Satisfaction of Vietnamese Patients and Their Families With Refugee and Mainstream Mental Health Services

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Objective: **The study examined levels of satisfaction with mainstream mental health services and specialized mental health services for refugees among Vietnamese psychiatric patients and their relatives. Demographic, diagnostic, symptomatic, and service-related issues that might influence satisfaction were investigated.** *Methods:* **Eighty-six Vietnamese patients were identified from case notes of mainstream inpatient services (N=31), mainstream community services (N=7), and a specialized refugee treatment unit (N=48). During an interview, a scale measuring satisfaction with treatment as well as measures of anxiety, depression, and posttraumatic stress disorder was administered to them. A modified satisfaction scale was administered to 56 relatives.** *Results:* **Patients and relatives were, on average, moderately satisfied with treatment. Patients expressed greater satisfaction with the specialized treatment unit for refugees than with mainstream services, a finding that was not influenced by diagnostic differences or symptom levels at the time patients responded. Further analyses controlling for multiple comparisons revealed that the extent of the information provided and the ease of negotiating changes in treatment were the most salient variables in distinguishing satisfaction levels across the two types of treatment centers. Patients' fluency in English and their relatives' level of education were inversely associated with satisfaction scores, tentatively suggesting that the greater the ability of patients and their families to evaluate services, the less likely they were to express satisfaction with treatment.** *Conclusions:* **Specialized mental health services for refugees may be more acceptable to refugee populations than their mainstream counterparts, perhaps because better communication with patients and their families is possible in the specialized services. Patients and families who are in a position to evaluate services fully are more likely to be critical of treatments offered. (*Psychiatric Services* 48:1064–1069, 1997)**

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In the past 20 years, substantial numbers of Indochinese refugees and immigrants have settled in Western countries such as the United States, Canada, and Australia. After being exposed to war-related stress, torture, and other forms of persecution in their homelands (1), many refugees have then been subjected to a continuum of trauma during the period of flight, internment in refugee camps, and final resettlement (2). Nevertheless, even though symptoms of anxiety, depression, and posttraumatic stress are prevalent among Indochinese refugees (3–5), members of the community tend to underutilize mental health services in the countries where they are resettled (6).

Several factors may deter refugees from gaining access to mental health services, including the stigma associated with mental illness, lack of familiarity with services, and the preferential use of traditional healing methods (7). Other barriers may prevent refugees from forming a trusting doctor-patient relationship, including difficulties in communication, cultural variations in the conceptualization of mental illness, and a mismatch between doctor and patient in their expectations of treatment (3,7). These factors may lead to dissatisfaction with health care among refugees and reluctance to pursue treatment within mainstream services.

Few empirical studies have exam-

ined levels of satisfaction with mental health services among refugee communities such as the Vietnamese and whether such groups prefer ethnospecific mental health services to mainstream services. Treating ethnic minorities within mainstream services avoids the risk of discrimination and makes economic and logistic sense. Nevertheless, concerns have persisted that mainstream services may not be sensitive enough to cultural issues (8) and that lack of cultural sensitivity may be particularly pronounced in treatment of traumatized refugees (2). In many Western countries, such arguments have given impetus to the development of mental health services dedicated to the treatment of refugees (9).

It is thus timely to assess whether refugee communities, such as the Vietnamese, indeed show a preference for specialized mental health services targeted to their ethnic group and, if so, which aspects of such services are deemed to be superior to their mainstream counterparts. In such an assessment, the level of satisfaction of patients' relatives who are primary caregivers is likely to be relevant, because the family is usually intricately involved in any problem that befalls the individual in the Vietnamese community (10).

The existence of both a mainstream public mental health service and a specialized public mental health service for refugees in one geographic area of southwest Sydney, Australia, provided the opportunity to compare the impact of different service styles on the satisfaction of patients and relatives. This region has the largest population of Vietnamese refugees in Australia, and they constitute the most prominent ethnic minority using public mental health services in that locality. All services, including the specialized refugee service—the Service for the Treatment and Rehabilitation of Torture and Trauma Survivors, which has been established for more than eight years (2,11)—are government funded and free of direct charge to patients.

The mainstream mental health services tends to focus on managing patients with psychotic disorders, whereas the specialized service for refugees focuses principally on the needs of refugee survivors of trauma. The preponderance of patients in the specialized refugee service receive a diagnosis of posttraumatic stress disorder, an anxiety disorder, or a depressive disorder. However, the widespread exposure to trauma and forced displacement among the Vietnamese refugee population has created substantial overlap in the social backgrounds of patients who use the specialized service and those who use the mainstream services.

Most patients in the specialized refugee service receive a diagnosis of posttraumatic stress disorder, an anxiety disorder, or a depressive disorder.

Methods

Subjects and recruitment

Patients born in Vietnam who had received psychiatric treatment over a 12-month period in 1992–1993 were identified retrospectively from the records of all mental health services in the designated geographic area. The services included inpatient units of two general hospitals, community health centers associated with the two hospitals, and the specialized mental health service for refugees.

The service that the patient had attended most recently during the study period was designated as the center for which satisfaction with treatment was assessed. Patients and their families were contacted by letter and then by phone, and their homes were visited if there was no response.

Patients who consented to participate and one close relative (or partner) were then interviewed separately by a Vietnamese psychologist or Vietnamese psychiatric nurse, neither of whom had any affiliation with the mental health services. Respondents were informed that the survey aimed at assessing various aspects of the services they had received, including their satisfaction with treatment. Participants were assured that their names would not be entered on questionnaires, that only averaged data would be reported, and that their responses would not prejudice their future access to services nor the quality of treatment offered.

An attempt was made to recruit an Australian-born comparison group from hospitals and community centers using the same methods, but that component of the study had to be abandoned because the response rate was less than 20 percent. The most common reason patients did not participate was that they had moved and could not be contacted.

Measures

Case notes were reviewed to collect data on demographic, diagnostic, and treatment characteristics. Patients were then visited at their homes, and each subject was administered a semistructured interview that assessed, among other things, English language proficiency, socioeconomic and educational status, history of migration, and specific aspects of the care received from the designated mental health service. Patients also completed the Vietnamese version of the Hopkins Symptom Checklist (HSCL) (12), which records levels of anxiety and depression, and the Harvard Trauma Questionnaire (HTQ) (13), which measures posttraumatic stress symptoms.

Because none of the questionnaires on satisfaction with services that were described in the literature were judged to be appropriate for this study, an eight-item measure was devised in Vietnamese. The eight items addressed the ease of obtaining help from the service, level of satisfaction with treatment, perceived usefulness of treatments, the extent to which trust was established with the therapist, the ease of communication with staff of the service, the quality of care received, the extent of information offered, and the ease of negotiating

changes in treatment. The items were rated on a 4-point scale from 0, very dissatisfied, to 3, very satisfied. (A copy of the full questionnaire is available from the authors.)

Analysis of the eight items yielded a Cronbach's alpha of .87, indicating an adequate level of internal consistency for the measure. Responses for each subject were summed to produce a total score ranging from 0 to 24, with higher scores reflecting greater levels of satisfaction. Wherever possible, one close relative (or a partner) completed a modified version of the satisfaction questionnaire as well as an abbreviated interview focusing on the demographic, family, and social characteristics of the relative.

Results

Subjects

Of the 143 eligible patients, 86, or 60.1 percent, participated in the study. More than 90 percent of the nonparticipants could not be contacted because they were no longer living at the given address. For the majority of these patients no forwarding address could be obtained despite inquiries with neighbors and attempts to contact the next of kin. The response rate did not differ across the mainstream and specialized refugee services. Fifty-six relatives agreed to be interviewed and to complete the satisfaction questionnaire.

Fifty-two of the patients in the sample were men (60.5 percent). The mean±SD age of the entire sample was 39.1±12.32 years. Fifty-eight percent were married. Thirty-one subjects, or 36 percent, were treated in one of the hospitals; 48 subjects, or 56 percent, were patients of the specialized refugee service; and the remaining seven, or 8 percent, had last attended a community health center. The mean±SD age of the relatives who participated in the study was 42.9±12.8 years. Thirty-five of the relatives, or 62.5 percent, were female, and 71 percent were married.

Clinical characteristics

None of the patients who had attended the specialized refugee service had been treated in mainstream services, and vice versa. According to the clinical notes from participating centers, 13 patients, or 15 percent, had received a primary diagnosis of posttraumatic stress disorder (PTSD); 29 patients, or 34 percent, a diagnosis of a psychotic disorder, such as schizophrenia, schizoaffective disorder, or bipolar disorder; and 25 patients, or 29 percent, a diagnosis of an anxiety, depressive or mixed anxiety-depressive disorder. The remaining 19 patients received a range of other primary diagnoses including drug or alcohol dependence, adjustment disorder, and somatoform disorder.

Site of treatment predicted satisfaction scores, whereas differences in diagnostic profiles across sites did not.

Fifty-seven percent of the hospital patients and all of the patients treated in the community centers had received a diagnosis of a psychotic disorder. In contrast, 80 percent of the patients who had attended the specialized refugee service had received a diagnosis of anxiety-depression or PTSD.

Mean scores on the HSCL for the entire sample were 1.9±.7 for depression and 1.7±.6 for anxiety. Possible scores on the HSCL range from 1 to 4, with higher scores indicating increased symptom levels. The mean HTQ posttraumatic stress symptom score was 1.5±.6. Scores on the HTQ can range from 1 to 4, with higher scores indicating greater symptom severity.

Satisfaction with services

The mean score on the measure of satisfaction with services was 16.5±4.9 for patients and 16.7±4.5 for relatives. The satisfaction scores of patients and their corresponding relatives were closely related ($r=.83$, $p<.001$).

These results suggested that, on average, both the patient and the relative groups were moderately satisfied with treatment. A preliminary analysis of the satisfaction scores of patients who received mainstream services revealed no differences between patients who had last been treated at a hospital and those who had last been treated at a community center. Therefore, all patients who had received mainstream services were grouped into one category for further analyses.

Variables that could potentially predict satisfaction and that shared adequate distributions in responses were grouped into three sets—demographic factors; diagnosis, symptom scores, and site of treatment (mainstream versus the specialized service); and treatment issues. Multiple regression analyses of each group of predictor variables used the total satisfaction score as the outcome variable. This approach allowed control of the family-wise error rate at the .05 level of significance across each group of variables.

The six demographic variables—sex, age, marital status, education level, employment status, and fluency in English—yielded a statistically significant regression equation ($F=2.5$, $df=6,60$, $p<.05$, $R^2=.12$). Examination of individual variables revealed that only fluency in English was statistically related to levels of satisfaction ($p<.05$), with less fluent patients expressing greater satisfaction with the mental health treatment they had received. A further univariate analysis revealed that patients in the specialized refugee service did not differ from those attending mainstream services in their English fluency.

The second multiple regression analysis included clinical diagnostic groupings, symptom scores on the HSCL and the HTQ, and site of treatment (mainstream services versus the specialized service). The overall equation was statistically significant ($F=3.2$, $df=6,37$, $p<.05$, $R^2=.34$), with site of treatment being the only individual variable showing a differential

Table 1

Mean scores on items of the measure of satisfaction with services among Vietnamese patients, by site of treatment and level of English fluency

Item on measure of satisfaction	Site of treatment[1]							English fluency[2]						
	Specialized refugee service		Mainstream services					Low		High				
	Mean	SD	Mean	SD	t	df	p	Mean	SD	Mean	SD	t	df	p
Ease of obtaining help	2.5	.9	2.1	.8	2.1	77	.039	2.4	.9	2.3	1.0	.4	76	ns
Level of satisfaction with treatment	2.3	.7	2.1	.7	1.6	79	ns	2.4	.6	2.0	.9	1.9	78	.057
Usefulness of treatment	2.2	.9	1.9	.8	1.1	77	ns	2.3	.7	1.7	.9	3.4	76	.001*
Trust in therapist	2.3	1.0	2.1	.8	1.2	80	ns	2.4	.7	1.9	1.1	2.6	79	.012
Ease of communication	2.5	.9	2.1	.7	2.4	79	.019	2.5	.7	2.0	1.0	2.7	78	.009
Quality of care	2.6	.6	2.3	.6	2.4	80	.018	2.6	.6	2.3	.6	2.5	79	.017
Extent of information offered	1.7	1.0	1.0	.9	3.1	76	.003*	1.4	1.0	1.4	1.0	.1	75	ns
Ease of changing treatment program	1.7	1.0	1.0	.9	3.0	73	.004*	1.4	.2	1.3	.2	.4	72	ns

[1] All significant differences indicate higher satisfaction among patients in the specialized refugee service.
[2] All significant differences indicate higher satisfaction among patients with low English fluency.
* Significant at the .05 level after Bonferroni correction for multiple comparisons

effect; that is, patients attending the specialized refugee service reported being more satisfied than those attending mainstream services ($p < .01$). In view of the possibility that depressive symptoms might bias subjects toward returning lower satisfaction scores, the regression was repeated excluding that HSCL parameter, but this analysis did not alter the results.

A third regression analysis investigating treatment variables such as whether an interpreter was used, whether the family or patient had received counseling, and whether medical assistance was available during treatment, was not statistically significant.

The statistically significant regression equations suggest that increased satisfaction with the specialized refugee service and low English fluency were associated with higher satisfaction scores. These two variables were examined more closely in relation to individual items of the satisfaction scale.

As the first column of Table 1 shows, univariate results indicated that patients in the specialized refugee service were more satisfied with several aspects of treatment, namely the ease of obtaining help, the quality of communication, the quality of therapists' care, the extent of information offered, and the ease of negotiating changes in treatment. However, only the latter two items remained statistically significant after a Bonferroni adjustment was made to correct for multiple comparisons.

Patients with low fluency in English reported that the treatment they had received was more useful, that they found it easier to trust the therapist, that they could communicate more easily with the therapist, and that the therapist was more caring. Only the first item—usefulness of treatment—remained significant after Bonferroni adjustment.

To determine factors associated with relatives' satisfaction with services, a regression analysis that included demographic variables and site of the patient's treatment was done. The overall result showed a trend toward significance ($F=2.1$, $df=7,27$, $p=.08$, $R^2=.35$); relatives of patients in the specialized service expressed greater satisfaction with services ($p<.01$), but those with higher levels of education returned lower satisfaction scores ($p<.05$).

Semistructured interview

The semistructured interview was undertaken to elicit more detailed information about possible sources of satisfaction or dissatisfaction. The interview included inquiries about the staff's explanations of services, diagnoses and treatments, whether inpatient or outpatient treatments were more acceptable, and the patient's willingness to use the same services in the future if the need arose.

Of the ten inquiries about mental health services included in the interview, four produced statistically more favorable responses from patients of the specialized refugee service—extent to which the service's program was explained, whether the diagnosis was communicated directly by the clinician to the patient, whether the diagnosis was fully explained, and the ease of understanding instructions about medications. Two items remained statistically significant after Bonferroni correction: 100 percent of patients who used the specialized service reported that clinicians' explanations about treatment programs were easy to understand, compared with 74 percent of the patients who used the mainstream services ($\chi^2=8.2$, $df=1$, $p<.01$), and 53 percent of the patients who used the specialized service reported that their psychiatric diagnosis had been communicated directly to them, compared with 19 percent of patients attending mainstream services ($\chi^2=9$, $df=1$, $p<.01$).

Discussion and conclusions

In considering the differences in satisfaction levels obtained across services and the possible origins of such differences, several limitations of the present study must be acknowledged. Only 60 percent of the eligible Vietnamese patients were interviewed, reflecting the high level of mobility among Indochinese refugees in Australia (3). Whether dissatisfaction with services is in any way associated with the tendency for patients and their families to change their residence is unknown. However, it is noteworthy that the rate of participation of patients who attended the specialized refugee service did not differ from that of patients who attended the mainstream services, suggesting that neither group was more motivated to respond.

Nevertheless, the assessment of satisfaction among various groups of patients inevitably raises questions about possible demand characteristics and social desirability effects. Vietnamese interviewers carried out all the interviews to maximize the accuracy of the information obtained. The interviewers were not associated with the services being assessed, provisions were taken to protect the anonymity of responses, and participants were assured that their responses would not affect their future utilization of services. Despite these steps, patients and family members still may have been reluctant to disclose their dissatisfaction with services to their own compatriots for fear of exposure either within the health service itself or within the wider ethnic community.

Such fears may have been greatest among the subgroup of patients with lower levels of English fluency, who were less acculturated and were more likely to give what they judged to be socially desirable responses. However, the level of English fluency of patients attending the specialized refugee service did not differ from that of patients attending the mainstream services, suggesting that if such biases existed, they should have exerted a broadly similar effect on satisfaction ratings across both types of services.

The measure of satisfaction devised for the purposes of the study was not subjected to extensive psychometric testing. Such an ad hoc approach seemed justifiable given the absence of an universally applicable satisfaction measure (14,15) that was sufficiently relevant to the Vietnamese community being studied. The internal consistency of the measure (alpha=.87) provided some indication of its construct validity. In that respect it is comparable to other measures used in past research on satisfaction with services (15–17). Also, a high level of correspondence was found between patients and their family members not only on global satisfaction scores but in associations between satisfaction and treatment site. In addition, the absolute scores indicated that, as a group, subjects expressed moderate levels of satisfaction with services, suggesting that extreme response biases did not predominate.

Patients who used the specialized refugee service were more satisfied with the information they received and the ease of negotiating changes in treatment.

An important limitation of the study, however, was the absence of an Australian-born comparison group, which, although not relevant in relation to satisfaction with the specialized refugee service, would have shed more light on the pattern of responses provided by the Vietnamese patients who attended the mainstream services. In addition, effects of differences in diagnosis among patients in the sample may not have been thoroughly addressed. The second regression analysis showed, however, that site of treatment predicted satisfaction scores whereas differences in diagnostic profiles across centers did not. However, it must be conceded that more subtle differences associated with diagnosis, such as the greater likelihood that psychotic patients would receive medications that cause disturbing side effects, were not fully examined.

Past research has found that the provision of information to patients and their families and the way it is communicated are closely associated with levels of satisfaction (14,18,19). The data from the study reported here support such findings. Item analysis controlling for multiple comparisons showed that the patients who used the specialized refugee service were more satisfied with the information they received and the ease of negotiating changes in treatment. On the semistructured interview, patients who attended the specialized service reported greater satisfaction with the extent to which the treatment program was explained and with the way in which their diagnoses were communicated to them.

It is possible that the bicultural counselor model used by the specialized service may have contributed to improved communication in that service (2,9), but this inference is only tentative given the limitations of the study. Several other factors could account for the observed differences in satisfaction between the two categories of services, including motivational issues (16), differences in preconceptions and expectations about the service (16), the physical environment of the respective services, and the greater potential stigma of attending a mainstream mental health service. The difference in satisfaction might also relate to a general trend for patients to be more satisfied with innovative services such as the specialized program for refugees (20).

In accord with past studies (21), the study reported here found that that few socioeconomic or diagnostic variables affected levels of satisfaction. Nevertheless, the associations between satisfaction and level of education of family members and between satisfaction and level of English proficiency among patients are notewor-

thy. Family members with higher levels of education were less satisfied with treatment, whereas patients with a poor grasp of English reported greater levels of satisfaction. Past research on the impact of education levels on satisfaction has yielded conflicting results, although a trend supports the present findings (16,22,23). Being educated and having better English language skills may allow Vietnamese patients and their families to evaluate services more critically. Conversely, those who are less educated or whose English is poor may not be in a position to judge the service critically or they may feel most marginalized and hence may lack the confidence to express any negative views about public services.

Whether the level of satisfaction with services in the present study has implications for future service utilization of the participants remains unclear—it is noteworthy that patients who used the two types of services did not differ in their expressed willingness to return to treatment at the respective services. Nevertheless, past research suggests that levels of satisfaction may influence adherence to treatment and possibly the outcome of interventions (16,19,24,25). If that is the case, it seems warranted to examine in more detail why the services provided by the specialized program for refugees, and possibly other similar ethnospecific services around the world (9), are more acceptable to patients and their families. ♦

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