

Evaluation of Patient Satisfaction in a State Reference Center of Bipolar Disorder

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Introduction

The change of view from a paternalist physician-patient relationship towards another based on patient autonomy has led to patients being considered as health care system users. Since this shift of focus, the opinions of patients has been keenly taken into consideration in the strategic plans of quality of the health care departments regarding perceived quality and customers' opinion about the overall quality of the service offered.^{1,2} According to the quality of care delivered by psychiatric services and the quality perceived by the patient, compliance to treatment regimes, promptness in seeking help for further episodes, and the patients' understanding of the disorder vary as does the prognosis of the disorder.³

One way to obtain these opinions is through patient satisfaction questionnaires. Donabedian was one of the first authors to measure quality using satisfaction questionnaires with the aim of integrating patients' opinions into the elaboration of improvement proposals.⁴ Later, numerous studies have reported the opinions of patients related to health care processes and their relationship with medical personnel, mainly within the hospital setting.⁵ After the first visit, receiving an explanation of the likely cause of the disorder and the expected duration of the presenting symptoms were variables that predicted satisfaction. In the follow-up visits, symptomatic improvement increased satisfaction while additional visits for the same symptoms decreased satisfaction.⁶ Therefore, satisfaction in patients can be influenced by the actual experience of care, expectation of care, and the need perceived. With regard to departments of psychiatry, Ruggeri proposed the use of these questionnaires among users of mental health care who had previously been considered as unreliable for participating in opinion studies.⁷ However, successive studies have shown that far from being a scarcely reliable population, the opinions of psychiatric patients are very reliable.⁸ To date, most studies within the psychiatric setting have been focused on hospitalization.⁹ Different questionnaires have shown that variables such as age, diagnosis, and legal situation are correlated with satisfaction.¹⁰⁻¹² Females, younger patients, and those detained were more dissatisfied.¹⁰⁻¹² In the Barker et al. study,³ inpatients with a diagnosis of a nonaffective psychotic illness or with lack of insight were much more likely to unfavorably respond in the satisfaction questionnaire. Interestingly, there is also robust evidence about a positive correlation between satisfaction and adherence: the higher the level of satisfaction, the greater the adherence to treatment in inpatients, therefore foreshadowing a better prognosis of the disorder of these patients.¹³

Fostering the outpatient settings rather than inpatient settings in the last decades has increased challenges for performing satisfaction studies.¹⁴ Patients with schizophrenia or with other psychotic disorders have been described as the least satisfied and with the lowest level of agreement with their therapists.¹⁵ In the Hasler et al. study,¹⁶ patients with somatoform, eating, and personality disorders were less satisfied than patients with affective, anxiety, and adjustment disorders. Symptom reduction and changes in the interpersonal domain were important outcomes associated with patient satisfaction. Patients who perceived improvements in pharmacotherapy as one of the most important treatment outcomes were less satisfied than others. Evidence also showed that coping with specific problems and symptoms was associated with satisfaction among male patients, whereas changes in the interpersonal domain seemed to produce satisfaction among female patients. Regarding psychotherapies, psychoeducation has been reported to increase patients' satisfaction,^{17,18} and in cognitive behavioral therapy for psychosis, high levels of satisfaction were associated with positive therapy expectations and perceptions of the therapist rather than with good clinical outcome.¹⁹ Moreover, when psychosocial factors are not taken into account, patients report greater dissatisfaction and demonstrate lower adherence to follow-up and to the treatments proposed which are key for maintaining patient stability. In a recent article, Easter et al.¹ stated that patients with serious mental illness placed greater emphasis on information about housing, employment, education, and benefits than therapists. Along the same line, agreement between patients and providers was associated with higher levels of patient satisfaction.¹⁵

The main aim of the present study was to evaluate and compare the satisfaction of outpatients attended in a state reference center linked to a tertiary-level hospital, the Bipolar Disorder Unit (BDU) of Hospital Clínic,^{20,21} with that of patients seen in an ordinary community mental health service (CMHS). Based on these results, process indicators were defined, opportunities for improvement were identified, and proposals of improvement were elaborated. Taking into account the current economic trends, this type of studies are essential to identify value processes and propose health care reforms.

Methods

Evaluation of satisfaction

To develop the satisfaction questionnaire, in-depth interviews were performed with the personnel linked to outpatient care (administrative personnel; psychiatrists including board-certified psychiatrists and psychiatrist trainees; psychologists, nursing staff consisting of registered nurses; and social workers).

This first phase led to the design of a self-administered questionnaire which preserves patient anonymity and was approved by all the authors. Anonymity was a matter of concern for the authors since a satisfaction score can be inflated by nonanonymous completion.²² The questionnaire consisted of (a) administrative data: six items including the date, entry and exit time, type of visit (first or follow-up), origin of the patient (within or from outside the reference area), staff performing the visit (psychiatrist, psychologist, nurse, social worker); (b) demographic data: four items (age, sex, education, occupational status); (c) recommendation question about the BDU or CMHS: range in score from 0 to 10; and (d) questions related to satisfaction: 11 items on appointment making, waiting room, staff, facilities, and general satisfaction. Satisfaction was scored according to a 5-item Likert scale (very dissatisfied, dissatisfied, neutral, satisfied, and very satisfied) with visual aids for numbering and emojis. A box indicating “N/A” (not applicable) was also added as well as a blank space for comments, suggestions, and/or recommendations. The staff in each area had similar curriculum vitae and years of experience except for psychiatrists and psychiatrist trainees. The waiting room facilities in the BDU and CMHS were identical regarding media resources.

The Net Promoter Score (NPS) was also calculated.²³ Regarding the recommendation question about the BDU or CMHS, questionnaire responders scoring 6 or below were considered to be detractors, while responders with scores between 7 and 8 were called passives, and those with scores between 9 and 10 were promoters. The NPS was obtained by subtracting the percentage of detractors from the percentage of promoters.

Study participants

Patients were consecutively recruited in the outpatient departments of the BDU and the CMHS of an area of Barcelona called Eixample Esquerre (CMHS-EE) during 2015. The inclusion criteria were patients from 18 to 75 years of age, clinically stable, and able to respond to the questionnaire without help. The exclusion criteria were mood instability, acute intoxication, intellectual disability, or other diseases which impeded responding to the questionnaire. Informed consent was provided by all the participants prior to participation in the study. The same clinical personnel performed the recruitment of both samples.

A total of 152 patients in the BDU and 136 in the CMHS-EE were recruited for the study. The study was approved by the Committee of Ethics and Investigation of the Hospital Clínic of Barcelona. No tangible incentives were given for participation in the study.

Data analysis

A descriptive sociodemographic analysis was carried out. To determine differences between the two population groups (BDU vs. CMHS-EE), the *t* test, χ^2 , and ANOVA with Tukey post hoc analysis were used as appropriate.

The statistical analyses were performed with the Statistical Package for Social Sciences version 18.0 (SPSS Inc., Chicago, U.S.A.). All statistical tests were two-tailed and were performed using a significance level of $\alpha \leq 0.05$.

Results

Sociodemographic characteristics of the sample

The BDU and CMHS-EE samples showed scarce sociodemographic differences except for the level of education ($p = 0.048$) and area of residence ($p = 0.0001$) (Table 1). This latter difference was expected since the patients from the CMHS-EE are by definition from a particular area of the city, Eixample Esquerre (EE), and those from the BDU are from EE and outside this area. A greater number of visits were made by the psychiatrists in both groups (Table 1).

Table 1
Sociodemographic data of the patients included in the study

		BDU ($n = 152$)*	CMHS-EE ($n = 136$) ^a	<i>p</i> value
Area of origin	Reference area	95 (62.50)	117 (86.03)	<i>0.001</i>
	Not reference area	57 (37.50)	0 (0.00)	
	Unknown	0 (0.00)	19 (13.97)	
Staff	Psychiatry	120 (78.95)	98 (84.48)	0.334
	Psychology	26 (17.10)	15 (12.93)	
	Nursing	6 (3.94)	2 (1.72)	
	Social worker	0 (0.00)	1 (0.86)	
Age (years)	18–25	6 (3.87)	6 (4.72)	0.600
	26–40	34 (21.94)	32 (25.20)	
	41–55	71 (48.81)	51 (40.16)	
	56–70	33 (21.29)	26 (20.47)	
	>71	8 (5.16)	12 (9.44)	
Sex	Male	68 (44.74)	34 (32.69)	0.069
	Female	84 (55.26)	70 (67.31)	
Education	Primary	20 (13.79)	15 (15.00)	<i>0.048</i>
	Secondary	74 (51.03)	34 (34.00)	
	University	50 (34.48)	49 (49.00)	
	None	1 (0.69)	2 (2.00)	
Occupational status	Student	3 (2.11)	7 (6.09)	0.100
	Active	36 (25.35)	36 (31.30)	
	Unemployed	24 (16.90)	20 (17.39)	
	Retired	56 (39.44)	29 (25.21)	
	Sick leave	23 (16.20)	23 (20.00)	

BDU Bipolar Disorder Unit, CMHS-EE Community Mental Health Service—Eixample Esquerre
p value in italic indicate statistical significance

^aValues expressed as *n*(%)

In relation to the BDU, possible sociodemographic differences were analyzed between the patients from the EE and outside this area. No differences were observed with respect to age, sex, educational level, or occupation among the two sub-samples ($p = 0.960$, $p = 0.618$, $p = 0.510$, $p = 0.509$, respectively). It was found that nursing staff significantly saw more male patients ($p = 0.019$) from 25 to 40 years of age ($p = 0.006$).

Scores in the satisfaction questionnaire

The high score obtained in both groups in relation to the question of recommendation was of note (Table 2). No significant differences were observed between the scores obtained in the BDU and the CMHS-EE ($p = 0.119$).

In regard to the analysis of satisfaction, the best scores were found in the assistance given by the administrative personnel, the relationship with the staff, and the technical knowledge of the BDU staff, with the score being greater than 4.60. The worst score was given for the waiting time in the BDU, being the only item with a score below 4 (Table 2). Significant differences were found in the grade of satisfaction by the two groups in three items: technical knowledge of the staff was assessed more highly in the BDU than that in the CMHS-EE ($p = 0.009$), the waiting time in the BDU was considered worse than that in the CMHS-EE ($p = 0.0001$), and the information received from the staff in the BDU was scored lower than that in the CMHS-EE ($p = 0.0001$) (Table 2). In general terms, the satisfaction perceived with the BDU was satisfactory (Fig. 1). Indeed, the NPS in the BDU was very positive, being 67% (Fig. 2).

Since referral to follow-up in the BDU is easier to achieve by patients with a family physician in the EE area compared to patients with a family physician outside this area, the level of satisfaction between the two groups was compared. Patients from outside the EE compared to those from the EE area presented a significantly higher score of BDU recommendation (9.37 ± 1.07 and 8.80 ± 1.86 , $p = 0.0001$) and greater satisfaction with respect to appointment making (4.75 ± 0.54 and 4.32 ± 0.926 , $p = 0.0001$) and administrative assistance (4.84 ± 0.37 and 4.65 ± 0.63 , $p = 0.022$). No significant differences were observed in the remaining items.

Table 2
Scores obtained in the satisfaction questionnaire

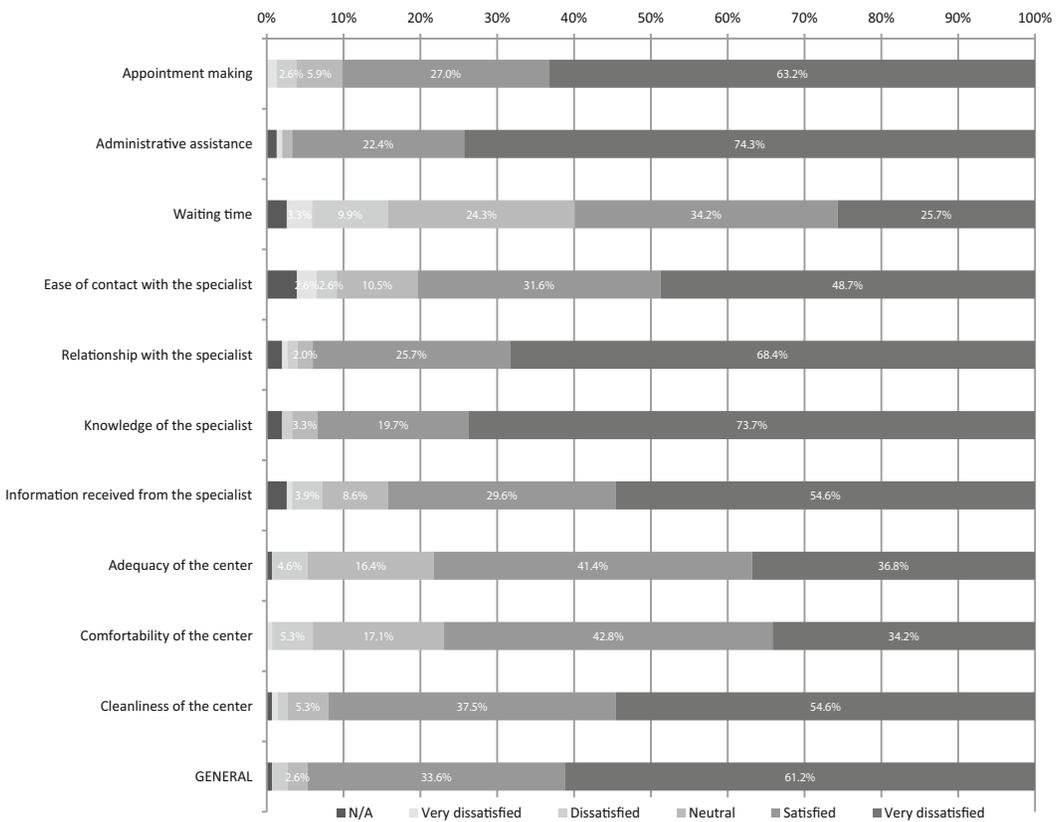
	BDU ($n = 152$) ^a	CMHS-EE ($n = 136$) ^a	<i>p</i> value
Unit recommendation question	9.01 (1.63)	9.14 (1.18)	0.119
Appointment making	4.48 (0.83)	4.50 (0.72)	0.190
Administrative assistance	4.72 (0.56)	4.66 (0.66)	0.143
Waiting time	3.71 (1.07)	4.14 (0.84)	<i>0.001</i>
Ease of contact with staff	4.26 (0.95)	4.25 (0.90)	0.866
Relationship with the staff	4.63 (0.66)	4.67 (0.58)	0.259
Technical knowledge of the staff	4.69 (0.60)	4.49 (0.70)	<i>0.009</i>
Information received from the staff	4.37 (0.86)	4.65 (0.60)	<i>0.001</i>
Adequacy of the center	4.11 (0.84)	4.19 (0.88)	0.422
Comfortability of the center	4.05 (0.89)	4.14 (0.91)	0.667
Cleanliness of the center	4.45 (0.72)	4.41 (0.70)	0.973
General satisfaction	4.55 (0.65)	4.57 (0.70)	0.983

BDU Bipolar Disorder Unit, CMHS-EE Community Mental Health Service—Eixample Esquerre

p value in italic indicate statistical significance

^aValues expressed as mean (standard deviation)

Figure 1
Grade of patients' satisfaction in the Bipolar Disorder Unit (BDU)



Opportunities for improvement

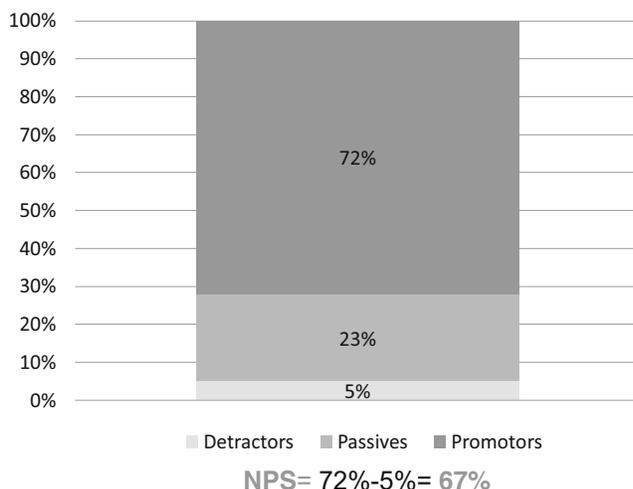
The customer orientation framework in Figure 3 shows that the waiting time of BDU patients can be considered as an opportunity for improvement. Significant differences were observed between the health care groups in the level of satisfaction related to the waiting time ($F = 5.456$, $p = 0.001$). Considering the groups of psychiatrists, psychiatrist trainees, psychologists, and registered nursing staff, the most highly evaluated were the psychiatrist trainees (4.33 ± 0.77) followed by the psychologists (4.08 ± 0.88), the psychiatrists (3.56 ± 1.08), and registered nursing staff (2.83 ± 1.33). According to the post hoc analysis, significant differences were found between the group of psychiatrist trainees and that of the psychiatrists ($p = 0.019$), between the psychiatrist trainees and the registered nursing staff ($p = 0.012$), and between the psychologists and the registered nursing staff ($p = 0.041$).

Discussion

This study compared the grade of satisfaction perceived by patients attending a state reference center linked to a tertiary-level hospital with that of patients from an ordinary community mental health service.²⁴ The patients attended at the BDU presented a higher grade of satisfaction related

Figure 2

Net Promoter Score of the patients performing the satisfaction questionnaire in the Bipolar Disorder Unit. *NPS* Net Promoter Score



to the technical knowledge of the staff but a lower level of satisfaction for the information received from the staff and the length of the waiting time. On comparing the patients attended in the BDU, from outside the EE area with those from within this area, a greater level of recommendation was observed as well as a higher level of satisfaction related to appointment making and administrative assistance.

The high score obtained in all the items of the satisfaction questionnaire was of note, even for the key question of recommendation. In regard to the scores of satisfaction, all were greater than 3, that is, satisfactory scores. Indeed, all the items were scored above 4 except for the visit waiting time among patients attended in the BDU.

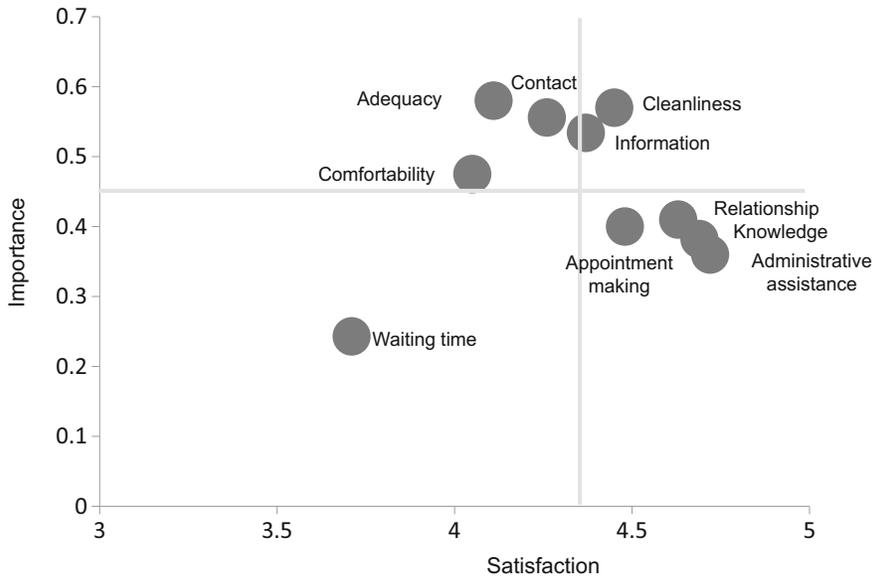
The prestige of the reference units may have influenced the evaluation of the technical knowledge of the staff.²⁰ The BDU was one of the first specialized units developed in Spain within the psychiatric setting.²⁵ The quality of its research and the teaching and training related to bipolar disorder are well known. Likewise, this prestige may have contributed to the higher levels of recommendation and satisfaction with the BDU reported by patients outside the EE area than among those within the EE area.

The lower scores obtained by the BDU in relation to the information received from the staff may be due to patient complexity. The tight visiting time of these patients may be invested in searching for less common and more complex pharmacological approaches and social support and resources rather than in providing explanations about the disorder. Likewise, in the Siponen et al. study,²⁶ patient satisfaction levels were low in the area in regard to the information received from the staff. Only about half of the patients perceived that they had been well informed about the effects of their medication or about their illness. Poor satisfaction with information about treatment and involvement in the treatment program has also been reported by relatives.¹¹ The fact that information provision to patients may be restricted due to the psychopathological state of the patient should not be considered as a justification for the poor result in this area. Therefore, greater effort to provide information to the patients and relatives should be made.

Along the same line, the complexity of the patient may be a reason for the low satisfaction associated with the visit waiting time in the BDU as well as the workload of the health care team.

Figure 3

Customer orientation framework of the patients performing the satisfaction questionnaire in the Bipolar Disorder Unit (BDU)



Patient complexity may prolong visit times and lead to accumulated delays in waiting time. Of interest were the differences in satisfaction with the waiting time according to the health care group. The group best evaluated was that made up of psychiatrist trainees. An explanation for this may be that an already trained team must also carry out management, teaching, and research activities in addition to health care visits. Waiting time has previously been rated with a low score in satisfaction questionnaires, and this fact seems to have an impact on the evaluation of general satisfaction.²⁶ Patients who considered the treatment waiting time to be too long were more dissatisfied with staff, their chance of influencing their own care, and the help they received, compared with patients who considered the wait to be reasonable in length.²⁶

Despite a waiting time score of above 3, there are opportunities for improvement in the area, and thus, the following proposals could be suggested: (1) redistribution of the workload in the BDU defining the time devoted to health care, management, teaching, and research; (2) implementation of audiovisual design-built equipment which identifies users upon arrival by their health care card or through a code in the appointment sheet. This would allow professionals to know the situation of the patient at any given time; and (3) according to the psychiatrists' opinion during the in-depth interviews, improvement of the electronic prescription system will also make the medical visit more efficient.

Considering the sociodemographic characteristics of the groups, the educational level achieved by the patients attended in the BDU was lower than that of those attended in the CMHS-EE. This may be related to the age of onset of the disorder. In the case of bipolar disorder, it begins at an earlier adult age, thereby having an impact on the educational level and, consequently, often on the occupational level as well.²⁷ Therefore, therapeutic strategies in early phases of the disorder are of the utmost importance to prevent the impact that the disorder may have in the long term.²⁸ Delman et al.² recently described facilitators to active participation among young patients with serious mental illnesses and identified psychiatrists'

openness to patients' perspectives, psychiatrists' availability outside office hours, the support of other mental health providers, and personal growth and self-confidence of young adults as facilitators. In addition, the approach to treatment at outset, accessibility by phone, satisfaction with the frequency of the sessions, and having enough time for questions are factors that consistently explained the quality indicators from patients and their parents in outpatient child and adolescent mental health services.²⁹ With regard to health assistance, it was striking that in the present study most visits were performed by psychiatrists. In other countries, access to the reference physician is probably not as direct as in Spain. For example, Great Britain is a paradigmatic case in which, according to the NICE guidelines, the family physicians, nursing staff, and social workers have greater health care responsibility and only request psychiatric consultation. Interestingly, the nursing staff in the BDU attended significantly more male patients from 25 to 40 years of age. A likely reason for this could be that injectable antipsychotic treatment is common in patients with these features, and that the nursing staff is usually in charge of the fortnightly or monthly administration of this treatment.

This study has some limitations. Firstly, this satisfaction questionnaire has not been validated and therefore does not allow the results to be compared with those of other samples. Likewise, the generalization of the results obtained in the BDU cannot be extrapolated to other state reference centers since the patients in this unit present a specific complexity and its intrinsic characteristics. Last but not least, studies of satisfaction in samples that come to the visit are potentially biased because dissatisfied patients are more likely to have dropped out of follow-up.³⁰

Considering progressive patient empowerment as health care system users, patients' opinions to improve health care services are fundamental. Users attended in a state reference unit such as the BDU reported being satisfied with their outpatient care. However, there are opportunities for improvement with the visit waiting time. An assessment after the implementation of the suggested proposals would be of the utmost importance for continuous improvement in these particular health care settings.

Implications for Behavioral Health

The opinion of patients has been increasingly taken into account when implementing changes in health care infrastructure^{31,32} and when public health models are debated.^{33,34} One way to obtain these opinions is through a satisfaction questionnaire. In this context, users attended in a state reference unit such as the BDU reported being satisfied with their outpatient care regarding the *Net Promoter Score* (NPS) of 67%. Assessment of satisfaction in a state reference unit such as the BDU opens the door to improvement in the management of these state reference units as well as to their promotion and capacity to obtain resources.

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Compliance with Ethical Standards

The study was approved by the Committee of Ethics and Investigation of the Hospital Clínic of Barcelona.

Competing Interests IG has a Juan Rodés Contract (JR15/00012) and a grant (PI16/00187) from the Instituto de Salud Carlos III, Ministry of Economy and Competitiveness of Spain; she has also consulted for Ferrer and has been a speaker for Ferrer and Janssen Cilag. Prof. E. Vieta has received grants and honoraria from AstraZeneca, Ferrer, Forest Research Institute, Gedeon Richter, GlaxoSmithKline, Janssen, Lundbeck, Otsuka, Pfizer, Sanofi-Aventis, Sunovion, and Takeda as well as from the Centro para la Investigación Biomédica en Red de Salud Mental (CIBERSAM), Grups Consolidats de Recerca 2014 (SGR 398), Seventh European Framework Programme (ENBREC), and Stanley Medical Research Institute. The remaining authors declare no competing interests.

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