been shown to increase when patients and therapists agree on treatment (Kuosmanen et al, 2006). A study by Stenhouse (2011) in an outpatient setting showed that patients expected nurses to approach them and have conversations with them. The failure to do so resulted in great patient dissatisfaction and patients' perception of nurses as uncaring and disinterested (Stenhouse, 2011).

Patients also have an expectation to be provided with information regarding their illness and treatment. Adequate information dispensation to patients about their illness and treatment has been linked to patient satisfaction as shown by a study by Summers & Happell (2003). According to Kuosmanen et al. (2006) the failures of information transfer to patients about treatment and illness are a frequent source of patient dissatisfaction. Brief consultation periods have been linked to patient dissatisfaction as shown by the Australian study by McCabe & Leas (2008) where a large proportion of participants were dissatisfied with the little time doctors spent with them.

2.7 Patient satisfaction and waiting times

Waiting times appear to be critical to patient's evaluation of psychiatric care, with short waiting times described as an indicator of increased patient satisfaction (WHO, 2008). Antonysamy, Wreck, & Wittkowski (2009) in a study in a psychiatric setting, indicated that patients showed satisfaction with the waiting time. In contrast, Summers & Happell (2003) showed that patients were dissatisfied with the long waiting time. This dissatisfaction with long waiting times was shown to be a triggering factor for escalation into aggressive behaviour, causing considerable anxiety for patients and their families, and could lead to the patient leaving the department without being consulted (Summers & Happell, 2003).

2.8 Patient satisfaction with psychiatric care in African countries

In spite of all the challenges facing the health care system in Africa, (some that anecdotally refer to challenges with quality of care) few studies exist in the developing world on the quality of psychiatric services. Of the available studies, Olusina et al. (2002) argue that it is imperative that researchers study the usefulness of patient satisfaction surveys as a measure of the quality of care. Owens and Batchelor (1996), report that 80% or more of psychiatric patients express satisfaction with their care, with few responding negatively, because of the fear of antagonism by staff and possible poor service in the future.

Olusina et al. (2002) conducted a patient and staff satisfaction survey on the quality of the inpatient psychiatric care in a Nigerian general hospital. The study showed that patients were satisfied with the staff-patient relationship but dissatisfied with the time spent with doctors (Olusina et al, 2002). In addition, there was a significant association

between patient age and gender and satisfaction variables (Olusina et al, 2002). Specifically, patient age was significantly associated with perception of access to staff, with patients aged above 25 years more likely than those younger than 25 to feel satisfied with access to staff (Olusina et al, 2002). Furthermore, patients aged above 45 years had the highest satisfaction with access to staff (Olusina et al, 2002). Female patients were significantly more likely than male patients to be satisfied with the ward environment (Olusina et al, 2002). In spite of the relevance of this study to quality of care, it is based on in-patients, who may experience psychiatric care differently to out-patients.

2.9 Study Aim and Objectives

The study aimed to determine adult (18 years and above) patients' satisfaction levels with the quality of psychiatric care at Mohlomi psychiatric clinic. In addition, the study aims to provide recommendations for improving the quality of psychiatric care at Mohlomi hospital's psychiatric outpatient clinic from the perspective of the service users themselves.

The specific objectives are:

- To describe the socio-demographic profile of the patients accessing psychiatric care at Mohlomi psychiatric out-patient clinic between May and June 2012.
- To measure participants' satisfaction levels with the quality of care within four specific dimensions namely, the staff-patient relationship, administrative services, responsiveness to patients' treatment expectations and waiting times at the Mohlomi psychiatric out-patient clinic.
- To obtain a summary measure of patient satisfaction with the quality of psychiatric care at Mohlomi outpatient clinic across all four dimensions.
- To examine associations between key socio-demographic variables and the four dimensions of care among the same sample.
- To document patient recommendations for improvement of the quality of services at Mohlomi hospital's psychiatric outpatient clinic.

2.10 Problem Statement

Given the centrality of the quality of public health service performance, to patients' health seeking behaviours, health care utilisation rates and treatment outcomes, research evaluating the quality of psychiatric care is imperative. In Lesotho, and specifically Mohlomi Psychiatric Hospital, which serves the entire psychiatric treatment needs of Lesotho, there is no available research to the knowledge of the researcher that investigates this neglected, yet critical area. Research into this area has important implications for improving the quality of services.

2.11 Justification for the Study

Despite Mohlomi Psychiatric Hospital being the only referral hospital in the country, to date, there has been no research that examines patients' satisfaction with the quality of psychiatric care in Lesotho. As such, there has been no means of assessing performance against any quality of service indicators, identifying areas for improvement or beginning to understand the potential associations between quality of services and treatment outcomes. The results of the study will guide management and staff to areas for improvement. The findings are likely to ensure better services at the clinic as an attempt to increase patients' health seeking behaviours, treatment compliance and outcome, as well as health care utilisation rates. In addition, it can serve as a performance indicator for justifying the need for larger budget allocations from the MOH, which in turn can continuously improve services. The latter is a key determinant in remaining competitive in the current mental health care context in Africa. This study, which would be the first in Lesotho's attempts to contribute to this knowledge.

CHAPTER 3: METHODS

3.1 Study setting

The Mohlomi Psychiatric outpatient clinic forms the out-patient section of the Mohlomi psychiatric hospital. It is located within the Maseru district in Lesotho, which has a population estimate of 222,880. The hospital serves as the only tertiary hospital in Lesotho and provides specialised psychiatric services for the entire country. The hospital accepts referrals from other health units and mental observation and treatment units (MOTUs), which provide first line psychiatric services, and are distributed in district hospitals in Lesotho. A clinical team which consists of a psychiatrist, clinical psychologist and psychiatric social worker are deployed on a weekly basis from the hospital to provide technical assistance and out-reach services to the MOTUs countrywide.

3.2 Study population

The Mohlomi Psychiatric outpatient clinic, which serves as the MOTU for the Maseru district has a monthly patient count of approximately 1000 outpatients, and provides psychiatric services for patients across a wide age spectrum from early childhood to elderly patients. The demographic profile of patients seeking services at the clinic is mainly Black females aged 35 to 55, presenting mostly with depression and psychotic illness. While men form a smaller portion of the demographic profile at the clinic, a majority of those seen at the clinic are aged between 18 to 35. The main problems for

which men present are substance abuse and psychotic illness. Children who are referred to the clinic are mostly of school going age between 6-12 years old and comprise the smallest proportion of patients. The majority of children present at the clinic with scholastic adjustment problems and childhood depression.

3.3 Study sample

Sampling was conducted using a convenience non-probability sampling technique to obtain a study sample of 271. The sampling approach was to sample as many participants as possible in the research timeframe set by the researcher and as the clinic schedule allowed. The sample consisted of 77 males and 194 females, 'new' (patients whose were consulting for the first time at the facility) and 'returning' (patients that previously consulted at the facility) outpatients. The sample contained 9 'new' patients and 262 'returning' patients. To qualify as a study participant, the following criteria had to be met:

- Adult (18 years and above) male and female patients accessing psychiatric services at the Mohlomi psychiatric outpatient clinic on Wednesdays and Fridays.
- All male and female patients aged 18 years and above who were Sesotho-literate.
- All patients who were stable and non-psychotic (the absence of delusions, hallucinations, confusion, impaired memory as explained by Sadock & Sadock, 2003).

3.4 Measurement

The interviewer-administered questionnaire was adapted from the Charleston Psychiatric Out-patient Satisfaction Scale (CPOS). The CPOS questionnaire was rendered valid and reliable for the United States of America (USA) context, with a Cronbach's alpha of 0.87 (Pellegrin et al, 2001). The original patient satisfaction measure included a 15-item scale, following the pilot study (described below) was adapted to a 12 item scale, which assessed patients' satisfaction with health services on four dimensions of care namely: Staff-patient relationship, administrative services, responsiveness to patients' treatment expectations and waiting times. Respondents were required to rate each item on a five-point Likert scale of 1-5, with 1 being poor and 5 being excellent. A 'not applicable' (N/A) response was included for each item for responses which did not apply to the respondent (*See Appendix D*). The questionnaire also had an open-ended section which consisted of two questions which required respondents to comment further on how services can be improved at the clinic (*See Appendix D*).

3.5 Procedure

3.5.1 Pilot study

An independent research assistant (RA) conducted a pilot study on 10 outpatients who attended the adjoining community rehabilitation unit at the Mohlomi Psychiatric hospital. The community rehabilitation unit provides support and rehabilitation services for substance abusers. This unit, while located within the Mohlomi Psychiatric hospital, functions independently of the outpatient psychiatric unit. The pilot study revealed general acceptability of the questionnaire by the patients. It also showed that there was some interference by some hospital staff members (e.g patients being called in for

consultations ahead of the agreed time and some staff members who chose to do activities such as group counselling during the time anticipated to have been used for the completion of questionnaires) while the participants were filling in the questionnaire, which caused delay in the completion of the questionnaire. Minor changes were made to the original questionnaire to match the patient profile and clinic set-up as follows:

- The pilot study revealed that the questionnaire should be reduced from a 15 item to a 12 item scale due to the irrelevance of some items to the Mohlomi context. The three items that were omitted from the questionnaire following the pilot study are: Parking, Clear and correct monthly bill, and Information provided about payment for services.
- The educational categories under the demographic section were changed to educational levels relevant to the Lesotho context (No education, Primary education, Secondary education, COSC/Matric and Tertiary education).
- The first item in the self-administered questionnaire (Helpfulness of the secretary/admin clerk) was changed to (Helpfulness of the secretary) to suit the clinic context (there is an administration unit in the hospital which does not interact with the patients, therefore the 'admin clerk' option seemed to confuse patients). Based on the above, minor revisions were made to the questionnaire.
- The adoption of the interviewer assisted mode of administration was preferred in order to reduce the chances of participants not completing the questionnaires on time. In order to achieve a better overall response rate on the study, as well as to ensure opportunity for clarity should queries arise, the RA read out each section of the questionnaire to the patients, who would fill the questionnaire as

the RA read out the different sections. The RA was trained to simply read out the questions and provide clarity if requested and not to influence the responses.

- In addition, participants were fluent in Sesotho, as opposed to English, so a decision was taken to administer the questionnaire in Sesotho.

3.5.2 Data collection

The same independent research assistant recruited and administered a paper pencil questionnaire to eligible patients attending the Mohlomi psychiatric out-patient clinic. In keeping with the schedule of the clinic, patients were recruited every Wednesday and Friday, during the month of May (30^{th}) to June (27^{th}) 2012 until the end of the research timeframe for this study. The decision to employ an RA was taken to avoid potential social desirability bias and perceived coercion, associated with having the researcher or a Mohlomi staff member collect the data. During the study period, the research assistant visited the out-patient clinic twice weekly and approached the psychiatric patients in the waiting room, where they were seated, awaiting their consultations with Mohlomi clinic staff. The RA introduced herself, informed the patients of the study purpose and invited them to participate. The RA then presented those patients who met the inclusion criteria with an information sheet and an informed consent form. Following this written informed consent, the research assistant presented the patients with an interviewer-administered paper pencil questionnaire. The questionnaire was administered in the waiting area of the clinic. The RA read out each section of the questionnaire to the patients, who filled in the questionnaire, progressing through the entire questionnaire. This interviewer assisted mode of administration was not initially preferred. However it was deemed necessary to accommodate unforeseen activities such as; doctors taking patients early for consultations, and also to allow time for other unanticipated clinic

activities. The patients then proceeded to drop the completed questionnaires into the collection box.

CHAPTER 4: DATA PROCESSING AND CODING

4.1 Data entry

Data were captured using the *Statistical Package for the Social Sciences* (SPSS) version 20 and analysed using SPSS version 21 (IBM SPSS Statistics; version 21; New York, USA). A 10% sample check was conducted to ensure data entry quality. The captured data was coded and analysed using SPSS version 20. As a general rule, any question/item for which there was more than 15% of data missing was to be excluded from the analysis. However the analysis showed that no question/items meeting this criterion was found.

4.2 Data processing

In order to conduct analysis, existing variables were computed into new variables by changing continuous variables into categorical variables (where appropriate) and coding them (age and treatment history). The categorical variables (gender, marital status, race, employment status, referral source, highest level of education) were also recoded to make categories more manageable for bivariate analysis or where very small cell numbers made analysis less meaningful. The 'marital status' variable was also recoded by reducing the categories for this variable from seven to four. The labels 'married (civil/traditional) living with a spouse', 'married (civil/traditional) not living with a spouse' and 'living in a non-married intimate relationship' were collapsed into one variable titled 'married or cohabiting'. Furthermore the labels 'living in a non-married intimate relationship' and 'never married (not living in a non-married intimate relationship' and 'other' were also collapsed into one variable titled 'single/never married'. The 'marital status' was further recoded to two labels namely 'married' and not 'married' (See Table 4.1 below). The 'highest level of education' variable was

recoded by combining the ‘No education’ and ‘Primary education’ into one variable titled ‘No/Primary education’, and ‘Matric/COSC’ was omitted, therefore leaving this variable with three labels titled ‘No/Primary education’, ‘Secondary education’, and ‘Tertiary education’ (See Table 4.1). The variable titled ‘Referral source’ initially had nine labels which were coded as follows: ‘Self/family/friends’, ‘Employers/work’, ‘Hospital/clinic’, ‘Courts/correctional services’, ‘Religious groups’, ‘Medical doctor’, ‘Social services’, ‘School’, and ‘Other’. However, the referral categories with small numbers were collapsed and the ‘Referral source’ variable was further re-coded into four labels as follows: 1=‘Self-family/friends’, 2=‘Hospitals/Clinics’, 3=‘Medical doctor’, 4=‘Other’.

In order to provide an overview of the levels of satisfaction with care at the psychiatric unit, the categories for the satisfaction, were combined as follows: good, very good and excellent= High satisfaction, while Poor and Fair = Low satisfaction and Not applicable, remained as is.

Data processing for the open-ended section involved reading through all the responses, identifying emerging dominant themes and counting how many sub themes fit into the dominant themes. Based on this process of thematic analysis, the following themes emerged: Access to service, medicine stock outs, time and patient management, waiting times, human resources and staff training, adequacy of services, unmet patient expectations with regard to information received given to them about their illness, and patient involvement in management plans**.**

Table 4.1: Operational definitions of study variables

Variable name	Variable source	Variable operalization	Variable coding	Variable Re-coding
Gender	Demographic section of Questionnaire	Gender of patient	1= male 2 =female	n/a
Age	Demographic section of Questionnaire	This variable was recoded from a continuous variable to age bands	1= 18-30 yrs 2= 31-40 yrs 3= 41-50 yrs 4= 51+ yrs	n/a
Race	Demographic section of Questionnaire	The original variable was recoded based on the frequency of distribution of the race in the sample	1=Black 2=Indian 3=Coloured 4=White	n/a
Marital status	Demographic section of Questionnaire	The original variable was recoded based on the frequency of distribution of marital status in the sample	1=Married or cohabiting 2=Divorced 3=Widowed 4= Single/never married	1=Married 2=Not married
Educational status	Demographic section of Questionnaire	Total education attained by the time of study	1=No education 2=Primary education 3=Secondary education 4=Tertiary education 5=Matric/COSC	1=No/Primary School 2=Secondary education 3=Tertiary education
Employment status	Demographic section of questionnaire	The original variable was recoded based on the frequency of distribution of employment status in the sample	1=Working part time 2=Working full time 3=Not working 4=Apprentice/internship 5=Scholar 6=Disabled/medically boarded 7=Housewife 8=Pensioner 9=Other	
Referral source	Demographic section of questionnaire	The original variable was recoded based on the frequency of distribution of sources of referrals in the sample	1=Self/family/friends 2=Employers/work 3=Hospital/clinic 4=Courts/correctional services 5=Religious groups 6=Medical doctor 7=Social services 8=School 9=Other	1=Self/family/friends 2=Hospital/clinic 3=Medical doctor 4=Other
Treatment history	Treatment history	Time period in which the patient has been accessing psychiatric treatment at Mohlomi	1=First time visitor 2=1-3 months 3=4-6months 5=More than a year	

4.3 Analysis

Univariate frequency analyses were conducted on the socio-demographic variables (age, gender, marital status, population group, education level, employment status) and other variables (referral source and treatment history). Following this frequency analyses were also conducted on all 12 items (after they had been recoded to reflect the categories as recoded above) of the Charleston Psychiatric Outpatient Scale (CPOS) and proportions obtained for the three response categories of the scale (poor, fair=Low satisfaction; good, very good, excellent= High satisfaction and NA) measuring each of the 12 items.

In order to examine satisfaction with treatment along separate dimensions of services, three satisfaction subscales (staff friendliness, administrative services, and responsiveness to patients' treatment expectations) were computed. The waiting time item was excluded from being a part of a subscale, as it had only one item. However, as it could function as a stand-alone measure, it was retained in its stand-alone form in the analysis. Subscales were computed in accordance with Pellegrin et al. (2001) understanding of the different dimensions of treatment satisfaction by summing the items for each subscale and creating a cut off for each subscale based on the mean score.

The staff friendliness subscale was computed by adding two items (helpfulness of the secretary, helpfulness of the services you have received); the administrative subscale was computed by adding four items (appearance of the waiting room, appearance of the office, office hours and location of the out-patient service); the responsiveness to patients' treatment expectations was computed by adding four items (matching of

treatment plan to your individual needs, respect shown for your opinions about treatment, amount of information given about your problem, overall quality of care provided); while the waiting times dimension was measured by one stand-alone item namely amount of time waiting to be seen. The twelfth item (how can we improve our services) was unscored in both the original scale and the adapted questionnaire. It was meant to trigger qualitative responses from the participants.

Following the summing of individual items to compute subscales; dummy variables were computed for the subscales such that each subscale was rated as lower, and higher satisfaction. The subscales for the staff friendliness dimension were 1 = lower, 2 = higher. The administrative services dimension had subscales recoded as 1= lower, 2= higher. The responsiveness to patients' treatment expectations was recoded as 1= lower, 2= higher. Thereafter, bivariate analysis was conducted for the socio-demographic variables and treatment history and these subscales. Cross-tabs and chi-square analysis were conducted to determine associations between socio-demographic variables, treatment history and satisfaction. The *p* value was set at 0.05.

For the open-ended questions section, both questions were collectively analysed thematically. Question one was titled 'how can we improve our service', while Question two was titled 'are there any other comments you would like to provide'. For Question two, 59% of the participants answered that they had no other comments, while the remaining 41% of participants linked their answers to those in Question one, that is 'how can we improve our service'. The responses for question one were coded into themes and sub-themes, which led to the emergence of eight dominant themes namely access to service, medicine stock-outs, time and patient management, waiting times, human resources and staff training, adequacy of services, unmet patient expectations

regarding information received given to them about their illness and patient involvement in management plans, and adequacy of service.

4.4 Ethics

Permission to conduct the study at the facility was obtained from the Director-General's office at the MOH Headquarters, the Director of Mental Health, and the hospital superintendent. Ethical Clearance (Clearance no: M111198) was granted from the Human Research Ethics Committee at the University of the Witwatersrand (*See Appendix A).* In addition to being invited to voluntarily participate in the study and being briefed on the study and its objectives, perceived benefits of the study (that is to improve quality of services) were communicated via an information sheet *(See Appendix B)* to the participants. Only those participants providing informed consent *(Appendix C)* were allowed to participate. In addition, participants were assured of anonymity and confidentiality, as well as the option to withdraw from the study. They were also given the opportunity to ask questions for clarity. To ensure anonymity, patients were not required to write their names on the questionnaires. The patients were also assured that they would be referred to the clinic for medical and psychiatric management should they display any physical, emotional or psychiatric discomfort resulting from participation in the study. Following questionnaire completion, the research assistant personally thanked participants for their willingness to participate in the survey. The patients were also informed that the data would only be accessible to the assistant, and the researcher. The completed questionnaires were stored in a locked cupboard and made accessible only to the assistant, and the researcher. The questionnaires would be kept under lock and key for up to two years, after which they

would be destroyed. In addition, results will be reported as group results, in order to protect any identifying information.

CHAPTER 5: RESULTS

This chapter presents the main results of the study. Socio-demographic details of the sample are presented. In addition, the results of univariate analysis, including treatment history and frequencies of the patient satisfaction scale are presented. Thereafter, bivariate results using the chi-square statistic were calculated by cross-tabulating socio-demographic variables with the three subscales. The open-ended section, where participants made comments about how services at the clinic can be improved is also included. The total sample size used for analysis for all variables is 271, however in some cases, sample sizes vary slightly due to missing cases.

5.1 Socio-demographic findings

Table 5.1 below illustrates the socio-demographic and background characteristics of the study sample. The study sample consisted of 271 adult patients (28.5% males and 71.5% female) with a mean age of 43 years and a median age of 42 years (See Table 5.1). In terms of racial distribution[1], the majority of the sample consisted of Black patients (94.1%), followed by Indians (3.3%) and Whites (2.6%). There were no Coloured patients in the sample. This demographic distribution is in keeping with the profile of the demographic groups living in the Maseru area. The majority of patients fell within the older age-group of 51 years and older (33.2%), followed by the 31-40 age group (25.1%). The 41-50 age-groups comprised the smallest proportion of patients accounting for (19.2%) of the sample (See Table 5.1).

[1] The terms "White, Black, Indian/Asian" refer to demographic markers and do not signify inherent characteristics. They refer to people of European, African, Asian ancestry respectively. Their continued use is important as accurate user profiles assist in identifying vulnerable sections of the population and in planning effective prevention and intervention programmes.

In terms of marital status of the sample, most patients were unmarried (62%), while below forty percent (36.2%) reported to be married (See Table 5.1). The majority of the patients (42.8 %) had no education or had attained primary school education, followed by those who had a secondary education (34.3%), and the least proportion (20.7%) of patients had a tertiary education (See Table 5.1).

Regarding employment status, the majority (42.9%) of the patients were unemployed; while less than ten percent of them were employed part-time (7.5%). The remaining patients' employment status is captured in Table 5.1.

Table 5.1: Socio-demographic and background characteristics of the sample

*N=271	*N	%
Gender		
Male	77	28.5
Female	193	71.5
Race		
Black	253	94.1
Indian	9	3.3
White	7	2.6
Age		
18-30	61	22.5
31-40	68	25.1
41-50	52	19.2
51+	90	33.2
Marital status		
Married	98	36.2
Not Married	168	62.0
Educational status		
No/Primary education	116	42.8
Secondary education	93	34.3
Tertiary education	56	20.7
Employment status		
Full-time employment	68	25.4
Part-time employment	20	7.5
Not working	115	42.9
Apprenticeship/internship	1	0.4
Scholar	24	9.0
Disabled/medically boarded	4	1.5
Housewife	19	7.1
Pensioner	9	3.4
Other	8	3.0

***Totals may not always add up to 271 due to missing values*

5.2 Univariate results: Treatment History, Referral Source and Satisfaction items

In terms of treatment history the majority (78.4 %) of patients were long term service users (more than a year), while first time service users were in the minority (3.4%). Patients who had a treatment history of 7-12 months constituted (6.7%) of the sample, while those who had a treatment history of 1-3 months constituted 5.6% of the sample. The remaining 6.0% consisted of patients who had a treatment history of 4-6 months (See Table 5.2). The most frequently cited source of referrals was by the patients themselves/family/friends (42.4%), followed by Hospitals/Clinics (26%), medical doctors who referred a quarter of the patients (25.7%). The broad category (Other, including, courts/correctional services , social services, and schools and employer/work environment respectively were the least likely (6%) to refer patients for health services (See Table 5.2 below).

Table 5.2: Characteristics of the sample by treatment history and referral source

*N=271 **Totals may not always add up to 271 due to missing values	*N	%
Treatment history		
First-time service users	9	3.4
1-3 months	15	5.6
4-6 months	16	6.0
7-12 months	18	6.7
More than a year	210	78.4
Referral source		
Self/family/friends	114	42.4
Hospitals/clinics	70	26.0
Medical doctor	69	25.7
Other (courts/correctional services, employer/work environment, social services, school and any other category not specified)	16	6.0

Totals may not always add to 100 due to rounding

5.2.1 Patient satisfaction with treatment across the CPOS scale

Results from the patient satisfaction scale showed that across all the 12 items measuring patient satisfaction, patients showed a higher level satisfaction with services at the clinic. The three items for which most patients showed higher satisfaction with are: ‘the helpfulness of the services received’ (87.8%), ‘respect shown for their opinions about treatment’ (87.6%), and ‘the overall quality of care’ (86.6%) See Table 5.3 below. The three items for which most patients showed lower satisfaction with are: ‘amount of time waiting to be seen’ (29.1%), ‘location of the out-patient service’ (27.5%), and ‘appearance of the waiting room’ (24.5%) See Table 5.3 below.

Table 5.3: Frequencies of the 12-item adapted CPOS scale

Item[2]	*N	Proportions in valid percentages (%)		
		Low Satisfaction	High satisfaction	N/A
1. Helpfulness of the secretary	271	40 14.8	225 83.3	5 1.9
2. Helpfulness of the services you have received	271	33 12.2	237 87.8	-
3. Overall quality of care provided	271	34 12.6	233 86.6	2 0.7
4. Amount of information given to you about your problem	271	61 23.3	194 74.0	7 2.7
5. Respect shown for your opinions about treatment	271	27 10.2	233 87.6	6 2.3
6. Matching of treatment plan to your individual needs	271	48 19.0	189 74.7	16 6.3
7. Appearance of the waiting room	271	66 24.5	202 75.1	1 0.4
8. Appearance of the office	271	37 13.9	224 84.2	5 1.9
9. Office hours	271	49 18.9	200 77.2	10 3.9
10. Location of this out-patient service	271	74 27.5	192 71.4	3 1.1
11. Amount of time waiting to be seen	271	77 29.1	187 70.6	1 0.4
12. Overall satisfaction	271	42 16.5	213 83.5	-

.
Item 3 (anchor item) was not included in the total sum of scores for total satisfaction.

5.2.2 The frequencies of the 3 subscales

In keeping with the Charleston Psychiatric Outpatient Scale (CPOS), the patient satisfaction scale was scored by summing the scores of all individual items (except for item 3), which is the anchor item (Pellegrin, et al, 2001). The total possible range of the sum of scores was 12-60. As the scale was adapted to account for contextual differences, the scores from the current study ranged from 17-57, with a standard deviation of 9.332 and a mean score of 42.59. In keeping with results from the frequency analysis, the majority of patients scored on the upper end of the satisfaction scale; that is mostly rating a higher satisfaction with the services at the clinic. Two subscales were created for the total satisfaction scale and recoded into low and high. The frequencies for the two subscales and waiting times are shown in Table 5.4 below:

Table 5.4: Frequencies of the 3 subscales and Waiting Times item

	Low (%)	**High (%)**
Staff Friendliness	22.7	77.3
Administrative Service	48.0	52.0
Responsiveness to Patient Treatment Expectations	35.0	65.0
Waiting Times	48.0	52.0

5.3. Bivariate results

5.3.1 Bivariate analyses results for socio-demographic variables, treatment history, referral source and satisfaction subscales: Chi-square analyses

In this part of the analysis, the associations between socio-demographic variables, treatment history, referral source, the three satisfaction subscales (staff friendliness, administrative services, responsiveness to treatment) and waiting times were examined using cross tabulation and chi-square analyses. The chi-square analysis results showed no significant associations between socio-demographic characteristics (gender) and any of the three subscales and waiting times. Similarly no significant associations were found between employment status, marital status or educational level and any of the three subscales and waiting times.

5.3.2. Socio-demographic variables and satisfaction

Significant associations were found between age and satisfaction with administrative services (χ^2 (3, 250) *p=.014).* Specifically, among the oldest age group (51+), 40.7% of participants rated the satisfaction with administrative services as high. In contrast, only (25.8%) indicated low satisfaction with administrative services. For the youngest age group (18-30), just (16.1%) of participants indicated high levels of satisfaction with administrative services while almost double (30%) indicated low satisfaction with administrative services. See Table 5.5.1.

Significant associations were also found between age and satisfaction with waiting times (χ^2 (3, 250) *p=.014)*. Specifically, 40.7% of participants among the oldest age group (51+) expressed high satisfaction with waiting times, while (25.8%) showed low satisfaction with waiting times at the clinic. Just over sixteen percent (16.1%) of participants who comprised the youngest age group (18-30) indicated high satisfaction with the waiting times at the clinic, while almost double (30%) the participants showed low satisfaction with waiting times at the clinic (See Table 5.5.1).

Marginally significant associations were found between age and satisfaction with the responsiveness to patient's treatment expectations (χ^2 (3, 243) *p=.063)*. Specifically, among the oldest age group (51+), 35.4% of participants rated the satisfaction with the responsiveness to patients' treatment expectations as high. In contrast, (29.4%) of participants indicated low satisfaction with the responsiveness to patients' treatment expectations. For the youngest age group (18-30), just (17.7%) of participants indicated high levels of satisfaction with the responsiveness to patients treatment expectations while almost thirty percent (28.2%) indicated low satisfaction with the responsiveness to patients treatment expectations (See Table 5.5.1).

Tables 5.5 Bivariate analyses results for socio-demographic variables and patient satisfaction subscales

Table 5.5.1 Age by Administrative Services, Waiting times & Responsiveness to Patients' Treatment Expectations

Administrative Services	**Low**	**High**	Chi-square	***p values***	***df***
	***N* (%)**	***n* (%)**			
***N=250**					
Age			10.627	.014	3
18-30	36 (30)	21(16.1)			
31-40	33(27.5)	29(22.3)			
41-50	20(16.6)	27(20.7)			
51+	31(25.8)	53(40.7)			
Waiting Times	**Low**	**High**	Chi-square	***p values***	***df***
	***n* (%)**	***n* (%)**			
***N=250**					
Age			10.627	.014	3
18-30	36 (30)	21(16.1)			
31-40	33(27.5)	29(22.3)			
41-50	20(16.6)	27(20.7)			
51+	31(25.8)	53(40.7)			
Responsiveness to Patients Treatment Expectations	**Low**	**High**	Chi-square	***p values***	***df***
	***n* (%)**	***n* (%)**			
***N=243**					
Age			7.307	.06	3
18-30	24(28.2)	28(17.7)			
31-40	25(29.4)	37(23.4)			
41-50	11(12.9)	37(23.4)			
51+	25(29.4)	56(35.4)			

5.4 Open-ended section

There were 199 responses for the open-ended section which were divided into themes and subthemes, with the dominant themes being access to service, medicine stock outs, time and patient management, waiting times, human resources and staff training, adequacy of services, unmet patient expectations with regard to information given to them about their illness and patient involvement in management plans as shown below.

5.4.1 Access to service

There were 45 responses which indicated participants' complaints of difficulty accessing services and food security issues.

5.4.1.1 Long travel distances

Of the 45 responses by participants, most 34, that is (76%) complained of long distances between the bus stop and the hospital, which posed a major access barrier. The participants recommended that the hospital should arrange a bus shuttle to transport patients between the bus stop and the hospital on an hourly basis, as shown below:

"The hospital is far from the main road, hospital management must make arrangements with transport services to arrange an hourly bus shuttle to drop us at the hospital compound and take us back to the main road after receiving services"(Female patient,55yrs)

5.4.1.2 Unavailability of specialised psychiatric services outside of Maseru

A few participants' indicated that psychiatric services were based in Maseru, which posed an access barrier particularly for patients from remote areas. The participants recommended that more psychiatric clinics should be constructed in remote areas to reduce the high influx of patients to the hospital, as shown below:

"We travel from rural areas for this service. We need psychiatric clinics in the rural areas" (Male, 48yrs)

"We can only access this service in Maseru, and we from rural areas have to travel from far. Management should construct more clinics in rural areas because we all come here for services" (Female, participant, 54yrs)

5.4.2 Medicine stock-outs

A few (4) participants' reported a repeated pattern of medicine stock-outs for long periods at the hospital. The participants indicated that management should devise strategies to combat this problem.

"On many occasions we are told that medication is finished and it takes a long time to arrive at the hospital. Management must make plans to stop this problem" (Female, 53yrs)

"We cannot keep wasting money on transport only to find medication finished" (Male, 49 yrs)

5.4.3 Time and Patient management

Participants reported 14 responses about time and patient management. Six responses reflected participants need for staff to increase their work pace at the clinic. Four responses indicated participants' preference for a one hour extension of clinic, working hours and that the clinic must be operational during weekends and public holidays. Another four responses indicated participants' proposal for patients to be segregated according to their different problems while awaiting services in the waiting room. There were four responses that indicated a need for more efforts on improving in and outpatient care. These responses are indicated below:

"Staff has to work more quickly" (Female, 40yrs)

"We want to have access to psychiatric services during weekends" (Male, 47yrs)

"Clinic operating times have to be increased by one hour, and the clinic must be open during weekends and public holidays" (Female, 45yrs)

"We should be grouped according to our different problems while in the waiting room" (Male, 50yrs)

"Management must increase efforts towards improving care for inpatients and outpatients" (Female, 49yrs)

5.4.4 Waiting times

Waiting times was a predominant theme in the participants responses . There were ten responses for waiting times. Two of the responses showed participants dissatisfaction with the time they waited for services, while eight responses, that is, (80%), specifically indicated participants' complaints of long waiting times to see the doctor and when collecting medication at pharmacy. This is shown below:

"We get her at 6am and leave at 12pm. We wait too long for services" (Male, 39 yrs.)

"We wait too long to see the doctor and at pharmacy when we collect our medicine" (Female, 40yrs.)

5.4.5 Human resources and staff training

There were 27 responses on human resources and staff training. Eleven of the responses indicated participant's need for increased staff, particularly doctors and nurses, with participants advocating increased salaries for nurses and doctors to boost morale. Approximately six responses indicated that interpreters did not convey patients' exact words during clinic consultations, and urged for qualified interpreters to be employed. One participant requested for the employment of Basotho doctors to enhance communication between the doctor and patient. Participants advocated for increased salaries for doctors and nurses salaries to boost their morale. Seven responses reflected participant's requests for the employment of Basotho doctors and training foreign doctors the Sesotho language to enhance communication with patients. Three responses indicated participants need for staff trainings including cleaners on good communication styles. This is indicated below:

"There needs to be more staff, especially doctors and nurses at the hospital" (Female, 39yrs)

"Management should increase doctors & nurses pay to boost their morale" (Male 51yrs)

"The hospital has to hire Basotho doctors, and train foreign doctors Sesotho so we can hear each other" (Female, 49 yrs)

"We need more Basotho doctors" (Male, 52yrs)

"Management should train staff on how to talk to patients well" (Female, 41yrs)

5.5 Adequacy of services

There were a total of 99 responses on adequacy of services. These included poor staff attitudes, administration issues and unmet patient expectations.

5.5.1 Poor staff attitudes

Poor staff attitudes accounted for 42 of the responses. Of these twenty-nine responses (69%) reflected participant's reports that staff (particularly nurses) were unfriendly and lacked respect for patients. Some responses (13) indicated participants' reports of poor attitudes and slow service at the pharmacy department. Participants advocated for improved staff attitudes (particularly at the pharmacy department), increased respect for patients, and prompt service:

"The staff here is unfriendly, especially nurses who lack respect for us. They must respect us" (Female, 39yrs)

"Staff at pharmacy is slow and unfriendly. They have to increase their pace of work" (Male, 49yrs)

5.5.2 Administration (27)

There were 27 responses on administration. 25, (71%) of the responses indicated participants dissatisfaction with the patients' waiting room. The participants recommended that the conditions in the waiting room should be improved by maintaining cleanliness, extending the waiting area space, increasing the number of chairs and setting up heaters in winter and fans in summer. There was one participant who expressed the need for a designated person to receive and inform patients of the order of the day, such as the availability of doctors during clinic days, while in the waiting room. Another participant complained about misplaced patient files and a lack of privacy while seeing the doctor. Participants advocated for proper care of patient files and the need for space to air their complaints:

"*The conditions in the waiting room are poor and they have to be improved" (Male, 44yrs)*

"Someone has to tell us how the day is going to proceed. When doctors are away, we have to know that only nurses will attend to us" (Female, 45yrs)

"Our files always go missing at the clinic. Files must be well kept. I also want to see the doctor in private not with other staff" (Female, 44yrs)

"We should have an opportunity to express our complaints" (Male, 42yrs)

5.5.3 Unmet patient expectations regarding information given to them about their illness and patient involvement in management plans

There were 30 responses on unmet patient education. Twenty of this, (66%) of the responses indicated the need for doctors and staff to inform patients about their individual illnesses and diagnoses. About six of the responses indicated participants requests that doctors should adopt a collaborative approach to patient treatment, and involve patients in the management of their illnesses (such as decreasing dosage/aborting medication when they are well enough). Four responses indicated participants need for their opinions regarding their treatment to be respected. This is indicated below:

"We should each be told about our illnesses and involved in management of our illnesses (e.g. cutting doses/stop meds if necessary)" (Female, 39yrs)

"Staff must respect our views regarding treatment of our illness" (Male, 43yrs)

CHAPTER 6: DISCUSSION

The specific aims of the study were to investigate adult patient satisfaction with the quality of psychiatric care at Mohlomi psychiatric outpatient clinic. The study sample consisted of a majority of Black female participants who were mostly aged 51 and above.

In keeping with findings from previous research (e.g. Barak et al, 2001) univariate results showed that above eighty percent (83.5%) of the participants showed a high satisfaction with the overall quality of care at the clinic, while just (16.5%) rated the quality of care at the clinic as low. However, when the results were disaggregated, age appeared to modify these satisfaction levels. This is not surprising, given that previous literature has shown an association between age (Blenkiron and Hammil, 2003; Hall & Dornan, 1990), and increased levels of satisfaction with psychiatric care. Specifically, the findings support previous research (Blenkiron & Hammil, 2003) that older patients are highly satisfied with psychiatric care and treatment than those that are young.

They (Blenkiron & Hammil, 2003) argue that increased patient satisfaction in older patients could be due to the fact that younger patients have higher expectations than older patients. They also show that older patients have a greater sense of duty not to complain about the services offered, and therefore have more respect for professional staff (Blenkiron & Hammil, 2003). Furthermore Crow, Gage, Hampson, Hart, Kimber, Storey, & Thomas (2002) have shown that old age may prompt more care and respect from providers, and that older patients are more tolerant and understanding of difficulties of the healthcare service delivery system.

The disaggregation of the results also revealed a different picture. When taken together, results showed that patients in the sample were at varying levels of satisfaction, depending on the dimension of satisfaction being measured. This is also in keeping with previous research (Siponen & Valimaki, 2003; Kessing, Hansen, Ruggeri, & Bech 2006).

Of note is the finding that despite most patients (70.6%) indicating high satisfaction with waiting times in the individual item scale, waiting times, when it was computed into a subscale, almost an equal proportion of patients (48% and 52%) rated waiting times as respectively low and high respectively. In addition, the bivariate results show a significant association between satisfaction and patient age. In particular older patients (51+) showed a higher satisfaction with the waiting times among the other aged groups, while in contrast, younger patients (18-30) expressed the least satisfaction with waiting times at the clinic. This finding is supported by previous research e.g. (Summers & Happell, 2003), which showed that long waiting times at facilities were a source of dissatisfaction for patients at health facilities, which also triggered aggressive behaviour and significant anxiety for patients and their families. This according to Summers & Happell (2003) could also result in patients leaving the health facility without being consulted.

Satisfaction with waiting times seems to increase with increasing age. The findings show that the proportion of participants who rated the satisfaction with waiting times as 'high' increased as the ages increased. Below twenty percent (16.1%) of participants who were aged 18-30 rated the satisfaction with waiting times as high, while (22.3%) of those aged 31-40 reported high satisfaction, and (40.7%) of participants who reported high satisfaction with waiting times fell within the 51+ age group. Previous

findings that older adults were more satisfied with treatment than younger patients may explain this finding.

Regarding age and satisfaction similar to satisfaction with waiting times, satisfaction with administration services seems to increase with increasing age. The results indicate that (40.7%) of older participants (51+) showed the highest satisfaction with administration services, while below twenty percent (16.1%) of the younger participants aged 18-30 showed low satisfaction with administration services. A little over twenty percent (22.3%) of participants who fell in the 31-40 age group showed a high satisfaction with administration services. The open ended responses have shown that participants are dissatisfied with access and administrative, factors such as the long distance between the bus stop and the clinic, the absence of specialised psychiatric services in rural and remote areas, the poor conditions in the waiting room, medicine stockouts as well as the time and patient management at the clinic. This is supported by past literature (Pickett et al,1995; Rosenheck et al, 1997) which has illustrated the impact that administration factors such as accessibility of services, long travel distances, timeliness and coordination of care can have on patient satisfaction. Further research on the association between age and administration services is needed.

The findings also show that age was also marginally significantly associated with the responsiveness to patients' treatment expectations. As with previous findings with age and satisfaction and administration services, the findings showed that satisfaction with the responsiveness to patients' treatment expectations increased with increasing age. The results show that (35.4%) of older participants (51+) showed the highest satisfaction with the responsiveness to patients' treatment expectations, while just

below twenty percent (17.7%) of participants showed high satisfaction with the responsiveness to patients treatment expectations, Almost a quarter (23.4%) of participants who belonged to the 31-40 age group and the 41-50 group respectively showed high satisfaction with the responsiveness to patients treatment expectations. The open ended responses showed that participants expressed dissatisfaction with the fact that staff (especially doctors) failed to discuss their treatment and management plan with them. They also seemed dissatisfied with the fact that doctors failed to give them explanations and information about their illnesses, and that their opinions about their treatment were not respected by doctors and staff. Past literature (Kuosmanen et al, 2006; Stenhouse, 2011; McCabe & Leas, 2008; Summers & Happell, 2003) supports these findings that patient satisfaction increases with the extent to which patients are involved in their treatment plans, the amount of information given to patients about their illness and the level of respect shown by staff for patients opinions about their treatment and management plans. However, further research about the association between age and the responsiveness to patients' treatment expectations is needed.

6.1. The Open-ended section

In spite of the high level of satisfaction indicated by initial analyses, the open ended section showed a nuanced picture of the satisfaction. Specifically, seven dominant themes namely: access to service; medicine stock outs; time and patient management; waiting times; human resources and staff training; adequacy of services, unmet patient expectations with regard to information given to them about their illness; and patient involvement in management plans.

About 76% of responses showed participants' complaints of access barriers such as long distances between the bus stop and the hospital, and the fact that psychiatric service are based in Maseru, which hinders access for patients from remote areas. Access issues are of great importance in public health, as shown by Ensor & Cooper (2004) that long distance to facilities negatively impact service utilization and impose costs on individuals, which may reduce demand. It is therefore unsurprising that a high percentage of participant complaints were about issues of access.

Waiting times also featured as a dominant theme, whereby 80 % of responses showed participants dissatisfaction with the time they had to await for doctors consultations and at the pharmacy. Waiting times appear to be critical to patient's evaluation of psychiatric care (WHO, 2008) therefore complaints about long waiting times for consultations should be taken seriously. These findings of dissatisfaction with waiting times are supportive of past research (Summers & Happell, 2003) and therefore reinforce the existing global public health focus of waiting times in health facilities.

Some responses were about participants' dissatisfaction with information. 66% of responses showed participants complaints regarding the information given to them about their illness, while 20% complained that providers failed to involve them in patient management plans. The failure of providers to transfer information to patients about their illness and treatment is a frequent source of patient dissatisfaction (Kuosmanen et al, 2006), therefore these findings support past literature. Furthermore the lack of a clear diagnosis and problematic patient-provider interactions could lead to inappropriate treatment action or compel patients to switch between numerous providers (Goudge, Gilson, Russell, Gumede & Mills, 2009). With the heavy emphasis of patient-provider collaboration in modern medicine and public health, these study findings are concerning and undermine patient empowerment.

6.2 Limitations of the Study

The study had several limitations. The cross-sectional nature of the study, with a non-probability sampling technique means that the findings are merely a snapshot of satisfaction levels among a convenience sample. Given that a convenience sample was used, inferences cannot be generalised to the entire population, but are limited only to the psychiatric outpatient section of Mohlomi clinic. Nonetheless it provides a useful first step to understanding the issues faced by psychiatric clinic attendees. The season in which data was collected (i.e. winter and during national political elections) may have resulted in low patient count on some data collection days. The study focused on outpatients only, thereby limiting the generalisability of the findings only to that subset of patients. As the study required self-report, there is a tendency of participants to underplay or exaggerate their responses. Finally, the study was limited by the need for

the administration of the questionnaire by a research assistant. The presence of an assistant may have resulted in some social desirability bias, whereby patient may have reported what they believed the assistant may want to read. Future studies, employing a mixed methods design and the absence of a research assistant may be useful in countering this bias. Despite these limitations, the results obtained from this study can nonetheless provide a useful starting point for improving the quality of care within an outpatient treatment population that has not previously been examined. As a first examination of treatment satisfaction, this study can point management and staff of Mohlomi clinic in a positive direction with regard to their administrative and treatment services and highlight issues that may not have been previously known or understood.

6.3 Conclusion and Recommendations

The study has shown that across all the 12 items measuring patient satisfaction, patients at Mohlomi psychiatric out-patient clinic were mostly highly satisfied with the services. However the open-ended section and the bivariate results indicated a more nuanced patient perspective of the quality of psychiatric care, with participants having lower satisfaction levels along certain aspects of care. The discrepancy between the univariate results and the open-ended and bivariate sections could be suggestive of the researcher's limited understanding of patient satisfaction with the quality of mental health services. It could also be due to some methodological issues, where patients were more comfortable with the open-ended section as opposed to the pre-determined questions in the other section, which were less open-ended.

The open-ended section showed seven dominant themes namely: access to service, medicine stock outs, time and patient management, waiting times, human resources and

staff training, adequacy of services, unmet patient expectations with regard to information given to them about their illness and patient involvement in management plans. It is recommended that future research employ mixed methods study designs are required to fully explore the quantitative and qualitative aspects of patient satisfaction.

Hospital staff and management should pay attention to the pertinent public health issues raised by patients', and implement improvements that would enhance patient satisfaction. These would include; providing a bus shuttle to transport patients between the bus stop and the hospital; ensuring that staff, especially doctors are punctual for work to avoid long patient waiting times; involving patients in their management plan and providing patients with more detailed information and diagnosis. There is also room for improvement in the procurement process to avoid medicine stock outs and the provision of a suggestion/complaint box for patients. Lastly, future research could assess the role of the care providers' perspectives and how they contribute to the patient's appraisal of satisfaction with the quality of psychiatric care.

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APPENDIX A

Ethical Clearance

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

Division of the Deputy Registrar (Research)

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)
R14/49 Ms Pulane Maphat'soe

CLEARANCE CERTIFICATE	M111198
PROJECT	Patient Satisfaction survey on the Quality of Psychiatric Hospital's Out-Patient Psychiatric Cae at Mohlomi Psychiatric Out-Patient Clinic in Lesotho
INVESTIGATORS	Ms Pulane Maphat'soe
DEPARTMENT	School of Public Health
DATE CONSIDERED	Ad hoc
DECISION OF THE COMMITTEE*	Approved unconditionally

Unless otherwise specified this ethical clearance is valid for 5 years and may be renewed upon application.

DATE 01/12/2011 **CHAIRPERSON** .....
(Professor P E Cleaton Jones)

*Guidelines for written 'informed consent' attached where applicable

cc: Supervisor : Ms L Ramsoor

DECLARATION OF INVESTIGATOR(S)

To be completed in duplicate and **ONE COPY** returned to the Secretary at Room 10004, 10th Floor, Senate House, University.
I/We fully understand the conditions under which I am/we are authorized to carry out the abovementioned research and I/we guarantee to ensure compliance with these conditions. Should any departure to be contemplated from the research procedure as approved I/we undertake to resubmit the protocol to the Committee. **I agree to a completion of a yearly progress report.**

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES

APPENDIX B

Information sheet

Good Day,

I am Pulane Mphats'oe, a Clinical Psychologist at the Mohlomi Psychiatric Clinic, psychology department. As a full-time (block release) student at the School of Public Health, University of Witwatersrand, and as part fulfilment of the requirements towards the Master of Public Health Degree, I am undertaking a study investigating patients' satisfaction with the quality of psychiatric care across four dimensions namely the staff-patient relationship, administrative services and clinic environment, responsiveness to patients treatment expectations and waiting times at the Mohlomi out-patient psychiatric clinic. I would be most grateful if you would consider participating in this study.

Why am I doing this?

Studies have shown that the perceived quality of care in health facilities is a critical determinant of the utilization of health facilities globally, and without satisfactory quality, psychiatric patients and the general public, are more likely to become disillusioned. This is likely to impact negatively on health seeking behaviour and care. However, few studies exist in the developing world on the quality of psychiatric services and Lesotho is no exception, since to date, there has been no research that explores patient satisfaction with the quality of psychiatric care in Lesotho. This has rendered it difficult for policy makers to adequately plan and allocate resources for mental health. Therefore this study would assist mental health practitioners and policy makers at Mohlomi psychiatric clinic in generating insight from the patients'

perspective, on areas to improve upon to ensure better services at the clinic. The research will run for 30 days where participants will be completing self-administered questionnaires.

What do we expect from the participants in the study? As you exit the clinic after your clinical consultation, you will be presented with a self-administered questionnaire which will take a maximum of 15 minutes that you will be required to complete, and a consent form that confirms your agreement to participate in this study. The first section of the self-administered questionnaire will deal with your demographic information while Section 2 will require you to rate the quality of psychiatric care you received today, based on four dimensions of care namely the staff-patient relationship, administrative services and clinic environment, responsiveness to patients treatment expectations and waiting times at the clinic. You will be required to rate each item or question on a scale of 1 to 5 with 1 indicative of poor and 5 indicative of excellent.

Are there benefits to the participants? Yes. Your participation in this research will have long lasting rewards because at the end of the study, I will present the findings to mental health practitioners at Mohlomi psychiatric clinic and policy makers as an effort to improve administration and patient management at the clinic. In addition should you experience any physical, emotional or psychiatric discomforts that require counselling or psychiatric intervention, you will be re-referred to the clinic. Upon completion of the questionnaire, you will be given a sticker which you will present at the refreshment stall for refreshments.

May I withdraw from the study? Certainly, you may do this at any time without having to give a reason. Your responses will be anonymous and you will not be victimized in

any way by not participating or by withdrawing from the study, that is, your treatment for future clinic visits will not be affected.

What about confidentiality? Anonymity and confidentiality will be maintained at all times. No names are required at any stage during the research. The study number will not be linked back to you as the participant and the raw data will be accessible only to the assistant, the researcher and the research supervisors which will be kept in the researchers locker that will be locked at all times. In addition, the findings will be reported as group results, in order to protect any identifying information.

If you have any queries, more information may be obtained from myself on this telephone number (+266) 28313034.

Should you wish to participate, please read and sign the attached consent form and complete the questionnaire and return it to the assistant who will be receiving the questionnaires.

Thank you

Pulane Mphats'oe

APPENDIX C

Informed consent form

CONSENT FORM

I agree to participate in the study titled **PATIENT SATISFACTION SURVEY ON THE QUALITY OF PSYCHIATRIC CARE AT MOHLOMI PSYCHIATRIC OUT-PATIENT CLINIC IN LESOTHO** as outlined in the information sheet.

Signature.....

Date.....

APPENDIX D

Adapted CPOS questionnaire

SECTION 1

DEMOGRAPHIC QUESTIONNAIRE

INSTRUCTIONS

Please answer **ALL** questions

Please not that your names are **not** required on the questionnaire. Please answer all questions. Thank you.

1. Date form completed: ---------/---------/--------

2. Who referred you for treatment? (Please mark the ONE answer most appropriate for you)

a) Self/family/friends
b) Employer/work
c) Hospital/Clinic
f.) Religious group
g.) Health Professional
h.) Social Services

d) Courts/correctional services

i.) School

e) Other (specify**) _____**

3. Are you male or female? **_____**

4. What is your age? _____

5. What population group do you belong to? (Please mark answer with an X)

African	**Asian**
Coloured	**White**

6. What is your highest level of education completed? (Circle grade/option)

None	**1 2 3 4 5 6 7**	**8 9 10 11 12**	**Any Tertiary**

7. What is your current employment status? (Please circle appropriate answer)

a. Working full-time

b. Working part-time

c. Not working

d. Apprentice/internship

e. Student/Pupil

f. Disabled/medically boarded

g. Housewife

h. Pensioner

i. Other (Specify)_____

8. If currently unemployed, what did you do previously?

e. Working full-time
f. Working part-time
g. Not working
h. Apprentice/internship
i. Other (Specify) _____

e. Student/pupil
f. Disabled/medically boarded
g. Housewife
h. Pensioner

9. What is your marital status? ***DQ***

i. Married (civil/traditional) living with spouse
j. Married (civil/traditional) not living with spouse
k. Living in a non-married intimate relationship
l. Divorced
m. Widowed
n. Never married (not living within non-married intimate relationship)
o. Other (specify) _____

SECTION 2: SELF ADMINISTERED QUESTIONNAIRE

Your opinions about us are very important. Please give your honest opinions on each question, but do not give your name. Please rate each item on the following scale of 1-5 with 1 being poor and 5 being excellent. If an item does not apply to you, circle DOES NOT APPLY (N/A)

	Check appropriate box	**Excellent**		**Very Good**		**Good**		**Fair**		**Poor**		**Does Not Apply**
	STAFF PATIENT RELATIONSHIP											
1	Helpfulness of the secretary	5		4		3		2		1		N/A
2	Helpfulness of the services you have received	5		4		3		2		1		N/A
3	Overall quality of care provided	5		4		3		2		1		N/A
	RESPONSIVENESS TO PATIENTS TREATMENT EXPECTATIONS											
4	Amount of information given to you about your problem	5		4		3		2		1		N/A
5	Respect shown for your opinions about treatment	5		4		3		2		1		N/A
6.	Matching of treatment plan to your individual needs	5		4		3		2		1		N/A

	ADMINISTRATIVE SERVICES											
7.	Appearance of the waiting room	5		4		3		2		1		N/A
8	Appearance of the office	5		4		3		2		1		N/A
9	Office hours	5		4		3		2		1		N / A
10	Location of this outpatient service	5		4		3		2		1		N/A
14.	**WAITING TIMES**											
15.	Amount of time waiting to be seen	5		4		3		2		1		N/A

16. Please rate your overall satisfaction from 1 to 5, with 1 being strongly satisfied and 5 being strongly dissatisfied.

Check appropriate box	**Strongly satisfied**		**Satisfied**		**Neutral**		**Dissatisfied**		**Strongly dissatisfied**	
Overall satisfaction	5		4		3		2		1	

16. Would you recommend this program to a friend or family member? (circle one below)

Yes, definitely

Yes, probably

No, probably not

No, definitely not

17. How could we improve our services?

18. Other Comments?

Thank you for your participation!