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Patients' Satisfaction with Community Mental Health Centers Services at Ministry of Health in Gaza Governorates

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بسم الله الرحمن الرحيم

" وَقُل رَّبِّ زِدْنِي عِلْمًا "

طه:114

* اللهم علمنا ما ينفعنا *

* وانفعنا بما علمتنا *

* وزدنا علما *

Abstract

One of the important goals of any health system is to deliver high quality health services and respond to the needs of service users. Patients' satisfaction is one of the most sensitive indicators of quality of services as it measures the gap between what is expected and ideal from one side and what actually exists in reality.

The aim of this study was to assess the level of patient satisfaction with community mental health services provided to them through six community mental health centers at Ministry of Health in Gaza Governorates and also to determine the factors influencing patient satisfaction for those services in order to provide information that could contribute to identify the most important aspects that could possess the satisfaction of service users, as well as the most important aspects that need improvement and development to enhance quality of services provided by community mental health centers. The study was conducted during the period from April to June 2012.

The design of this study is quantitative, descriptive, analytical, cross-sectional one. Interviewed questionnaire was developed and focused on patient's satisfaction. The study sample 400 patients were randomly selected, 271 of them actually participated in the study and completed face to face interviewed questionnaire according to Likert scale within the centers filled by the researcher himself and two well trained data collectors with a response rate of 67%. Validity and reliability of the instrument were tested and the total instrument reliability test (Cronbach's Alpha) was 0.93.

Six dimensions of patients' satisfaction were considered in this study; namely, general impressions, accessibility of services, communication, interaction and information, physical environment of the center, technical quality and convenience and responsiveness. The findings elicited satisfaction scores about these domains varied and ranged from 58.19% to 77.81% with moderate level of overall satisfaction 66.89%. The highest level of satisfaction was found with the physical environment of the center while, the lowest level of satisfaction was found with accessibility of services. The study revealed that, there were statistically significant differences in the overall satisfaction with place of living, so that the patients who living in Rafah governorate more satisfaction with the services than other governorates. In contrast, age, sex, marital status, level of education, current occupation, income, the diagnosis and duration of disorder did not show statistically significant difference on patients' level of satisfaction.

The study recommended the geographical redistribution of community mental health centers to enable the patients easy access to services, increase number of home visits for patients who are unable to attend to receive the service, make improvements to the internal environment of the centers, and provision of sufficient quantities of drugs permanently, reduce waiting times of patients by scheduling to review patients, involving patients in the development of therapeutic plans, and improve communication skills and interaction between service providers and patients, all of these factors are important for improving the level of patients' satisfaction with community mental health centers services.

ملخص الدراسة

إن أحد الأهداف الهامة لأي نظام صحي هو تقديم خدمات صحية عالية الجودة والاستجابة لاحتياجات متلقي الخدمة. ويعتبر رضا المرضى هو واحد من المؤشرات الأكثر حساسية في نوعية وجودة الخدمات المقدمة حيث أنه يقيس الفجوة بين ما هو متوقع ومثالي من جانب وما هو موجود فعلا في الواقع.

هدفت هذه الدراسة إلى قياس مستوى رضا المرضى عن الخدمات المقدمة لهم من خلال مراكز الصحة النفسية المجتمعية التابعة لوزارة الصحة بمحافظات غزة وأيضا لتحديد العوامل المؤثرة في رضا المرضى عن تلك الخدمات وذلك من اجل توفير المعلومات التي يمكن أن تساهم في التعرف على أهم الجوانب التي يمكن أن تحوز على رضا متلقي الخدمة، فضلا عن أهم الجوانب التي تحتاج إلى تحسين وتطوير للارتقاء بنوعية وجودة الخدمات التي تقدمها مراكز الصحة النفسية المجتمعية.

صممت هذه الدراسة كدراسة وصفية تحليلية نفذت في مراكز الصحة النفسية المجتمعية الحكومية الستة خلال الفترة من ابريل إلى يونيو 2012 وقد بلغ حجم العينة 400 مريضا شارك منهم فعليا271 مريضا تم اختيارهم بشكل عشوائي وتم إجراء مقابلات وجها لوجه لهم داخل المراكز بواسطة الباحث واثنين من الخريجين تم تدريبهم بشكل جيد لتعبئة استبانه وفق تدريج لكرت الخماسي تم إعدادها بواسطة الباحث واشتملت الاستبانة على 6 أبعاد للرضا هي: الرضا العام، سهولة الوصول والحصول على الخدمة، التواصل والتفاعل والمعلومات، البيئة الداخلية للمركز، الكفاءة الفنية وأخيرا مدى ملاءمة الخدمة والاستجابة للخدمة وبلغت نسبة تجاوب المرضى للمشاركة في الدراسة 67%. وقد تمتعت استبانه الدراسة بدرجة ثبات عالية بلغت (0.93) حسب مقياس كرونباخ ألفا. وقد تم تحليل البيانات باستخدام برنامج المعالجة الإحصائية.

أظهرت نتائج هذه الدراسة مستوى رضا عام متوسط عن الخدمات بلغ (66.89%) حيث تراوح ما بين 58.19% إلى 77.81% كان أعلاها الرضا عن البيئة الداخلية للمركز وأدناها الرضا عن سهولة الوصول والحصول على الخدمة. كذلك أظهرت الدراسة أن المرضى الذين يسكنون في محافظة رفح يتمتعون بمستوى رضا أعلى من المرضى في باقي المحافظات.

لم تظهر نتائج الدراسة أي فروق ذات دلالة إحصائية في مستوى الرضا عن الخدمات بين المرضى من حيث العمر والجنس والحالة الاجتماعية ومستوى التعليم والمهنة الحالية والدخل الشهري والتشخيص المرضي والفترة الزمنية للاضطراب. أيضا أظهرت نتائج الدراسة ستة أبعاد للرضا تتضمن الرضا العام، سهولة الوصول والحصول على الخدمة، التواصل والتفاعل والمعلومات، البيئة الداخلية للمركز، الكفاءة الفنية و مدى ملاءمة الخدمة والاستجابة وأوضحت النتائج انه توجد علاقة ذات دلالة إحصائية في مستوى الرضا لدى المرضى وتلك الأبعاد الستة للرضى.

أوصت الدراسة بإعادة التوزيع الجغرافي لمراكز الصحة النفسية المجتمعية لتمكين المرضى من سهولة الوصول إلى الخدمات، زيادة عدد الزيارات المنزلية للمرضى الذين لا يستطيعون الحضور لتلقي الخدمة، إدخال تحسينات على البيئة الداخلية للمراكز، توفير الكميات اللازمة من الأدوية النفسية بشكل دائم، تقليل أوقات انتظار المرضى من خلال تحديد مواعيد لمراجعة المرضى، إشراك المرضى في وضع الخطط العلاجية، وتحسين مهارات الاتصال والتفاعل بين مقدمي الخدمات والمرضى، كل هذه العوامل مهمة لتحسين مستوى رضا المرضى عن خدمات مراكز الصحة النفسية المجتمعية.

Dedication

To the pure spirit of my father.

To my beloved mother.

To my dear wife.

To my sons, Mahmoud, and Momen.

To my daughters, Zainab and Maram.

To my brothers, my sisters and my family.

To my friend Alaa.

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ANOVA	Analysis of Variance
CMH	Community Mental Health
GCMHP	Gaza Community Mental Health Program
GGs	Gaza Governorates
GS	Gaza Strip
IUG	Islamic University of Gaza
MOH	Ministry of Health
NGOs	Non Governmental Organizations
NIS	New Israeli Sheqel
PNA	Palestinian National Authority
	Palestinian Central Bureau of StatisticsPCBS
SPSS	Statistical Package of Social Science
UNRWA	United Nations Relief and Works Agency for Palestine Refugees in the Near East
WB	West Bank
WHO	World Health Organization

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Chapter (1)

Introduction

1.1 Background:

One of the important objectives of any health system in the world is to provide high-quality health services and respond to needs and expectations of service users. Patients' satisfaction with the services provided to them is one of the important indicators on the quality of those services, so any health institution wants success and excellence have achieved the highest level of satisfaction with services in order to reduce the gap between what patients expect from health services, and what is actually exists in reality.

Dr. Irwin Press in his book cited, that patients' satisfaction has become an integral component of the measurement of health care quality, and the multi dimensions of that satisfaction are at the fore of today's consumerism. It is commonly acknowledged that patients' reports of their satisfaction with the quality of care and services are as important as many clinical health measures. In the patients' minds perception is reality, and patients' satisfaction is valid outcome indicators of the quality of the totality of care experienced (Press, 2002).

Over the past few decades, patients' opinions regarding the assessment of services have gained prominence (Sitzia and Woods, 1997). Also, every organization nowadays is concerned with satisfying the users of its products or services, they are known as clients, customers, consumers or patients. Satisfaction, like many other psychological concepts, is easy to understand but hard to define. The concept of satisfaction with similar themes such as happiness, contentment, and quality of life. Satisfaction is not some pre-existing phenomenon waiting to be measured, but a judgment people form over time as they reflect on their experience (Al Sharif, 2008).

The researcher found that during the past years Ministry of Health (MOH) worked in collaboration with World Health Organization (WHO) to improve and development of mental health services in Gaza Strip (GS), therefore established six centers for Community Mental Health (CMH) in Gaza Governorates (GGs) to meet needs of Palestinian society for CMH services and provision of mental health services to the patients in a community context and the integration of psychiatric patients in their families and community.

The researcher think that psychiatric patients are the capital of CMH centers, the focus of service providers, doctors, nurses, psychologists and social workers in all work as a team in order to facilitate for patients and visitors to the appropriate service through the promotion and development of the communication process and work to solve their problems psychological, social and improve the level of quality of services is not only the involvement of patients in the plans and programs and explore their views and aspirations about these services and know the reasons and motives for their satisfaction or dissatisfaction. Therefore, health services for psychiatric patients in CMH centers represent one of the objectives of health care as well as that as the satisfaction achieved in the patient for the services of a physician or nursing or administrative services is an indication of the success of service providers in the work according to the values of patients and their achievement to their expectations. A study of patients' satisfaction is important vehicle for the advancement of services and to develop appropriate policies for health care and attention to the citizen.

Once reliable client satisfaction measures are available, they can be used for routine or periodic ‘check-ups’ on the quality of services from the clients’ perspective. They also can be used to assess client reactions to changes in service delivery being implemented (WHO, 2000).

The study of patients' satisfaction with the services they receive help them learn positive and negative aspects in services and growth, improvement and development it is the patient right to receive psychosocial care according to the highest specifications at the lowest possible cost.

The degree of patients' satisfaction can be used as means of assessing the quality of health care and the personnel. It reflects the ability of the provider to meet patients’ needs (Al-Doghaither et al 2001). Patients' satisfaction is as important as other clinical health measures and is a primary means of measuring the effectiveness of health care delivery (Al Sharif, 2008).

This study contributes to identify the most important aspects that can cause user satisfaction for this service, as well as the most important aspects in need of improvement and development in order to develop setoff recommendations that contribute to further upgrading the quality of service provided by CMH centers.

This study examined patients' satisfaction with CMH centers services at MOH in GGs, satisfaction with services provided by these centers, such as curative medical services, nursing services, administrative services and psychosocial services, and clarifies the relationship between this satisfaction and socio-demographic variables of the patients such as age, sex, marital status, level of education, place of living, occupation, income, psychiatric diagnosis, and duration of disorder.

Therefore; a better understanding of the determinants of patients' satisfaction will help policy and decision makers to implement programs tailored towards patients needs and also to help patients get the best from their encounters with the health care delivery system (Daniel, 2009).

1.2 Research problem:

Patients' satisfaction is one of the components of total quality management in health institutions; because the goal of any health institution is to provide health services for patients, the patients are the capital of these institutions and the absence of patients' satisfaction mean low quality of the health services of its institutions, and measuring patients' satisfaction with the services provided to them is one of the most important indicators of quality of the services and help decision-makers in developing policies, strategies and plans to raise the level of health. Due to absence of a local study measures satisfaction of psychiatric patients for services provided to them, most of the studies addressed the groups and places other than psychiatric patients and CMH centers, from here was the need to measure patients' satisfaction with services provided to them by CMH centers at MOH in GGs.

1.3 Justification of the study:

Through working the researcher as psychiatric nurse in CMH centers listening to the complaints of some patients about the level of mental health services in these centers and the weakness in the quality of services and lack of psychiatric drugs all the time, in addition to pressure of work and the many reviewers, researcher encouraged and motivated to conduct this study for evidenced base results to make sure these complaints and lack of satisfaction fealty the reviewers.

Then, the researcher conducted an interview with 10 psychiatric patients in West Gaza center and have been an open question, to the extent of satisfaction with services of the centre, 5 of them expressed dissatisfaction and two showed a low level of satisfaction and three showed a high level of satisfaction and then asked the patients who showed their dissatisfaction about aspects of dissatisfaction with the services and they said that the medication is not always available and the centre is narrow and crowded with the patients and psychiatrist doesn't give them enough time and information about diagnosis and treatment plane.

The study of patients' satisfaction is an indication of the success of service providers and is an important means of promoting health services and to develop appropriate policies for health care and psychiatric care for the sick and reflects the quality and effectiveness of these services.

As the health services provided to citizens free of charge, the element of competition disappear in government institutions that provide health services to a large extent, which leads to lack of interest in identifying the views of patients about the health service and indifference to their liking for these services. In addition to that, since the establishment of CMH centers in the sector has not conducted a local study on patients satisfaction for its services is encouraged to do this study.

1.4 Aim of the study:

1.4.1 General objective:

To assess the level of patients' satisfaction with CMH centers services at MOH in GGs; and subsequently, provide suggestions and recommendations for decision makers and mental health professionals regarding improving the quality of CMH services.

1.4.2 Specific objectives:

1. To assess patients' satisfaction with CMH centers services provided to them.
2. To explore the main dimensions of patients' satisfaction with CMH services.
3. To determine the relationship between socio-demographic variables of members of the sample and satisfaction with CMH services.
4. To provide suggestions and recommendations for decision makers and mental health professionals regarding improving the quality of CMH services.

1.5 Research questions:

1. What is the level of patients' satisfaction-dissatisfaction with services provided by CMH centers in GGs?
2. What is the level of patients' satisfaction for each domain of satisfaction?
3. What are the factors related to the patients' satisfaction with services provided by CMH centers in GGs?
4. Are there significant differences in the level of patients' satisfaction with CMH centers services at MOH in GGs in related to demographic characteristics such as (age, sex, marital status, place of living, psychiatric diagnosis and duration of disorder)?
5. Are there significant differences in the level of patients' satisfaction with CMH centers services at MOH in GGs in related to socio-economic characteristics such as (level of education, occupation and income)?
6. What are the suggestions and recommendations for future possible interventions?

1.6 Study hypothesis:

The study explores the following hypothesis:

1. There is no statistically significant difference at $\alpha = 0.05$, of the satisfaction with CMH centers services according to age.
2. There is no statistically significant difference at $\alpha = 0.05$, of the satisfaction with CMH centers services according to sex.
3. There is no statistically significant difference at $\alpha = 0.05$, of the satisfaction with CMH centers services according to marital status.
4. There is no statistically significant difference at $\alpha = 0.05$, of the satisfaction with CMH centers services according to level of education.
5. There is no statistically significant difference at $\alpha = 0.05$, of the satisfaction with CMH centers services according to place of living.
6. There is no statistically significant difference at $\alpha = 0.05$, of the satisfaction with CMH centers services according to occupation.
7. There is no statistically significant difference at $\alpha = 0.05$, of the satisfaction with CMH centers services according to income.
8. There is no statistically significant difference at $\alpha = 0.05$, of the satisfaction with CMH centers services according to psychiatric diagnosis.
9. There is no statistically significant difference at $\alpha = 0.05$, of the satisfaction with CMH centers services according to duration of disease.
10. There is significant relationship at $\alpha = 0.05$, between the satisfaction and general impressions of CMH centers services.
11. There is significant relationship at $\alpha = 0.05$, between the satisfaction and accessibility to CMH centers services.
12. There is significant relationship at $\alpha = 0.05$, between the satisfaction and communication, interaction and information of CMH team.
13. There is significant relationship at $\alpha = 0.05$, between the satisfaction and physical environment of CMH centers.
14. There is significant relationship at $\alpha = 0.05$, between the satisfaction and technical quality of CMH team.
15. There is significant relationship at $\alpha = 0.05$, between the satisfaction and convenience and responsiveness of CMH centers services.

1.7 Context of the study:

1.7.1 Gaza governorates demographic characteristics:

The GS is a narrow piece of land with an area of 360 sq. km, lying along the coast of the Mediterranean Sea. The area has a very dense population, due to the tiny area and the lack of freedom of movement. The population of 1.3 million is mainly concentrated in cities, towns and refugee camps (WHO, September 2006).

Because three quarters of the Palestinian population is under the age of 30, with a very small proportion over the age of 60 years, it can be assumed that there would be a high presentation of mental illness that is typical among younger people (such as first episode psychosis) and a low rate of presentation of mental illness more typical among older people (such as dementia and geriatric depression) (WHO, September 2006).

Due to the social structure of Palestinian society, and its emphasis on the extended family, even the severely mentally ill tend to remain in the family environment and are cared for by relatives. This may in part account for a relatively low (45-55%) occupancy level in the psychiatric hospitals. It also reinforces the need to strengthen community-based outpatient services, as well as to build support systems for the families of those suffering from mental health problems (WHO, September 2006).

1.7.2 Palestinian health care system:

The Palestinian health care system is a combination of 4 major actors providing health care services to the Palestinian people inside the occupied Palestinian territory and to refugees from Palestine in the surrounding Arabs countries, Syria, Lebanon, Egypt, and Iraq. The 4 major subsystems are the MOH, Non Governmental Organizations (NGOs), United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA), and private sector (MOH, 2006).

The MOH is still responsible for the largest portion of primary, secondary, and tertiary health care services for the Palestinian people resident in GS and West Bank (WB), but no health services provided for the Palestinian people outside the occupied Palestinian territory by the MOH. The UNRWA is the largest humanitarian organization in the Near East; it has been the main primary health care provider for the refugees from Palestine not only in the occupied Palestinian territory but also in the surrounding Arabs countries (WHO, September 2006).

1.7.3 Mental health services:

The Palestinian Authority's MOH inherited from the Israeli military administration health services that had been neglected and starved for funds during the years of Israeli occupation (Giacaman et al., 2009).

Mental health was particularly neglected. While the Palestinian MOH, with support from the WHO, is continuing to make attempts to expand services beyond the hospital, most services continue to be hospital-based, fragmented and rooted in a biomedical oriented approach (WHO, WB and Gaza Office, 2006).

Currently, the Palestinian MOH operates two psychiatric hospitals, one in Bethlehem with 280 beds serving the WB, and another in Gaza City with 39 beds

serving the GS. These hospitals have dominated in formally providing for the mentally ill, with community services remaining patchy. In 2004 the Ministry was operating 13 mental health outpatient clinics, 9 on the WB and 4 in the GS. The mental health department of the Ministry of Education and Higher Education assures the addition, the UNRWA has been running a mixture of mental health and counseling services within the health and school system in the WB and GS with programs fluctuating in response to the vagaries of funding (Steering Committee on Mental Health, 2004).

By 1995 MOH run 6 CMH centers distributed through GGs; one of them based in Rafah governorate, one in Khan-Younis governorate, one in Mid-Zone, two in Gaza city and one in north Gaza, according MOH planning to cover mental health services in community based, these mental health center provide counseling for mentally ill client and psychopharmacology treatments.

MOH is the main statutory health provider in the outpatient responsible for supervision, regulation, licensure and control of the whole health services. Other health providers include UNRWA, health services belonging to national and international NGOs and some private health sector (for profit) organizations (WHO Final Report, February 2004).

1.7.3.1 Governmental mental health services:

In GGs, from 1978 to 2008, mental health services used to be under-resourced and fragmented. Part of it used to fall under the general directorate of primary health care, while the other part was under the general directorate of hospitals.

General Directorate of Mental Health consists of 3 departments: mental health services, mental health development and mental health rehabilitation. As well as, the Mental Health directorate runs one psychiatric hospital in Gaza city (now called psychosocial rehabilitation center) in addition to 6 government run CMH centers distributed on all GS districts as following; Al Sourani and West Gaza centers in Gaza governorate, Abu Shabak centre in the North governorate, Nasserite center in the Middle governorate, Gasser Al agha center in Khan-Younis governorate, Tal Al-Sultan center in Rafah governorate (General Directorate of Mental Health Report, 2010).

General Directorate of Mental Health at MOH has been established in 2008 to provide a comprehensive and integrative mental health services to meet our people needs, who suffer from difficult political and economic conditions because of the ongoing occupation and the strict siege imposed on Gaza, this increases stress related mental disorders. The following description of programs, activities and services were provided by General Directorate of Mental Health at MOH according to General Directorate of Mental Health Report (2010):

- **Treatment services:** Reception, assessment, diagnosis, follow-up, and treatment of psychiatric and neurological patients, children and adolescents and drug addicts by psycho-pharmacology, psychotherapy, nursing care, psychosocial support, counseling, psychometrics, electroencephalogram and hospitalization.

- **Training programs:** Supervision and training for students and graduates from the faculties of medicine, nursing and humanitarian sciences. In addition to train internship doctors and Palestinian board students. In-service training for staff

through training courses, study days, workshops, lectures, presentation, case study and courses through video-conference. Training of primary care practitioners on principles of mental health and common mental illness and how to deal with them through intervention guidelines. Organize training courses for other health practitioners in order to help them to provide bio-psycho-social services to clients organizing training courses for workers in other ministries and NGOs.

- **Health education programs:** Provide educational programs through audio and visual media. Provide community education lectures in schools, universities, kindergartens, summer camps, youth clubs and women's institutions.

- **Home visits program:** CMH team visit patients in their homes to assess their condition and give them the necessary treatment and guidance, and to provide their families with education and support and keep monitoring their psychological wellbeing in order to re-integrate the patients in their family and in the community.

- **Institutions visit program:** CMH team visit institutions, associations, youth forums, summer camps, schools and kindergartens to provide psychosocial support and counseling, health education and early detection of cases.

- **Scientific research:** Through organization of and participation in conferences, study days and workshops and provide advice and assistance to researchers. Through medical archive we make monthly and annual statistics about occupancy hospitalization rates, reviewers, and prevalence and incidence rates.

- **Counseling and psychological support program:** Provide psycho-social support to high school students through committee's exams. Provide family counseling programs to guide families to better ways to deal with their children, especially in crisis.

- **Rehabilitation services:** Mental health team provides rehabilitation services for mental health patients and drug addicts to integrate them in the community.

- **Coordination with local and international institutions:** Conduct visits to institutions, centers and associations working in mental health field to promote cooperation, coordination and exchange of expertise and integration of services. Coordinate with schools for early detection and management of mental disorders among children and adolescents. Assess cases and write medical reports for patients who are receiving welfare supports from the Ministry of Social Affairs and UNRWA. Evaluate criminal cases transferred from public prosecutor and courts in order to determine the degree of legal responsibility. Coordinate and cooperate with international organizations such as WHO for the development and organization of mental health services and developing the capacity of mental health workers (General Directorate of Mental Health Report, 2010).

1.7.3.2 Non-Governmental mental health services

NGOs have pioneered provision of preventative and mental health services. A key NGO offering CMH services in the GS is the Gaza Community Mental Health Programme (GCMHP), which was established in 1990 to address population mental

health needs in the midst of significant social upheaval. GCMHP has adopted a community based approach which not only offers clinical services but also works on public awareness efforts to combat the stigma of mental illness as well as preventative measures. GCMHP engages in advocacy, lobbying for such issues as the prevention of torture and the empowerment of women. GCMHP employs 45 professionals at four clinics and four women's centers across Gaza. Each clinic has a CMH team consisting of psychiatrist, psychologist, GP, social worker and psychiatric nurses. Also supporting units are available which employ an occupational therapist, a physiotherapist and an Electroencephalogram technician. Their priorities are women, children, victims of torture and other human rights violations, training and education (WHO Final Report, February 2004).

1.7.3.3 UNRWA mental health services

In May/June 2002, UNRWA Gaza started a programme in prevention in mental health, to answer the needs of the refugees during the second Intifada. It involves 66 counselors working in schools, medical centers and community centers in the camps. Activities are at the level of prevention and patients are referred when professionals in mental health are needed. The link with resources in the community is developed. The counselors are mainly involved in group counseling with parents, teachers, children, adolescents. A significant number of refugees attend the government-run mental health clinics. UNRWA have reported plans to develop a crisis intervention service by hiring 14 mental health counselors and, through NGOs, 15 CMH activists. They also state that they will contract private psychiatrists and psychologists to accept referrals of clients that cannot be managed by mental health counselors. UNRWA has indicated that they will pay for the first twelve sessions of treatment (WHO Final Report, February 2004).

1.8 Definition of terms:

1.8.1 Patients' Satisfaction:

Patient satisfaction refers to the extent to which patients are happy, satisfied and have positive attitudes towards the services they received. Patient satisfaction with the services affected by the extent of these services to meet their needs and requirements and how to achieve their ambitions, aspirations and preferences.

Linder-Peltz (1982a) defines patient satisfaction as *"...positive evaluations of distinct dimensions of the health care,"*. Harris and Poertner (1998) defined client satisfaction as clients' perspectives on aspects of the service transaction important to them.

1.8.2 Community mental health:

A treatment philosophy based on the social model of psychiatric care that advocates that a comprehensive range of mental health services be readily accessible to all members of the community (Mosby's Medical Dictionary, 2009).

1.8.3 Community mental health services:

CMH services in this study refer to the services provided by the CMH centers

for the people who are suffering and who do not suffer from mental problems or disorders, both within the center or in institutions or homes, including psychopharmacology, all types of psychotherapy ; individual and collective, counseling, psychological support and mental health education and family therapy.

CMH practice is a multidimensional intervention process that effectively meets a community's need for appropriate mental health services through both engaging available local, tertiary and national resources and capabilities and stimulating multiple stakeholder awareness and commitment (wood et al., 2009).

Thornicroft et al. (2011) in their Oxford Textbook of CMH defines of CMH care comprises the principles and practices needed to promote mental health for a local population by: 1) addressing population-based needs in ways that are accessible and acceptable; 2) building on the goals and strengths of people who experience mental illnesses; 3) promoting a wide network of supports, services, and resources of adequate capacity; and 4) emphasizing services that are both evidence based and recovery-oriented (Thornicroft et al., 2011).

1.8 Layout of the study:

1.8.1 Chapter 1: Introduction

In this chapter, the researcher presented a simplified background for the study, then sets the research problem and explained the importance and justification of the study and then sets objectives, questions and hypothesis of the study. After that, the researcher provides some details about the context of the study.

1.8.2 Chapter 2: Conceptual framework and literature review

Here, the researcher talked about the theoretical and conceptual framework for the study, and explain the dimensions of patient satisfaction. Thus, the researcher reviewed of the results of previous studies on patient satisfaction for health services and methods and techniques used to measure patient satisfaction.

1.8.3 Chapter 3: Methodology of the study

This chapter focuses on the research methodology used in this study, where the researcher explains select study design, study population, study setting, study period, sampling and sampling process, sampling and ethical considerations; the researcher also explains the study instrument, method of validity, reliability, piloting and data collection. After that, the researcher explains methods of entry analyses, eligibility criteria and the limitations of the study.

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1.8.4 Chapter 4: Results

In this chapter, the researcher presents the results of statistical and descriptive analysis of the data. Also, the level of patient's satisfaction with CMH services in relation to dependent variables and the differences between the selected variables and overall satisfaction scores and with sub-scales were explored by using different analytical statistical tests. In addition to results of hypotheses and description of the statistical significance and insignificance between dependent and independent variables. And finally present the results of qualitative data.

1.8.5 Chapter 5: Discussion

In this chapter, the researcher discusses the aspects of the findings that are consistent with previous studies and theoretical explanations and those that are not in agreement. Also; discussion of study hypotheses.

1.8.6 Chapter 6: Conclusions and recommendations

The study conclusions are the researchers attempt to show what has been knowledge gained by the study and attempt to generalize the findings and also an attempt to summarize and recommended some suggestions.

Chapter (2)

Conceptual framework
and
Literature review

2.1 Introduction:

This chapter reviews the literature that reflects different issues related to patients' satisfaction. A detailed description and discussion in the light of previous studies for each domains of satisfaction and the factors affecting satisfaction such as; socio-demographic factors of psychiatric patients, mental disorders related factors and CMH centers delivery factors. Also; CMH centers development in Palestine. After that, definition, concept, values and theories of patients' satisfaction. The relationship between satisfaction and quality of care. How to measuring of patients' satisfaction. Lastly, an extensive review of studies conducted in Palestine about patient's satisfaction and about patients' satisfaction with mental health services.

2.2 Conceptual framework:

The patients' satisfaction is the most important indicators on the quality and effectiveness of services provided by any health institution, and to improve the quality of health services, mental health managers and CMH team need to identify factors influencing patient satisfaction and determinants of patients' satisfaction and to identify factors related to patient and factors related to services provided by all of this will be seen in the following view through a review of the literatures:

The evaluation of patient satisfaction enables services to obtain a more complete and balanced view on the overall quality of care, and also presents an opportunity to involve patients in identifying areas for improvement (Delgadillo, 2010). Patients' satisfaction has always been and will, to a greater extent, continue to be, a fundamental requirement for the clinical and financial success of any sized organization providing health care, regardless of specialty (Shelton, 2000).

2.2.1 Domains of satisfaction:

2.2.1.1 General impression:

Refers to the degree of general impression of the patients with all of the services provided to them, it measures the overall impression about the mental health team, quality of the services, the environment and CMH services in general.

2.2.1.2 Accessibility of care:

Refers to the degree of how the CMH services at MOH are accessible to patients. Blazevska et al. (2004) defined accessibility as a performance dimension addressing the degree to which an individual or a defined population can approach, enter, and make use of needed health services. Reaching services that are affordable and available at convenient times and places, are fully accessible with no physical barriers, and have no inappropriate eligibility requirements or social barriers (COPE, 2005)

2.2.1.3 Communication, interaction and information:

Refers to ability of the CMH team to communicate and interact with patients in professional manner. It reflects to extent the CMH team succeeded in exchanging

related information with patients, degree of patients respectful by mental health care providers and level of responsiveness, empathy, effective listening between mental health team and the patients.

2.2.1.4 Physical environment of the center:

Physical environment of the center refers to the physical setting in terms of cleanliness, availability of comfortable seating, wide waiting area, arrangement of furniture, good lighting and ventilation, clean bathrooms and water.

2.2.1.5 Technical quality:

Refers to the ability of CMH team members to deliver a good quality of CMH care to the patients and working with Show the highest level of professionalism.

2.2.1.6 Convenience and responsiveness:

Refers to the extent of convenience expressed by patients regarding waiting time, noise and crowdedness.

2.2.2 Factors affecting satisfaction:

Patients' satisfaction is determined by their expectations for CMH services they receive. There are several factors affecting patients' satisfaction, some of these external factors, some related to the patient and his psychological state. These factors are:

2.2.2.1 Socio-demographic factors of psychiatric patients:

Satisfaction could be influenced and impacted by age, sex, marital status, level of education, place of living, occupation and income.

Hall and Dornan (1990) review the evidence of the relationship between patient satisfaction and patient socio-demographic characteristics using quantitative meta-analytic techniques. The researchers used standard and accepted methods for identifying published quantitative analyses of patient satisfaction where information on the association among patient characteristics and satisfaction were presented. 110 published reports were included in the analysis. For each study, each correlation was extracted and coded as to which of the 11 aspects of care it pertained to; the 11 aspects of care were: access, cost, overall quality of care, humaneness of providers, competence of providers, information given by providers, bureaucracy, physical facilities, providers' attention to psychosocial problem, continuity of care and outcome of care. The study reports several interesting contrasts among variables, such as sex and ethnicity. The researchers conclude by stating that in overall terms, it appears that patient satisfaction is associated with age and education and nearly significantly associated with social and marital status. The researchers continue to state that the associations may be due to response patterns on the part of the groups identified or they may be mediated by events and processes that occur during the medical care encounter (Hall and Dornan, 1990).

2.2.2.2 Mental disorders related factors:

There are factors other than socio-demographics can affect patients' satisfaction that other factors related to mental health status, duration of disorder and psychiatric diagnosis.

2.2.2.3 CMH centers delivery factors:

In addition to socio-demographics and mental disorders related factors, the mode of service delivery affects more or less on patients' satisfaction and these factors such as, the continuity of provider, mental health education for patients, drug supply, continuity of service, access for unable to attend to CMH centers and patient adherence to treatment plane.

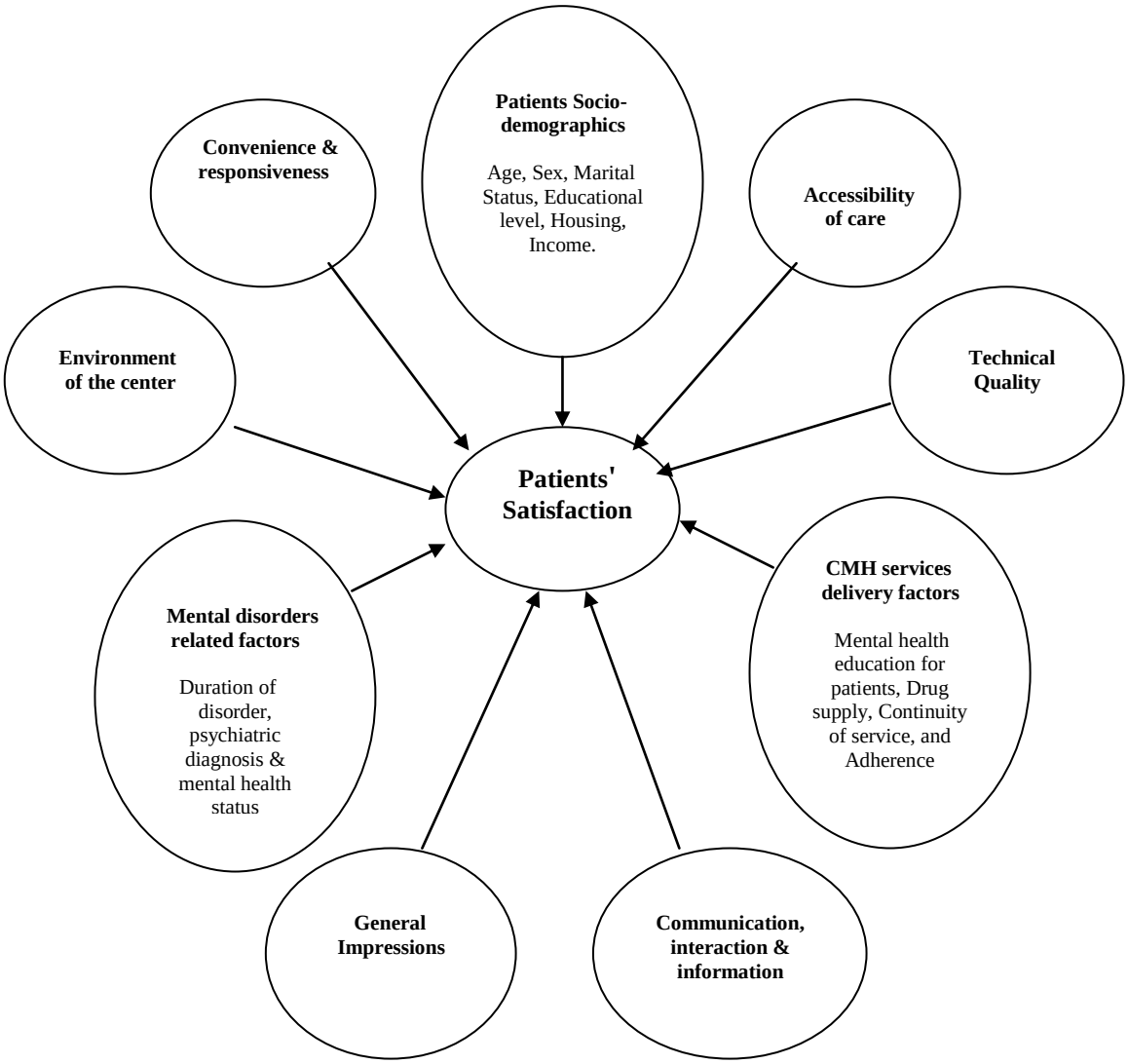

Figure 2.1 Conceptual framework self developed

2.2.3 CMH centers development in Palestine:

Abu Sway, mental health officer at WHO in article published in This Week in Palestine that, Palestinians are exposed to multiple risk factors compounded by the harsh everyday realities of the occupation. This leads to a loss of perspective, anger, frustration, humiliation, and a feeling of entrapment, which increases the risk of developing stress-related mental health problems (such as anxiety and depression) and potentially worsens the outcomes of serious mental health problems (such as schizophrenia and bipolar disorder). But even though the whole population suffers from the occupation and its consequences on daily life, specific groups, such as children, youth, women, the elderly, and people with mental disorders, are much more vulnerable and at risk than others. There is a consistent body of evidence to suggest that there are well-defined risk factors or determinants that impact very significantly on the prevalence and outcome of common mental health problems, for example, poverty, continuous conflict situations, stressful life events, unemployment, low levels of education, drug abuse, gender-based and domestic violence, and chronic physical health problems such as physical disabilities, heart disease, diabetes, and other non-communicable disorders. According to WHO's global burden of disease (Mental Health Report, 2001), 33 percent of the years lived with disability are due to psychiatric disorders. This growing burden mounts a huge cost in terms of human misery, disability, and economic loss. The widening recognition of mental health as a significant international public health issue has led to the growing need to demonstrate that investment of resources in service development is not only required but also worthwhile. WHO has developed a pyramid framework which conceptualizes an optimal mix of services for mental health? It reinforces the idea that no single service will meet all needs, and that what is needed is an optimal mix of a range of services. In Palestine there are two psychiatric hospitals, one in Bethlehem (180 inpatient beds) and one in Gaza (50 inpatient beds), several CMH centers, local NGOs, and traditional healers. In 2004, the Palestinian MOH adopted its national mental health strategy, whose main objective was to strengthen, organize, and improve the mental health services in Palestine based on a community-based approach and with the support of international and local partners, through the implementation of the following specific objectives:

- To develop CMH services (e.g., day centers, rehabilitation services, therapeutic and residential supervised services, etc.)
- To integrate people with mental health disorders into society so that they can be productive and valued members of the community.
- To raise awareness about mental health issues in order to lessen the stigma and fear surrounding people with mental health problems who are often stigmatized, marginalized and assumed to be lazy, weak, unintelligent, and incapable of making decisions.
- To decrease admissions to psychiatric hospitals and to strengthen CMH services in general hospitals primary health care programmes.
- To improve the capacity of primary health care in detecting, assessing, and treating people with common mental health problems.

Palestine is regarded as a regional pioneer in the development of a national mental health strategy that encourages community-based mental health centers. Nevertheless the development of CMH services in Palestine is still in progress and needs further support and long-term commitment to ensure the provision of comprehensive services and support to sufferers and their families (Abu Sway, 2010).

There are many advantages to providing mental health centers based in the community: Enhances continuity and comprehensiveness of care. Addresses the essential elements of a comprehensive psychosocial rehabilitation strategy that includes social reintegration, employment, housing and general welfare. Improves outcomes and cost-effectiveness of treatments, particularly when informal mental health services such as traditional healers, families, self-help groups and volunteer's workers are given adequate direction, support and opportunities to develop (Final Report, February 2004).

2.2.4 Definition of satisfaction:

Satisfaction; like many other psychological concepts, is easy to understand but hard to define. The concept of satisfaction overlaps with similar themes such as happiness, contentment, and quality of life. Satisfaction is not some pre-existing phenomenon waiting to be measured, but a judgment people form over time as they reflect on their experience. A simple and practical definition of satisfaction would be the degree to which desired goals have been achieved (Health Strategy Implementation Project, 2003). Another definition, the satisfaction means the degree to which the individual regards the health care service or product or the manner in which it is delivered by the provider as useful, effective, or beneficial (Mondofacto Medical Dictionary, Dec 1998).

Also, Sitzia and Woods (1997) defined Satisfaction as fulfilling expectations, needs, or desires. It also viewed satisfaction as a function of expectations and the degree to which the experienced performance differs from expectations (Sitzia and Woods, 1997). Patient satisfaction is the appraisal, by an individual, of the extent to which the care provided has met that individual's expectations and preferences (Brennan, 1995). Then, Linder-Pelz (1982), defined patient satisfaction as "the individual's positive evaluations of distinct dimensions of health care" (Linder-Pelz, 1982). Moreover, Harris and Poertner (1998) defined Client satisfaction as clients' perspectives on aspects of the service transaction important to them (Harris and Poertner, 1998).

2.2.5 Concept and values of patients' satisfaction:

Satisfaction is a psychological concept which is defined in different ways. Sometimes satisfaction is considered as a judgment of individuals regarding any object or event after gathering some experience over time. According to some theorists, satisfaction is a cognitive response whereas some others consider satisfaction as emotional attachment of individuals (Chakraborty and Majumdar, 2011). The concept of patient satisfaction has a long history of controversy and debate. Yet patient satisfaction remains a topic of scientific investigation. But little is known about its relations and importance regarding the monitoring of the right to health (Mpinga and Chastonay, 2011). Also, Donabedian (1988) defines patient satisfaction as the expression of patient's judgment on the quality of care received in all aspects, but particularly as concerns the interpersonal process (Donabedian, 1988).

Moreover; Sitzia and Wood (1997) suggest that patient satisfaction could be assessed by measuring 1) the degree to which patients believe that care possesses certain attributes and 2) the patient's evaluation of those attributes. They suggest that satisfaction is not single concept made up of multiple determinants, but that there exists three independent models of satisfaction, each associated with one determinant. Thus,

there is the “need for the familiar,” the “goals of help-seeking” and the “importance of emotional needs.” Furthermore, there is evidence that there are two states of satisfaction, stable ones related to health care generally and dynamic ones related to specific health care interactions (Sitzia and Wood, 1997).

Linder-Pelz (1982) deconstructs the concept of patient satisfaction in order to develop a more coherent theory of the concept. The author starts by reviewing the various components that have been hypothesized to constitute patient satisfaction: accessibility/convenience, availability of resources, continuity of care, efficacy/outcomes of care, finances, humanness, information gathering, information giving, pleasantness of surroundings, and quality/competence. The author found no theoretical formulation of patient satisfaction and thus began her own theoretical work from theories of job satisfaction, as seemingly little ethnographic work on patient satisfaction had been conducted. The author concludes that patient's satisfaction is an attitudes or affective response. However, as there was a question as to what theoretically patient satisfaction was, there was also a question as to what determines levels of patient satisfaction. The author turned theories of attitudes and beliefs and found that the relationship between expectations (beliefs that something will happen) and whether they are met or not determine attitudes (Linder-Pelz, 1982).

Over time and years the concept of patient satisfaction shows an evolution towards complexity, while becoming more operational (Mpinga and Chastonay, 2011).

2.2.6 Theories of patient satisfaction in health care:

Gill and White In their study that conducted under the entitled, A critical review of patient satisfaction of summarizing the theories behind studies of patient satisfaction in health care, which they said that; The major patient satisfaction theories were published in the 1980s with more recent theories being largely “restatements” of those theories (Hawthorne, 2006). Five key theories can be identified:

(1) Discrepancy and transgression theories of Fox and Storms (1981) advocated that as patients’ healthcare orientations differed and provider conditions of care differed, that if orientations and conditions were congruent then patients were satisfied, if not, then they were dissatisfied.

(2) Expectancy-value theory of Linder-Pelz (1982) postulated that satisfaction was mediated by personal beliefs and values about care as well as prior expectations about care. Linder-Pelz identified the important relationship between expectations and variance in satisfaction ratings and offered an operational definition for patient satisfaction as “positive evaluations of distinct dimensions of healthcare” (p 578). The Linder-Pelz model was developed by Pascoe (1983) to take into account the influence of expectations on satisfaction and then further developed by Strasser et al. (1993) to create a six factor psychological model: cognitive and affective perception formation; multidimensional construct; dynamic process; attitudinal response; iterative; and ameliorated by individual difference.

(3) Determinants and components theory of Ware et al. (1983) propounded that patient satisfaction was a function of patients’ subjective responses to experienced care mediated by their personal preferences and expectations.

(4) Multiple models theory of Fitzpatrick and Hopkins (1983) argued that expectations were socially mediated, reflecting the health goals of the patient and the extent to which illness and healthcare violated the patient’s personal sense of self.

(5) Healthcare quality theory of Donabedian (1980) proposed that satisfaction was the principal outcome of the interpersonal process of care. He argued that the expression of satisfaction or dissatisfaction is the patient's judgment on the quality of care in all its aspects, but particularly in relation to the interpersonal component of care (Gill and White, 2009).

2.2.7 Satisfaction and quality of care:

Quality management has become one of the most important and most debated topics within the service sector (Anderson and Zwelling, 1996). Service quality arose out of the need for a concept which described how customers perceived the quality of a service, with particular reference to the service industry. It was believed that once the service provider knew how customers evaluated the quality of its service, it would be in a better position to not only influence these evaluations in a desired direction, but also to relate the service to customer benefits (Gray, 2007).

Wolosin considers that patient satisfaction as an indicator of the quality of care and integrates in its definition the patients' experiences as a key-element of (un)satisfaction. Wolosin argues that experiences that exceed expectations lead to satisfied patients, while those that fail to meet expectations cause dissatisfaction. Patient's satisfaction is the voice of patient that counts since it reflects the response to experienced interactions with the care givers (Wolosin, 2005). Providers can minimize the risk of malpractice suits by focusing on patient satisfaction outcomes (Abeln, 1994). At another point; Abeln said that, *Ensuring patient satisfaction can provide therapists with an edge in managing the risk of medical negligence claims* (Abeln, 1994). Patient satisfaction survey data provide valuable information about how well healthcare organizations and their individual departments are meeting the needs and expectations of their patients. Lack of sufficient data can severely inhibit an organization's ability to understand its strengths and to target areas in which performance can be improved (Allen, 1998). Then, Allen (2000) said that *the patient complaint tracking system enables staff, managers, teams, and departments to develop improvement efforts based on quantitative and qualitative data.* Al-Mailam (2005) concluded that patient satisfaction surveys can be of great value to health care providers not only in recognizing and improving the quality of care, but also as predictors of return-to-provider behavior of the patients (Al-Mailam, 2005).

The researcher sees that patients could relatively pass judgment on those services provided to them if they like the services and gained satisfaction This rule them on the quality of those services and the opposite side, if patients are impressed and satisfied those services, it means that those services is poor to the extent that it did not possess satisfaction and patient acceptance.

2.2.8 Measurement of patients' satisfaction:

Satisfaction and its measurement are important for public policy analysts, healthcare managers, practitioners and users. Despite problems with establishing a tangible definition of "satisfaction" and difficulties with its measurement, the concept continues to be widely used. In many instances when investigators claim to be measuring satisfaction, more general evaluations of healthcare services are being undertaken. Then; Satisfaction can be measured indirectly by asking users to rate the quality of services they have received, or report their experiences. Selection (or de-

selection) of providers is an objective behavioral indicator of satisfaction in healthcare systems where consumers' choices are not constrained. Healthcare is a multi-dimensional service, but many means of measuring satisfaction do not show consumers' relative preferences for different attributes, even though such information is important for cost-effective decision-making (Crow et al., 2002).

Measuring of patient satisfaction is the most important mechanisms for evaluation and follow-up, is an essential step to analyze the strengths and weaknesses in performance, and develop ideas for the development and improvement in services provided. Measuring patient satisfaction: Is the systematic efforts by the health institution to determine the degree of satisfaction of their patients about what to offer their services and programs in order to provide institutional and programmatic adjustments necessary to become more responsive to the needs and aspirations of patients and members of the community which it serves (Harris and Poertner, 1998).

Then, the measurement of client satisfaction is becoming increasingly popular because of its role in quality assurance and continuous quality improvement systems. Clients have a wealth of information regarding the functioning of social service programs, and gathering their views can provide insight and information useful for improving services (Harris and Poertner, 1998).

The measurement of patient satisfaction is of value to the health system: indeed, it allows a) to describe and characterize its functioning; b) to identify existing problems in the sector; c) to evaluate the quality of care (Stizia and Wood, 1997).

The most common method for assessing client satisfaction is with self-administered questionnaires. These may be given to clients as they enter or leave services, or at various times in between. They can also be administered at some point after treatment has been completed, when the outcomes of treatment are clearer to the client (WHO, 2000).

Client satisfaction also can be assessed in face to face or telephone interviews or focus groups. These strategies are more expensive than self-completed questionnaires. If interviews or focus groups are used, it is preferable to have them conducted by someone who is not connected directly with the service. This may be an independent evaluator, volunteers or former clients themselves trained to take on this role. If interviews or focus groups must be done by a manager or staff member, it is best not to have the individual's principal therapist ask about client satisfaction because clients may be reluctant to comment negatively about their treatment directly to their therapist (WHO, 2000).

On other hand, Greg Ford; stated in his report about measuring consumer feedback that, patient satisfaction surveys are one of a number of methods available to hospitals to seek consumer feedback. By themselves, patient satisfaction surveys are a passive form of consumer participation and provide hospitals with only a limited picture of what consumers think about their care. Integrated with other methods of seeking consumer feedback and as a component of a larger consumer participation program, patient satisfaction surveys add valuable information about consumers' overall perceptions of their care (Ford, 2001).

After reviewing the methods used to measure patient satisfaction, such as, self-administered questionnaires, face to face interviews, telephone interviews and focus

groups a researcher preferred to use face to face interviewing questionnaire method on other methods as a tool to measure patient satisfaction for ease of application among psychiatric patients.

2.2.9 Dimensions of patients' satisfaction:

There are several dimensions of satisfaction emerged from the literature. In the study conducted in GS by Al Hindi (2002) explored the clients satisfaction with radiology services in GS. The researcher identified these dimensions of satisfaction as organizational culture, continuity and affordability, availability, communication and interaction, attitude and perception, comfort and privacy, and approach of care (Al Hindi, 2002).

Also, a study done in GS by Mousa (2000) studied clients satisfaction with family planning services in GS included domains of satisfaction; attitude and expectations, information and counseling, communication and interaction, mechanism of care and delivery of care (Mousa, 2000).

Furthermore, Abu Shuaib (2005) conducted a study to assess women perception and experience of childbirth services at governmental hospitals in GS. The researcher identified these dimensions of satisfaction, approach of women care, approach of baby care, counseling, attitude and respect, information and communication, decision participation, privacy and ward environment (Abu Shuaib, 2005).

In other study conducted by Abu Salleek (2004) to assess level of clients satisfaction with nursing care provided at selected hospitals in GS, The researcher identified six dimensions of satisfaction with nursing care; information and interaction, availability/attentiveness and openness, comfort and environment, nurses skills and professionalism, organizational culture, counseling and advising (Abu Salleek, 2004).

Another study conducted by Alkariri (2010) to assess patients' satisfaction with the outpatients services at Alshifa Hospital, identified five dimensions of satisfaction, access to care, physical environment, patent expectations, waiting time, information and interaction (Alkariri, 2010).

Moreover, Sitzia and Wood (1997) in a study patients' satisfaction: A Review of Issues and Concepts; suggest three components of satisfaction consist of: structural, technical and interpersonal aspects of care. The structural aspects includes: access, physical setting, costs, convenience, and treatment by non-clinical staff/insurers. The technical aspects include knowledge, competence/quality of care, interventions, and outcomes. The interpersonal aspects includes: communication, empathy, and education (Sitzia and Wood, 1997).

Backhouse and Brown (2000) explored the patient satisfaction in large general hospital. The study explored 5 dimensions of care; primary nursing, information, ward environment, discharge planning and social activity (Backhouse and Brown, 2000).

The researcher used 6 domains of patients' satisfaction with CMH services based on literature review as follows: accessibility of care, communication, interaction and information, physical environment, technical quality, convenience and responsiveness.

2.2.9.1 Accessibility of care and patients' satisfaction:

Possibility and ease of access of patients to health services they need will affects their level of satisfaction with the services provided.

Witt (2006) talked about the important of access for the patient in appointments, phone access (wait time), staff responsiveness, access to physicians for questions, results reporting (laboratory, imaging, etc.), timeliness of referrals, and office wait time. Accessibility and certain organizational aspects are the dimensions that patients most commonly mentioned as causes of dissatisfaction (Mira et al, 2002).

Kroneman et al. (2006) in their study in 18 European countries addressed the question, to what extent the direct access to health care services affects the level of patients' satisfaction with the GP services. The study concluded that, higher level of satisfaction was reported among patients who had a direct access to services than those with a gate keeping services (Kroneman et al, 2006).

2.2.9.2 Communication, interaction and information and patients' satisfaction:

Focusing on the patient has drawn attention to the importance of the interpersonal aspects of care, such as communication between the health care provider and patient (Press, 2002). Altschul (1983) said that, *Lack of communication with patients is most frequently criticized by patients and by nurses. Because of these nurses increasingly believe that patients may need help to make their views known and increasingly incorporate patient-advocacy in their role* (Altschul, 1983).

Kattel (2010) study conducted to examine doctor patient communication to ensure better quality of health service delivery in Nepal. 7 doctors and 30 patients participated in the study. Both doctors and patients were handed out a questionnaire survey. Data collection also included non-participatory observation in medical out-patient department and inpatient medical department. Structured interview was carried out with 5 administrative personnel. The result depicted patients responding on a positive tone regarding their communication with doctors more than half of the patients were satisfied with the care and had no complaints. Good doctor patient communication has not received much attention in the study of health care service delivery in Nepal. Quality medical care depends on effective communication between patients and health professionals. Misunderstanding can occur in any medical setting but can be further compounded by lack of compliance by patients, dissatisfaction, and negative health outcome and increase risk of malpractices. The result was consistent with patient's age, gender, occupation and education and that patient's low literacy and health awareness inhibited them to take control of their health. Doctors low communication skill and lack of support from hospital managements was another factor for them to focus on the biomedical perspective of health. Understanding about doctor patient communication is still not taken as an important part in treatment practice. This is due to both parties, on one hand, doctor's lack of time and understanding of patient's behavior and work pressure where as on the other hand patients low awareness level, technological problems, and status gap between doctor and patients (Kattel, 2010).

Ruggeri et al. (2003) conducted a study on 404 schizophrenic patients in 5 European sites and addresses 5 questions focused on site, service, and patient

characteristics as that might explain service satisfaction, using the verona service satisfaction scale. Patient satisfaction differed significantly across sites (highest in Copenhagen, lowest in London). In all sites; patients were least satisfied with involvement of relatives in care and information about illness (Ruggeri et al., 2003).

Brown et al. (1999) study conducted to test the effects of a common communication skills building program designed to increase physician's listening and communication skills on patient satisfaction ratings of provider communication during specific medical care encounters. The intervention group simply attended the program in advance of the control group. Patient satisfaction was assessed using the Art of Medicine Survey and assessed patients' satisfaction with communication skills during a specific encounter and overall with care received from the clinician. General estimating equations were created, controlling for baseline patient satisfaction scores and results indicated that while patient satisfaction scores were higher among the intervention group, the difference was not statistically significant. Providers in the intervention group reported improvements in communication skills and lower frustration with visits. The authors concluded that while communication has been determined to be related to patient satisfaction it is unrealistic to expect a single brief continuing education course to improve general patient satisfaction in the "contemporary health care environment. (Brown et al., 1999).

Roter et al, (1997) studied communication patterns and their relationships with patient satisfaction. 127 physicians and 537 patients from 11 ambulatory care clinics and private practices in the US were participants in the study. Patient satisfaction was measured using a 43-item measure that taps 5 distinct and reliable dimensions of patient satisfaction: task-directed skill, attentiveness, interpersonal skill, emotional support, and physician-patient partnership. Results indicated that of visits fell into one of the following five provider communication patterns: narrowly biomedical, expanded biomedical, bio-psychosocial, and psychosocial and consumerist. Patient satisfaction was related to communication pattern; in multivariate models, patient satisfaction was significantly higher for patients in the psychosocial pattern of communication. The lowest ratings were for the narrowly and expanded biomedical model patterns, followed by the bio-psychosocial and the consumerist. Interestingly physicians were also dissatisfied with the narrowly biomedical pattern of communication (Roter et al., 1997).

2.2.9.3 Physical environment of the center and patients' satisfaction:

There is no doubt that the internal and external environment of the health center, such as hygiene, ease of movement, a widening in the waiting room, lighting and good ventilation all of this directly affects the level of satisfaction with the services provided.

Enhancing the facilities of the patient care environment improved patients' overall perceptions of the quality of their hospital stay (Kline et al., 2007). Then, Sadjadian et al. (2004) study conducted to examine patient satisfaction among women attending the Iranian Centre for Breast Cancer. The findings suggest that the physical environment and physicians' style of consultation contribute most to the patients' overall satisfaction.

2.2.9.4 Technical quality and patients' satisfaction:

Technical competence of service providers in health institutions is one of the most important determinants of patient satisfaction with the quality service they receive. Tam (2007) found that doctor's technical quality is the first of the nine identified factors that were key aspects of the medical service encounter that influenced patient satisfaction.

Edlund et al. (2003) study conducted to analyze the relationship between satisfaction and technical quality of care for common mental disorders. A nationally representative telephone survey of 9,585 individuals. Using multinomial logistic regression techniques the researchers investigated the association between a five-level measure of satisfaction with the mental health care available for personal or emotional problems and two quality indicators. The first measure, appropriate technical quality, was defined as use of either appropriate counseling or psychotropic medications during the prior year for a probable depressive or anxiety disorder. The second, active treatment indicated whether the respondent had received treatment for a psychiatric disorder in the past year. Covariates included measures of physical and mental health and socio-demographic indicators. Finding revealed that appropriate technical quality of care was significantly associated with higher levels of satisfaction. The strength of the association was moderate. Researchers concluded that satisfaction is associated with technical quality of care. However, profiling quality of care with satisfaction will likely require large samples and case-mix adjustment, which may be more difficult for plans or provider groups to implement than measuring technical indicators (Edlund et al., 2003).

Al-Hamdan (2009) study conducted to examine the link between the waiting time and various dimensions of service quality using the SERVQUAL tool. In addition to assessing the level of outpatient satisfaction and determining the variables that affect the overall outpatients satisfaction in major hospitals in Kuwait (Al-Hamdan, 2009).

Alasad and Ahmad (2003) have conducted a study to assess patients' satisfaction with nursing care at a major teaching hospital in Jordan. A total of 266 in-patients participated in the study. The findings showed that patients in surgical wards had lower levels of satisfaction than patients in medical or gynecological wards. Gender, educational level, and having other diseases were significant predictors for patients' satisfaction with nursing care (Alasad and Ahmad, 2003).

Al-Elisa et al. (2003) have conducted a study to examine patients' satisfaction with primary health care services at capital health region in Kuwait a cross sectional survey using questionnaire was conducted on convenient sample of 1250 patients aged 18 years and above was included in the study , the response rate of completed questionnaire was 82.8%, the results of this study showed that although the overall satisfaction was high , some aspects of the services indicated some degree of dissatisfaction , and some physicians service items need suggestions and corrective intervention (Al-Elisa et al., 2003).

2.2.9.5 Convenience and responsiveness and patients' satisfaction:

In study conducted by Alkariri (2010) in Gaza to assess patients' satisfaction with the outpatient's services at Alshifa Hospital, revealed that domain of waiting time reported the lowest level of satisfaction 58.8%, this could be attributed to overloaded outpatients. In another study conducted by Westaway and colleagues (2003) to determine the underling dimensions affecting patients satisfaction in South Africa's primary health care settings, pointed that irrespective of the country setting the highest degree of dissatisfaction are with the waiting time which can reach to an hour or more (Westaway et al., 2003).

2.3 Literature review:

2.3.1 Patients' satisfaction with health care services in Palestine:

There are some studies in Palestine regarding patients' satisfaction but this study considered the first study in Palestine (to the knowledge of the researcher) concerned on patients' satisfaction with CMH services.

El khatib (2010) investigated level of satisfaction among patients with Non-Communicable Diseases receiving services from UNRWA health centers in GGs. 400 patients were completed questionnaire with response rate (81.8%). The findings showed that, unmarried, working, living in the south, educated, and patients who received educational materials were statistically significantly more satisfied than their counterparts. In contrary, gender, age, presence of disability, type of treatment provided, and duration of NCDs showed no statistically significant differences in level of satisfaction. Then the study reported overall satisfaction level with NCDs services was moderately high (71.9%) (El khatib, 2010).

Al kariri (2010) assessed patient level of satisfaction with health services provided at Outpatients Department at Al Shifa Hospital. 450 patients were completed questionnaire with response rate (90%). 5 dimensions of patients' satisfaction were considered; access to care, physical environment, patients' expectations, waiting time and information and interaction. The overall patients' level of satisfaction was 63.9%. The patients' expectation dimension reported highest level of satisfaction (68.1%), while, waiting time dimension reported the lowest (58.5%). The study revealed that, there were statistically significant differences in overall satisfaction with old patients, females, low educated, patients with low income and patients with chronic diseases are more satisfied than their counterparts. In contrast, residency place, marital status, number of visits, presence of disability, recipient outpatient clinic, and place that consumed most of the visit time did not show statistically significant difference on patients' level of satisfaction. The study recommended that reduced patients' time in the outpatient clinic, introducing improvement on existing physical environment of the department and improving way of communication and interaction between health care providers and patients are important factors for improving the patients' level of satisfaction (Al kariri, 2010).

Ahmad (2009) in a study conducted to investigate women's levels of satisfaction with obstetric care received at Shifa Hospital. 425 women interviewed and completed questionnaire. The overall level of satisfaction was 61.8%. The study concluded 6 dimensions comprising clients satisfaction; technical competency, availability and responsiveness of services, information and communication, interpersonal manner and physical environment. The dimensions of information and communication and the physical environment elicited the lowest scores (49%). Older women, women with low educational levels, housewives, women with unemployed husbands and women with lower household monthly incomes had greater satisfaction levels with statistically significant differences in comparison to their counterparts. The study provided a frame for improving women satisfaction about delivery services at Shifa Hospital. There is a need to reinforce information and communication and to improve the physical setting of the delivery services (Alhmad, 2009).

Hillis (2008) in study to evaluate level of outpatients' satisfaction with physiotherapy services in outpatients physiotherapy departments at Al-Shifa Hospital and Al-Wafa Medical Rehabilitation Hospital in Gaza. 151 patients were selected conveniently. The findings indicates that; level of patient satisfaction in both hospitals has been (87.4%). There are no significant statistical relationships between the demographic variables (gender, and age groups) and patient satisfaction level with physiotherapy services, but there are significant relationships between residency place and patient satisfaction level. There are no significant statistical differences between the socio-economic variables (marital status, and educational level) regarding patient satisfaction while there are significant statistical differences between occupation and patient satisfaction with physiotherapy services. There are significant statistical differences between the organizational variables (payment sources of medical care, medical diagnosis groups, hospital knowledge groups, the first experience of hospital, the first experience of physiotherapy services, the physiotherapy session duration and physiotherapy sessions number) and the patient satisfaction, while there are no significant statistical differences between waiting time and patient satisfaction with physiotherapy services. There are correlations in level of patient's satisfaction with physiotherapy services regarding the patients' acceptance of physiotherapist except in appointments registration domain (Hillis, 2008).

Al Sharif (2008) in a study conducted to measure patients' satisfaction with services provided at Nablus hospitals, and to determine factors affecting patients' satisfaction including room services, technical quality and interpersonal skills of health care providers, accessibility and availability of services. 365 adult inpatients were interviewed using a questionnaire. The study revealed that the patients in non-governmental hospitals were more satisfied than patients in governmental hospitals. About 70.2% of respondents rated their general satisfaction with governmental hospitals as good to very good. While in non-governmental hospitals, more than 90 % rated it as good to very good. The results indicated that older patients were more satisfied than the younger ones; females were found more satisfied than males. In addition to this, patients with high income were more satisfied than others with low income. Also healthier patients were more satisfied than sicker patients. However, patients who were waiting long time in the reception area, to get a bed in the hospital, were less satisfied than the others, while obstetric patients were found to be the most satisfied (Al Sharif, 2008).

El-haj (2008) in study conducted to assess perception of hospitalized patients about services provided at European Gaza Hospital. The findings revealed that, clients with lower education levels reported higher scores of satisfaction with hospital services than clients with higher education levels. The researcher mentioned that females usually have better perception about the health care services than males. He said that most studies showed that older age are more satisfied than younger ones about the services they receive. In addition, people were not fully aware about their rights in receiving health care services. Study conclude that delivery of higher quality health care services would return population overall trust in the health care system and it would necessarily decreased numbers of referrals outside GG (El-haj, 2008).

Abu Hashem (2007) study, aimed to identify the level of patient's satisfaction, and the expenses of the treatment abroad services that presented by Palestinian MOH. A purposeful sample was 102 subjects who were transferred in year 2005 for treatment in Jordan, Israel, and Egypt. Across-sectional design was used. The study findings presented 52% tend to satisfied from the services that offered by Abroad Unit at MOH.

About 52.9% of subjects reported their satisfaction with the performance of the medical doctors at local hospital before traveling to abroad. The subjects were reported 69.9% of satisfaction level from the treatment abroad as follows: The highest satisfaction level from Jordan 88.9%, then Israel 76.9%, and the lowest percentage was Egypt 60.3%. Also, the study revealed that high cost of medical services abroad that led to a financial burden on MOH. The researcher recommended that the need to improve the performance of doctors to alleviate burden on MOH and patients from travel suffering (Abu Hashem, 2007).

Abu Mourad et al. (2007) in study conducted to identify the level of patients' satisfaction with primary care physicians. Data were gathered from an exit interview using a standardized questionnaire (EUROPEP) and background variables. A total of 956 patients in 50 primary health care clinics in GS participated. Outcome measures are positive patient satisfaction (good and excellent ratings in EUROPEP Index). As results, the mean percentage of positive satisfaction with medical services was poor (41.8%). The poorest performance was recorded for: getting through to the clinic on the phone, being able to speak to physician on the telephone, time spent in waiting rooms and helping the patient deal with emotional problems. The comparison between clinical behavior dimension and organization of care showed that clinical behavior was evaluated higher. In conclusion, Palestinian patients expressed overall dissatisfaction with services provided by primary care physicians. These findings present a real challenge for Palestinian authority policy makers and administrators in terms of designing appropriate quality improvement strategies (Abu Mourad et al., 2007).

Abu Shuaib (2005) study conducted to assess women perception and experience of childbirth services at governmental hospitals in GS. The researcher identified these dimensions of satisfaction, approach of women care, approach of baby care, counseling, attitude and respect, information and communication, decision participation, privacy and ward environment. 450 women from 4 hospitals were completed an exist interview questionnaire . Response rate was 86.9%. The finding revealed that, the overall mean of perception scores was 2.1 (70%) in all hospitals indicating that women generally had positive perception about the services they received. The study concluded that the demographics, socio-economic variables including the age, place of living, household monthly income and education level showed a statistically significant impact on perceptions. Also, maternal variables as woman age at first marriage, No. of parity and past experience showed a statistically significant impact on perceptions and their satisfaction. On the other hand, age of woman and employment status showed no significant impact on women's perception and satisfaction with childbirth services. The study concluded that maternity services for women in GS should respond to call for greater women involvement, and introducing policies to support the development of woman centered maternity services. (Abu Shuaib, 2005).

Abu Harbeid (2004) study conducted to assess degree of women's satisfaction with antenatal care provided at MOH and UNRWA in GS. Exit interview for 504 clients randomly selected at primary health care. The response rate was 92.8%. The findings revealed that, level of satisfaction represented with provider competence was 83%, service provider consultation was 62%, interpersonal relations was 81%, waiting time was 86%, accessibility was 89.5%, infrastructure was 82%, drug availability was 79.5%, general satisfaction was 89.5% and overall satisfaction was 79.3%, The study revealed some variables influencing satisfaction include age, educational level, employment status, service provider consultation, waiting time, health provider manners

and type of health sector. The study concludes that health education issues particularly services provider consultation needs intensive attention from health decision makers also, the waiting time has real impact on satisfaction level and active participation in communication process (Abu Harbeid, 2004).

Abu Saileek (2004) study conducted to assess level of clients' satisfaction with nursing care provided at European Gaza hospital and Nasser hospital in GS. Systematic randomized sample of a total of 427 clients admitted to medical and surgical wards and receiving nursing care during hospitalization. The response rate was 93.6%. The study identified 6 domains of satisfaction including; information and interaction, availability/attentiveness and openness, comfort and environment, nurses skills and professionalism, organizational culture, counseling and advising. The results showed that there is significant relationship between the service provider and satisfaction level. Overall satisfaction was 70.1% in both hospitals. The clients' in European Gaza hospital reported higher satisfaction 84.2% than the clients' in Nasser hospital 61.7%. The study concluded that the demographics, socio-economic variables including age, place of living, marital status, income, and education level showed a great influencing on the level of satisfaction. Also, the type of institution and organizational variables as; the payment of medical care, referral source, previous hospitalization in other hospitals, admission days, medical diagnosis groups, and choosing the same hospital in the future showed a significant relationship on the level of clients satisfaction. While, gender, and the ward showed no significant relationship on the level of clients satisfaction with nursing care (Abu Saileek, 2004).

Al Hindi (2002) in a study to assess the level of satisfaction with radiology services in Gaza. 410 clients completed structured questionnaire with response rate (78.04%). The study explored 7 dimensions of satisfaction including: organizational culture, continuity and affordability, availability, interaction and communication, attitude and perception, comfort and privacy and approach of care. The findings showed that clients reported a relatively high degree of satisfaction with radiology services (82.5%). The study concluded that the type of institution and organizational variables including the number of visits, waiting time and procedure time showed a great impact on the level of clients' satisfaction. On the other hand, age, gender, residency place and occupation of the respondents showed no significant impact on the level of clients' satisfaction (Al Hindi, 2002).

Mousa (2000) studied client's satisfaction with family planning services in GS. 377 family planning users were interviewed randomly. The response rate was 96.5% from UNRWA and 79.6% from MOH. The study included 5 domains of clients satisfaction; attitude and expectations, information and counseling, communication and interaction, mechanism of care and delivery of care. The overall satisfaction level of the family planning services was 72%. Clients attending UNRWA clinics were more satisfied of the services they received than clients attending MOH clinics. The findings reported that information and counseling process have high satisfaction level (89%), whilst; communication and interaction have the lowest degree of satisfaction (54%). Also, the study reported that the younger clients were more satisfied of the services than old age group; highly educated clients showed a higher level of dissatisfaction than lower educated clients, clients living inside refugee camps more satisfied with family planning services than clients outside refugees. The study concluded that the voices and views of clients are essential, but often neglected aspect in initiatives to determine areas of services were if improved could increase the level of satisfaction (Mousa, 2000).

2.3.2 Patients' satisfaction with mental health services:

It is very difficult to measure patient satisfaction on acute inpatient psychiatric units. The traditional method of using written surveys has a number of weaknesses. Cognitive impairment associated with acute exacerbations of schizophrenia, schizoaffective disorder, and severe depression can substantially influence patients' ability to complete these surveys, leading to inaccurate results. Unless surveys are conducted daily, a problem that can diminish patient satisfaction may persist for days before coming to the attention of staff. In many general hospitals, inpatient psychiatry is excluded from written patient satisfaction surveys, and thus the issue is ignored altogether. Yet the need to measure patient satisfaction in an accurate and timely manner persists (Maffei et al., 2009). Therefore, the researcher preferred to conduct the study on outpatient because of their psychological and mental health status relatively stable, insight and many of them visit the center and take their treatment alone. However, the researcher found a lot of studies conducted on psychiatric patients, whether they are in patients or outpatients.

Gani et al. (2011) study aimed to measure patient satisfaction in a tertiary care hospital. The cross-sectional study conducted at out-patient and inpatient departments of the institute of psychiatry, Benazir Bhutto Hospital, Rawalpindi. 246 patients; which included 123 participants from Out-patient and In-patient departments each patient aged 18 and above, of both genders. Learning disabled patients, frankly psychotic and those with severe cognitive impairment and severe co-morbid physical illnesses were excluded. The Client Satisfaction Questionnaire-8 was then orally administered in the native language to assess the degree of patient satisfaction. Among the participants, 72% were mostly satisfied, 18.7% mildly satisfied and 9.3% dissatisfied with the psychiatric care. Age was significantly associated with satisfaction however no such associations could be found for gender and economic status. The study concluded that majority of the patients were satisfied with the psychiatric services. The younger people were more satisfied. Gender and economic status had no influence on patient satisfaction (Gani et al., 2011).

Kantorski et al. (2009) Qualitative and quantitative study conducted in psychosocial health care services in the states of Paraná, Santa Catarina and Rio Grande do Sul, Southern Brazil. Quantitative epidemiological data from a cross-sectional study including 1,162 users of 30 psychosocial health care services was used. Brazilian version of WHO Users' Satisfaction Scale (SATIS-BR) was used. Qualitative data was collected from 5 case studies using a fourth generation approach. The SATIS-BR scale showed that users positively evaluated all items, overall mean 4.4. Communication and relationship with psychosocial healthcare services staff had mean 4.5, and access to information through staff had mean 4.8. Satisfaction with care service was the lowest, mean 4.1, and general service infrastructure had mean 3.9. The qualitative study revealed that, according to users, the quality of treatment provided was good and the outcome was satisfactory. The complementary results of both study approaches showed that users are satisfied with care provided at the psychosocial healthcare services studied (kantorski et al., 2009).

Davy et al. (2009) in study examined client satisfaction in different types of psychiatric outpatient care facilities and its association with treatment setting, patient socio-demographic and clinical variables. The 12 public outpatient psychiatric clinics

for adults in Geneva, Switzerland, offer a rich variety of settings including general psychiatry clinics, crisis centers and specialized programmes for specific disorders (depressive disorders, bipolar disorder, borderline personality disorder, early psychotic disorders and family and marital counseling). 918 patients agreed to answer 3 self-administered satisfaction questionnaires (the CSQ-8 Client Satisfaction Questionnaire measuring global satisfaction, the CIC questionnaire examining various components of service and a qualitative questionnaire with open-ended questions). These forms were adequately completed by 707 subjects, who constituted study group. The global satisfaction rate was high (38.5% satisfied and 54.6% very satisfied). Reasons for greater satisfaction were therapeutic interventions, relationship with staff and confidentiality, while a lower satisfaction was related to information on disease and medication, adjustment of the program to patient expectations, clinic organization and environment. Socio-demographic and clinical characteristics were not homogeneously distributed across the 3 types of treatment settings. A significantly larger proportion of male, single, pensioned, chronically-ill patients with minimum education were followed at the general psychiatric consultation centers, where diagnosis of schizophrenia was the most frequent. In the crisis centers, none chronically disabled patients with a short psychiatric history (<1 year) and diagnosis of depression were more prevalent. Logistic regression showed a significant association between high satisfaction and gender (female), civil status (not single), financial resources (not receiving a disability pension or other social aid), main diagnosis (not presenting a psychotic disorder), and setting (attending a specialized programme). The study conclude that satisfaction of psychiatric outpatients could be improved by adjusting the programme content or setting according to these findings (systematic clarification of patient expectations, more information about disease and medication, appropriate frequency and length of appointments, specialized care and medical follow-up, greater attention to physical environment), but it should be taken into account that client appreciation is also influenced by socio-demographic and clinical characteristics (Davy et al., 2009).

Deventer et al. (2008) study conducted to evaluate clinic-based mental health services in all 4 sub-districts in North West province. The main finding of the study was the extremely poor documentation regarding mentally ill patients as well as an inadequate system of review by doctors and nurses. There was general satisfaction with the current services. Some dissatisfaction was expressed regarding issues of individualized care versus integration into the general primary care services. Concerns were expressed about resource constraints – in terms of human and physical resources, communication, training, and the role of specialized care. The study highlights issues around integration of mental health care services into primary care, and has provided information for managers and clinicians to utilize in the improvement of mental health care (Deventer et al., 2008).

In a study conducted by Bjorngaard et al. (2008) to compared patient experiences with psychiatric treatment provided by private practitioners and public outpatient clinics. Questionnaires were completed by 642 outpatients in private practice and 6677 outpatients in public clinics. The questionnaire included 6 items: treatment outcome, enough time for contact and dialogue with clinician, clinicians' understanding of patient's situation, suitability of therapy and treatment, clinician follow-up of planned actions, and influence on treatment. Patients in private practice had generally better experiences than patients in public outpatient treatment. The difference between private and public patients was largest for patients with poor self-evaluated mental health or those who had just one consultation in the previous three

months. Private practitioners appear to have an important role in mental health services delivery, and patients have relatively good experiences with services (Bjorngaard et al., 2008).

In another study conducted by Bjorngaard et al. (2008) to examine user satisfaction with child and adolescent mental health services. The study was undertaken in 49 of 72 Norwegian outpatient CAMHS. A total of 2253 parents (87%) responded. Parent satisfaction was measured using 2 summated scales: clinician interaction/information and treatment outcome. The results show that about 96-98% of the parent satisfaction variance could be attributed to factors within CAMHS, leaving only 2–4% of the variance attributable to the CAMHS level. Parents of patients aged 0–6 years were more satisfied than older patients' parents. Longer treatment episodes were positively associated with satisfaction. Parents whose children had been referred with externalizing symptoms were less satisfied with treatment outcome than those referred for internalizing symptoms. Waiting time was negatively associated with treatment outcome satisfaction. Adjustments for patient characteristics did not substantially change the relative effect of CAMHS on satisfaction ratings. The study concluded that the results indicate that information from user satisfaction surveys has clear limitations as an indicator of CAMHS quality. From a quality improvement perspective, the factors affecting the variance within CAMHS are of dominating importance compared to factors affecting between CAMHS variance (Bjorngaard et al., 2008).

Also, in another study conducted by Bjorngaard et al. (2007) to assess patients' experiences and clinicians' ratings of the quality of outpatient teams in psychiatric care units in Norway. A questionnaire was mailed to 15,422 outpatients who attended Norwegian clinics; 43% responded. Patients' experiences were measured on an 11-item index and 3 subscales: outcomes, interaction with clinicians, and information. Differences in patients' scores were determined largely at the patient level, with teams accounting for 2% of the total variance and organizational levels of clinics and health trusts not contributing to patients' experiences. Team-level clinician quality scores were not significantly associated with patients' experiences. Better experiences were significantly associated with patients' female gender, older age, better self perceived health, absence of an inpatient history, longer treatment episodes, frequent consultations, and waiting times perceived as acceptable. Study concludes that the organizational contributions to patients' experience scores were minimal. Although clinicians' ratings of quality are not a substitute for patients' perceptions of quality, surveys of outpatients' experiences and satisfaction may not be appropriate for cross sectional comparisons of health care providers (Bjorngaard et al., 2007).

Moreover; Bjorngaard et al. (2007) study conducted to analyze the impact of mental illness on patient satisfaction with the therapeutic relationship. Data from 969 patients from 40 different treatment teams collected from 8 Norwegian CMHCs were analyzed. Patient satisfaction with the therapeutic relationship was assessed with a 6-item scale: sufficient time for contact/dialogue, clinicians' ability to listen and understand follow-up of planned interventions, respect for patients' views/opinions, cooperation among clinicians, and patients' influence on treatment. Finding show that Satisfaction was associated with treatment outcome, better health as assessed using HoNOS, being female, of older age and having less psychiatric team severity indicated by the teams' mean GAF score. Patients with a schizophrenia spectrum disorder were more satisfied when treated as in- and day patients, compared without patient treatment.

Patients in other diagnostic categories were less satisfied with day treatment. The study concluded that patients' perceptions of the therapeutic relationship may be influenced by psychopathology. Teams comprising many patients with severe mental illness may constrain the therapeutic relationship. Hence, resources and organizational measures should be carefully considered in such care units (Bjorngaard et al., 2007).

Almeida and Adejumo (2004) study conducted on a consumer evaluation of the delivery and aspects of services provided at 3 community-run mental health centers. 111 clients attending the psychiatric community health clinics responded to a self-report questionnaire that elicited information on their satisfaction with several aspects of their clinical care in CMHCs. Items on the questionnaire included clients' level of overall satisfaction and degree of acceptability of the services to the clients, the effectiveness of health care service delivery, clients' views of the quality and outcome of therapy, the clinic's effectiveness, future behavior in similar situations, and recommendations of the clinic to others. Study showed that participants were generally satisfied with the mental health service provided (Almeida and Adejumo, March 2004).

Blazevska et al. (2004) study conducted to assess patients' satisfaction with the health care services provided by ambulatory care units. Self-administrated questionnaire took place at outpatient psychiatric, dermatology, immunology and nuclear departments at the university teaching hospital in Lodz. Result of the survey indicates that overall, clinical patients are satisfied with the outpatients services in psychiatry, dermatology, immunology and nuclear department received at the university teaching hospital. The study concluded that almost all of the patients would like to utilize this outpatient care again in the future. The willingness to recommend the provider to their family and friends in general was very high, related to such factors as staff behavior, communication, and information, patient's participation in decision making, waiting time, care, and hospital environment (Blazevska et al., 2004).

Ruggeri et al. (2003) conducted a study on 404 schizophrenic patients in 5 European sites and addresses 5 questions focused on site, service, and patient characteristics as that might explain service satisfaction, using the verona service satisfaction scale. Patient satisfaction differed significantly across sites (highest in Copenhagen, lowest in London). In all sites; patients were least satisfied with involvement of relatives in care and information about illness. A multiple regression model showed that lower level of total service satisfaction were associated with living in London or Santander, being retired/unemployed, having more hospital admissions, having more severe psychopathology, having more unmet needs, or having lower satisfaction with life. This model explained 31% of variance in service satisfaction (Ruggeri et al., 2003).

Blenkiron and Hammill (2002) study investigated whether patients' satisfaction with their mental health care and quality of life is related to their age, gender, psychiatric diagnosis, and duration of mental disorder. 120 adults of working age who were receiving input from a CMH team in North Yorkshire were completed the Corers and User s Expectations of Services, User Version (CUES-U) questionnaire, Results showed CUES-U rating were lowest for social life and highest for relationships with physical health workers, satisfaction with psychiatric services correlated significantly with patients age and their satisfaction in other areas of their lives such housing, money, and relationships. Those with psychiatric disorders rated

their quality of life as higher than other respondents. Gender and duration of mental disorder were unrelated to service satisfaction. Conclusions of the study confirmed that patient satisfaction ratings have been promoted as an outcome measure when evaluating the quality of their mental health services. Certain factors influencing an individual's satisfaction with the care provided are not directly under the control of professionals (Blenkiron and Hammill, 2002).

Van Slyke (2002) study conducted to define attributes of patient satisfaction with acute care mental health services. Thematic analysis was used to analyze the data from 14 individual interviews. This study of patient satisfaction is consistent with the need to include consumers' opinions in evaluating health care services. It responds to the challenge to explore patient satisfaction beyond the constraints of traditional surveys. The findings define patient satisfaction, and the attributes influencing it, as experienced by the participants interviewed in the southern region of New Brunswick. 5 themes as well as a number of sub-themes and more descriptive attributes were found to contribute to patient satisfaction. The main themes include the care experience continuum, ward and hospital environment, personal connections, safety and communications management. The findings are expected to have local clinical relevance to nursing and other stakeholders involved in the delivery of mental health services (Van Slyke, 2002).

Tobin et al. (2002) in examining the impact and effectiveness of consumer participation initiatives in their own service, the authors undertook a qualitative study exploring the extent and quality of consumer participation following a three-year period of support and funding. Using trained consumers as interviewers, current consumers were asked about their perceptions and personal experience of "participation". Findings identified low familiarity and involvement with the concept of consumer participation overall. Barriers to involvement included lack of motivation or invitation, stigma, and a lack of information. A need to integrate consumer participation activities into the wider system was also noted. The study conclude that simply devoting energy and resources to consumer initiatives, and thereby achieving a politically correct approach, may not be a worthwhile exercise. Such initiatives need to be based on evidence, available resources and identifiable and achievable outcomes, with a balance struck between endorsing the value of consumer participation and establishing realistic goals for what can be offered and managed (Tobin et al., 2002).

Olusina et al. (2002) study aimed to assess how satisfied the patients and staff in an acute admission psychiatric unit were with experiences in the ward, including the physical environment, freedom, comfort, attitudes of staff towards patients, access to staff, and duration of hospitalization. The researchers used a descriptive study of all patients admitted for functional psychiatric disorders in a 5-month period were conducted. Patients and staff completed similar 16-item self-rated Likert-type questionnaires. Satisfaction was rated as follows: dissatisfaction (< 50 % positive appreciation), bare satisfaction (50-65 %), moderate (66-74 %), and highest satisfaction (> or = 75 %). The results showed 118 patients were dissatisfied with items that indicated curtailment of their freedom, while the 35 staff was dissatisfied with the physical facilities for care. The highest satisfaction for patients and staff were for items on staff-patient relationship. Barely satisfactory items for patients included the time spent with doctors. Patients had a higher positive appraisal of the adequacy of physical facilities than staff, while staff had a more positive appraisal of

their relationship with patients. There were no significant differences in satisfaction among diagnostic groups. The study concluded that logical and discriminating manner in which patients assessed satisfaction supports the impression that they can be relied upon to make objective appraisal of the process of care, and that patient satisfaction is a valid index of the quality of care (Olusina et al., 2002).

Rohland et al. (2000) study theorizes that there is a relationship between satisfaction with services on the one hand and mental health status and increased life satisfaction on the other. Participants were selected from a sample of 18-64 year-old Medicaid recipients who received mental health services. The random sample was selected within each category of the following stratifications: diagnosis (schizophrenia, affective disorders, anxiety disorders, and adjustment disorders), severity of illness, and Urban/rural County of residence. Surveys, sent to 2,530 patients and returned by 815 persons (32.3% response rate), assessed life satisfaction, satisfaction with services (focusing on the quality of interpersonal experience), and self-reported mental health status. Schizophrenics had higher levels of satisfaction with services and life than others, and a statistically significant relationship was found between life satisfaction and service satisfaction for schizophrenics, and those with affective and adjustment disorders (Rohland et al., 2000).

2.3.3 Commentary on previous studies related to patients' satisfaction with mental health care services:

After an overview of the previous studies that measured patients' satisfaction with mental health services, the researcher have noted that studies conducted in Europe, Asia and Africa, a researcher did not find any study in Arab countries about satisfaction with mental health services, and that this study is the first conducted in Palestine (to the knowledge of the researcher) to measure the patients satisfaction with mental health services provided to them. Researcher noted that most of the studies conducted on adult patients, but there is a study conducted by Bjorngaard et al. (2008) to examine User satisfaction (Parent satisfaction) with child and adolescent mental health services — impact of the service unit level. Most studies also focused on the study of outpatients, but some studies conducted combined inpatient and outpatient and few conducted on hospitalized patients. Regarding the methodology, most of studies used cross-sectional design with similar with the present study design. In addition, most researchers in previous studies have not used self developed questionnaire but they adopted scales or questionnaire as; Verona Expectations for Care Scale (VECS), the Verona Service Satisfaction Scale (VSSS) Brazilian version of the WHO Users' Satisfaction Scale (SATIS-BR), Brazilian version of the WHO Users' Satisfaction Scale (SATIS-BR), and Corers and User s Expectations of Services, User Version (CUES-U) questionnaire. Also, most of the previous studies were qualitative and quantitative studies, so questionnaire used as a source of quantitative information in addition to the open questions at the end of the questionnaire to get detailed information and suggestions as qualitative. The studies identified some domains of satisfaction with mental health services including; Communication and relationship, general service infrastructure, the quality of treatment, therapeutic interventions, relationship with staff and confidentiality, information on disease and medication, adjustment of the program to patient expectations, clinic organization and environment, sufficient time for contact/dialogue, clinicians' ability to listen and understand follow-up of planned interventions, respect for patients' views/opinions, cooperation among clinicians and patients' influence on treatment. The researcher has noted that some studies were face to face interviewing questionnaire, some were self reported questionnaire and one was E-mail questionnaire. Accordingly, the researcher benefited from these studies in different points, especially in definition patient satisfaction, determining patient satisfaction domains, writing the conceptual framework, study design, determining sample size, self developing of the study instrument, factors that affect on patient satisfaction, explanation of issues and recommendations. Finally, the results differ from study to another according to aims of study, the patients were satisfied in some domains or factors that influencing patient satisfaction but another revealed not satisfied in other domains and factors. So; the researcher takes consideration to use some domains in preparing the instrument that had a great impact on the patient satisfaction and use closely the same methodology in previous studies to assess the level of patient satisfaction.

Chapter (3)

Methodology

3.1 Introduction:

This chapter explains the methodology used in this study, It begins with the study design, study population, study setting, study period, sampling and sampling process, and ethical considerations. Then, it presents the instrument, its validity and reliability, data collection, entry and analysis and eligibility criteria. Finally; it demonstrates selection criteria, piloting and study variables.

3.2 Study design:

The study design was a descriptive analytic cross-sectional one to assess patients' satisfaction with CMH centers services at MOH in GGs. Descriptive research is undertaken to describe characteristics of a population or phenomena. Descriptive studies are based on some previous understanding of the nature of the research problem (Zikmund, 2003). Cross-sectional design involves the collection of data at single point of time (at a fixed point in time). Then; the cross-sectional design usually used to assess the level of satisfaction of a group of clients at various stages of the process of receiving the services (Burns and Grove, 1997). Moreover; the main advantages of cross-sectional design are practical, easy to do and relatively economical (Polit, 2004).

3.3 Study population:

The study population in this study is all those patients are registered and those have files and reviewing in 6 CMH centers in GGs at the time of data collection. A total of 3300 patients are registered at CMH centers (Annual Report of General Directorate of Mental Health, 2010).

3.4 Study setting:

The study was conducted at 6 CMH centers at MOH in GGs (Al Surani, West Gaza, Abu Shebak, Al-Nuseirat, Khan-Younis and Rafah).

3.5 Study period:

The study was conducted in the first half of year 2012 according to the time table that has been prepared for the study. A letter was sent to General Directorate of Mental Health at MOH in the first half of April 2012, to seek approval to conduct the study at CMH centers. Then, the pilot study was conducted in the second half of April 2012. Actual data were collected from 2 May till 15 June 2012. Data entry and analysis in second half of June, finally discussion of the results and finishing was completed by the end of September 2012.

3.6 Sample size determination:

A total of study population are 3300 patients registered at 6 CMH centers, according to sample size calculator, 344 patients calculated sample based on calculation at confidence level of 95%; as we show in figure (3.1). The researcher was increased the sample up to 400 individuals among those presenting to CMH centers to cover for possible non respondents.

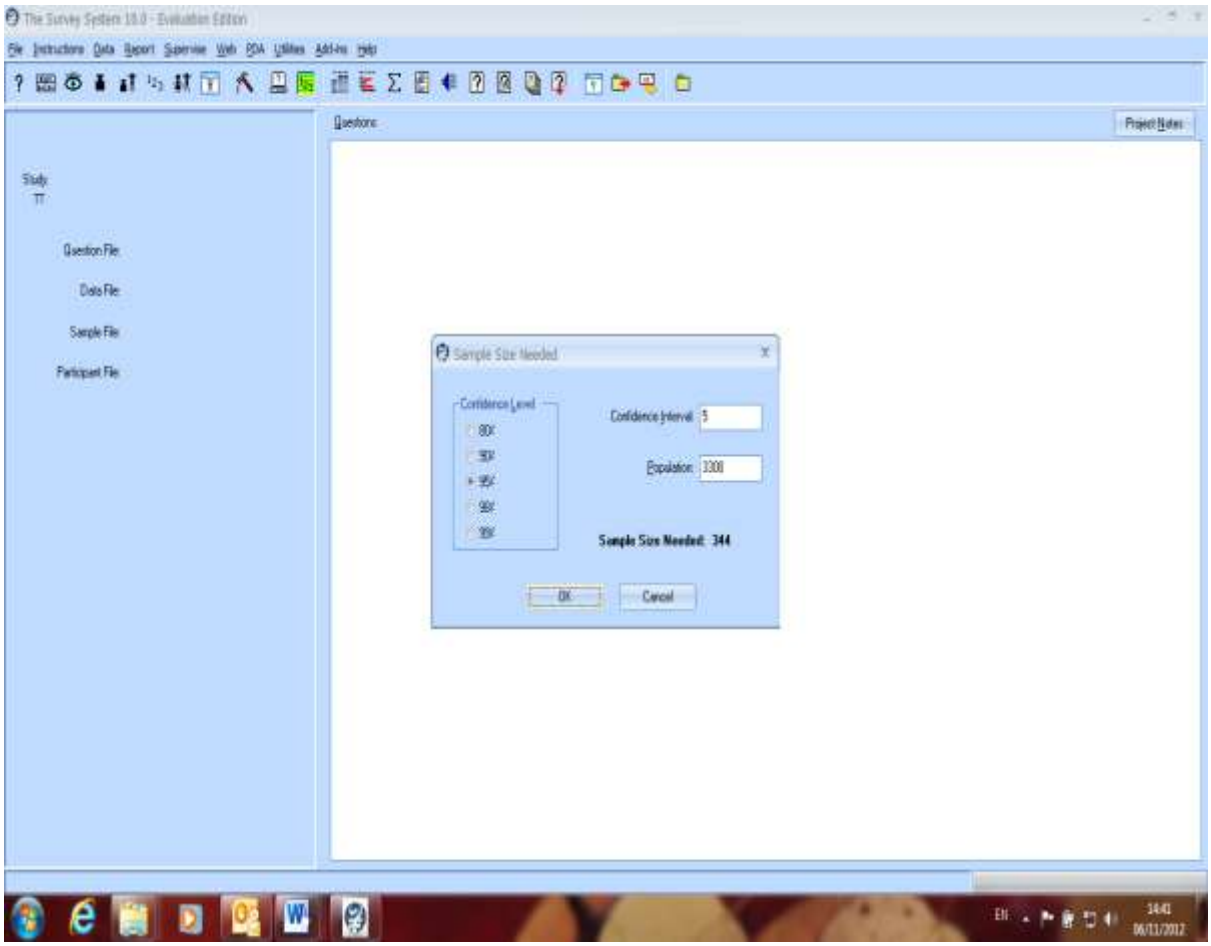

Figure (3.1): Calculation of sample size needed

3.7 Sampling process:

The sample of the 400 clients was divided among GGs areas according to their representation from 6 CMH centers. Then, a probability systematic selection for patients was done accordingly; the Kith patient in patient records of each center with interval 3.

3.8 Eligibility criteria:

3.8.1 Inclusion criteria:

The researcher was included in the study all of the patients over 18 years old who are registered in CMH centers and follow up for more than 6 months in 6 CMH centers at MOH in GGs.

3.8.2 Exclusion criteria:

Who have been excluded from this study: Newly reviewers who less than 6 month, child patients, drugs and substances abusers, the patients who attend their relatives for the taking of their drugs and patients who refuse to participate.

3.9 Ethical considerations:

- Approval of General Directorate of Mental Health at MOH to carry out the study was obtained (Annex 1).
- Approved of patients who participated in the study through written and oral consent about the purpose of the study and indicating that the participation is voluntary, anonymity, and confidentiality will be assured for all of them (Annex 2).

3.10 Study instrument:

The study instrument was a structured questionnaire which was designed by the researcher based on the review of the literature and researcher observations and experience in health care field and under the guidance of the supervisors. The questionnaire includes combination of both types of questions closed and open questions. Many researchers tend to use a combination of both open and closed questions. That way, it is possible to find out how many people use a service and what they think about that service on the same form. Many questionnaires begin with a series of closed questions, with boxes to tick or scales to rank, and then finish with a section of open questions for more detailed response (Dawson, 2002). The questionnaire was designed in Arabic language to be able to filling by participants, then, was translated to English language, and took approximately 20 minutes to complete (Annex 3 and 4).

The questionnaire consists of two parts:

Part 1: contains 17 items explored information about demographic, socioeconomic profile of the patients, disease related variables and service delivery.

Part 2: contains 72 items explored the patient's satisfaction with CMH services provided to them, in 6 domains of satisfaction as: general impression, accessibility of service, communication, interaction and information, physical environment of the center, technical quality, and convenience and responsiveness. The 68 items out of 72 was developed and respondents are asked to respond to a 5-point Likert-type scale ranging from "strongly agree" to "strongly disagree". Last 4 questions in the questionnaire are open-end questions in order to obtain qualitative data about the conceptions and patients satisfaction with the CMH centers services and those questions focused on what likes and dislikes of the services and their vision and suggestions to improve those services. Qualitative data attempts to get an in-depth opinion from participants. As it are attitudes, behavior and experiences. Open-ended questionnaires might be used to find out what people think about a service (Dawson, 2002).

3.11 Study variables:

The study was includes group of dependent and independent variables:

- Independent variables include 9 variables: age, sex, marital status, level of education, place of living, current occupation, income, psychiatric diagnoses, and duration of disorder.
- Dependent variables include 6 domains of satisfaction: general impressions, accessibility of services, communication, interaction and information, physical environment of the center, technical quality and convenience and responsiveness.

3.12 Pilot study:

The pilot study was done to test and prove that the questionnaire questions are clear to be answered in a way that help to achieve the purpose of the study. The pilot study is pre-test of the instrument and the results of it direct the researcher to modify, cancel and rephrase some items and questions. It examined clarity, ambiguity, length and suitability of questions before the beginning of data collection (Polit, 2004).

A piloting was conducted for 33 patients selected randomly by the researcher from west Gaza and Abu Shebak CMH centers to insure the validity and reliability of the questionnaire. Table (3.1) showed higher degree of validity and reliability. Patients who were selected for piloting were included in the study sample.

3.13 Validity and reliability:

3.13.1 Validity:

3.13.1.1 Face and content validity:

Validity of an instrument means that the degree to which an instrument measures what it is supposed to be measured. Face validity refers to whether the instrument looks as though it is measuring the appropriate construct (Polit, 2004).

Face validity helped the researcher to reach the complement of readability and clarity of the instrument (Chikomo, 2011).

Content validity concerns the degree to which an instrument has an appropriate sample of items for the construct being measured. An instrument's content validity is necessarily based on judgment (Polit, 2004). The questionnaire was submitted to researcher and expert's panel with experience and knowledge in the field as arbitrates who make suggestions and judgment about the adequacy of the questionnaire. The experts expressed their opinions and suggestions about the clarity, ease, simplicity, comprehensiveness of items, domains and statements of the questionnaire and therefore the researcher had some changes in the questionnaire, such as delete or merge or re-formulation of some items (Annex 5).

3.13.1.2 Internal consistency validity:

Internal consistency validity or criterion-related validity involves determining the relationship between an instrument and an external criterion. The instrument is said to be valid if its scores correlate highly with scores on the criterion (Polit, 2004). Internal consistency of the questionnaire was measured by a pilot sample, which consisted of 33 questionnaires, through measuring the correlation coefficients between each paragraph in one field and the whole filed. (Annex 6a, 6b, 6c, 6d, 6e, 6f and 6g) shows the correlation coefficient and p-value for each field items. The p-values are less than 0.05 or 0.01, so the correlation coefficients of this field are significant at $\alpha = 0.01$ or $\alpha = 0.05$, so it can be said that the paragraphs of this field are consistent and valid to be measure what it was set for. Furthermore, the questionnaire was filled by direct face to face interview and in order to maintain complete confidentiality no names recorded.

3.13.2 Reliability:

Reliability of the instrument is the degree of consistency or accuracy with which an instrument measures an attribute. The higher the reliability of an instrument, the lower the amount of error in obtained scores (Polit, 2004). In this study the researcher was used Cronbach's Alpha Coefficient and Split Half technique to estimating the internal consistency reliability of an instrument. Correlation coefficients can range from -1.00 (a perfect negative relationship) through zero to +1.00 (a perfect positive relationship). Reliability coefficients usually range from .00 to 1.00, with higher values reflecting greater reliability (Polit, 2004). As show in table (3.1), the Cronbach's coefficient alpha was calculated for the 6 fields. The results were in the range from 0.8848 and 0.9438, and the general reliability for all items equal 0.9387. This range is considered high; the result ensures the reliability of the questionnaire. Also; the following steps was done to assure instruments reliability:

- Training of data collectors on the client interviewing steps and the way of asking questions to assure standardization of questionnaire filling.
- Data entry in the same day of data collection would allow possible interventions to check the data quality or to re-fill the questionnaire when required.
- Re-entry of 5% of the data after finishing data entry will assure correct entry procedure and decrease entry errors.
- Data cleaning and checking.

Table (3.1): Cronbach's Alpha for reliability

No.	Field	No. of Items	Cronbach's Alpha
1	General impressions	8	0.9053
2	Accessibility of services	8	0.9245
3	Communication, interaction and information	15	0.9438
4	Physical environment of the center	10	0.8848
5	Technical quality	16	0.9428
6	Convenience and responsiveness	11	0.9348
	Total	68	0.9387

Then, Split-Half method was done to finding Pearson correlation coefficient between the means of odd rank questions and even rank questions of each field of the questionnaire. Then, correcting the Pearson correlation coefficients can be done by using Spearman Brown correlation coefficient of correction. The corrected correlation coefficient (consistency coefficient) is computed according to the following equation:

Consistency coefficient = $2r/(r+1)$, where r is the Pearson correlation coefficient. The normal range of corrected correlation coefficient $2r/(r+1)$ is between 0.0 and + 1.0 as shown in Table No. (24), all the corrected correlation coefficients values are between 0.8780 and 0.9231 and the general reliability for all items equal 0.9111 , and the significant (α) is less than 0.05 so all the corrected correlation coefficients are significance at $\alpha = 0.05$. It can be said that according to the Half Split method, the dispute causes group are reliable.

Table (3.2): Split-Half Coefficient method

No.	Field	Person-correlation	Spearman-Brown Coefficient	Sig. (2-(Tailed
1	General impressions	0.7957	0.8862	0.000
2	Accessibility of services	0.8246	0.9038	0.000
3	Communication, interaction and information	0.8554	0.9221	0.000
4	Physical environment of the center	0.7825	0.8780	0.000
5	Technical quality	0.8572	0.9231	0.000
6	Convenience and responsiveness	0.8438	0.9153	0.000
	Total	0.8368	0.9111	0.000

3.14 Data collection:

Data collection is the distinctive systemic collection of information pertinent to the research purpose or the specific objectives, questions or premise of a study (Burns and Grove, 1997). The researcher and two assistants were collected of data. The assistants were graduated from university, trained and prepare well on how to filling questionnaire by face to face interviews. Consent form was obtained from the patients to participate in the study, after clarifying the purpose of the study and confirmed the anonymity and confidentiality of information and there is lack of risks or potential benefits from participation in this study and to assure to patients at their right to withdraw or refuse to participate in order to filling questionnaire clear and accurate and encourage a high response. After those steps respondents indicate on a 5 point Likert scale the extent to which they agree or disagree with each item. In addition, respondents were also asked to provide some consumer characteristic data and to answer 4 open-ended questions.

3.15 Data entry:

3.15.1 Quantitative part:

The researcher was used Statistical Package of Social Science (SPSS) program for data entry and analysis. Frequency tables that show sample characteristics and plot differences between various CMH centers at GGs and patients characteristics variables were done. Moreover, cross tabulation for main findings and T test or one way ANOVA test to compare means of numeric variables was done when required to analyze questionnaire data.

3.15.2 Qualitative part:

The researcher was obtains the main findings from the transcripts of the interviews. Then, categorization of related ideas, and comparison and integration between the quantitative and the qualitative findings was done to create rich items for discussion and representation.

3.16 Data analysis:

The purpose of data analysis is to classify the interviews and present a narrative that confirmed what happened or why and to provide a description of the norms and values that instigate a topic or cultural activities (Rubin and Rubin, 1995).

Several different statistical techniques were used for data analysis including:

- Frequencies and percentile were conducted the study variables.
- Means and standard deviations were computed for the continuous numeric variables.
- Testing reliability and validity of the instrument.
- Alpha-Cronbach Test for measuring reliability of items of the questionnaire.
- Person correlation coefficients for measuring validity of the items of the questionnaire.
- Spearman –Brown Coefficient
- Independent t- test and One Way ANOVA tests were carried out to investigate the relationships between the independent study variables with the total and sub-scores of the satisfaction level.
- Scheffe test for multiple comparisons between the means of samples.

3.17 Response rate:

According to the calculated sample, 400 patients were selected to participate in the study, but participants were only 271, representing 67.75% of the study population and non participate patients a few of them refused to participate and some of them relatives attended to receive their medication.

In study conducted by Bjørngaard et al. (2007) to assess patients' experiences and clinicians' ratings of the quality of outpatient teams in psychiatric care units in Norway. A questionnaire was mailed to 15,422 outpatients who attended Norwegian clinics; 43% responded.

In another study conducted by Rohland et al. (2000) to theorize that there is a relationship between satisfaction with services on the one hand and mental health status and increased life satisfaction on the other. Participants were selected from a sample of 18-64 year-old Medicaid recipients who received mental health services. The random sample was selected within each category of the following stratifications: diagnosis (schizophrenia, affective disorders, anxiety disorders, and adjustment disorders), severity of illness, and Urban/rural County of residence. Surveys sent to 2,530 patients and returned by 815 persons (32.3% response rate).

Anyway; the response rate is very acceptable for a response rate in other studies of psychiatric patients the interviewing questionnaires usually result in higher response than the self-administered questionnaire (Burns and Grove, 1997).

3.18 Limitations of the study:

- The study was included CMH centers at MOH and there are other CMH centers for UNRWA and NGOs not included.

- The study was included out patients of CMH centers while inpatients of Psychiatric Hospital in Gaza not included.

- Some patients was included in the study, their relatives came to take their medication, while the questionnaire designed to measure patient satisfaction not their relatives.

- The study did not include the perception and satisfaction of families of patients with the services provided to their patients.

- Lack of a computerized system for data and statistics related to mental health services in Palestine.

- Difficult of political and socioeconomic conditions of the patients especially the siege imposed on the GS which prevents the crossing enough psychotropic drugs through border crossings might have some effect on their satisfaction level on general during this study.

- Time limitation, the data was collected in limited time.

Chapter (4)

Results

4.1 Introduction:

This chapter presents the results of statistical and descriptive analysis of the data. Descriptive analysis of the sample includes socio-demographic characteristics, mental health related factors and CMH services related factors of the subjects and factor analysis and related subscale dimensions. Moreover, the level of patient's satisfaction with CMH services in relation to dependent variables and the differences between the selected variables and overall satisfaction scores and with sub-scales were explored by using different analytical statistical tests. In addition to results of hypotheses and description of the statistical significance and insignificance between dependent and independent variables. And finally present the results of qualitative data.

4.2 Descriptive analysis of the sample:

4.2.1 Study sample according to CMH centers:

Table (4.1): Distribution of study sample according to CMH centers

CMH center	Frequency	Percentages
Al Surani	52	19.18
West Gaza	50	18.45
Abu Shabak	42	15.49
Nuseirat	45	16.60
Khan-Younis	50	18.45
Rafah	31	11.80
Total	**271**	**100.0%**

Note in table (4. 1) and figure (4.1), that more than one-third of the patients from Gaza governorate, the largest governorate in GGs where there are two CMH centers, and note that the representation of participants from each CMH center commensurate with the number of patients at the center**.** Note also that 11.80% of the patients from Rafah governorate, the smallest in population

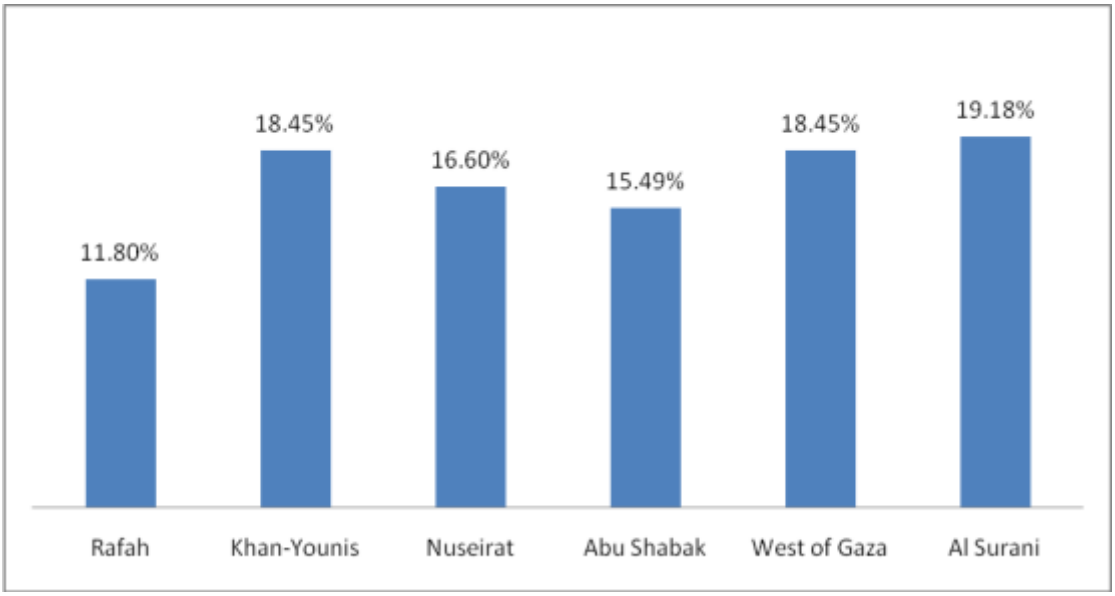

Figure (4.1): Distribution of study sample according to CMH center

4.2.2 Study sample according to socio-demographic data:

Table (4.2): Socio-demographic characteristics of the study population

Variables	Frequency	Percentages
Sex		
Male	209	77.1
Female	62	22.9
Age (in years)		
From 18 – 24 years	20	7.4
From 25 – 34 years	55	20.3
From 35 – 44 years	81	29.9
Over 45 years	115	42.4
Marital Status		
Single	52	19.2
Married	203	74.9
Divorced	11	4.1
Widow	5	1.8
Place of living		
Gaza	96	35.4
The North	45	16.6
The Med-zone	50	18.5
Khan-younis	49	18.1
Rafah	31	11.4
Level of education		
Illiterate	58	21.4
Primary	49	18.1
Prep.	71	26.2
Secondary	76	28.0
University or higher	17	6.3
Current occupation		
Working	23	8.5
Not working	248	91.5
Income		
Below 500 NIS	166	61.3
From 500-1500 NIS	92	33.9
From 1501-2500 NIS	8	3.0
Above 2500 NIS	5	1.8

Table (4.2) summarizes distribution of important study variables such as age, sex, marital status, place of living, level of education, current occupation, and income, we notice that:

- More than three-quarters of the sample (77.1%) is males while females represented 22.9%.

- More than half of psychiatric patients from the youth and middle age, as 7.4% of the cases their age were between 18 - 24 years, 20.3% were from 25 - 34 years, 29.9% were from 35 - 44 years, and 42.9% were over 45 years. In figure (4.2),

The researcher note that tow thirds of the cases over a middle-aged (over age of 35 years).

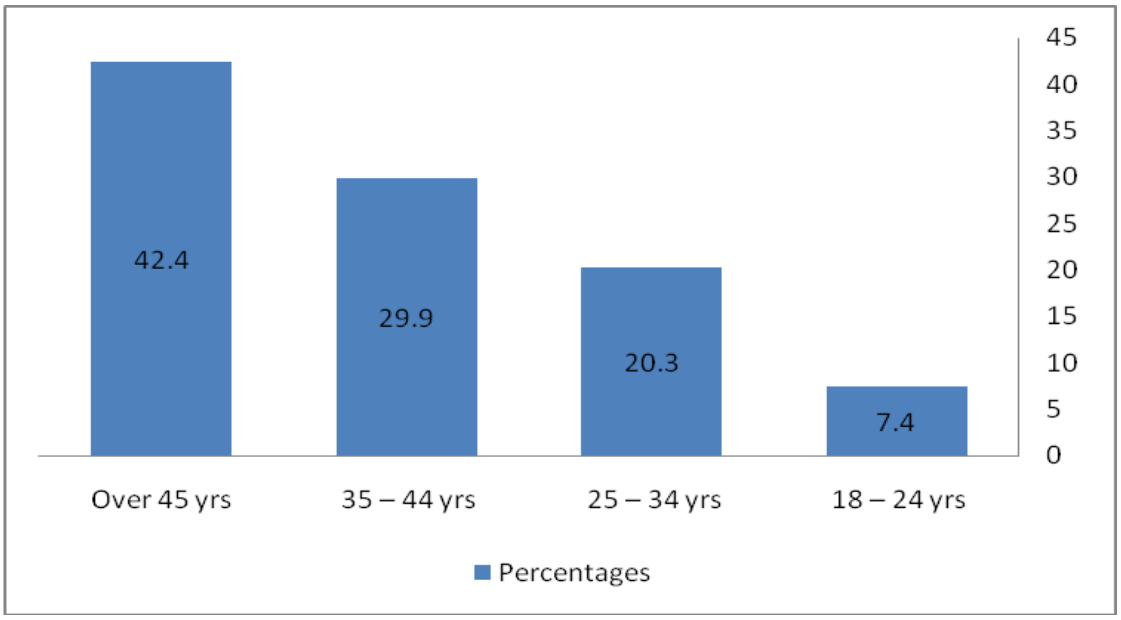

Figure (4.2): Distribution of study population by age group

- Also; 74.9 % was married, single was 19.2%, divorced was 4.1%, and widow was 1.8%.

- Also note that; 35.4% from the sample from Gaza governorate, 16.6% from The North governorate, 18.5% from The Med-zone governorate , 18.1 % from Khan-younis governorate , and 11.4% from Rafah governorate.

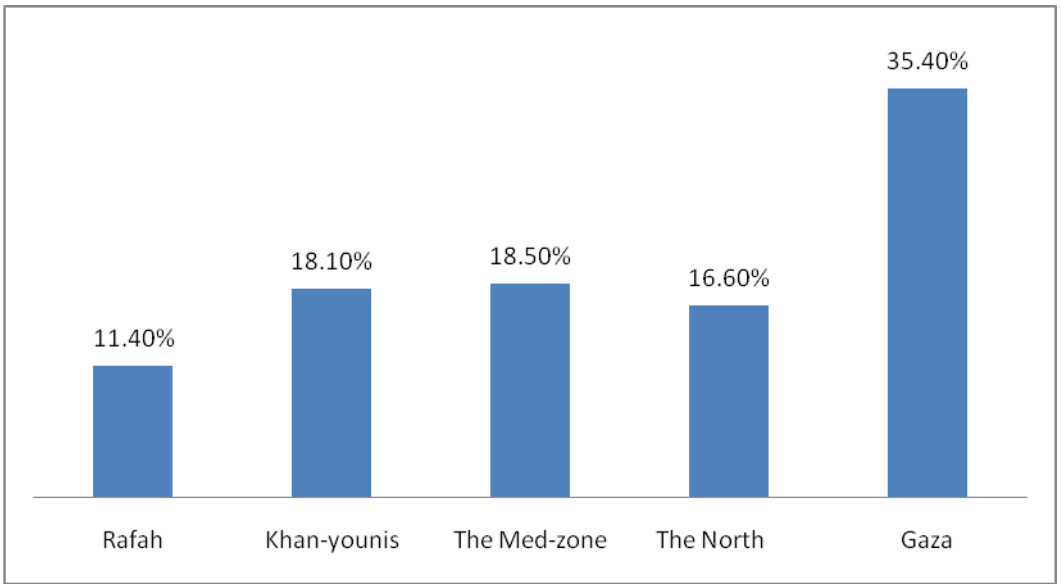

Figure (4.3): Distribution of study population according to place of living

- Moreover; 28.0% have had attained secondary level of education, 26.2% have had attained prep level of education, 21.4% were illiterate, 18.1% have had attained primary level of education, 6.3% only had university degree or higher.

- Table (4.2) reflects high unemployment rate among psychiatric patients, so show that the majority (91.5%) of the study population were not working while (8.5 %) were working.

- Table (4.2) reflects high levels of poverty among psychiatric patients, so show that 61.3% of the study population their income below 500 NIS, 33.9% their income from 500-1500 NIS, 3.0% their income from 1501-2500 NIS, and 1.8% their income above 2500 NIS. The researcher here would like to mention that in addition to majority of the study population were not working (91.5%) as shown in table (4.8); also many of psychiatric patients receive financial aid and foodstuffs from the Ministry of Social Affairs, the UNRWA and civil institutions and associations.

4.2.3 Study sample according to mental disorders related factors:

Table (4.3): Distribution of population by mental health related variables

Variables	Frequency	Percentages
Psychiatric diagnosis		
Psychotic disorder	80	29.5
Mood disorder	93	34.3
Anxiety disorder	37	13.7
Somatoform disorder	18	6.6
Other disorder	43	15.9
Duration of disorder		
From 6 months- less than 2 years	27	10.0
From 2-5 years	75	27.7
Over 5 years	169	62.4
Type of service or treatment		
Pharmacotherapy	269	85.1
Psychotherapy	15	4.7
Family therapy	0	0.0
Counseling	24	7.6
Home visit	8	2.5
Physical disability		
Yes	15	5.5
No	256	94.5
Self-evaluation of mental health		
Excellent	2	0.7
Very good	30	11.1
Good	108	39.9
Fair	75	27.7
Poor	56	20.7

Table (4.3), illustrates distribution of study sample by mental health related variables, such as psychiatric diagnosis, duration of disorder, types of treatment, physical disability and patients self-evaluation of mental health, we notice that:

- Also; 34.3% of the study population has mood disorder, 29.5% have psychotic disorder, 13.7% have anxiety disorder, 6.6% have somatoform disorder, and 15.9% have other disorders or problems.

- The patients who had disorder for over 5 years represented 62.4% of the study population, 27.7% had disorder for 2-5 years, while those who had disorder for less than 2 years represented 10.0% of the study population.

- Table (4.3) reflects various services provided by CMH centers, where show that 85.1% of the study population receiving pharmacotherapy services, 7.6% receiving counseling services, 4.7% receiving psychotherapy services, 2.5% receiving home visit, and none of the study population received family therapy.

- Most of the study population 94.5% does not have physical disability, while 5.5 % have physical disability.

- Table (4.3) reflects the patients self evaluation to the level of their mental health , where we show that 0.7% of the study population evaluated their mental health status as excellent, 11.1% as very good, 39.9% as good, 27.7% as fair, and the remaining 20.7% as poor.

4.2.4 Study sample according to CMH services related variables:

Table (4.4): Distribution of subject by CMH services related variables

Variables	Frequency	Percentages
Receiving CMH services elsewhere		
Yes	74	27.3
No	197	72.7
Purchasing extra medications		
Yes	61	22.5
No	210	77.5
Reasons for purchasing extra medications		
Unavailable	23	37.7
Not enough	38	62.3
Readiness of CMHC for disabled		
Fully equipped	5	33.3
Partially equipped	7	46.7
Not equipped	3	20.0
Present of system to measure patient satisfaction		
No	271	100.0

Table (4.4), illustrates distribution of subjects by CMH services related variables, such as receiving CMH services elsewhere, purchasing extra medications, reasons for purchasing extra medications, readiness of CMH centers for disabled, and present of system to measure patient satisfaction, we notice that:

- Also; 27.3% of the study population receiving mental health services in any other place than CMH centers, while 72.7% of them not receive mental health services in any other place than CMH centers. And this was due to the Palestinian MOH provides free mental health services for psychiatric patients.

- Note that; 22.5% of the study population buys other medication for treatment of their disorder than those provided by CMH center, while 77.5% depend fully on

CMH centers and not buys other medication for treatment of their disorder than those provided by CMH centers.

- Table (4.4) shows acute shortage of psychiatric drugs, show that in 37.7% of those who purchased additional medication the reason was unavailability of these medication on a regular bases at CMH centers, while, 62.3 % of them attributed the reason for not enough.

- Moreover; 80% out of 15 patients who had a disability thought that CMH center is equipped either fully or partially to facilitate their within it, while 20.0% thought it is not equipped.

- All of the study population (100%) agrees that there is no system to follow up satisfaction of users in CMH centers.

4.3 The level of patient's satisfaction with CMH centers services:

The researcher used a one sample t test to test level of patients' satisfaction-dissatisfaction with services provided by CMH centers in GGs and the results shown in table (4.5) which show that average mean for all fields equal 3.34 and weight mean equal 66.89% which is greater than 60% and the value of t test equal 27.083 which is greater than the critical value which is equal 1.97 and the p- value equal 0.000 which is less than 0.05, that means level of patients' satisfaction-dissatisfaction with services $\alpha = 0.05$ provided by CMH centers in GGs is acceptable at significant level

Table (4.5): level of patients' satisfaction-dissatisfaction with CMH centers in GGs

No.	Field	Mean	Standard deviation	Weight mean	t-value	P-value
1	General impressions	3.83	0.365	76.51	37.233	0.000
2	Accessibility of services	2.91	0.374	58.19	-3.977	0.000
3	Communication, interaction and information	2.92	0.364	58.40	-3.620	0.000
4	Physical environment	3.89	0.478	77.81	30.659	0.000
5	Technical quality	3.39	0.372	67.71	17.041	0.000
6	Convenience and responsiveness	3.34	0.431	66.70	12.786	0.000
	Total	3.34	0.210	66.89	27.083	0.000

Critical value of t at df "270" and significance level 0.05 equal 1.97

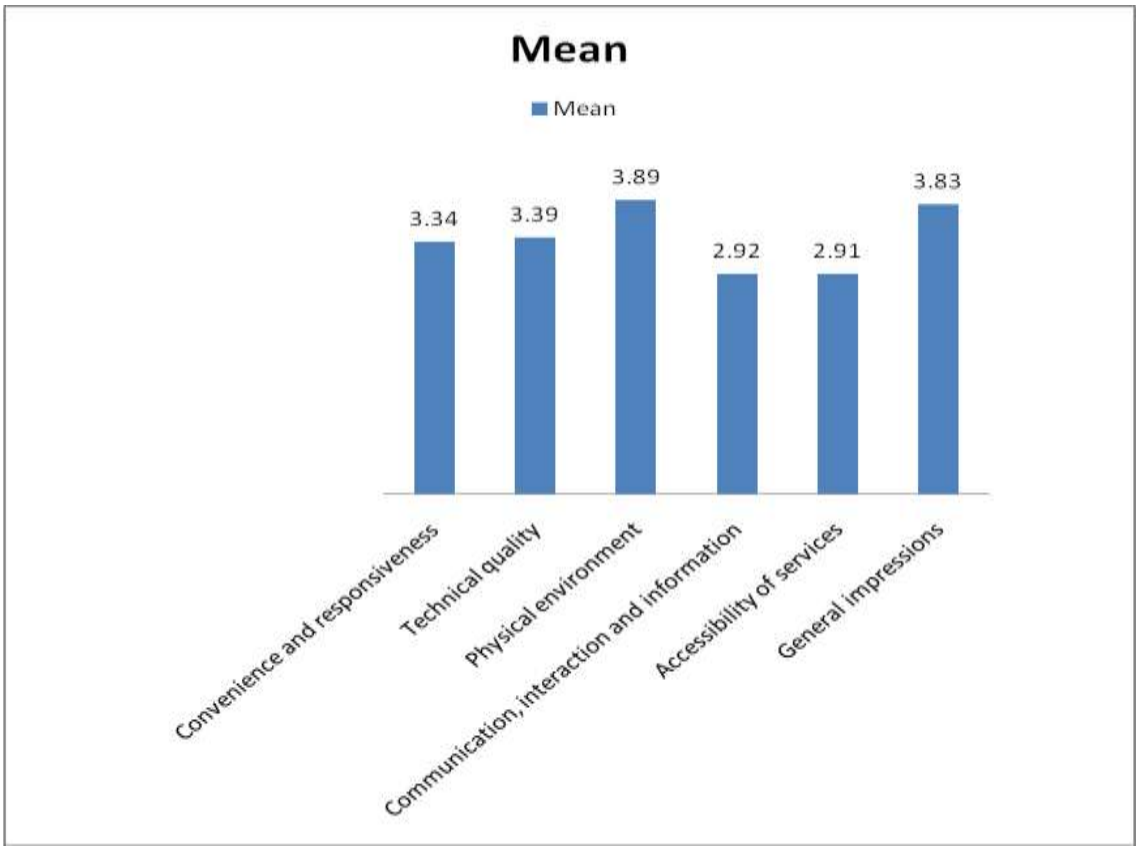

Figure (4.4): Means of satisfaction dimensions

4.3.1 General impressions:

The researcher used a one sample t test to test if the opinion of the respondent about general impressions and the results shown in table (4.6) as follows:

The 3 highest statements according to weight mean as follows:

1. In item No. (3) the weight mean equal (85.61%), which is greater than 60.0% and the p-value equal (0.000) which is less than 0.05 , that means (I will continue to receive service in this center).

2. In item No. (6) the weight mean equal (84.87%), that which is greater than 60.0% and the p-value equal (0.000) which is less than 0.05 , means (If a friend or relative need same service, I will recommended this center to him).

3. In item No. (8) the weight mean equal (80.07%), which is greater than 60.0% and the p-value equal (0.000) which is less than 0.05 , that means (CMH services were delivered in an appropriate manner).

And the 3 lowest statements according to weight mean as follows:

1. In item No. (7) the weight mean equal (71.59%), which is greater than 60.0% and the p-value equal (0.000) which is less than 0.05 that means (I feel dissatisfied with some aspects of the service I received).

2. In item No. (2) the weight mean equal (71.22%), which is greater than 60.0% and the p-value equal (0.000) which is less than 0.05 that means (I received the service as I expected).

3. In item No. (4) the weight mean equal (65.09%), which is greater than 60.0% and the p-value equal (0.000) which is less than 0.05 that means (I am not satisfied with the mental health services I received in the past year).

In general the results for all items of the general impressions field show that the average mean equal 3.83 and the weight mean equal76.51% which is greater than 60% and the value of t test equal 37.233 which is greater than the critical value which is equal 1.97 and the p- value equal 0.000 which is less than 0.05, that means the general impressions is good at significant level $\alpha = 0.05$.

Table (4.6): General impressions

No.	Items	Mean	Standard deviation	Weigh t mean	t-value	P-value
1	I have a good experience with CMH services s in this center.	3.75	0.844	75.06	14.679	0.000
2	I received the service as I expected.	3.56	0.912	71.22	10.120	0.000
3	I will continue to receive service in this center.	4.28	0.573	85.61	36.779	0.000
4	I am not satisfied with the mental health services I received in the past year.	3.25	1.028	65.09	4.077	0.000
5	There is some areas need improvement in the health service I received.	3.93	0.759	78.60	20.160	0.000
6	If a friend or relative need same service, I will recommended this center to him.	4.24	0.530	84.87	38.604	0.000
7	I feel dissatisfied with some aspects of the service I received.	3.58	1.011	71.59	9.432	0.000
8	CMH services were delivered in an appropriate manner.	4.00	0.837	80.07	19.749	0.000
	Total	3.83	0.365	76.51	37.233	0.000

Critical value of t at df "270" and significance level 0.05 equal 1.98

4.3.2 Accessibility of services:

The researcher used a one sample t test to test if the opinion of the respondent about accessibility of services and the results shown in table (4.7) as follows:

The 3 highest statements according to weight mean as follows:

1. In item No. (3) the weight mean equal (78.45%), which is greater than 60.0% and the p-value equal (0.000) which is less than 0.05 ,that means (I can easily access to services when I need it).

2. In item No. (4) the weight mean equal (78.08%), which is greater than 60.0% and the p-value equal (0.000) which is less than 0.05 , that means (I see a psychiatrist when I need to do so).

3. In item No. (1) the weight mean equal (63.17%), which is greater than 60.0% and the p-value equal (0.028) which is less than 0.05 ,that means (Place of CMH center suitable for my residential place).

And the 3 lowest statements according to weight mean as follows:

1. In item No. (8) the weight mean equal (51.96%), which is less than 60.0% and the p-value equal (0.000) which is less than 0.05 , that means (The drugs is not available in the centre pharmacy).

2. In item No. (5) the weight mean equal (50.70%), which is less than 60.0% and the p-value equal (0.000) which is less than 0.05 ,that means (I think working overload at the center affect employees in responding to my needs).

3. In item No. (2) the weight mean equal (29.37%), which is less than 60.0% and the p-value equal (0.000) which is less than 0.05 , that means (Mental health team not visit me in my house when I cannot attend the center).

In general the results for all items of the accessibility of services field show that the average mean equal 2.91and the weight mean equal 58.19% which is greater than 60% and the value of t test equal 3.977 which is greater than the critical value which is equal 1.96 and the p- value equal 0.000 which is less than 0.05, that means it's not easy to access to service at significant level $\alpha = 0.05$.

Table (4.7): Accessibility of services

No.	Items	Mean	Standard deviation	Weight mean	t-value	P-value
1	CMH center place suitable for my residential place.	3.16	1.183	63.17	2.207	0.028
2	Mental health team visit me in my house when I cannot attend the center	1.47	0.950	29.37	-26.547	0.000
3	I can easily access to services when I need it	3.92	0.588	78.45	25.824	0.000
4	I see a psychiatrist when I need to do so	3.90	0.595	78.08	25.024	0.000
5	I think working overload at the center does not affect employees in responding to my needs.	2.54	0.946	50.70	-8.094	0.000
6	Took a lot of effort and time to reach the center.	2.91	1.235	58.23	-1.180	0.239
7	Stigma of mental illness affects the services I receive.	2.78	1.209	55.57	-3.014	0.003
8	Drugs available in the centre's pharmacy	2.60	1.185	51.96	-5.587	0.000
	Total	2.91	0.374	58.19	-3.977	0.000

Critical value of t at df "270" and significance level 0.05 equal 1.98

4.3.3 Communication, interaction and information:

The researcher used a one sample t test to test if the opinion of the respondent about communication, interaction and information and the results shown in table (4.8) as follows:

The 3 highest statements according to weight mean as follows:

1. In item No. (15) the weight mean equal (89.37%), which is greater than 60.0% and the p-value equal (0.000) which is less than 0.05 ,that means (Service providers take into account the privacy and confidentiality during treatment).

2. In item No. (3) the weight mean equal (84.28%), which is greater than 60.0% and the p-value equal (0.000) which is less than 0.05 ,that means (Service providers show their empathy with me).

3. In item No. (1) the weight mean equal (83.76%), which is greater than 60.0% and the p-value equal (0.000) which is less than 0.05 ,that means (All of service providers respect my needs and take them into account).

And the 3 lowest statements according to weight mean as follows:

1. In item No. (2) the weight mean equal (34.91%), which is less than 60.0% and the p-value equal (0.000) which is less than 0.05 ,that means (I am not feel ignored by service providers in this center).

2. In item No. (14) the weight mean equal (32.40%), which is less than 60.0% and the p-value equal (0.000) which is less than 0.05 ,that means (Service not providers continue to my family when needed).

3. In item No. (13) The weight mean equal (31.29%), which is less than 60.0% and the p-value equal (0.000) which is less than 0.05, that means (Service not Providers take the initiative to contact me when I miss the place for a long time.).

In general the results for all items of the communication, interaction and information field show that the average mean equal 2.92 and the weight mean equal 58.40% which is less than 60% and the value of t test equal 3.620 which is greater than the critical value which is equal 1.97 and the p- value equal 0.000 which is less than 0.05, that means communication, interaction and information is not at significant level $\alpha = 0.05$.

Table (4.8): Communication, interaction and information

No.	Items	Mean	Standard deviation	Weight mean	t-value	P-value
1	All of service providers respect my needs and take them into account.	4.19	0.671	83.76	29.170	0.000
2	I feel ignored by service providers in this center.	1.75	0.783	34.91	-26.386	0.000
3	Service providers show their sympathy with me.	4.21	0.595	84.28	33.589	0.000
4	Overall I am satisfied with the way service provider's deal with me.	3.96	0.631	79.11	24.938	0.000
5	Have received sufficient information about my condition and the therapeutic plan.	2.36	0.989	47.16	-10.684	0.000
6	Service providers gives me impression that my service of their priorities.	3.68	0.804	73.65	13.971	0.000
7	Service providers explain to me information related to my condition in understandable way.	2.30	1.045	45.98	-11.046	0.000
8	Doctor telling me some medical terminology without explanation of their meanings.	1.89	0.852	37.86	-21.395	0.000
9	Service providers take into account my level of education and culture when dealing with me.	3.42	0.874	68.49	7.994	0.000
10	I feel that all patients are treated by one notch.	3.65	0.714	72.99	14.971	0.000
11	Service providers respect my right to change the therapist if necessary.	2.75	0.867	54.98	-4.765	0.000
12	I am having difficulty in communicating with service providers.	1.99	1.031	39.78	-16.145	0.000
13	Service providers take the initiative to contact me when I miss the place for a long time.	1.56	0.936	31.29	-25.242	0.000
14	Service providers continue to my family when needed.	1.62	1.064	32.40	-21.346	0.000
15	Service providers take into account the privacy and confidentiality during treatment.	4.47	0.682	89.37	35.464	0.000
	Total	2.92	0.364	58.40	-3.620	0.000

Critical value of t at df "270" and significance level 0.05 equal 1.98

4.3.4 Physical environment of the center:

The researcher used one sample t test to test if the opinion of the respondent about physical environment of the center and the results shown in table (4.9) as follows:

The 3 highest statements according to weight mean as follows:

1. In item No. (10) the weight mean equal (83.10%), which is greater than 60.0% and the p-value equal (0.000) which is less than 0.05 ,that means (center rooms are adequate ventilation center).
2. In item No. (1) the weight mean equal (81.70%), which is greater than 60.0% and the p-value equal (0.000) which is less than 0.05 ,that means (center rooms are clean).
3. In item No. (3) the weight mean equal (79.04%), which is greater than 60.0% and the p-value equal (0.000) which is less than 0.05 ,that means (bathrooms in the center clean).

And the 3 lowest statements according to weight mean as follows:

1. In item No. (7) the weight mean equal (75.42%), which is greater than 60.0% and the p-value equal (0.000) which is less than 0.05 ,that means (Signage in place is sufficient).
2. In item No. (4) the weight mean equal (74.39%), which is greater than 60.0% and the p-value equal (0.000) which is less than 0.05 , that means (There are adequate parking areas in the center).
3. In item No. (9) the weight mean equal (71.88%), which is greater than 60.0% and the p-value equal (0.000) which is less than 0.05 ,that means (Drinking water available and clean).

In general the results for all items of the field (physical environment of the center) show that the average mean equal 3.89 and the weight mean equal 77.81% which is greater than 60% and the value of t test equal 30.659 which is greater than the critical value which is equal 1.97 and the p- value equal 0.000 which is less than 0.05, that means physical environment of the center at significant level $\alpha = 0.05$.

Table (4.9): Physical environment of the center

No.	Items	Mean	Standard deviation	Weight mean	t-value	P-value
1	Center rooms are clean.	4.08	0.408	81.70	43.723	0.000
2	Bathrooms have enough for all.	3.92	0.718	78.45	21.137	0.000
3	Bathrooms in the center clean.	3.95	0.597	79.04	26.232	0.000
4	There are adequate parking areas in the center.	3.72	0.908	74.39	13.043	0.000
5	Convenient and comfortable seats.	3.89	0.804	77.79	18.201	0.000
6	Lighting inside the center enough to work well.	3.89	0.789	77.86	18.642	0.000
7	Signage in place is sufficient.	3.77	0.847	75.42	14.985	0.000
8	There is order and system in the waiting area.	3.92	0.739	78.45	20.556	0.000
9	Drinking water available and clean.	3.59	1.042	71.88	9.383	0.000
10	Center rooms are adequate ventilation.	4.15	0.729	83.10	26.081	0.000
	Total	3.89	0.478	77.81	30.659	0.000

Critical value of t at df "270" and significance level 0.05 equal 1.98

4.3.5 Technical quality:

The researcher used one sample t test to test if the opinion of the respondent about technical quality and the results shown in table (4.10) as follows:

The 3 highest statements according to weight mean as follows:

1. In item No. (16) the weight mean equal (86.27%), which is greater than 60.0% and the p-value equal (0.000) which is less than 0.05 ,that means (Service providers provide me the necessary privacy).
2. In item No. (15) the weight mean equal (82.14%), which is greater than 60.0% and the p-value equal (0.000) which is less than 0.05 ,that means (There is order in front of the receptionist's office).
3. In item No. (4) the weight mean equal (81.33%), which is greater than 60.0% and the p-value equal (0.000) which is less than 0.05 that means (The receptionist explains things quietly).

And the 3 lowest statements according to weight mean as follows:

1. In item No. (4) the weight mean equal (47.16%), which is less than 60.0% and the p-value equal (0.000) which is less than 0.05 ,that means (Service providers help me in choosing a therapeutic way).
2. In item No. (2) the weight mean equal (44.58%), which is less than 60.0% and the p-value equal (0.000) which is less than 0.05 ,that means (no actively participate in preparation of the treatment plan).

3. In item No. (3) the weight mean equal (34.69%), which is less than 60.0% and the p-value equal (0.000) which is less than 0.05 ,that means (I have not some doubt in the ability of service providers involved in my treatment).

In general the results for all items of the field (Technical quality) show that the average mean equal 3.39 and the weight mean equal 67.71% which is greater than 60% and the value of t test equal 17.041which is greater than the critical value which is equal 1.96 and the p- value equal 0.000 which is less than 0.05, that means Technical quality is satisfied at significant level $\alpha = 0.05$.

Table (4.10): Technical quality

No.	Items	Mean	Standard deviation	Weight mean	t-value	P-value
1	I trust in service providers.	3.99	0.612	79.78	26.622	0.000
2	Actively participate in preparation of treatment plan.	2.23	1.099	44.58	-11.557	0.000
3	I have some doubt in ability of service providers involved in my treatment.	1.73	0.867	34.69	-24.037	0.000
4	Service providers help me in choosing a therapeutic way.	2.36	1.126	47.16	-9.388	0.000
5	A doctor seriously takes my complaint.	3.99	0.608	79.70	26.659	0.000
6	I felt that my health has improved after I attended this center.	3.57	1.051	71.44	8.957	0.000
7	Service providers provide me with sufficient information about my health.	2.45	1.049	49.00	-8.629	0.000
8	Service providers make sure my understanding of the treatment plan clearly.	2.47	1.060	49.45	-8.193	0.000
9	Show service providers willing to help me all time.	3.94	0.439	78.75	35.181	0.000
10	Service providers respond to my requirements quickly.	3.89	0.553	77.79	26.456	0.000
11	Pharmacist explains to me how to use the treatment.	3.04	1.157	60.89	0.630	0.529
12	I see number of service providers sufficient in center.	4.01	0.748	80.22	22.259	0.000
13	Medical staff is working to alleviate my anxiety and stress.	4.01	0.479	80.15	34.611	0.000
14	The receptionist explains things quietly.	4.07	0.505	81.33	34.777	0.000
15	There is order in front of receptionist's office.	4.11	0.661	82.14	27.578	0.000
16	Service providers provide me necessary privacy.	4.31	0.689	86.27	31.367	0.000
	Total	3.39	0.372	67.71	17.041	0.000

Critical value of t at df "270" and significance level 0.05 equal 1.98

4.3.6 Convenience and responsiveness:

The researcher used one sample t test to test if the opinion of the respondent about convenience and responsiveness and the results shown in table (4.11) as follows:

The 3 highest statements according to weight mean as follows:

1. In item No. (11) the weight mean equal (85.31%), which is greater than 60.0% and the p-value equal (0.000) which is less than 0.05 ,that means (I believe that service providers respect the time).
2. In item No. (9) the weight mean equal (82.29%), which is greater than 60.0% and the p-value equal (0.000) which is less than 0.05 ,that means I found that service providers collaborators. (The time I spend in the center to complete my service is available for me).
3. In item No. (10) the weight mean equal (81.92%), which is greater than 60.0% and the p-value equal (0.000) which is less than 0.05 ,that means (The time I spend in the center to complete my service is available for me).

And the 3 lowest statements according to weight mean as follows:

1. In item No. (2) the weight mean equal (49.37%), which is less than 60.0% and the p-value equal (0.000) which is less than 0.05 , that means (I have to wait for a long time before to be seen by the doctor).
2. In item No. (1) the weight mean equal (48.86%), which is less than 60.0% and the p-value equal (0.000) which is less than 0.05 ,that means (I have to wait for a long time before issue of my file).
3. In item No. (3) the weight mean equal (48.78%), which is less than 60.0% and the p-value equal (0.000) which is less than 0.05 ,that means (I have to wait for a long time before receiving my medication).

In general the results for all items of the field (convenience and responsiveness) show that the average mean equal 3.34 and the weight mean equal 66.70% which is greater than 60% and the value of t test equal 12.786 which is greater than the critical value which is equal 1.97 and the p- value equal 0.000 which is less than 0.05, that means convenience and responsiveness are good at significant level $\alpha = 0.05$.

Table (4.11): Convenience and responsiveness

No.	Items	Mean	Standard deviation	Weight mean	t-value	P-value
1	I have to wait for a long time before issue of my file.	2.44	1.002	48.86	-9.158	0.000
2	I have to wait for a long time before to be seen by the doctor.	2.47	0.995	49.37	-8.788	0.000
3	I have to wait for a long time before receiving my medication.	2.44	0.994	48.78	-9.290	0.000
4	The center is crowded with patients	2.90	1.099	58.01	-1.492	0.137
5	There is noise in the center.	2.67	1.040	53.36	-5.256	0.000
6	I believe that service providers work as a team in the provision of the service.	4.04	0.719	80.74	23.736	0.000
7	I cannot sit with the doctor because of our province from patients.	3.24	1.059	64.72	3.671	0.000
8	I feel that the work system is going on comfortably for the patient.	4.02	0.561	80.37	29.897	0.000
9	I found that service provider's collaborators.	4.11	0.582	82.29	31.521	0.000
10	The time I spend in the center to complete my service is available for me.	4.10	0.576	81.92	31.335	0.000
11	I believe that service providers respect the time.	4.27	0.611	85.31	34.089	0.000
	Total	3.34	0.431	66.70	12.786	0.000

Critical value of t at df "270" and significance level 0.05 equal 1.97

4.4 Hypotheses results:

4.4.1 Result of 1st hypothesis:

The difference of the satisfaction with CMH centers services according to age.

To test significant value the researcher used Independent Samples T-Test for the sex and current occupation variables and one way ANOVA Test with the other variables.

Table (4. 12): T-Test and ANOVA Test of the general satisfaction and other independent variables

Variables	t	Sig value
Sex	1.288	0.199
Current occupation	0.549	0.584
	F	**Sig value**
Age	0.675	0.568
Marital Status	0.698	0.554
Place of living	6.009	0.000
Level of education	0.801	0.525
Income	0.543	0.653
Psychiatric Diagnosis	0.760	0.552
Duration of Disorder	0.399	0.671

*** At α = 0.05**

To test the hypothesis the researcher used one way ANOVA and the result illustrated in table (4.12) which show that the p-value equal 0.568 which is greater than 0.05 and the value of F test equal 0.675 which is less than the value of critical value which is equal 2.64, that's means, there is no statistically significant difference at α = 0.05, of the satisfaction with CMH centers services according to age (Annex 7).

4.4.2 Results of 2nd hypothesis:

The difference of the satisfaction with CMH centers services according to sex.

To test the hypothesis the researcher used Independent Samples Test and the result illustrated in table (4.12) which show that the p-value equal 0.199 which is greater than 0.05 and the absolute value of T test equal 1.288 which is less than the value of critical value which is equal 1.97, that's means There is no statistically significant difference at α = 0.05, of the satisfaction with CMH centers services according to sex (Annex 8).

4.4.3 Results of 3rd hypothesis:

The difference of the satisfaction with CMH centers services according to marital status.

To test the hypothesis the researcher used one way ANOVA and the result illustrated in table (4.12) which show that the p-value equal 0.554 which is greater than 0.05 and the value of F test equal 0.698 which is less than the value of critical value which is equal 2.64, that's means, there is no statistically significant difference at α = 0.05, of the satisfaction with CMH centers services according to marital status (Annex 9).

4.4.4 Results of 4th hypothesis:

The difference of the satisfaction with CMH centers services according to level of education.

To test the hypothesis the researcher used one way ANOVA and the result illustrated in table (4.12) which show that the p-value equal 0.525 which is greater than 0.05 and the value of F test equal 0.801 which is less than the value of critical value which is equal 2.41, that's means there is no statistically significant difference at α = 0.05, of the satisfaction with CMH centers services according to level of education (annex 10).

4.4.5 Results of 5th hypothesis:

The difference of the satisfaction with CMH centers services according to place of living.

To test the hypothesis the researcher used one way ANOVA and the result illustrated in table (4.12) which show that the p-value equal 0.000 which is less than 0.05 and the value of F test equal 6.009 which is greater than the value of critical value which is equal 3.02, that's means, there is a statistically significant difference at α = 0.05, of the satisfaction with CMH centers services according to place of living (Annex 11), and according to scheffe test for multiple comparison table (4.13) show that the a difference between Gaza and Rafah in favor of Rafah, and there is a difference between Rafah and The Med-zone in favor of Rafah, and there is a difference between Rafah and Khanyounis in favor of Rafah.

Table (4.13) Scheffe test

Mean difference	Gaza	The North	The Med-zone	Khanyounis	Rafah
Gaza		-0.039	0.031	0.016	-0.174*
The North	0.039		0.070	0.055	-0.135
The Med-zone	-0.031	-0.070		-0.015	-0.205*
Khanyounis	-0.016	-0.055	0.015		-0.190*
Rafah	0.174*	0.135	0.205*	0.190*	

***The difference is significant at 0.05 level**

4.4.6 Results of 6th hypothesis:

The difference of the satisfaction with CMH centers services according to occupation.

To test the hypothesis the researcher used Independent Samples Test and the result illustrated in table (4.12) which show that the p-value equal 0.584 which is less than 0.05 and the absolute value of T test equal 0.549 which is greater than the value of critical value which is equal 1.97, that's means there is no statistically significant difference at α = 0.05, of the satisfaction with CMH centers services according to occupation (Annex 12).

4.4.7 Results of 7th hypothesis:

The difference of the satisfaction with CMH centers services according to income.

To test the hypothesis the researcher used one way ANOVA and the result illustrated in table (4.12) which show that the p-value equal 0.653 which is greater than 0.05 and the value of F test equal 0.543 which is less than the value of critical value which is equal 2.64, that's means there is no statistically significant difference at α = 0.05, of the satisfaction with CMH centers services according to income (Annex 13).

4.4.8 Result of 8th hypothesis:

The difference of the satisfaction with CMH centers services according to psychiatric diagnosis.

To test the hypothesis the researcher used one way ANOVA and the result illustrated in table (4.12) which show that the p-value equal 0.552 which is greater than 0.05 and the value of F test equal 0.760 which is less than the value of critical value which is equal 2.41, that's means there is no statistically significant difference at α = 0.05, of the satisfaction with CMH centers services according to psychiatric diagnosis (Annex 14).

4.4.9 Result of the 9th hypothesis:

The difference of the satisfaction with CMH centers services according to duration of mental disorder.

To test the hypothesis the researcher used one way ANOVA and the result illustrated in table (4.12) which show that the p-value equal 0.671 which is greater than 0.05 and the value of F test equal 0.399 which is less than the value of critical value which is equal 3.03, that's means there is no statistically significant difference at α = 0.05, of the satisfaction with CMH centers services according to duration of mental disorder (Annex 15).

4.4.10 Result of the 10th hypothesis:

The relationship between the satisfaction and general impressions of CMH centers services.

Table (4.14): Correlation between the satisfaction and general impressions of CMH centers services

Field	Statistic	The satisfaction
General impressions of CMH centers services	Pearson coloration	0.358
	p-value	0.000
	N	271

Critical value of r at significance level 0.05 and df equal 269 equal 0.157

Table (4.14) illustrate that the p-value equal 0.000 which is less than 0.05, and the value of Pearson correlation is equal 0.358 which is greater than the critical value which is equal 0.157 that means there is significant relationship at α = 0.05, between the satisfaction and general impressions of CMH centers services.

4.4.11 Result of the 11th hypothesis:

The relationship between the satisfaction and accessibility to CMH centers services.

Table (4.15): Correlation between the satisfaction and accessibility to CMH centers services

Field	Statistic	The satisfaction
Accessibility to CMH centers services	Pearson coloration	0.458
	p-value	0.000
	N	271

Critical value of r at significance level 0.05 and df equal 269 equal 0.157

Table (4.15) illustrate that p-value equal 0.000 which is less than 0.05, and value of Pearson correlation is equal 0.458 which is greater than the critical value which is equal 0.157 that means there is significant relationship at $\alpha = 0.05$, between the satisfaction and accessibility to CMH centers services.

4.4.12 Result of the 12th hypothesis:

The relationship between the satisfaction and communication, interaction and information of CMH team.

Table (4.16): Correlation between the satisfaction and communication, interaction and information of CMH team

Field	Statistic	The satisfaction
Communication, interaction and information of CMH team	Pearson coloration	0.704
	p-value	0.000
	N	271

Critical value of r at significance level 0.05 and d.f equal 269 equal 0.157

Table (4.16) which illustrate that p-value equal 0.000 which is less than 0.05, and value of Pearson correlation is equal 0.704 which is greater than the critical value which is equal 0.157 that means there is significant relationship at $\alpha = 0.05$, between the satisfaction and communication, interaction and information of CMH team.

4.4.13 Result of the 13th hypothesis:

The relationship between the satisfaction and physical environment of CMH centers.

Table (4.17): Correlation between the satisfaction and physical environment of CMH centers

Field	Statistic	The satisfaction
Physical environment of CMH centers	Pearson coloration	0.353
	p-value	0.000
	N	271

Critical value of r at significance level 0.05 and df equal 269 equal 0.157

Table (4. 17) which illustrate that p-value equal 0.000 which is less than 0.05, and value of Pearson correlation is equal 0.353 which is greater than the critical value

which is equal 0.157 that means there is significant relationship at α = 0.05, between the satisfaction and physical environment of CMH centers.

4.4.14 Result of the 14th hypotheses:

The relationship between the satisfaction and technical quality of CMH team.

Table (4.18): Correlation between the satisfaction and technical quality of CMH team

Field	Statistic	The satisfaction
Technical quality of CMH team	Pearson coloration	0.790
	p-value	0.000
	N	271

Critical value of r at significance level 0.05 and df equal 269 equal 0.157

Table (4.18) illustrate that p-value equal 0.000 which is less than 0.05, and value of Pearson correlation is equal 0.790 which is greater than the critical value which is equal 0.157 that means there is no significant relationship at α = 0.05, between the satisfaction and technical quality of CMH team.

4.4.15 Result of the 15th hypothesis:

The relationship between the satisfaction and convenience and responsiveness of CMH centers services.

Table (4. 19) Correlation between the satisfaction and convenience of CMH centers services

Field	Statistic	The satisfaction
Convenience and responsiveness of CMH centers services	Pearson coloration	0.338
	p-value	0.000
	N	271

Critical value of r at significance level 0.05 and df equal 269 equal 0.157

Table (4.19) illustrate that p-value equal 0.000 which is less than 0.05, and value of Pearson correlation is equal 0.338 which is greater than the critical value which is equal 0.157 that means there is no significant relationship at α = 0.05, between the satisfaction and convenience and responsiveness of CMH centers services.

4.5 Qualitative data results:

The researcher has collected answers about 35 of the patients participating in the study on 4 open questions at the end of the questionnaire in order to obtain qualitative data about patient concepts and satisfaction with CMH centers services, the questions focused on what they like and dislike and their vision and suggestions to improve these services. The researcher organized and arranged qualitative data in table (4.20).

Table (4.20) Analysis of qualitative data

The center	Like	Dislike	Aspects need to improve	Suggestions / comments
Al Surani	Cleanliness Staff collaborators Reception system Good communication	Lack of medicine No appointment system Center in upper floor Lack of time sitting with therapist	Provide medicines Social activities Appointment system	- Providing psycho-social rehabilitation programs - Activate home visits - Coordination with institutions to provide support and facilities - Providing electroencephalography device in the southern region - Recreational trips - Provide vocational rehabilitation programs - Focus on psychotherapy & sessions - Educational meetings & awareness - Medication Exchange all days - Transport patients to the centers or deliver drugs to them
West Gaza	Cleanliness Staff collaborators Good communication	Lack of medicine Narrow center Lack of time sitting with therapist No appointment system	Provide medicines Appointment system Providing rooms for sessions Expanding center	
Abu Shabak	Cleanliness Quietness Staff collaborators Comfortable system	Lack of medicine No appointment system Center in upper floor Lack of time sitting with therapist Far from place of living	Provide medicines Provide cold water Appointment system	
Al Nuseirat	Cleanliness Staff collaborators Good communication	Lack of medicine Narrow center/ Crowding No appointment system Far from place of living Lack of time sitting with therapist	Provide medicines Provide cold water Expanding center Appointment system Providing rooms for sessions	
Khan-Younis	Cleanliness Staff collaborators Signage Comfortable system	Lack of medicine Center in upper floor Narrow center/ Crowding Lack of time sitting with therapist No appointment system length of waiting time Far from place of living	Provide medicines Provide an alternative place Run the elevator always Widening waiting area Appointment system Providing rooms for sessions	
Rafah	Cleanliness Quietness Signage Comfortable system Teamwork	Lack of medicine No appointment system Lack of time sitting with therapist Far from place of living	Provide medicines Appointment system	

Chapter (5)

Discussion

5.1 Introduction:

This chapter presents discussion of the findings and conduct comparisons of this study findings and other studies done in the region and globally in terms of agree and disagree and discussion of study hypotheses.

5.2 Discussion results of socio-demographic characteristics of the study sample:

Note in table (4.2), summarizes distribution of important study variables such as sex, age, marital status, place of living, level of education, current occupation, and income. Regarding sex, males represents more than three-quarters (77.1%) of the study sample, while females less than quarter (22.9%), and this reflects the culture of our society and their view of mental illness for females and enable them to seek treatment. This finding inconsistent with Al Kariri (2010) study to assess patient's satisfaction with outpatients at Alshifa Hospital which found that males represented 51.4% and females represented 48.6% of the study sample.

Regarding age, two thirds of the study sample over the age of 35 years over a middle-aged. The researcher divided the ages into 4 groups, the first from 18 – 24 years (7.4 %), the second from 25 – 34 years (20.3%), the third from 35 – 44 years (29.9%), and the fourth over 45 years (42.9%). About more than half of the study sample of young and middle-age and this corresponds with studies which show that mental illness appears at an early age, in addition to that young people are more subjected to psychological, social and economic stressors, so young people are the largest group of psychiatric patients.

On one hand, the married respondents showed higher percentage, which represented (74.9%). Researcher thinks that a lot of psychiatric patients who are reviewing the CMH centers in stable condition and able to marry and build a family, so about three-quarters were married. In addition to the divorce rate have less than that of ordinary people.

Note that, more than fifth sample of the study are illiterate (21.4%) and more than half of people with little education, reflecting the low levels of public education in psychiatric patients and the extent of their need for special education and vocational rehabilitation.

Also; note that, the largest proportion of psychiatric patients do not work (91.5%), reflecting the very high unemployment rate among psychiatric patients and the economic burden on their families and society. So; that those who are working and the proportion of (8.5%) are from low-income and living below the poverty line (95.2%) of the sample monthly income under 1,500 NIS. According to report of Palestinian Central Bureau of Statistics (PCBS) in 2010, the poverty line for the reference household (2 adults and 3 children) stood at 2,237 NIS (PCBS report, 2009-2010). Moreover, the poor economical condition and living below the poverty line with low monthly income of respondents made them unable to deal with modern or specialized mental health services or exposure to other kind of services. This made patients satisfied with any services that they were provided. In addition to, Elhaj (2008) study revealed that unemployment rate (74.8%) was close to our findings. The researcher confirms that

although majority of the patients do not work and who work are from low-income, but most psychiatric patients receive financial aids and foodstuffs from the Ministry of Social Affairs, the UNRWA and civil institutions and associations. Above all, the researcher believes that psychiatric patients have the ability to engage in simple occupations and works suit their abilities and skills, also they need to provide employment opportunities for them, and need to vocational rehabilitation programs.

5.3 Discussion results of mental disorders related factors of the sample:

Note that more than three-quarters of the study sample of people with common mental disorders, so those are insight and have good judgment. Note that majority of the patients are chronic so, they have long experience with CMH services and able to judge well on the services provided to them from these centers.

Note that majority of the patients receiving pharmaceutical services (85.1%) and very little of the patients were receiving psychological support services or psychotherapy or counseling or home visit and absence of family therapy, which reflects the absence of a holistic view of services and not rely of bio-psychosocial approach of the care and focus on biologic approach. Researcher appeals decision makers and managers of mental health reconsideration to other types of modern therapy approach in treatment of psychiatric patients and adopt a holistic approach that does not focus on the organic aspect, but it also extends to the psychological, social, and spirituality aspects of the care, and is focusing on the all types of psychotherapy, especially that most psychologists hold higher diploma in cognitive behavioral therapy and the majority of nurses hold a CMH Master.

Note also, that a small proportion of psychiatric patients with physical disabilities (5.5%). So they need to rehabilitation programs suit their disabilities and reduce the proportion of the social burden on families.

The finding reflects that half of study sample have low mental health level. So the researcher show that they need to re-evaluate of the health status, and they need to psychosocial support programs and needs to educate stress management such as; exercises, relaxation, meditation and problem-solving skills.

5.4 Discussion results of CMH services related variables of the sample:

Results show that only 27.3% of the study population had received mental health services in other organizations, remaining 72.7% receive services from CMH centers, which shows the importance of these services and its effectiveness for patients and also; reflects the focus of mental health services in the government sector, as mental health services free of charge. In addition, El Khatib study revealed that 23.5% of the study population had received non communicable diseases services in other organizations, and 76.5% receive services from UNRWA was close to our findings.

On other hand, 22.5% of the study population was purchasing drugs other than those provided by CMH centers and 77.5% depend fully on CMH centers to supply them with drugs. In 62.3% of the 61 patients those who purchased additional drugs the reason was not enough of these drugs at CMH centers, while the remaining 37.7% the reason unavailability of these drugs.

Also shows that 80% out of the 15 patients who had a disability restriction thought that CMH centers are equipped either fully or partially to facilitate their movement, while 20.0% thought it is not equipped.

It is worth noting, that entire study sample (100.0%) agreed that there was no system to measure and evaluate patient satisfaction with the services which confirmed the importance of a system such as a questionnaire or suggestions and complaints box to identify levels of satisfaction among patients periodically.

5.5 Discussion of the results of levels of satisfaction:

According to the results, patients in this study exhibited levels of satisfaction; 76,51% of them were satisfy with the CMH care provided and almost all of them will continue to receive service from CMH centers and 84.87% of them will recommend the services to their relatives and friends if needed same service. This result close to the result of Abu Saileek (2004) study conducted to assess the level of clients' satisfaction with nursing care provided at selected hospitals in GS (European Gaza hospital and Nasser hospital). Overall satisfaction level was 70.1% in both hospitals. The clients' in European Gaza hospital reported higher satisfaction 84.2% than the clients' in Nasser hospital 61.7%. Also our finding consisted with Gani et al. (2011) study to measure patient satisfaction in a tertiary care hospital in order to know the patients' perspectives and expectations of the services and make appropriate improvements accordingly. 72% of the participants were mostly satisfied, 18.7% mildly satisfied and 9.3% dissatisfied with the psychiatric care. In Al kariri (2010) study to assess the patient level of satisfaction with health services provided at Outpatients Department at Al Shifa Hospital. The overall patients' level of satisfaction was 63.9% was less than satisfaction in this results. Also in study of Ahmad (2009), to investigate women's levels of satisfaction with obstetric care received at Shifa Hospital. The overall level of satisfaction was 61.8%. Similar finding revealed by Al Sharif (2008), study to measure patients' satisfaction with services provided at Nablus hospitals, about 70.2% of respondents rated their general satisfaction with governmental hospitals as good to very good. While in non-governmental hospitals, more than 90 % rated it as good to very good. While in Abu Mourad et al. (2007) study conducted to identify the level of patients' satisfaction with primary care physicians. The mean percentage of positive satisfaction with medical services was poor (41.8%).

In contrast; Davy et al. (2009) study reported higher level satisfaction (93.1%). Also, Hillis (2008) study to evaluate the level of outpatients' satisfaction with physiotherapy services in outpatients physiotherapy departments at Al-Shifa Hospital and Al-Wafa Medical Rehabilitation Hospital in Gaza. The level of patient satisfaction with physiotherapy services in both hospitals has been (87.4%). Another study conducted by Al Hindi (2002) to assess the level of satisfaction with radiology services in Gaza. The findings showed that clients reported a relatively high degree of satisfaction with radiology services (82.5%).

The researcher show in this study the political and socio-economic situations in Palestinian community is unstable, these situations might affect on their satisfaction level, so the patients recorded the low to moderate percentage of satisfaction level. In addition, the qualitative data may direct the researcher to explore the dissatisfied areas that need more enhancements to improve the quality of CMH services.

5.6 Discussion results of the hypotheses:

5.6.1 Discussion result of the 1st hypothesis (age and general satisfaction):

The result indicated that there is not statistically significant difference of age and general satisfaction. So we accept the hypothesis and conclude that there are no significant differences of age and general satisfaction. This is agreed with Sadjadian et al. (2004) study conducted to examine patient satisfaction among women attending the Iranian Centre for Breast Cancer. The findings suggest that none of the demographic variables showed any significant association with patients' overall satisfaction. And the findings of this study are similar to Buckley (2009) study, found no statistically significant relationships between any consumer characteristics and satisfaction. In contrast with Mousa (2000) study results who discussed that the lack of general satisfaction level with age increasing and he found that the older women were dissatisfied with family planning services. Moreover, our findings are emphasized by Odgerel (2010) study, showed no significant relationship between age and satisfaction. Moreover, this agreed with Navpour et al. (2011) study that indicate that the majority of research units within both the control group and the case study, (before and after intervention) that there was no statistically significant differences between patients' age between the 2 groups. Compared with Abu Saileek (2004) study, found significant relationship between age groups and client satisfaction. Also our result consisted with Elkatib (2010) study reported there were not statistically significant difference of age. Then, consisted with Stein et al. (1993) results indicated that demographic characteristics were unrelated to satisfaction. In contrast; Alkariri (2010) study revealed age is statistically significant difference on patient level of satisfaction. While; Al Hindi (2002) found no differences between age groups. Also; this finding congruent with Ahmed (2009) who found that no differences between age at marriage regarding the satisfaction level. Compared with results of Blenkiron and Hammill (2002) study to determine patient's satisfaction with their mental health care and quality of life reported that age was related to service satisfaction.

The researcher found that there was no relationship between patients' satisfaction and age groups that reflects that age variable is ineffective factor on patients' satisfaction in our study.

5.6.2 Discussion result of the 2nd hypothesis (sex and general satisfaction):

The results indicated that there is not statistically significant difference of sex and general satisfaction. So we accept the hypothesis and conclude that there are no significant differences of sex and general satisfaction. This finding is consistent with Sadjadian et al. (2004) study suggests that none of the demographic variables showed any significant association with patients' overall satisfaction. And consistent with finding at Buckley (2009) who found no statistically significant relationships between any consumer characteristics and satisfaction. In contrast; Alkariri (2010) study revealed the gender statistically significant difference on patient level of satisfaction. Moreover, our study is consistent with findings Odgerel (2010) study showed no significant relationship between genders. This result is endorsed by Elkatib (2010) who reported there were not statistically significant difference of gender and level of education. Then, consisted with Stein et al. (1993) study results indicated that demographic characteristics were unrelated to satisfaction. In addition to Abu Saileek

(2004) study pointed that there are no differences between males and females in their level of satisfaction with nursing care. Also; this finding congruent with study conducted by Ahmed (2009) who found that no differences between gender regarding the satisfaction level. Moreover, the findings consistent with Blenkiron and Hammill (2002) study, who investigated the determines patients' satisfaction with their mental health care and quality of life. The results showed that no relationship between gender and service satisfaction.

The researcher shows that both male and female patients undergo similar situations and circumstances that lead both male and female patients to express and expect in similar way. Also, the researcher interprets that sex might haven't any impact on the patients' perceptions and expectations.

5.6.3 Discussion result of the 3rd hypothesis (marital status and general satisfaction):

The results indicated that there is not statistically significant difference of marital status and general satisfaction. So we accept the hypothesis and conclude that there are no significant differences of marital status and general satisfaction. This is agreed with Sadjadian et al. (2004) study suggests that none of the demographic variables showed any significant association with patients' overall satisfaction. And consistent with Buckley (2009) study, found no statistically significant relationships between any consumer characteristics and satisfaction. Compared to Abu Saileek (2004) study reported that the married higher level of satisfaction. Also; our study is consistent with findings Al Sharif (2008) who found no statistically significant differences due to marital status and general satisfaction. Then, consisted with Navpour et al. (2011) study indicate that the majority of research units within both the control group and the case study, (before and after intervention) were married and that there were no statistically significant differences between marital statuses between the 2 groups. Moreover, its results consisted with Stein et al. (1993) results indicated that demographic characteristics were unrelated to satisfaction. Also Alkariri (2010) study revealed marital status did not show statistically significant difference.

5.6.4 Discussion result of the 4th hypothesis (level of education and general satisfaction):

The result indicated that there is not statistically significant difference of level of education and general satisfaction. So we accept the hypotheses and conclude that there are no significant differences of level of education and general satisfaction. This is agreed with Sadjadian et al. (2004) study, the findings suggest that none of the demographic variables showed any significant association with patients' overall satisfaction. In contrast, our finding inconsistent with Stein et al. (1993) study results indicated that more educated people being less satisfied with their care. But our result consistent with finding Buckley (2009) who found no statistically significant relationships between any consumer characteristics and satisfaction. Compared to Alkariri (2010) study revealed level of education is statistically significant difference on patient level of satisfaction. While, Al Sharif (2008) study found no statistically significant differences due to educational level and general satisfaction. Moreover, our study is consistent with findings Odgerel (2010) the result of the study showed no significant relationship between education. While, This finding is inconsistent with Abu Saileek (2004) study that showed that the clients' with low educational level were more

satisfied with nursing care than the clients' with high educational level. Then, our finding consisted with Navpour et al. (2011) study that indicate that the majority of research units within both the control group and the case study, (before and after intervention) were married and that there was no statistically significant differences between education between the 2 groups. Compared with Al Hindi (2002) study that pointed that the clients' with higher educational level reported a higher satisfaction level. Also this result consisted with Elkatib (2010) study, who reported there was not statistically significant difference of level of education. In contrast with Mousa (2000) that illustrated that the clients were more satisfied with the lower educational level and the clients were less satisfied with the higher educational level.

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5.6.5 Discussion result of the 5th hypothesis (place of living and general satisfaction):

The study found that there is a statistically significant difference at $\alpha = 0.05$, of the satisfaction with CMH centers services according to place of living, and according to scheffe test for multiple comparison table (4.13) show that the a difference between Gaza and Rafah in favor of Rafah , and there is a difference between Rafah and The Mid in favor of Rafah, and there is a difference between Rafah and Khan-younis in favor of Rafah , and there is a difference between Rafah and The North in favor of Rafah.

This result is consisted with Abu Shuaib (2005) study, showed that were significant differences between dimensions of women's perspectives and governorates, where the women who were living in Rafah Governorate had more positive perspective than women who were living in other Governorates, while the women who were living in Gaza Governorate reported the lowest score. This result is endorsed by Al sharif (2008) study, revealed that there are significant statistical differences between residency place and patients' satisfaction. The results show that city residents who reported higher level of overall satisfaction scores (mean 192.7986) than camp residents (mean 168.8333). Also the city residents reported higher level of satisfaction in some satisfaction domains (communication and information) and overall satisfaction. Compared with Ahmed (2009) study who found that no differences between residency places regarding the satisfaction level. While, agreed with Elkatib (2010) study, who reported difference between place of living of the study population and patient's satisfaction. Where those who living in the south have higher scores where those who living in the middle area scored the highest, but people living in Gaza and North area have the lowest scores. On the other hand, this result inconsistent with AlKariri (2010) study, found no differences between residency places regarding the satisfaction level. Also, this result is inconsistent with Al Hindi (2002) study, cited that there were no significant statistical differences between residency place and patients' satisfaction. While, our result is consistent with Ab Saileek (2004) study, pointed the cities clients reported higher percentage of satisfaction level than the clients who were living in camps. Moreover, Mousa (2000) found that the clients who were living inside refugees camps were more satisfied with family planning services by MOH and UNRWA than the clients' who were living outside refugee camps.

The researcher shows that place of living of the patients has effects on their satisfaction, and the researcher takes into account this variable regarding patients' satisfaction.

5.6.6 Discussion result of the 6th hypothesis (occupation and general satisfaction):

The results indicated that there is not statistically significant difference of current occupation and general satisfaction. So we accept the hypothesis and conclude that there are no significant differences of current occupation and general satisfaction. This is agreed with Sadjadian et al. (2004) study suggests that none of the demographic variables showed any significant association with patients' overall satisfaction. And consistent with Buckley (2009) study who found no statistically significant relationships between any consumer characteristics and satisfaction. Compared with Al sharif (2008) study, shows that unemployed patients reported higher level of overall satisfaction scores (mean 195.9208) than employed patients (mean 180.7400). Moreover, our results consistent with Odgerel (2010) study showed no significant relationship between occupations. Then, our finding consisted with Navpour et al. (2011) study that indicate that the majority of research units within both the control group and the case study, (before and after intervention) were married and that there was no statistically significant differences between profession between the 2 groups. Moreover, this result indorsed by Al Hindi (2002) result shows no significant statistical differences between occupation and patients' satisfaction.

5.6.7 Discussion result of the 7th hypothesis (income and general satisfaction):

The results indicated that there is not statistically significant difference of income and general satisfaction. So we accept the hypothesis and conclude that there are no significant differences of income and general satisfaction. This is agreed with Sadjadian et al. (2004) study suggests that none of the demographic variables showed any significant association with patients' overall satisfaction. And consistent with Buckley (2009) study, who found no statistically significant relationships between any consumer characteristics and satisfaction. In contrast; Alkariri (2010) study revealed income is statistically significant difference on patient level of satisfaction. While, consisted with Stein et al. (1993) results indicated that demographic characteristics were unrelated to satisfaction.

5.6.8 Discussion result of the 8th hypothesis (psychiatric diagnosis and general satisfaction):

The results indicated that there is not statistically significant difference of psychiatric diagnosis and general satisfaction. So we accept the hypothesis and conclude that there are no significant differences of psychiatric diagnosis and general satisfaction. Our finding is consistent with results of Sadjadian et al. (2004) suggest that none of the demographic variables showed any significant association with patients' overall satisfaction. And agreed with Buckley (2009) study who found no statistically significant relationships between any consumer characteristics and satisfaction. While, inconsistent with the result of Blenkiron and Hammill (2002) study reported that psychiatric diagnosis was related to service satisfaction. But consisted with Navpour et al. (2011) study that indicate that the majority of research units within both the control group and the case study, (before and after intervention) were married and that there was no statistically significant differences between diagnoses between the 2 groups. In While, this result disagree with Abu Saileek (2004) study, the result showed that the clients who had chronic illness represented percentage (37.3%) and were more satisfied with nursing care than others, while the clients with injuries represented percentage only (14.8%) and were less satisfied. Moreover, it consisted with Stein et al. (1993) results

indicated that demographic characteristics were unrelated to satisfaction. Compared with Al sharif (2008) study, the findings showed that the patients with neurological conditions reported higher satisfaction level than patients with orthopedic conditions.

5.6.9 Discussion of the results of the 9th hypothesis (duration of disorder and general satisfaction):

The results indicated that there is not statistically significant difference of duration of disorder and general satisfaction. So we accept the hypothesis and conclude that there are no significant differences of duration of disorder and general satisfaction. Our finding is consistent with results of Sadjadian et al. (2004) study; the findings suggest that none of the demographic variables showed any significant association with patients' overall satisfaction. And consistent with Buckley (2009) study who found no statistically significant relationships between any consumer characteristics and satisfaction. In contrast; Alkariri (2010) study revealed duration of disease is statistically significant difference on patient level of satisfaction. Moreover, our study is consistent with Odgerel (2010) study showed no significant relationship between length of stay in hospital. Then, agreed with Navpour et al. (2011) study that indicate that the majority of research units within both the control group and the case study, (before and after intervention) were married and that there was no statistically significant differences between history of hospital admissions between the 2 groups. Also, consisted with Stein et al. (1993) results indicated that demographic characteristics were unrelated to satisfaction. Moreover, consistent with the result of Blenkiron and Hammill (2002) study reported that duration of mental disorder was unrelated to service satisfaction.

5.6.10 Discussion of the results of the 10th hypothesis (Relation between general satisfaction and general impressions of CMH centers services):

The study found that there was significant relationship between general satisfaction and general impressions of CMH centers services ($p = 0.000$). This means that general impressions of CMH centers services play role in the level of patient's satisfaction. General impressions of the CMH centers services dimension included 8 items (annex 4); it refers to the overall impression of the way the CMH services are provided at CMH centers, the appropriateness of service delivery and reflects patients good experience with services. Findings showed that general impressions domain reported a mean 3.83 (76.51%) of satisfaction level which means that patients are generally satisfied with CMH centers services. This is evident through their willingness to continue to receive services from the center and their recommended CMH centers services to others. In addition, most patients are unemployed and some of them unable to work also free health insurance for services, making them dependent entirely on the CMH centers services.

5.6.11 Discussion of the results of the 11th hypothesis (Relation between general satisfaction and accessibility to CMH centers services):

The study found that there was significant relationship between general satisfaction and accessibility to CMH centers services ($p = 0.000$). Also, this means that

accessibility to CMH centers services play role in the level of patient's satisfaction. Accessibility to CMHCSs dimension included 8 items (annex 4); it refers to ability to access the CMH services. In this study, findings showed that accessibility to services domain reported a mean 2.91 (58.19%) of satisfaction level which means that patients have lower level of satisfaction with accessibility of services, In other words; that it is not easily accessible for service and benefit from them, so should the decision-makers to reconsider the geographical distribution of centers and increase the number of CMH team to reduce work overload to enable professionals to respond to the needs of patients and also provide medicine and always focusing on the program and home visits to provide services to those who did not have access to the centers. As a result of analysis of open ended questions, many patients expressed dissatisfaction about lack of permanent and adequate medications so; that going to leave without taking treatment sometimes, also; Khan-Younis center patients expressed dissatisfaction with the presence of the center on the fourth floor in addition to the lack of an elevator permanently and the majority of patients suggests finding an alternative location in ground floor. Then; the majority of the patients suggests provide treatments exchange all the week not on specific days.

In a similar result to some extent shown by Alkariri (2010**)** study to assess patients' satisfaction with the outpatients services at Al-shifa Hospital, showed that 67.3% of the patients were satisfied with access to care dimension. In other hand; Mira et al. (2002) found that accessibility and certain organizational aspects are the dimensions that patients most commonly mentioned as causes of dissatisfaction. Also; in study conducted by Kroneman et al. (2006) in 18 European countries addressed the question, to what extent the direct access to health care services affects the level of patients' satisfaction with the GP services. The study concluded that, higher level of satisfaction was reported among patients who had a direct access to services than those with a gate keeping services.

5.6.12 Discussion of the results of 12th hypothesis (Relation between general satisfaction and communication, interaction and information of CMH team):

The study found that there was significant relationship between general satisfaction and communication, interaction and information of CMH team ($p = 0.000$). Communication, interaction and information dimension included 15 items (annex 4). This refers to the communication and interaction between patients and CMH team; it reflects the degree of respect, empathy, appreciation, privacy and confidentiality of the service providers for the patient and the amount of information obtained regarding disease, health status and treatment plan. In this study, findings showed that communication, interaction and information domain reported a mean 2.92 (58.40%) of satisfaction level which means that patients have lower level of satisfaction with communication, interaction and information of CMH team. As a result of analysis of open ended questions, a lot of patients expressed dissatisfaction with the lack of continuity in communication the CMH team with them and with their families when their absence and the lack of information that they receive from professionals about their illness and treatments.

Similar finding revealed by Mousa (2000) study, which assess client's satisfaction with family planning services in GS. The researcher reported that communication and interaction have the lowest degree of satisfaction (54%). Also; in

study conducted by Ahmed (2009) to examine women satisfaction about delivery services provided at Al-shifa Hospital; the dimension of information and communication elicited the lowest scores (49%). Compared with the results of Al Hindi (2002), pointed to the level of satisfaction that the clients' reported in the communication and interaction domain about (77.5%). In the study conducted by Alkariri (2010**)** to assess patients' satisfaction with the outpatients services at Alshifa Hospital, showed that 64.7% of the patients were satisfied with information and interaction dimension. While, in Elkhatib (2010) study, to assess the level of satisfaction among patients with non-communicable diseases, receiving from UNRWA health centers in GGs showed that 76.31% of the patients were satisfied with communication, interaction and information dimension. Compared with Al sharif (2008) study, showed that the patients have reported satisfaction level (64.2%) in communication and information domain. Also; in study conducted by Ruggeri et al. (2003) on 404 schizophrenic patients in 5 European sites. In all sites; patients were least satisfied with involvement of relatives in care and information about illness. On the other hand, Davy et al. (2009) study reported greater satisfaction was relationship with staff, while a lower satisfaction was related to information on disease and medication.

The researcher show that lower level of satisfaction with communication, interaction and information of CMH team reflects importance of spending adequate time with patients, answered the patients' questions, giving the patients' enough information about their condition and treatment plane, and give their chance to express about their worries that lead to promote patients satisfaction and wellbeing. Therefore, the enhancement of communication skills and build positive therapeutic relationships between patient and mental health team lead to high quality of patient-therapist interactions and to fulfill these by various continuous training courses how to deal with patients, and develop the abilities of mental health team to breakdown the gaps between them, listening skills and strengthening the communication channels that reflect positively on the psychology of patients.

5.6.13 Discussion of the results of 13th hypothesis (Relation between general satisfaction and physical environment of CMH centers):

The study found that there was significant relationship between general satisfaction and physical environment of CMH centers (p = 0.000). Physical environment dimension included 10 items (annex 4). This refers to the comfort and cleanliness of the health facility; it reflects what extent patients are satisfied with physical environment of CMH centers, this is evident through their impressions about the cleanliness and ventilation of rooms and bathrooms of the center. In this study, findings showed that physical environment domain reported a mean 3.89 (77.8%) of satisfaction level which means that patients have highest level of satisfaction with physical environment of CMH centers. As a result of analysis of open ended questions, patients expressed their satisfaction about cleanliness centers, ventilation and lighting, easy system and tranquility within the centers but some complained of the small central Khan-Younis and west of Gaza and the lack of room to sit down with the patient alone.

This result is agreed with Abu Shuaib (2005) study, to assess women's perceptions of childbirth services provided at governmental Hospital in Gaza Strip; that reported 76.1% of perspective level. Whilest; in Alkariri (2010**)** study, the patients expressed low satisfaction level (61.3%) with physical environment dimension. Also; in study conducted by Ahmed (2009) to examine women satisfaction about delivery services provided at Alshifa Hospital; the dimension of physical environment elicited

the lowest scores (49%). Moreover, in Davy et al. (2009) study clinic organization and environment reported a lower satisfaction.

The researcher suggests that to enhance the patients satisfaction in this domain compared to findings of other studies, the service provider may provide enough bathrooms in the centers, pay attention about cleanliness, lighting and ventilation of rooms and provide a comfortable atmosphere inside the CMH centers.

5.6.14 Discussion of the result of the 14th hypothesis (Relation between general satisfaction and technical quality of CMH team):

The study found that there was significant relationship between general satisfaction and technical quality of CMH team (p = 0.000). Technical quality dimension included 16 items (annex 4). This means that professional competence and practical experience of service providers, an important indicator of patient satisfaction with the services provided to them. In this study, findings showed that technical quality domain reported a mean 3.39 (67.71%) of satisfaction level which means that patients have moderate level of satisfaction with technical quality of CMH team. As a result of analysis of open ended question, Many patients have notes and reservations about the CMH team's focus on drug therapy and the omission of psychotherapy and sessions and do not include the patient in the treatment plan and the lack of information that provides them about their illness and lack of clarification pharmacist how to use the treatment.

This finding is inconsistent with other studies showed a higher level. Abu Shuaib's (2005) study, explained high perspective level 85.5% with childbirth services. Elhaj (2008), showed level of satisfaction 82.5% with services provided at the European Gaza Hospital. Also Al-Hindi (2002) reported level of satisfaction 80% with radiology services. This may be related to the novelty of service providers where many of them new employment and lack of experience and professional skills in addition to work overload and the huge number of patients. Also this may be related to the nature of mental disorder that makes the patient loses confidence in himself, others and everything around him. Moreover, CMH team may need more training programmers' and the involvement of the patient in treatment plan to improve technical quality for them. Then; Tam (2007), found that doctors technical quality is the first of the nine identified factors that were key aspects of the medical service encounter that influenced patient satisfaction. Also; Edlund et al. (2003) study conducted to analyze the relationship between satisfaction and technical quality of care for common mental disorders. Finding revealed that appropriate technical quality of care was significantly associated with higher levels of satisfaction.

The researcher interprets that the improvement of CMH team skills and competences is achieved by training, refreshing courses in mental health field to develop their experience, practical and theoretical knowledge.

5.6.15 Discussion of the result of the 15th hypotheses (Relation between general satisfaction and convenience and responsiveness of CMH centers services):

The study found that there was significant relationship between general satisfaction and convenience and responsiveness of CMH centers services (p = 0.000). Convenience and responsiveness dimension included 11 items (annex 4). It refers to the waiting time before getting served, crowed and noise in the center. In this study,

findings showed that convenience and responsiveness domain reported a mean 3.34 (66.7%) of satisfaction level which means that patients have moderate level of satisfaction with convenience and responsiveness of CMH centers services. This result related to crowded CMH centers patients felt inconvenient as have to wait for a long time before to being seen by the doctor, issue of file and receiving medication. Organizing and arranging the work and improving the appointment system will alleviate the complaining of the patients and improves responsiveness and convenience level. Open ended questions analysis; some patients expressed that they are waiting for a long time to receive service and complain about the crowds and the noise in the center and they cannot sit with the therapist because of the boycott of the reviewers.

The study findings consistent with Alkariri (2010) study, revealed that domain of waiting time reported the lowest level of satisfaction 58.8%. Compared with Al Hindi (2002), the clients' reported a higher percentage of satisfaction level (90%) with comfort and privacy domain in receiving radiology services. Also; In Westaway et al. (2003) study to determine the underling dimensions affecting patients satisfaction in South Africa's primary health care settings, pointed that irrespective of the country setting the highest degree of dissatisfaction are with the waiting time which can reach to an hour or more. Then, result consistent with Elkhatib (2010) study found that the convenience of the clinic environment improves client's satisfaction with services. While, Al Sharif (2008) study showed that the patients have reported (96.7%) of satisfaction level with environment comfort and convenience domain.

The researcher suggests that to enhance the patients satisfaction in this domain, the service provider may provide enough seats in waiting area, pay attention about noise and provide a comfortable atmosphere inside the CMH centers.

5.7 Discussion of qualitative data:

The researcher note through the analysis of qualitative data for patients answers to open-ended questions at the end of the questionnaire, note that what more impressed patients in centers cleanliness and arrangement, this is compatible with the result of higher satisfaction for patients was satisfaction with physical environment of the centers, also showed patients admiration of cooperation, communication and interaction of mental health team with them. On the opposite side the patients expressed disliked with lack of psychiatric drugs permanently; while lack of medicine stands obstacle without developing CMH services, as many of the patients initially require psychiatric drugs to control the symptoms and to help to be insight and then can be entered later in psychological, social or functional rehabilitation programs, in addition to the displeasure of patients there is no appointment system, which in turn helps to regulate the work and reduce overcrowding and the length of the waiting time and increases the time stay patient with the therapist, as well as the center far from place of living of the some patients; which hinders their access to get the service, also this is consistent with the result of lower satisfaction level was access to the centers so that policy-makers redistribution centers to fit with the geographical distribution of the population blocks. In the context of the patients' responses to their vision for development and improvement of services emphasized the provision of medicines, adoption of an appointment system, expand the centers and increase the rooms. In the end, made some patients recommendations and suggestions that would develop and improve the services are all about change work approach in the centers from physician approach focuses on prescription of medication to a broader commensurate with the philosophy of working in community-based; so that it adopts bio-psychosocial approach. So patients called for activating home visits, social and recreational activities and provide rehabilitation programs and focus on other psychological therapies and alternative medicine, as well as to facilitate access of patients to centers through transport patients to the centers or deliver drugs to them in their homes.

Chapter (6)

Conclusion
And
Recommendation

6.1 Conclusions:

This study was conducted to understand patient's satisfaction, perception, concerns and views about the CMH services provided at CMH centers in GS. The study findings might help in improving the quality of CMH services provided to the concerned patients by highlighting the strengths and weaknesses of the services provided and the opinion of patients and their satisfaction with those services.

The study explored the main domains of patient's satisfaction with the CMH services. Then; the study explored the differences within socio-demographic variables, mental disorders related factors and CMH services related factors that related to patients satisfaction. The response rate was moderate at 67.75 %. The reliability coefficient of the study instrument was high at 0.93. .

The reported overall satisfaction level was 66.89%. The domains of satisfaction towered CMH services were extracted to include, general impression, accessibility of service, communication, interaction and information, physical environment of the center, technical quality, and convenience and responsiveness. The study found and explained the relation between general satisfaction and all domains of satisfaction.

Highest expressed level of satisfaction was physical environment of the centers (77.8). This reflects what extent patients are satisfied with physical environment of CMH centers. This is evident through their impressions about the cleanliness and ventilation of rooms and bathrooms of the center, in despite of their criticism of some issues such as insufficient signage and clean drinking water.

Additionally patients expressed high level of satisfaction with general impressions reflects what extent patients are generally satisfied with the CMH services provided at CMH centers in despite of their criticism of some issues. This is evident through their willingness to continue to receive services from the center and their recommended CMH centers services to others.

Moderate satisfaction with technical quality, this probably due to the novelty of service providers where many of them new employment and lack of experience and professional skills in addition to work overload and the huge number of patients, however, they need intensive training and the involvement of the patient in treatment plan. However the technical quality of the CMH team expected to improve, especially after students graduated Master of CMH - Nursing Sciences and Higher Diploma students graduated in psychotherapy (cognitive behavior therapy) but remain need to hone their professional skills by receiving intensive specialized training courses.

Then, moderate satisfaction with responsiveness and convenience. As a result of crowded CMH centers patients felt inconvenient as have to wait for a long time before to being seen by the doctor, issue of file and receiving medication. They also expressed their dissatisfaction about overcrowding noising of the centers. More organization of work and improving the appointment system will alleviate the complaining of the patients and improves responsiveness and convenience level.

In the other hand, lower level of satisfaction was reported with accessibility of services. This required re-examine the geographical distribution of centers and increase

the number of employees and focus on delivering services to those who do not able to access to the centers as disabled, elderly people and no insight patients through intensive home visits to them. Then, lower level of satisfaction was reported with communication, interaction and information. Therefore necessary to develop the skills of service providers in the areas of communication and interaction with patients and provide them with information, brochures and pamphlets that necessary for patients about their illness, treatment plan and therapeutic alternatives.

The study showed no statistically significant difference with socio-demographic variables such as; sex, current occupation, marital status, level of education, income, psychiatric diagnosis, duration of disorder and general satisfaction, except the place of living. So we accept the hypotheses and conclude that there are no significant differences of these variables and general satisfaction. The patients living in Rafah governorate rated the satisfaction level higher than other patients those living in other governorates.

The study results reflected the high level of unemployment in psychiatric patients (91.5%) in addition to the low level of income as most of them below the poverty line and also the level of education they have low. The study also reflected the trend of CMH team to focus on psychopharmacology and the omission of psychotherapy and other interventions therapies. As results of the study showed that the percentage of handicapped amounted to (5.5%), And that half of the patients live their psychological between good to very good. All patients agree that there is no system to measure patient satisfaction with the services they receive.

Also; this study exhibited levels of satisfaction; 76,51% of them were satisfy with the CMH care provided and almost all of them will continue to receive service from CMH centers and 84.87% of them will recommend the services to their relatives and friends if needed same service.

Moreover; the study reflected some of the shortcomings in service points highlighted the strengths and weaknesses of the psychological services provided in the government sector. The study showed the importance of patient empowerment and facilitates the arrival and receiving and responding and juggled community-based mental health services. And also reflected the importance of the physical and internal environment of the center for the patient and the extent of its impact on satisfaction with the service

6.2 Recommendations:

The results of the study helped the researcher to develop in-depth understanding of the issues and problems relating to patients satisfaction with CMH services, where the researcher tried to find solutions to those issues and problems and formulated it in recommendations can be decision-makers, mental health managers and mental health professionals applied it to improve quality of the services and gain a higher level of patient satisfaction:

- Mental health professions need to improve communication, interaction skills and informativeness. Mental health professionals need training on communication skills and interaction with patients and their families. Two ways communication with politeness and friendliness should be applied during the provision of CMH services to the patients. Good communication model should be established for the CMH centers as soon as possible so that it will help to increase level of patient satisfaction. Also mental health professionals need to provide patients with the information and teaching patients about their conditions, treatment, and care at home through guidance, oral comments, distributing leaflets or holding seminars for patients and their families.

- Decision-makers need to facilitate and enable psychiatric patient's access to services through geographical redistribution of services and provide transportation for patients to come to centers or visit them in their homes periodically. Also; increasing number of employees from doctors, nurses, psychologists, social workers and administrators to reduce work overload and to enable professionals to respond to patients needs and provision of sufficient quantities of drugs permanently. In addition to activating mental health integration program in primary health care to facilitate access of patients to primary health care centers for treatment.

- Distribution of a questionnaire to patients monthly to measure satisfaction with the services provided to them for the continuous development and improvement and also to involve patients in planning for these services.

- Put suggestions and complaints boxes in all of CMH centers so that patients and visitors to express their opinions and perceptions about the services provided and submit their suggestions to improve and develop these services.

- Encourage continuous educational training program that positively influence the mental health professionals and make them more professional and competent.

- Mental health managers and mental health professionals should be informed about results of this study to overcome any complaints or shortage in CMH services.

Recommendations for further studies:

The researcher recommended to conducts further studies about:

- Patients' satisfaction with health services in every area of services.
- Patients' satisfaction with psychosocial rehabilitation center services to conduct comparison of inpatients' satisfaction and outpatients' satisfaction and to be harmony and integration between inpatients and outpatients services.
- Service providers satisfaction with services they provide.
- satisfaction of the families of patients for services provided to their children.
- The relationship between patient's satisfaction and job satisfaction of mental health professions.

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Annexes

Annex 1: MOH approval

Palestinian National Authority
Ministry of Health
Mental Health General Administration

السلطة الوطنية الفلسطينية
وزارة الصحة
الإدارة العامة للصحة النفسية

الرقم:

Date: 11/04/2012

السادة / المدراء الطبيين للمراكز حفظهم الله،،،

السادة / المدراء الإداريين للمراكز حفظهم الله،،،

السلام عليكم ورحمة الله وبركاته،،

الموضوع / تسهيل مهمة الباحث

بخصوص الموضوع أعلاه يرجي تسهيل مهمة الباحث الحكيم/ هشام محمود المدلل رقم وظيفي 41956 الملتحق ببرنامج ماجستير الصحة النفسية المجتمعية بالجامعة الإسلامية و بعنوان البحث:

" رضي المرضي عن خدمات مراكز الصحة النفسية المجتمعية بوزارة الصحة بمحافظات غزة "

حيث سيقوم الباحث بالاطلاع على ملفات المرضي والاستعانة بالطواقم الفنية في عيادات الصحة النفسية المجتمعية وأخذ نتائج التحاليل اللازمة لبحثه، كما سيقوم بتعبئة الاستبيانات لعينة من المرضي وذلك حيث لا يكون بتعارض مع مصلحة العمل في المراكز ويكون ضمن أخلاقيات البحث العلمي دون تحمل المراكز والمرضي بالمراكز أي أعباء من إجراء هذا البحث.

وتفضلوا بقبول فائق الاحترام والتقدير،،،

د. عايش سمور

مدير عام الصحة النفسية

فلسطين – غزة – شارع العيون – مستشفي الطب النفسي تلفاكس: 08.2879845

Email : g.d.o.mental_health_gaza@hotmail.com

Annex 2: Invitation for participation in the study

Dear Client,

Thank you for accepting to participate in this study, which is a part of the requirements to master's degree in community mental health from the Islamic University. The aim of this study is to measure your satisfaction with community mental health services that you receive in the center. This questionnaire reflects your views and your satisfaction with aspects of the services and the results of this study will give recommendations for decision-makers which I wish to contribute to the development and improvement of the quality of services provided to you.

- Information you give us her secret so need to write your name on the questionnaire.
- Please answer all the questions in your opinion and views.
- There is no right or wrong answers.
- You are free not to answer any question you do not want to answer.
- Answering these questions may take 20 minutes of your time.
- Review voluntary and you absolute right not to participate.
- Thank you for your cooperation and the mobilization of this questionnaire.
- I welcome any comments or suggestions about the service you receive.

The researcher: Hisham M. El-Mudallal

Email: h.m.y.m @ hotmail.com

Mobile: 0599906704

Annex 3: Questionnaire "English version"

Date: / / 2012. No.: ……. (For researcher using).

Community Mental Health Center:.....

Questionnaire to measure Patients' Satisfaction with Community Mental Health Centers Services at Ministry of Health in Gaza Governorates.

Part I/primary data:

1- Sex:
- Male
- Female

2- Age in years:
- From 18 – 24
- From 25 - 34
- From 35 – 44
- Over 45

3- Marital status:
- Singe
- Married
- Divorced
- Widow

4- Place of living (Governorates):
- Gaza
- The North
- The Middle
- Khan-younis
- Rafah

5- Level of education:
- Illiterate
- Primary
- Prep
- Secondary
- University or high

6- Current occupation:
- Working
- Not working

7- Income (NIS):
- Below 500
- From 500-1500
- From 1501-2500
- Above 2500

8- Psychiatric diagnosis (Disorder):
- Mood disorder
- Anxiety disorder
- Somatoform disorder
- Psychotic disorder
- Other disorder

9- Duration of Disorder:

- From 6 months- less than 2 years
- From 2-5 years
- Over 5 years

10- Did you receive mental health services in any other place than this place?

- Yes
- No

If yes, specify……

11- What type of service or treatment do you receive at the center*?*

(You can select more than one option)

- Pharmacotherapy
- Psychotherapy
- Counseling
- Family therapy
- Home visit

12- Do you buy other medication for treatment of your disorder than those provided by this center?

- Yes
- No

13- If yes, Why?

- Unavailable
- Not enough
- Poor quality
- Other

14- Do you have any physical disability?

- Yes
- No

If yes, answer the following question:

15- Is the center well equipped and designed to facilitate your movement within it?

- Fully equipped
- Partially equipped
- Not equipped

16- In general, how would you rate your mental health?

- Excellent
- Very good
- Good
- Fair
- Poor

17- Is there a system to follow up the satisfaction of users in this center?

- Yes
- No

If yes, specify……

Part II / your experience with the community mental health services

Choose the score that describe show you felt:

(1 = strongly disagree, 2 = disagree, 3 = I do not know, 4 = agree, 5 = strongly agree)

No.	Items	Score
	General impressions	
1	I have a good experience with the services in this the center.	
2	I received the service as I expected.	
3	I will continue to receive service in this center.	
4	I am not satisfied with mental health services I received in the past year.	
5	There is some areas need improvement in the health service I received.	
6	If a friend or relative need same service, I will recommended this center to him.	
7	I feel dissatisfied with some aspects of the service I received.	
8	The services were delivered in an appropriate manner.	
	Accessibility of services	
9	Place of the center suitable for my residential place.	
10	Mental health team visit me in my house when I can not attend the center	
11	I can easily access to services when I need it	
12	I see a psychiatrist when I need to do so.	
13	I think working overload does not affect service providers in responding to my needs.	
14	Took a lot of effort and time to reach the center.	
15	The stigma of mental illness affects the services I receive.	
16	The drugs available in the centre pharmacy	
	Communication, interaction and information	
17	All of service providers respect my needs and take them into account.	
18	I feel ignored by service providers in this center.	
19	Service providers show their sympathy with me.	
20	Overall I am satisfied with the way service provider's deal with me.	
21	Have received sufficient information about my condition and the therapeutic plan.	
22	Service providers gives me impression that my service of their priorities.	
23	Service providers explain to me information related to my condition in understandable way.	
24	Doctor telling me some medical terminology without explanation of their meanings.	
25	Service providers take into account my level of education and culture when dealing with me.	
26	I feel that all patients are treated by one notch.	
27	Service providers respect my right to change the therapist if necessary.	
28	I am having difficulty in communicating with service providers.	
29	Service providers take the initiative to contact me when I miss the center for a long time.	
30	Service providers continue to my family when needed.	
31	Service providers take into account privacy and confidentiality during treatment.	
	Physical environment of the center	
32	Center rooms are clean.	
33	Bathrooms have enough for all.	
34	Bathrooms in the center clean.	
35	There are adequate parking areas in the center.	
36	Convenient and comfortable seats.	
37	Lighting inside the center enough to work well.	

38	Signage in place is sufficient.	
39	There is order and system in the waiting area.	
40	Drinking water available and clean.	
41	Center rooms are adequate ventilation.	
	Technical quality	
42	I trust in service providers.	
43	Actively participate in preparation of the treatment plan.	
44	I have some doubt in the ability of service providers involved in my treatment.	
45	Service providers help me in choosing a therapeutic way.	
46	Therapists take my complaint seriously.	
47	I felt that my health has improved after I attended this center.	
48	Service providers provide me with sufficient information about my health.	
49	Service providers make sure my understanding of the treatment plan clearly.	
50	Show service providers willing to help me all the time.	
51	Service providers respond to my requirements quickly.	
52	Pharmacist explains to me how to use the treatment.	
53	I see number of service providers sufficient in the center.	
54	Service providers are working to alleviate my anxiety and stress.	
55	The receptionist explains things quietly.	
56	There is order in front of the receptionist's office.	
57	Service providers provide me the necessary privacy.	
	Responsiveness and convenience	
58	I have to wait for a long time before issue of my file.	
59	I have to wait for a long time before to be seen by the doctor.	
60	I have to wait for a long time before receiving my medication.	
61	The center is crowded with patients	
62	There is noise in the center.	
63	I believe that service providers work as a team in the provision of the service.	
64	I cannot sit with therapist because of our province from patients.	
65	I feel that the work system is going on comfortably for the patient.	
66	I found that service provider's collaborators.	
67	The time I spend in the center to complete my service is available for me.	
68	I believe that service providers respect the time.	

69 -What are the most things that you like in the community mental health services provided at this center?

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70 -What are the most things that you dislike in the community mental health services provided at this center?

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71 -What are the areas that need improvement and development in the Centre to improvement the quality of services provided?

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72 -Do you have any comments or other suggestions?

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Thanks for filling this questionnaire

Annex 4: Questionnaire "Arabic version"

التاريخ: / / 2012 المركز: ..... الرقم: ..... (للباحث)

استبيان لقياس رضا المرضى عن خدمات مراكز الصحة النفسية المجتمعية بوزارة الصحة في محافظات غزة

الجزء الأول / البيانات الأولية:

1- الجنس:
- ذكر
- انثى

2- العمر بالسنوات:
- من 18- 24
- من 25 – 34
- من 35 - 44
- فوق 45

3- الحالة الاجتماعية:
- اعزب/انسة
- متزوج/ة
- مطلق/ة
- ارمل/ة

4- مكان السكن:
- محافظة غزة
- محافظة الشمال
- محافظة الوسطى
- محافظة خان يونس
- محافظة رفح

5- مستوى التعليم:
- امي
- ابتدائي
- اعدادي
- ثانوي
- جامعي فما فوق

6- الوضع المهني الحالي:
- يعمل
- لا يعمل

7- الدخل الشهري (بالشيكل):
- اقل من 500
- من 500- 1500
- من 1501- 2500
- اكثر من 2500

8- التشخيص:
- اضطراب مزاج
- اضطراب قلق
- اضطراب جسدنة
- اضطراب ذهاني
- غير ذلك

9- المدة الزمنية للمرض:

- من 6 شهور- اقل من سنتين
- من 2 – 5 سنوات
- اكثر من 5 سنوات

10- هل تلقيت خدمات صحة نفسية في أي مكان آخر غير هذا المركز؟

- نعم
- لا

اذا كانت الاجابة نعم حدد.....

11- ما نوع الخدمة أو العلاج الذي تتلقاه في المركز؟ (يمكن *اختيار أكثر من بديل*)

- علاج دوائي
- علاج نفسي
- علاج عائلي
- ارشاد نفسي
- زيارة منزلية

12- هل تشتري علاجات أخرى لعلاج مرضك غير التي يزودك بها المركز؟

- نعم
- لا

اذا كانت الاجابة نعم حدد.....

***13*- في حال نعم، لماذا؟**

- غير متوفرة
- غير كافية
- رديئة النوعية
- غير ذلك

14- هل تعاني من اعاقة جسدية؟

- نعم
- لا

اذا كانت الاجابة نعم، اجب عن السؤال التالي:

15- هل تصميم المركز يسهل لك الحركة داخله؟

- مجهز تماما
- مجهز جزئيا
- غير مجهز

16- بشكل عام كيف تقيم صحتك النفسية؟

- ممتازة
- جيدة جدا
- جيدة
- مقبولة
- سيئة

17- هل يوجد نظام لمتابعة رضا المنتفعين بالمركز؟

- نعم
- لا

اذا كانت الاجابة نعم، حدد .....

الجزء الثاني

اختر المدى الذي يصف شعورك:

(1 = غير موافق بشدة، 2 = غير موافق، 3 = لا ادري، 4 = موافق، 5 = موافق بشدة)

م	الفقرة	المدى
	محور الرضا العام	
1.	لدي تجربة جيدة مع الخدمات في هذا المركز.	
2.	تلقيت الخدمة بالشكل الذي كنت أتوقعه.	
3.	سأستمر بالتردد على هذا المركز لتلقي الخدمة.	
4.	أنا غير راضي عن الخدمة التي تلقيتها خلال العام الماضي.	
5.	هناك بعض النواحي بحاجة إلى تحسين في الخدمة الصحية التي تلقيتها.	
6.	إذا احتاج صديق أو قريب لنفس الخدمة، سأوصيه بالتوجه إلى هذا المركز.	
7.	أشعر بعدم الرضا عن بعض جوانب الخدمة التي تلقيتها.	
8.	الخدمات المقدمة أعطيت لي بطريقة مناسبة.	
	محور سهولة الوصول والحصول على الخدمة	
9.	موقع المركز ملائم لمكان سكني.	
10.	يزورني فريق الصحة النفسية في بيتي عندما لا استطيع الحضور للمركز	
11.	استطيع الحصول على الخدمات بسهولة حينما احتاجها	
12.	أستطيع رؤية الطبيب النفسي حينما احتاج لذلك.	
13.	أعتقد أن ضغط العمل لا يؤثر على مقدمي الخدمة في الاستجابة لاحتياجاتي.	
14.	استغرق كثير من الجهد و الوقت للوصول إلى المركز.	
15.	وصمة المرض النفسي تؤثر على حصولي على الخدمات.	
16.	الأدوية متوفرة في صيدلية المركز	
	محور التواصل والتفاعل والمعلومات	
17.	يحترم كل مقدمي الخدمة احتياجاتي ويأخذوها بعين الاعتبار.	
18.	اشعر بالتجاهل من قبل مقدمو الخدمة في هذا المركز.	
19.	يظهر مقدمو الخدمة تعاطفهم معي.	
20.	بشكل عام أنا راضي عن الطريقة التي يعاملني بها مقدمو الخدمة.	
21.	تلقيت معلومات كافية عن مرضي وعن خطة علاجي.	
22.	يعطيني مقدمو الخدمة انطباعا أن خدمتي من أولوياتهم.	
23.	يشرح لي مقدمو الخدمة المعلومات المتعلقة بحالتي بطريقة مفهومة.	
24.	الطبيب يحدثني ببعض المصطلحات الطبية دون توضيح لمعانيها.	
25.	يراعي مقدمو الخدمة مستواي التعليمي والثقافي عند التعامل معي.	
26.	اشعر أن جميع المرضى يتم معاملتهم بدرجة واحدة.	
27.	يحترم مقدمو الخدمة حقي في تغيير المعالج إذا لزم الأمر.	
28.	أواجه صعوبة في التواصل مع مقدمي الخدمة.	
29.	يبادر مقدمو الخدمة إلى الاتصال بي حين أتغيب عن المركز لفترة طويلة.	
30.	يتواصل مقدمو الخدمة بعائلتي عندما يلزم الأمر.	
31.	يراعي مقدمو الخدمة الخصوصية والسرية أثناء العلاج.	
	محور البيئة الداخلية للمركز	
32.	غرف المركز نظيفة.	
33.	تتوفر الحمامات بصورة كافية للجميع.	
34.	الحمامات في المركز نظيفة.	
35.	توجد مساحات انتظار ملائمة في المركز.	
36.	المقاعد ملائمة ومريحة.	
37.	الإضاءة داخل المركز كافية للعمل بصورة جيدة.	

38.	اللوحات الإرشادية في المركز كافية.	
39.	هناك ترتيب ونظام في صالة الانتظار.	
40.	مياه الشرب متوفرة ونظيفة.	
41.	تهوية غرف المركز ملائمة.	
	محور الكفاءة الفنية	
42.	أثق في مقدمي الخدمة.	
43.	أشارك بفعالية في وضع الخطة العلاجية.	
44.	لدي بعض الشك في مقدرة مقدمي الخدمة المشاركين في علاجي.	
45.	يساعدني مقدمو الخدمة في اختيار طريقة علاجي.	
46.	يأخذ المعالج النفسي شكواي على محمل الجد.	
47.	شعرت بان حالتي الصحية تحسنت بعد ترددي على هذا المركز.	
48.	يزودني مقدمي الخدمة بمعلومات كافية عن حالتي الصحية.	
49.	يتأكد مقدمو الخدمة من فهمي لخطة العلاج بوضوح.	
50.	يبدي مقدمو الخدمة استعدادا للمساعدة في كل وقت.	
51.	يستجيب مقدمو الخدمة لمتطلباتي بسرعة.	
52.	يوضح لي الصيدلي كيفية استعمال العلاج.	
53.	أرى أن عدد مقدمي الخدمة كاف في المركز.	
54.	يعمل مقدمو الخدمة على تخفيف قلقي وتوتري.	
55.	موظف الاستقبال يوضح الأمور بهدوء.	
56.	هناك ترتيب أمام مكتب موظف الاستقبال.	
57.	مقدمو الخدمة يوفروا لي الخصوصية اللازمة.	
	محور مدى ملاءمة الخدمة والاستجابة	
58.	علي الانتظار لمدة طويلة قبل استخراج ملفي.	
59.	علي الانتظار لمدة طويلة قبل أن أرى الطبيب.	
60.	انتظر وقت طويل قبل أن استلم علاجي.	
61.	المركز مزدحم بالمراجعين.	
62.	يوجد ضوضاء في المركز.	
63.	أرى أن مقدمي الخدمة يعملون كفريق أثناء تقديم الخدمة.	
64.	لا أستطيع الجلوس مع المعالج النفسي بسبب مقاطعتنا من المراجعين.	
65.	أشعر أن نظام العمل يسير بشكل مريح للمريض.	
66.	وجدت أن مقدمي الخدمة متعاونين.	
67.	الوقت الذي أمكثه في المركز لانجاز خدمتي مناسب لي.	
68.	أرى أن مقدمي الخدمة يحترمون الوقت.	

69- ما هي أكثر الأشياء التي نالت إعجابك بالنسبة لخدمات الصحة النفسية المجتمعية المقدمة ؟

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70- ما هي أكثر الأشياء التي لم تنل إعجابك بالنسبة لخدمات الصحة النفسية المجتمعية المقدمة ؟

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71- ما هي النواحي التي بحاجة لتحسين وتطوير داخل المركز لرفع مستوى جودة الخدمات المقدمة؟

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72- هل لديك ملاحظات أو اقتراحات أخرى؟

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شكرا لتعبئتك هذا الاستبيان

Annex 5: List of arbitrates

No.	Name	Job Title	Working Place
1.	Dr. Ayesh Sammour	General director of mental health	MOH
2.	Dr. Khadra Amassi	Director of training and improvement department	MOH
3.	Mr. Dyaa Sayma	Mental health Officer	WHO
4.	Dr. Yusuf Awad	Assistant Prof. of Psychology	MOH
5.	Mr. Hasan Juda	Director of Nursing Unit	MOH
6.	Mr. Ibrahim Mansur	Director of Nursing Unit	MOH
7.	Mr. Emad Habboub	Psychiatric nurse	MOH
8.	Dr. Abed Al karem Rodwan	Dean of Nursing faculty Assistant Prof. of Psychology	IUG
9.	Dr Nabil Dukhan	Assistant Prof. of Psychology	IUG
10.	Mr. Ismail Abu Rekab	Head of Improvement Dep.	MOH
11.	Dr. Abed Elfattah Alhams	Assistant Prof. of Psychology	IUG
12.	Dr. Etaf Aabed	Assistant Prof. of Psychology	IUG

Annex 6a: The correlation coefficient between each item in the domain of general impressions and the whole domain

No	Item	Pearson coefficient	P-value
1	I have a good experience with the CMH services in this center.	0.490	0.003
2	I received the service as I expected.	0.649	0.000
3	I will continue to receive service in this center.	0.467	0.005
4	I am not satisfied with the mental health services I received in the past year.	0.559	0.001
5	There is some areas need improvement in the health service I received.	0.540	0.001
6	If a friend or relative need same service, I will recommended this center to him.	0.421	0.013
7	I feel dissatisfied with some aspects of the service I received.	0.376	0.029
8	CMH services were delivered in an appropriate manner.	0.620	0.000

Annex 6b: The correlation coefficient between each item in the domain of accessibility of services and the whole domain

No	Item	Pearson coefficient	p-value
9	Place of CMH center suitable for my residential place.	0.355	0.040
10	Mental health team visit me in my house when I cannot attend the center	0.609	0.000
11	I can easily access to services when I need it	0.342	0.048
12	I see a psychiatrist when I need to do so.	0.519	0.002
13	I think working overload at the center does not affect employees in responding to my needs.	0.442	0.009
14	Took a lot of effort and time to reach the center.	0.577	0.000
15	The stigma of mental illness affects the services I receive.	0.355	0.040
16	The drugs available in the centre Pharmacy	0.609	0.000

Annex 6c: The correlation coefficient between each item in the domain of communication, interaction and information and the whole domain

No	Item	Pearson coefficient	p-value
17	All of service providers respect my needs and take them into account.	0.684	0.000
18	I feel ignored by service providers in this center.	0.372	0.030
19	Service providers show their sympathy with me.	0.699	0.000
20	Overall I am satisfied with the way service provider's deal with me.	0.441	0.009
21	Have received sufficient information about my condition and the therapeutic plan.	0.485	0.004
22	Service providers gives me impression that my service of their priorities.	0.596	0.000
23	Service providers explain to me information related to my condition in understandable way.	0.437	0.010
24	Doctor telling me some medical terminology without explanation of their meanings.	0.491	0.003
25	Service providers take into account my level of education and culture when dealing with me.	0.588	0.000
26	I feel that all patients are treated by one notch.	0.434	0.010
27	Service providers respect my right to change the therapist if necessary.	0.393	0.022
28	I am having difficulty in communicating with service providers.	0.640	0.000
29	Service providers take the initiative to contact me when I miss the place for a long time.	0.450	0.008
30	Service providers continue to my family when needed.	0.579	0.000
31	Service providers take into account the privacy and confidentiality during treatment.	0.494	0.003

Annex 6d: The correlation coefficient between each item in the domain of physical environment of the center and the whole domain

No	Item	Pearson coefficient	p-value
32	Center rooms are clean.	0.624	0.000
33	Bathrooms have enough for all.	0.628	0.000
34	Bathrooms in the center clean.	0.560	0.001
35	There are adequate parking areas in the center.	0.768	0.000
36	Convenient and comfortable seats.	0.428	0.012
37	Lighting inside the center enough to work well.	0.505	0.003
38	Signage in place is sufficient.	0.702	0.000
39	There is order and system in the waiting area.	0.674	0.000
40	Drinking water available and clean.	0.574	0.000
41	Center rooms are adequate ventilation center.	0.468	0.005

Annex 6e: The correlation coefficient between each item in the domain of technical quality and the whole domain

No	Item	Pearson coefficient	p-value
42	I trust in service providers.	0.736	0.000
43	Actively participate in preparation of the treatment plan.	0.668	0.000
44	I have some doubt in the ability of service providers involved in my treatment.	0.483	0.004
45	Service providers help me in choosing a therapeutic way.	0.393	0.021
46	A doctor seriously takes my complaint.	0.492	0.003
47	I felt that my health has improved after I attended this center.	0.625	0.000
48	Service providers provide me with sufficient information about my health.	0.630	0.000
49	Service providers make sure my understanding of the treatment plan clearly.	0.650	0.000
50	Show service providers willing to help me all the time.	0.650	0.000
51	Service providers respond to my requirements quickly.	0.782	0.000
52	Pharmacist explains to me how to use the treatment.	0.464	0.006
53	I see number of service providers sufficient in the center.	0.592	0.000
54	Medical staff is working to alleviate my anxiety and stress.	0.562	0.001
55	The receptionist explains things quietly.	0.764	0.000
56	There is order in front of the receptionist's office.	0.487	0.003
57	Service providers provide me the necessary privacy.	0.850	0.000

Annex 6f: The correlation coefficient between each item in the domain of convenience and responsiveness and the whole domain

No	Item	Pearson coefficient	p-value
58	I have to wait for a long time before issue of my file.	0.677	0.000
59	I have to wait for a long time before to be seen by the doctor.	0.646	0.000
60	I have to wait for a long time before receiving my medication.	0.470	0.005
61	The center is crowded with patients	0.659	0.000
62	There is noise in the center.	0.434	0.010
63	I believe that service providers work as a team in the provision of the service.	0.501	0.003
64	I cannot sit with the doctor because of our province from patients.	0.503	0.003
65	I feel that the work system is going on comfortably for the patient.	0.569	0.001
66	I found that service provider's collaborators.	0.716	0.000
67	The time I spend in the center to complete my service is available for me.	0.545	0.001
68	I believe that service providers respect the time.	0.490	0.003

Annex 7: Difference in patients' satisfaction with CMH services according to age

Field	Source	Sum of Squares	df	Mean Square	F value	Sig.(P-Value)
General impressions	Between Groups	1.033	3	0.344	2.632	0.050
	Within Groups	34.947	267	0.131		
	Total	35.981	270			
Accessibility of services	Between Groups	0.267	3	0.089	0.632	0.595
	Within Groups	37.550	267	0.141		
	Total	37.816	270			
Communication, interaction and information	Between Groups	0.072	3	0.024	0.179	0.910
	Within Groups	35.614	267	0.133		
	Total	35.686	270			
Physical environment of the center	Between Groups	1.075	3	0.358	1.578	0.195
	Within Groups	60.640	267	0.227		
	Total	61.715	270			
Technical quality	Between Groups	0.492	3	0.164	1.187	0.315
	Within Groups	36.928	267	0.138		
	Total	37.420	270			
Convenience and responsiveness	Between Groups	1.602	3	0.534	2.930	0.034
	Within Groups	48.665	267	0.182		
	Total	50.267	270			
The satisfaction with CMH centers services	Between Groups	0.089	3	0.030	0.675	0.568
	Within Groups	11.763	267	0.044		
	Total	11.852	270			

Critical value of f at degrees of freedom (3,267) and sig. level 0.05 equal 2.64

Annex 8: Difference in patients' satisfaction with CMH services according to sex

Field	Sex	N	Mean	Std. Deviation	T	P-value
General impressions	Male	209	3.832	0.350	0.520	0.603
	Female	62	3.804	0.414		
Accessibility of services	Male	209	2.903	0.374	-0.523	0.601
	Female	62	2.931	0.376		
Communication, interaction and information	Male	209	2.894	0.321	-2.199	0.029
	Female	62	3.009	0.472		
Physical environment of the center	Male	209	3.901	0.430	0.697	0.487
	Female	62	3.853	0.616		
Technical quality	Male	209	3.383	0.353	-0.211	0.833
	Female	62	3.394	0.435		
Convenience and responsiveness	Male	209	3.310	0.401	-1.788	0.075
	Female	62	3.421	0.516		
The satisfaction with CMH centers services	Male	209	3.336	0.187	-1.288	0.199
	Female	62	3.375	0.273		

Critical value of t at df "269" and significance level 0.05 equal 1.97

Annex 9: Difference in patients' satisfaction with CMH centers services according to marital status

Field	Source	Sum of Squares	df	Mean Square	F value	Sig.(P-Value)
General impressions	Between Groups	0.342	3	0.114	0.854	0.465
	Within Groups	35.638	267	0.133		
	Total	35.981	270			
Accessibility of services	Between Groups	0.275	3	0.092	0.651	0.583
	Within Groups	37.542	267	0.141		
	Total	37.816	270			
Communication, interaction, and information	Between Groups	0.336	3	0.112	0.847	0.469
	Within Groups	35.349	267	0.132		
	Total	35.686	270			
Physical environment of the center	Between Groups	0.152	3	0.051	0.220	0.883
	Within Groups	61.563	267	0.231		
	Total	61.715	270			
Technical quality	Between Groups	0.401	3	0.134	0.964	0.410
	Within Groups	37.019	267	0.139		
	Total	37.420	270			
Convenience and responsiveness	Between Groups	0.502	3	0.167	0.898	0.443
	Within Groups	49.765	267	0.186		
	Total	50.267	270			
The satisfaction with CMH centers services	Between Groups	0.092	3	0.031	0.698	0.554
	Within Groups	11.760	267	0.044		
	Total	0.342	3	0.114		

Critical value of f at degrees of freedom (3,267) and sig. level 0.05 equal 2.64

Annex 10 : Difference in patients' satisfaction with CMH centers services according to level of education

Field	Source	Sum of Squares	df	Mean Square	F value	Sig.(P-Value)
General impressions	Between Groups	0.533	4	0.133	1.000	0.408
	Within Groups	35.448	266	0.133		
	Total	35.981	270			
Accessibility of services	Between Groups	0.645	4	0.161	1.154	0.332
	Within Groups	37.171	266	0.140		
	Total	37.816	270			
Communication, interaction and information	Between Groups	0.808	4	0.202	1.541	0.191
	Within Groups	34.877	266	0.131		
	Total	35.686	270			
Physical environment of the center	Between Groups	1.053	4	0.263	1.154	0.332
	Within Groups	60.663	266	0.228		
	Total	61.715	270			
Technical quality	Between Groups	1.124	4	0.281	2.059	0.087
	Within Groups	36.296	266	0.136		
	Total	37.420	270			
Convenience and responsiveness	Between Groups	1.243	4	0.311	1.686	0.154
	Within Groups	49.024	266	0.184		
	Total	50.267	270			
The satisfaction with CMH centers services	Between Groups	0.141	4	0.035	0.801	0.525
	Within Groups	11.711	266	0.044		
	Total	11.852	270			

Critical value of f at degrees of freedom (4,266) and sig. level 0.05 equal 2.41

Annex 11: Difference in patients' satisfaction with CMH centers services according to place of living

Field	Source	Sum of Squares	df	Mean Square	F value	Sig.(P-Value)
General impressions	Between Groups	1.653	4	0.413	3.203	0.014
	Within Groups	34.327	266	0.129		
	Total	35.981	270			
Accessibility of services	Between Groups	1.719	4	0.430	3.166	0.014
	Within Groups	36.098	266	0.136		
	Total	37.816	270			
Communication, interaction, and information	Between Groups	1.771	4	0.443	3.472	0.009
	Within Groups	33.915	266	0.127		
	Total	35.686	270			
Physical environment of the center	Between Groups	24.412	4	6.103	43.519	0.000
	Within Groups	37.303	266	0.140		
	Total	61.715	270			
Technical quality	Between Groups	2.613	4	0.653	4.993	0.001
	Within Groups	34.807	266	0.131		
	Total	37.420	270			
Convenience and responsiveness	Between Groups	5.945	4	1.486	8.919	0.000
	Within Groups	44.322	266	0.167		
	Total	50.267	270			
The satisfaction with CMH centers services	Between Groups	0.982	4	0.246	6.009	0.000
	Within Groups	10.870	266	0.041		
	Total	11.852	270			

Critical value of f at degrees of freedom (4,266) and sig. level 0.05 equal 2.41

Annex 12 : Difference in patients' satisfaction with CMH centers services according to occupation

Field	Occupation	N	Mean	Std. Deviation	T	P-value
General impressions	Working	23	3.826	0.279	0.006	0.995
	Not Working	248	3.826	0.372		
Accessibility of services	Working	23	2.973	0.426	0.847	0.398
	Not Working	248	2.904	0.369		
Communication, interaction and information	Working	23	2.951	0.400	0.422	0.673
	Not Working	248	2.917	0.361		
Physical environment of the center	Working	23	3.804	0.524	-0.902	0.368
	Not Working	248	3.898	0.474		
Technical quality	Working	23	3.454	0.312	0.921	0.358
	Not Working	248	3.379	0.377		
Convenience and responsiveness	Working	23	3.368	0.457	0.377	0.707
	Not Working	248	3.332	0.430		
The satisfaction with CMH centers services	Working	23	3.368	0.204	0.549	0.584
	Not Working	248	3.343	0.210		

Critical value of t at df "269" and significance level 0.05 equal 1.97

Annex 13: Difference in patients' satisfaction with CMH centers services according to income

Field	Source	Sum of Squares	df	Mean Square	F value	Sig.(P-Value)
General impressions	Between Groups	0.440	3	0.147	1.103	0.349
	Within Groups	35.540	267	0.133		
	Total	35.981	270			
Accessibility of services	Between Groups	0.111	3	0.037	0.261	0.853
	Within Groups	37.706	267	0.141		
	Total	37.816	270			
Communication, interaction and information	Between Groups	1.387	3	0.462	3.599	0.014
	Within Groups	34.299	267	0.128		
	Total	35.686	270			
Physical environment of the center	Between Groups	0.767	3	0.256	1.120	0.341
	Within Groups	60.948	267	0.228		
	Total	61.715	270			
Technical quality	Between Groups	0.733	3	0.244	1.778	0.152
	Within Groups	36.687	267	0.137		
	Total	37.420	270			
Convenience and responsiveness	Between Groups	0.775	3	0.258	1.394	0.245
	Within Groups	49.492	267	0.185		
	Total	50.267	270			
The satisfaction with CMH centers services	Between Groups	0.072	3	0.024	0.543	0.653
	Within Groups	11.780	267	0.044		
	Total	11.852	270			

Critical value of f at degrees of freedom (3,267) and sig. level 0.05 equal 2.64

Annex 14: Difference in patients' satisfaction with CMH centers services according to psychiatric diagnosis

Field	Source	Sum of Squares	df	Mean Square	F value	Sig.(P-Value)
General impressions	Between Groups	0.583	4	0.146	1.096	0.359
	Within Groups	35.397	266	0.133		
	Total	35.981	270			
Accessibility of services	Between Groups	0.525	4	0.131	0.937	0.443
	Within Groups	37.291	266	0.140		
	Total	37.816	270			
Communication, interaction, and information	Between Groups	0.706	4	0.177	1.343	0.254
	Within Groups	34.979	266	0.132		
	Total	35.686	270			
Physical environment of the center	Between Groups	1.749	4	0.437	1.940	0.104
	Within Groups	59.966	266	0.225		
	Total	61.715	270			
Technical quality	Between Groups	1.488	4	0.372	2.753	0.029
	Within Groups	35.932	266	0.135		
	Total	37.420	270			
Convenience and responsiveness	Between Groups	0.624	4	0.156	0.835	0.504
	Within Groups	49.644	266	0.187		
	Total	50.267	270			
The satisfaction with CMH centers services	Between Groups	0.134	4	0.033	0.760	0.552
	Within Groups	11.718	266	0.044		
	Total	11.852	270			

Critical value of f at degrees of freedom (4,266) and sig. level 0.05 equal 2.41

Annex 15: Difference in patients' satisfaction with CMH centers services according to duration of mental disorder

Field	Source	Sum of Squares	df	Mean Square	F value	Sig.(P-Value)
General impressions	Between Groups	0.113	2	0.056	0.422	0.656
	Within Groups	35.868	268	0.134		
	Total	35.981	270			
Accessibility of services	Between Groups	0.351	2	0.176	1.257	0.286
	Within Groups	37.465	268	0.140		
	Total	37.816	270			
Communication, interaction and information	Between Groups	0.600	2	0.300	2.293	0.103
	Within Groups	35.085	268	0.131		
	Total	35.686	270			
Physical environment of the center	Between Groups	0.658	2	0.329	1.445	0.238
	Within Groups	61.057	268	0.228		
	Total	61.715	270			
Technical quality	Between Groups	0.305	2	0.153	1.101	0.334
	Within Groups	37.115	268	0.138		
	Total	37.420	270			
Convenience and responsiveness	Between Groups	0.849	2	0.424	2.301	0.102
	Within Groups	49.419	268	0.184		
	Total	50.267	270			
The satisfaction with CMH centers services	Between Groups	0.106	2	0.053	1.206	0.301
	Within Groups	11.747	268	0.044		
	Total	11.852	270			

Critical value of f at degrees of freedom (2,268) and sig. level 0.05 equal 3.03