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ORIGINAL ARTICLE

Saudi service users' perceptions and experiences of the quality of their mental health care provision in the Kingdom of Saudi Arabia (KSA): A qualitative inquiry

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ABSTRACT: *This paper presents, as part of a larger mixed-methods design, a study generating a theoretical understanding of issues pertinent to the quality of mental health care in the KSA from the perspective of those using services. Semi-structured interviews were undertaken with thirty service users admitted to inpatient psychiatric wards, using an interview guide developed by the researchers, based on relevant literature. Findings from the thematic analysis showed five themes: (1) The hospital as a prison: a custody versus care dilemma, (2) quality of interactions between staff and service users, (3) quality of services, (4) staff qualities and (5) suggestions for achieving quality of care. A theoretical model drawing upon Donabedian Health Care Model for Evaluating quality of care and the Andersen Behavioural Model of Health Service Use is evident from the data. Structural aspects of care include staff experience and qualifications and key enablers around social and financial support, service users' health needs and status and the physical infrastructure and ward rules. These drive processes of care based upon robust rates of interaction between staff and service users and appear central to quality of mental health care in KSA. Quality of mental health care in KSA is manifested by a therapeutic ethos with a high degree of interaction between professional carers and service users, with the former being highly educated, competent, compassionate, with a high degree of self-awareness, and specialized in mental health. We have uncovered elements of Fanon and Azoulay's 'Cultural Originality' as well as contemporary examples of Goffman's mortification of the self.*

KEY WORDS: *mental health, mental health services, perception, quality of health care, Saudi Arabia.*

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BACKGROUND

Healthcare services have improved dramatically in KSA over the past few decades, although this has also presented challenges for stakeholders, emphasising a need to improve healthcare quality. These challenges include the growing demands placed on healthcare services; rising costs; changing patterns of disease; staff shortages; the absence of a national health information system; a lack of indigenous healthcare providers; a significant annual pilgrim population; a rise in the incidence of medical errors, and long waiting times (Almalki *et al*. 2011; Qureshi 2010; Qureshi *et al*. 2013). Therefore, the Saudi Ministry of Health (MOH) has intensified its efforts to improve the quality of mental healthcare services in KSA, mainly by drafting health plans and policies. However, to the best of the author's knowledge, no other studies have hitherto been conducted on the quality of Saudi mental health care.

Mental health is currently counted as a major healthcare area by the Saudi government. In moves to make mental health services more available and accessible to the Saudi population, a number of specialized hospitals and primary healthcare centres (PHCs) have been established in the Kingdom (Ministry of Health 2016). The Saudi government's first step in this direction was to create the General Department for Mental and Social Health (GDMSH) in Riyadh in 1983, aimed at meeting the needs of mental health service users nationwide (Ministry of Health 2017). Thus, the GDMSH adopted the First National Strategic Plan for improving and developing psychiatric services in KSA, with a focus on developing both modern infrastructure and competent staff, as well as improving the quality and availability of mental health nationwide (Al Habeeb & Qureshi 2010). In addition, the GDMSH administers all aspects of professional mental health care, from PHCs to specialized therapeutic services, while safeguarding the rights of service users.

In 1989, a national mental health programme was developed in KSA, making essential mental health services available in primary healthcare centres (WHO 2006). One of its main tasks was to provide in-service training for primary healthcare physicians in diagnosing and managing mental health issues, thereby equipping them to refer complex cases (Atlas 2011). The Saudi Constitution declares Sharia (Islamic law) as the national law. In practice, health legislation aligns with both Sharia and international standards. Moreover, mental health legislation in KSA is well established to regulate the relationship between healthcare providers and mental health service users, with its Mental Health Act (MHA), most recently revised in 2014 (GDMSH 2014). Mental health services in KSA are organized by region, with mental health hospitals providing essential outpatient, inpatient and emergency care services.

In 2014, ~508 703 mental health service users consulted psychiatric clinics, and over 22 064 service users received inpatient mental health care in KSA, where 21 psychiatric hospitals are widely distributed in the public sector (3328 beds: including 92 outpatient psychiatric clinics in both specialist and general hospitals; three-day treatment facilities for service users with comorbid psychiatric disorders) (Ministry of Health 2016). There is one psychiatric hospital in the Western Region (around 670 beds), 14 other psychiatric hospitals (30–120 beds each) and 61 psychiatric departments and clinics connected to general hospitals. Aside from this, there are three hospitals, located in Riyadh, Jeddah and Dammam (280 beds each) to provide integrated inpatient and outpatient services for substance misuse disorders. Additionally, there are military, National Guard and University Hospitals (total = 165 psychiatric beds) and private general hospitals that offer some psychiatric care (146 beds) (World Health Organization & World Organization of Family Doctors 2008). Meanwhile rehabilitation services are mainly concentrated in the private mental health sector and criminals with concomitant mental disorders are treated in secure units within inpatient psychiatric facilities. Finally, paediatric psychiatric services are mainly delivered in outpatient clinics (World Health Organization & World Organization of Family Doctors 2008).

Overall, the continued attention and support of the Saudi MOH has driven significant improvements in mental health service delivery over recent years, despite many ongoing challenges (Qureshi *et al*. 2013). These include the need for community mental health facilities nationwide (outpatient and inpatient; residential); the integration of mental health services into primary healthcare settings; mental health training for professionals in all disciplines; the encouragement of research into mental healthcare services nationwide (with an allocated research budget); and improvement to the overall quality of mental healthcare services and their outcomes. While these aspects of mental health care have received little attention in the past, they are now among the main objectives of Saudi Arabia's current development strategy (Ministry of Health 2017). However, while there is clearly work to be done at an infrastructural level to optimize mental healthcare

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provision in practice, this falls somewhat outside the scope of this paper, which rather looks at the socio-cultural factors bearing upon attitudes and uptake in relation to mental health services.

Given the influence of culture and religion on the population of KSA, it is crucial to look at the Kingdom's mental healthcare provision against this backdrop of sacred, deeply embedded traditions and belief systems. In KSA, Islam is more than a religious ideology; indeed, it has defined an entire social system with detailed prescriptions for every aspect of life. However, the Saudi population varies widely in its understanding, interpretation and practice of Islam. For example, in the past, women in KSA generally avoided mental health care provided by male psychiatrists, due to a reluctance to disclose personal information to male strangers. Nevertheless, one recent study revealed that female Saudi medical students planning to specialize in psychiatry now outnumber men in a ratio of 3:1 (Koenig *et al*. 2013). Therefore, the number of female psychiatrists is increasing in the Kingdom.

Socio-cultural factors are also influential in the way that families deal with mentally ill relatives. For example, in Saudi culture, great importance is attached to interpersonal relations between family members, particularly where female relatives are concerned. Additionally, there may be a reluctance to accept or disclose mental illness in a female relative, resulting in family secrecy, especially among first-degree family members. This is intended to protect the female relative's marriage prospects, which could be damaged if her illness became publicly known (Al-Krenawi & Graham 2000). Moreover, female mentally ill family members are more likely than their male counterparts to be accompanied by a relative on seeking clinical help.

On a global scale, QoC and the improvement of service user outcomes has received considerable attention in recent years. Service users' perceptions can be a valuable source of understanding for stakeholders, as they appraise the QoC provided by their area of service (Tasso *et al*. 2002). Moreover, the discovery of service users' perspectives is based upon a philosophy that puts service users at the centre of care by listening and responding to their experiences, preferences, and needs, as a means of gaining insights into the ways in which standards of quality and policy formulation can advance in the hope of improving service users' QoC (Al-Zaru *et al*. 2011).

While there is an expansive literature relating to service users' experiences of quality of mental health care, evidence concerning the impact on service user outcomes in KSA and other Arab countries (e.g., Jordan, Egypt, Iraq and Kuwait) is lacking (Afifi 2005; Jaalouk *et al*. 2012; Marie *et al*. 2016; Okasha & Karam 1998). Our qualitative study, embedded within a large project of research related to quality of mental health care, had as its principal aim to generate a theoretical understanding of issues pertinent to the quality of mental health care in the KSA from the perspective of those using services.

Cultural and ethical aspects of staff

The nursing profession is still a work in progress in KSA, struggling to meet the health care demands of a growing population. This is compounded by an ongoing staffing crisis in healthcare institution nationwide, necessitating the recruitment of foreign nurses (Aldossary *et al*. 2008). This is the case in the hospital sampled for this study, where ~23.3% of the female nurses are Indian or Filipino, recruited through agencies in their home countries. They are well qualified in scientific and general aspects of nursing, but have no grounding in Saudi culture. Overall, low care quality tends to be associated with a poorer cultural understanding.

Therefore, Saudi nurses would be able to deliver more culturally appropriate holistic care to Saudi service users (Aldossary *et al*. 2008), without the additional language barrier. Moreover, unique features of Saudi Islamic culture, such as gender segregation, stipulate female–female and male–male care for Saudi service users. Extra time and resources are therefore required to orient foreign nurses into Saudi healthcare culture, instead of training a native nursing workforce (AL-Dossary 2018). The problems associated with foreign nurses from diverse cultural and ethnic backgrounds inevitably affect the quality of service user outcomes.

Regardless of the commitments in policy and the undoubted importance of cultural sensitivity, foreign nurses may know little about Saudi culture and Islam. Therefore, Mebrouk (2008) declared that foreign nurses working in KSA find it difficult to understand the cultural requirements of their service users. It has been suggested that most foreign nurses are required to undergo cultural training during their first stay in the country in order to provide optimal care for Arabic service users. However, confidence in proving culturally congruent was not evident until after a year of work experience (Aboul-Enein 2002). Consequently, it becomes very difficult to draw a conclusion about the level of competence of foreign nurses in providing culturally sensitive nursing care to Saudi population. The lack of studies on this topic in the KSA hinders the

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identification of the needs of foreign nurses related to cultural competence development. With this, it becomes essential to conduct this study to have a basis for planning and implementing transition programmes that include cultural training to ensure cultural competence development among migrant/overseas nurses.

Besides, the Saudi health system is concerned with integrating complementary care rendered to the service users, including spiritual and religious activities. This practice is evident through providing religious sessions and health education booklets and religious books such as the Holy Quran for service users, as the hospital administration offers some copies of the Holy Quran in each ward for its use by service users. Service users in KSA tend to favour religious activities (or Islamic practices), such as praying, reading the Holy Quran and attending religious services to cope with their disorder (Aldossary *et al*. 2008), over crying, blaming themselves or isolating themselves from others. Such activities encourage service users to engage with their condition as part of their destiny (thus avoiding blame of self and others), while proactively seeking a cure. However, since the Holy Quran is a sacred book, nurses are keen to preserve its sanctity by not giving it to service users with known organic brain damage, or who are unable to read it, due to the incapacitating effects of their disorder, thus rendering them unable to utilize.

Regarding nursing ethics, the Saudi MOH has issued a Policies and Procedures Manual for Mental Health Hospitals (available in Arabic only) for all disciplines to ensure high-quality care and preserve service users' rights and dignity. However, no standards are currently in place for professional nursing practice in KSA (Tumulty 2001). Instead, these MOH guidelines specify the minimum level of professional performance expected to meet service users' physical, spiritual, psychological, and social needs through holistic care. The guidelines detail practical nursing skills along a continuum, commencing with access to services; the promotion of individual health and well-being for patients and their visitors (friends, family); a commitment to education and professional development, and ethical practice, integrated into professional identity.

However, KSA falls far behind many other countries in terms of developing ethical standards of professional nursing conduct and the protection of service users' rights. For example, in the United States numerous organizations have promoted nursing quality and ethical standards, leading to the establishment of a Nursing Code of Ethics, which clarifies nurses' ethical and moral commitment to their patients and profession (Association 2001). Although this Code was developed in a different culture, it could still be tested by Saudi nursing staff for its feasibility and appropriateness. Furthermore, as identified in the literature review, there are general ethical standards agreed upon in Islam and the international community (AL-Dossary 2018). This finding highlights the importance of communicating directly with the Saudi MOH to initiate the development of national professional standards for the nursing profession, with particular reference to the mental health sector.

METHODS

Design

A qualitative, exploratory study using semi-structured, face-to-face interviews was conducted.

Setting

The participants were recruited from a mental health hospital in KSA. The reasons for selecting this hospital as a case study included the following:

- It is one of the largest mental health hospitals in KSA.
- It provides care for service users from all over the country, as well as locally.
- It receives mentally ill service users with serious psychiatric issues (e.g. penal cases) on referral for integrated inpatient and outpatient psychiatric services, including forensic medicine.
- Its bed capacity is far higher than in other hospitals in the country. The scale of its staffing therefore enabled a large sample to be drawn.

In sum, these reasons strongly indicate this hospital as one of the foremost in the country in terms of size, range of services, and quality of care (QoC). It is also regarded as a model of mental healthcare practice and service user management in KSA, reflecting MOH standards, rights, policies, and objectives. It was therefore anticipated to provide a rich source of data, perceptions, and experiences of QoC, representative of mental health hospitals in the Kingdom.

Participants

The interview sample consisted of 30 participants, comprising six female (20%) and 24 male (80%) service users. This sample was selected purposively from

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multiple inpatient wards between June 2014 and December 2014 (Table 1), based on age, gender, and educational background, and recruited via a member of their usual healthcare team. The following inclusion criteria were applied: aged 18 years or over and diagnosed with a mental disorder according to the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association 2013); capable of giving informed consent, and able to speak Arabic.

The huge gender imbalance in the interview sample is due to more men than women generally being admitted to the Hospital (11 male wards/3 female wards). Moreover, only patients on the acute female ward were appropriate for interview and met the inclusion criteria. On the other two female wards, the service users were unsuitable for interview, because of their intellectual disability (making communication difficult), or their lack of capacity to give consent (due to their disorder). The lower admission rates for women could be explained by the fact that in Arab societies, families are often reluctant to admit female relatives to psychiatric hospitals, due to the accompanying stigma, fear of damaging future marriage prospects, and increased likelihood of separation or divorce (Al-Krenawi & Graham 2000). Therefore, psychiatric outpatient services tend to be accessed for female patients and then only in emergencies, such as when a mentally ill female family member becomes impossible to control.

To further explain the gender skewness in this study, the researcher discussed the topic with the participants, whose diverse socio-demographic characteristics generated extensive and detailed information from both genders. Moreover, their differences did not seem to have much effect on the quality of information obtained from either gender. This may have been partially due to their familiarity with the topic, as well as the relative ease with which they could discuss it (compared to, e.g. sexual abuse). Besides, even though two distinct groups (based on gender) were represented, normally expected to have differing experiences of quality in their mental health care, the interviews revealed no differences between their perceptions of the care received. The study findings can therefore be generalized across the gender divide.

Interviews

Interviews were semi-structured, using a guide developed originally by the researchers (Table 2), based on the relevant literature. The first author carried out all the interviews, which were conducted and recorded in Arabic. Interviews took place at an assigned office in the ward setting and lasted ~45–60 min. All interviews were recorded, with consent, and fully transcribed, anonymized, and transferred into NVivo 11 © software for data management.

TABLE 1: *Participants characteristics* (n = *30)*

Characteristics	Number
Age (years)	
23–30	4
31–40	10
41–50	13
>50	3
Gender	
Male	24
Female	6
Educational level	
Illiterate	1
Primary school	6
Intermediate school	8
Secondary school	4
College (diploma)	2
Graduate	8
Postgraduate	1

Data analysis

Data were analysed using 'inductive thematic analysis'. This approach is inductive to ensure that the analysis is grounded in the data and that no pre-defined categories or themes are applied; that is, the themes are derived from the data themselves (Braun & Clarke 2006). The recommended (six) sequential steps were followed: familiarization with the data, generation of initial codes, the search for themes, review of the themes, defining and naming the themes, and producing a final report.

RESULTS

Five themes are developed from the data.

Hospital as prison; the custody versus care dilemma

The participants described their experience of the hospital and the care received, comparing it to a prison. A striking feature of the interviews was that the majority of the participants expressed a fundamentally negative perception of hospital care, while only a few commented that it exceeded their reasonable expectations

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of such care. Here, 28 participants described hospital unequivocally as a prison and described: *delayed service user discharge, feeling of imprisonment, lack of activities, and punishment*.

Delayed service user discharge

Thirteen of the participants talked about delayed discharge from the hospital, resulting in them suffering for a wide range of reasons. For example, eight of the participants attributed delayed discharge to the refusal of their families to take them home and the failure of the hospital to address this, resulting in them languishing in hospital, even after being declared fit for discharge. One participant reported: *'All patients are ready for discharge but their families refused to receive them…'*. A further nine of the participants expressed the belief that their delayed discharge from the hospital was due to the health system being unresponsive to them as service users (especially after them being cleared for discharge). For example, one participant reported that the hospital should reject the administrative barriers (due to legal issues) that prevent the discharge of service users, such as obtaining an official letter from a higher authority (e.g. the local Province or even the Police Station): *'Its source is the Prince of [city name] through my father, he sent him a letter… He [the Prince of ****] didn't see me and he didn't know me. I'll stay here for my whole life unless my father discharges me'*.

This experience was echoed by other participants, when they were asked to describe their experiences as service users in other hospitals and the issue of their release from hospital. The participants expressed the opinion that other mental hospitals discharged service users whose conditions had improved and that their discharge from inpatient psychiatric facilities was obligatory. One participant commented: *'With the care there, at [hospital name], if your condition has improved, you get compulsory discharge, while here, no, you will be neglected, forgotten'*.

TABLE 2: *Service users' interview guide – key questions*

No.	Interview questions
1.	How did you find the nursing care, doctors, social workers, etc...?
2.	What about other aspects of your care?
3.	What aspects of the care do you find most helpful?
4.	What aspects of care do you find the least helpful?
5.	What would improve the quality of your care?
6.	How do you think this quality can be achieved?
7.	How does the care here compare with other places?
8.	What makes it better/worse?
9.	If you described your experience here to a family member, what would you say?
10.	What other things would like to say about your care?

Feeling of imprisonment

Statements relating to the ward area and ambience were negatively perceived. Nine of the participants described the ward area as prison-like, citing specific instances, such as confinement in a locked ward. The following participant's comment summarized the general perception of a locked ward: *'We don't see light, we don't see sun. All windows have been sealed with steel covers'*.

Keeping service users out of the bedrooms and denying them access to their own beds during the day as a way of preventing them from sleeping in the daytime was also mentioned in six of the interviews. This action was perceived by the service users as unacceptable, leading to many of them feeling restricted on the ward, with their freedom being limited. For example, one participant reported that closing off the bedrooms during the daytime was a mistake on the part of the hospital management: *'…the room is closed and this [closing the room] is the fault of the Hospital […] they are supposed to open them for us, especially in the morning, because we receive psychiatric treatment that makes us sleep'*. In fact, opening the bedrooms was viewed as therapeutic for reducing feelings of discomfort: *'…they closed them. If they left them open, we would feel more comfortable…no,open the bedrooms and we can go in them at any time'*.

Eleven of the participants reported that they felt as if they were confined in a prison-like inpatient psychiatric ward. When asked to describe the QoC in the hospital one interviewee reported: *'… I don't acknowledge that this place, where we are now, is in fact a hospital. I say this place is a prison, not a hospital […] Here, the detainees are like Guantanamo detainees, I say this honestly'*.

Lack of activities

A lack of recreation (activities and areas) resulting in boredom was cited by 17 of the participants. In contrast, the presence of natural features in the hospital was felt to be desirable, as it would provide an opportunity for service users to enjoy some recreation and improve their use of leisure time, reducing their feeling of imprisonment during hospitalization. This was in addition to the importance of natural features for personal well-being (yard therapy). According to one participant, there was a lack of such things in the hospital:

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'There are no leisure activities here [like playing] football, having a change of scene, going out to get some fresh air. Such things are lacking here…'.

Punishment

Another prison-like aspect of the hospital was that around 20 of the participants reported receiving punishment. The participants who reported this perceived the consequences of particular staff behaviours and responses to their own activities, including the likelihood of being physically restrained or assaulted by staff, perceived by the participants as acts of punishment, whereby the nurse became the perpetrator of retributive action and was consequently feared by the service user as a disciplinarian: *'I'm worried about his reaction… he may create some blocks to prevent me from going home, you know, or he may say "it is not your business… you're a patient…"'.*

A common feeling reported by the participants was powerlessness in the face of the terror of being restrained, and one service user was even afraid to complain about the hospital food. This contributed to the escalation of his situation and the realization of his worst fear of being considered as a troublemaker: *'I haven't told anybody. I just eat silently […]. I'm afraid if I talk they'll tie me up'.*

A different participant reported being afraid to follow official complaint procedures, indicating that the system's mechanism for service user complaints/feedback was disregarded*: 'I was thinking of writing a complaint against him [the physician], but after lots of thought, I cancelled it, because I don't want to create problems with him or his colleagues, because all of them will take this subject personally…'.*

A number of participants described being restrained. All were involuntarily detained when the restraint occurred and all reported it as a negative experience. All counts of restraint were dealt with by force. When asked to describe their experiences of being restrained, they narrated a form of assault. For example, one participant reported that being restrained was a bad experience leading to physical injury: *'They tie us very tightly and sometimes they lift the bed up and tie a person from one shoulder. I cried and shouted "My shoulder, shoulder!" […] They really tried to break my hands and twisted them behind my back…'.*

Quality of interaction

This theme refers to service users' perceptions of the quality of their interaction with staff. The sub-themes within this category are as follows: *Communication* and *Staff members' behaviour and ways of dealing with service users*.

Communication

The 'communication' sub-theme represented the interpersonal aspects of care which include communication from staff involved in the treatment of service users and general interpersonal empathy and skills. These should be intrinsic to the professional role and contribute to QoC, particularly in mental health contexts. Four of the participants perceived that a positive relationship related to the ability of staff to create an atmosphere where they could express themselves openly and where service users felt heard and accepted. This produced positive feelings, in contrast to the restriction of interaction in the provision of biomedical care: *'He [the physician] never deals with you as a patient, like you just take your medication and go. Instead, he asks you things, I mean you feel as if he gives you confidence in yourself. It means, for example, you have the ability to change, to alter, to try, to talk'.*

Other participants highlighted a lack of care for the needs of service users; for example, not listening to the service user attentively, which should be an integral part of their work. This issue is reflected in the following participant interview: *'Nurses don't listen to patients' problems. They just say "Go there" or they may say "*porjak ya hamam*" [lit. "go to your perch [v.], pigeon"]'.* The presence of foreign staff and a lack of indigenous service providers tended to be implicated in the generally low QoC narrated by three of the participants and was instrumental in their struggles associated with cultural understanding: *'I would prefer Saudi nurses, not foreigners, because the Saudis are kind and understand their patients' psychology. It is difficult for foreign nurses to understand and deal with the patients…'.*

Staff members' behaviour and ways of dealing with service users

This sub-theme represented the aspects of professional practice and behaviour with service users. Staff approaches to their work with service users may have exerted an important influence on the degree to which service users felt that they could comply with staff instructions and the openness with which they felt that they could talk with them. Responses to staff behaviour fell into three main categories, classified as 'good', 'bad' and 'mixed' (i.e. both good and bad). The first category

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of perceptions indicated a moderate or even high level of satisfaction with staff behaviour. A number of participants judged the QoC itself primarily in terms of the empathy and respect that staff members displayed towards them and thought that consideration and basic good manners were an important part of their care, as reflected in the following participant's view: *'The ward manager, I mean when you ask him something, he usually says 'Okay'. This ['Okay'] is sufficient for me, even he if he does not do anything . . .You feel that he treats you as a human being'*.

Five participants also offered negative descriptions relating to the negative impact of staff behaviour on their care in a number of ways. Two described the social stigma associated with mental disorder, whereby staff deal with them in an unprofessional way by labelling them as mentally ill: *'They do not ask me these questions and if I ask them, they say, "Because you are crazy"'*.

Three of the participants felt that they were treated differently in terms of having their needs met by healthcare providers and that their needs might not be taken as seriously: *'They look at a psychiatric patient as if he is a mad person and they take him lightly [not seriously], saying to him, "Ok, ok, later"'*.

Quality of services

This theme comprises the three sub-themes *'satisfactory'*, *'unsatisfactory'*, and *'not being totally satisfied'*.

Satisfactory services

This sub-theme encompassed the participants' positive responses regarding the quality of services received. More specifically, it focused on their satisfactory experience of services within the healthcare facility. Twenty-nine of the participants interviewed overtly expressed their satisfaction with the hospital's services, particularly when asked about the hospital healthcare services directly, even in cases where they otherwise cited a chronicle of abuse and neglect. However, it should be clarified that three of the participants understood 'services' primarily to mean biomedical treatment and referral to speciality care. Thus, they highlighted the importance of an available referral system to other hospitals (if required) and described this as prompt and very useful. For example: *'. . .here is a quick intervention for emergency cases and referral to other hospitals. All these services are useful'*.

Helping service users with issues in their lives in the community, such as official business, banking, and lending money were perceived to demonstrate care and were valued, exemplified in phrases such as: *'The nurses are cooperative with us, even over our issues from our lives outside [the hospital], they do stuff, for example [going with a nurse] to court, a notary, government offices or to the bank to open accounts'* and *'. . .regarding patients' storage, they give us 100 riyals every week, which is good to spend for the whole week'*.

Unsatisfactory services

Unsatisfactory services were a challenging area of care for the participants, and the interviews revealed a high level of concern. The findings revealed that dissatisfaction with services referred to either the service itself or the employees' work-related actions in the ward environment. Statements relating to facilities such as personal clothing, cleaning, lack of prayer facilities, (bad) physical environment (e.g., comfort levels), and provision of food were problematic in the hospital. As a result, they were anxious about the material accoutrements of holistic care and considered such things to be an indicator of poor service, for example: *'. . .there are not enough carpets here, we have one that you see and another one in the balcony, they gave it to us after a thousand times of asking and its quality is bad. I need socks for protection. I asked for some, but they didn't have any'*.

Additionally, participants wanted more information regarding spiritual needs in health service provision, in enhancing their health outcomes. They were particularly interested in spiritual therapy and considered its absence as an impediment to their recovery, reflecting the general Muslim perspective of illness. When asked about entertainment, four of the participants mentioned the Quran, or rather the absence thereof and of spiritual resources in general: *'. . .there is no Holy Quran. The religious awareness in this hospital is somewhat lacking in terms of providing religious books and health education booklets for patients'*.

Not being totally satisfied with the service

When asked how they found the general quality of services received on the ward (without implicating any particular personnel), a number of the participants reported that they were not totally satisfied with the hospital's services. For example, two participants indicated that they were not fully satisfied with the services, but were not vociferously critical: *'The level of service on this ward is not so high and not so bad, which means it's medium'*.

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Staff qualities

This theme highlights service users' perceptions of the qualities of the staff on their wards in terms of education, experience, and competence in providing care. In general, the service users commented negatively on the qualities of the nurses, who were contrasted unfavourably with the physicians. For example, two of the participants reported that the nurses were not well-trained and needed more courses on how to deal with mentally ill service users: *'I don't blame the [nurses], maybe they don't have any education, or maybe not a very high level of education. They need courses in psychiatric nursing'*.

Conversely, many positive comments were made by seven of the participants regarding the competence of the physicians, who they generally described as skilful and knowledgeable in their work*: 'The doctors here are very good, educated and they know everything'*.

The lack of nursing skills was equally considered as a demonstration of low-quality care. One participant pointed out that he was exhausted, because of deficiencies in nurses' skills with regard to routine matters, such as taking blood or administering injections: *'. . .what is going on is that in terms of injections, they are not good at taking blood or finding veins. Yes, some of them are excellent and smart, but some of them don't even know what it is to take blood. They make the patient feel exhausted. . . he feels exhausted and he tries to escape from this. . .'*.

Suggestions for achieving quality of care

When asked to offer suggestions for improving care quality at the hospital, service users offered the following:

- The need for expert nurses, with the knowledge and capability to work with mentally ill service users; one participant suggested considering important personal traits in the recruitment of nurses, in order to enhance care provision.
- One participant had a different view, whereby he suggested sub-contracting companies that were specialized in providing high-quality health services for the operation of the hospital.
- Another participant stated, *'to improve the services here, we also need to have awareness courses. . . for the foreign workers, in terms of explaining to them what a patient is. . . Their problem is that they don't respect us and they treat us as something like offal, you know'*.

DISCUSSION

The findings suggest that the majority of the participants were dissatisfied with their stay in hospital, expressing generally negative perceptions of its care services (understood here as *hospital services*, as opposed to the personal care received from specific health care personnel), with many describing it quite openly as a prison. In the findings, delayed service user discharge was identified as a problematic area in the 'service context' dimension. However, chronic mental disorders are usually treated with prolonged hospitalization, where discharge may be delayed for a number of reasons, including the family's refusal to care for mentally ill relatives; active psychiatric symptoms; rehabilitation needs; a lack of community services or halfway homes (now incorporated in the agenda of the National Strategic Plan); and the administrative barriers such as legal issues surrounding the risk of premature discharge, making psychiatrists cautious (Koenig *et al*. 2014). However, this last point is not unique to KSA, but continues to pose a problem for mental healthcare systems in other countries (Lewis & Glasby 2006), sometimes leading psychiatrists to make less than optimal clinical decisions.

Given these findings, the reasons behind delayed discharge are apparent. They point to a need for government policy to promote the development of patient-centred services, and to encourage user involvement in the shaping of health service organization and delivery. In these ways, healthcare outcomes could be improved. Moreover, appropriate legislation is necessary to govern mental health programmes and services, supported by the necessary infrastructure. Thus, an adequate range of well-funded mental health and community resources could be offered, sufficiently staffed by competent mental healthcare workers (Jacob *et al*. 2007).

Perceptions relating to locked wards, the closing off of bedrooms and insufficient space on the ward were acute in situations where the participants felt that they were restricted, with limited freedom on the wards. Several studies have indicated that locking ward doors has a profound impact on the personal experience of service users, often manifesting in increased aggression (Bowers *et al*. 2009), potential self-harm (Bowers *et al*. 2008), and the refusal of medication (Baker *et al*. 2009). It has been argued that the association between locked wards and aggressive or confrontational behaviour is due to a sense of imprisonment and confinement.

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Given the strength of the conviction among the service users that they were locked out of their bedrooms during the day to prevent them from sleeping, it is unlikely that they could ever be genuinely satisfied with the psychiatric services provided. The effect of a locked door is partly psychological and partly physical (Muir-Cochrane *et al*. 2012). In the UK, Bowers (2014) demonstrated that the physical environment has a major effect on service users and that locked doors were observed precipitating greater susceptibility to anger/resistance or a slump in self-esteem and potential self-harm.

The overriding issue in this study was the lack of available recreational facilities, and this issue underpinned most of the concerns commented upon during the interviews. The participants identified a lack of recreational activities or areas that could help distract them from thinking of mental illness as a major problem, which exacerbated their lack of satisfaction. As noted in our findings, it is clear that there were no individual care plans incorporating the needs of service users, beyond medication. However, they made it clear that they wanted physicians to consider their holistic needs in terms of recreation and fitness.

Providing such facilities (indoor and outdoor) and involvement in normal everyday activities is generally beneficial for users of mental health services, providing them with a distraction from their mental illness (Walsh & Boyle 2009). Several studies recommend the inclusion of recreational facilities (O'Brien & Cole 2003; Walsh & Boyle 2009) for enhancing overall service user care and to help manage mental health disorders.

Perceptions relating to punishment following admission to hospital were also a matter of concern for the participants. Approximately 20 of the participants reported being physically restrained or assaulted by staff, in acts that they perceived as punitive, whereby nurses became the perpetrators of retributive action and were consequently feared by the service users as disciplinarians. A number of previous studies have highlighted concerns about the attitudinal dimension, which appears to endorse restriction, control, seclusion, and punishment in handling mental health service users (Meehan *et al*. 2000, 2006; Moghadam *et al*. 2013).

Inadequate staffing was additionally cited and perceived as a major challenge for the hospital, resulting in the ad hoc drafting of non-nursing staff members, such as cleaners and security personnel to compensate for the shortage of nurses. Evidence from prior study suggests that the deployment of non-nursing staff is expedient strategies used to address the shortage of nurses and exert preventive control over challenging service user behaviour in acute psychiatric settings (Hueske 2008). The management of aggression in psychiatric wards, especially acute wards, requires staff with specialist skills (Hueske 2008); the deployment of non-specialist personnel, particularly employees who are not even healthcare professionals, can be expected to have negative effects on QoC. However, there was a pressing expedient need for such deployment to maintain general safety on wards in the event of untowards events, although many service users also reported being restrained and abused[1] due to interpersonal problems with staff. In tandem with the general shortage of nurses, increasing numbers of service users were being accommodated in cramped ward conditions (Moghadam *et al*. 2013).

This perceived lack of caring was detrimental to their behaviour and psychological well-being, giving rise to thoughts about retaliatory aggression. To address this, a number of policies and guidelines have been issued by Saudi GDMSH, incorporated into the *Policies and Procedures Manual for Mental Health Hospitals* (available in Arabic only) to govern nursing practice (51 policies) in the mental healthcare system (GDMSH 2014).

Careful consideration of the findings also revealed that the participants took pains to speak positively about their psychiatrists, who clearly acted as powerful gatekeepers for their discharge. However, at various points in the narratives, there appeared to be palpable fear of retribution, potentially exacerbating service users' health conditions and giving rise to their worst fears, namely of being considered as a troublemaker. Psychiatrists and other staff are committed to working with mentally ill service users; ensuring that each benefits from his or her hospitalization, without being hurt or punished. In other words, psychiatrists should help service users to enjoy relationships based on respect, not abuse, as well as giving them confidence and safeguarding their rights.

To address service users' concerns, stakeholders concerned with service user rights need to regularly monitor and evaluate all hospital services, in order to guarantee these rights. Mental health legislation has a major influence on how the relationship between service providers and mentally ill individuals is regulated. The MHA passed by the Saudi MOH was designed to enforce service users' rights at local and national level (Qureshi *et al*. 2013). According to the MHA (GDMSH

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2014), service users have the right to lodge a complaint against any individual in a mental health facility, if justified, without prejudice to their QoC. Service users should also be protected against degrading treatment and financial, physical, sexual, or any other form of abuse. Moreover, they must not be subjected to or threatened by physical or psychological punishment on any grounds whatsoever. Yet, the service user data in this study were contradictory, as the respondents spoke positively about psychiatrists, but at other points in the data collection, expressed palpable fear of retribution.

The participants described their experiences of aspects of staff' interactions with them, reporting the need for an atmosphere of open communication with staff, which would have a positive effect on their care outcomes. These experiences supported some of Schröder *et al*.'s (2006) findings. The above authors advocated that service users should feel that they can trust staff in an atmosphere of open conversation and supportive guidance. This finding places greater emphasis on the interpersonal relationship between the service user and healthcare provider (Huycke & All 2000). According to McIntyre *et al*. (1989), simply talking to a member of staff could be regarded as the most helpful aspect of care.

Inadequate information provision, especially regarding medication, was also recognized among the participants, consistent with the findings of Walsh and Boyle (2009). These researchers explored psychiatric service users' strategies for coping with mental disorders and found that although a significant number of participants found medication to be the most useful, there was a consensus on dissatisfaction with the information provided about the benefits and side effects of medication. This lack of information was perceived to be problematic by approximately four of the participants, who reported that this had been their experience.

A perception of staff members' behaviour and ways of dealing with service users (due to stigma, see Reference (Corrigan 2004)) as also of concern, which stresses the importance of restructuring the mental healthcare system in KSA. The data reveal that such attitudes can lead to service users being labelled in unacceptable ways, as indicated by some of the participants, who highlighted their need to be treated in a professional manner. In keeping with previous research, most studies on the impact of distress and trauma associated with psychiatric hospitalization have found participants to have negative perceptions of their hospitalization, arising from harsh treatment by nurses, which had resulted in considerable personal distress and trauma. These are bad outcomes in themselves and could worsen other outcomes (Stein *et al*. 2015). Moreover, our findings support previous research demonstrating that poor awareness of mental disorders in the form of mental illness labelling is linked with the internalization of stigma, which is known to have a negative impact on service users' well-being (Sibitz *et al*. 2011). Likewise, Boyd *et al*. (2014) found that internalized stigma was linked with higher rates of depression, lower self-esteem, and greater severity of symptoms.

The findings of the present study reinforce the importance of a medical care framework, where service users' rights and their involvement in formulating a treatment plan are emphasized, especially in the case of service users suffering from (acute) psychiatric manifestations (Perkins & Repper 1998). Accordingly, this could alleviate paternalism and authoritarianism in mental health institutions (McCabe & Unzicker 1995). Overall, user participation in establishing treatment plans in mental health services, as well as decision-making about their medication, is essential for improving the quality of mental health care, which will in turn influence outcomes.

The participants generally expressed very negative experiences of some aspects of their care, which failed to meet their needs, such as social and spiritual care, which were perceived to be supportive in terms of increasing their self-efficacy and social functioning. For example, individuals often require both social and spiritual care when endeavouring to overcome any disability associated with psychological pressures and difficulties with life (Smith *et al*. 2003). Thus, a large number of the participants highlighted their need for these services and bemoaned the current lack of such provision in the hospital.

Conversely, the participants generally reported that they were happy with some aspects of the care provided by staff, especially their prompt responses to non-biomedical needs (such as buying them snacks from the hospital cafeteria), and the availability of certain services, such as referral systems to other hospitals, basic materials and complementary care, financial support, and assistance with issues relating to daily life in the community, which were all valued by the participants. In the context of the present study, it may be argued that structural characteristics, such as the availability of services, mix of staff, and attractiveness of the physical environment (such as the cleanliness of the wards), had a positive impact on the service users. In addition, these and other characteristics relating to

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structure had the potential to affect staff conduct (Larson & Muller 2002). This result is widely supported by published evidence, showing that a prompt response to service users' requests, symptoms (Schmidt 2003), or actual and potential difficulties (Beech & Norman 1995) is positively associated with the QoC delivered.

Interestingly, participants in this study highlighted the need to improve the quality of the recreational facilities provided, which were perceived as lacking in the hospital. This was evident when there were no individual care plans integrating the needs of service users beyond the administration of medication. The general approach was to provide a minimum level of QoC, chiefly understood in pharmacological terms, in settings overtly analogous to prison conditions, in terms of individual capacity and sphere of influence, with no provision for activities and no inclusion of service users in therapeutic care planning. This is despite decades of research advocating the inclusion of recreational facilities as part of holistic care, particularly in promoting social care for the health and well-being of long-term psychiatric inpatients (Barton & Pretty 2010).

Our findings revealed that the participants perceived nurses as caring and helpful in terms of encouraging their self-care and self-reliance. Tasso *et al*. (2002) found that factors such as the friendliness and helpfulness of nurses, as well as the competence of physicians and their readiness to inform, led to greater patient satisfaction with health care services, suggesting that these may be regarded as central to service user satisfaction. In developing countries, service user satisfaction is also associated with QoC. For example, in a study conducted by Andaleeb (2001) to identify the factors of service quality that are important to service users in the hospital context in Bangladesh, five factors were identified, including responsiveness (being caring, helpful, and courteous), assurance (skilled staff and competence), communication (explanation of actions and answering questions), discipline (cleanliness of the facilities and staff), and the expectation of gratuities (*baksheesh*; services were not provided properly without tips).

It was also reported that certain nurses failed to show any interest in their work and/or in them as service users while delivering care. This reflected negatively on the QoC provided, such as in terms of understanding the service users' needs and prompt response (Schmidt 2003). A lack of interest can partially be explained as the failure to *be there* (poor attendance), referring to nurses being fully present and engaged in care provision for service users. It is this which will render the latter more open and honest with service providers (Schafer & Peternelij-Taylor 2003).

In addition to personal qualities of staff, service users valued the demonstration of knowledge and the importance of professional experience in building on this. However, they felt that these nurses had acquired relevant knowledge through their long experience in the job. This result could be explained by the fact that the time spent by staff with service users in the provision of direct care over a prolonged period had led to them (the nurses) becoming more experienced and knowledgeable in their service provision. This is in line with the findings of previous research conducted by Versteeg *et al*. (2012) who found that team members' level of education, years of professional experience, and previous involvement in quality improvement efforts appeared to be associated with improved mental healthcare quality.

Participation in various activities and recreation, learning new skills, and going on outings were all considered helpful for directing service users' attention away from morbid or obsessive thoughts about their illness and circumstances. Research has shown that a lack of meaningful activities both within the framework of formal care and in general life circumstances is a potential source of frustration, potentially leading to aggressive behaviour (Meehan *et al*. 2006).

The interview approach was purely pragmatic, as it formed part of a larger mixed-methods design, incorporating quantitative surveys, that are not reported here. Those interviewed were clearly eligible to participate and able to judge the care that they had experienced or perceived.

The qualitative themes emerging from the participants' interviews in this study correspond to perceptions reported for mental health service users elsewhere in the world, particularly in the West. To the researcher's knowledge, no other study on the quality of mental health care in an Arab context exists to serve as a point of comparison. Therefore, it cannot be determined whether the themes identified are unique to Saudi culture. Moreover, the present study findings are based on perceptions and experiences, which are not necessarily unique to the specific nation or culture. This view is supported by Cutcliffe *et al*. (2015), who evaluated mental health care in the UK, Portugal, Canada, Switzerland, Germany and Australia, finding that based on service users' perceptions, inpatient mental health care lacked warmth. It therefore differed from conventional therapeutic relationships, where there is respectful interaction, the provision of

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information, a choice of medication, and formal or informal communication. Instead, negative experiences were cited, including coercion, disinterest, inhumane practices, custodial and controlling practitioners, and a gross over-use of antipsychotic medication. Therefore, it could be argued that the qualitative findings (five themes) of this current study provide a benchmark for mental health services, against which past and future efforts to enhance mental healthcare quality can be compared and evaluated. Future study is certainly required to understand the reasons for the current situation and how it can be improved.

The findings from this study can be broadly described as a combination of the Donabedian Health Care Model for Evaluating QoC and the Andersen Behavioural Model of Health Service Use. The Donabedian Framework is the overarching model, consisting of structure, process, and outcome, with the Andersen Behavioural Model embedded within it. The Andersen Model is a framework that is widely used to explore mental health services among service users (Williams & Peter Cabrera-Nguyen 2016). This Model posits that structural (contextual) characteristics, such as factors of health organizations and healthcare providers, combined with enabling factors and the need for service factors, influence processes of care and service user outcomes (see Figure 1 for the conceptual model).

This Model suggests that there are two main domains of care quality processes: quality of interaction and quality of service. Both these domains can affect service user satisfaction – an outcome of quality care. The process column of the Model includes measures of mental health care produced by the qualitative strand of this study, that is quality of interaction and quality of services. Quality of interaction also comprises staff-service user communication, such as caring; listening attentively; the perception of shared decision-making over the treatment plan; the perception of actions explained; the perception of health-related education; and staff attitudes to service users and mental health. Meanwhile, quality of service contains variables relating to health services, which should be measured to allow for an accurate evaluation of the impact of process of care variables on outcomes. Measures could include appropriate treatment (e.g. medication type or a referral system), frequent monitoring of the condition of service users, and the availability of basic materials and complementary care (e.g. the supply of food and facilities, such as clothes and a prayer area/religious texts – namely the Holy Quran, in this context).

Furthermore, staff characteristics may affect outcomes, including education/qualifications, professional experience in the hospital, and staffing (e.g. levels, ratios, and turnover rates – continuity of staff). In addition to staff qualities, the structural column of the Model also contains enabling and need factors, since these variables, along with staff characteristics, should be measured and controlled to allow for the precise evaluation of the impact of process of care variables on service user outcomes. The enabling factors that could influence service user satisfaction with heathcare services include social and financial support, the latter being regarded as an enabler, because it acts as a psychological barrier affecting satisfaction with care. Need characteristics refer to service users' state of health and their need for health care, as identified by their health care providers. This includes services that diminish the impact of hospitalization and the care received within it, such as the penal atmosphere (e.g. obstructed discharge from hospital, the lack of activities, and stringent ward rules); the monitoring of health status (physical, mental, social, and spiritual health); and the physical environment (e.g. comfort level, ward space, and cleanliness), which may predict service user outcomes. Further research is therefore required to validate the relationship between the Model's parameters for assessing mental healthcare quality. The qualitative data could, however, support the development of a revised model of the factors that appear to be relevant to the quality of mental health care provided in KSA, from the perspective of the service user and thus adopting a completely novel approach. Future studies could then be undertaken to obtain quantitative data for testing the revised Model (a potential model for quality mental health care in KSA).

The authors are not aware of previous similar studies exploring issues investigated here. Such studies in Arabic countries and cultures appear rare. The work of Frantz Fanon (1925–1961), psychiatrist, philosopher, and revolutionary, has relevance here. With Azoulay, Fanon (1954) studied the impact of social therapy in two wards in Blida Joinville Psychiatric Hospital in Algiers one of which composed Muslim men of Arabic origin. Established in the Francophile tradition and the Western 'Europeanness' psychiatric approaches of an inherently biomedical model resulting from such traditions, Fanon and Azoulay's attempt to introduce a westernized form of social therapy failed, due largely to it having overlooked the functional, cultural, and anthropological approaches, inherent in a system built upon theocratic and gerontocratic principles.

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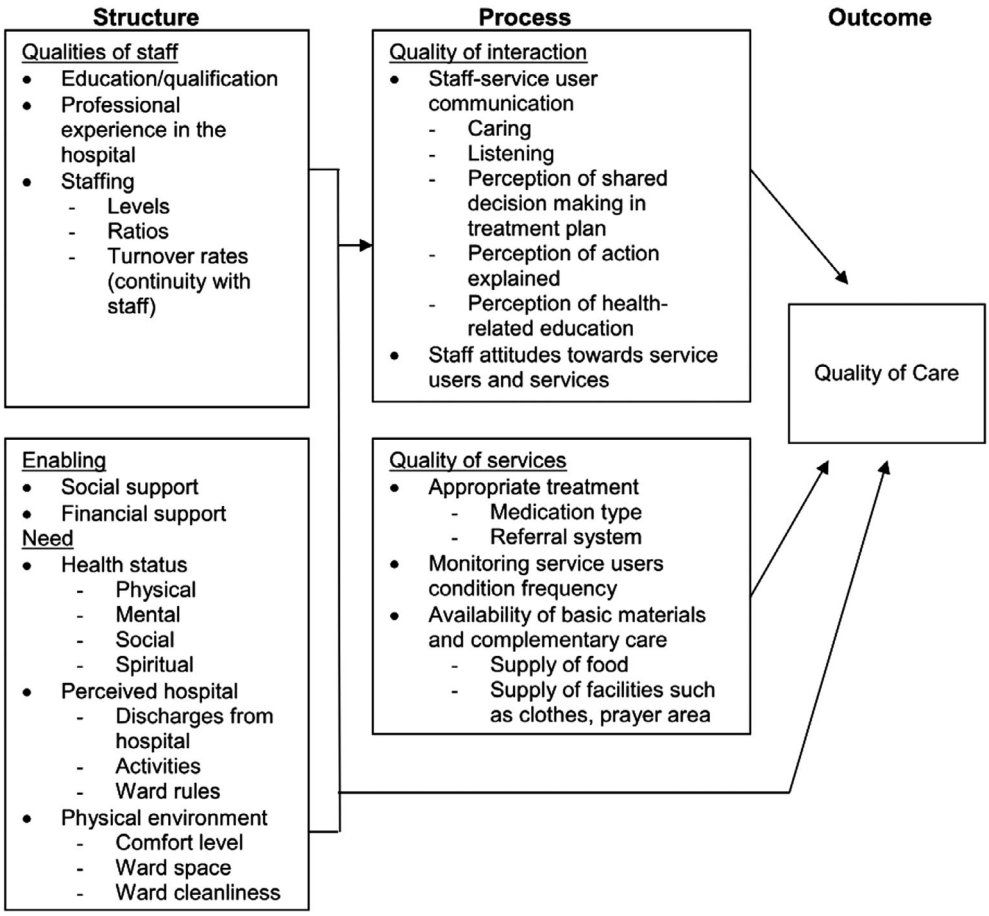

FIG. 1: *Conceptual model understanding issues central to the quality of mental health care in KSA.*

Arguably KSA is a modern metropolis that has assimilated much of westernized practices of psychiatry: medical assessment, diagnosing, and inherently medical treatments, in a system with a patient populace of upholding many of the theocracy and gerontocracy Fanon and Azoulay found in Algeria. In Fanon and Azoulay's own words, their 'attempts to assimilate 'westernized' social therapy was an anticipated failure, largely it seems as it blurred the 'cultural originality' and we argue the everyday cultural reality of the lives of people institutionalized people unable, or unwilling to accept the practices of the institution.

Still, 'failure' has its rewards as it led Fanon on a journey to develop more culturally appropriate forms of mental health care as well as significant contributions to the training of nursing staff delivering this care.

We share Fanon and Azoulay's sense of failure to some degree. In a large quantitative element of the study (paper in preparation), of which the qualitative results reported here are a significant part, we tested the Donabedian Model tripartite model of Quality Health Care, and found it has little validity in the KSA wards. The work reported here was an attempt to understand this and develop an alternative 'model' of QoC, that tried to capture the overlooked 'cultural originality' to which Fanon and Azoulay refer and the 'cultural reality' inherent here.

The experiences of some of our participants also speak to Goffman's (1961) 'mortification of the self' principle in that the degree of abuse reported appears to have degraded and humiliated these individuals. It seems unlikely, judging from the response of the authorities to whom we reported these incidents, that it was deliberate policy on the part of the institution concerned, contrary to what Goffman reported.

LIMITATIONS

The most obvious limitation is that the interview sample was recruited from only one psychiatric hospital in KSA. Thus, the results may be less transferable to

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healthcare facilities in other regions or facilities of varying size, although hospital capacity will not affect service users' level of comfort, if the ward capacity is equivalent. Neither will they necessarily be applicable to facilities that are essentially different, such as new buildings with rehabilitation centres and a yard connected to the wards. The availability of such facilities in a hospital could lead to the service users forming different perceptions of the quality of their mental healthcare provision.

CONCLUSION

Quality of mental health care in KSA is manifested by a therapeutic ethos with a high degree of interaction between professional carers and service users, with the former being highly educated, competent, compassionate, with a high degree of self-awareness, and specialized in mental health. We have uncovered elements of Fanon and Azoulay's 'Cultural Originality' as well as contemporary examples Goffman's mortification of the self.

IMPLICATIONS FOR PRACTICE AND/OR POLICY

Our findings provide theoretical insights regarding indicators of quality underlying the care received in KSA. The majority of their perceptions were negative, and this was revealed when they discussed specific aspects, regardless of their apparent satisfaction expressed in response to general and direct questions. The findings can act as a framework for development of an approach to QoC that improves outcomes in Saudi users of mental health services.

As the field of mental healthcare quality is of interest to the MOH in KSA, the policy implications associated with mental healthcare quality may have significant positive effects on outcomes for service users. Currently, the improvement of mental healthcare quality is on the agenda of the National Strategic Plan for improving and developing mental healthcare services in KSA (Al Habeeb & Qureshi 2010).

The findings also point to a need for richer and more nuanced education in ethics and service users' rights, pertinent to mental healthcare facilities. Education of this nature would promote positive relationships and ethical treatment in a healthy and humane environment, empowering service users and their families by protecting their human rights and providing a meaningful context for QoC.

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ETHICAL APPROVAL

University of Nottingham, Faculty of Medicine and Health Sciences Research Ethics Committee (Ref. OVS13022014 SoHS), and the Saudi General Directorate of Research and Studies – Ministry of Health and the Institutional Review Board at King Fahad Specialist Hospital – Dammam, KSA (Ref. MoH0170) granted ethical approval.

Note

[1] The researchers were sufficiently concerned to hear such reports and informed the management of the hospital that these issues had been raised, while protecting the anonymity of the service users.

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