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Patients' Views Towards Care Received From Psychiatrists

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Background. Measurement of the quality of psychiatric care including assessment of patients' views have become increasingly important as expectations of the standard of care rises.
Method. Attitudes and satisfaction of acute psychiatric in-patients were investigated using a questionnaire looking at satisfaction, patients' views on personal and professional qualities of psychiatrists, empowerment and insight.
Results. The response rate was 79.2% (137 out of 173). Patients with a diagnosis of a non-affective psychotic illness, particularly those lacking insight were significantly less satisfied with their care. Respondents were more satisfied with the personal rather than the professional qualities of the doctors, and less satisfied with their empowerment and doctors' availability.
Conclusions. In-patients' attitudes towards their psychiatric care involves a complex relationship between clinical and sociocultural characteristics. Satisfaction studies can serve as an important monitor and reminder of patient dissent.

Patients' views and the measurement of the quality of care delivered by mental health services are increasingly being seen as an important step towards improving the general quality of clinical care (Kelstrup *et al*, 1993). Quality of care from the psychiatric services and psychiatrists and the patient's satisfaction with that care appears to influence compliance to treatment regimes, promptness in seeking help for further episodes, and the patient's understanding and retention of information (Ware & Davies, 1983). Attitudes also influence treatment outcome and prognosis (Small *et al*, 1965). Patients' satisfaction may be influenced by perceived need, and expectation of care as well as actual experience of care (Williams & Wilkinson, 1995). Allen *et al* (1993) hypothesised that levels of patient satisfaction may also be dependent on the subject's attitudes to life in general, self-esteem and illness behaviour, as well as on the system of care received. Thus Shaw (1986) suggests that patient satisfaction has become an appropriate measure of outcome, an attribute of quality, and a legitimate health care goal.

Patients' attitudes have been reviewed extensively by Weinstein (1981) and most studies and questionnaires originate from the USA. More recently in the UK, mental health professionals are becoming increasingly interested in how patients view them (Myers *et al*, 1990) and this has been emphasised by Government initiatives such as the 'Patient's Charter'. Nevertheless, there has been a relative dearth of published work on patients' views about their care. Perhaps psychiatrists are afraid that patients may view them in an unfavourable light or do not have a particular interest in patients' views. Doctors may regard in-patients as too unwell, psychotic or disturbed to be reliable or appropriate informers (Weinstein, 1981). Sheppard (1993) points to six factors that may be relevant discrepancies when considering patient satisfaction as a means of evaluating mental health care provision. These include the fact that 'satisfaction' *per se* is too general a term to prove a meaningful guide to the way patients think; satisfaction may be related to the way service is given rather than the outcome; patients may be 'blind' to other alternatives while proclaiming satisfaction; simply asking may result in favourable views; one will obtain only a 'snapshot' of views and levels of satisfaction may change significantly from moment to moment; levels of satisfaction may depend more on patients' sociocultural background and expectations than their actual experience of care. Ruggeri (1994) concludes, however, that despite these reservations patient satisfaction remains a necessary although not sufficient factor in the assessment of quality and efficacy of mental health care provision. The aims of this study were to investigate levels of patient satisfaction with their psychiatrists and psychiatric care in general, and to compare patient

characteristics such as diagnosis, voluntary status and insight with satisfaction and attitudes.

Method

Patients studied were acute psychiatric in-patients selected from a number of hospitals in the North London Psychiatric Training Rotation. The questionnaire consisted of 26 statements using a Likert scale (strongly agree, agree, uncertain, disagree and strong disagree). A comments section was included at the end. Statements included direct and indirect questions and were made free of medical jargon and worded as appropriately as possible with an approximately equal distribution of negative and positive statements. Less emotive topics were placed earlier so as to reduce emotional colouring of subsequent responses. The questionnaire was developed from previous research findings (Oppenheim, 1983), clinical impressions of psychiatric and nursing staff, and the views of patients who were interviewed during the pilot work about what was important in the care they received from psychiatrists. The pilot study in 15 day hospital patients showed the questionnaire was easy to complete and all agreed to participate. The questionnaire covered the following areas:

(a) General satisfaction and views of general quality of service.
(b) Attitudes towards psychiatric doctors in terms of: professional qualities and competence; approach and personal qualities; communication and explanation; and availability and convenience of contact.
(c) Other areas, including patient attitudes to their empowerment; questions assessing insight and knowledge about psychiatric training.

Patients were requested to complete the questionnaire after verbal consent was obtained. Those excluded were patients judged by staff to be too disturbed, incoherent or distressed and those who were unavailable (e.g. on leave). Patients were handed questionnaires by one of two investigators, (DB and SS) accompanied by a ward nurse. Patients were given the opportunity to abandon the questionnaire.

Additional data were obtained from the medical notes and interviews with staff, including sociodemographic characteristics, diagnosis, treatment, mental health act status, and level of observation. The additional data were also obtained for those who refused to complete the questionnaire (non-responders). The data were analysed using SPSS-PC and appropriate non-parametric statistical tests, such as χ^2 and Kendall's tau.

Results

One hundred and seventy-three out of the total of 200 in-patients were approached with the questionnaire (27 patients were either too disturbed or unavailable during the period of investigation). Of those approached 137 (79.2%) completed the questionnaire.

The mean age was 40. Ninety-one (52.6%) patients were men and 82 (47.4%) were women. The mean length of stay in hospital of all patients included in the study was 60.3 days. One hundred and thirty-five (78.0%) were White of British Isles origin, 12 (6.9%) were Black Afro-Caribbean, 7 (4.0%) were Black African, 7 (4.0%) were Asian, 5 (2.9%) were White Other and 7 (4.0%) were of other ethnic origin. Eighty (46.2%) of all patients had a diagnosis of a non-affective psychotic disorder (schizophrenia or a paranoid psychosis). Thirty-three (19.1%) had an affective psychosis, 44 (25.4%) had a non-psychotic depression and 16 (9.2%) had other diagnoses including alcohol or drug dependence (8), personality disorder (7) and anorexia nervosa (1).

Comparison of responders with non-responders

There were no significant differences between the responders and the non-responders regarding ethnicity. Non-responders were more likely to be male, suffering from schizophrenia, have a previous history of psychiatric admission, and to have been admitted after assessment in the community rather than via self-referral. Table 1 compares the characteristics of the responders with non-responders.

Table 1
Comparisons between characteristics of the responders and non-responders

Patient characteristics	Responders	Non-responders
Male	68 (49.6%)	23 (63.9%)
Age under 45	96 (70.1%)	24 (66.7%)
Schizophrenia/paranoid psychosis	59 (43.1%)	21 (58.3%)
Self-referral	38 (27.7%)	5 (13.9%)
Domiciliary referral	17 (12.4%)	11 (30.6%)
First admission	28 (20.4%)	2 (5.6%)
Currently on antipsychotics	96 (70.1%)	24 (66.7%)
Currently on a section	54 (39.4%)	12 (33.3%)
Social class five**	119 (86.9%)	35 (97.2%)
Living alone	69 (50.4%)	21 (58.3%)
Total	137	36

**P=0.05

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Satisfaction with psychiatric care

Most (104: 78.2%) patients felt that psychiatric doctors at the hospital were caring (see Table 2) and 61.2% were "satisfied with their care". About one-half of respondents thought psychiatric help was improving and the same proportion felt that overall we have a good psychiatric service. Only 48 (36.9%) felt that psychiatric doctors were better trained than in the past, and just 59 (44.4%) felt they had a say in their own treatment. Negative statements yielded lower satisfaction rates (Table 3). For example, 81 (60.0%) felt psychiatrists depended on drugs too much and most (78: 57.8%) felt doctors always thought they knew best. Only 38 (29.4%) said there were hardly any treatments for the mentally ill. Forty-one (30.3%) of patients thought their doctors used too many technical terms.

The eight questions not included in Tables 2 and 3 are discussed below. Although 73 (56.2%) of responders said they saw the psychiatric doctor every week (16 (12.3%) said they saw the doctor twice a week), 41 (31.5%) said they saw their doctor less than once a week or 'rarely'. Around half (65: 50.4%) said they had seen their consultant three or more times during their admission, whereas 51 (29.1%) said they had never seen their consultant.

Thirty-nine (29.1%) respondents thought they did not have a psychiatric illness, whereas 53 (39.6%) said they did and 42 (31.3%) did not know. Forty-eight (36.9%) thought they needed psychiatric care, whereas 21 (16.2%) disagreed and 61 (46.9%) were uncertain. Fifty-three (39.5%) felt they did not need to be in hospital, whereas 58 (43.3%) felt they did need in-patient care.

Seventy-five (55.1%) of respondents thought all psychiatrists were qualified doctors and 74 (54.5%) thought all psychiatrists were specially trained to read peoples' minds. Twenty-four (18.9%) thought psychiatrists and psychologists were essentially the same.

Factors associated with attitudes towards psychiatric care

Further analysis investigated possible associations between age, and gender, and patients' views about their quality of care. The most salient (taken at face value) attitude statements were selected for comparison. No relationship was found between gender and satisfaction with care.

Age

Older patients were more satisfied with the care they received (Kendall's tau -0.136, $P=0.03$) and were less likely to feel their care could be substantially improved (tau 0.107, $P=0.08$). They were also more likely to think that psychiatric help was improving (tau -0.110, $P=0.07$), overall there was a good psychiatric service (tau -0.241, $P=0.0005$), psychiatric doctors were caring (tau -0.186, $P=0.007$), and doctors listened carefully to their patients (tau 0.202, $P=0.003$). The youngest age group were less likely to feel they had a say in their own treatment (tau 0.148, $P=0.021$).

Patients with a diagnosis of a non-affective psychotic illness

These patients were significantly less satisfied with the care they received ($\chi^2=12.24$, $P=0.02$); more likely to say their treatment could be improved ($\chi^2=21.17$, $P=0.0003$); tended to think there were hardly any useful treatments for people with mental health problems ($\chi^2=8.39$, $P=0.08$); less likely to think psychiatrists knew what they were doing ($\chi^2=21.14$, $P=0.0003$); more likely to say it was difficult to see a doctor ($\chi^2=11.9$, $P=0.02$) and felt psychiatrists depended on drugs too much for treating patients ($\chi^2=8.53$, $P=0.08$).

Patients on a section

Compared to informal patients, patients on a section were significantly less satisfied with the care they received ($\chi^2=12.18$, $P=0.02$); felt many things about their treatment could be improved ($\chi^2=17.8$, $P=0.001$); were less likely to feel psychiatrists knew what they were doing ($\chi^2=12.56$, $P=0.01$), more likely to consider it difficult to see a doctor ($\chi^2=10.31$, $P=0.04$), said psychiatrists depended on drugs too much for treating patients ($\chi^2=13.25$, $P=0.01$) and felt they were not good at communicating with patients ($\chi^2=11.53$, $P=0.02$).

Insight and attitudes

Patients who did not believe they had a psychiatric illness also felt there were many things about their treatment that could be improved (tau 0.214, $P=0.002$), it was difficult to talk to the doctors (tau 0.187, $P=0.005$), and the doctors depended on drugs too much (tau 0.18, $P=0.005$). Patients who said they did not need psychiatric care felt psychiatrists did not know what they were doing (tau 0.267, $P=0.0001$), were not as caring towards their patients (tau 0.03, $P=0.0008$) and were less likely to consider that doctors had explained their treatment clearly to them (tau -0.21, $P=0.002$). Finally, patients who felt they did not need to be in

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Table 2
Patients' attitudes towards positive statements about psychiatric care

Questionnaire statement	Strongly agree	Agree	Don't know	Disagree	Strongly disagree
Psychiatric doctors here are caring towards their patients	18 (13.5%)	86 (64.7%)	15 (11.3%)	7 (5.3%)	7 (5.3%)
I am satisfied with the care I get here	16 (11.9%)	66 (49.3%)	25 (18.7%)	12 (9.0%)	15 (11.2%)
The psychiatrists here know what they are doing	16 (11.9%)	60 (44.4%)	31 (23.0%)	18 (13.3%)	10 (7.4%)
Psychiatric care is improving all the time	18 (13.5%)	49 (36.8%)	41 (30.8%)	18 (13.3%)	7 (5.3%)
Overall we have good psychiatric service	13 (9.6%)	55 (40.7%)	40 (29.6%)	18 (13.3%)	9 (6.7%)
Doctors here have explained my treatment clearly to me	9 (6.8%)	52 (39.8%)	21 (15.9%)	36 (27.3%)	14 (10.6%)
I do have a say in the treatment I receive here	12 (9.0%)	47 (35.3%)	37 (27.8%)	17 (12.8%)	20 (15.0%)
Psychiatric doctors are better trained than ever before	13 (10.0%)	35 (26.9%)	61 (46.9%)	10 (7.7%)	11 (8.5%)

Table 3
Patients' attitudes towards negative statements about psychiatric care

Questionnaire statement	Strongly agree	Agree	Don't know	Disagree	Strongly disagree
Psychiatrists depend on pills and drugs too much for treating patients	30 (22.2%)	51 (37.8%)	23 (17.0%)	23 (17.0%)	8 (5.9%)
Psychiatric doctor always think they know best	21 (15.6%)	57 (42.2%)	30 (22.2%)	24 (17.8%)	3 (2.2%)
There are many things about my treatment here that could be improved	25 (19.1%)	44 (33.6%)	37 (28.2%)	20 (15.3%)	5 (3.8%)
The help available for mental health problems is not good enough	14 (10.7%)	47 (35.9%)	35 (26.7%)	28 (21.4%)	7 (5.3%)
It is hard for me to see a doctor here when I need to	19 (14.3%)	40 (30.1%)	32 (24.1%)	38 (28.6%)	4 (3.0%)
It is difficult to talk to the doctors here about your problems	14 (10.7%)	44 (33.1%)	25 (18.8%)	45 (33.8%)	5 (3.8%)
In general psychiatrists are not good at communicating with patients	13 (9.7%)	31 (23.1%)	31 (23.1%)	49 (36.6%)	10 (7.5%)
Most psychiatric doctors do not listen carefully to what patients say to them	10 (7.6%)	33 (25.0%)	24 (18.2%)	51 (38.6%)	14 (10.6%)
Doctors here use too many technical terms	11 (8.1%)	30 (22.2%)	23 (17.0%)	64 (47.4%)	7 (5.2%)
There are hardly any useful treatments for people with mental health problems	11 (8.5%)	27 (20.9%)	29 (22.5%)	51 (39.5%)	11 (8.5%)

hospital were less satisfied with their general care (tau 0.21, $P=0.0003$), less likely to think psychiatrists knew what they were doing (tau 0.226, $P=0.0008$) and more likely to feel their treatment could be improved (tau 0.217, $P=0.001$).

Discussion

Methodological issues

The response rate was good for a study of this kind (Ruggeri, 1994). This was aided by the design of the questionnaire and recruiting familiar nurses to accompany the investigators when handing out the questionnaires. The use of staff to decide which patients were too disturbed to complete the questionnaire may have given a biased sample. However, it was clear that not all patients were sufficiently settled to fill it in and asking the nursing staff was probably the best option as they are in greatest day to day contact with patients. A number of patients could not be approached at all because they were off the ward (e.g. on leave). However, this problem was minimised by repeated visits to the sites over a period of about a week. Although impractical in the context of busy psychiatric acute units, we would ideally have preferred to have all the patients on the ward at the same time to hand out the questionnaire. There have been conflicting opinions on whether satisfied or dissatisfied patients are more likely to respond to satisfaction questionnaire studies. Nguyen *et al* (1983) suggested that satisfied clients are more likely to return questionnaires than those who are not pleased. In contrast Ware *et al* (1983) found that those more satisfied with the quality of their care tended not to return questionnaires. The response rate of this study suggests that we had a representative sample of the attitudes of the patients on the ward who were capable of responding.

Comments on the results

Respondents appeared happier with certain personal attributes such as being caring, as opposed to

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professional qualities (e.g. training) of the doctors treating them. Personal qualities also scored higher satisfaction scores when compared with communication by doctors. General satisfaction with services lagged behind. The patients were least satisfied with the availability and convenience of getting hold of doctors, and with their empowerment. Dissatisfaction with getting access to psychiatric doctors as an in-patient, may be an important issue bearing in mind findings by McIntyre *et al* (1989), who concluded that simply talking to a care giver, be they a nurse or a doctor, appeared to be what patients viewed as the most helpful aspect of care. In our study there was a high level of ignorance towards the simple aspects of psychiatrists' training (for example, knowledge of whether all psychiatrists are medically qualified) and it would be interesting to look at the views of the general population. Since many positive statements yielded high levels of satisfaction and many negative statements yielded low satisfaction levels the possibility remains that some patients tended to passively agree with statements.

Patients with a diagnosis of a non-affective psychotic illness were much more likely to respond unfavourably to a number of key items. Lack of insight was also associated with regarding doctors and psychiatric services unfavourably. Patients who felt that they did not have a psychiatric illness were less satisfied than those who did not wish to be in hospital. Patients who do not want to be in hospital may well be unhappy with the services and doctors. They may acknowledge that they are unwell, but have a differing view of illness to the doctors. Patients may see the term 'psychiatric illness' as stigmatising and so prefer to regard problems as emotional or physical. A higher level of observation and formal status was associated with dissatisfaction among the more disturbed patients, a finding also noted by Hansson (1989) but diagnosis of a psychosis was not related to satisfaction. Gove & Fain (1977), found no differences in satisfaction between patients admitted formally or informally.

Previous studies have looked at associations between patient characteristics and satisfaction. Lebow (1982) noted an association between 'race' and satisfaction but this has not been a consistent finding. Lebow (1983) found no clear relationship between patient satisfaction and age, education, family size, income, marital status, occupation, religion, sex, social class, and diagnosis. In contrast, Hansson *et al* (1985) noted that some previous studies have suggested that older, married, well-educated and professionally active patients are more satisfied. In our study patients who were more satisfied were older. This may reflect both generational differences in attitude or lower levels of disturbed behaviour (indicated by fewer being on a section). A meta-analysis of the literature on satisfaction with mental health services between 1955 and 1983 (Lehman & Zastowny, 1983) found that chronically ill patients were less satisfied with their treatment. In our study those living alone were less satisfied, probably reflecting the higher level of non-affective psychosis in that group, and a general dissatisfaction related to social deprivation. Lebow (1982) and Kelstrup *et al* (1993) note that other studies have linked low satisfaction and drug abuse, suicidal behaviour and psychosis.

Further study

Most patients in this study had favourable attitudes towards their doctors and the services but a substantial proportion were dissatisfied. We are conducting a one-year follow-up of these patients with the same questionnaire to see if attitudes change. Validity, reliability and internal consistency of the questionnaire are in the process of evaluation.

Future studies should incorporate items on patient expectation, arguably an important factor in how patients view their care (Williams & Wilkinson, 1995), and attitudes to the physical (ward) environment, which has been consistently linked with patient satisfaction (Myers *et al*, 1990). Standardised evaluation of mental status can be helpful in investigating associations between psychological disturbance and attitudes, especially as some professionals feel that patients who are acutely unwell are unable to make rational and reliable comments on their quality of care.

Conclusion

This study highlights the complex nature of patients' satisfaction and suggests that further investigation of the relationship between satisfaction and insight may be fruitful. Further research could usefully evaluate patients' expectations about psychiatric services across a variety of settings. Our study has highlighted those groups of patients who may need more careful explanations of their clinical condition and treatment. This area of research appears fraught with a number of methodological problems and remains relatively underdeveloped. Present findings may help address current concerns of mental health consumers, and aid future planning of mental health services to meet the needs of the users.

Clinical implications

- More needs to be done in educating and communicating to patients what to expect from the psychiatric service.
- Mental health staff particularly doctors need to carefully explain all aspects of management to their patients and the need for this should be emphasised in professional training.
- Auditing of attitudes and levels of satisfaction are useful in the monitoring of the quality of care delivered by mental health care systems and helpful in evaluating and shaping changes in the organisation of care.

Limitations

- Patients' cultural and educational background may lead to misunderstanding of the wording of some of the items.
- Poor concentration, distractibility or dismissive replies of respondents.
- Patients may respond favourably to please doctors.

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