Assessing the Impact of Mental Health Programs upon Community: the Perspectives of Primary Caregivers and Consumers*

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Since 1985, there has been a significant movement in Spanish mental health services away from provision of care in psychiatric hospitals and toward a community mental health model (CMMH). This reform has ushered in changes not only for the patients but also for both their relatives and their primary caregivers. However, no survey has ever been carried out to obtain these parties' perceptions of the CMMH.

Two studies have now been designed to describe the acceptability of the CMMH to these two key groups. The goals of the two projects were, firstly, to assess the opinions of primary care professionals about CMMH and, secondly, to sample the opinions of the patients' relatives regarding mental health care.

In the first survey, 884 primary caregivers (general practitioners (GPs), pediatricians, nurses and social workers) filled out a 14-item questionnaire with a five-point response scale. Several aspects of care were evaluated: accessibility, referral facilities, therapeutic support, training or teaching activities, communication between primary care and mental health professionals for their mutual collaboration, and appropriateness of resources.

Most of the primary caregivers reported that the community psychiatric model improved accessibility, treatment and communication between the different levels. Nurses and pediatricians reported dissatisfaction with the CMMH.

In the second survey, the satisfaction of patients' relatives with the services provided by the therapists was assessed, using the Satisfaction with Therapist Questionnaire (STQ). The STQ consists of 15 items with a three-point response scale. Amount and adequacy of the information provided, accessibility, and style of conducting the appointment were assessed as measures of satisfaction. A sample of relatives of schizophrenic patients was surveyed by mail (76 relatives answered, a response rate of 31.13%). In summary, relatives were satisfied with therapists' competence but dissatisfied with their communication skills.

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INTRODUCTION

In 1985, the Spanish Ministry of Health and Consumer Affairs published a report [1] proposing an in-depth reform of the country's mental health care system. This reform meant the introduction of a community model of mental health (CMMH). CMMH is characterized by a wide spectrum of care, including outpatient, inpatient and residential facilities, multidisciplinary team work, different types of care devoted to defined populations, and close liaison between the different medical and social resources (in particular, primary caregivers) [2–5]. CMMH has been suggested by proponents of many different viewpoints as a way to improve the mental health care system [6–9].

The conclusions of the ministerial report were later included in the Spanish Health Law. This proposal was defended as an alternative to the traditional model based on mental hospital assistance. In the Spanish setting, the CMMH was positively received because the specialists perceived it as an improvement of the mental health care system. However, some aspects of the reform were seen as difficult to accept. In particular, there were serious doubts about the acceptability of CMMH to patients' relatives, due to their doubts about the reform's timing. In the minds of some professionals, creation of alternative psycho-social resources for severely ill patients could not compensate for the reduction of psychiatric hospital beds.

The Spanish health care system

Spain is divided into 17 autonomous communities. The 1986 Health Law established a National Health Service (NHS) comprising the current health services of each of these 17 autonomous communities [10]. Each community has the responsibility for unifying and coordinating all the health resources within their geographic limits into a unique health care system. To achieve this objective, a decentralization process was designed to transfer health care from the central government to the autonomous communities' authorities. This decentralization process

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started in 1981, when Cataluny received INSALUD [INSALUD (National Health Institute) is an autonomous institution created, in 1978, for the management of the Social Security medical care services] resources (personnel, hospitals, health centres and financial resources) from the central government. At the present time, INSALUD has been conferred on seven other autonomous communities (Basque Country, Navarra, Andalusia, Canaries, Balearics, Galicia and Valencia), while the other communities are still on the waiting list.

Each autonomous community has been divided into geographical units called "health areas". Each health area has at least one general hospital and includes several primary health centers. In Spain, primary health centers are staffed by GPs, pediatricians, nurses, social workers, auxiliary personnel and, depending on the organizational elements in each autonomous health-care system, other professionals, such as physiotherapists, midwives, or, for children only, dentists. In this model, GPs (or pediatricians in the case of children) are the gatekeepers of the health care system, including mental health care [11]. However, not every Health Area has replaced its old structures with primary health centers. Currently, the old and new organizational schemes in primary care coexist.

Reform of psychiatric care

In 1985, INSALUD started a reform to improve mental health care. INSALUD developed a network of so-called "mental health units", designed to provide appropriate diagnosis, treatment and rehabilitation in an out-patient setting. Access to these mental health units was, as explained above, strictly restricted to referrals from GPs. At the same time, INSALUD added psychiatric beds to several general hospitals, staffed by specialized personnel, such as psychiatrists, psychologists, nurses and auxiliary clinical personnel. At this time, each autonomous community with health responsibilities started its own reform process. Although, for the most part, these reform processes are similar, some also have unique features.

In the autonomous community of Valencia, the psychiatric reform began in 1986 as a pilot project, but was expanded in 1992 to provide significant resources for both out-patient and in-patient care [12]. This so-called "new model" of mental health care is based on mental health units, formed by multidisciplinary teams who staff hospital and primary clinics in a defined geographic area (health area) with a determined population.

In this model, the GP must decide how to work with each patient. When necessary, the GP can refer the patient to the mental health unit. Alternatively, the GP can request a consultation to obtain an expert opinion about the patient. There are also specific mental health units specializing in infant disorders, and pediatricians at the primary care centers can refer infant patients to these units. CMMH has introduced a significant change for patients' relatives, emphasizing the patient's need to remain in his/her social and community environment.

Impact upon the community of the reform of psychiatric care

Evaluation of the mental health care system can be carried out at different levels in the system [13]. One important focus for evaluation is the impact of the mental health care reform upon the community, in other words, its acceptability or its capacity to satisfy the expectations of both primary caregivers and consumers [11].

This study was designed to assess the acceptability of the reform of psychiatric care to both primary caregivers and consumers. Two surveys were conducted. The first explored the primary caregivers' views of the psychiatric reform, whereas the second explored the consumers' satisfaction with the therapists in this new model of mental health care.

FIRST SURVEY: THE PRIMARY CAREGIVERS' VIEWPOINT

Although the Spanish mental health units were designed to support first level professionals (GPs, pediatricians, nurses and social workers) in their duties, no investigation had ever been made of the impact of this reform on them. The objective of this study was to assess whether or not the new mental health units are useful for primary caregivers.

Method

A descriptive study was carried out to assess the primary caregivers' views about the reform of psychiatric care in the Valencian autonomous community. The first step of this study was to develop a questionnaire to assess positive and negative views about the reform. Afterwards, a mail survey was conducted, guaranteeing anonymity to the survey respondents.

Subjects. A total of 2140 primary health care professionals (937 physicians, 1120 nurses and 85 social workers) were surveyed; 884 professionals responded to a mailed questionnaire within a 1-month period. The response rate was 41.31%. The response rates for physicians, nurses and social workers were 48.13, 28.21 and 43.53%, respectively. The mean age of the respondents was 36.21 (SD = 8.28).

The measurement tools. A questionnaire entitled "Impact" was used for the survey. It consists of 14 items with a five-point response scale, ranging from "strongly agree" to "strongly disagree", and is based on previous research of general practitioners' views about their Health District reference hospital [14], exploring three dimensions: support activities, satisfaction with CMMH and CMMH resources.
TABLE 1. Results of ANOVA. Effects of profession and work status on impact scores

<table>
<thead>
<tr>
<th>Factors</th>
<th>Support activities</th>
<th>Satisfaction</th>
<th>Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Profession</td>
<td>9.02* (3,617)</td>
<td>13.40* (3,617)</td>
<td>1.07† (3,617)</td>
</tr>
<tr>
<td>Work status</td>
<td>11.83* (1,617)</td>
<td>3.63† (1,617)</td>
<td>0.004† (1,617)</td>
</tr>
<tr>
<td>Interaction</td>
<td>0.58† (3,617)</td>
<td>0.31† (3,617)</td>
<td>2.07† (3,617)</td>
</tr>
</tbody>
</table>

Degrees of freedom are shown in parentheses.
*P< 0.0001.
†Not significant.

(1) Support activities. The six items in this dimension include accessibility, referral facilities, therapeutic support, training or teaching activities and some advice on patient follow-up.

(2) Satisfaction with CMMH. This dimension consists of six items that were designed to explore views about communication between primary care and mental health professionals for their mutual collaboration, and about the waiting list, as well as to explore the professionals' overall views of the system.

(3) CMMH resources. The two items in this dimension include questions about the number and adequacy of mental health resources in their particular Health District.

The internal validity of each dimension was computed by Cronbach's Alpha (support activities α = 0.78; satisfaction α = 0.77; resources α = 0.45).

Statistical analysis. Analysis of variance (ANOVA) was carried out using “Impact” scores as dependent variables. In this analysis, profession (that is, GP, pediatrician, nurse or social worker) and work status (temporary employees vs permanent staff) were introduced as factors. In a subsequent analysis, dimensions' and items' scores on “Impact” were considered as dependent variables in a series of mean differences analyses in which profession and work status were considered as independent variables.

Results

Among the dimensions, “Satisfaction with CMMH” received the highest score (mean score = 3.47, SD = 0.74, CI—99% 3.41–3.53), next was “Support activities” (mean score = 3.22, SD = 0.74, CI—99% 3.15–3.29), and finally “Resources” (mean score = 2.83, SD = 0.81, CI—99% 2.76–2.90).

ANOVA revealed a highly significant effect of profession on the scores for “Support activities” and “Satisfaction with CMMH”, whereas the interaction did not. ANOVA also indicated an effect of work status on “Support activities”, reflecting that temporary employees were prone to find advantages in CMMH (Table 1).

Pediatricians and nurses reported the most negative views relating to “Support activities” (F-test \( F_{3,720} = 14.18, P=0.0001 \)) and “Satisfaction with CMMH” (F-test \( F_{3,765} = 18.27, P=0.0001 \)), as shown in Table 2.

One-way ANOVA was calculated for each item. This analysis revealed that GPs have a more positive view of the psychiatric reform process than the other caregiver groups, except when they referred to the extent and adequacy of mental health resources, the teaching facilities and the waiting list. Figures 1–3 include the items' scores in each dimension (one graph for each). In these graphs, \( P \) values represent the differences between professional groups.

Primary caregivers were also asked about their knowledge of the reform in their community. Almost 43% of the sample failed to show appropriate knowledge of this reform (Fig. 4). Paediatricians and nurses were the professionals that had the least information (F-test \( F_{3,748} = 4.64, P=0.0032 \)).

Discussion

Previous studies conducted in the UK suggest that general practitioners have a positive view of the movement of psychiatric care from hospitals to primary care clinics [15–17]. However, the UK studies were based on small numbers of physicians. Moreover, the literature
FIGURE 1. Viewpoints about CMMH—support activities.

FIGURE 2. Viewpoints about CMMH—satisfaction with CMMH.

FIGURE 3. Viewpoints about CMMH—resources.
Reform of the mental health care impact

FIGURE 4. Knowledge of the reform of psychiatric care among primary care professionals.

does not provide information on the views of other primary care professionals, such as pediatricians, social workers or nurses. In countries with a national health system, the caregivers’ views of a CMMH have important implications for several aspects of the health care system, such as the training of medical and related professionals, particularly community nurses, encouragement of a more efficient work relationship and improved access to care, in particular referrals. Primary caregivers, especially GPs, may be the best judges in an evaluation of mental health care reform. GPs not only refer patients to mental health units, they also provide the follow-up care at the conclusion of psychiatric treatment.

The reform of mental health care in our autonomous community meant great improvements for the patients according to the views of a majority of the caregivers surveyed in our study. Most of the primary caregivers said that the community psychiatric model improved accessibility, treatment and communication between the different levels of care. In the case of the extent and adequacy (appropriateness) of mental health care resources, the opposite result was found. Pediatricians and nurses were dissatisfied with the level of resources. In the case of pediatricians, the limited number of infant mental health units is a possible explanation for these views. In addition, nurses have not received the same amount of information or support from mental health units as GPs or social workers.

The mental health care reform was considered to have benefitted patients (greater accessibility, improved information and better treatment), except for patients under 14 years of age for whom no resources were provided. Physicians were satisfied with mental health facilities, with the exception of the pediatricians. A majority of physicians acknowledged that they normally received adequate information about their patients and held positive views of the work of the mental health services. However, one unexpected result was that almost half of the primary caregivers were not familiar with the ongoing reform of psychiatric care. A possible explanation of this could be the lack of importance attributed to the internal communications in our health organizations.

Finally, although this outcome seems to advocate in favor of the CMMH, we must take into account that this study did not attempt to assess the clinical benefits of this model.

SECOND SURVEY: THE CONSUMERS’ VIEWPOINT

It has been said that the reform of psychiatric care has resulted in greater responsibilities for the relatives of the severely ill patient. CMMH emphasizes the role of the therapists in the community. Among other changes, improved accessibility, increased professional support and quick therapy when necessary are key aspects of the mental health care reform. From this point of view, it would be interesting to assess the relatives’ satisfaction with the patient’s therapist in order to monitor the process.

The purpose of this survey was to find out the relatives’ views of the reform of psychiatric care in the Alicante province (in the autonomous community of Valencia). This study tries to answer the question: “Are therapists complying with the objectives of the reform?” In other words, “Has the reform been accepted by the relatives of the schizophrenic patients?”

Method

A descriptive study to obtain relatives’ views about mental health care was carried out. The data were gathered through a mailed survey in which anonymity was guaranteed. Satisfaction with the patient’s therapist was assessed by means of a questionnaire especially developed for this purpose.

Subjects. Three hundred and eighteen families of severely mentally ill patients (all patients met DSM-III-R criteria for schizophrenia) were surveyed in strict anonymity. All patients were treated in outpatient mental health units in three health areas in the Alicante province. Seventy-six of the 318 questionnaires posted were answered and sent back. Twenty-three were returned by the postal service because of wrong addresses. Of the sample, 31.13% provided adequate
answers. There was no pre-selection of subjects. All families having a member who was a psychiatric patient living with them who met the criteria were surveyed.

Seventy per cent of patients in the sample were male. The average age of the patients was 36 years (SD = 9.70), with a mean duration of disease of 12.30 years (SD = 8.12). Thirteen per cent, 6% and 71% were married, divorced and single, respectively. Review of the demographic characteristics of patients revealed no significant differences with respect to sex and marital status ($\chi^2 = 5.28, P = 0.07$), sex and age (t-test$_{51} = 0.95, P = 0.34$), or sex and duration of illness (t-test$_{51} = 0.51, P = 0.61$).

**Measurements.** The Satisfaction with Therapists Questionnaire (STQ) includes 15 items with a three-point response scale ranging from never to always. The 15 items were factor-analysed, and three factors were extracted.

1. Communication skills consists of nine items that describe a therapist who takes into account the relatives' opinions and their suffering, tells them what is appropriate and inappropriate, shows a realistic point of view, and is seen as an expert by the relatives (Cronbach's $\alpha = 0.89$).

2. Receptive-methodological skills consist of four items, including therapist's accessibility, listening skills and appropriate use of time during appointments (Cronbach's $\alpha = 0.73$).

3. Warm manners consists of two items reflecting the therapist's style of conducting the appointment (Cronbach's $\alpha = 0.49$).

**Statistical analysis.** Age, gender, marital status and length of illness were computed as independent variables, and factor scores were considered as dependent variables in a series of mean differences analyses.

**Results**

Mean scores and confidence intervals were calculated for all three factors of the STQ (Fig. 5). In order of the resulting scores, the aspects that were most positively viewed were found to be those that reveal the therapist as warm and kind in dealing with patients (mean score = 2.62, SD = 0.52, CI—95% 2.48–2.76). Of secondary importance was that the therapist is receptive and organized during the consultation (mean score = 2.48, SD = 0.46, CI—95% 2.36–2.60). The third most important aspect was that the therapist should be a good communicator (mean score = 2.39, SD = 0.53, CI—95% 2.25–2.53).

Table 3 shows the mean scores for each of the STQ's items in rank order. The more highly valued aspects are that: (1) the therapist listens carefully when spoken to, (2) the therapist takes the family into account when putting the therapy into practice and (3) that he/she is kind. The aspects considered less important are: (1) that the therapist provides clear and important information for the family and (2) that he/she speaks clearly when explaining the treatment objectives. None of the independent variables showed any significant differences on factor scores.

**TABLE 3. Scores of the STQ in hierarchy order**

<table>
<thead>
<tr>
<th>Our therapist...</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Listens carefully when we talk to him</td>
<td>2.72</td>
</tr>
<tr>
<td>Relies on us to go on with the therapy</td>
<td>2.67</td>
</tr>
<tr>
<td>Is kind in his/her dealing with us</td>
<td>2.67</td>
</tr>
<tr>
<td>Makes us feel at ease in the consulting time</td>
<td>2.58</td>
</tr>
<tr>
<td>Makes convenient use of the consulting time</td>
<td>2.53</td>
</tr>
<tr>
<td>Is available whenever we need him/her</td>
<td>2.5</td>
</tr>
<tr>
<td>Is realistic in his/her explanations</td>
<td>2.42</td>
</tr>
<tr>
<td>Takes our comments into consideration</td>
<td>2.41</td>
</tr>
<tr>
<td>We think he/she has considerable experience with mental illness</td>
<td>2.41</td>
</tr>
<tr>
<td>Understands that it is difficult to live with an ill person</td>
<td>2.39</td>
</tr>
<tr>
<td>Tell us what we do right or wrong</td>
<td>2.36</td>
</tr>
<tr>
<td>Knows the fact that we are suffering and worried</td>
<td>2.35</td>
</tr>
<tr>
<td>Gives us clear information</td>
<td>2.34</td>
</tr>
<tr>
<td>Gives us information that is important to us</td>
<td>2.31</td>
</tr>
<tr>
<td>Is straightforward when explaining the therapy's objective</td>
<td>2.29</td>
</tr>
</tbody>
</table>
Discussion

Patient satisfaction has usually been evaluated as an outcome of care [18]. This type of study tends to find a relationship between satisfaction and information provided, care continuity, pleasant manners and treatment adherence [19]. Over the past three decades, the patient satisfaction literature has demonstrated an increased interest in these aspects of care [20], and a large number of questionnaires have been designed to assess patient satisfaction. However, many of these questionnaires present methodological problems [21]. Some of the most frequently used patient satisfaction questionnaires in the Anglo-American literature, such as the Patient Satisfaction Questionnaire, Satisfaction with Physician and Primary Care Scale and the Client Satisfaction Questionnaire, were not designed to be used with patients with severe mental disorders. These instruments have been found to be reliable and valid, and they are feasible in large populations. However, in the field of patient satisfaction, as it relates to mental health care, methodological difficulties emerge in interviews with patients who refuse to acknowledge their illness, or when the patient has cognitive handicaps or behavioral disorders [22,23]. In this situation, the literature offers an evaluation of the relatives' satisfaction as an alternative measure.

However, consumer satisfaction data provide unclear results in the case of mental health care [24,25]. When patients are interviewed, opinions about hospitalization and level of satisfaction are often highly positive, whereas, when relatives are interviewed, both opinions and level of satisfaction may be negative [26–33].

The results of the present study showed that the amount and quality of the information provided was not rated as useful by the relatives, whereas therapists were seen as receptive and as having a warm manner during appointments. Relatives also reported that therapists were found when necessary, that they provided a realistic prognosis, and that they were very competent in their professional tasks. In short, relatives of the severely ill patients saw therapists as competent, available and polite. However, they found the therapists to be lacking in skills for adequate communication with patients and families.

Therapists were accessible, kind and competent. These characteristics support the goals of the reform. However, therapists were not sufficiently skilful to establish a good communication process with the patients' relatives. These results are less positive because if families do not have adequate information about the mental disorder, the prognosis or the treatment, they will not be able to collaborate actively with the treatment for their own well-being and that of the patient.

These findings are not easy to explain. The relatives may have expected to receive different information from that which the therapists provided. Perhaps relatives expected a definitive solution for the patient's disorder. Indeed, perhaps therapists should be cautious about the information that they provide.

We can assume that the reform of psychiatric care has been accepted among those patients' relatives who responded to the questionnaire. However, we should not forget that relatives also expressed helplessness, that they want to understand the disorder, to know more about the prognosis, and to learn how to cope with and how to face extravagant behaviors, and how to prevent new crises. Probably, relatives, like primary caregivers, were dissatisfied with the extent and localization of the mental health care resources.

Finally, this type of study has an advantage. It has improved our knowledge of the consumers' views about the healthcare system. Any reform of the system must take into account the opinions of those who are its ultimate recipients.

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