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STIGMATIZING ATTITUDES TOWARDS MENTAL ILLNESS: IMPLICATIONS ON CLIENTS' FAMILIES

BY

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STATEMENT OF SOURCES

The idea of the present investigation and planning of the experiments resulted from discussions between the author and Dr Hector Tsang.

The present investigations were completed solely by the author.

The author declares that the work presented in this thesis is, to the best of the author's knowledge and belief, original, except as acknowledged in the text, and that the material has not been submitted, either in whole or in part, for a degree at this or any other University.

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ABSTRACT

Background: Previous research has shown that mental illness brought heavy burden to relatives of mental health consumers, and that stigmatization of mental illness hindered consumers' recovery. However, there was little information on the relationship between stigma and family burden. This study explored the possible links between stigmatization and the burden on consumers' relatives.

Methods: In Phase One of the study, a description of people's attitudes towards mental health consumers was obtained through a questionnaire survey, the respondents being 1007 friends and relatives of primary and secondary school students. In Phase Two, individual interviews were conducted with 10 family members of persons with mental illness, to seek their views and experience of stigma and burden. Results from the two phases of the study were compared and discussed in the context of mental health services in Hong Kong.

Results: Stigmatization of mental health consumers was evident in the community. Not only did stigma directly affect the social participation of consumers and families, but the marginalization reflected in social policies and mental health services also fostered isolation and dependence of consumers, leading to practical and emotional burden on their relatives.

Conclusions: Stigmatization increased the burden on relatives of mental health consumers. To combat stigma and adopt a proactive approach to rehabilitation are necessary measures to ease the burden on consumers' families.

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CHAPTER 1

INTRODUCTION

Mental illness causes serious impairment in different aspects of living, including employment, domestic duties, self-care and social activities, as clients' attention span, reasoning, comprehension and communication skills are compromised (American Psychiatric Association, 1994; Gelder, Mayou & Geddes, 1999). Because of the wide range of functions affected, there is much need for care and support from clients' families.

The demands and burden on relatives of mental health consumers have been well-documented (e.g. Fadden, Bebbington & Kuipers, 1987a; 1987b; Lefley, 1996). They include physical fatigue, financial difficulties, sacrifice of personal pursuits, frustration and anxiety. However, rather than helping these families, the public has contributed to prolonging clients' illness through stigmatization and discrimination (Harding, Zubin & Strauss, 1987). Stigmatizing attitudes towards mental health consumers have been reported in various studies (e.g. Chou & Mak, 1998; Yu, 1996), and discriminatory practices in housing, employment and social spheres have been found in different communities (Corrigan, 1998; Page, 1995).

Yet, despite the detailed accounts of family burden and stigmatizing attitudes, little discussion has been devoted to the relationship between them. Mechanic (1989) pointed out that values and attitudes influence the resource allocation among various needs of the society. When the public continues to adhere to the 'Just World Assumption' (Lerner, 1980) and blame the victims for their misfortune, such attitudes will affect policies regarding mental health care, services for families, and legislations against discrimination. At the same time, stereotyping of mental health consumers as violent or harmful to society fosters hostility towards them (Brunton, 1997). The alienation not only presents major barriers to clients' reintegration into the community, but also intensifies the practical and emotional burden on their relatives. Employers' discrimination of consumers directly increases the financial burden on families, and indirectly delays their social reintegration, thereby increasing the burden of care. Stigmatization of consumers' families leaves them socially isolated and intimidated from seeking help. Since these issues have important implications on the lives of many consumers and families, it should prove worthwhile to study the relationship between stigmatizing attitudes of the public and the burden on families of people with mental illness.

CHAPTER 2

LITERATURE REVIEW

2.1. MENTAL ILLNESS

2.1.1. Definition

No single definition of mental illness has been satisfactory to researchers and practitioners of different theoretical orientations. Whether the term 'mental illness' should be used is itself a subject of controversy, as some have argued that the term implies a disease model which is incapable of explaining deviant behaviors (Szasz, 2000). When the term *is* used, the scope of it is unclear: Should dementia, epilepsy and substance dependence be considered mental illness? Even the differentiation of mental disorders from physical disorders leads to the question of whether they are conditions of the mind or the body, a dualism that is received with reservation today (American Psychiatric Association, 1994).

The Encyclopaedia Britannica (1998) defined a mental disorder as "any illness with significant psychological or behavioral manifestations and that is associated with either a painful or distressing symptom or impairment in one or more important areas of functioning". This thesis adopts the definition of mental disorder in the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) which is widely used among clinicians and researchers in North America, Hong Kong and mainland China: "a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g., a painful symptom) or disability (i.e., impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom.... Whatever its original cause, it must currently be considered a manifestation of a behavioral, psychological, or biological dysfunction in the individual" (American Psychiatric Association, 1994, pp. xxi-xxii).

2.1.2. Significance

In Hong Kong, the Health and Welfare Bureau estimated that there would be 96,005 people with mental illness requiring psychiatric services in 2002 (Health and Welfare Bureau, 1999). Functional psychoses and organic psychoses were expected to account for 25.7% and 40.2% of the cases respectively, and 15.8% of the cases were expected to be child and adolescent psychiatric disorders. Chen (1995) estimated that the prevalence rate of mental illness in mainland China was approximately 11 per 1000 people in the 1980s. This number translates into a total of over 10 million people. The World Health Organisation (2000b) estimated that in 1999, 106,845,000 life years were lost to unipolar major depression, bipolar disorder, psychoses, post traumatic stress disorder, obsessive-compulsive disorder and panic disorder in WHO regions. Apart from decreasing life expectancy, mental illness causes much suffering and is very debilitating. People with mental illness frequently suffer impairments in cognitive functions such as reasoning and communication, and in daily activities such as working and sleeping (*DSM-IV*, 1994). Even more unfortunately, mental illness is often chronic and has early onset. According to the World Health Organisation International Consortium in Psychiatric Epidemiology (2000a), the median ages of onset were estimated to be 15 years and 26 years for anxiety disorders and mood disorders respectively. Because of the severity and chronicity of impairments, much efforts have been devoted to the study of mental illness and the development of effective interventions, to reduce suffering in those with mental illness and reduce dependence on social care.

2.1.3. Treatment

Due to the large number of theories about the causes of mental illness, e.g. social, biochemical, and neuropathological, different treatment approaches have been developed along these lines, including family therapy, electroconvulsive therapy and pharmacological therapy. In Hong Kong and most Asian societies, pharmacological therapy is the dominant mode of treatment. However, although psychiatric medications used today are mostly effective in controlling symptoms, they have serious side effects such as hypersomnia, abnormal facial gestures and tardiness of movement. For these side effects themselves often interfere with mental health consumers' living, many consumers show poor drug compliance, which can lead to relapse. Though medications with less side effects have been developed, public hospitals and clinics in Hong Kong still prescribe psychiatric medications developed in the 1950s and 60s to over 90% of the consumers, due to cost considerations.

Consumers with severe symptoms and those who are believed to be potentially dangerous to themselves or others may be hospitalized voluntarily or involuntarily. Following the deinstitutionalization movement, much more efforts have been put into community-based rehabilitation programs and day centers. Vocational rehabilitation and supported employment have received more attention than before (Secretary for Health and Welfare, 1995). Local researchers have developed training and psychoeducational programs, such as the pilot supported employment services of Kwai Chung Hospital (Wong et al., in press), the goal attainment program of Castle Peak Hospital (Ng & Tsang, 2000), and the vocational social skills training developed by Tsang and Pearson (2000) which has been shown effective in increasing employment rates among participants. However, due to a lack of resources and government support, vocational rehabilitation is not available to all, and supported employment services are only provided to a small number of consumers. Even less accessible are psychosocial interventions for family members of consumers, though such interventions have been found effective in facilitating rehabilitation (Dixon et al., 2001). Although mental health workers are aware of the benefits of involving families in the treatment process, and some have taken the initiative to provide services to families in their clinical settings, the provision of these services is very limited, driven mostly by spontaneity and benevolence, but constrained by the lack of manpower and funding.

2.2. ATTITUDES & STIGMA

2.2.1. Definitions

Attitude as a theoretical construct has been defined in many different ways. The definitions differed in their emphases on the different theoretical components of attitude, namely affect, behavior and cognition. Allport (1935) offered the definition "the degree of affect for or against an object or a value". English and English (1958) defined an attitude as "an enduring learned predisposition to behave in a consistent way toward a given class of objects", focusing on the operational aspect of attitudes.

Katz (1960) proposed a definition which emphasized cognition: “the predisposition of the individual to evaluate some symbol or object or aspect of his world in a favorable or unfavorable manner”. Later theorists defined attitudes using a combination of the affective, behavioral and cognitive aspects. Krech, Crutchfield and Ballachey (1962) offered the definition “an enduring system of positive or negative evaluations, emotional feelings, and pro or con action tendencies with respect to a social object”. Hilgard and Atkinson (1967) defined an attitude as “an orientation towards or away from some object, concept, or situation, and a readiness to respond in a predetermined manner to these, or related objects, concepts, or situations”. Triandis (1971) suggested the definition “an idea charged with emotion which predisposes a class of actions to a particular class of social situations”. For the purposes of this thesis, the definition offered by Shaw and Wright (1967) was adopted, which simplified the concept by framing affect and cognition as different types of behavior. An attitude was defined as “a relatively enduring system of affective, evaluative reactions based upon and reflecting the evaluative concepts or beliefs which have been learned about the characteristics of a social object or class of social objects”. Thus the action of “saying that one agrees with an evaluation” is a behavior interesting in itself, without assumptions about the tendencies to react or the structure of cognition.

Miles (1981) defined stigma as "a societal reaction which singles out certain attributes, evaluates them as undesirable and devalues the persons who possess them." Thara and Srinivasan (2000) similarly defined stigma as "social devaluation of a person because of personal attribute leading to an experience of sense of shame, disgrace and social isolation." Goffman (1964) considered physical deformity, abnormal behavior and race the first causes of stigma, which were later extended to broader and more subtle characteristics. It is widely recognized that stigmatizing attitudes exist towards mental illness. Kelly and McKenna (1997) pointed out that, although the more recent survey data such as those presented by Gould (1992) and Brockington et al. (1993) suggested positive attitudes in the community, the expressed attitudes were not mirrored by mental health consumers' experience. The majority of consumers in Kelly's (1997) study had experienced harassment or victimization. A study in Ireland (Murphy, Black & Duffy, 1993) found that 3% of the respondents would object to having ex-mental health consumers as neighbors, 18% would object to their closest of kin marrying a consumer, and 33% would object to having babysitters with a previous mental illness. As Gould (1992) suggested, people would accept mental health consumers in the community only if they were kept at a social distance. Chou, Mak, Chung and Ho (1996) reported that in Hong Kong, 40% of the people were reluctant to have mental health consumers live in their neighborhood. Fifty-five percent of their respondents believed that people with mental illness should remain in psychiatric hospitals before they have recovered completely. Following 976 telephone interviews in Hong Kong, Yu (1996) reported that 36.4% of the respondents believed that people with mental illness were violent; 11.1% of the respondents believed that mental illness was retribution for evil done by family members.

In Chinese societies, there is more stigmatization against relatives of mental health consumers, as Chinese culture attaches more importance to the collective representation of families, and having a mentally ill relative is considered something one should feel ashamed of, for it can imply an inferior origin of the family, failure of the parents, or even sin committed by ancestors (Hsu, 1995). Hence, many Chinese families have concealed their relatives' mental illness in order to avoid stigma. This results in social isolation, and limitation of emotional and practical resources important for dealing with the illness. Findings from a survey conducted among mental health professionals in Beijing also highlighted the significance of stigma in China. Nearly 80% of the respondents rated social stigma as a major problem faced by people with mental illness returning to the community (Tsang, Weng & Tam, 2000).

2.2.2. Social psychology of stigma

Corrigan (2000) pointed out that the attribution model of social psychology had important implications on the formation and maintenance of mental illness stigma.

Attribution is the process by which people infer causes of events and behaviors. Biased attribution of mishaps to the poor personal qualities of the victim is a common phenomenon. Mental illness stigma also represents a stereotype of mental health consumers, as people overgeneralize negative characteristics of some mental health consumers to all those who have mental illness (Corrigan, 1998).

The mass media have been considered as the culprit in the formation and maintenance of stigmatizing attitudes towards mental health consumers. In his study of media influence, Philo (1991) demonstrated that people's memory of the miners strike in the UK in 1984-85 was more consistent with media accounts than with the actual situation. He pointed out that it was very difficult to challenge the accounts made by the dominant media as alternative sources of information were not readily available. Indeed, dominant media are, by definition, what has the greatest influence on representations of people and events. When the public has little contact with mental health consumers, cinematic images of madness may remain unchallenged, which in turn prevents future contact. As Corrigan and Penn (1999) pointed out, contact with persons with mental illness is an effective way of dispelling psychiatric stigma; when stereotypes lead to contempt or fear which prevents contact, it is more difficult to change stigmatizing attitudes.

2.3. FAMILY BURDEN

2.3.1. Significance

The burden on the family having a member with mental illness is an important issue in psychiatric rehabilitation because it affects not only the lives of clients' families, but also the recovery of clients. As has been demonstrated by the classical research on the relationship between family environment and schizophrenic relapse, high expressed emotion (EE) in the family is predictive of greater chances of relapse (Brown, Monk, Carstairs & Wing, 1962; Brown, Birley & Wing, 1972). Defined in three key dimensions, i.e. criticism, hostility and emotional over-involvement, EE is essentially an indicator of the amount of stress at home. Research has shown that EE is associated with relatives' burden (Scazufca & Kuipers, 1998) . Given its impact on people with mental illness and their relatives, family burden and its consequences have received much research attention. For example, Fadden, Bebbington & Kuipers (1987a; 1987b) studied the burden on families of persons with affective disorders; Östman and Hansson (2000) compared the burden on parents, spouses and adult children of mental health consumers; Benazon and Coyne (2000) suggested that emotional disturbances experienced by spouses of people with depression were attributable to the burden of care.

2.3.2. Definitions

Caregiver burden has been defined as "the extent to which caregivers perceive their emotional or physical health, social life, and financial status as suffering as a result of caring for their relative" (Zarit, Todd & Zarit, 1986) (p. 261). This definition focuses on caregiver's experience of burden from their perspectives, and emphasizes the diversity of priorities and needs in different families. Hence in this thesis, family burden refers to the extent to which family members perceive their emotional or physical health, social life, and financial status as suffering as a result of the mental illness of a relative.

2.3.3. Background

Families of people with mental illness face a range of practical and emotional stresses. The financial burden brought by unemployment and medical expenses, the day-to-day work of caring and seeking treatment for the relative, changed relationships in the family, worries about the relative, frustration during the course of rehabilitation, and feelings of loss, anger and even guilt and shame are all salient sources of stress (Farina, Fisher & Fischer, 1992; Judge, 1994; Spaniol & Zipple, 1994).

Hoenig and Hamilton (1966) proposed a division of family burden into objective and subjective burden. Objective burden involves symptoms and behaviours of the person, and their consequences on different aspects of the social environment such as domestic routines, family relations, social relations, leisure, work, finances, and children and siblings (Schene, 1990). Subjective burden involves the illness' impact on the psychological and physical health of the caregivers. Anxiety and depression associated with caring for the relative are examples.

The objective burden of families of the mentally ill has been well documented. Gopinath and Chaturvedi (1992) reported problems in families about clients' poor personal hygiene, slowness, and non-performance of work or domestic duties. Fadden, Bebbington & Kuipers (1987) reported that spouses of persons with affective disorders had to supervise their ill partners like children. Responsibilities thus multiply for the client's family members (Judge, 1994). And as Lefley (1996) puts it,

> *Examples of objective burden go far beyond mere caregiving responsibilities. They include (a) the mentally ill person's economic dependency and inability to fulfill expected role functions, (b) disruption of household routines, (c) caregivers' investments of time and energy in help-seeking and negotiating the mental health system, (d) confusing and often humiliating interactions with service providers, (e) financial costs of the illness, (f) deprivation of needs of other family members, (g)*

> *curtailment of social activities, (h) impaired relations with the outside world, and (i) inability to find appropriate alternatives to hospitalization or facilities for residential placement outside the home.* (p.69)

The subjective burden of mental illness on family members is also profound. Feelings of stigmatization, worries and empathic suffering for the ill relative, and inability to attain personal goals are all difficult issues for the client's family (Lefley, 1996). Badger (1996) reported health problems and impaired overall functioning in family members of persons with depression. Many of these family members reported that they were so stressed to the point that they needed therapy themselves. Benazon and Coyne (2000) also reported emotional disturbance in spouses of depressed patients which was attributable to the burden of care.

In Hong Kong, the burden on relatives of mental health consumers is even heavier due to the high costs of living, crowded environment, stressful lifestyle, and limited social care. Leung (1994) found that only one in ten consumers received after-care. In Sun's (1994) study on families of persons with schizophrenia, half of the relatives considered that the support they received was inadequate. Half of the families in the sample showed deficiencies in family functioning. Because of the lack of halfway houses, most dischargees from psychiatric hospitals lived with their families. However, education and resources for relatives were scarce, and they were given the responsibility of looking after the consumer without being treated as partners in care. Many family members lacked information on how to deal with symptomatic behaviors, and it was difficult to find a professional who was knowledgeable about the consumers' treatment plan (Pearson & Tsang, under review). These reports indicated that the difficult conditions reported by the Department of Psychiatry of the University of Hong Kong (1987), where 80% of consumers' relatives experienced heavy subjective and objective burden, had persisted.

2.4. RELATIONSHIP BETWEEN STIGMA AND BURDEN

Stigma and prejudice against people with mental illness is arguably the most important source of stress for families of mental health consumers, because it exacerbates other difficulties (Lefley, 1996). For example, discrimination by employers adds to the financial burden of consumers' families. Negative public attitude towards mental health consumers and community psychiatric facilities has been reported in various studies conducted in different societies (e.g. Madianos, Economou, Hatjiandreou, Papageorgiou, & Rogakou, 1999). In Hong Kong, Chou and Mak (1998) reported that over 40% of the people were against the establishment of psychiatric rehabilitation facilities in the community. The results replicated the findings of Yu (1996) and Chou et al. (1996). In spite of the efforts of governments and voluntary organizations in education and advocacy, there continues to be stigmatization of mental health consumers and their families (e.g. Kuipers, Leff & Lam, 1992; Lefley, 1992). Such negative attitudes of the public have profound consequences. As Lefley (1996) pointed out, stigmatizing attitudes bring societal and iatrogenic stress to mental health consumers by devaluation of them and neglect of their needs. 'The massive underfunding of services and research and negative expectations of recovery clearly affect the resources available to caregivers.' (p.77) Also, accusations about the dysfunctional family causing the illness and prejudice by association lead to rejection and social isolation of consumers' families (Lefley, 1992; Kuipers et al., 1992). This is particularly true in Hong Kong, as in the Chinese culture, having a family member with mental illness may lead the whole family to be seen as inferior (Hsu, 1995).

Resource allocation is one of the most important aspects where public attitudes can influence the provision of treatment and other services to mental health consumers. As pointed out by Mechanic (1989), resources are always limited and priorities invariably depend on values. Attitudes and beliefs influence the resource allocation among various needs of the society, such as housing and mental health care, as well as the resource allocation among different forms of mental health services. Public policies regarding mental health services are shaped by concepts of mental health: how important it is, what problems are considered more severe and what needs are more urgent, etc. Different concepts of mental illness also lead to different approaches to diagnosis, treatment and care. Deinstitutionalization is the present trend in developed countries, for it is believed to facilitate consumers' social integration and rehabilitation. (Carling, 1995; Stein & Test, 1980) The decrease of funding for psychiatric hospitals and the consequent decrease of hospital services had great impact on the course of many consumers' illness. When deinstitutionalization is not accompanied by adequate increase in community care facilities, due to low levels of mental health concerns in the community or keen competition for resources in the locality, the recovery of consumers as well as the quality of living for their families will be affected (Lefley, 1992; 1996).

Another way in which negative public attitude can hinder tangible support (Orford, 1992) for mental health consumers is by directly obstructing the establishment of psychiatric care facilities in the community. In Hong Kong, protest rallies against the establishment of psychiatric rehabilitation facilities had been held in local communities (Cheung, 1990). In 1989, residents in Kwun Tong opposed strongly against the proposal to build a rehabilitation service center in the district. Under pressure, the authorities had to withhold the proposal. It was not until 1992 that grants were secured from the Lotteries Fund to construct the premises; in the same year, residents of Lam Tin protested against the relocation of a mental health day center into the area.

At the personal level, negative attitudes towards mental health consumers can also adversely affect their rehabilitation through negative social interactions such as rejection and avoidance. (Link, Cullen, Mirotznik & Struening, 1992) Stigmatization of mental health consumers has been seen by researchers as a phenomenon which 'diminishes its victims' and 'fosters feelings of self-devaluation and alienation' (Lefley, 1992), and therefore may intensify the illness (Harding, Zubin & Strauss, 1987).

Stigmatization of mental illness also discourages participation in treatment activities; given the negative effects of delaying intervention and poor treatment adherence on the course of many consumers' illness (Cramer & Rosenbeck, 1998; Corrigan, Liberman, & Engel, 1990), stigmatization indeed increases the burden on consumers' relatives. The social barriers put up against consumers and their families, leading to feelings of isolation and helplessness and also making it difficult for them to seek help with practical problems, affect their ability to cope with the illness and support the consumer (Lefley, 1992).

Though numerous studies on stigma and accounts of family burden exist in the literature, stigma has typically been framed as one of the factors contributing to the unemployment of mental health consumers and social isolation of their families, without further examination of the relationship between stigma and family burden. Given the influence that stigma can have on resource allocation and service delivery, it should be of interest to mental health workers and researchers to study in more dimensions the possible relationship between stigma and family burden.

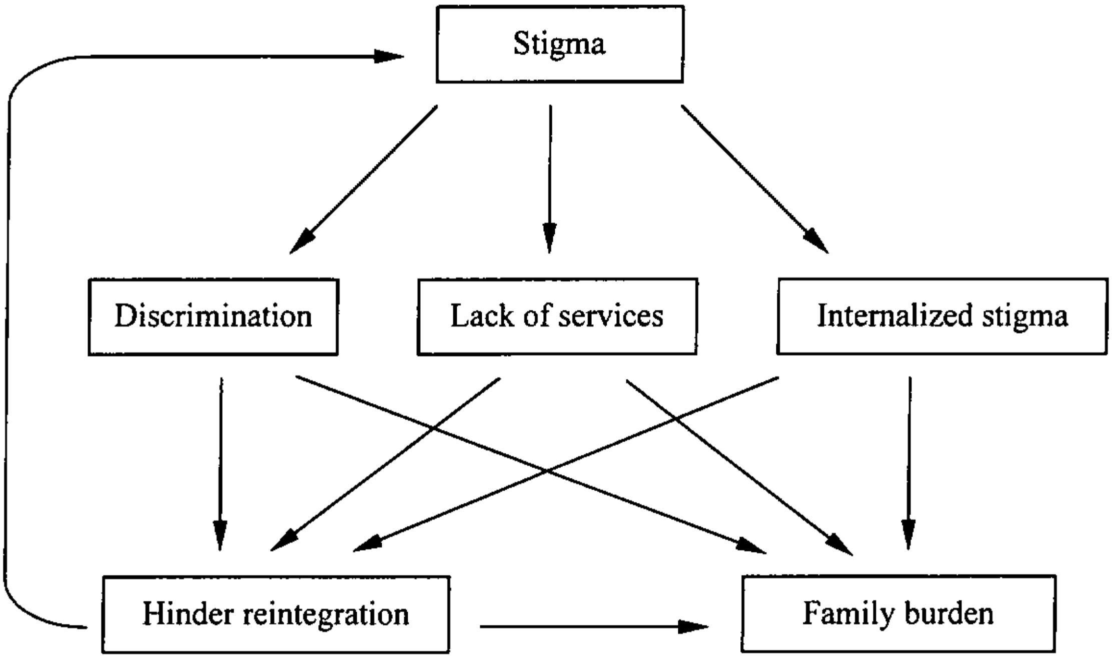

Figure 1. The influence of stigma on family burden.

Figure 1 summarizes how stigmatization of mental illness may affect the burden on families of mental health consumers. Stigma can lead to discrimination against consumers and their relatives in different spheres such as employment and social life. Stigmatization of consumers, negative expectations of recovery and indifference to their needs contribute to the lack of services for consumers and families. Self-stigmatization may occur in those individuals who are subjected to stigmatization and marginalization. Discrimination, lack of services and internalized stigma have direct impact on family burden, and they also increase the burden on relatives as they hinder the reintegration of consumers.

2.5. OBJECTIVE

This thesis set out to explore the relationship between stigmatizing attitudes of the public towards mental illness and the burden on relatives of mental health consumers. Specifically, this study aimed to seek an understanding of the following:

- Perceptions of and attitudes towards mental health consumers in Hong Kong
- The burden on families of mental health consumers in Hong Kong
- Families' experience of negative attitudes
- How the burden on families had been influenced by negative attitudes of the public

It was expected that:

- There was stigmatization of mental health consumers in Hong Kong

- Families of mental health consumers bore heavy subjective and objective burden
- Stigmatization experienced by families directly increased their burden
- Stigmatization at the societal level was reflected in social policies, thereby limiting the support available to consumers' families.

The study was conducted in two phases. In the first, a questionnaire survey tapped people's attitudes towards mental health consumers, such that those attitudes which might have an impact on consumers and families could be identified. Because of the cultural sensitivity requirement of this kind of attitude surveys, and the special emphasis of this study on issues that might affect consumers' families, a questionnaire was developed for this study. The questionnaire development, survey procedure and results are reported in Chapter 3.

In the second phase of the study, relatives of mental health consumers were interviewed on their experience of having a family member with mental illness. Analyses of the qualitative data were informed by results from the attitude survey. Issues raised by consumers' relatives were compared with people's attitudes expressed in the survey. Patterns of consistencies and inconsistencies were discussed, in exploration of possible relationships between public attitudes and family burden. This phase of the study is reported in Chapter 4.

CHAPTER 3

QUESTIONNAIRE SURVEY

3.1 RATIONALE OF METHODOLOGY

To explore the relationship between public attitudes and family burden, a description of both is necessary, before patterns could be identified and compared. The purpose of the questionnaire survey was to seek a better understanding of the perceptions and beliefs about persons with mental illness in Hong Kong.

The pencil-and-paper self-report format was chosen over telephone interviews and intercept interviews for three reasons. First, response rates of telephone and intercept interviews tended to be low in Hong Kong, usually under 40% for telephone interviews and even lower for intercept interviews, which did not only introduce a potential source of bias but also meant higher costs. Second, the anonymity offered by the pencil-and-paper format could serve to reduce social desirability bias. The third advantage was the minimization of interviewer effects (Schwarz & Sudman, 1996; Sudman, Bradburn & Schwarz, 1996).

Resources did not permit the collection of a true random sample of sufficient size from the entire population of Hong Kong. A cluster sample was collected through primary and secondary schools in different areas in Hong Kong, which was expected to include respondents from diverse backgrounds. As the study aimed at understanding the attitudes that existed in the community rather than finding the true proportion of people who held certain attitudes, the non-probability sample was adequate for the purposes of this study.

3.2 METHODOLOGY

3.2.1 Questionnaire Development

3.2.1.1 Generation of items

As there was no available questionnaire that addressed attitudes towards mental illness in relation to the burden on consumers' families, a questionnaire was devised to measure public attitudes towards mental illness with special reference to issues which affect the burden on consumers' families. To gather items, a review of existing scales for measuring attitudes towards people with disabilities, including the Opinions About Mental Illness Scale (OMI) (Cohen & Struening, 1962) and the Attitude Toward Disabled Persons Scale (ATDP) (Yuker, Block & Campbell, 1960), was conducted. The literature on attitudes and family burden also suggested additional items. For example, the item '*Psychiatric rehabilitation facilities should be far from the community*' was adopted from Chou et al. (1996). Link et al (1987) found that perceived dangerousness was an important component of the stigma against people with mental illness; thus an item stating '*People with mental illness are mostly violent*' was included to test whether negative attitudes were associated with perceptions of danger. Then five mental health workers (including one psychologist, one social worker, one researcher, and two occupational therapists in different settings) and three people with mental illness were interviewed by the present author and invited to suggest new items. The open-ended interview guide in Chinese and its English translation are included in Appendix 1. To ensure a comprehensive list of items, five lay people were invited to talk about their perceptions of people who had been mentally ill.

The literature review and interviews generated a list of items which covered respondents' beliefs about mental illness, impressions of mental health consumers, willingness to interact with them, and attitudes towards helping them. Repetitive items were then deleted from the list. The remaining items were translated (English-Chinese for items originally in English, and vice versa for items originally in Chinese) and back-translated by another translator to verify that the Chinese and English versions of the items were equivalent. An expert panel of 10 mental health workers (one psychiatric nurse, two occupational therapists, two clinical psychologists, three social workers and two mental health researchers) then examined the list and commented on the relevance of each item. The Chinese and English versions of the evaluation form are in Appendix 2.

A content validity ratio (CVR) was calculated for each item using Lawshe's (1975) method. Of the 39 items, 33 had CVRs of 1 (i.e. considered valid by all panel members) and 6 had CVRs of .80 (i.e. considered valid by nine out of ten members). Since all items had CVRs above the criterion .62, they were adopted in the pilot questionnaire.

A five-point Likert-type scale from "strongly agree" to "strongly disagree" was used on items pertaining to attitudes, such as "*I am in favor of increasing funding for psychiatric rehabilitation services*" and "*Elderly homes should not take in elderly people who have been mentally ill*"; a neutral option was allowed. However, a four-point scale without a neutral option was used on items such as "*As an employer, I would screen out job applicants who have been mentally ill without interviewing them.*" The options provided were "definitely", "probably", "probably not" and "definitely not". This was arranged because respondents might be prone to avoid making a decision when presented with sensitive statements.

At the end of the questionnaire there was a section seeking demographic information of participants. The information sought included sex, age, occupation, education level and monthly income of participants.

3.2.1.2 Pilot study

A pilot study was then conducted at a local secondary school chosen by convenience. Eighty first-form and fourth-form students (equivalent to American Grade 7 and Grade 10) were asked to either complete the questionnaires themselves or ask a relative or acquaintance aged 16 or above to complete it. Fifty-nine completed questionnaires were returned, constituting a response rate of 75%. Responses made to similar items (e.g. '*Those who had been mentally ill are dangerous no matter what*' and '*I think people who have recovered from a mental illness are.... dangerous*') were checked for consistency, i.e. it was checked whether the same respondent who endorsed "strongly agree" or "agree" to the first question also responded to the second in the same direction. Similarly, those who gave a positive response to "*If one of my friends became mentally ill, I would show my concern and help him/her as much as I can*" were also expected to respond positively to "*I can make friends with people who have recovered from a mental illness.*" The high consistency showed that respondents have understood the questionnaire, and that the different wordings in the questionnaire had little effect on responses. Based on the results, items with very high correlations (>.9) were either deleted or combined. The questionnaire was thus shortened to 35 items. The new form was validated using a think-aloud procedure with two volunteers in two separate sessions. The items were interpreted as intended. The final questionnaire and its English translation are in Appendix 3.

3.2.1.3 Level of Contact Sub-scale

To control for the effect of previous contact with mental health consumers, the ordinal contact scale developed by Holmes et al. (1999), with which ordinal contact scores from 1 to 12 could be assigned to reflect respondents' different levels of contact with mental health consumers, was translated and adapted. The 12 items in the original scale (see Table 1 for English version and Appendix 4 for Chinese translation) were translated, back-translated, and both the Chinese and English versions were examined by 11 mental health workers (two psychiatrists, three social workers, four occupational therapists, one psychologist and one researcher) for ranking and comments. Some items were considered repetitive ("*My job involves providing services/treatment for persons with a severe mental illness*" and "*My job includes providing services to persons with a severe mental illness.*") Some items were clear statements on their own but unhelpful for differentiating between people who had frequent contact with mental health consumers and people who did not. For example, "*I have a relative who has a severe mental illness*" and "*A friend of the family has a severe mental illness*" gave no indication of the frequency of contact. These items were then rewritten (see Table 2 for English version and Appendix 5 for Chinese version). The revised scale was pilot-tested with a convenient sample of 20 lay respondents and 5 mental health workers, known to the researcher's friends or colleagues. Respondents were aged between 22 and 58; seven of them were educated to secondary level and eighteen had post-secondary education. The respondents interpreted the items as the researcher had intended. Items were re-arranged to minimize memory effect on a retest two weeks afterwards. Test-retest reliability was .95. The sub-scale was then incorporated into the main questionnaire.

Table 1. The original Level of Contact Scale by Holmes et al. (1999).

Item	Score
I have a severe mental illness.	12
I live with a person who has a severe mental illness.	11
I have a relative who has a severe mental illness.	10
A friend of the family has a severe mental illness.	9
My job involves providing services/treatment for persons with a severe mental illness.	8
My job includes providing services to persons with a severe mental illness.	7
I have worked with a person who had a severe mental illness at my place of employment.	6
I have observed persons with a severe mental illness on a frequent basis.	5
I have watched a documentary on the television about severe mental illness.	4
I have watched a movie or television show in which a character depicted a person with mental illness.	3
I have observed, in passing, a person I believe may have had a severe mental illness.	2
I have never observed a person that I was aware had a severe mental illness.	1

Table 2. Revised level of contact scale.

Item	**Score**
I have had a mental illness.	8
I have lived with someone with a mental illness.	7
I have frequent contact with a friend or relative who has a mental illness.	6
It is my main duty to provide service to people with mental illness.	5
I often encounter people with mental illness (at least twice a month).	4
I encounter people with mental illness occasionally.	3
I have observed, in passing, someone who might have a mental illness.	2
I have seen realistic portrayals of people with mental illness in newspapers, magazines, films or TV programs.	1
None of the above is true.	0

3.2.2 Procedure

3.2.2.1 Participants

Participants were recruited through three primary and four secondary schools in Hong Kong. Sixty secondary schools and sixty primary schools drawn randomly had been contacted before principals' approval for data collection was granted at the seven schools. At each participating school, two to four classes were drawn at random. Each student was given a copy of the questionnaire and cover letter (see Appendix 6) and asked to invite a friend or relative aged 16 or above to complete the questionnaire.

Of the 1360 questionnaires distributed, 1007 validly completed questionnaires were returned. The response rate was 74%. Table 3 presents the characteristics of the sample. People aged 25 or below accounted for 29.4% of the sample; 48.5% were aged 26 to 45; 13.0% were over 46. Those with primary education or below made up 16.1% of the sample; 59.4% were educated to secondary level; 15.6% had post-secondary education or above.

3.2.2.2 Data collection

Each questionnaire was accompanied by a cover letter which explained the purpose of the survey and stated that participation was voluntary and anonymous. Instructions for completing and returning the questionnaire were printed on the first page of the four-page questionnaire, which was printed on both sides of folded A3-size paper. Questionnaires were self-administered and were collected in classrooms one week after distribution.

3.2.2.3 Data analyses

Statistical analyses were conducted using SPSS versions 9.0 and 10.0. Items 1, 4, 5, 6, 9, 11, 12, 13, 16, 17, 18, 22, 24, 25, 27 and 28 were coded in reverse. Frequency statistics were first computed. The categories "strongly agree" and "agree" were combined and so were the categories "strongly disagree" and "disagree", due to the small percentages of endorsement to the extreme options. Percentages of positive, negative and neutral responses were calculated for each item. An exploratory factor analysis (EFA) was then conducted to identify major factors in respondents' attitudes towards mental illness. Chi-square and correlation statistics were obtained between factors extracted as well as between factors and demographic variables.

To test whether the amount of contact with mental health consumers had an effect on respondents' attitudes towards them, Kendall's tau_b correlation coefficients were calculated between the attitude factors and the contact scores. Whether knowledge about mental illness had an effect on attitudes was tested similarly. A knowledge score was first computed for each respondent by counting the number of 'correct' answers out of eight items. Kendall's tau_b correlations between the knowledge score and the attitude factors were calculated. The effect of demographic variables on attitudes and knowledge was tested with one-way ANOVA procedures. Chi-square tests were performed between each of the attitude factors and exposure to formal channels, i.e. education at school, promotion by public organizations, talks and seminars, cultural activities and web pages.

Table 3. Sample characteristics (N=1007)

Sex		
Male	36.7%	(370)
Female	58.0%	(584)
Age		
16-25	29.4%	(296)
26-35	5.2%	(52)
36-45	43.3%	(436)
46-55	12.0%	(121)
Over 55	1.0%	(10)
Education		
Primary or below	16.1%	(162)
Secondary	59.4%	(598)
Post-secondary	8.5%	(86)
Tertiary	7.1%	(71)
Occupation		
Managers and administrators	3.6%	(36)
Professionals	2.6%	(26)
Associate professionals	3.7%	(37)
Clerical workers	6.1%	(61)
Service workers	3.3%	(33)
Craft workers	5.2%	(52)
Plant and machine operators	3.7%	(37)
Elementary occupations	2.9%	(29)
Students	29.1%	(293)
Home-makers	24.0%	(242)

Table 4. Attitudes towards people with mental illness and their relatives. (N=1007)

Item	Agree	Disagree	Undecided
1. Elderly homes should not take in old people who have been mentally ill.*	27.6% (278)	46.2% (465)	26.2% (264)
2. Discrimination and alienation against psychiatric patients can affect their recovery.	83.8% (844)	5.5% (55)	10.7% (108)
3. Modern drugs can keep psychiatric conditions under control.	48.4% (487)	12.8% (129)	38.6% (389)
4. The majority of psychiatric patients became ill because of their parents' wrong approaches to bringing up children.*	12.2% (123)	66.6% (671)	21.2% (213)
5. Only severely deranged people would need to take psychiatric drugs.*	22.0% (222)	57.4% (578)	20.5% (206)
6. Counselling is only for those who have severe mental problems.*	24.4% (246)	61.0% (614)	14.4% (145)
7. I am in favour of increasing funding for psychiatric rehabilitation services.	68.4% (689)	5.3% (53)	26.2% (264)

8. I am in favour of allotting more resources to provide more support for family members of people with mental illness.	61.8% (622)	7.5% (76)	30.6% (308)
9. Property owners should not be blamed for refusal to lease properties to people with mental illness.*	36.4% (367)	32.0% (322)	31.6% (318)
10. In Hong Kong, people who have been mentally ill are treated unfairly.	53.1% (535)	16.4% (165)	30.4% (306)
11. If there has never been any case of mental illness in the family, no family member would become mentally ill in future.*	10.0% (101)	70.0% (705)	20.0% (201)
12. I do not know how to get along with people who have been mentally ill.*	48.8% (491)	16.2% (163)	34.3% (345)
13. I do not want to work with people who have been mentally ill.*	14.1% (142)	41.1% (414)	44.8% (451)
14. Regarding cases of offence that involve psychiatric patients, I think the portrayals in newspapers are exaggerated.	50.1% (505)	12.0% (121)	36.9% (372)
15. Given appropriate assistance, people with mental illness may lead a normal life again.	83.3% (839)	4.0% (40)	12.4% (125)

16. It is more important to help those with a physical handicap than those with a mental illness.*	22.1% (223)	39.7% (400)	37.9% (382)
17. People who have been mentally ill are dangerous no matter what.*	28.9% (291)	36.4% (367)	34.6% (348)
18. Psychiatric rehabilitation facilities should be located away from people's residence.*	19.3% (194)	40.1% (404)	39.4% (397)
19. I consider it unacceptable to subject people with mental illness to alienation.	61.0% (614)	11.7% (118)	26.6% (268)
20. The government is not paying enough attention to the welfare and rights of people with mental illness.	48.2% (485)	10.4% (105)	41.2% (415)
21. Among ex-mental patients in employment, there are many successful examples with high levels of performance.	71.7% (722)	3.7% (37)	24.4% (246)
22. Children of psychiatric patients should not be hired in positions where guns may be used, even if they have never had mental illness themselves.*	18.8% (189)	44.2% (445)	36.8% (371)
23. If a family member said he/she was very depressed, I would suggest him/her see a counsellor.	87.6% (882)	11.8% (119)	N/A

24. If the government or other organizations propose to set up halfway houses near my home, I will oppose strongly.*	29.2% (294)	69.8% (703)	N/A
25. If a new neighbour was mentally ill, I would try to avoid his/her family.*	18.8% (189)	80.2% (808)	N/A
26. If a newcomer to my workplace had been mentally ill, I would try to help him/her adapt to the job.	86.6% (872)	12.5% (126)	N/A
27. If the person sitting next to me on public transport keeps muttering to himself/herself, I will leave my seat.*	50.3% (507)	48.8% (491)	N/A
28. As an employer, I would screen out job applicants who have been mentally ill without interviewing them.*	22.6% (228)	76.1% (766)	N/A

*Items marked with an asterisk are statements to which people with better knowledge / more positive attitudes should disagree.

Table 5. Mean ratings of each item. 1=strongly agree, 3=undecided, 5=strongly disagree.

Item no. and content		Mean	sd
1	Elderly homes should not take in seniors who had been mentally ill	3.26	1.06
2	Discrimination and alienation can affect recovery	1.93	0.85
3	Modern drugs can keep psychiatric conditions under control	2.61	0.84
4	Most MI caused by parents' wrong approaches to bringing up children	3.65	0.91
5	Only severely deranged people would need to take psychiatric drugs	3.41	1.04
6	Counseling is only for those with severe mental problems	3.43	1.14
7	In favor of increasing funding for psychiatric rehabilitation services	2.20	0.85
8	In favor of allotting more resources to provide more support for families	2.31	0.87
9	Property owners not to be blamed for refusal to lease	3.00	1.04
10	People with MI treated unfairly in Hong Kong	2.57	0.91
11	Family members will not acquire MI if no MI had occurred in family	3.71	0.86
12	Don't know how to get along with people with MI	2.63	0.85
13	Don't want to work with people who have had MI	3.30	0.83
14	Newspaper portrayals regarding cases of offence are exaggerated	2.54	0.85
15	Given appropriate assistance, people with MI may lead a normal life again	2.00	0.76
16	Helping those with physical handicap is more important	3.17	0.94
17	People who have been mentally ill are dangerous no matter what	3.09	0.94
18	Rehabilitation facilities should be far away from people's residence	3.24	0.92
19	Alienation of people with MI is unacceptable	2.44	0.93
20	Government not paying enough attention to their welfare and rights	2.55	0.84
21	There are many successful examples among employed ex-patients	2.21	0.74
22	Children of mental health consumers should not be employed in armed forces	3.32	0.97
23	If family member was depressed, would suggest seeing a counselor	1.97	0.96
24	Will oppose strongly to establishment of halfway house near own home	3.45	1.17
25	If new neighbor had MI, would avoid the family	3.76	1.05
26	Would help newcomer to workplace with previous MI	2.06	0.96
27	Would leave seat on public transport if passenger muttered to oneself	2.94	1.30
28	Would screen out job applicant with previous MI without interview	3.68	1.12

3.3 RESULTS

3.3.1 Descriptive Statistics

Table 4 presents the numbers and percentages of responses to Items 1 to 28. Very high proportions of participants were aware that '*Discrimination and alienation against people with mental illness can affect their recovery*' (Item 2, 83.8%) and that '*Given appropriate assistance, people with mental illness may lead a normal life again*' (Item 15, 83.3%). There was also much support for increasing funding for psychiatric rehabilitation services (Item 7, 68.4%) and providing more support for family members of people with mental illness (Item 8, 61.8%). However, 48.8% of the participants expressed that they did not know how to get along with people who had been mentally ill (Item 12) and 22.6% would screen out job applicants with previous mental illness without interviewing them (Item 28). Also, 27.6% of the participants believed that '*Elderly homes should not take in seniors who have been mentally ill*' (Item 1) and 36.4% considered it acceptable for property owners to reject potential tenants with mental illness (Item 9).

The mean scores and standard deviations for each item are presented in Table 5. Items with the lowest means were Item 2 ('*Discrimination and alienation can affect recovery*', mean 1.93 i.e. *agree*, sd 0.85), Item 23 ('*If a family member was depressed, I would suggest him/her to see a counselor*', mean 1.97 i.e. *agree*, sd 0.96), and Item 15 ('*Given appropriate assistance, people with mental illness may lead a normal life again*', mean 2.00 i.e. *agree*, sd 0.96). Items with the highest means were Item 25 ('*If a new neighbor had mental illness, I would avoid the family*', mean 3.76 i.e. *disagree*, sd 1.05) and Item 11 ('*Family members will not acquire mental illness if no mental illness had occurred in the family*', mean 3.71 i.e. *disagree*, sd 0.86). The pattern of responses revealed by the means and standard deviations was consistent with that shown by the frequency measures. As frequency measures were better able to reflect the actual responses of participants, it was treated as the primary measure.

3.3.2 Exploratory Factor Analysis

3.3.2.1. Exploratory factor analysis of Items 1-28

An exploratory factor analysis was conducted and 8 factors with eigenvalues over 1.0 were extracted. Items belonging to each factor were identified using Varimax rotation with Kaiser normalization. (See Tables 6 and 7) The factors identified accounted for 50.6% of the total variance.

Factor 1 consisted of Item 24 (‘*If the government or other organizations propose to set up halfway houses near my home, I will oppose strongly*’), Item 25 (‘*If a new neighbour was mentally ill, I would try to avoid his/her family*’), Item 28 (‘*As an employer, I would screen out job applicants who have been mentally ill without interviewing them*’), Item 13 (‘*I do not want to work with people who have been mentally ill*’), Item 17 (‘*People who have been mentally ill are dangerous no matter what*’) and Item 18 (‘*Psychiatric rehabilitation facilities should be located away from people's residence*’). Endorsement to this factor reflected *hostility* towards mental health consumers and support for *segregation.* The alpha coefficient for this factor was .76, and the mean and standard deviation were 3.42 and 0.68 respectively. This factor explained 16.0% of the total variance.

Factor 2 included Item 5 (‘*Only severely deranged people would need to take psychiatric drugs*’) and Item 6 (‘*Counselling is only for those who have severe mental problems*’). This factor represented the negative perception that those who

Table 6. Factor analysis on Items 1 to 28.

	Initial Eigenvalues			Extraction Sums of Squared Loadings	Percentage Variance Explained	
Component	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %
1	4.486	16.023	16.023	4.486	16.023	16.023
2	2.325	8.305	24.328	2.325	8.305	24.328
3	1.835	6.555	30.883	1.835	6.555	30.883
4	1.259	4.495	35.377	1.259	4.495	35.377
5	1.121	4.003	39.380	1.121	4.003	39.380
6	1.064	3.801	43.181	1.064	3.801	43.181
7	1.046	3.737	46.918	1.046	3.737	46.918
8	1.022	3.649	50.567	1.022	3.649	50.567
9	.949	3.390	53.957			
10	.915	3.267	57.224			
11	.861	3.074	60.298			
12	.831	2.968	63.265			
13	.823	2.938	66.204			
14	.797	2.847	69.051			
15	.771	2.754	71.805			
16	.741	2.646	74.451			
17	.726	2.594	77.045			
18	.706	2.521	79.566			
19	.692	2.472	82.038			
20	.681	2.430	84.468			
21	.651	2.326	86.795			
22	.614	2.192	88.987			
23	.606	2.163	91.150			
24	.568	2.027	93.177			
25	.531	1.897	95.074			
26	.514	1.836	96.909			
27	.458	1.636	98.546			
28	.407	1.454	100.000			

Extraction Method: Principal Component Analysis.

Table 7. Rotated component matrix for Items 1 to 28.

Item	Factor							
	Hostility	Aberrant	Openness	Resources	Acceptance	Rights	Misgivings	Accommodation
24 Oppose strongly to halfway house near home	**.642**	.134	.033	-.077	-.004	-.072	-.086	.077
25 If new neighbor had MI, would avoid the family	**.623**	.048	-.139	-.019	-.285	.027	-.045	-.082
18 Rehab facilities far away from residences	**.615**	.056	-.242	-.103	.173	-.113	.257	.116
28 Screen out job applicant without interview	**.607**	.120	-.040	.015	-.300	-.045	-.065	.039
17 Ex-consumers dangerous	**.548**	-.008	-.064	-.145	.145	.022	.312	.178
13 Don't want to work with ex-consumer	**.528**	.054	-.198	-.016	-.180	-.009	.423	.078
27 Leave seat if fellow passenger act strangely	.484	-.007	.189	-.049	-.033	-.091	-.237	.359
6 Counseling only for severe mental problems	.001	**.792**	-.022	-.024	-.083	-.075	-.032	-.038
5 Medications only for severely deranged	.057	**.756**	-.048	-.022	.025	-.047	.023	.031
11 Kin will not have MI if none occurred in family	.113	.461	-.353	.093	-.111	-.078	-.184	.107
16 Helping physical handicap more important	.371	.433	.109	.050	-.229	-.019	.158	-.177
4 Most MI due to faulty child-rearing	.083	.381	-.312	.010	-.061	.299	-.193	.161
22 Consumers' children not serve in armed forces	.257	.334	-.059	-.106	.066	.119	.118	.095
23 Suggest counseling if relative depressed	.113	-.093	**.692**	.145	-.046	.115	-.173	.060
26 Would help newcomer to workplace	-.233	-.090	**.586**	.076	.105	.091	.112	.093
15 May lead normal life given appropriate help	-.107	-.026	.420	.168	.416	.042	.227	-.138
7 More funding for psychiatric rehabilitation	-.082	-.047	.162	**.795**	.080	.122	.116	-.094
8 In favor of more support for families	-.157	-.010	.112	**.744**	.054	.250	.053	.021
19 Alienation unacceptable	-.099	-.110	.033	.002	**.618**	.261	-.101	-.065
21 Some ex-consumers successful at work	-.181	.026	.459	.096	**.504**	.104	.021	-.104
3 Modern drugs can control	.040	.068	-.055	.461	.478	-.188	-.272	.078
2 Discrimination can affect recovery	-.066	-.249	.091	.222	.371	.283	.277	.073
10 Treated unfairly in Hong Kong	.011	.028	.040	.002	.014	**.787**	.000	-.041
20 Government not enough attention	-.051	-.043	.212	.214	.101	**.575**	-.009	.030
14 Newspaper portrayals exaggerated	-.132	-.073	.015	.141	.268	.458	.109	-.075
12 Don't know how to get along with	.054	-.009	.065	.099	-.034	.037	**.697**	.132
1 Elderly homes should not take in	.047	.059	-.077	-.025	-.101	.023	.057	**.796**
9 Property owners' rejection acceptable	.254	.005	.138	-.003	.026	-.088	.295	**.550**

Extraction Method: Principal Component Analysis. Rotation Method: Varimax with Kaiser Normalization. Rotation converged in 22 iterations.

sought mental health services were *aberrant*; 8.3% of the variance was accounted for by this factor. This factor had an alpha coefficient of .64, a mean score of 3.42 and a standard deviation of 0.94.

Factor 3 was made up of Item 23 ('*If a family member said he/she was very depressed, I would suggest him/her see a counsellor*'), and Item 26 ('*If a newcomer to my workplace had been mentally ill, I would try to help him/her adapt to the job*'). This factor reflected an *openness* towards mental illness as a treatable condition; 6.6% of the total variance could be explained by this factor. The alpha coefficient of this factor was .39; the mean and standard deviation were 2.01 and 0.76 respectively.

Factor 4 comprised Item 7 ('*I am in favor of increasing funding for psychiatric rehabilitation services*') and Item 8 ('*I am in favor of allotting more resources to provide more support for family members of people with mental illness*'). Endorsement to this factor indicated respondents' support for the government to provide more *resources and services* for mental health consumers and families. This factor, with an alpha coefficient of .75, accounted for 4.5% of the total variance. The mean score for this factor was 2.25, and the standard deviation was 0.77.

Item 19 ('*I consider it unacceptable to subject people with mental illness to alienation*') and Item 21 ('*Among ex-mental patients in employment, there are many successful examples with high levels of performance*') constituted Factor 5, which reflected positive *acceptance* of mental health consumers in the community. This factor had an alpha coefficient of .44, and explained 4% of the total variance. The mean score and standard deviation were 2.33 and 0.67 respectively.

Factor 6 comprised Item 10 ('*In Hong Kong, people who have been mentally ill are treated unfairly*') and Item 20 ('*The government is not paying enough attention to the welfare and rights of people with mental illness*'). This factor indicated respondents' concern about the *rights* of mental health consumers. This factor had an alpha coefficient of .53, a mean of 2.56, and a standard deviation of 1.04. It accounted for 3.8% of the variance.

Factor 7 consisted of Item 12 ('*I do not know how to get along with people who have been mentally ill*'), reflecting *misgivings* over interacting with mental health consumers. This factor had a mean score of 2.63 and a standard deviation of 0.85 and explained 3.7% of the variance.

Factor 8 was made up of Item 1 ('*Elderly homes should not take in old people who have been mentally ill*') and Item 9 ('*Property owners should not be blamed for refusal to lease properties to people with mental illness*'), indicating *rejection* of mental health consumers from *accommodations*. This factor had an alpha of .45 and accounted for 3.6% of the total variance. The mean score was 3.13, with a standard deviation of 0.84.

As the exploratory analysis aimed at the identification of issues and concerns that might have affected respondents' attitudes towards mental health consumers, rather than finding the statistically optimal number of factors, Factors 6, 7, and 8 were retained despite their low percentages of variance accounted for, allowing more correlations and comparisons to be made in subsequent analyses.

Table 8 presents the frequencies of positive responses ('agree' or 'yes') to each of these factors. A positive response to any factor means one or more positive responses to items belonging to that factor. *Hostility and segregation* (Factor 1) was endorsed by 58.1% of the respondents (n=585), while 34.8% had the view that people who sought mental health services were *aberrant* (Factor 2). Fifty percent of the respondents (n=503) would *reject* mental health consumers from 'normal'

Table 8. Endorsement rates to each component (N=1007).

Component	*n*	% of total
1 Hostility and segregation	585	58.1%
2 Service recipients as aberrant	350	34.8%
3 Openness towards mental illness	959	95.2%
4 More resources and services	768	76.3%
5 Acceptance in community	832	82.6%
6 Rights of mental health consumers	680	67.5%
7 Misgivings about interactions	491	48.8%
8 Rejection from accommodation	503	50.0%

Table 9. Alpha coefficient of each factor.

Factor	Alpha
1 Hostility and segregation	.76
2 Service recipients as aberrant	.62
3 Openness towards mental illness	.45
4 More resources and services	.75
5 Acceptance in community	.45
6 Rights of mental health consumers	.53
7 Misgivings about interactions	-
8 Rejection from accommodation	.45

Factor 7 consisted of only one item.

accommodations (Factor 8); 48.8% (n=491) expressed *misgivings* about interacting with consumers (Factor 7). Negative attitudes are evident although 76.3% of respondents (n=768) agreed that the government should provide more *resources and services* to consumers and families (Factor 4), and 67.5% (n=680) were concerned about the *rights and welfare* of people with mental illness (Factor 6). An attitude of *openness* towards mental illness (Factor 3) was displayed by 95.2% of respondents (n=959), and 82.6% (832) showed positive *acceptance* of mental health consumers in the community (Factor 5).

3.3.2.2. Exploratory factor analysis of descriptions in Item 31

The numbers and percentages of respondents endorsing each of the descriptions in Item 31 are shown in Table 10. An exploratory factor analysis was conducted on the descriptions provided. Five significant factors with absolute values of rotated factors over 0.5 were extracted, which covered 51.9% of the total variance (see Tables 11 and 12). Factor 1 consisted of the descriptions "honest", "diligent", "friendly", "polite", "obey rules" and "responsible", giving the impression of ex-mental health consumers as *respectable* personalities. This factor had an alpha value of .83. Factor 2 consisted of the descriptions "fearful", "dirty", "clumsy" and "cannot integrate into society", implying ex-consumers to be *inferior*; the alpha coefficient of this factor was .61. Factor 3 comprised the stems "introverted", "have low self-esteem", "timid" and "shy", conveying the image of being ex-consumers being *weak*. The alpha value of this factor was .63. Factor 4 comprised "quick-tempered", "unpredictable" and "violent", implying ex-consumers to be *dangerous*; the alpha value was .64. Factor 5 included the descriptions "able to control oneself",

Table 10. Impressions of people who had been mentally ill

Item	**Endorsement rate**	**(Number)**
Introverted	51.1%	515
Have low self-esteem	46.7%	470
Quick-tempered	46.6%	469
Unpredictable	38.7%	390
May contribute to society	37.8%	381
Timid	30.4%	306
Shy	29.4%	296
Not different from others	29.3%	295
Friendly	25.0%	252
Have a tendency to violence	24.1%	243
Hard-working	23.9%	241
Honest	21.7%	219
Polite	20.7%	208
Obey rules	20.6%	207
Cannot integrate into society	19.4%	195
Clumsy	17.2%	173
Fearful	16.5%	166
Able to control oneself	16.4%	165
Talkative	14.2%	143
Responsible	13.7%	138
Dirty	9.1%	92

Table 11. Factor analysis of descriptions of mental health consumers.

	Initial Eigenvalues			Extraction Sums of Squared Loadings	Percentage Variance Explained	
Component	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %
1	3.861	18.387	18.387	3.861	18.387	18.387
2	3.212	15.296	33.683	3.212	15.296	33.683
3	1.505	7.167	40.850	1.505	7.167	40.850
4	1.276	6.078	46.929	1.276	6.078	46.929
5	1.042	4.964	51.893	1.042	4.964	51.893
6	.893	4.252	56.144			
7	.848	4.037	60.181			
8	.787	3.747	63.928			
9	.766	3.647	67.575			
10	.746	3.553	71.128			
11	.668	3.180	74.308			
12	.638	3.040	77.348			
13	.621	2.957	80.305			
14	.595	2.835	83.140			
15	.578	2.754	85.894			
16	.560	2.665	88.559			
17	.550	2.617	91.176			
18	.527	2.508	93.684			
19	.490	2.333	96.017			
20	.432	2.059	98.076			
21	.404	1.924	100.000			

Table 12. Rotated component matrix of descriptions under Item 31.

Description	Factor				
	Respectable	Inferior	Weak	Dangerous	Competent
Polite	**.768**	.014	-.037	-.014	.084
Honest	**.739**	.000	-.026	-.025	-.104
Friendly	**.725**	-.003	-.011	-.145	.122
Diligent	**.709**	-.072	.147	-.090	.101
Obey rules	**.705**	-.030	.026	.047	.225
Responsible	**.695**	.080	.068	.032	.195
Dirty	.002	**.750**	.009	.040	.014
Fearful	-.033	**.658**	-.011	.284	-.020
Clumsy	.110	**.586**	.191	.114	-.132
Cannot integrate into society	-.092	**.512**	.288	.122	-.074
Introverted	.042	-.082	**.691**	.159	-.059
Low self-esteem	-.079	.089	**.663**	.238	-.061
Shy	.205	.151	**.644**	-.211	.120
Timid	.017	.332	**.634**	.071	.007
Unpredictable	-.115	.042	.039	**.751**	.013
Quick-tempered	-.062	.086	.253	**.714**	-.131
Violent	-.090	.377	.085	**.585**	-.094
Talkative	.114	.297	-.009	**.473**	.090
No different from others	.069	-.102	.029	-.137	**.741**
Can contribute to society	.235	-.275	.061	.151	**.597**
Self-control	.306	.169	-.160	-.060	**.555**

Extraction Method: Principal Component Analysis. Rotation Method: Varimax with Kaiser Normalization. Rotation converged in 6 iterations.

Table 13. Endorsement rates to each component of Item 31 (N=1007).

Component	No. of responses	Percentage of total
1 Respectable	462	45.9%
2 Inferior	379	37.6%
3 Weak	727	72.2%
4 Dangerous	606	60.2%
5 Competent	557	55.3%

Table 14. Alpha coefficients of each factor.

Factor	Alpha
1 Respectable	.83
2 Inferior	.61
3 Weak	.63
4 Dangerous	.64
5 Competent	.43

"no different from others" and "can contribute to society", representing ex-consumers as *competent* members of society. This factor had an alpha coefficient of .43.

The endorsement rates for each of these five factors are shown in Table 13. Endorsement to a factor was defined as checking one or more of the descriptions belonging to that factor. On the positive side, 45.9% of the respondents (n=462) described ex-mental health consumers as *respectable* personalities (Factor 1), and 55.3% (n=557) described them as *competent* members of society (Factor 5). However, they were regarded as *weak* characters (Factor 3) by 72.2% of the respondents (n=727). The more negative impression of ex-consumers as *dangerous* figures (Factor 4) was endorsed by 60.2% of the respondents (n=606); 37.6% of respondents (n=379) perceived ex-consumers to be *inferior* (Factor 2).

3.3.3 Correlations Between Contact, Knowledge and Attitudes

The number of people indicating different levels of previous contact with mental health consumers are given in Table 15. Three quarters of the sample had seen realistic portrayals of people with mental illness in the media; one-third encountered mental health consumers occasionally, and one-tenth had frequent contact with a friend or relative who had mental illness. Each respondent was assigned a contact score based on the highest level of contact he/she indicated. Table 16 presents the frequencies of this score.

Table 15. Number of respondents endorsing each level of previous contact with mental health consumers.

Item	Endorsement rate	(n)
I have had a mental illness.	1.9%	(19)
I have lived with someone with a mental illness.	3.8%	(38)
I have frequent contact with a friend or relative who has a mental illness.	9.7%	(98)
It is my main duty to provide service to people with mental illness.	3.4%	(34)
I often encounter people with mental illness (at least twice a month).	6.4%	(64)
I encounter people with mental illness occasionally.	32.4%	(326)
I have observed, in passing, someone who might have a mental illness.	44.9%	(452)
I have seen realistic portrayals of people with mental illness in newspapers, magazines, films or TV programs.	74.6%	(751)

Table 16. Frequencies of the contact score.

Score	Item	Frequency (%)
8	I have had a mental illness.	19 (1.9%)
7	I have lived with someone with a mental illness.	32 (3.2%)
6	I have frequent contact with a friend or relative who has a mental illness.	81 (8.0%)
5	It is my main duty to provide service to people with mental illness.	17 (1.7%)
4	I often encounter people with mental illness (at least twice a month).	29 (2.9%)
3	I encounter people with mental illness occasionally.	231 (22.9%)
2	I have observed, in passing, someone who might have a mental illness.	192 (19.1%)
1	I have seen realistic portrayals of people with mental illness in newspapers, magazines, films or TV programs.	271 (26.9%)
0	None of the above is true.	108 (10.7%)

The hypotheses H_0: Level of contact had no correlation with attitudes and H_1: Level of contact was correlated with attitudes were tested. Table 17 shows the correlations between levels of previous contact and endorsement to the attitude factors identified, using Kendall's tau_b coefficient. Higher levels of contact were associated with more *openness* towards mental illness, more support for increasing *resources and services* for consumers and families, more *acceptance* of consumers

Table 17. Correlations between level of contact and attitude components using Kendall's tau_b correlation coefficient.

Component	Correlation coefficient	p-value
Hostility and segregation	-.015	.587
Consumers as aberrant	.005	.849
Openness towards metal illness	.064	.025
More resources and services	.102	.000
Acceptance in community	.150	.000
Rights of consumers	.125	.000
Misgiving over interaction	.016	.577
Rejection from accommodations	.006	.843
Respectable	.082	.004
Inferior	.031	.272
Weak	.080	.005
Dangerous	.044	.125
Competent	.065	.023

Table 18. Distribution of responses to items used in obtaining the knowledge score. Numbers in bold type are frequencies of responses counted as correct.

Questionnaire Item	Yes		No		No comment/ Don't know	
2. Discrimination and alienation against psychiatric patients can affect their recovery.	**844**	**(83.8%)**	55	(5.5%)	108	(10.7%)
4. The majority of psychiatric patients became ill because of their parents' wrong approaches to bringing up children.	123	(12.2%)	**671**	**(66.6%)**	213	(21.2%)
29. The crime rate among people with mental illness is higher than that of the general population.	131	(13.0%)	**363**	**(36.0%)**	498	(49.5%)
30. Which of the following disorders belong to the field of psychiatry?						
a. Autism	**556**	**(55.2%)**	216	(21.4%)	165	(16.4%)
b. Anorexia nervosa	**167**	**(16.6%)**	488	(48.5%)	214	(21.3%)
c. Depression	**687**	**(68.2%)**	133	(13.2%)	143	(14.2%)
d. Attention-deficit hyperactivity disorder	**308**	**(30.6%)**	329	(32.7%)	258	(25.6%)
e. Parkinson's disease	**125**	**(12.4%)**	461	(45.8%)	282	(28.0%)

Table 19. Frequencies of the knowledge score (N=1007).

Score	**No. of respondents**	**(%)**
0	27	2.7%
1	70	7.0%
2	143	14.2%
3	206	20.5%
4	238	23.6%
5	197	19.6%
6	83	8.2%
7	32	3.2%
8	11	1.1%

Table 20. Correlations between knowledge score and attitude components using Kendall's tau_b correlation coefficient.

Component	Correlation coefficient	p-value
Hostility and segregation	-.067	.016
Consumers as aberrant	-.110	.000
Openness towards metal illness	.090	.001
More resources and services	.155	.000
Acceptance in community	.161	.000
Rights of consumers	.155	.000
Misgiving over interaction	.077	.006
Rejection from accommodations	.047	.091
Respectable	.003	.926
Inferior	-.072	.009
Weak	.122	.000
Dangerous	.029	.301
Competent	.115	.000

in the community, more concern about the *rights* of consumers, and higher likelihood to regard consumers as *respectable* and *competent* members of society. However, greater amount of contact was also associated with the impression of mental health consumers as *weak* personalities. Different levels of contact made no difference to *hostility* towards consumers, the impression of consumers as *aberrant*, *misgivings over interaction* with consumers, *rejection* of consumers from 'normal' *accommodations*, and the impression of consumers being *inferior* and *dangerous*.

Tables 18 and 19 summarize the knowledge scores of respondents. The hypotheses H_0: Knowledge had no correlation with attitudes and H_1: Knowledge was correlated with attitudes were tested. Table 20 presents Kendall's tau_b correlations between the knowledge score and the attitude factors identified through factor analyses. Better knowledge of mental illness was, like higher level of contact, correlated with more *openness* towards mental illness, more support for increasing *resources and services* for consumers and families, more *acceptance* of consumers in the community, more concern about the *rights* of consumers, and higher likelihood to regard consumers as *competent* members of society. It was also correlated with less *hostility* and less adherence to the *aberrant* and *inferior* image of mental health consumers. However, knowledge about mental illness had no effect on *rejection* of consumers from *accommodations*, the *dangerous* impression, or the impression of consumers as *respectable* persons. Knowledge was even positively correlated with *misgivings over interaction* and the impression of consumers as *weak* personalities.

The results suggested that increasing knowledge would be more effective in reducing *hostility* and discrediting the *aberrant* and *inferior* image of mental health consumers, while actual contact might be more effective in building the image of mental health consumers as *respectable* citizens. *Misgivings over interaction*, the intention to *reject* consumers from 'normal' *accommodations*, and the *dangerous* impression were most resistant to change by increasing knowledge or contact. Higher levels of contact and better knowledge were correlated with the *weak* image of consumers, meaning that respondents might have learnt about the weaknesses of consumers during their contact or while receiving information about them.

3.3.4 Analyses of Variance and Partial Correlations on Demographic Variables

Respondents with different levels of education (primary or lower, secondary, post-secondary, and tertiary) and those who did not provide information on their education levels were compared for their knowledge scores and endorsement to each of the attitude factors. People with more education were consistently more knowledgeable about mental illness, and respondents who chose not to disclose information about their education levels had the lowest knowledge scores (F=21.55, df=4, 991, p=.000). Respondents with more education were also less likely to endorse descriptions that depicted mental health consumers as *inferior* ("fearful", "dirty", "clumsy" and "cannot integrate into society"), and people whose education levels were unknown had the highest endorsement rate to these items (F=2.59, df=4, 991, p=.036). The same pattern was observed in responses to Items 5 and 6 (Attitude factor 2), i.e. the attitude that mental health consumers were *aberrant* (F=5.93, df=4, 991, p=.000).

The more highly educated groups were more supportive of providing more *resources and services* to mental health consumers and their families (Attitude factor 4, Items 7 and 8); again the group who gave no information on their education were least supportive (*F*=2.79, *df*=4, 991, *p*=.026). People with more education also expressed a higher level of *acceptance* towards mental health consumers in the community (Attitude factor 5, Items 19 and 21); those who did not disclose their education level showed least acceptance (*F*=3.00, *df*=4, 991, *p*=.018). The only attitude factor on which the group with the highest education level were less positive than the other groups was Attitude factor 8 (Items 1 and 9). Respondents with tertiary education were most likely to *reject* mental health consumers from *accommodations* (*F*=4.39, *df*=4, 991, *p*=.002); the other groups showed no significant difference on this factor.

Partial correlations were computed between income and knowledge score, between income and all attitude factors, between occupation and knowledge score, and between occupation and attitude factors, with the effects of education level controlled for. Except that income was positively correlated with rejection of consumers from accommodations (Attitude factor 8) even after adjusting for the effect of education, all the other partial correlations were insignificant at α =.05 level. Given that one's educational level was a logical predictor of his/her occupation and income, it was unnecessary to treat occupation or income as independent socioeconomic factors, except for Attitude factor 8. As this factor comprised Item 1 'Elderly homes should not take in seniors who have been mentally ill' and Item 9 'Property owners should not be blamed for refusal to lease properties to mental health consumers', people with higher income i.e. those who were more likely to be properly owners might show discrimination out of self-interest. In this case income would be a more plausible predictor variable than education.

3.3.5. Chi-square Tests Between Media and Attitudes

Percentages of respondents who indicated that they had learnt about mental health consumers through each medium (Item 32) are shown in Table 21. Chi-square tests were performed between each of the attitude factors extracted and

Table 21. Sources of information - Number of respondents who have learnt about people with mental illness from each source (N=1007)

Source	**No. of respondents**	**(%)**
TV programmes	687	68.2%
Newspapers	645	64.1%
Radio programmes	397	39.4%
Magazines	392	38.9%
Films	381	37.8%
Promotion by government/voluntary bodies	325	32.3%
Books	263	26.1%
Education in schools	191	19.0%
Talks/seminars	179	17.8%
Previous contact with patients	171	17.0%
Opinions of friends and relatives	161	16.0%
Drama/other cultural activities	85	8.4%
Web pages	74	7.3%

Table 22. The effect of exposure to the formal media on attitudes towards mental illness.

Component	Endorsement rate (n)		p-value
	With exposure to formal media	Without exposure to formal media	
Hostility and segregation	55.4% (260)	60.4% (325)	.111
Consumers as aberrant	34.8% (163)	34.8% (187)	.999
Openness towards metal illness	97.2% (456)	93.5% (503)	.006
More resources and services	82.9% (389)	70.4% (379)	.000
Acceptance in community	87.2% (409)	78.6% (423)	.000
Rights of consumers	74.2% (348)	61.7% (332)	.000
Misgiving over interaction	49.7% (233)	48.0% (258)	.585
Rejection from accommodations	45.6% (214)	53.7% (289)	.010
Respectable	57.8% (271)	35.5% (191)	.000
Inferior	40.9% (192)	34.8% (187)	.043
Weak	78.9% (370)	66.4% (357)	.000
Dangerous	62.3% (292)	58.4% (314)	.208
Competent	65.2% (306)	46.7% (251)	.000

exposure to formal channels, i.e. education at school, promotion by government or voluntary bodies, talks and seminars, cultural activities and web pages. As Table 22 shows, people who had learnt about consumers through these channels were more open about mental illness, more supportive of providing resources and services to consumers and families, and more receptive of consumers in the community. They were also more concerned about the rights of mental health consumers and more ready to accept them in 'normal' accommodations. Exposure to these formal media was also associated with perceptions of mental health consumers as respectable and competent members of society. However, the formal media had no effect on hostility towards consumers or stereotyping of consumers as aberrant. They were also ineffective in reducing people's misgiving over interacting with consumers. Exposure to the formal media made no difference to perceptions of dangerousness, and even reinforced perceptions of consumers as inferior and weak personalities.

3.4 SUMMARY: ATTITUDES AND FAMILY BURDEN

The majority of respondents were aware that many difficulties confront mental health consumers and their relatives, and would welcome the provision of more comprehensive services to these people by public bodies. Among our respondents, 68.4% would support increases in funding for psychiatric rehabilitation services, and 61.8% were in favor of allotting more resources for the support of consumers' families. However, stigmatization of mental health consumers still existed. Stereotyping of consumers as dangerous and aberrant was common; 60.2% of the sample used at least one of the terms "unpredictable", "violent" and "quick-tempered" to describe ex-consumers. People who sought mental health service were considered by 34.8% of the sample as aberrant. Though 83.3% of the respondents agreed that mental health consumers could lead a normal life again if given appropriate support, and 83.8% recognized that discrimination and alienation would adversely affect their recovery, people were still unwilling to accept mental health consumers in the community. Fifty percent of the respondents believed that to reject mental health consumers from accommodations was justifiable; 29.2% would "oppose strongly" to proposals to establish halfway houses near their residences; 22.6% would screen out job applicants with previous mental illness without interviewing them. Regarding personal interactions, 48.8% of the sample expressed that they did not know how to get along with people who had been mentally ill. The results showed that respondents had beliefs and perceptions which made them reluctant to give opportunities for mental health consumers to reintegrate in society. When attitudes of the public curtailed consumers' social reintegration, the burden of care on their families would increase. Thus the results had significant implications on the burden on consumers' relatives.

The results also pointed towards discrimination of consumers and families which would directly increase their practical and emotional burden. As 27.6% of the participants believed that ex-consumers should not be given a place in elderly homes, there could be difficulty for relatives to accommodate them in old age. Relatives who decided to live with ex-consumers might even have difficulty finding accommodation for themselves, because 36.4% of the respondents considered it acceptable for property owners to reject them, and the proportion was even higher among the high-income group. Declining job applications of ex-consumers without interviewing them, as mentioned above, had financial implications on consumers' families. Even the employment opportunities of relatives could be affected by consumers' illness; 18.8% of the sample believed that children of consumers should not be hired in armed forces, and 36.8% were hesitant about their employment in these positions.

That 18.8% of neighbors would avoid consumers' families and that 50.3% of the sample would move away if a fellow passenger exhibited awkward behavior on public transport implied that relatives might face embarrassment if they wanted a social life. Furthermore, 12.2% of the sample believed that the majority of mental health consumers became ill due to parents' wrong approaches to bringing up children; 10.0% of the sample believed that mental illness could only occur in families which were inherently different from others. There were thus stigmatization and social isolation adding to the emotional burden of families. Together with the fact that only 39.7% of the respondents recognized helping mental health consumers to be as important as helping people with physical handicap, the figures implied that negative attitudes towards mental health consumers and families might be preventing help-seeking and increasing their burden.

3.5 DISCUSSION

3.5.1 Stigmatization of Mental Illness

3.5.1.1 "Not in my backyard"

Overall, the pattern of results suggested that respondents were aware that mental health consumers *should* enjoy equal opportunities in society, and that they *should* be given assistance to reintegrate into the community; yet the label of mental illness still carried connotations such as dangerous, aberrant and inferior, and people have misgivings about interacting with consumers. They regarded helping mental health consumers the responsibility of the government, and supported the allocation of more resources to help consumers and their relatives. The fact that personal interactions in the community had great impact on the recovery of consumers was overlooked, and the 'Not In My Backyard' phenomenon was evident. Compared to the 19.3% of respondents who thought that psychiatric rehabilitation facilities should be located away from people's residence, 29.2% would 'oppose strongly' to proposals to establish halfway houses near their homes. An examination of the distribution of responses for each item confirmed that, the more personal contact an item implied, the more negative the responses (see Figure 2).

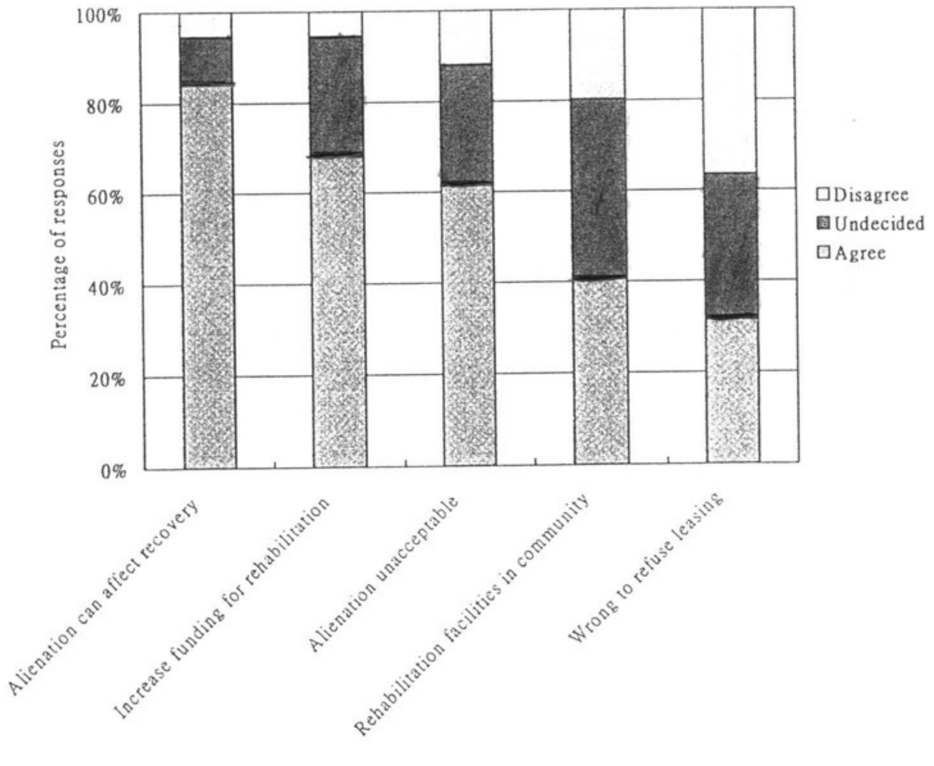

Figure 2. Percentage of responses to Items 2, 7, 19, 18 and 9. Items 18 and 9 are worded in reverse here for comparison.

Some findings were comparable to those from two surveys conducted in Hong Kong in 1994 (Chou et al., 1996) and 1996 (Chou & Mak, 1998). The proportion of respondents indicating reluctance to live near psychiatric rehabilitation facilities were 39.8% and 43.3% respectively in 1994 and 1996; in the present study 29.2% of the sample would oppose strongly if the government proposed to set up halfway houses near their residences. In the 1994 survey, 43.8% of the respondents opined that psychiatric rehabilitation facilities should be located far from the community; the figure dropped to 41.1% in 1996, and in the present study it further decreased to 19.3%. Though the two previous questionnaire surveys were conducted through telephone interviews and thus had different sample recruitment procedures from this study, the demographic characteristics of the samples were similar. For example, in the 1996 survey 18.7% of the sample were homemakers, 60.5% of the sample had secondary education, and 17.6% had post-secondary education or above. In the present sample, 24.0% were homemakers, 59.4% were educated to secondary level, and 15.6% had higher education. Sampling error alone was unlikely to have caused the large difference in opinions. An alternative explanation would be that some positive changes have occurred in people's attitudes during this period. The author speculates that the Equal Opportunity Commission's law suits and publicity efforts against discrimination in recent years have promoted public awareness of equal-opportunity principles. The most well-known example was the law suit against the Hong Kong government in March 2000 for its discriminatory practice in recruitment. Three successful applicants to positions in the police force and the fire services had been rejected or dismissed from employment due to their relatives' history of mental illness. They were subsequently awarded over 2.7 million Hong Kong dollars in damages, and the case attracted much public attention. With the Commission's anti-discrimination efforts, more people are now aware that there should be equal opportunities for all. Further research would be necessary to try this hypothesis.

3.5.1.2 Effects of contact and knowledge

Previous research has shown that contact with persons with mental illness diminishes negative attitudes towards them (Angermeyer & Matschinger, 1997; Chou & Mak, 1998). In the present study, higher levels of contact were associated with more *openness* towards mental illness as treatable conditions, more support for increasing *resources and services* for consumers and families, more *acceptance* of consumers in the community, more concern about the *rights and welfare* of consumers, and higher likelihood to regard consumers as *respectable* and *competent* members of society. However, greater amount of contact was also associated with the impression of mental health consumers as *weak* personalities, being timid and having low self-esteem. Also, different levels of contact made no difference to *hostility* towards consumers, the impression of consumers as *aberrant*, *misgivings over interaction* with consumers, *rejection* of consumers from 'normal' *accommodations*, and the impression of consumers being *inferior* and *dangerous*. In other words, increased contact might encourage benevolence towards people with mental illness, but at the same time reinforce the impression that they are pitiful, possibly because people learn more about consumers' weaknesses (e.g. low self-esteem) through the contact. The suspicion that mental health consumers may become irrational and violent without signs is the most resistant to change, and people still want to keep away from these persons. The author speculates that this is because the *absence* of danger can never be proved, and the myth about the potentially violent consumer cannot be logically refuted.

Better knowledge of mental illness was, like higher level of contact, correlated with *openness* towards mental illness as treatable conditions, support for increasing *resources and services* for consumers and families, *acceptance* of consumers in the community, concern about the *rights and welfare* of consumers, and consideration of consumers as *competent* members of society. It was also correlated with less *hostility* and less adherence to the *aberrant* and *inferior* image of mental health consumers. However, knowledge about mental illness had no effect on *rejection* of consumers from *accommodations*, the *dangerous* impression, or the impression of consumers as *respectable* persons. Knowledge was even positively correlated with *misgivings over interaction* and the impression of consumers as *weak* personalities. Taken together, the results showed that people with better knowledge of mental illness were also more aware of the principles such as equal opportunities for mental health consumers. However, the effect of knowledge was limited, and it was not effective in easing qualms about interacting personally with consumers.

The results were probably influenced by the kind of information required on the items used to estimate respondents' knowledge. Whether autism is a psychiatric disorder and the etiology of mental illness are factual information that were most likely to have been acquired from formal sources rather than personal experience. Respondents might have been exposed to equal opportunity propaganda on the same occasions as they received information on mental illness. Such information was effective in increasing awareness of the difficulties faced by mental health consumers, but insufficient to change the impression that persons with mental illness were dangerous, nor sufficient to dispel doubts about interacting with them.

3.5.1.3 Suggestions for public education

Penn et al. (1999) put forward that information on the prevalence rates of violent behavior among persons with mental illness helped to reduce beliefs about mental health consumers being dangerous. Arikan, Uysal and Cetin (1999) suggested that knowledge of the positive outcomes of psychiatric treatment decreased stigmatization. While the latter type of information has been included in Hong Kong's anti-stigma propaganda (e.g. television advertisements describing mental illness as treatable, like other illness of the body; advertisements featuring people who have recovered from mental illness and participating in employment), and seemed effective in promoting an awareness that psychiatric disorders were treatable problems, more need to be done to educate the public about the impression of violence. More solid information of the type suggested by Penn et al. are needed to dispel the myth that mental health consumers are dangerous.

The results suggested that increasing knowledge would be more effective in reducing *hostility* and discrediting the *aberrant* and *inferior* image of mental health consumers, while actual contact might be more effective in building the image of mental health consumers as *respectable* citizens. Hence providing opportunities for personal contact with consumers would be a strategy to employ in future anti-stigma campaigns. For example, ex-consumers can be invited to give talks in schools, and volunteer activities can be organized jointly by consumers and non-consumers.

Apart from its traditional means of anti-stigma promotion, i.e. posters, talks and exhibitions, the government should utilize the media especially television and newspapers, as they reach more people. This survey showed that people who had learnt about mental illness through talks and government promotions were likely to be the same group. Thus campaigns may be more cost-effective and bring better results if other media are employed. As Salter and Byrne (2000) suggested, employed strategically, the media can be very effective in dispelling mental illness stigma.

Results from this survey indicated that respondents with higher levels of education had more positive attitudes towards mental health consumers. This could be due to the knowledge they acquired through their education about mental illness; it was also likely that they had more exposure to equal opportunity propaganda for people with disabilities. A study examining the attitudes of occupational therapy students towards establishment of treatment facilities in the community using conjoint analysis provided empirical support to this speculation. Final-year students in general showed more positive attitudes than first-year students towards people with disabilities (Tsang, Chan & Chan, under review). The results suggested that education in Hong Kong was able to contribute towards the reduction of stigma, yet the current curricula were inadequate in dispelling qualms about personal interactions with persons with mental illness. Despite their better education, people with higher income showed more discrimination against consumers seeking to rent accommodation. There was still considerable hostility where personal interests might be affected. This was resonant with the pattern of responses that the more personal the interaction, the more rejection people showed. Thus future public education initiatives should move beyond spreading the message that 'mental health consumers should enjoy equal rights' to changing the stereotype that mental health consumers are dangerous and encouraging social interaction with consumers.

3.5.2 Social Policy and Family Burden

People's neglect of the needs of mental health consumers was reflected in public administration. By the end of 1998, Hong Kong had three long stay care homes offering accommodation, nursing care and skills training to 570 chronic consumers, while the waiting list had 1,258 persons (Health and Welfare Bureau, 1999). An additional 800 care home places were expected to be available by 2002-03, still falling short of the projected demand by 1,643 places. Similarly, there were 1,217 places in halfway houses as at December 1998, while 396 consumers were on the waiting list. Despite the shortage, only 200 more places would be provided by 2002-03, giving rise to a projected shortfall of 948 places. (Health and Welfare Bureau, 1999) It was clear that mental health care was not a high-priority item in the allocation of social resources.

Equally interesting was the pattern of services provided. Public hospitals in Hong Kong had a total of 5,068 psychiatric beds as at December 1998, with an average utilisation rate of 90.8%. Though the number of beds appeared sufficient, the Hospital Authority planned to provide 704 extra places by 2004-05. (Health and Welfare Bureau, 1999) Considering that psychiatric hospital beds had much higher unit cost (HK$27,250 per month in 1997-98) than places in long stay care homes and halfway houses (HK$7,704-$11,778 per month in 1997-98), and that there was a severe lack of the latter, the Authority's strategy of meeting mental health care demand seemed even more curious. In its plan for rehabilitation services, the Authority pledged to closely monitor the demand and provide additional places to meet the demand "subject to the availability of resources and suitable premises". (Health and Welfare Bureau, 1999) While resources may be made available by redistribution from reserves for hospital beds, the availability of premises may be a key factor affecting the provision of halfway house places and long stay care home places. One likely difficulty is that people in the community may reject the establishment of these rehabilitation facilities in their neighborhood, as has been reflected in past incidents of resident protests as well as the results of the present survey. To further explore the possibility that people's indifference to consumers' needs affects public administration, the author studied the minutes of all Council and Committee meetings of the Eastern District Council held between December 1999 and December 2000, as well as 189 questions raised by Legislative Councilors to the government from October 2000 to January 2001. Mental health service was not mentioned in any of the questions scheduled for Legislative Council meetings, though questions raised could be as trivial as the numbers of printed copies of the Government Gazette expected to be saved after an online version was released. It was also found that, among the myriad of local administration issues raised at the District Council and its Committees, including the improvement of geriatric medical service, the addition of pedestrian crossings, the cleanliness of certain areas, etc., the provision of mental health service was mentioned only once, in response to a government proposal to build a halfway house within a local hospital. At that Councilors welcomed the choice of location for it was separate from the daily activities of local residents, and thus was least likely to arouse opposition. The Councilors supported the establishment of halfway houses to facilitate the social reintegration of mental health consumers, but complying with the majority's wish to keep consumers at a distance was of higher priority in their agenda. People's reluctance to live near psychiatric facilities influenced decision making at a societal level, and the facility intended to encourage social interaction and reintegration was, paradoxically, situated away from the activities of the community. The fact that Councilors were only concerned about whether the setting up of halfway houses would upset people in the community reflected the public's reluctance to accept mental health consumers in the community, which also pointed to difficulties for the authorities to find suitable premises to establish long stay care homes and halfway houses.

The shortage of long stay care homes and halfway houses had significant impact on the burden on consumers' families. Without the transitional service, consumers spend more time in hospitals, segregated from the community, and those discharged from hospitals return home without the services and mutual support that would otherwise be available at a halfway house to help them adjust to life in the community. Family members have to take up the responsibility of looking after the consumer's daily living, social activities, as well as follow-up services. The work itself can cause a burden to families. More importantly, consumers returning directly to home have much more limited social networks than people who have had a chance to make friends in halfway houses, and thus they have less resources and opportunities to participate in the community. Reintegration and recovery are affected, which increases the practical and emotional burden on relatives.

The severe shortage of manpower in mental health services also showed that the low priority of mental health care to the public and the administration influenced resource allocation and thereby added to the burden of consumers' families. According to the rehabilitation program plan of the Health and Welfare Bureau (1999), the standard manning ratio of aftercare workers (i.e. social workers equivalent to case managers in the United States) to consumers discharged from halfway houses was 1:50, and there were only 7.5 aftercare workers as at December 1998. In addition to the inadequacy of aftercare service, there was only one resource center to provide information for parents and relatives of consumers. Therapeutic group training for people with mild symptoms of mental illness were provided only by some non-governmental organizations using non-governmental funding. In spite of the lack of support for relatives, the administration planned not to increase the supply of group workers for therapeutic group training, but expected existing service units to incorporate group training into current individual casework if group training was to be given at all. The scarcity of resources allotted to mental health services clearly reflected the society's neglect of the needs of mental health consumers and the burden on their relatives.

The author's personal communications with some psychiatrists of public hospitals also revealed that the lack of resources was affecting the treatment and recovery of many consumers. The psychiatrists frequently encountered cases for which they believed weekly psychotherapy sessions could have been very effective, and yet manpower limitations only permitted 20-minute appointments every few months. Psychiatrists had to resort to medications though in many cases that was not the most effective alternative. This has important implications on the course of many consumers' illness and hence the burden on their families. All in all, the needs of consumers and relatives have been overlooked in resource allocation, to the extent that the delivery of effective treatment is hampered, and the burden of the illness subsequently increased.

While the results of Phase One revealed public attitudes that bore significant implications on the practical and emotional burden of consumers' families, Phase Two of the study was designed to seek an understanding of their experience of burden. In Phase Two, relatives of consumers were invited to talk about their experience of dealing with the illness, and issues raised in these interviews would be considered in the context of the results discussed above.

3.5.3 Limitations

Students and home-makers were over-represented in the sample, which limited the generalizability of the results to the public. As respondents were recruited through students, the sample could be expected to over-represent people who lived with a student and people who were considered approachable by students. Another potential source of bias was that the principal's approval was required for any school to participate in the study. Whether approval would be granted might reflect some characteristics of the schools which could be correlated with parents' characteristics. On the other hand, this recruitment method was economical and follow-up comparisons could be done with relative ease, and the results should be helpful in identifying needs for anti-stigma education in schools.

Where resources permit, future studies of public attitudes towards mental illness may improve representativeness by using a geographical sample of the entire population. Mail surveys and telephone interviews may be done, while questionnaires must be kept short to reduce self-selection bias.

CHAPTER 4

INDIVIDUAL INTERVIEWS

4.1 RATIONALE OF METHODS

In Chapter 3, stigmatizing attitudes towards mental health consumers were reported, and the possible links between such attitudes and the burden on consumers' families were discussed. To further explore the effects of negative public attitudes on family burden, individual interviews were conducted with consumers' relatives in the second phase of the study, seeking to understand the burden on mental health consumers' relatives from their perspectives. Since this study was concerned with their emotional burden in addition to practical difficulties, the interviews aimed at more than a factual account of the difficulties they had encountered; interviewees' perceptions of burden, the importance they attached to different issues, and the feelings they had about the illness were all important information. Therefore, a combination of unstructured and semi-structured interviewing was used. Unstructured interviewing offered the best occasions for interviewees to raise issues that concerned them most. As this method of interviewing allows more flexibility for participants to talk about whatever they considered relevant, the conversations would more readily reveal their subjective experiences and beliefs. At the same time, there were certain issues, such as participants' social life and employment, that were of interest to this research whether or not interviewees raised them as problems, because the absence of burden and effective coping were also informative. Thus the semi-structured part of the interview was included to cover key topics which had not been mentioned in the unstructured interview.

4.2 METHODS

4.2.1 Self Cultural Interview

In pursuing an understanding of the burden on respondents, the author held a constructivist view of reality: individuals construct their own realities with their past and ongoing experience, and the construction of knowledge is influenced by the social and cultural context (e.g., Von Glaserfeld, 1990; Vygotsky, 1978). This view of the construction of reality applied to both the respondents' perceptions of their burden and the author's understanding of their burden.

The author was aware that, having the literature review and research hypotheses in mind, the author had assumed that mental illness brought practical and emotional burden to consumers' relatives. It was also assumed that negative attitudes of the public towards mental health consumers affected the coping resources available to relatives. The author noted pre-existing personal beliefs as potential sources of bias and cautioned against cueing respondents or making biased judgments during interviews and analyses.

4.2.2 Participants

Ten interviewees were recruited through occupational therapists at the psychiatric clinic of East Kowloon Polyclinic and the psychiatric day hospital of Alice Ho Miu Ling Nethersole Hospital in the New Territories, with approval from the ethics committees of the hospitals. Each interviewee had at least one family member receiving outpatient psychiatric service. Three interviewees had more than one relatives who had been mentally ill, one of these other relatives was receiving treatment at the time of the interview. Six interviewees were mothers of clients; one was a father and one was wife. One interviewee was father and husband of clients; another was daughter and sister.

Of the 11 current clients concerned, ten had schizophrenia and one had bipolar disorder. Six clients were male and five were female. Clients were aged between 18 and 66 with histories of illness from two months to twenty years (see Table 23). All of them were Hong Kong Chinese.

4.2.3 Interview guide

Since the interviews were primarily qualitative, there was not a fixed questionnaire, but an open-ended interview guide with a list of suggested questions (see Appendix 7) which might be asked as appropriate, and which could be changed and followed with further questions. Questions were written to address issues noted in the literature review, e.g. employment, social activities, caring responsibilities etc.,

Table 23. Demographic data of clients.

	No. of clients
Sex	
Male	6
Female	5
Age	
18-25	4
26-35	3
36-45	2
Over 45	2
History of illness	
0-2 years	3
3-5 years	3
6-9 years	3
10+ years	2
Diagnosis	
Schizophrenia	10
Bipolar disorder	1
Education	
No formal schooling	1
Primary	2
Secondary	6
Post-secondary	2

and some aimed at tapping relatives' subjective experience of public attitudes, for comparison with attitudes reported in the survey. The list served as a reminder of issues to address, but questions asked during interviews varied with characteristics of the case and the ongoing narration by interviewees.

4.2.4 Procedure

Interviews took place at interviewees' residences or clinics/hospitals that their relatives were attending, according to their choice. In one case the consumer was present during the interview. No other mental health worker was present apart from the researcher. The purpose and method of the interviews as well as the anonymous and voluntary nature of participation were explained to interviewees (Appendix 8). Each interviewee then signed a consent form.

Seven interviewees consented to the audio-recording of interviews. Records of the remaining three interviews were made using written field notes. Interviews were conducted in Cantonese; quotations in this thesis were translated into English.

4.2.5 Analysis

Transcripts and interview notes were analyzed using McCracken's (1988) method of interpretive interview analysis. Utterances were first considered separately. Then observations drawn from these utterances were studied and their relationships were examined. The themes identified were reviewed and refined treating all interviews as a collective body of data. Trustworthiness of interpretations was established through independent coding of excerpts by another researcher experienced in interviewing relatives of mental health consumers but not involved in this study otherwise. Interpretations by the author and the independent researcher were consistent. The following excerpt from an interview transcript demonstrates interpretations made by the author ("A") and the independent researcher ("IR"):

"I wanted to find some place where people would look after him during the day, so I could go to work. I asked the social worker if he could go somewhere during the day. S/he said there's no such place. S/he said I could give up work and look after him myself. There's no such service. S/he suggested me to look after him myself and apply for social welfare. I was very unwilling to give up work, but I had no choice. If there was a place to look after him, I would not have given up my work. I've never wanted to live on social welfare. I want to earn my own living. We want to support ourselves. If you get social welfare, people look down on you, like you're lazy and useless or something. I was very unhappy. I feel so useless."	A: lack of service IR: no day care A: lost income/financial autonomy, sacrifice IR: personal need unfulfilled, became dependent on welfare A: grievance, shame IR: shame, wronged, deprived opportunity	A: model/ availability of service increased relative's burden of care and thus caused emotional distress IR: inadequate service → practical burden → emotional burden

4.3 FINDINGS

4.3.1 Objective Burden

4.3.1.1 Social isolation

Interviewees spoke of their objective burden with great emotional intensity, and much of that burden was related to stigma. A father said, "People want to keep away from you once they hear about the illness." Another respondent said, "They've heard too much of those things about crazy people hacking others; when they know you've such an illness, they're afraid of you." While these interviewees had been distanced by friends and relatives, others had avoided social activities. One of them said, "Someone in my family has this illness. I feel ashamed." Another couple almost severed all their social links to conceal the illness of their only child, because the mother perceived strong discrimination in the community. "She's so young. She'll have to work and she has to live on. If people knew that she's got this illness, it'll affect her in finding a job and making friends. I want absolutely no one to know about it. Not even my mother or sister." Hence it was clear that stigmatization had curtailed the social activities of consumers' relatives, which was consistent with Lefley's (1996) description of objective burden on families.

Those parents who chose to conceal the illness said that, because of the decision, they could not get support from kins or friends when they needed help. In fact, the fear of stigma impacted on family burden from the time the first signs of illness were noticed. Mrs. T's experience illustrated the difficulty. As she found that her daughter did not recognize her but believed herself to be in danger, Mrs. T asked to take Miss T to see a doctor. Miss T refused because she believed it was a plot against her. Mrs. T was anxious to help her daughter but did not know where to turn. She concealed the problem from friends and relatives for fear that Miss T would be discriminated against. She even concealed it from her husband because he was "very traditional". "He wouldn't believe me. If I told him our daughter had mental illness, he'd surely say I was the one who's crazy. I was all alone." Because referral by a general practitioner was necessary for access to psychiatric service, but Miss T refused to see a doctor, Mrs. T had to visit many centers in secret before she finally found the professionals who would visit her home. As she said, "It's a hard time for me. The pressure was huge."

4.3.1.2 Taking care of relatives' treatment and progress

The burden associated with seeking treatment was not only increased by relatives' fear of stigma. The complex system of mental health services was itself the cause of much difficulties. The experience of Mrs. E illustrated this:

It was when her son requested to see a psychologist that Mrs. E realized he had been having problems for 3 months. While they were trying to find help, his son's teacher noticed his problems and told the family to take him to a doctor. So they went to a general practitioner's clinic, but that was not helpful. The doctor only prescribed sleeping pills but that did not help him. Then the school referred them to a social worker, and they visited a counseling center. The staff there told them to go to a psychiatric clinic, but they were mistaken and went to a hospital instead. That hospital referred them to another hospital. At the second hospital, the staff on duty told them they had gone to the wrong place, and asked the client a few questions. The client gave no response, so the staff told them to go to a psychiatric hospital directly.

Unless the first episodes of the illness immediately attracted police intervention, relatives had to find their way through a labyrinth-like system before they could access mental health services. In many cases, relatives wanted to seek advice from social workers and counselors, but did not know where to find these services. An interviewee said, "How would I know things like these? I knew nothing about such things." As noted above, some of them were reluctant to ask for advice from friends or relatives due to their fear of stigma; and in some cases their social networks had not been very adequate to start with. Thus the only readily accessible place for consultation was the general practitioner's clinic, but it offered only medical but not counseling service. Even after consumers had accessed a service provider, the only service they most reliably received was that of the psychiatrist; relatives still did not know where to find the counseling services they wanted. In fact, during and after the interviews, over half of the interviewees asked the interviewer where to seek training and counseling services for their relatives.

Interviewees felt that the mental health system had grossly neglected consumers' need to improve and lead a meaningful life. Treatment consisted mainly of medication and hospitalization without training; the model of service had hindered rather than promoted consumers' recovery. The following utterances showed the relatives' concern about the lack of social and vocational interventions: “It’s no good staying home all day. She needs to have something to do, otherwise she just keeps dwelling on gloomy thoughts. I’m sure she’ll recover much faster if they could give her some kind of work or training.” “I really hope they could find someone to talk with him and understand his problems. It’d be better if he sees a counselor.”

Two mothers talked about their sons' involuntary hospitalization against the wish of the families, and both commented that the hospital had been a worse environment than home for treating their problems. One of them said,

“I saw all the other patients lying on the floor.... they're very serious. But my son's not like that. He had a problem, but he's not that serious. He's no danger to others, not like those who're violent.... He wouldn't hurt anybody. I can't see why they should lock him up.”

“(The hospital ward) was very small and very restrictive.... At home he’d play computer games, listen to music, or watch TV. There’s nothing at the hospital. He wasn’t allowed to have his MD player or mobile phone.... And he had to ask to call home; very often the staff wouldn't let him call home.... He didn't even get medications. No, he didn't even get medications; only got sleeping pills. So what's the point of putting him there? ....He'd become ill if he hadn’t been ill.”

The other consumer was harassed and assaulted by a workman at the hospital. Other inpatients followed suit and the consumer suffered severe injuries. His mental problem became serious after the incident. Later he was transferred to another hospital. When he finally returned to a normal state, he heard that he would be transferred to the hospital where he had been assaulted. The fear and worries caused his condition to deteriorate rapidly. The family felt that the system had failed him. "I said he shouldn't stay at hospital, but you doctors said he should stay here to be treated. Now what's been done? How can you make him suffer like that?" Although they tried very hard, he got worse with every incident.

Interviewees also complained that the side effects of medications brought significant burden. They felt that heavy dosages of medications had been prescribed without careful consideration of the side effects. As noted in these utterances:

"(The psychiatrist) raised the dosage to several times more than before, all of a sudden, and for no reason; and he got an injection too. He didn't even know himself after taking those drugs. So I asked the doctor to cut the dosage, but he refused, and then I got the social worker to talk to him. In the end he agreed to cut the dosage, and he (patient) improved immediately. Soon he was discharged. If those doctors would listen to us.... We don't know much about the drugs, but we can feel if he's all right or not. We visit him every day and observe him."

Another interviewee had to check on the consumer frequently while at work, because of the hypersomnia brought by his medications: "I'm very careful. I ring him up many times. But he just sleeps and doesn't answer the phone. 'This is mum. Have you had lunch?' He goes back to sleep and won't pick up the phone again. I ring him twenty, thirty times. I'm scared more and more. When his sister gets home, 'He's sleeping.' I'd be calm and worry less about him. It's very hard. I always worry about him."

Once the consumer was admitted to the system of service, the professionals would make all decisions for them regarding their treatment, including the length of hospitalization, whether and when they should receive occupational therapy, etc. Many interviewees wished to see changes in their relatives' treatment, but they had little influence in the decision making. Reasons for relatives' powerlessness included a lack of respect for consumers and families, general lack of resources for the services they required, and the frequent shifting of psychiatrists. Regarding the lack of respect for consumers, an interviewee said, "They think they're the professionals, you're not." Taken together with relatives' disagreement to hospitalization and medications as noted above, consumers seemed to be stigmatized by the system as individuals incapable of self-determination, and their relatives were treated as ignorant. In one case, when the consumer was going to pay her outpatient fee at the clinic, the person before her stayed in front of the counter and blocked the way. She said 'excuse me' a few times but the man did not move, so she slipped beside him and gave her papers to the staff. The man was unhappy about it and started a quarrel. During the quarrel, the consumer said 'Hack you!' and was heard by a nurse. That was considered a tendency to violence and she was hospitalized immediately. No attention was paid to her defence. In addition to the grievance, her family bore a heavier burden when they had to travel long distances to visit her, and they had no one to cook meals. Most importantly, the social reintegration of the consumer suffered.

As for the lack of resources for services required, relatives were mostly concerned about the lack of social and vocational interventions, as mentioned above. Two interviewees had actively sought training opportunities for their young relatives. An occupational therapist agreed to teach one of the consumers to use the computer in the hospital; but because it was not his official duty, he had to leave the consumer frequently to attend to other business. The consumer did not learn much. The consumer later attended a private course but the cost was too high for him to continue learning. His carer was still looking for subsidized courses.

An interviewee said that her relative's condition had been well-controlled for several months, and the only problem was his shyness in interacting with people. The occupational therapist had him attend group sessions with other consumers, but that proved unhelpful because all other consumers were in symptomatic conditions and unable to communicate. The therapist was aware of the special need of the higher-functioning consumer, but there were no other suitable services available. It was clear that the service model and resource allocation affected consumers' reintegration and thus affected family burden.

The frequent change of psychiatrists also increased their hardship. An interviewee's experience of the policy was: “The doctor agreed to let him transfer to the other hospital. But when he went back for follow-up, that doctor’s gone, and the new doctor wouldn’t let him transfer. So I had to start it all over again.... He was referred to another clinic, and then I asked the doctor to write a (referral) letter. That’s how he came to this clinic.” Another interviewee expressed confusion about the contradictory instructions by different clinicians. Once when he visited his relative in the morning, he was told that she should stay in that hospital for several weeks more, and she would receive physiotherapy there. In late night on the same day, he was asked to bring her home immediately, for no obvious reason to them. It was said at that time that she should return for physiotherapy as an outpatient. However, when the relative later called the hospital, he was told that only inpatients could receive physiotherapy there. It was after much argument and negotiation that the consumer finally received the treatment.

Viewed together, relatives' dissatisfaction with services reflected that not enough consideration had been put into the care of mental health consumers. Stigmatization of consumers as long-term dependents even existed in the services; there was marginalization of their needs, reflected by the lack of resources for services they required.

4.3.1.3 Financial burden

Financial difficulties frequently arose in consumers' families because relatives had to retire early or quit their jobs to take care of the consumer. A single parent who had been running a successful retail and wholesale business closed it down in order to care for her son who was diagnosed with schizophrenia. After they had exhausted their savings, they became reliant on social security. Explaining her decision to close her business, she said, "I wanted to find some place where people would look after him during the day, so I could go to work. I asked the social worker if he could go somewhere during the day. S/he said there's no such place. S/he said I could give up work and look after him myself. There's no such service. S/he suggested me to look after him myself and apply for social welfare. I was very unwilling to give up work, but I had no choice. If there was a place to look after him, I would not have given up my work. I've never wanted to live on social welfare." It was clear in this case that the absence of day care service had added to the burden on the family.

Loss of income due to unemployment of the consumer was common. Most consumers in this study had full-time work before the onset of their illness, but became unable to meet the job requirements as the illness developed. Half of them had their employment terminated abruptly by hospitalization. Others resigned voluntarily as they found it increasingly difficult to do the job or get along with co-workers. Only one was dismissed by the employer due to symptoms. Except one teenager who expected to return to school after recovery, and one aged over 60, all consumers wanted to return to the workforce, but finding employment was extremely difficult. Among those who had tried to seek employment, travelling long distances to interviews and getting rejected were like the routine. As one interviewee said, "He (the client) has tried (looking for jobs) everywhere. He goes to Kwai Chung; he goes to Tsuen Wan, Shamshuipo, even Tuen Mun and Yuen Long. (The family residence was in Tai Po.) But those people say they've hired someone already, or they tell him to go home and wait for their call." Only one consumer had secured a full-time job as a cleaner. One other had been a helping hand at her father's small business, but became unemployed after the business was later closed down. For those who were seeking employment or expecting to do so after their conditions had improved, chances seemed slim to most, as all were aware of the discrimination. A father said, "How would the employer hire you, if he knows you've this illness?" One consumer was invited to join a company which was already employing ex-consumers. His post-secondary education might have been helpful.

The financial consequences of consumers' unemployment were profound. One of the consumers was the sole breadwinner for his family of three. They had to depend on social security and felt that they were unable to provide anything above food and clothing for their 1-year-old child. In another family, both the consumer and her husband held unskilled jobs and both incomes were needed to support their living. Since she became unemployable, the family had much financial difficulty. Their daughter, who was preparing for university entrance examinations, did not even have a desk but did all her homework in her bed.

For younger, single consumers with a shorter history of illness and whose income had never been the major source for the family, their parents were more concerned about the consumers' future than their present financial situations. Although their lost income affected the family's standard of living to some extent, whether they could recover and be capable of supporting themselves in future was far more worrying for their parents. Relatives were worried that the consumers might not be able to find a job due to discrimination by employers.

The relatives interviewed were mostly not concerned about the costs of treatment and rehabilitation, as charges of public hospitals and clinics were low. Medical costs were fully covered for recipients of social security. However, one interviewee whose son had been assaulted at a public psychiatric hospital said that she would send her son to see a private psychiatrist in any future episodes. Despite the high fees and their stringent finances, she felt it was necessary to prevent involuntary hospitalization and the "extremely horrible" experience from re-occurring.

Some relatives said that the illness had increased their daily expenditure, especially during the consumers' hospitalization, because travelling to and from hospitals added significantly to their usually meager expenses, as did making Chinese soups to ease side effects of medications. This situation was reflected by relatives who were receiving social security. The keep they received only permitted basic necessities; buying some more meat to make the soup was already stretching their resources.

4.3.2 Subjective burden

4.3.2.1 Frustration and anxiety

The objective and subjective burden on families were in fact intertwined. When relatives had difficulty meeting practical demands, they would most likely also had a negative emotional response; such emotional response would in turn affect their ability to cope with practical demands. In other words, objective and subjective burden could augment each other. For example, consumers' failures in job search brought financial burden as well as frustration and anxiety in their families. The stress could aggravate symptoms, and the frustration made further attempts even more difficult. Among the interviewees, discrimination against consumers seeking employment had caused considerable distress. Consumers were met with repeated failures and returned home disappointed, sad, and sometimes angry. One of the consumers often "blew a temper on himself" at home after he was rejected without even the opportunity to talk about the position or his skills. His relatives were frustrated by the discrimination, and worried that the consumer's condition might deteriorate if the rejection continued. Relatives were also worried that if no employer would hire the consumers, they would not be able to support themselves in future.

It was not only stigmatization by employers that caused relatives' worries. The general lack of vocational training and placement services were also contributing factors. During interviews, relatives commonly expressed concerns such as “It's no good staying home all day. She needs to have something to do.... I'm sure she'll recover much faster if they could give her some kind of work or training.” "I wish (someone) can help him find a job. (The staff of) the hospital said there's no place (in the sheltered workshop) for him, and he's got to wait.... Just any job will do. If he goes on like this, he can't recover." Though clinicians were aware of the benefits of vocational interventions, the supply of these services was very limited. The mental health system had focused on controlling symptoms with medications, but failed to provide adequate resources for proactive programs of rehabilitation. This service model implied an assumption that people with mental illness could not be productive members of society, that their quality of life was unimportant, and that the goal of treatment was to keep them from causing disturbance. This stigmatization of consumers on an institutional scale, though inadvertent, had caused much frustration and helplessness in consumers' families.

The difficulty to access psychiatric services, as mentioned in Section 4.3.1 on objective burden, also caused subjective burden on families. In the case of Mr. and Mrs. E, who had to take their son to several clinics and hospitals before they finally found a psychiatric service for him, the objective burden of seeking treatment was associated with much perplexity and frustration. Furthermore, their experience after they had found the service was described as "very miserable". They were shocked to learn that by bringing their son to the psychiatric hospital, they were taken to be applying for his admission. Their request to bring him home was declined. “We never knew he’d be locked up for the night. We never thought about it. We only meant to take him to see the doctor, how could we have thought it’d be like that?” “I wept through the night. We couldn’t sleep at all. I was so scared. We had to go through door after door, all of them locked, before we got to his room. When we came out, the nurse locked the doors one by one again. It's like a prison. Very horrible." "Nobody had explained to us before what the facility was like, or how his condition was. Otherwise we'd be prepared and we'd have a choice. Once we're there, they wouldn't let him go. It's terrible. I wept and wept those days." Their experience illustrated that the rights of clients' families had been neglected in the service delivery. While people with heart disease or other physical problems uniformly had their conditions and treatment alternatives explained to them and their families, and had the right to seek a second opinion, in psychiatric services clients had no such rights. Even the families of clients were regarded as unfit for making informed decisions. Section 4.3.1 has described the void objection of relatives to the administration of medications with serious side effects. Stigmatization of clients' families clearly existed in mental health services.

4.3.2.2 Low self-esteem and helplessness

Shame and isolation was experienced by many interviewees, as reported in Section 4.3.1. Utterances such as "People want to keep away from you once they hear about the illness" and "Someone in my family has this illness. I feel ashamed" reflected stigmatization of mental health consumers and families. In some cases the stigma was internalized and damaged the self-esteem of relatives. Many had avoided social activities. Some sacrificed their social links to conceal the illness of their relatives, so that the consumers could avoid the discrimination against people with mental illness. In addition to the loneliness, concealing the illness for fear of stigma also limited the coping resources available to relatives. When relatives could not ask for the help they needed, e.g. in seeking treatment, anxiety and helplessness could easily set in.

Stigmatization of consumers' families and "blaming the victim" was so prevalent that even the relatives themselves held those beliefs. Feelings of guilt for causing the illness were expressed by two interviewees. Both were consumers' mothers. One of them thought that the consumer might not have developed the illness if she had devoted less time to work and more time to care for her children. In the other family, the mother and child had been deserted decades ago, and the mother thought that growing up in a single-parent family had contributed to her son's illness. She had had to work long hours to earn a living for her son and herself, so she had little time to care for her son. She blamed herself for not having provided a "complete" family for him.

Some relatives regretted not noticing earlier signs of the illness. A parent said, "I thought she's only bad-tempered. She had problems getting along with colleagues, and she never stayed on a job for long.... If she had gone to a doctor when it's not so serious, she might have been better." The majority of interviewees said because they knew little about mental illness, they did not realize the problem from the first signs of it. These expressions of subjective burden reflected the society's stigmatization of consumers' families, and the lack of psychoeducation and counseling services for these families.

The lack of community support services added to families' subjective burden as relatives had to give up their work to take care of the consumers. A mother who closed down her business to care for her son because no day care service was available said, "I want to earn my own living. We want to support ourselves. If you get social welfare, people look down on you, like you're lazy and useless or something. I was very unhappy. I feel so useless." In another family, the parents stopped renewing the contract of their small business to take care of their son, but had great difficulty finding a new job. Unemployed, savings running out, but still having to pay mortgage, they found life very stressful. They were frustrated by the job search and worried about their finances. As the mother said, the pressure was enormous and they did not dare thinking about the future. These parents' loss of employment caused emotional distress both directly through the sacrifice of a career and indirectly through the financial pressure. If mental illness stigma could be dispelled and families needed not be afraid to advocate for the services they needed, such as day hospital service, their burden might be eased.

Many relatives experienced empathetic suffering with the consumer. In one case, the consumer inadvertently touched a woman in a crowded street, but was accused of indecent behavior. Frightened and unable to express himself, the consumer was beaten by a passer-by and was later detained at the police station. Though he was ruled innocent by court in the end, the fear and grievance caused severe distress both for himself and the family. In fact, the consumer had been beaten several times before, but he could not tell others what happened. His relative had constant worries and fears that he might get into trouble again and that he would not be able to take care of himself. "Alas, these people.... people like him really need others to look after them." "If he doesn't go out but just sleeps here, it's miserable too." "He's such a big boy now, who's gonna look after him? Nobody would bother about someone like that." The worries of this family were shared by the mother of another consumer. He was involuntarily admitted to a psychiatric hospital against the family's will, but a workman of the hospital harassed and attacked him. Other inpatients followed suit and the consumer suffered severe injuries. His mother said it was "extremely painful" to see such sufferings of her son, and she had insomnia afterwards. Beyond anger, she was worried that her son was defenseless against harms, and that such episodes would cause her son's condition to deteriorate. This kind of emotional burden on families could be avoided if day hospital services were available, the police more alert when consumers were accused of misdemeanor, and consumers better protected in hospitals.

4.4 DISCUSSION

It was evident that stigmatization of persons with mental illness had added to the burden on their families. People's alienation of mental health consumers in various spheres, such as employment and social life, had constituted major barriers to consumers' reintegration into society, and hence had intensified the practical and emotional burden on their relatives. As the interviewees reported, consumers were faced with discrimination by employers and experienced frustration and grievance. Unemployment also meant financial pressure and deprivation of opportunities to reintegrate into society. Stigmatization and alienation by members of the community had affected consumers' self-esteem and social participation. All these accounts agreed with the existing literature which pointed out that the public had contributed towards prolonging consumers' illness through stigmatization and discrimination (Harding, Zubin & Strauss, 1987; Page 1995). The consequences on consumers' families included increased burden of care, frustration and helplessness, and worries about consumers' future. The difficulties and stresses due to persistence of the illness were consonant with previous reports of family burden (Fadden, Bebbington & Kuipers, 1987a; Lefley, 1996).

Reports of interviewees' experience agreed with previous research on the unmet needs and low quality of life of mental health consumers. Relatives expressed their worries and disappointment about the consumers' social isolation and lack of meaningful activities, as well as the lack of protection for consumers' physical and financial security; they were also concerned about the insufficient information and services available to consumers and families. Such unmet needs had been identified by Perese (1997) as significant factors affecting the life satisfaction and recovery of mental health consumers, and there was evidence both from the literature and from this study that stigmatization had hindered the fulfillment of these needs. Kotak (1999) described the difficulty for people with mental illness to obtain adequate medical care for their physical health, as stereotyping could easily lead medical professionals to mistake genuine complaints for manifestations of the mental illness. Discriminatory practices in employment had been reported in the literature and in the present interviews. Interviewees also described the effects of stigma on consumers' social life, which was consistent with those reported by Perese (1997). It was clear that stigmatization had added much adversity for mental health consumers, and thus led to increased burden of care and empathetic suffering of their relatives.

While stigmatization of mental health consumers increased family burden through hindering consumers' reintegration, stigmatization of consumers' relatives also caused additional burden. There was stigmatization by association, as relatives of consumers reported being distanced and treated as inferior when people learnt about their relatives' illness. Their reports supported the observation that in the Chinese culture, having a family member with mental illness could lead the whole family to be seen as inferior (Hsu, 1995). Apart from the collective representation of the family, the literature had also considered accusations against the family for causing the illness as a contributing factor to the rejection and social isolation of consumers' relatives (Lefley, 1992; Kuipers et al., 1992). However there was no evidence from the present interviews that interviewees had been confronted with such accusations by others (see next paragraph). In spite of this, stigmatization of consumers' relatives had clearly added to their burden. The social isolation limited their practical and emotional resources to cope with the mental illness of the consumer; the burden of care also increased as relatives were intimidated from seeking help for fear of stigma. Interviewees had to seek mental health services, monitor consumers' progress and daily routines, and deal with unemployment; their experience illustrated that coping with such burden without support was inducive to anxiety and depression.

Furthermore, there was evidence of internalized stigma among family members of mental health consumers. Some interviewees believed that having a relative with mental illness was shameful, and the sense of inferiority discouraged them from social activities. Some felt guilty as they held themselves responsible for causing the mental illness, showing an internalization of the society's "blaming the victim". Though there was no evidence from the interviews that interviewees had been accused by others for causing their relatives' illness, such beliefs might have been held before the consumers' developed the illness, when some of the relatives might have the same negative attitudes as the general public (Katschnig, 2000). The self-stigmatization affected not only their self-esteem but also the will to seek improvement of their conditions. When relatives believed themselves to be unworthy of respect, they would easily lose hope of maintaining a healthy social network. Previous research has shown that social support to consumers' relatives is an important predictor of their mental health and consumers' rehabilitation outcome (Dixon et al., 2001); self-stigmatization impeded successful coping and augmented the burden on consumers' relatives.

The mental health system and funding policies also reflected stigmatization of mental health consumers at the societal level. As interviewees reported, the treatment provided to their relatives consisted mainly of hospitalization and medication; and there was a serious lack of vocational and social rehabilitation services to facilitate their reintegration. The focus of treatment was controlling symptoms and preventing consumers from causing disturbance to others. Whether persons with mental illness had the best possible opportunities to function independently in the community was not the main concern, and the system had neglected that they needed a meaningful life and a sense of fulfillment like other people did. The model of services had clearly affected the burden on consumers' families. The lack of day hospital service and the use of medications with debilitating side effects directly increased relatives' burden of care. The over-reliance on hospitalization, together with the lack of social skills training, vocational training and placement services, hindered consumers' social reintegration and increased both the practical and emotional burden on relatives. The unemployment and social isolation of consumers meant not only practical difficulties in finances, daily routines and social lives, but also emotional stress, anxiety and frustration when consumers failed to recover.

Using the analogy of a jigsaw puzzle, the survey results and review of mental health care policies reported in Chapter 3 and the findings from the individual interviews were pieces of the puzzle, and together they suggested a pattern where stigma intensified family burden. Interviewees' experience of stigma as revealed in the individual interviews supported that the public had misgivings about interacting with mental health consumers and were unwilling to engage in personal interactions with them. Helping mental health consumers was regarded by individuals as something that should better be left to "other people". The marginalization of consumers and their relatives was reflected in social policies, as resources and services were provided not in ways that should best serve consumers and families, but rather in a way that was acceptable to the public. Consistent with Mechanic's (1989) proposition, the society's collective decision-making and allocation of resources were influenced by norms and values. Where the public gave scant regard to the welfare of mental health consumers and their relatives, but attached more importance to guarding against allegedly dangerous consumers, the restrictive model of mental health services became understandable. As Lefley (1992) had argued, "the massive underfunding of services and research and negative expectations of recovery clearly affect the resources available to caregivers." (p.77) With the lack of rehabilitation services such as halfway houses and vocational counseling, the mental health system had inadvertently fostered isolation and dependence of consumers, thereby increasing the burden on their families.

The results from the questionnaire survey and the individual interviews supported the expected findings stated in Chapter 2, which were:

- There was stigmatization of mental health consumers in Hong Kong
- Families of mental health consumers bore heavy subjective and objective burden
- Stigmatization experienced by families directly increased their burden
- Stigmatization at the societal level was reflected in social policies, thereby limiting the support available to consumers' families.

4.4.1 Recommendations for Services

The reduction of stigma was thus clearly necessary for mental health consumers and their relatives to attain an adequate quality of life. In particular, anti-stigma campaigns among policy-makers, administrators and healthcare professionals are important in promoting their welfare. There needs to be more awareness among decision makers and service providers that mental health consumers have the same needs for social participation as non-consumers, that they are capable of assuming meaningful roles in the community, and that they deserve equal respect as any other citizen.

Mental health services should adopt a proactive approach to facilitate the reintegration of consumers. Providing adequate information and help to consumers' families, including sufficient contact with service providers, day care and respite care service, information on stress management etc., will be important measures to take under this approach. There should also be more support for consumers and families to set up self-help groups. Vocational rehabilitation and supported employment services must be strengthened, and more resources should be made available for the establishment of halfway houses and recreational/educational facilities.

Existing public education programs may be refined, by including more information on positive treatment outcomes and prevalence rates of violent behavior among consumers, as well as introducing actual contact with consumers. Initiatives for students or the general public to work with mental health consumers on charity projects, such as fund-raising walks or tree-planting, would provide opportunities for dispelling myths about persons with mental illness. However, the ultimate way to eliminate stigma and ease the burden on families will still be the improvement of mental health services (Montenegro, 1999), which should be proactive in the provision of treatment and rehabilitation services, and maximizes opportunities for consumers to reintegrate into society and achieve their own life goals.

4.4.2 Limitations

Participants in the interviews might not be representative of relatives of mental health consumers in Hong Kong, thus the extent to which their concerns were shared by other consumers' families was unclear. Another limitation was that this phase of the study focused entirely on participants' reports of burden. Though standardized measures of burden cannot replace personal accounts in pursuing understanding of family burden, such measures and their relationship with personal accounts should prove informative. Future studies may include a standardized assessment of burden where suitable participants and research personnel are available.

CHAPTER 5

CONCLUSION

The results of this study showed that there was still stigmatization of mental health consumers in Hong Kong. The myth about their being dangerous had persisted. Helping them reintegrate into society was considered the government's responsibility, and individuals were unwilling to engage in personal interactions with consumers. Though most people were aware that mental health consumers should enjoy equal opportunities, the "not in my backyard" mentality was evident.

Families of mental health consumers in Hong Kong bore a heavy burden of care due to the lack of rehabilitation services and support. The society's stigmatization of their relatives caused them additional adversity, as the social isolation and unemployment of consumers led to much practical and emotional burden, including financial difficulties and anxiety.

Mental health services were focused on controlling symptoms, but largely neglected the quality of life of consumers and families. Insufficient resource had been devoted to social and vocational rehabilitation, and little attention had been paid to consumers' needs for personal growth. The model of services reflected the stigma that mental health consumers could not be competent members of society.

To maximize opportunities for consumers' reintegration and relieve the burden on their families, public education to fight stigma would be necessary; yet the most critical would be the adoption of a proactive approach in mental health services. When there were genuine respect for consumers and concern about their life goals in the mental health system, consumers and families could be free from the impact of stigma.

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Appendix 1

Interview Guide - Collection of Questionnaire Items

Interview Guide

(Pool of questions which may be asked during item collection)

1. Purpose of the product questionnaire

   To measure public attitudes towards mental health consumers and their families in Hong Kong, and to identify factors related to positive and negative attitudes (e.g. knowledge of mental illness, previous contact with consumers, etc.)

2. Aims of the interview:

   To collect (a) suggestions on the content area of the questionnaire
   (b) actual items
   from interviewees based on their knowledge and observations in the area.

3. The interview

   This interview is part of a study into the relationship between public attitudes towards mental health consumers and the burden on their families.

   我們在做一個研究，是關於公眾對精神病患者的態度 怎樣影響病者家屬的負擔。

   We are going to conduct a questionnaire survey to measure public attitudes towards mental health consumers and their families in Hong Kong, and to identify factors related to positive and negative attitudes (e.g. knowledge of mental illness, previous contact with consumers, etc.)

   我們將會做一個問卷調查，看看香港的公眾對於精神病患者和他們的家屬的態度是怎樣，和看看有哪些因數會影響他們的態度(如對精神病的認識，有否接觸過患者等)

   We would like to seek your advice on what kinds of questions to include, and what actual items to use if possible.

   我們想請教你的意見，看看有哪些問題應該包括在問卷裡面。

   Overall, do you think the general public in Hong Kong accepts mental health consumers as equal members of the society?

   你覺得香港人一般是否接受精神病患者，平等對待他們?

   In what areas is there prejudice or discrimination?

在哪些方面有偏見或歧視?

Could you give some examples of discrimination behaviour?

可否舉些例子，有哪些歧視行爲?

In what context does that happen most often? What are the responses of the other people present?

這樣的事多數在什麼情況下發生? 周圍的人會有什麼反應?

Do you think the public generally accepts overt discrimination?

你覺得公衆是否一般都接受歧視行爲?

Do you think these behaviours are connected with misunderstandings about mental illness?

你認爲這些行爲是否與對精神病的誤解有關?

Could you give examples of such misconceptions?

可不可以舉些例子，有哪些誤解?

So do you think it is appropriate to include ______________ as an item in the questionnaire?

那如果問卷裡面問這樣一個問題: ____________ 你覺得是否適當?

What other items would you suggest to include in the questionnaire?

有哪些其他問題 你覺得可以放在問卷裡?

Are there other factors that you think would affect people's attitude towards mental illness?

有哪些其他因數 是你覺得會影響人們對精神病的態度的呢?

Do you have any other comments about the questionnaire? Are there potential problems that you can see?

你對這份問卷有沒有其他意見? 有沒有看到一些潛在問題?

Appendix 2

Questionnaire Items Evaluation Form

As part of a project titled 'The Hong Kong Public's Attitudes towards Psychiatric Patients and the Effects on the Burden of Families', a questionnaire survey will be conducted to measure public attitudes towards psychiatric patients in Hong Kong, and to identify factors related to positive and negative attitudes (e.g. knowledge of mental illness, previous contact with patients, etc.) The following items have been gathered for use in the questionnaire**. We would like to seek your expert advice regarding the validity of these items before we proceed to pretests.

For each item, please mark one of the boxes 'Relevant', 'Irrelevant' or 'Undecided' to indicate whether the content of the item is relevant to the measurement of public attitudes towards psychiatric patients and respondents' knowledge about mental illness. Please also write any comments you may have in the space provided under each item, particularly when you have marked 'Irrelevant' or 'Undecided'.

Thank you very much for your time.

(Items 1 – 29 use a five-point scale from 'Strongly agree' to 'Strongly disagree'.)

1. Elderly homes should not take in old people who had been mentally ill.

☐ Relevant ☐ Irrelevant ☐ Undecided

Comments: ______________________________

____

____

2. Patients who had been admitted to psychiatric hospitals need time to adapt before they can reintegrate into society.

☐ Relevant ☐ Irrelevant ☐ Undecided

Comments: ______________________________

____

____

3. Discrimination and alienation against psychiatric patients can affect their recovery.

☐ Relevant ☐ Irrelevant ☐ Undecided

Comments: ______________________________

____

____

**The original items in Chinese will be used in the survey. While every effort has been made to preserve the content and tone of the items in this English translation, the level of language proficiency required of the reader is in many cases higher in this version.

4. Psychiatric patients in Hong Kong are isolated by society.

☐ Relevant ☐ Irrelevant ☐ Undecided

Comments: ______________________________

5. Psychiatric patients in Hong Kong are treated unfairly.

☐ Relevant ☐ Irrelevant ☐ Undecided

Comments: ______________________________

6. I consider it unacceptable to subject psychiatric patients to alienation.

☐ Relevant ☐ Irrelevant ☐ Undecided

Comments: ______________________________

7. Families of psychiatric patients live under much pressure and need more support.

☐ Relevant ☐ Irrelevant ☐ Undecided

Comments: ______________________________

8. The public have misunderstandings about psychiatric patients.

☐ Relevant ☐ Irrelevant ☐ Undecided

Comments: ______________________________

9. Counselling is only for those who have severe mental problems.

☐ Relevant ☐ Irrelevant ☐ Undecided

Comments: ______________________________

10. Only those who have severe mental problems need to see a psychiatrist.

☐ Relevant ☐ Irrelevant ☐ Undecided

Comments: ____________________

____

____

11. Anyone can benefit from counselling when he/she is emotionally disturbed, even if the problem is not serious.

☐ Relevant ☐ Irrelevant ☐ Undecided

Comments: ____________________

____

____

12. Only those whose thoughts are seriously disordered need to take psychotropic drugs.

☐ Relevant ☐ Irrelevant ☐ Undecided

Comments: ____________________

____

____

13. If there has never been any case of mental illness in the family, no family member would become mentally ill in future.

☐ Relevant ☐ Irrelevant ☐ Undecided

Comments: ____________________

____

____

14. Among the ex-mental patients in employment, there are many successful examples with high levels of performance.

☐ Relevant ☐ Irrelevant ☐ Undecided

Comments: ____________________

____

____

15. I don't know how to get along with people who had been mentally ill.

☐ Relevant ☐ Irrelevant ☐ Undecided

Comments: ______________________________

____

____

16. Modern drugs can keep psychiatric conditions under control.

☐ Relevant ☐ Irrelevant ☐ Undecided

Comments: ______________________________

____

____

17. The crime rate among psychiatric patients is higher than that in the general population.

☐ Relevant ☐ Irrelevant ☐ Undecided

Comments: ______________________________

____

____

18. I don't want to work with people who had been mentally ill.

☐ Relevant ☐ Irrelevant ☐ Undecided

Comments: ______________________________

____

____

19. Normal social activities are necessary for ex-mental patients to integrate into society.

☐ Relevant ☐ Irrelevant ☐ Undecided

Comments: ______________________________

____

____

20. Those who had been mentally ill are dangerous no matter what.

☐ Relevant ☐ Irrelevant ☐ Undecided

Comments: ______________________________

____

____

21. I believe people recovering from a mental illness should enjoy equal opportunities in society.

☐ Relevant ☐ Irrelevant ☐ Undecided

Comments: ____________________

22. Psychiatric rehabilitation facilities should be located away from people's residence.

☐ Relevant ☐ Irrelevant ☐ Undecided

Comments: ____________________

23. It is more important to help those with a physical handicap than those with a mental illness.

☐ Relevant ☐ Irrelevant ☐ Undecided

Comments: ____________________

24. Regarding cases of offence that involve psychiatric patients, I think the portrayal in newspapers are exaggerated.

☐ Relevant ☐ Irrelevant ☐ Undecided

Comments: ____________________

25. The majority of psychiatric patients became ill because of their parents' wrong approaches to bringing up children.

☐ Relevant ☐ Irrelevant ☐ Undecided

Comments: ____________________

26. Given appropriate assistance, psychiatric patients can lead a normal life.

☐ Relevant ☐ Irrelevant ☐ Undecided

Comments: ____________________

____

____

27. I am in favour of increasing funding for psychiatric rehabilitation services.

☐ Relevant ☐ Irrelevant ☐ Undecided

Comments: ____________________

____

____

28. I can be friends with people who had been mentally ill.

☐ Relevant ☐ Irrelevant ☐ Undecided

Comments: ____________________

____

____

29. The government is not paying enough attention to the welfare and rights of psychiatric patients.

☐ Relevant ☐ Irrelevant ☐ Undecided

Comments: ____________________

____

____

(Items 30 – 40 use a five-point scale from 'Definitely' to 'Definitely not'.)

30. If a family member said he/she was very depressed, I would suggest him/her see a counsellor.

☐ Relevant ☐ Irrelevant ☐ Undecided

Comments: ____________________

____

____

31. If a family member said he/she was very depressed, I would suggest him/her see a doctor.

☐ Relevant ☐ Irrelevant ☐ Undecided

Comments: ______________________________

____

____

32. If the government proposes to set up half-way houses near my home, I will oppose strongly.

☐ Relevant ☐ Irrelevant ☐ Undecided

Comments: ______________________________

____

____

33. If one of my friends became mentally ill, I would show my concern and help him/her the best I can.

☐ Relevant ☐ Irrelevant ☐ Undecided

Comments: ______________________________

____

____

34. If one of my friends became mentally ill, I would see him/her less often.

☐ Relevant ☐ Irrelevant ☐ Undecided

Comments: ______________________________

____

____

35. If a new neighbour was mentally ill, I would avoid talking to him/her as much as possible.

☐ Relevant ☐ Irrelevant ☐ Undecided

Comments: ______________________________

____

____

36. If a new neighbour was mentally ill, I would avoid talking to his/her relatives as much as possible.

☐ Relevant ☐ Irrelevant ☐ Undecided

Comments: ______________________________

____

____

37. If given a chance to get along with those who have recovered from a mental illness, I will make allowances for them.

☐ Relevant ☐ Irrelevant ☐ Undecided

Comments: ______________________________

____

____

38. If I found that my colleague had been mentally ill, I would distance myself from him/her.

☐ Relevant ☐ Irrelevant ☐ Undecided

Comments: ______________________________

____

____

39. If the person sitting next to me on public transport keeps muttering to himself, I will leave my seat.

☐ Relevant ☐ Irrelevant ☐ Undecided

Comments: ______________________________

____

____

40. As an employer, I would reject a job applicant if he/she had been mentally ill.

☐ Relevant ☐ Irrelevant ☐ Undecided

Comments: ______________________________

____

____

41. I think those people who had been mentally ill .... (Choose any number of items)

☐ are introverts
☐ are honest
☐ are quiet
☐ are dirty
☐ are hard-working
☐ are dangerous
☐ are friendly
☐ have low self-esteem
☐ obey rules
☐ are shy
☐ are frightening
☐ may hurt other people
☐ are polite
☐ lose their temper easily
☐ are no different from other people
☐ are stupid
☐ are able to control themselves
☐ can contribute to society
☐ cannot integrate into society
☐ are talkative

☐ Relevant ☐ Irrelevant ☐ Undecided

Comments: ____

____

____

(Items 42a, 42b and 42c provide three response options: 'Yes', 'No', 'Don't know'.)

42. Do the following disorders belong to the field of psychiatry?

a. Autism
b. Anorexia nervosa
c. Depression

☐ Relevant ☐ Irrelevant ☐ Undecided

Comments: ____

____

____

Any other comments or suggestions?

____

____

- End -

Your help is much appreciated.

Appendix 3

Questionnaire - Survey on Attitudes

Appendix 3

公眾對精神病康復者的態度 - 意見調查

此項不記名的問卷調查，旨在了解本港公眾人士對精神病康復者的態度和對精神病的認識。問卷約需十五分鐘完成；請於填妥後交回＿＿＿＿＿＿＿＿＿＿＿＿，以便研究人員收集。如閣下對此項調查有任何疑問，請聯絡香港理工大學康復治療科學系助理教授曾永康博士(電話 2766 6750，傳真 2330 8656，電郵 rshtsang@　　　　)或研究生譚幗貞(電話 2766 4840，電郵 rsrsch5@　　　　　)。多謝合作。

請在適當的空格內劃上 ✓ 號。

		十分同意	同意	無意見	不同意	十分不同意
1	老人院不應接受有精神病紀錄的老人入住。	□	□	□	□	□
2	別人的歧視和排擠會影響精神病患者的康復。	□	□	□	□	□
3	現時的藥物可以有效控制精神病的病情。	□	□	□	□	□
4	大部分精神病患者都是因父母管教方法不當而致病的。	□	□	□	□	□
5	只有嚴重精神錯亂的人，才需要服食精神科藥物。	□	□	□	□	□
6	有嚴重精神問題的人，才需要心理輔導。	□	□	□	□	□
7	我贊成增加撥款予精神病復康服務。	□	□	□	□	□
8	我贊成增撥資源，爲精神病患者的家屬提供更多支援。	□	□	□	□	□
9	業主拒絕向精神病康復者租出物業，是可以諒解的。	□	□	□	□	□

		十分同意	同意	無意見	不同意	十分不同意
10	香港的精神病康復者受到不公平對待。	□	□	□	□	□
11	如果家族過去從沒有人患精神病，家族成員將來也一定不會患上精神病。	□	□	□	□	□
12	我不知道應該怎樣與精神病康復者相處。	□	□	□	□	□
13	我不想與精神病康復者一同工作。	□	□	□	□	□
14	我覺得報章過分渲染精神病患者的犯罪個案。	□	□	□	□	□
15	只要有適當的協助，精神病患者是可以重過正常生活的。	□	□	□	□	□
16	幫助身體有缺陷的人，比幫助精神病患者重要。	□	□	□	□	□
17	精神病康復者始終是危險的。	□	□	□	□	□
18	精神病復康設施應該遠離民居。	□	□	□	□	□
19	我認爲排擠精神病患者的行爲是不能接受的。	□	□	□	□	□
20	政府對精神病患者的福利和權益關注不足。	□	□	□	□	□
21	受僱工作的精神病康復者，也有很多表現優良的成功例子。	□	□	□	□	□
22	精神病患者的子女，即使本身沒有精神病紀錄，也不應受聘爲需使用槍械的執法人員。	□	□	□	□	□

		一定會	應該會	應該不會	一定不會
23	假如我的家人表示感到非常抑鬱，我會建議他尋求心理輔導。	□	□	□	□
24	如果政府或有關機構提出在我家附近設立中途宿舍，我會強烈反對。	□	□	□	□
25	如果一位新鄰居患有精神病，我會因此而避免跟他的家人交往。	□	□	□	□
26	如果新來的同事是精神病康復者，我會盡量幫助他適應新工作。	□	□	□	□
27	在公共交通工具上，如果我鄰座的人喃喃自語，我會離開原來的座位。	□	□	□	□
28	如果我是僱主，我會拒絕曾患精神病的求職者參加面試。	□	□	□	□

		是	不是	不知道
29	精神病患者的犯罪率較一般人高。	□	□	□
30	以下的病症是否屬於精神科的範疇？			
a	自閉症	□	□	□
b	厭食症	□	□	□
c	抑鬱症	□	□	□
d	過度活躍症	□	□	□
e	柏金遜症	□	□	□

31 我覺得精神病康復者__________________（可選多項）

- □ 內向
- □ 可怕
- □ 誠實
- □ 能控制自己
- □ 骯髒
- □ 容易發脾氣
- □ 勤勞
- □ 友善
- □ 笨拙
- □ 跟其他人沒有分別
- □ 有禮貌
- □ 自卑
- □ 可以對社會有貢獻
- □ 守規則
- □ 無法融入社會
- □ 怕事
- □ 負責任
- □ 行爲無法預計
- □ 害羞
- □ 說話很多
- □ 有暴力傾向

32 我對精神病患者的認識,來自____________________ (可選多項)

- □ 電影
- □ 親友意見
- □ 電視節目
- □ 過往與精神病患者接觸
- □ 報章
- □ 雜誌
- □ 電台節目
- □ 政府／志願團體宣傳
- □ 學校教育
- □ 講座／研討會
- □ 書籍
- □ 互聯網頁
- □ 話劇／其他文化活動
- □ 其他(請註明)____________________

<u>受訪者資料</u>

是	不是	
□	□	我曾與精神病患者同住
□	□	我的主要職責是爲精神病患者提供服務
□	□	我在報刊、電影或電視節目中看過有關精神病患者的寫實描述
□	□	我跟一位患有精神病的親友或同事經常有接觸
□	□	我曾患有精神病
□	□	我遇見過可能患有精神病的人，並對他／他們留意過片刻
□	□	我常常有機會接觸到精神病患者(每月最少兩次)
□	□	我偶然會接觸到精神病患者

年齡：____________ 性別： □男 □女

職業：____________

教育程度： □小學或以下 □中一至中五 □預科/工業學院
□大專或以上 □其他(請註明)____________________

個人收入(每月)： □學生／失業／無薪工作
□$7,000 以下 □$7,001 至$12,000
□$12,001 至$20,000 □$20,001 至$30,000
□$30,001 至$50,000 □$50,000 以上

問卷完，謝謝！

Questions 1 to 22 have five response options from "Strongly agree" to "Strongly disagree".

1. Elderly homes should not take in seniors who have been mentally ill.
2. Discrimination and alienation against psychiatric patients can affect their recovery.
3. Modern drugs can keep psychiatric conditions under control.
4. The majority of psychiatric patients became ill because of their parents' wrong approaches to bringing up children.
5. Only severely deranged people would need to take psychiatric drugs.
6. Counselling is only for those who have severe mental problems.
7. I am in favour of increasing funding for psychiatric rehabilitation services.
8. I am in favour of allotting more resources to provide more support for family members of people with mental illness.
9. Property owners should not be blamed for refusal to lease properties to people with mental illness.
10. In Hong Kong, people who have been mentally ill are treated unfairly.
11. If there has never been any case of mental illness in the family, no family member would become mentally ill in future.
12. I do not know how to get along with people who have been mentally ill.
13. I do not want to work with people who have been mentally ill.
14. Regarding cases of offence that involve psychiatric patients, I think the portrayals in newspapers are exaggerated.
15. Given appropriate assistance, people with mental illness may lead a normal life again.
16. It is more important to help those with a physical handicap than those with a mental illness.

17. People who have been mentally ill are dangerous no matter what.

18. Psychiatric rehabilitation facilities should be located away from people's residence.

19. I consider it unacceptable to subject people with mental illness to alienation.

20. The government is not paying enough attention to the welfare and rights of people with mental illness.

21. Among ex-mental patients in employment, there are many successful examples with high levels of performance.

22. Children of psychiatric patients should not be employed as armed officers, even if they have never had mental illness themselves.

Questions 23 to 28 have four response options: "Definitely", "Probably", "Probably not" and "Definitely not".

23. If a family member said he/she was very depressed, I would suggest him/her see a counsellor.

24. If the government or other organizations propose to set up halfway houses near my home, I will oppose strongly.

25. If a new neighbour was mentally ill, I would try to avoid his/her family.

26. If a newcomer to my workplace had been mentally ill, I would try to help him/her adapt to the job.

27. If the person sitting next to me on public transport keeps muttering to himself/herself, I will leave my seat.

28. As an employer, I would screen out job applicants who have been mentally ill without interviewing them.

Questions 29 and 30a to 30e have three response options: "Yes", "No" and "Don't know".

29. The crime rate among people with mental illness is higher than that of the general population.

30. Do the following disorders belong to the field of psychiatry?

a. autism
b. anorexia nervosa
c. depression
d. attention-deficit hyperactivity disorder (ADHD)
e. Parkinson's disease

<u>On Question 31, respondents may check any number of stems.</u>

31. I feel that people who had been mentally ill are....

- Introverted
- Fearful
- Honest
- Able to control oneself
- Dirty
- Quick-tempered
- Hard-working
- Friendly
- Clumsy
- Not different from others
- Polite
- Have low self-esteem
- Able to contribute to society
- Obey rules
- Cannot integrate into society
- Timid
- Responsible
- Unpredictable
- Shy
- Talkative
- Have a tendency to violence

Appendix 4

Chinese Translation of the Original Level of Contact Scale

by Holmes et al. (1999)

Chinese translation of the Level of Contact Scale by Holmes et al. (1999)

Item	**Score**
我曾患有嚴重的精神病	12
我曾與嚴重精神病患者同住	11
我的家族中有嚴重精神病患者	10
我和家人都認識一位患有嚴重精神病的朋友	9
在工作崗位上，我須要為嚴重精神病患者提供服務／治療	8
在工作崗位上，我須要為嚴重精神病患者提供服務	7
在我的工作地點，我和一位曾患嚴重精神病的同事合作過	6
我曾經常地觀察嚴重精神病患者的舉動	5
我在電視上看過有關嚴重精神病的紀錄片	4
我在電影／電視節目中看過有關精神病患者的寫實描述	3
我曾遇見一個可能患有嚴重精神病的人，並對他留意過片刻	2
以我所知，我見過的人當中並沒有嚴重精神病患者	1

Appendix 5

Chinese Version of Revised Contact Sub-scale

Chinese version of the revised level of contact sub-scale

Item	**Score**
我曾患有精神病	8
我曾與精神病患者同住	7
我跟一位患有精神病的親友或同事經常有接觸	6
我的主要職責是為精神病患者提供服務	5
我常常有機會接觸到精神病患者(每月最少兩次)	4
我偶然會接觸到精神病患者	3
我遇見過可能患有精神病的人，並對他／他們留意過片刻	2
我在報刊、電影或電視節目中看過有關精神病患者的寫實描述	1

Appendix 6

Cover Letter to Survey Participants

Appendix 6

THE HONG KONG
POLYTECHNIC UNIVERSITY
香港理工大學

公眾對精神病康復者的態度 - 意見調查

參加者須知

香港理工大學康復治療科學系的研究人員邀請閣下參加一項問卷調查，內容有關公眾對精神病康復者的態度。研究結果將有助提供復康和輔導服務予精神病患者及其家屬。

問卷調查以不記名方式進行，參加者的身分及參與的學校名單均會保密。研究亦不會爲參加者帶來直接的影響或得益。

閣下是否參加此項研究，完全以閣下的意願爲依歸。閣下可交回未經填寫的問卷，而毋須作任何解釋。

閣下如有任何問題，可聯絡香港理工大學康復治療科學系助理教授曾永康博士(電話 2766 6750，傳真 2330 8656，電郵 rshtsang@)或研究生譚幗貞(電話 2766 4840，電郵 rsrsch5@)。

Appendix 7

Interview Guide - Interviews with Consumers' Relatives

香港公眾對精神病患者的態度對患者家屬的影響

訪問問題

照顧病者

- 你從事甚麼職業？
- 你的工作有沒有因為要照顧______而受到影響？
- 同事們知道你的______患病嗎？
- 工作對你個人而言是否重要？

社交生活

- 你平日有甚麼社交活動嗎？有否跟親戚、朋友聚會？
- 有沒有人因為_______的病而避免跟你們交往？
- _______本人又有甚麼社交活動？
- _______曾否在公眾地方表現不尋常而令你感到尷尬？在場的人怎麼反應？你會因此而減少/避免外出嗎？
- 你認為大多數人是否都樂意跟精神病康復者交往？
- 你認為是甚麼原因令一些人不願意跟精神病康復者交往？(不知道應該怎樣與精神病康復者相處？)
- 你覺得一般人是否理解，別人的歧視和排擠會影響精神病患者的康復?
- 你認為有多大比例的人會贊同"排擠精神病患者的行為是不能接受的"？(這對你們有沒有影響？)

就業

- ______有工作嗎？他找工作有困難嗎？你認為這個問題是否普遍？
- 如果僱主知道求職者曾患精神病，你覺得他有沒有機會參加面試？
- 如果一個精神病康復者找到新工作，你覺得同事們會不會幫助他適應新環境？
- 你覺得一般人會不會抗拒跟精神病康復者一同工作？
- 法庭裁定精神病患者的子女也可以擔任需使用槍械的執法人員。你認為大眾是否贊同法庭的決定？
- 反歧視宣傳中常有"只要有適當的協助，精神病患者是可以重過正常生活的"、"受僱工作的精神病康復者，也有很多表現優良的成功例子"一類訊息；你又怎樣看精神病患者康復的機會？社會上普遍的看法呢？

住屋

- 你覺得普遍來說業主是否都不願意向精神病康復者租出物業？你認為公眾是否接受或認同這種態度/做法？(這對你們有沒有影響？這樣會不會對你們構成壓力？你們

有過這樣的經驗嗎？)

- 以你所知，老人院會不會接受有精神病紀錄的老人入住？你認為公眾是否接受或認同這種態度/做法？
- 有人認為精神病復康設施應該遠離民居，你認為這種看法有多少人支持？有多少人會反對在自己的住所附近設立中途宿舍?

資源分配

- 你認為政府對精神病患者的福利和權益是否關注不足？你覺得其他人是否跟你想法一樣？
- 你相信大部分市民都會贊成增加撥款予精神病復康服務嗎？
- 如果要增撥資源，為精神病患者的家屬提供更多支援，你認為一般市民會不會贊成？
- 身體有缺陷或其他長期病患的人是否比精神病患者更需要或更值得幫助？你覺得你的看法會得到公眾的贊同嗎？精神病患者和其他長期病患者實際上是否都得到應得的服務?你認為有甚麼因素使他們不能得到更好的服務？

公眾對精神病的認識/對精神病患者的印象

- 從你的觀察，你覺得香港人普遍對心理治療有多少認識？對精神病的認識呢？大部分人會怎樣看以下的問題？

  只有嚴重精神錯亂的人，才需要服食精神科藥物?

  有嚴重精神問題的人才需要心理輔導?

  精神病完全是遺傳所致；精神病患者的家屬或多或少總有點不正常？

  子女患上精神病，是父母的錯?
- 你認為一般香港人對精神病康復者的印象是怎樣的呢？

□ 內向
□ 可怕
□ 誠實
□ 能控制自己
□ 骯髒
□ 容易發脾氣
□ 勤勞
□ 友善
□ 笨拙
□ 跟其他人沒有分別
□ 有禮貌
□ 自卑
□ 可以對社會有貢獻
□ 守規則
□ 無法融入社會
□ 怕事
□ 負責任
□ 行為無法預計
□ 害羞
□ 說話很多
□ 有暴力傾向

- 你認為報章是否過分渲染精神病患者的犯罪個案？你覺得大眾普遍的看法又是怎樣？
- 你覺得香港人是否普遍相信精神病患者的犯罪率比一般人高？
- 你覺得有多大比例的人會認為精神病康復者始終是危險的?
- 你認為怎樣才能消除這種誤解？

Public attitudes towards people with mental illness: The consequences for patients' families

Interview questions

Caring for the patient

- What is your occupation?
- Have your employment been affected by the need to care for _______?
- Do your colleagues know about _______'s illness?
- Is it important for you personally to have a job?

Social life

- Do you participate in social activities? Do you meet your friends and relatives regularly?
- Has anyone avoided you because of _______'s illness?
- What social activities does _______ have?
- Has _______ ever behaved strangely in a public place and embarrassed you? What was the response of those present? Would you avoid going out / go out less frequently because of this?
- Do you think most people are willing to make friends with people who had been mentally ill?
- What do you think are the reasons for some people's unwillingness to interact with people who had been mentally ill? (Do not know how to get along with people who had been mentally ill?)
- Do you think people understand that discrimination and alienation can affect the recovery of people with mental illness?
- From your observation, what percentage of people would agree that "Alienation against people with mental illness is unacceptable"? (Does that affect you?)

Employment

- Does ______ have a job? Did s/he have difficulty finding a job? Do you think this problem is common?
- If it is known to the employer that a job applicant had been mentally ill, do you think s/he has a chance to be interviewed?
- If an ex-mental patient finds a new job, do you think his/her colleagues will help him/her adapt to the new environment?
- Do you think people would object to working with someone who had been mentally ill?
- The court has ruled that children of psychiatric patients should be allowed to work as armed officers in law enforcement agencies. Do you think the court's decision is supported by

the public?

- Campaigns against discrimination often carry messages like "Given appropriate assistance, people with mental illness may lead a normal life" or "Among ex-mental patients in employment, there are many successful examples with high levels of performance"; what do you think about the chance for psychiatric patients to recover? What about the prevalent view in our society?

Accommodation

- In general, do you think property owners are unwilling to lease their properties to people who had been mentally ill? Do you think such attitude/practice is accepted by the public? (Have you been affected by this? Has it caused any pressure on you? Have you had such experience?)
- To your knowledge, would elderly homes take in old people who had been mentally ill? Do you think such attitude/practice is accepted by the public?
- Some people believe that psychiatric rehabilitation facilities should be located away from people's residence. How much support do you think there is for this view? What percentage of people would oppose to the establishment of halfway houses near their own homes?

Resource allocation

- Do you think the government is not paying enough attention to the rights and welfare of people with mental illness? Do you think your view is shared by others?
- Do you think most people would agree that we should increase funding for psychiatric rehabilitation services?
- If we need to increase the input of resources in order to provide more support for relatives of people with mental illness, do you think there will be popular support for this proposal?
- Do people with physical disabilities or other chronic diseases need or deserve more help than people with mental illness? Do you think your view is shared by the public? Do psychiatric patients and people with other chronic diseases actually get the services they should get? In your opinion, what is preventing the provision of better services?

Knowledge of the public about mental illness / Impression of people with mental illness

- From your observation, what do Hong Kong people know about psychotherapy? And what do people know about mental illness? What is the majority's view on the following questions?
  - ~ Psychiatric medications are only for those who are severely deranged?
  - ~ Psychotherapy is only for those who have severe mental problems?
  - ~ Mental illness is solely caused by heredity; relatives of psychiatric patients are all

abnormal, albeit to different extents?

~ It is the parents' fault if their children became mentally ill?

- What impression do Hong Kong people commonly have of people who had been mentally ill?

☐ introverted
☐ fearful
☐ honest
☐ able to control oneself
☐ dirty
☐ bad-tempered
☐ diligent
☐ friendly
☐ clumsy
☐ no different from others
☐ polite
☐ have low self-esteem
☐ may contribute to society
☐ obey rules
☐ cannot integrate into society
☐ timid
☐ responsible
☐ unpredictable
☐ shy
☐ talkative
☐ prone to be violent

- Do you think cases of offence committed by psychiatric patients are exaggerated in newspapers? What is your perception of the public's view?
- Do you think most people in Hong Kong believe that the crime rate among psychiatric patients is higher than that in the general population?
- According to your observation, what percentage of people would agree that people who have been mentally ill are dangerous no matter what?
- In your opinion, what needs to be done before such misunderstandings could be rid of?

Appendix 8

Notes for Participants and Consent Form

The Hong Kong Polytechnic University
Department of Rehabilitation Sciences

Project title: Public attitudes towards people with mental illness in Hong Kong and the consequences for patients' families

Researchers of the Department of Rehabilitation Sciences of the Hong Kong Polytechnic University would like to invite you to participate in a research project on public attitudes towards people with mental illness and the consequences for patients' families. We would like to know if the attitudes of the public towards people with mental illness have affected your living. The results of the study would help us understand the needs of people with mental illness and their relatives, and facilitate the development of mental health education.

Your participation

Participants will be interviewed by a researcher once or twice. Interviews may take place at Alice Ho Miu Ling Nethersole Hospital, the Hong Kong Polytechnic University, or other places designated by the participant. With the consent of the participant, interviews may be tape-recorded.

Confidentiality

The identity of participants and all personal information given will be kept confidential. Information gathered from participants will be treated collectively when results are published.

Freedom to participate or withdraw

Participation in this study is entirely voluntary. You may withdraw from the study for any reason at any time. Whether or not you participate, the service you and your relative(s) receive will not be affected.

Risks and benefits

Your participation will not involve direct risks or benefits, although the information gathered will conduce to better understanding of the needs of people with mental illness and their relatives.

Consent Form

I agree to be interviewed for the said study. I understand that I am at liberty to participate or refuse to participate, and that I may withdraw from the study at any time; the service I and my relative(s) receive will not be affected. The identity of myself and my relative(s) receiving treatment will be kept confidential.

I have been given sufficient time to consider and I have had the opportunity to ask questions, which have been answered to my satisfaction. If I have any other questions, I may contact

Dr Hector Tsang
Assistant Professor
Department of Rehabilitation Sciences
The Hong Kong Polytechnic University
(Tel: 2766 6750)

_______________________________ _______________________

Signature of participant Date

Statement by researcher

I have explained to the participant the content and purpose of the said study, and the rights of participants. To the best of my knowledge and belief, the participant understands the above information.

_______________________________ _______________________

Signature of researcher Date

香港理工大學

康復治療科學系

研究題目：　香港公眾對精神病患者的態度對患者家屬的影響

香港理工大學康復治療科學系的研究人員邀請閣下參加一項研究，內容有關公眾對精神病患者的態度對患者家屬的影響。我們希望得知公眾對精神病患者的態度有否影響到閣下的生活。研究結果將有助了解精神病患者與患者家屬的需要，及發展精神健康教育。

閣下的參與

研究人員將訪問參加者一至兩次。訪問可在葵涌醫院、香港理工大學、或參加者指定的其他地點進行。如參加者同意，訪問過程可被錄音。

資料保密

參加者的身分與訪問中提及的所有個人資料均會保密。研究結果發表時，將綜合所有參加者提供的資料。

參與或退出的自由

閣下是否參加此項研究，完全以閣下的意願爲依歸。閣下可隨時爲任何原因退出。無論閣下參加與否，閣下與家屬獲得的服務均不會受到影響。

風險與得益

此項研究不會直接對參加者構成風險或帶來得益，但收集所得的資料將有助了解精神病患者與患者家屬的需要。

同意書

本人同意爲上述研究接受訪問。本人明白，本人可自由決定是否接受訪問，亦可隨時退出研究，而本人與家屬獲得的服務均不會受到

影響。研究不會直接對本人構成風險或帶來得益。本人與接受治療的家屬的身分將會保密。

本人已有足夠時間考慮，亦有機會提問，並已獲得滿意答覆。本人如有其他問題，可聯絡香港理工大學康復治療科學系助理教授曾永康博士(電話 2766-6750)。

參加者簽署　　　　　　日期

研究員聲明

本人已向參加者解釋上述研究的內容、目的及參加者的權利。就本人所知及相信，參加者已明白以上資料。

訪問員簽署　　　　　　日期