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DEVELOPMENT AND INITIAL VALIDATION OF PERCEIVED REHABILITATION NEEDS QUESTIONNAIRE FOR PEOPLE WITH SCHIZOPHRENIA (PRNQ—S)

BY

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CERTIFICATE OF ORIGINALITY

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ABSTRACT

Purpose: The Perceived Rehabilitation Needs Questionnaires for people with schizophrenia (PRNQ—S), a culturally relevant and multi-faceted assessment tool for measuring perceived needs of people with schizophrenia, was developed and initially validated. **Methods:** 43 participants including people with schizophrenia, their caregivers, and mental health professionals were recruited for six rounds of focus group discussion to identify issues pertaining to rehabilitation needs of schizophrenia. Results were then used to develop PRNQ—S. An initial validation study among a convenience sample consisting of 219 people with schizophrenia was conducted to examine its psychometric properties. **Results:** Exploratory Factor Analysis yielded a seventeen-factor solution accounting for 70.7% of the total variance which resulted in a 75-item PRNQ-S. The instrument had excellent internal consistencies and intra-rater reliability. **Conclusions:** The PRNQ—S has been developed and psychometrically tested in Hong Kong. It can be used to assess perceived rehabilitation needs for individuals with schizophrenia in Hong Kong. Upon further validations, it may be applied in other Chinese societies such as Singapore and the mainland. Similar research methodology can also be used for assessing needs in other types of psychiatric disability groups.

PUBLICATIONS ARISING FROM THE THESIS

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TABLE OF CONTENTS

LIST OF TABLES

LIST OF APPENDICES

CHAPTER 1: INTRODUCTION

1.1. OVERVIEW OF STUDY

Schizophrenia is a chronic disease associated with a significant and long-lasting health, social, and financial burden, not only for patients but also for their caregivers, and society (Knapp, et al, 2004). The prominent prevalence rate and burden of the group of schizophrenia accounted for the fact that schizophrenia is the mental illness that consumes most mental health care resources. In order to better allocate and prioritize resources in psychiatric services, investigating and understanding their needs from clients and professionals' perspectives are important for formulating rehabilitation services and public policy pertaining to mental health issues. This study aims at gleaning scientific information which provides better understanding on the rehabilitation needs of this group of people and mental health professionals which could hopefully be used to help psychiatric rehabilitation policy formation and development.

1.2. PURPOSE OF STUDY

1. To identify issues pertaining to rehabilitation needs of people with schizophrenia in Hong Kong.

2. To develop and conduct initial validate a questionnaire for measuring perceived rehabilitation needs for people with schizophrenia

1.3. SIGNIFICANCE OF STUDY

The Perceived Rehabilitation Needs Questionnaires for people with Schizophrenia (PRNQ—S) that we developed and validated may serve as the standardized instrument to assess the perceived needs of people with schizophrenia in the long run. It may be used by researchers, epidemiologists, administrators, and policy makers to assess the perceived importance and satisfaction of needs of people with schizophrenia for research and policy purposes. Results collected from PRNQ—S in future studies can provide useful information to guide the government develop relevant public policies and provide effective mental health services to better cater the rehabilitation needs of this group of people in the community in Hong Kong.

CHAPTER 2: LITERTURE REVIEW

2.1. SCHIZOPHRENIA

Mental disorders are found in people of all ages, regions, countries, and societies, presented at any point in time in 10 percent of the adult population (WHO, 2001). Among various kinds of mental disorders, schizophrenia deserves particular attention as it is one of the top ten causes of disability and premature death among the world (Murray & Lopez, 1996). In Hong Kong, it is estimated that about 68,500 persons with mental problems need rehabilitation services in the community in which about 80% have a diagnosis of schizophrenia in 2001 (Hong Kong Government, 2001; Chan & Yu, 2004). In 1993, the prevalence rate of schizophrenia in China was 6.6 per 1000 among individuals aged 15 or above (Chen, et al., 1998) which translated to a population of 6.6 million. Literature reveals that only 58% of the person with schizophrenia in China had received any kind of psychiatric treatment (Xiang et al, 2008). In rural China, mental health services are even less available and more people have never received treatment (Ran, et al., 2009). These figures are remarkably lower than the 80% reported from the USA (Kendler et al., 1996).

The aetiology of schizophrenia is heavily inclined towards genetic origin with environmental vulnerability factors (Arnold et al., 2005). The development

of this illness usually commences between the late teenage years and the early thirties (American Psychiatric Association, 1994). Jablensky (1997) estimated that one out of 100 individuals has the chance to develop schizophrenia during their lifetime. People with schizophrenia is characterized by their positive (e.g., delusion, hallucination, bizarre behaviours, etc.), negative (e.g., blunt affect, anhendonia, alogia) as well as cognitive (e.g., deficits in attention, memory, executive function, etc.) symptoms (Liddle, 1987). Due to above deficits, people with schizophrenia often have substantial impairments in personal behavior, impaired role, and social functioning (Mueser & MuGurk, 2004).

In addition to health burden, the social and economic costs of schizophrenia are wide ranging, long lasting, and enormous. Apart from the health and social service costs, lost employment and reduced productivity, the impact on families and caregivers, levels of crime and public safety, and the negative impact of premature mortality, there are many other immeasurable costs that have not been taken into account, such as lost opportunity costs to individual and families (WHO, 2001). It was estimated that the direct and indirect cost of schizophrenia in the United States in 2002 was $62.7 billion (McEvoy, 2007). These prominent prevalence rate and high burden of the group of schizophrenia accounted for the fact that people with schizophrenia are consuming most mental

health care resources when compared with other types of psychiatric consumers. Thus, we should take serious considerations about formulating effective polices for the individuals with mental illness and facilitate their recovery.

2.2. NEEDS

Murray (1938) provided the definitive list of human needs to account for behavior and motivation. The original list provided by Murray included needs connected to inanimate objects, expression of ambition, power, injury to self or others, affection, and other social goals. This definition attempted to specify the full range of human needs which have been proved to be highly influential. Maslow (1954) specified five different levels of need to describe the psychological development of people, which included physiological, safety, love, esteem, and self actualization needs. The work of Murray and Maslow has been regarded as the foundational and theoretical definition of needs. Psychiatric rehabilitation however seldom applies the above frameworks to understand the needs of people with mental illness.

Psychological theories have used the concept of need as the basis for understanding behavior. Psychiatry, in contrast, often uses the construct to inform service provision and plan individual care (Slade, 1994). Needs for

severely mental ill persons in this respect are ambiguous concepts. There are several approaches to definitions and measurements. One basic concern is the "objectivity" of needs (Wiersma, et al., 1998). Brewin (1987) refers need to an objective lack of health or well-being, a lack of access to appropriate forms of care, and a lack of adequate interventions. Needs could be objectively assessed by experts in an assessment instrument.

In terms of mental health services, need is defined as the requirements of individuals to enable them to achieve, maintain, or restore an acceptable level of social independence or quality of life (Department of Health Social Services Inspectorate, 1991). It can be measured in both subjective and objective manners through normative, perceived, expressed and relative perspectives (Bradshaw, 1972). Kettner, Moroney and Martin (1999, p. 39-42) refer normative needs as "*the existence of some standards or criterion established by custom, authority, or general consensus against which the quantity or quality of a situation or conditions is measured*", and perceived needs as "*what people think their need are or feel their needs to be*". The expressed needs is regarded as "*the actual attempts to obtain a service rather than judges by some experts that the individual needs that service*", whereas the relative need is "*the gap between the*

level of service existing in one community and those existing in similar communities or geographic areas".

In recent decades, people with schizophrenia no longer focus on single dimension of need but resort to the view of "recovery" which involves a number of semi-independent domains (Liberman, et al., 2008). Their needs go far beyond symptoms management and restoration of normal function alone (Harrow, et al., 1997, Robinson, et al., 2004), and include the pursuit of meaningful life in the community (Lysaker, et al., 2008). Thus, review of different needs is necessary to the conceptualization of unique psychiatric service modality and promotes recovery from mental illness.

2.3. RECOVERY FROM MENTAL ILLNESS

2.3.1. DEFINITIONS OF RECOVERY

Recovery for individuals with severe mental illness has recently received much attention from researchers and policy makers (Anthony, 1993; 2000). The New Freedom Commission on Mental Health recommended the promotion of research on factors contributing to rehabilitation and recovery from mental illness (New Freedom Commission on Mental Health, 2003). Both mental health practitioners and policy makers attempt to understand the meaning of recovery

(Jacobson, 2001). Practitioners try to facilitate the recovery of the clients with mental illness while policy makers aim at promoting the "recovery oriented" systems. Many traditional mental health researchers view recovery as objective and measurable outcomes such as reduction of hospitalizations or symptoms (Lehman & Steinwachs, 1998). They suggest that recovery could be achieved through scientific methods such as medication or rehabilitation techniques. Other experts claim that true recovery is a subjective and dynamic process through the interaction of numerous personal and environmental factors (Mancini, Hardiman & Lawson, 2005). William Anthony (1993), a supporter of the recovery model, defined recovery as "…a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles". It is a way of living a satisfying, hopeful, and contributing life, amid limitations caused by the illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness." (p. 15)**.** Patricia Deegan (1998), a clinical psychologist with schizophrenia and an advocator of the recovery model, defined recovery as the development of new meaning and purpose in one's life, beyond the symptoms, disability and stigma of mental illness. She emphasized that recovery is not cure but a lifelong process (Deegan, 1993). Ridgeway (2001) described recovery as a nonlinear process in which

individuals slowly took steps to become hopeful and active participants in their own lives. Sullivan (1994) presented a broad definition of recovery as "not only focuses on the management of the illness, but also highlights the consumer's performance of instrumental role functions and notions of empowerment and self-directedness."

The recovery model is sometimes presented as an alternative approach of medical model to the treatment for individuals with serious mental illness. The medical model is highly paternalistic which emphasizes illness over health, weaknesses rather than strengths, and limitations rather than potential for growth (Munetz & Frese, 2001). Conversely, the recovery model is a more subjective and personalized approach of caring for persons suffered from mental illness (Frese, et al., 2001). The recovery model emphasized that responsibility for and control of the recovery process must be given to the persons who have mental illness. Supporters of the recovery model suggest that persons with mental illness should have freedom to choose their treatment and to participant in and contribute to the mental health system (Frese & Davis, 1997; Frese, et al., 2001). The recovery model implies that the chances for recovery are optimized when a person is given maximum control of their conditions. Many persons who are able to be well recovered from mental illness even their symptoms still consistently

persist. In the other words, service providers and service users nowadays concern personal recovery instead of clinical recovery.

2.3.2. PROCESS OF RECOVERY

For persons with severe mental illness, controlling symptoms, regaining a positive sense of self, dealing with stigma and discrimination, and trying to lead a productive and satisfying life is increasingly referred to as the ongoing process of recovery (Markowitz, 2001). The core elements of recovery consist of symptoms of the illness, self-concept, and aspects of social well-being involving employment, relationship and housing (Anthony, 1991; 1993). Recovery is not considered as an end point where symptoms have ceased and sense of self and quality of life are restored to some optimal level, but rather as an ongoing process where these elements interact over time (Anthony, 1991; 1993; Weingarten, 1994). In order to maximize the recovery outcome, the responsibility is shared by both mental health service providers and service users. However, Torrey and Wyzik (2000) suggested that embracing a recovering vision is not easy for most practitioners. This difficulty results from the concept being poorly defined and not operationalised. Many practitioners carry a large caseload and concentrate on high priorities, which may not involve

evidence-based practices. As a result, service users continue receive services that have never been scrutinized scientifically (Liberman, et al., 2008). Thus, appropriate need assessment is important to clarify the consumers' needs and triangulate comprehensive plan before service provision for people with schizophrenia.

2.4. NEEDS ASSESSEMENT

Need assessment is of increasing concern to policy makers. It is also regarded as a means to gaining more understanding of the health related quality of health of consumers via the process of identifying the consumers' healthcare needs and the unmet health care demands (Van den Bos & Triemstra, 1999). Such assessments must cover multiple aspects, not only health but also social welfare, housing, employment, education, etc. Thus, previous studies used both qualitative and quantitative approaches to assessing the needs of people with schizophrenia so as to provide accurate and triangulated results for policy makers.

As to qualitative approach, focus group is the most commonly used quality strategy for exploring views of service users (Green & Thorogood, 2004) and thus policy research (Fontana & Frey, 1994). For instances, Wagner and King

(2005) conducted a study employing focus groups of people with psychotic disorders and caregivers to examine their perceptions on existential needs of people with psychotic disorders. Byrne and colleagues (2001) conducted a study using focus groups and individual interviews to explore the service needs of families with a parent with an affective illness. Given the above studies, focus group was an useful technique to collect information from different types of users in the field of psychosocial rehabilitation.

Regarding quantitative approach, standardized need assessment is regarded as a means to gaining more understanding of the health related quality of life of consumers via the process of identifying their healthcare needs and the unmet healthcare demands (Van de Bos & Triemstra, 1999). There are several instruments designed to assess needs for care. Camberwell Assessment of Need (CAN) developed by the Psychiatric Research in Service Measurement (PRiSM) at the Institute of Psychiatry in London (Slade et al., 1999; Phelan et al., 1995) is one of the most popularly adopted need assessment instrument in this field. CAN is based on a model which interprets need as a subjective conception. It has been developed and validated in different countries to assess the need for care of people with schizophrenia. The CAN assessment procedure is carried out as a structured interview, assessing 22 items: accommodation, food, looking after the

home, self care, daytime activities, physical health, psychotic symptoms, information about condition and treatment, psychological distress, safety to self, safety to others, alcohol, drugs, company, intimate relationships, sexual expression, child care, basic education, telephone, transport, money, and benefits. Despite its popularity, CAN focuses only on measuring personal and social functioning which is largely clinically oriented. It measures the extent to which general needs in each domain were met, but does not provide in-depth information about a domain's multi-dimensional components. For instances, the general area of "housing needs" may refer to living space, location, or choices, while "vocational needs" may refer to work skills, opportunities, or workplace relationships. In addition, CAN is psychometrically weak because of its low internal consistency and uncertain convergent validity (McCrone, et al., 2000; Slade, et al., 1999). Previous studies using CAN yielded inconsistent results in terms of what variables were actually measured (Wennstrom, et al., 2004). The above review demonstrated that CAN adopted a narrow perspective in studying needs of people with schizophrenia. In addition, its psychometric properties is statistically unsatisfactory.

Another assessment to measure needs is the Medical Research Council Needs for Care Assessment (MRC-NCA; Brewin, et al., 1987). The MRC-NCA

is based on the assumption that need is a normative concept that is to be defined by experts. However, it is difficult to agree on what constitutes a need because of its complicated nature (Nielsen, et al., 1999). The St Louis Inventory of Community Living Skills (SLICLS; Evenson & Boyd, 1993) is also commonly used to assess the community living skills and predict the level of community care for the people with severe mental illness. Although the content of SLICLS is similar to CAN and has been culturally validated for the Chinese population with sound psychometric properties (Au, et al., 2005), it is also too clinically oriented and emphasizes only the clinical outcomes instead of truly assessing the perceived needs of target population.

More importantly, comprehensiveness is always considered one of the major concerns for the assessment's development (Wallace, et al., 2000). A common weakness of above assessments is the lack of depth in assessing the perceived rehabilitation needs. MRC-NCA, CAN, and SLICLS consist only of seventeen, twenty-two, and fifteen items respectively, which are insufficient to fully understand the holistic aspects of need. Consequently, results gleaned from above tools are difficult to translate to an effective public policy in our field.

2.5. LOCAL STUDIES AND TOOLS ON NEED ASSESSMENT

In Hong Kong, similar studies to assess the needs of people with schizophrenia are extremely scarce. Chien and colleagues (2001) validated the Chinese version of the Educational Needs Questionnaire to identify the specific educational needs of Chinese people with schizophrenia. But it only assesses the educational needs instead of a holistic picture of rehabilitation needs for people with mental illnesses. Literature review also unveils that there does not exist any locally validated questionnaire which may be used to assess rehabilitation needs in an objective manner of the Chinese populations with schizophrenia. Moreover, most of the abovementioned instruments are too clinically oriented which focus on the clinical aspects of needs. There have been limited studies to apply the results in public policy development.

Given the above, we suggest that there is a lack of a comprehensive, culturally relevant, and validated instrument to assess rehabilitation needs of Chinese with schizophrenia in Hong Kong, and mainland China. There is an urgent need to develop a culturally relevant and multi-faceted need assessment to better understand the perceived needs in this particular population. The results can be further used for mental health policies formulation.

2.6. SOCIAL POLICY IMPLICATION OF STUDY

Jenkins (2001) also emphasized that effective policy should address the needs of the population and estimate the extent of unmet needs and the services required to meet those needs. In western countries such as the United Kingdom, the importance of assessing need for services has been fully recognized by government legislation (House of Commons, 1990). However, such awareness and practice is not given due attention in Hong Kong. The Hong Kong Government has just published two policy papers for people with disabilities for the past decade which included the *White Paper on Rehabilitation* (Hong Kong Government, 1995) and the *Hong Kong Rehabilitation Program Plan 1998-99 to 2002-03: Towards a New Rehabilitation Era* (Health and Welfare Bureau, 1999). Details of psychiatric rehabilitation services for people with mental illness were discussed together with other disability groups in these two policy documents. However, the contents of these policy documents did not address the special needs of people with schizophrenia and their caregivers based on independent scientific study (Tsang et al., 2002; Yip, 2004). Moreover, the sample size of above studies is far from adequate as the input come only from a minority of the service users. A target-specific need assessment is essential for better assessing and formulating tailored policies for people with schizophrenia.

Social policy researchers suggest that a ‘needs-led’ approach of planning allows the supply of services to be better matched to those needed and better structuring of service delivery (Harvey & Fielding, 2003). Review of clients’ needs is, therefore, an essential determinant and information in setting priorities of mental health services (Koppel & McGuffin, 1999). As the “Recovery” model is getting much attention in the field of psychosocial rehabilitation. Its supporters advocated a more positive attitude, and demanded a more holistic care of mental health services. An updated and multi-facet need assessment is necessary to further explore their needs in order to cater their multi-dimensional needs nowadays.

Apart from mental health consumers, different stakeholder groups including consumers, their family members, mental health workers, services providers, government agencies, academic institutions, professional associations, non-government organizations, and other advocacy groups should also participate in the process of mental health policy formulation and implementation (World Health Organization, 2004). Thus, the perspectives from mental health professionals, people with schizophrenia, and their caregivers are equally important. By investigating the rehabilitation needs from various perspectives via qualitative and quantitative studies, a holistic picture may be obtained which may

help us review the adequacy of current mental health rehabilitation services and policies.

As mentioned above, local research based on probability sampling on rehabilitation needs of mental health consumers is limited which may constitute the cause for a lack of a sensitive and effective policy framework for psychiatric rehabilitation in Hong Kong. Literature review also unveils that there does not exist any locally validated questionnaire which may be used to assess rehabilitation needs of the Chinese populations with schizophrenia. Translation of previously developed instruments may often be the only option when addressing research questions to people whose language is not English. However, there are several limitations of the existing instruments developed in foreign countries if they are applied in Hong Kong. In order to better prioritize current resources and formulate future psychiatric rehabilitation policy, there is an urgent need to develop culturally relevant multi-facet need assessments in order to help us get a better understanding of the rehabilitation needs and facilitating recovery of people with schizophrenia.

The current study allowed the opinions of different stakeholders' to be collected via focus groups discussion. The qualitative results were used to develop an updated, comprehensive, and cultural relevant need assessment (i.e.

PRNQ—S). Results collected from PRNQ—S in future studies can provide useful information to guide the HKSAR to develop public policies and provide effective mental health services for the people with schizophrenia in Hong Kong.

CHAPTER 3 OVERALL DESIGN OF RESEARCH STUDY

This research study consisted of two phases. The aim of phase one study was to identify the perceived rehabilitation needs of people with schizophrenia via focus groups discussion. The aims of phase two study were to develop the Perceived Rehabilitation Needs Questionnaire for people with schizophrenia (PRNQ—S) based on the results gleaned from phase one and to initially validate PRNQ—S in order to ensure its psychometric properties for further clinical and research purposes.

3.1 PHASE ONE: IDENTIFYING REHABILITION NEEDS

3.1.1 OBJECTIVES

1) To identify issues pertaining to rehabilitation needs of people with schizophrenia in Hong Kong via focus groups discussion

3.1.2 FOCUS GROUPS INTERVIEW

Focus group interview is the most commonly used strategy for exploring service users' views (Green & Thorogood, 2004) and policy research (Fontana & Frey, 1994). It can produce a concentrated amount of information in the interested topics in an effective way. In order to ensure the trustworthiness of this study, we obtained multiple data sources from the perspectives of people with

schizophrenia, their caregivers, and mental health professionals from different fields.

3.1.2.1 PARTICIPANTS

Forty- three participants were recruited by convenience sampling from Kowloon Hospital, and three non-government organizations (NGOs) in Hong Kong including New Life Psychiatric Rehabilitation Association, The Salvation Army, and The Hong Kong Family Link Mental Health Advocacy Association. Fourteen were people with schizophrenia, thirteen were caregivers of people with schizophrenia, and sixteen were mental health professionals. All participants were aged from 18 to 60 and fluent in Cantonese. For people with schizophrenia, the participants were diagnosed with schizophrenia for at least 1 year according to diagnosis made by certified psychiatrists in Hong Kong following DSM-IV (American Psychiatric Association, 1994). For the caregivers of people with schizophrenia, the participants were primary caregivers and had taken care of their relative for at least 1 year. We adopted the operational definition of main caregivers by Nehra, Chakrabarti, Kulhara, and Sharma (2005, p. 330) as "*a relative who had been staying with the patient for some time, and was intimately involved in his/her care, which meant looking after the patient's daily needs,*

supervising medication, accompanying the patient to the hospital, liaising with hospital staff, etc.". For the group of mental health professionals, the participants had at least 1 year of experience working with people with schizophrenia. Table 1 shows the demographic data for the three groups in the sample.

Table 1. The demographic information for participants in the focus groups

	Focus groups		
	Schizophrenia (*n*=14)	Caregivers (*n*=13)	Professionals (*n*=16)
Age	39.6 ± 10.8	49.8 ± 9 .8	N/A
Sex			
Male	7 (50%)	2 (15.4%)	8(50%)
Female	7 (50%)	11 (84.6%)	8(50%)
Educational level			
Primary	3 (21.4%)	1 (7.7%)	0(0%)
Secondary	11 (78.6%)	6 (46.2%)	0(0%)
Tertiary	0 (0%)	6 (46.2%)	16 (100%)
Duration of illness	17.9 ± 11.3	N/A	N/A
Year of taking care of people with schizophrenia	N/A	7.9 ± 5.7	N/A
Experience in working in the field of mental health (Year)	N/A	N/A	6.5 ± 5

3.1.2.2. DATA COLLECTION

Six focus group interviews were conducted from May 2007 to July 2007, which included two groups for people with schizophrenia, two groups for caregivers of people with schizophrenia, and two for mental health professionals. Each focus group consisted of six to eight participants. Written consent from each participant and information relating to the demographic data form (See Appendices 1.1-1.4) was obtained before the focus group interview began. The whole focus group process was audio-taped. Each focus group interview was conducted by a research assistant from The Hong Kong Polytechnic University and me, following standard methodology with the use of trained interviewer, post-session debriefings, and audiotapes. Each focus group lasted for one and half hour. The focus group interview covered four topics: 1) What problems hindering the rehabilitation and recovery of health of people with schizophrenia, 2) What do they need for solving the above problems, 3) How much of their need is satisfied, and 4) Suggestions regarding how the government improves the existing services, resources and policies for people with schizophrenia. The discussion on various needs was guided by a checklist throughout the process. (Please see Appendix 2 for the interview guide).

3.1.2.3. DATA ANALYSIS

The data from the focus group was analysed by the content analysis approach (Stemler, 2001). The contents of the focus groups were transcribed by a research assistant of the Neuropsychiatric Rehabilitation Laboratory, Department of Rehabilitation Sciences, at The Hong Kong Polytechnic University and me. Both were native Cantonese speaker. The transcripts and literature review were then used to generate the codebook for further analysis.

3.1.2.3.1. GENERATION OF PRELIMINARY CODEBOOK

Two out of six transcripts were randomly selected to develop the codebook. This codebook consisted of the items related to problems encountered and rehabilitation needs of people with schizophrenia. The preliminary codebook had 73 items divided into eighteen categories. Sixty-eight items were extracted from the transcripts and the remaining five items were based on the literature that did not appear on the transcripts (Please see appendix 2).

3.1.2.3.2. CALCULATION OF CONCORDANCE RATES

Second, two out of remaining four transcripts were randomly selected for thematic analysis by two independently researchers. Concordance rate was then

calculated in order to assess its inter-coder reliability. The calculation of concordance rate (CR) was the number of consistently coded items of both coders divided by the total number of items.

$$CR = \frac{\text{(no. of items that both coders agreed + no. of items that both coders disagreed)}}{\text{Total no. of items of codebook}}$$

The concordance rate on the first analysis was 81.9%. Inconsistently coded items were then discussed between the two coders under the supervision of the chief supervisor until consensus was reached (please see Appendices 3 & 4). The preliminary codebook was revised accordingly resulting in 80 items with 19 categories.

With the revised codebook, the remaining two transcripts were coded independently by two researchers again to check the inter-coder reliability. The concordance rate was 94.4%. Again, inconsistently coded items were discussed between the two coders under the supervision of my chief supervisor until consensus was reached. No further items of the codebook were added. The revised codebook was therefore regarded as the final for further analysis. Table 2 summarizes the results of concordance rates of two thematic analyses.

Table 2. Concordance rates of two thematic analysis

	1st thematic analysis		2nd thematic analysis	
Transcript no.	Transcript 1	Transcript 2	Transcript 3	Transcript 4
Consistent coding for both coders (a)	28+34=62	27+31=58	18+58=76	37+38=75
Total no. of items in codebook (b)	73	73	80	80
Concordance rate (a/b)	84.9%	78.9%	95%	93.8%
Overall concordance rate	81.9%		94.4%	

3.1.2.3.3. FREQUENCY COUNT OF ITEMS

The six transcripts were then used for the frequency counts by the final codebook by me and a research assistant again. Items with frequency lower than 4 were sorted or grouped in case there were overlapping. Finally, 4 items were combined into 2 items based on their nature and 2 items were deleted. (Please see Appendices 5 & 6)

3.1.3. RESULTS

Seventy-six items on the needs and problems of people with schizophrenia were identified which were tentatively divided into nineteen categories based on thematic analysis and frequency count by the two independent coders. The nineteen categories were named tentatively based on the nature of items. The names of the preliminary factors were “Occupation (13 items)”, “Symptoms Management (4 items), “Knowledge and Information on Mental Illnesses (2 items)”, “Self Care (3 items)”, “Medical Services (9 items)”, “Social (3 items)”, “Intimate Relationship (2 items)”, “Family (6 items), “Care of Children (1 item)”, “Entertainment (3 items)”, “Participation in Treatment (3 items)”, “Housing (4 items)”, “Finance (4 items)”, “Education (2 items)”, “Discrimination (5 items)”, “Social Welfare and Security (3 items)”, “Budget Management (2 items)”, “Stress Management (4 items)” and “Create Harm on the Public and Oneself (3 Items). Table 3 shows the results of the finalized items.

Table 3. Finalized items generated from phase 1 study

Factors	Items
Occupation	1. Enhance motivation to work 2. Increase employment opportunities 3. Improve relations with co-workers 4. Improve relations with supervisors 5. Enhance working skills 6. Enhance job tenure 7. Provide more on-going vocational support 8. Provide job training opportunities 9. Strengthen interview skills 10. Allow staff take leaves for psychiatric follow up 11. Improve promotion prospect 12. Obtain a reasonable salary 13. Increase the varieties of work types
Symptom Management	14. Alleviate positive and negative symptoms 15. Maintain emotional stability 16. Improve personal hygiene 17. Increase ways of handling symptoms
Knowledge and Information on Mental Illnesses	18. Enhance knowledge on mental illnesses and the medication 19. Provide sufficient channels to obtain relevant information
Self-care	20. Improve self-care skills 21. Improve ability of household management 22. Improve ability of financial management
Medical Services	23. Provide sufficient mental health professionals for follow up 24. Increase resources for community rehabilitation 25. Improve the understanding of patients' psychological needs

	26. Avoid frequent change of medical staff to maintain a stable relationship 27. Being prescribed of the appropriate medication 28. Reduce the side-effect of medication 29. Increase the duration of psychiatric consultation 30. Reduce the waiting time for each psychiatric consultation 31. Improve patients' right for choosing the types of treatment
Social	32. Improve social skills 33. Expand social network 34. Enhance motivation in social life
Intimate Relationships	35. Boost confidence and improve skills getting along with other sex **(Jungbauer, 2001)** 36. Gain proper sex knowledge
Family	37. Improve the relations with the family 38. Avoid over-expectation of the family **(Brent, 2007)** 39. Able to get emotional support from the family 40. Able to get tangible support from the family 41. Acquire sufficient knowledge on birth and family planning 42. Increase family members' understanding on mental illnesses
Care of Children	43. Improve the skills of taking care of children
Entertainment	44. Provide sufficient leisure opportunities 45. Develop appropriate leisure arrangement 46. Increase interest in leisure
Participation in Treatment	47. Attend psychiatric appointment timely **(Gouzoulis, 2004)** 48. Improve the drug compliance 49. Participate actively in treatment

Housing	50. Provide sufficient transitional housing arrangement 51. Improve living space 52. Avoid too long distance from residence to service network 53. Provide sufficient choices of housing
Finance	54. Provide sufficient food 55. Provide sufficient transport expenses 56. Provide sufficient entertainment expenses 57. Provide sufficient medical expenses
Education	58. Provide sufficient opportunities of basic education 59. Provide sufficient opportunities of education and further studies
Discrimination	60. Reduce the chance of being excluded 61. Reduce being discriminated by the family 62. Reduce being discriminated by the community 63. Reduce self-discrimination and the sense of inferiority 64. Reduce the lack of opportunities due to mental illnesses
Social Welfare and Security	65. Provide sufficient amount of CSSA allowance 66. Provide sufficient assistance by the community 67. Increase channels of seeking help
Financial Management	68. Avoid over spending 69. Enhance ability of budget management
Stress Management	70. Reduce anxiety 71. Reduce pressure of everyday life 72. Improve stress management skills (**Hoffmann, 2005**) 73. Develop a structural daily life

Create harm on the public and oneself	74. Reduce suicidal behavior 75. Reduce aggressive behavior 76. Reduce alcoholic behavior

3.2. PHASE TWO: DEVELOP AND VALIDATE PRNQ—S

3.2.1. OBJECTIVES

1) To develop questionnaire for measuring perceived rehabilitation needs for people with schizophrenia (PRNQ—S)

2) To initially validate PRNQ—S for clinical and research purposes.

3.2.2. QUESTIONNAIRES DEVELOPMENT (PRNQ—S)

As the literature reveals that there does not exist any psychometrically validated and cultural relevant questionnaires to measure the rehabilitation need of people with schizophrenia. Thus, based on the results generated in Phase One study, the PRNQ--S was developed to measure the perceived rehabilitation needs rehabilitation needs of this group of people. PRNQ—S was written in Chinese to improve its applicability to Chinese speaking population. This scale is easily administered by the informants who have good language capability.

3.2.2.1. DESIGN OF THE PRNQ—S

Based on the finalized items from phase one study, the PRNQ-S was constructed which is used for assessing their perceived rehabilitation needs in multiple facets. PRNQ—S includes three sections. The first section requires

respondents to rate their perceived importance of needs following a five-point Likert scale, with 1 denoting ‘never important’, 2 denoting ‘seldom important’, 3 denoting ‘sometimes important’, 4 denoting ‘usually important’, and 5 denoting ‘always important’. This section also requires respondents to answer to what extent they are satisfied with each need if they have received any kind of service fulfilling that need following a five-point Likert scale, with 1 denoting ‘never satisfy’, 2 denoting ‘seldom satisfy’, 3 denoting ‘sometimes satisfy’, 4 denoting ‘usually satisfy’ and 5 denoting ‘always satisfy’. Respondents can go to the next item if they have not received any service fulfilling the need concerned. The items occurred in the first section were drawn from the results generated in phase one study. Thus, there are also seventy-six items with nineteen categories in this part of questionnaire. The second section requires respondents to rate their perceived importance of various psychiatric rehabilitation services following a five-point Likert scale, with 1 denoting ‘never important’, 2 denoting ‘seldom important’, 3 denoting ‘sometimes important’, 4 denoting ‘usually important’ and 5 denoting ‘always important’. This section also requires respondents to answer to what extent they satisfy with each kind of service if they have received it previously following a five-point Likert scale, with 1 denoting ‘never satisfy’, 2 denoting ‘seldom satisfy’, 3 denoting ‘sometimes satisfy’, 4 denoting ‘usually

satisfy', and 5 denoting 'always satisfy'. Respondents can go to the next item if they have not received that service. The types of service included in this section were based on an expert panel consisting of eight experienced mental health professionals. Thirty-one mental health services divided into eleven categories were used in this part of questionnaire. At the end of first and second section, there is an open-ended question asking their opinion towards their rehabilitation needs or service provision, which is able to provide us with the holistic picture concerning the requests of the people with schizophrenia in the future. Finally, the third section of PRNQ—S requires client to provide basic demographic information for further analysis. (Please see appendices 7 & 8)

3.2.3. VALIDATION OF THE PRNQ—S

After the completion of the development of PRNQ—S, pilot test was then conducted on five people with schizophrenia. PRNQ—S was smoothly implemented after minor revisions. The next step of study was to validate PRNQ—S in terms of its intra-rater reliability, internal consistency, and structural validity. In this study, not all of the respondents had to fill the latter part of the first section if they had not received any service fulfilling each need. This study focused only on initial validation of the former part of the first section of PRNQ--S.

3.2.3.1 PARTICIPANTS

A total of 219 people with schizophrenia were recruited to complete the PRNQ—S. All participants were recruited from the New Life Psychiatric Rehabilitation Association (NLPRA) and Yung Fung Shee Psychiatric Center (YFSPC) by convenience sampling following the same inclusion and exclusion criteria as the focus groups described earlier in Phase One of the study. NLPRA is a NGO providing community-based psychiatric services to people with mental illness, while YFSPC is managed by the Hospital Authority funded by the government of the Hong Kong Special Administrative Region. With reference to Nielsen et al.'s study (1999), if an ICC coefficient of 0.85 is assumed for the items, the reliability can be estimated with a marginal error of 0.15 at 95% confidence level which translated to 49 subjects. As a result, the first 49 people with schizophrenia were used for assessing the intra-rater reliability, whereas the entire group of participants was used for exploring the structural validity. Demographic information of the participants is summarized in Table 4.

Table 4. Demographic Information of the Participants for the Validation Study

		n=219 Frequency (Percent)
Gender		
	Male	116 (53.0%)
	Female	103 (47.0%)
Age		
	18-25	10 (4.6%)
	26-35	52 (23.7%)
	36-45	69 (31.5%)
	46-55	63 (28.8%)
	56 or above	25 (11.4%)
Educational level		
	Illiterate	3 (1.4%)
	Primary	53 (24.2%)
	Secondary	147 (67.1%)
	Tertiary or above	16 (7.3%)
Marital status		
	Single	122 (55.7%)
	Married	70 (32%)
	Divorced	23 (10.5%)
	Widowed	4 (1.8%)
Living condition		
	Live alone	46 (21.0%)
	With family members	170 (77.6%)
	Half way House	3 (1.4%)
Employment status		
	Open employment	63 (28.8%)
	Supported employment	5 (2.3%)
	Shelter Workshop	8 (3.6%)
	Unemployed	143 (65.3%)
Duration of receiving mental health service	2 years or below	14 (6.4%)
	2-5 years	38 (17.4%)
	5-10 years	59 (27.1%)
	10 years or above	108 (49.1%)

3.2.3.2. INSTRUMENTS

The Perceived Rehabilitation Needs Questionnaire for people with schizophrenia (PRNQ—S). The PRNQ—S described earlier was used for assessing perceived importance of rehabilitation needs of people with schizophrenia (76 items) and their satisfaction towards service provision in the field of mental health (31 items). Items for perceived importance of rehabilitation needs and satisfaction towards service provision were categorized into 19 and 11 aspects respectively. Demographic information such as respondent's age, gender, educational level, living condition, and duration of illness were collected.

3.2.3.3. DATA COLLECTION

Written consent from each participant was obtained before data collection began. One of the three trained assessors (a qualified occupational therapist, a social worker, and a graduate with a Master degree in psychology) was randomly selected to ask the questions and record the answers from the participants through face-to-face interviews. For the first 49 participants, intra-rater reliability of the PRNQ—S was further assessed by the other assessor with the same participant again within one to two weeks after the first administration. All independent assessors were trained on how to use the instruments by the first

author under the supervision of the corresponding author. The first author also coordinated the data collection process.

3.2.3.4 DATA ANALYSIS

The data were analyzed by SPSS version 13.0. All analyses were done based on the sample consisting of 219 participants, except for the analysis of intra-rater reliability (*n*=49). Descriptive and frequency statistics were used to summarize the demographic characteristics of participants. Coefficient alpha was used to evaluate the internal consistencies of the overall scale and sub-scales. Intra-rater reliability of instrument was assessed by two-way mixed intraclass correlation (ICC) coefficient using scores in the first and second administrations of the scale (Portney & Watkins, 1993).

Factor analysis was performed to improve our understanding on the structural validity of the scale. Exploratory factor analysis (EFA) was used to explore the interrelationships among items of the scale. The Kaiser-Guttman rule (eigenvalue greater than one) and the Cattell's scree test were then applied to determine the number of factors to be retained.

3.2.4. RESULTS

3.2.4.1. VALIDITY

3.2.4.1.1. STRUCTURAL VALIDITY

An exploratory factory analysis was first performed on the 76-item PRNQ—S in order to examine its structural validity and finalize the number of factors of this tool. The format of the results presented in the latter part was based on assigned factors from EFA.

The data was found to be suitable for factor analysis by the Kaiser-Meyer-Oklin value (0.856) and the Barlett's Test of Sphericity (0.000). Using Kaiser-Guttman rule and the Cattell's scree test, a seventeen-factor solution accounting for 70.7% of the total variance was indicated. Most of the factors were found to have good and simple structure. The main principle of items allocation was based on its significant factor loadings from the EFA results and its nature of content. All items did not have very low factor loadings in EFA. The majority of items could be meaningfully interpreted in assigned factors. The only exception was Item 64 "Reduce the lack of opportunities due to mental illnesses" which was eventually deleted. The PRNQ--S finally consists of 75 items in the scale. All of the factors were then re-named based on its factors' nature. (Please also see the structure matrix presented in Table 5).

Table 5. Factorial structure and factor loadings of PRNQ—S items

Factor	% of variance	Item	Factor loading*
1. Occupation (13 items)	8.6%	9. Strengthen interview skills	.77
		2. Increase employment opportunities	.76
		4. Improve relations with superiors	.74
		1. Enhance motivation to work	.73
		8. Provide job training opportunities	.66
		3. Improve relations with co-workers	.64
		5. Enhance working skills	.61
		7. Provide on –going vocational support	.61
		11. Improve promotion prospect	.54
		10. Allow staff take leaves for psychiatric follow up	.54
		6. Enhance job tenure	.53
		12. Obtain a reasonable salary	.50
		13. Increase the varieties of work types	.49
2. Social Welfare and Security (7 items)	6.6%	55. Provide sufficient transport expenses	.78
		54. Provide sufficient food	.74
		56. Provide sufficient entertainment expenses	.70
		57. Provide sufficient medical expenses	.66
		65. Provide sufficient amount of Social Security Allowance	.64
		67. Increase channels for help seeking	.57
		66. Provide sufficient assistance in the community	.45
3. Medical Services (6 items)	5.3%	23. Provide sufficient mental health professionals for follow up	.72
		26. Avoid frequent change of medical staff to maintain a stable relationship	.67
		24. Increase resources for community rehabilitation	.58
		25. Improve the understanding of patients' psychological needs	.44

			19.	Provide sufficient channels to obtain relevant information	.42
			29.	Increase the duration of psychiatric consultation	.37
4.	Family (6 items)	5.1%	40.	Able to get tangible support from the family	.71
			38.	Avoid over-expectation from the family	.52
			41.	Acquire sufficient knowledge on birth and family planning	.43
			39.	Able to get emotional support from the family	.37
			42.	Increase family's understanding on mental illness	.35
			37.	Improve the relationship with family	.33
5.	Social and Intimate Relationship (5 items)	5.0%	33.	Expand social network	.79
			34.	Enhance motivation in social life	.73
			32.	Improve social skills	.70
			35.	Improve skills getting along with other sex	.56
			36.	Gain proper sex knowledge	.43
6.	Behavior and Impulse Control (5 items)	4.8%	75.	Reduce aggressive behavior	.79
			74.	Reduce suicidal behavior	.73
			76.	Reduce alcoholic behavior	.70
			68.	Avoid over spending	.56
			69.	Enhance ability of budget management	.43
7.	Symptom Management (5 items)	4.6%	17.	Increase ways of handling symptoms	.79
			15.	Maintain stable emotion	.72
			14.	Alleviate positive and negative symptoms	.70
			18.	Enhance knowledge on mental illnesses and medication	.38
			47.	Attend psychiatric appointment timely	.36
8.	Right for Treatment	3.4%	27.	Being prescribed of the appropriate medication	.77 .73

	(5 items)		28. Reduce the side-effect of medication	.55
			30. Reduce the waiting time of for first psychiatric consultation	.50
			31. Improve patients' right for choosing their types of treatment	.34
			49. Participate actively in psychiatric treatment	
9.	Discrimination (4 items)	4.5%	62. Reduce being discriminated by the community	.68
				.59
			61. Reduce being discriminated by the family	.47
			63. Reduce self-discrimination and the sense of inferiority	.45
			60. Reduce the chance of being excluded	
10.	Housing (4 items)	4.2%	51. Improve living space	.78
			53. Provide sufficient choices of housing	.71
			52. Avoid too long distance from residence to service network	.59
			50. Provide sufficient transitional housing arrangement	.58
11.	Self Care (4 items)	4.4%	21. Improve ability of household management	.82
				.71
			20. Improve self-care skills	.68
			22. Improve ability of managing own property	.45
			16. Improve personal hygiene	
12.	Stress Management (3 items)	3.1%	70. Reduce anxiety	.73
			71. Reduce pressure of everyday life	.61
			72. Improve stress management skills	.59
13.	Leisure (3 items)	2.9%	46. Increase interest in leisure	.68
			44. Provide sufficient leisure opportunities	.68
			45. Develop appropriate leisure Arrangement	.67
14.	Education (2 items)	2.6%	59. Provide sufficient opportunities for further studies	.76

		58.	Provide sufficient opportunities of basic education	.65
15. Care of Children (1 item)	1.9%	43.	Improve the skills of taking care of children	.66
		64.	Reduce the lack of opportunities due to mental illnesses (Item was deleted)**	.33
16. Treatment compliance (1 items)	1.8%	48.	Improve the drug compliance	.59
17. Lifestyle (1 item)	1.8%	73.	Develop a structural daily life	.68

**Only the highest factor loading of items were presented. The remaining factor loadings that were not the highest score or below 0.3, were not listed in this table.*

***Item 64 was deleted and not included in the final version of PRNQ—S due to its redundant nature and low factor loading*

Factor 1: Occupation. There were thirteen items within this factor. The items were mainly related to the vocational needs such as employment opportunties, workplace relationships, work skills concerns, and the benefits from the occupation. The alpha coefficient computed for the total sample was 0.90 which indicated excellent internal consisitency of the items constituting this factor.

Factor 2: Social Welfare and Security. There were seven items for this factor. The items were related to social welfare concerns including food, transport, entertainment, and medicine expenses. The alpha coefficient was 0.88 indicating a very high internal consistency within this factor.

Factor 3: Medical Services. There were six items belonging in this factor. The items were mainly related to the medical services such as the quality and quantity of psychiatric treatment, medication, and the channels of acquring psychiatric knowledge in the system. The alpha coefficient was 0.82 indicating a very good internal consistency within this factor.

Factor 4: Family. There were also six items for this factor. The items were related to family concerns regarding the level of support, relatioships, and family's attitudes and knowledge towards mental illness. The alpha coefficient was computed to be 0.77 indicating a good internal consistency within this factor.

Factor 5: Social and Intimate Relationship. There were five items for this factor. The items were mainly related to their social network, social skills, and sex knowledge towards opposite sex. The alpha coefficient was 0.85 indicating a very good internal consistency within this factor.

Factor 6: Behavior and Impulse Control. There were five items for this factor. The items were related to various impulsive behavoir such as alcoholism, violence, suicide, overspending, and the related skills of getting rid of these problems. The alpha coefficient was 0.46 indicating a good internal consistency.

Factor 7: Symptom Management. There were five items for this factor. Means of handling psychiatric symtpoms, maintaining stable emotion, and treatment compliance were the main concerns for this factor. The alpha coefficient was 0.83 representing a very good internal consistency within this factor.

Factor 8: Right for Treatment. There were also five items belonging this factor. Right of receiving and selecting appropriate treatments were the main focus in this factor. The alpha coefficient was 0.79 indicating a good internal consistency in this factor.

Factor 9: Discrimination. There were four items comprising this factor. The items were mainly related to different kinds of discriminations from self to public. The alpha coefficient was 0.77 representing a good internal consistency within this factor.

Factor 10: Housing. There were also four items for this factor. The items pertained mainly to their living standard, locality, choice, and transitional housing problem. The alpha coefficient was 0.78 demonstrating a good internal consistency within this factor.

Factor 11: Self Care. There were four items for this factor and which concerned about self care issues including different personal and instrumental

daily living skills. The alpha coefficient was 0.81 revealing a very good internal consistency in this factor.

Factor 12: Stress Management. There were three items falling in this factor. The items were related to skills for handling anxiety and stress in daily life. The alpha coefficient was 0.87 indicating a very good internal consistency in this factor.

Factor 13: Leisure. There were also three itmes for this factor. Items were on interests cultivation, opportunites, and its arrangmenet. The alpha coefficent was 0.89 demonstrating a very good internal consistency.

Factor 14: Education. This factor consisted of two items concerning the opportunites of participating in basic education or related studies. The alpha coefficient was 0.77 indicating a good internal consistency within this factor.

Factor 15: Care of Chidren. There were two items for this factor originally. However, the factor loading of items 64 “Reduce the lack of opportuniteis due to mental illness” was found to be redundant and had a very low factor loading (0.33). Items 64 was finally deleted from this factor and the remained item concerns about child care. No alpha coefficent was computed due to this was a single item factor.

Factor 16: Treatment Compliance. This factor consist one item only regarding the treatment compliance. No alpha coefficent was computed due to this was a single item factor.

Factor 17: Lifestyle. This factor also consisted of only one item on the need of structured daily life. Again, no alpha coefficent was computed due to this was a single item factor.

As a result, there were a total of seventeen factors generated following EFA. They were *Occupation* (Number of items: *N=13;* Cronbach alpha: α=0.90), *Social Welfare and Security* (*N=7;* α=0.88), *Medical Services* (*N=6;* α=0.82), *Family* (*N=6;* α=0.77), *Social and Intimate Relationship* (*N=5;* α=0.85), *Behavior and Impulse Control* (*N=5;* α=0.79), *Symptom Management* (*N=5;* α=0.83), *Right for Treatment* (N=*5;* α=0.79), *Discrimination* (N=*4;* α=0.77), *Housing* (N=*4;* α=0.78), *Self Care* (*N=4;* α=0.81), *Stress Management* (*N=3;* α=0.87), *Leisure* (*N=3;* α=0.89) and *Education* (*N=2;* α=0.77). All of the alpha coefficients indicated very good to excellent internal consistency for each factor. The remaining three factors which consisted only of one item without alpha coefficient (α) were *Care of Chidren*, *Treatment Compliance,* and *Lifestyle* respectively.

3.2.4.2. RELIABILITY

3.2.4.2.1. INTERNAL CONSISTENCIES

Coefficient alpha of the total score of both part one (perceived important of rehabilitation needs) and part two (satisfaction of service provision) were very good (both were 0.91). The internal consistencies of different sub-scales of part one were good which ranged from 0.77 (Family, Discrimination, Education) to 0.90 (Occupation), and that of part two were also good which ranged from 0.64 (Emergency Service) to 0.94 (Housing Service).

3.2.4.2.2. INTRA-RATER RELABILITY

The ICC coefficient of perceived importance of rehabilitation needs was 0.88 for the total score. The coefficients for its subscales ranged from 0.73 (Medical Services) to 0.93 (Stress Management). The ICC coefficient of satisfaction towards service provision was 0.85 for the total score. The coefficients for its subscale ranged from 0.62 (Housing service) to 0.92 (Community rehabilitation). All of these coefficients showed good stability of PRNQ—S score over time.

3.2.4.3. DESCRIPTIVE STATISTICS

Regarding perceived importance of rehabilitation needs, "Symptom Management" (*M*=4.20, *SD*=0.82), "Right for Treatment" (*M*=4.14, *SD*=0.81) and "Medical Services" (*M*=0.94, *SD*=0.82) were perceived as the most important rehabilitation needs. Regarding rehabilitation services, "Psychiatric Medication" (*M*=3.60, *SD*=0.99), "Social Welfare" (*M*=3.54, *SD*=1.2) and "Community Outreaching Services" (*M*=3.52, *SD*=1.38) were regarded as the most important services towards the participants. Details of mean score, standard deviation, ICC, and coefficient alpha are summarized in Table 6 & 7.

Table 6. Mean Scores, Standard Deviation, ICC, Coefficient Alpha in Part I of PRNQ—S

				***n*=219**	
Name of Subscales (Part I of PRNQ—S)	**Number of items**	***M***	***SD***	***ICC (n=49)***	***Alpha***
1. Occupation	**13**	**3.79**	**0.81**	**0.84****	**0.90**
2. Social Welfare and Security	**7**	**3.66**	**1.02**	**0.81****	**0.88**
3. Medical Services	**6**	**3.94**	**0.82**	**0.73****	**0.82**
4. Family	**6**	**3.73**	**0.81**	**0.82****	**0.77**
5. Social and Intimate Relationship	**5**	**3.73**	**0.99**	**0.90****	**0.85**
6. Behavior and Impulse Control	**5**	**2.96**	**1.09**	**0.90****	**0.79**
7. Symptom Management	**5**	**4.20**	**0.82**	**0.76****	**0.83**
8. Right for Treatment	**5**	**4.14**	**0.81**	**0.82****	**0.79**
9. Discrimination	**4**	**3.44**	**1.14**	**0.83****	**0.77**
10. Housing	**4**	**3.30**	**1.13**	**0.84****	**0.78**
11. Self Care	**4**	**3.30**	**1.12**	**0.92****	**0.81**
12. Stress management	**3**	**3.87**	**1.07**	**0.93****	**0.87**
13. Leisure	**3**	**3.47**	**1.17**	**0.83****	**0.89**
14. Education	**2**	**3.68**	**1.22**	**0.82****	**0.77**
15. Care of Children	**1**	**2.70**	**1.49**	**0.74****	**N/A**
16. Treatment compliance	**1**	**3.14**	**1.55**	**0.88****	**N/A**
17. Lifestyle	**1**	**3.91**	**1.15**	**0.85****	**N/A**
Total	**75**	**3.58**	**0.68**	**0.88****	**0.91**

*** p<0.01; *p< 0.05*

Table 7. Mean Scores, Standard Deviation, ICC, Coefficient Alpha in Part II of PRNQ—S

				***n*=219**	
Name of Subscales (Part I of PRNQ—S)	**Number of items**	***M***	***SD***	***ICC (n=49)***	***Alpha***
1. Vocational Rehabilitation	**6**	**3.14**	**0.99**	**0.79****	**0.81**
2. Community Rehabilitation	**1**	**3.52**	**1.38**	**0.92****	**N/A**
3. Family Intervention	**2**	**3.01**	**1.32**	**0.79****	**0.82**
4. Residential Services	**4**	**2.15**	**1.07**	**0.62****	**0.94**
5. Psychotherapy	**1**	**3.15**	**1.39**	**0.72****	**N/A**
6. Psychiatric Medication	**2**	**3.60**	**0.99**	**0.81****	**0.75**
7. Self Management Programs	**1**	**3.34**	**1.40**	**0.86****	**N/A**
8. Social Activities	**4**	**2.90**	**1.09**	**0.79****	**0.82**
9. Social Welfare	**3**	**3.54**	**1.20**	**0.81****	**0.75**
10. Emergency Services	**2**	**2.99**	**1.39**	**0.75****	**0.64**
11. Others	**5**	**2.53**	**1.01**	**0.72****	**0.84**
Total	**31**	**3.07**	**0.92**	**0.85****	**0.91**

*** p<0.01; *p< 0.05*

Response choices for PRNQ—S:

1 = 'never important' 2 = 'seldom important' 3 = 'sometimes important',

4 = 'usually important' 5 = 'always important'

CHAPTER 4: DISCUSSION

4.1. IMPLICATION OF QUALITATIVE RESULTS

Prior to the development and validation process of PRNQ—S, we conducted six focus groups for different stakeholders to collect qualitative results on the perceived rehabilitation needs of people with schizophrenia. The results indicated that the needs of people with schizophrenia nowadays are much more diversified and complicated. They no longer focus only on fulfilling basic needs such as food or living place alone, but also pursue the quality of service, acceptance from community, and human right in the society that cannot be fully captured by the existing need assessments. Qualitative study provides additional information to supplement the data gleaned from the quantitative study.

For instances, in the vocational aspect, people with schizophrenia nowadays express their need to receive pre-vocational training or a training placement, request more job opportunities, have longer job tenure, enjoy more on-going vocational support, and entitle for more reasonable salary in the competitive employment market. Some of them prefer competitive employment and seek more comprehensive vocational services in the community instead of receiving traditional vocational rehabilitation training.

For the aspect of medical services, their needs cover the quality and quantity of medical and community resources, channels of information, and help seeking. Our data indicates that the people with schizophrenia in Chinese culture focus not only on psychiatric medication and symptoms management alone, but also psychosocial rehabilitation in the community which requires a more holistic service provision. They are eager to manage their own illness by receiving more psycho-education and self management programs in order to understand and acquire handling strategies instead of putting all the responsibilities of recovery on mental health professional solely.

Our respondents raised concerns in dealing with public and self related stigma. Much literature has suggested that discrimination is negatively associated with one's mental health. For instances, public stigma brings consequences for people with stigmatizing conditions, such as loss of employment or social isolation (Corrigan & Penn 1999), whereas self stigmatization is negatively associated with the psychosocial treatment compliance (Fung, Tsang & Corrigan, 2008).

Our data reflects that the fundamental housing need for people of schizophrenia pertains to concerns on living standard, housing choice, and accessibility of services network when dealing with their housing issue.

Given the above, the perceived rehabilitation needs of people with schizophrenia in Hong Kong are much more diversified and complicated when compared with past decades. Using existing measures (e.g. CAN, MRC-NCA or SLICLS, etc) are not enough to fully capture their needs in this millennium. A multi-dimensional, comprehensive, and in-depth needs assessment for people with schizophrenia is urgently needed to capture the profile of their needs. The results provided solid and sound evidence, justification, and framework for developing the PRNQ—S.

4.2. PSYCHOMETRIC PROPERTIES OF THE PRNQ—S

In order to explore the factor structure of PRNQ—S, an EFA was performed at the initial stage to explore the constructs of perceived need of people with schizophrenia. Although it is recommended that at least a sample size of 300 is required for factor analysis to yield stable and satisfactory results (Comrey & Lee, 1992), the results showed that most of the items were able to be meaningfully fitted into the empirically derived factor structure. Most of the factors had satisfactory to good factor loadings and yielded a seventeen-factor solution which provided preliminary evidence to the content and structural validity. The only item that could not be explained was item 64 “Reduce the lack of

opportunities due to mental illnesses". This item did not fit well into the suggested factor solution neither by its factor loading score nor its nature. The factor loading of this item was the lowest (0.33) among all items in PRNQ—S and it overlapped with the items in the factor "Discrimination". As a result, we deleted this item which resulted in a 75-item PRNQ—S.

The PRNQ—S also appears to have face validity. All the items of PRNQ—S were directly extracted from the focus groups, literature and opinion from the expert panel. In addition, assessors and respondents filled in the questionnaire smoothly during the data collection process.

Apart from validity, results of this study also suggest that the PRNQ—S has excellent internal consistency. It is reliable in a sense that the scores are internally consistent within the subscales. The results reflected the items of the subscales are measuring the same construct. As to the intra rater reliability, all of the subscales are statistically significant and most of the subscales show good reliability. This indicates that the instrument's scores are stable over time. Though this study was still in the stage of initial validation, the above evidences indicated that PRNQ—S has sounded psychometric properties for clinical and research used.

4.3. COMPARSION OF PRNQ—S AND CAN

The results of EFA showed that the factor structure of PRNQ—S has similarities as well as differences when compared with the Camberwell Assessment of Need (CAN). The results of the comparison reveal that PRNQ—S consists of 17 factors whereas CAN consists of 22 factors. Most of the factors of PRNQ—S are similar to CAN. The main discrepancies are that PRNQ—S lacks the factors on "Sexual Expression", "Alcohol", "Safety to Self", "Safety to Others", "Food", "Transport", "Money" and "Telephone". The reasons of such discrepancies may be due to the fact that PRNQ—S summarized the questions related to "Alcohol", "Safety to Self", and "Safety to Others" to the subscale "Behavior and Impulse Control". Categories of "Food", "Transport", and "Money" from CAN were summarized to the subscale of "Social Welfare and Security". "Sexual Expression" from CAN was embraced by the category "Social and Intimate Relationship". PRNQ—S does not consist of any items pertinent to "Telephone" as we did not generate this item neither by focus groups nor literature review. Based on the above results, PRNQ—S should have certain extent of convergent validity with CAN. As the number of items of PRNQ—S (75 questions) is much more than CAN (22 questions), a more specific and comprehensive profile of rehabilitation needs can be generated using PRNQ—S.

It will be of greater help in the formulation of policy to cater for the needs of the target population. In this particular case, we refer to people with schizophrenia in in Hong Kong. However, upon further validations, it may be used for other Chinese societies including Singapore and mainland China.

4.4. LINKAGE BETWEEN PRNQ—S AND RECOVERY

The results generated from EFA parallel the phenomena in the western countries. The people with schizophrenia in Chinese culture not only focused on traditional psychiatric rehabilitation such as medication and symptoms management (Harrow, et al., 1997; Robinson, et al., 2004), but also concerned the various aspects of recovery process which is in line with the worldwide trend (Sullivan, 1994). The essence of the recovery model is that persons with mental illness should pursue a hopeful and an empowered life (Deegan, 1996; Lysaker, et al., 2008; Peyser, 2001), deal with stigma and discrimination (Markowitz, 2001; Tsang& Chen 2007), and have great freedom to choose their treatment, participant in, and contribute to the mental health system (Frese, et al., 2001). According to the "New Freedom Commission on Mental Health", there are three concerns hindering the process of recovery which includes stigma, unfair treatment choices, and fragmented mental health services (US Department of

Health and Human Services 2003). PRNQ—S has involved a number of independent domains such as “Discrimination”, “Right for Treatment”, and other related aspects in a more coherent manner which may bridge the niche between traditional psychiatric rehabilitation and recovery in the field of mental health that CAN and other need assessments do not cover.

The recovery journey is a dynamic process. People with schizophrenia, service providers, and mental health professionals play a significant role in facilitating its process. With the introduction of PRNQ—S, stakeholders could obtain results on both perceived needs of people with schizophrenia and their feedback on service provision. This may enhance mutual understanding between service users, mental health professionals, and service providers. The understanding would facilitate the recovery process of people with schizophrenia. Policy makers and service providers should fully utilize the PRNQ’s results for prioritizing the resources and designing the services so as to echo the rehabilitation needs of people with schizophrenia with a more recovery-orientated approach evidently.

4.5. RECOMMENDATIONS ON POLICY BASED ON THE DESCRIPTIVE RESULTS FROM PRNQ—S

The findings of this study have identified the rehabilitation needs and priority of people with schizophrenia. Regarding perceived importance of rehabilitation needs, “Symptom Management”, “Right for Treatment” and “Medical Services” (*M*=0.94, *SD*=0.82) were perceived as the most important rehabilitation needs. Regarding rehabilitation services, “Psychiatric Medication”, “Social Welfare”, and “Community Outreaching Services” were regarded as the most important services towards the participants. Based on the above preliminary results, the view of recovery of the people with schizophrenia is focusing on symptoms management, but in a more self determined manner. They tend to manage their psychiatric symptoms by means of psycho-educational and self management approach instead of relying only on psychotropic medications. The reason of that may be due to the promotion of recovery concept locally. People with schizophrenia nowadays are advocated for seeking more patient’s right and treatment’s choices in the health care system. The freedom of selecting psychiatric medications and interventions, however, is still dominated by mental health professionals in Chinese society. For instances, people with schizophrenia cannot select their psychotropic medication and cannot access to mental health

services easily in the community which resulted from the limitation of resources and manpower in Hong Kong. Consequently, it leads to treatment non-compliance and relapse of the people with schizophrenia and they resort to manage themselves by a more self-decisive method. More resources, recovery-oriented interventions and integrated model of psychiatry services should be emphasized when reviewing or formulating policies pertaining to psychiatric rehabilitation in Hong Kong.

The followings are recommendations based on the findings of this study that the HKSAR government may consider:

- Allocate more resources in terms of funding and manpower on the provision of rehabilitation services (e.g., family intervention, psychotherapy, etc).
- Adopt second generation psychotropic drugs to reduce side effects and improve recovery.
- Strengthen social, welfare, and financial support to people with schizophrenia (e.g. Comprehensive Social Security Assistance, advocacy groups, etc).
- Adopt an “Integrated Community Psychiatric Services” which allows better utilization of available community resources and provides one-stop

service including early identification, intervention, crisis support, protected housing, sheltered employment and integrated supported employment.

- Empower people with schizophrenia to set up channels or recruit as committee members in the organization to solicit their opinions in developing mental health care policy and rehabilitation services.
- Formulate policies and strategies to reduce social stigma on mental illness.
- Develop complementary and alternative approaches to the treatment of mental illness such as mindfulness-based interventions and cognitive remediation training.

The recommendations were based on the preliminary results gleaned by PRNQ—S in this study. Although the sample size was not representative enough to generalize to the population in Hong Kong, it provides insight for the government and service providers when they are planning for future directions of service provision. According to the importance placed on needs-led services (Evans, Greenhalgh, & Connelly, 2000), we should in the long run implement periodic large scale rehabilitation needs study in Hong Kong to obtain updated

information concerning the rehabilitation needs of people with schizophrenia so as to better adjust the direction of rehabilitation policies timely in the society.

4.6. LIMITATIONS AND FUTURE RESEARCH DIRECTION

This study has a number of limitations. Although we did not have sufficient sample to carry out a statistically perfect factor analysis in this study, we still attempted to explore the factor structures of PRNQ—S by EFA as an initial validation exercise. Fortunately, all items in PRNQ—S were extracted via qualitative approach scientifically and most items were able to be meaningfully categorized by EFA during the initial stage of validation. More full-blown validation studies such as assessing the concurrent validity with reference to CAN, and recruiting larger sample size for a more comprehensive validation exercise are recommended.

Results that we obtained in this study provided a solid foundation on further development of psychiatric rehabilitation in Hong Kong. Further studies to explore the relationship between PRNQ--S and recovery are strongly recommended. For instances, Recovery Measurement Tool (RMT; Ralph, 2004), Recovery Assessment Scale (RAS; Giffort, et al., 1995) or other kinds of recovery-related instruments may be used for establishing predictive and

convergent validity with PRNQ-S in the future. Further to our knowledge, the theoretical framework of needs has yet to be scientifically conceptualized. Confirmatory Factor Analysis (CFA) is also recommended to verify the constructs of PRNQ--S. Thus, it sheds light on future research's direction by using similar methodology but larger sample size to verify the entire constructs of need.

Further amendment of PRNQ—S is also suggested for the used in specific age groups or in different subtypes of schizophrenia. Evans, Greenhalgh, and Connelly (2000) suggested that different problems and patterns of service utilization are found between older adults and youngsters with psychiatric illness. We may add age-related and diagnosis-specific items in the questionnaire to obtain a more relevant and specific information concerning rehabilitation needs of people belonging to different age groups or subtypes of schizophrenia in the future.

In addition, PRNQ—S was mainly designed for local use as all focus groups and data collection were conducted in Hong Kong. However, this instrument still has great potential to be used in some modernized cities in the mainland such as Beijing and Shanghai because these cities have undergone rapid westernization and modernization recently and have developed a similar mental health system

and possessed medical technologies which are comparable to Hong Kong. Further studies are needed to justify this possibility.

Future studies on rehabilitation needs could simply be conducted by adopting the methodology and questionnaires developed in the present study. The questionnaire developed in this study provides a comprehensive, valid, and reliable way in investigating perceived needs of people with schizophrenia. Using similar methodology and the amendment of questionnaire, needs and its satisfaction in other types of psychiatric conditions (e.g., bipolar disorder, or substance abuse, etc) and/or people with other disabilities may be further assessed.

CHAPTER 5: CONCLUSION

The PRNQ—S was developed and initially validated. It may be used by researchers, epidemiologists, and administrators to assess the perceived importance and satisfaction of needs of people with schizophrenia for research and policy purposes. With this tool, a large-scale epidemiological study could be carried out in Hong Kong. Results collected from the proposed study can further provide useful information to guide the government to develop relevant public policy and provide effective mental health services to better cater the rehabilitation needs of this group of people in the community in Hong Kong. More vigorous validation exercises such as concurrent, convergent and predictive studies with other related instruments are recommended. Upon further validations, the PRNQ—S may be applied in other Chinese societies such as Singapore and the mainland China. Using the same research methodology, similar studies to assess needs and in other groups of psychiatric disabilities such as individuals with mood disorders and personality disorders can be conducted.

REFERENCES

American Psychiatric Association. (1994). *Diagnostic and Statistical Manual of Mental Disorder*, 4th ed. Washington, DC: American Psychiatric Association.

Anthony, W.A. (1991). Recovery frommental illness: the new vision of services researchers. *Innovations and Research, 1,* 13-14.

Anthony, W.A. (1993). Recovery from mental illness. The guiding vision of the mental health service system in the 1990's. *Psychosocial Rehabilitation Journal, 16(2),* 11-23.

Anthony, W. (2000). A recovery oriented service system. Setting some system level standards. *Psychiatric Rehabilitation Journal*, *24*, 159-168.

Arnold, S.E., Talbot, K., Hahn, C.G.. (2005). Neurodevelopment, neuroplasticity, and new genes for schizophrenia. *Development, Dynamics and Pathology Neural Networks: From Molecules to Functional Circuits* 147, 319-345.

Au, R.W.C., Tam, P.W.C., Tam, G.W.C. & Ungavri, G.S. (2005). Cross-cultural validation of the St Louis Inventory of Community Living Skills for Chinese patients with schizophrenia in Hong Kong. *Psychiatric Rehabilitation Journal, 29,* 34-40.

Bradshaw, J. (1972). The concept of social need. *New Society,* 30, 640-643.

Brent BK, Giuliano AJ (2007). Psychotic-spectrum illness and family-based treatments: A case-based illustration of the underuse of family interventions. *Harvard Review of Psychiatry 15 (4),* 161-168.

Brewin, C. R., Wing, J. K., Mangen, S. P., et al. (1987). Principles and practice of measuring needs in the long-term mentally ill: the MRC Needs for Care Assessment. *Psychological Medicine, 17,* 971-981.

Byrne, C., Pape, B., Ivask, A., et al. (2001). Service needs of families where one parent has an affective illness: implications for service, education, and policy. *Canadian Journal of Community, 20,* 107-121.

Chan, S. & Yu, I. W. (2004). Quality of life of clients with schizophrenia. *Journal of Advanced Nursing, 45(1),* 72-83.

Chen, C.H., Shen, Y.C., Zhang, W.X., Li, S.R., Huang, Y.Q., Wang, J.R., Wang, D.P., Tu, J., Ning, Z.X., Fu, L.M., et al. (1998). Epidemiological survey on schizophrenia in 7 areas of China (in Chinese). *Chinese Journal of Psychiatry, 31,* 72-74.

Chien, W. T., Kam, C. W., & Lee, I. F. K. (2001). An assessment of the patients' needs in Mental Health Education. *Journal of Advanced Nursing, 34,* 304-311.

Comrey, A. L., Lee, H. B. (1992). *A First Course in Factor Analysis.* (2nd ed). Hillsdale, NJ: Lawrence Erlbaum Associates Publishers.

Cooper, J.E. & Sartorius, N. (1996). *Mental disorder in China.* Washington D.C.: American Psychiatric Press.

Deegan, P. (1993). Recovering our sense of value after being labeled mentally ill. *Journal of Psychosocial Nursing,* 3*1*, 7-11.

Deegan, P. (1998). Recovery: The lived experience of rehabilitation. *Psychosocial Rehabillitation Journal, 11(4),* 11-19.

Deegan, P.E. (1996). Recovery as a journey of the heart. *Psychiatric Rehabilitation Journal, 19,* 91–97.

Department of Health Social Services Inspectorate. (1991). *Care Management and Assessment: Summary of Practice Guidance*. London: HMSO.

Evan, S., Greenhalgh, J., & Connelly, J. (2000). Selecting a mental health needs assessment scale: Guidance on the critical appraisal of standardized measures. *Journal of Evaluation in Clinical Practice, 6(4),* 379-393.

Evenson, R.C. & Boyd, M.A. (1993). The St Louis Inventory of Community Living Skills. *Psychosocial Rehabilitation Journal, 17,* 93-97.

Fontana, A. & Frey, J. H. (1994). Interviewing: the art of science. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of Qualitative Research* (pp. 361-376). Thousand Oaks: Sage Publications.

Frese, F.J., & Davis, W.W. (1997). The consumer-survivor movement, recovery, and consumer professionals. *Professional Psychology-Research and Practice*, *28(3),* 243-245

Frese, F.J., Stanley, J., Kress, K. & Vogel-Scibilia, S. (2001). Integrating evidence-based practices and the recovery model. *Psychiatric Services*, *52(11),* 1462-1468.

Gouzoulis M E (2004). Dual diagnosis of psychosis and addiction. From principles to practice. *Nervenarzt 75 (7),* 642

Green, J. & Thorogood, N. (2004). *Qualitative Methods for Health Research*. London: Sage Publications.

Giffort, D., Schmook, A., Woody, C., Vollendorf, C., & Gervain, M. (1995). *Construction of a scale to measure consumer recovery.* Springfield, IL: Illinois Office of Mental Health.

Harvey, C. A. & Fielding, J. M. (2003). The configuration of mental health services to facilitate care for people with schizophrenia. *Medical Journal of Australia, 178,* S49-52.

Harrow, M., Sands, J.R., Silverstein, M.L., et al. (1997). Course and outcome for schizophrenia versus other psychotic patients: a longitudinal study. *Schizophrenia Bulletin, 23,* 287–303.

Health and Welfare Bureau. (1999) *Hong Kong Rehabilitation Programme Plan (1998-99 to 2002-03): Towards a new rehabilitation era*. Government Secretariat, Hong Kong

Hoffmann,VP, Meyers A, Schuh L (2005). Wellness intervention for patients with serious and persistent mental illness. *Journal of Clinical Psychiatry, 66(12),* 1576-1579

Hong Kong Government. (1995). *White Paper on Rehabilitation.*

Hong Kong Government. (2001). *Fact Sheet – Rehabilitation.* Information Services Department, Hong Kong.

House of Commons. (1990). *The National Health Service and Community Care Act.* London: HMSO.

Jablensky, A. (1997). The 100-year epidemiology of schizophrenia. *Schizophrenia Research, 28,* 111-125.

Jacobson, N. (2001). Experiencing recovery: A dimensional analysis of recovery narratives. *Psychiatric Rehabilitation Journal, 24(3),* 248-254.

Jenkins, R. (2001). Making psychiatric epidemiology useful : the contribution of epidemiology to government policy. *Acta Psychiatrica Scandinavica, 103*: 2-14.

Jungbauer, J., Bischkopf, J. & Angermeyer, M.C. (2001).This illness has completely changed our lives - Stressful burden on the spouses of schizophrenic patients at the onset of the disease. *Psychiatrische Praxis 28 (3):* 133-138.

Kendler, K.S., Gallagher, T.J., Abelson, J.M., & Kessler, R.C. (1996). Lifetime prevalence, demographic risk factors, and diagnostic validity of nonaffective psychosis as assessed in a US community sample. The National Comorbidity Survey. *Archive of General Psychiatry, 53***,** 1022–1031.

Kettner, P.M., Moroney, R.M., & Martin, L.L. (1999). *Designing and managing Programs: An effective-based approach (2nd ed.)*. London: Sage Publication.

Knapp, M., Mangalore, R. & Simon, J. (2004). The global costs of schizophrenia. *Schizophrenia Bulletin, 30 (2),* 279-293.

Koppel, S. & McGuffin, P. (1999). Socio-economic factors that predict psychiatric admissions at a local level. *Psychological Medicine, 29,* 1235-1241.

Lau, A. L. D., Cummins, R. A. & Mcpherson, W. (2005). An investigation into the cross-cultural equivalence of the personal wellbeing index. *Social Indicator Research, 72,* 403- 430

Lehman, A.F., & Steinwachs, D.M. (1998). Survey coinvestigators of the PORT project: Translating research into practice: the Schizophrenia Patient Outcomes Research Team (PORT) treatment recommendations. *Schizophrenia Bulletin, 24,* 1-10

Liberman J.A, Drake R.E, Sederer L.I, Belger A., Keefe R., Perkins D & Stroup, S. (2008). Science and recovery in schizophrenia. *Psychiatric Services, 59(5),* 487-96.

Liddle, P.F. (1987). The symptoms of chronic schizophrenia: A Reexamination of the positive and negative dichotomy. *British Journal of Psychiatry 151,* 145-151.

Lysaker, P.H., Salyers, M.P., Tsai, J., et al. (2008). Clinical and psychological correlates of two domains of hopelessness in schizophrenia. *Journal of Rehabilitation Research and Development, 45,* 911-920.

Mancini, M.A., Hardiman, E.R., & Lawson, H.A. (2005). Consumer providers' theories about factors facilitating and impeding recovery from psychiatric disabilities. *Psychiatric Rehabilitation Journal, 29(1),* 48-55.

Markowitz, F.E. (2001). Modeling processes in recovery from mental illness: Relationships between symptoms, life satisfaction, and self-concept. *Journal of Health and Social Behavior, 42(1),* 64-79.

Maslow, A. H. (1954). *Motivation and Personality.* New York: Harper.

McCrone, P., Leese, M., Thornicroft, G., et al. (2000). Reliability of the Camberwell Assessment of Need-European Version: EPSILON study 6. *British Journal of Psychiatry, 177(suppl.39),* S34-40.

McEvoy, J,P. (2007). The costs of schizophrenia. *Journal of Clinical Psychiatry, 68(suppl. 14),* 4-7.

Mueser, K.T. & MuGurk, S.R. (2004). Schizophrenia. *Lancet, 363,* 2063-2072

Murray, C. J. L., & Lopez, A. D. (1996). *The Global Burden of Disease: A Comprehensive Assessment of Mortality and Disability from Diseases, Injuries, and Risk Factors in 1990 and Projected to 2020.* Cambridge, Mass.: Harvard School of Public Health.

Munetz, M.R., & Frese, F.J. (2001). Getting ready for recovery: reconciling mandatory treatment with the recovery vision. *Psychiatric Rehabilitation Journal, 25(1),* 35-42.

Murray, H. A. (1938). *Explorations in Personality.* New York: Oxford University Press.

Nehra, R., Chakrabarti, S., Kulhara, P., & Sharma, R. (2005). Caregiver-coping in bipolar disorder and schizophrenia: A re-examination. *Social Psychiatry and Psychiatric Epidemiology, 40,* 329-336.

New Freedom Commission on Mental Health. (2003). *Achieving the promise: Transforming mental health care in America. Final Report. DHHS Pub. No. SMA-03-3832*. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Nielsen, L. F., Middelboe, T., Werdelin, G. et al. (1999). Need assessment in long-term psychiatric patients: inter-rater reliability and test-retest reliability of the Danish version of the Camberwell Assessment of Need. *Nordic Journal of Psychiatry, 53,* 371-376.

Peyser, H. (2001). What is recovery? A commentary. *Psychiatric Services, 52,* 486–487.

Phelan, M., Slade, M., Thornicroft, G., et al. (1995). The Camberwell Assessment of Need(CAN): the validity and reliability of an instrument to assess the needs of people with severe mental illness. *British Journal of Psychiatry, 167,* 589-595.

Portney, L.G., Watkins, M.P., (1993). *Foundations of Clinical Research: Applications to Practice.* Appleton & Lange, United States.

Ralph, R. O. (2004). At the individual level: A personal measure of recovery. In *NASMHPD/NTAC e- Report on Recovery.* Retrieved March, 2005 from Hhttp://www.nasmhpd.org/spec_e-report_fall04measures.cfmH.

Ran, M.S., Chan, C.L.W., Chen, E.Y.H., Mao, W.J, Hu, S.H., Tang, C.P., Lin, F.R. & Conwell, T. (2009). Differences in mortality and suicidal behavior between treated and never-treated people with schizophrenia in rural China. *The British Journal of Psychiatrty, 195,* 126-131.

Ridgeway, P. (2001). Re-storying psychiatric disability: Learning from first person narrative accounts of recovery. *Psychiatric Rehabilitation Journal, 24(4),* 335-343.

Robinson, D.G., Woerner, M.G., McMeniman, M, et al. (2004). Symptomatic and functional recovery from a first episode of schizophrenia or

schizoaffective disorder. *American Journal of Psychiatry, 161,* 473–479.

Slade, M. (1994). Needs assessments. *British Journal of Psychiatry,16,* 293-296.

Slade, M., Thornicroft, G., Loftus, L., et al. (1999). *The Camberwell Assessment of Need (CAN).* London: Gaskell and Royal College of Psychiatry.

Stemler, S. (2001). An overview of content analysis. *Practical Assessment, Research & Evaluation, 7*(17).

Sullivan, P. (1994). Recovery from schizophrenia: what we can learn from the developing nations. *Innovations and Research in clinical Services, Community Support, and Rehabilitation, 3(2),* 7-15

Thornicroft, G., Rose, D. & Kssam, A. (2007) Discrimination in health care against people with mental illness. *International Review of Psychiatry 19 (2),* 113-122.

Torrey W.C., & Wyzik, P. (2000) The recovery vision as a service improvement guide for community mental health center providers. *Community Mental Health Journal, 36(2),* 209-16.

Tsang, H.W.H., & Chen, E. Y. H. (2007). Perceptions on remission and recovery in schizophrenia. *Psychopathology, 40,* 469-469.

Tsang, H. W. H., Pearson, V., & Yuen, C. H. (2002). Family needs and burdens of mentally ill offenders. *International Journal of Rehabilitation Research, 25*, 25-32.

US Department of Health and Human Services (2003). *President's New Freedom Commission on Mental Health.*

Van de Bos, G.A.M., & Triemstra, A.H.M. (1999). Quality og life as an instrumeny for need assessment and outcome assessment of health care in chronic patients. *Quality in Health Care, 8(4),* 247-252.

Wagner, L. C. & King, M, (2005). Existential needs of people with psychotic disorders in Porto Alegre, Brazil. *British Journal of Psychiatry, 186,* 141-145.

Wallace, C.J., Liberman, R.P., Tauber, R. & Wallace, J. (2000). The Independent Living Skills Survey. *Schizophrenia Bulletin, 26,* 631-658.

Weingarten, R. (1994). The ongoing process of recovery. *Psychiatry, 57,* 369-375.

Wennstrom, E., Sorbom, D., & Wiesel, F. X. (2004). Factor structure in the Camberwell Assessment of Need. *British Journal of Psychiatry, 185,* 505-510.

Wiersman, D., Nienhuis F.J., Giel R., Slooff, C.J. (1998). Stability and change in needs of patients with schizophrenic disorder: a 15- abd 17-year follow up from first onset of psychosis, and a comparison between "objective" and "subjective" assessments of needs for care. Social Psychiatry and *Psychiatric Epidemiology, 33*, 49-56.

World Health Organization. (2001). *The World Health Report 2001: Mental Health, New Understanding, New Hope*. Geneva: WHO.

Xiang, Y.T, Ma, X., Cai, Z. J., Li, S. R., Xiang, Y. Q., Guo, H. L., Hou, Y. Z., Li, Z. B., Li, Z. J., Tao, Y. F., Dang, W. M., Wu, X. M., Deng, J., Lai, K. Y. C. & Ungvari, G. S. (2008). Prevalence and socio-demographic correlates of schizophrenia in Beijing, China. *Schizophrenia Research, 102 (1-3),* 270-277

Yip, K. S. (2004). The situation of family caregivers for people with mental illnesses in Hong Kong. *Psychiatric Rehabilitation Journal, 28,* 136-141.

Appendix 1.1a

Consent Form (Chinese Version)

THE HONG KONG
POLYTECHNIC UNIVERSITY
香港理工大學

香港理工大學康復治療科學系科研同意書

科研題目：香港精神分裂症患者及照顧者的復康需要調查：對設立公共政策的應用

科研負責人：

香港理工大學康復治療科學系副教授曾永康博士

科研內容：

此項研究的目的是辨認香港精神分裂症患者及其照顧者的復康需要。本調查所得的結果能協助公共政策的制定及精神健康服務的提供，並協助政府及自願機構藉著服務使用者的需要更妥善地安排資源及提高服務質素。本調查中所涉及的聚焦小組需要花閣下約一個半小時/問卷調查需要花費閣下約半小時。

這項調查不會引起任何不適的感覺，但閣下需要做以下所要求的事項(如：錄音)。 凡有關閣下的資料均會保密，一切資料的編碼只有研究人員知道。

謝謝閣下有興趣參與這項研究。

THE HONG KONG
POLYTECHNIC UNIVERSITY
香港理工大學

同意書：

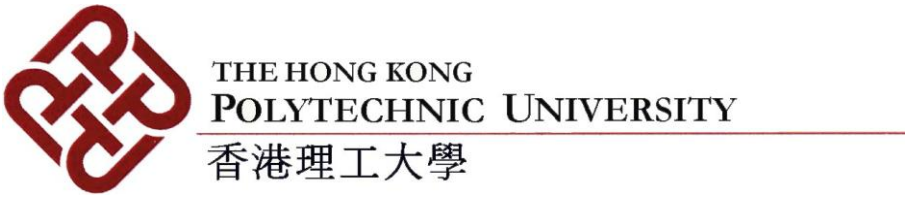
本人_____已瞭解此次研究的具體情況。本人願意參加此次研究，本人有權在任何時候、無任何原因放棄參與此次研究，而此舉不會導致我受到任何懲罰或不公平對待。本人明白參加此研究課題的潛在危險性；本人的資料將不會洩露給與此研究無關的人員；我的名字或相片不會出現在任何出版物上。

本人可以就此項研究相關的任何問題，用電話 27666750 來聯繫此次研究課題負責人，曾永康博士。若本人對此研究人員有任何投訴，可以聯繫梁女士（部門科研委員會秘書），電話：27665397。本人亦明白，參與此研究課題需要本人簽署一份同意書。

簽名(參與者)：_____ 日期：_____

簽名(證人)：_____ 日期：_____

Appendix 1.1b Consent Form (English Version)



Research Project Informed Consent Form

Project title: Rehabilitation Needs of People with Schizophrenia and their Caregivers in Hong Kong: Implication for Public Policy

Principal Investigator

Dr. Hector Tsang, Associate Professor of the Department of Rehabilitation Sciences at The Hong Kong Polytechnic University

Project information:

The aim of this study is to identify rehabilitation needs of people with schizophrenia and their caregivers in Hong Kong. The results of the study could provide information and direction for formulation of public policy and provision of mental health services which can help the government and service providers better allocate and prioritize resources based on the needs of clients and caregivers, and provide better quality of services to fit their aggregated needs. The study will involve participating in a focus group interview which will take you about one and half hour.

The interview should not result in any undue discomfort, but you will need to be audio-taped in the focus group interview. All information related to you will remain confidential, and will be identifiable by codes known only to the researcher.

Thank you for your interest in participating in this study.

THE HONG KONG
POLYTECHNIC UNIVERSITY
香港理工大學

Consent:

I, _____, have been explained the details of this study. I voluntarily consent to participate in this study. I understand that I can withdraw from this study at any time without giving reasons, and my withdrawal will not lead to any punishment or prejudice against me. I am aware of any potential risk in joining this study. I also understand that my personal information will not be disclosed to people who are not related to this study and my name or photograph will not appear on any publications resulted from this study.

I can contact the chief investigator, Dr Hector Tsang at telephone 27666750 for any questions about this study. If I have complaints related to the investigator(s), I can contact Mrs Michelle Leung, secretary of Departmental Research Committee, at 27665397. I know I will be given a signed copy of this consent form.

Signature (subject): _____ Date: _____

Signature (witness):_____ Date_____:

Appendix 1.2

Demographic Data Collection Form

For people with schizophrenia

Participant number: _____Date of focus group: _____

---

1. Name of participant: _____

2. Gender*: □ Male □ Female

3. Age: _____

4. Educational level*:

□ Primary □ Secondary □Tertiary

5. Martial status*:

□ Single □ Married □ Divorce □ Widow

6. Living with*:

□ Family_____ □ Alone □ Friend □ Half-way house/ Hostel

□ Others, please specify: _____

7. Occupation: _____

8. Principal source of income*:

□ Self earned □ Savings □Family □ N.D.A./H.D.A.

□ C.S.S.A. □ Other, please specify: _____

9. Date of onset: _____

10. Mental health services received:

_____

Appendix 1.3

Demographic Data Collection Form
For caregivers of people with schizophrenia

Participant number: _____ Date of focus group: _____

---

1. Name of participant: _____

2. Gender*: □ Male □ Female

3. Age: _____

4. Educational level*:

□ Primary □ Secondary □Tertiary

5. Martial status*:

□ Single □ Married □ Divorce □ Widow

6. Living with the client*: □ Yes/ No

7. Occupation: _____

8. Principal source of income*:

□ Self earned □ Savings □Family □

N.D.A./H.D.A. □ C.S.S.A. □ Other, please specify:

_____

9. How many years do you take care of the client? _____

10. Mental health services received: _____

Appendix 1.4.

Demographic Data Collection Form

For mental health professionals

Participant number: _____

Date of focus group: _____

---

1. Name of participant: _____

2. Gender*: ☐ Male ☐ Female

3. Field of professional qualification:

☐ Nurse ☐ Occupational Therapist ☐ Psychiatrist

☐ Psychologist ☐ Social Worker

☐ Other Rehabilitation Practitioner, please specify: _____

4. Organization: _____

5. Years of experience in mental health rehabilitation: _____

Appendix 2a.

Focus Group Interview Guide for person with Schizophrenia (Chinese Version)

聚焦小組訪問指引

引言

早晨/ 晚安，歡迎大家參與香港理工大學康復治療科學系舉辦的聚焦小組。我是這個聚焦小組的組長 XXX，而他是這個聚焦小組的副組長 XXX，我們都是理大的研究人員。今天聚焦小組的目的是探討精神分裂症患者及其照顧者的復康需要。這次聚焦小組約需時一個半小時，訪問過程將會錄音。今日收集到的資料將有助我們更深入了解你們的需要。

聚焦小組的內容將分為兩部分：在第一部分，我們將討論精神分裂症患者的復康需要；在第二部分，我們將轉為討論照顧者的需要及面對的難題。請注意，這些問題是沒有絕對正確的答案或意見的，我希望大家能夠互相尊重，在其他人分享他們的觀點及經驗的時候，不要反駁或打斷他們說話。

我們會將研究結果向政府報告，協助計劃日後以使用者為主導復康服務。你們的意見是十分重要的，可以直接影響精神健康復康的發展。因此請大家踴躍發表意見。

組長/副組長指引

1. 聚焦小組開始前須先得到參加者的書面同意。
2. 聚焦小組進行期間請依照下列的引導問題，就這些開放式的問題，參加者可自由發表意見。如有需要可改變發問問題的先後次序。
3. 聚焦小組進行期間，除非參加者的回應與問題無關或過分壟斷，否則應儘量避免打擾參加者的談話。
4. 只有在參加者不明白如何回答問題或回應與問題無關時，才需要作出提示。提示的目的提示是協助參加者更清楚問題及發表意見。
5. 聚焦小組進行期間切勿作出判斷及分析。小組組長及副組長必須避免參加者之間出現不和，及確保聚焦小組順利進行。
6. 如參加者對某個範疇沒有特別意見，切勿強迫參加者作出回應。
7. 如有需要，可鼓勵聚焦小組內被動或表現猶豫的參加者發表意見，或協助清楚說明回應內容。
8. 如討論的內容迅速離題，小組組長及副組長應協助引導至原來的意思。
9. 聚焦小組需時約 90 至 120 分鐘。

引導問題

第一部分： 精神分裂症患者的復康需要

1. 根據你的經驗及理解，作為精神分裂症患者，你認為在日常生活中會遇到甚麼難題？

    - 就業方面
    - 住宿方面
    - 社交方面
    - 財政方面

2. 你有那些需要可幫助你解決上述的難題及改善生活質素？

    - 就業、住宿、社交、財政等
    - 誰提供幫助
    - 怎樣提供幫助

3. 你認為自己的需要滿足了多少？為甚麼？

    - 滿足了那些需要
    - 沒有滿足那些需要
    - 任何遺漏的地方

4. 你認為現有的服務、資源及政府政策有沒有配合你的需要？為甚麼？

- 就業服務
- 住宿服務
- 社區服務
- 醫療服務
- 財政系統
- 社會福利

5. 你對政府如何改善現有對精神分裂症患者的服務、資源及政策有甚麼建議？

- 就業服務
- 住宿服務
- 社區服務
- 醫療服務
- 財政系統
- 社會福利

6. 任何有關的意見及建議是以上的討論中未曾提及的

Appendix 2b.

Focus Group Interview Guide for person with Schizophrenia (English Version)

Introduction

Good morning / Good evening, welcome to the focus group organised by Department of Rehabilitation Sciences of the Hong Kong Polytechnic University. I am the group leader of this focus group, XXX. S/he is the assistant group leader of this focus group, XXX. Both of us are researchers of the Hong Kong Polytechnic University. Our aim today is to explore the needs of rehabilitation of the patients with schizophrenia and that of their caregivers. This focus group is going to take one and a half hours. The interview will be tape-recorded. The information we collect today will help us understand more about your needs.

The focus group is divided into two parts: In the first part we will discuss the needs of the caregivers; in the second part, we will move to the discussion of the needs of rehabilitation and the problems faced by patients with schizophrenia. Please note that there are no absolute right or wrong answers to these questions. I hope that we can respect each other. When the others are sharing their viewpoints and experiences, please do not answer back or disturb them.

We will present our research findings to the government, in order to help plan the user-oriented rehabilitation services in the future. Your opinions are very important. They may directly affect the development of rehabilitation of mental health. So, please feel free to express your opinions.

Instructions for group leader / assistant group leader

1. Written consent is required before the focus group starts.
2. Please follow the guiding questions during the focus group. Participants may express their opinions freely based on these open-ended questions. If necessary, the order of asking these questions can be changed.
3. During the focus group, unless the participants' responses are unrelated to the questions or they are over-dominant, otherwise, disturbances on participants' conversations should be avoided.
4. Hints should only be provided when the participants do not understand how to answer the questions or give responses that are unrelated to the questions. The purpose of giving hints is to help the participants to be clearer about the questions and then express their opinions.
5. Do not give judgments or analyses during the focus group. The group leader and assistant group leader should avoid arguments among the participants to ensure that the focus group is carried out smoothly.
6. If the participants do not have particular opinion on a certain aspect, DO NOT force the participant to give responses.
7. If necessary, try to encourage the passive or undetermined participants to express their opinions, or help them explain the content of their responses more clearly.
8. If the content of discussion wanders from the subject quickly, the group leader and assistant group leader should guide the discussion back to the original meaning.
9. The focus group needs about 90 to 120 minutes.

Guiding questions

Part 1: The needs for rehabilitation of patients with schizophrenia

1. Based on your experiences and understanding, what problems do patients with schizophrenia face in their daily life?

    - Employment
    - Accommodation
    - Social interaction
    - Finance

2. What do you need for solving the above problems and improving the quality of living?

    - employment, accommodation, social interaction, finance, etc.
    - who provide assistance
    - how to provide assistance

3. In your opinion, how much of your need is satisfied? Why?

    - which needs are satisfied
    - which needs are not satisfied
    - what are neglected

4. In your opinion, do the existing services, resources and government policies suit your needs? Why or why not?
    - employment services
    - accommodation services
    - social services
    - medical services
    - financial system
    - social welfare

5. What suggestion do you have regarding how the government improves the existing services, resources and policies for caregivers of patients with schizophrenia?
    - employment services
    - accommodation services
    - social services
    - medical services
    - financial system
    - social welfare

6. Do you have any other suggestion(s) or recommendation(s) that did not mention during the group?

Appendix 3.

Preliminary Codebook for thematic analysis

1. 工作問題

內容		備註
缺乏工作動機		
就業機會低		
同事關係不和		
上司關係不和		
工作技巧/能力不足		
不能維持穩定工作		
缺乏工種選擇		
僱主不願意員工假覆診		
缺乏在職支援/輔導		
缺乏工作訓練		
缺乏晉升機會		
工資被剝削		

2. 病徵問題

內容		備註
被陽性及負性病徵困擾		
幻聽		
妄想		
情緒不穩定		
行為問題		
缺乏處理方法		

3. 精神病的資料及認識

內容		備註
對精神病及其藥物缺乏認識		
缺乏渠道以得到有關資訊		

4. 自我照顧能力

內容		備註
自理技巧/個人衛生問題		
家居管理問題(如煮食及清潔)		

5. 醫療

內容		備註
缺乏病人權益及選擇權		
首次排診時間過長		
診症時間不足		
缺乏其他的精神科專業人仕幫助		
醫療服務人員經常轉變，難與醫療人員建立良好關係		
藥物不合適		
藥物副作用的困擾		
社區復康資源不足		
缺乏心靈需要，只著重病徵		

6. 社交

內容		備註
缺乏社交技巧		
社交網絡狹窄		
缺乏渠道結交朋友		
社交退縮		

7. 親密關係

內容		備註
沒信心與異性相處/建立關係		
缺乏異性相處技巧		
缺乏性知識		

8. 家庭

內容		備註
家人關係不和睦，經常摩擦		
家人期望過高，導致壓力		
家人對精神病缺乏認識，對病人並不接納		

9. 子女照顧

內容		備註
缺乏照顧兒童技巧		

10. 娛閒

內容		備註
缺乏娛閒機會		
缺乏娛閒安排		
缺乏興趣		

11. 參與治療問題

內容		備註
不定時覆診		
服食藥物習慣問題		
參加治療缺乏積極性		

12. 住屋

內容		備註
缺乏居住安排		
空間太少		
地點較偏遠		

13. 經濟

內容		備註
缺乏食物		
交通費用過高		
娛樂費用過高		

14. 教育

內容		備註
缺乏基本教育機會		

15. 歧視

內容		備註
被家人歧視		
被公眾歧視		
自我歧視		
因精神病缺乏自信		
因精神病缺乏機會		

16. 社區福利及支援

內容		備註
綜援金額不足		
社區援助不足		
未得到應有援助		
缺乏渠道求助		
缺主動尋求社區幫助		

17. 金錢管理

內容		備註
過度揮霍		
缺乏理財能力		

18. 壓力管理

內容		備註
焦慮		
日常生活/工作壓力		
缺乏壓力管理技巧		

Appendix 4 <u>Amendments on inconsistent coding in the codebook</u>

Items with inconsistent coding	Reason of inconsistent coding	Recommendation
病徵問題		
自殺, 暴力, 酗酒	曾經自殺…打人…. 飲酒消愁. in original transcript	Added to new category 對公眾或自身構成危害
財物管理問題	"病發 ge 時候…..保管保護自己 d 物品個人物品" in original transcript	Added to be a new item
家庭		
家人缺乏物質上支持	"即覺得屋企人唔係咁在上經濟支持自己啦"	Added to be a new item
住屋		
缺乏居住安排	"在住宿的問題上…和家人爭執了半年時間才能進入中途宿舍"	Rename the item to 缺乏居住過渡安排
缺乏住屋選擇	住宿方面，基本上，精神病患者或者精神分裂症患者在選擇不多 in original transcipt	Added to be new item
經濟		
交通費用過高	Missing code "還有他們 CSSA，就不能幫補到他們的生活，無論是車資……"	Rename item to 未能應付交通費用
未能應付藥物費用	"如果你還要他們是新藥的話，他們就更加負擔不起" in original transcript	Added to be new item
教育		
缺乏升學支援	"教育果方面呢, 咁我覺得呢咁就應該照應到一下殘疾人士"	Rename to item 未能得到合適教育或進修
未能融入普通教育	"因為病個問題而影響到我學業啦…….. d 同學咪又度鬧我啊我啊杯葛我"	Rename to item 被公眾歧視 and shift to the part of 歧視

Appendix 5.

Results of frequency count in codebook

工作問題

內容	Frequencies
缺乏工作動機	4
就業機會低	8
同事關係不和	5
上司關係不和	4
工作技巧/能力不足	10
不能維持穩定工作	8
缺乏工種選擇	5
僱主不願意員工假覆診	4
缺乏在職支援/輔導	4
缺乏工作訓練	8
缺乏晉升機會	3
工資被剝削	4
缺乏面試技巧	4

2. 病徵問題

內容	Frequencies
被陽性及負性病徵困擾	10
情緒不穩定	4
行為問題	4
缺乏處理方法	4

3. 精神病的資料及認識

內容	Frequencies
對精神病及其藥物缺乏認識	8
缺乏渠道以得到有關資訊	6

4. 自我照顧能力

內容	Frequencies
自理技巧/個人衛生問題	12
家居管理問題(如煮食及清潔)	4
財物管理問題	4

5. 醫療

內容	Frequencies
缺乏病人權益及選擇權	6
首次排診時間過長	6
診症時間不足	7
缺乏其他的精神科專業人仕幫助	10
醫療服務人員經常轉變，難與醫療人員建立良好關係	5
藥物不合適	8
藥物副作用的困擾	12
社區復康資源不足	6
缺乏心靈需要，只著重病徵	4

6. 社交

內容	Frequencies
缺乏社交技巧	5
社交網絡狹窄	8
缺乏渠道結交朋友	6
社交退縮	4
缺乏社交動機	4

7. 親密關係

內容	Frequencies
沒信心與異性相處/建立關係	2
缺乏異性相處技巧	0 (Jungbauer, 2001)
缺乏性知識	4

8. 家庭

內容	Frequencies
家人關係不和睦，經常摩擦	9
家人期望過高	0 (Brent, 2007)
家人對精神病缺乏認識，對病人並不接納	9
家人缺乏支持	4
缺乏生育及家庭計劃的認識	4

9. 子女照顧

內容	Frequencies
缺乏照顧兒童技巧	4

10. 娛閒

內容	Frequencies
缺乏娛閒機會	4
缺乏娛閒安排	4
缺乏興趣	4
建立良好生活模式	3

11. 參與治療問題

內容	Frequencies
不定時覆診	0 (Gouzoulis 2004)
服食藥物習慣問題	12
參加治療缺乏積極性	4

12. 住屋

內容	Frequencies
缺乏居住過渡安排	6
空間太少	5
地點較偏遠	4
缺乏選擇	4

13. 經濟

內容	Frequencies
缺乏食物	4
未能應付交通費用	10
未能應付娛樂費用	4
未能應付藥物費用	4

14. 教育

內容	Frequencies
缺乏基本教育機會	4
未能得到合適教育或進修	4

15. 歧視

內容	Frequencies
被家人歧視	6
被公眾歧視	10
自我歧視	4
因精神病缺乏自信	4
因精神病缺乏機會	10

16. 社區福利及支援

內容	Frequencies
綜援金額不足	6
社區援助不足	6
未得到應有援助	6
增加求助地方	3
缺乏求助服務	1

17. 金錢管理

內容	**Frequencies**
過度揮霍	4
缺乏理財能力	4

18. 壓力管理

內容	**Frequencies**
焦慮	4
日常生活/工作壓力	4
缺乏壓力管理技巧	0 (Hoffmann 2005)

19. 對公眾或自身構成危害

內容	**Frequencies**
有自殺行為	4
有暴力行為	4
有酗酒行為	4

Appendix 6.

Amendments after the frequency count of codebook

Item's frequency (f) lower than 4	Recommendation
家庭	
避免家人期望過高 (f=0)	Item was deleted. Similar to the item 改善與家人關係
歧視	
減少自我歧視 (f=3)	Combined to item 減少自我歧視及自卑感 because it seemed to be causal relationship.
減少因精神病而缺乏自信 (f=2)	
親密關係	
增強信心與異性相處 (f=2)	Combined to a new item "Boost confidence and improve skills getting along with other sex" 增強信心及改善與異性相處技巧
增強與異性相處技巧 (f=0)	
社區福利及支援	
增加求助地方 (f=3)	Refined to "increase the channels of help seeking"增加求助渠道
缺乏求助服務 (f=1)	Items was deleted. Similar to the item "increase the channels of help seeking"
壓力管理	
建立良好生活模式 (f=3)	Refined to item "Develop a structural daily life" 建立有規律的生活模式

Appendix 7. Perceived Rehabilitation Needs Questionnaire (Schizophrenia) – [PRNQ – S]

Questionnaire on the Rehabilitation Needs of Persons with Schizophrenia in Hong Kong

Introduction

This questionnaire aims at identifying the rehabilitation needs of schizophrenia patients in Hong Kong. The research findings will help in the formulation of public policies in Hong Kong and in the provision of mental health services in the future. The findings will also help the government and voluntary organizations allocate resources more appropriately according to the needs of service users and enhance the quality of service.

There are 3 parts in the questionnaire. Part I assesses **the importance of each type of rehabilitation need to you and your satisfaction** towards it. Part II assesses **the importance of each type of rehabilitation service at present and your level of satisfaction** towards it. Part III is about your background information for data analysis.

Part I: Rehabilitation Needs

There are a total of 19 types and 76 items of rehabilitation needs of mental illness patients. Please rate **the importance of each rehabilitation need to you** using the scale 1 to 5 with 1 being not very important and 5 being very important. Hence, please assess **your satisfaction towards the present services** using the scale 1 to 5 with 1 being not satisfactory and 5 being very satisfactory.

A. Occupation	Importance					Have you used this service before? (if yes,) ⟶		Satisfaction				
	Not Very Important ←-----→ Very Important							Not Satisfactory←----------→ Satisfactory				
1. Enhance motivation to work	**1**	**2**	**3**	**4**	**5**	**Yes**	**No**	**1**	**2**	**3**	**4**	**5**
2. Increase employment opportunities	**1**	**2**	**3**	**4**	**5**	**Yes**	**No**	**1**	**2**	**3**	**4**	**5**
3. Improve relations with co-workers	**1**	**2**	**3**	**4**	**5**	**Yes**	**No**	**1**	**2**	**3**	**4**	**5**
4. Improve relations with superiors	**1**	**2**	**3**	**4**	**5**	**Yes**	**No**	**1**	**2**	**3**	**4**	**5**
5. Enhance working skills	**1**	**2**	**3**	**4**	**5**	**Yes**	**No**	**1**	**2**	**3**	**4**	**5**
6. Enhance work tenure	**1**	**2**	**3**	**4**	**5**	**Yes**	**No**	**1**	**2**	**3**	**4**	**5**
7. Provide more on-going vocational support	**1**	**2**	**3**	**4**	**5**	**Yes**	**No**	**1**	**2**	**3**	**4**	**5**
8. Provide job training opportunities	**1**	**2**	**3**	**4**	**5**	**Yes**	**No**	**1**	**2**	**3**	**4**	**5**
9. Strengthen interview skills	**1**	**2**	**3**	**4**	**5**	**Yes**	**No**	**1**	**2**	**3**	**4**	**5**
10. Allow staff take leaves for psychiatric follow up	**1**	**2**	**3**	**4**	**5**	**NA**						
11. Improve promotion prospect	**1**	**2**	**3**	**4**	**5**	**NA**						
12. Obtain a reasonable salary	**1**	**2**	**3**	**4**	**5**	**NA**						
13. Increase the varieties of work types	**1**	**2**	**3**	**4**	**5**	**NA**						

B. Social Welfare and Security	Importance					Have you used this service before? (if yes,)		Satisfaction				
	Not Very Important ←-----→ Very Important							Not Satisfactory←----------→ Satisfactory				
14. Provide sufficient food	**1**	**2**	**3**	**4**	**5**	**Yes**	**No**	**1**	**2**	**3**	**4**	**5**
15. Provide sufficient transport expenses	**1**	**2**	**3**	**4**	**5**	**Yes**	**No**	**1**	**2**	**3**	**4**	**5**
16. Provide sufficient entertainment expenses	**1**	**2**	**3**	**4**	**5**	**Yes**	**No**	**1**	**2**	**3**	**4**	**5**
17. Provide sufficient medical expenses	**1**	**2**	**3**	**4**	**5**	**Yes**	**No**	**1**	**2**	**3**	**4**	**5**
18. Provide sufficient amount of Social Security Allowance	**1**	**2**	**3**	**4**	**5**	**Yes**	**No**	**1**	**2**	**3**	**4**	**5**
19. Increase channels for help seeking	**1**	**2**	**3**	**4**	**5**	**NA**						
20. Provide sufficient assistance in the community	**1**	**2**	**3**	**4**	**5**	**NA**						

C. Medical Services	Importance					Have you used this service before? (if yes,)		Satisfaction				
	Not Very Important ←-----→ Very Important							Not Satisfactory←----------→ Satisfactory				
21.Provide sufficient mental health professionals for follow up	**1**	**2**	**3**	**4**	**5**	**Yes**	**No**	**1**	**2**	**3**	**4**	**5**
22. Increase resources for community rehabilitation	**1**	**2**	**3**	**4**	**5**	**Yes**	**No**	**1**	**2**	**3**	**4**	**5**
23.Improve the understanding of patients' psychological needs	**1**	**2**	**3**	**4**	**5**	**Yes**	**No**	**1**	**2**	**3**	**4**	**5**
24. Provide sufficient channels to obtain relevant information	**1**	**2**	**3**	**4**	**5**	**Yes**	**No**	**1**	**2**	**3**	**4**	**5**

25. Avoid frequent change of medical staff to maintain a stable relationship	**1**	**2**	**3**	**4**	**5**	**NA**
26.Increase the duration of psychiatric consultation	**1**	**2**	**3**	**4**	**5**	**NA**

D. Family	Importance					Have you used this service before? (if yes,) →		Satisfaction				
	Not Very Important ←-----→ Very Important							Not Satisfactory←----------→ Satisfactory				
27.Acquire sufficient knowledge on birth and family planning	**1**	**2**	**3**	**4**	**5**	**Yes**	**No**	**1**	**2**	**3**	**4**	**5**
28.Increase family's understanding on mental illness	**1**	**2**	**3**	**4**	**5**	**Yes**	**No**	**1**	**2**	**3**	**4**	**5**
29.Improve the relationship with family	**1**	**2**	**3**	**4**	**5**	**Yes**	**No**	**1**	**2**	**3**	**4**	**5**
30.Able to get emotional support from the family	**1**	**2**	**3**	**4**	**5**	**NA**						
31.Avoid over-expectation from the family	**1**	**2**	**3**	**4**	**5**	**NA**						
32.Able to get tangible support from the family	**1**	**2**	**3**	**4**	**5**	**NA**						

E. Social and Intimate Relationship	Importance					Have you used this service before? (if yes,) ⟶		Satisfaction				
	Not Very Important ←-----→ Very Important							Not Satisfactory←----------→ Satisfactory				
33.Expand social network	**1**	**2**	**3**	**4**	**5**	**Yes**	**No**	**1**	**2**	**3**	**4**	**5**
34.Enhance motivation in social life	**1**	**2**	**3**	**4**	**5**	**Yes**	**No**	**1**	**2**	**3**	**4**	**5**
35.Improve social skills	**1**	**2**	**3**	**4**	**5**	**Yes**	**No**	**1**	**2**	**3**	**4**	**5**
36.Improve skills getting along with other sex	**1**	**2**	**3**	**4**	**5**	**Yes**	**No**	**1**	**2**	**3**	**4**	**5**
37.Gain proper sex knowledge	**1**	**2**	**3**	**4**	**5**	**Yes**	**No**	**1**	**2**	**3**	**4**	**5**

F. Behavior and Impulse Control	Importance					Have you used this service before? (if yes,) ⟶		Satisfaction				
	Not Very Important ←-----→ Very Important							Not Satisfactory←----------→ Satisfactory				
38.Reduce aggressive behavior	**1**	**2**	**3**	**4**	**5**	**Yes**	**No**	**1**	**2**	**3**	**4**	**5**
39.Reduce suicidal behavior	**1**	**2**	**3**	**4**	**5**	**Yes**	**No**	**1**	**2**	**3**	**4**	**5**
40.Reduce alcoholic behavior	**1**	**2**	**3**	**4**	**5**	**Yes**	**No**	**1**	**2**	**3**	**4**	**5**
41.Avoid over spending	**1**	**2**	**3**	**4**	**5**	**Yes**	**No**	**1**	**2**	**3**	**4**	**5**
42.Enhance ability of budget management	**1**	**2**	**3**	**4**	**5**	**Yes**	**No**	**1**	**2**	**3**	**4**	**5**

G. Symptom Management	Importance					Have you used this service before? (if yes,) ⟶		Satisfaction				
	Not Very Important ←-----→ Very Important							Not Satisfactory←----------→ Satisfactory				
43.Increase ways of handling symptoms	**1**	**2**	**3**	**4**	**5**	**Yes**	**No**	**1**	**2**	**3**	**4**	**5**
44.Maintain stable emotion	**1**	**2**	**3**	**4**	**5**	**Yes**	**No**	**1**	**2**	**3**	**4**	**5**
45.Alleviate positive and negative symptom	**1**	**2**	**3**	**4**	**5**	**Yes**	**No**	**1**	**2**	**3**	**4**	**5**
46.Enhance knowledge on mental illnesses and medication	**1**	**2**	**3**	**4**	**5**	**Yes**	**No**	**1**	**2**	**3**	**4**	**5**
47.Attend psychiatric appointment timely	**1**	**2**	**3**	**4**	**5**	**Yes**	**No**	**1**	**2**	**3**	**4**	**5**

H. Right for Treatment	Importance					Have you used this service before? (if yes,) ⟶	Satisfaction
	Not Very Important ←-----→ Very Important						Not Satisfactory←----------→ Satisfactory
48.Being prescribed of the appropriate medication	**1**	**2**	**3**	**4**	**5**	**NA**	
49.Reduce the side-effect of medication	**1**	**2**	**3**	**4**	**5**	**NA**	
50.Reduce the waiting time of first psychiatric consultation	**1**	**2**	**3**	**4**	**5**	**NA**	
51.Improve patients' right for choosing their types of treatment	**1**	**2**	**3**	**4**	**5**	**NA**	
52.Participate actively in psychiatric treatment	**1**	**2**	**3**	**4**	**5**	**NA**	

I. Discrimination	Importance					Have you used this service before? (if yes,) →		Satisfaction				
	Not Very Important ←-----→ Very Important							Not Satisfactory←----------→ Satisfactory				
53.Reduce being discriminated by the community	**1**	**2**	**3**	**4**	**5**	**Yes**	**No**	**1**	**2**	**3**	**4**	**5**
54.Reduce being discriminated by the family	**1**	**2**	**3**	**4**	**5**	**Yes**	**No**	**1**	**2**	**3**	**4**	**5**
55.Reduce self-discrimination and the sense of inferiority	**1**	**2**	**3**	**4**	**5**	**Yes**	**No**	**1**	**2**	**3**	**4**	**5**
56.Reduce the chance of being excluded	**1**	**2**	**3**	**4**	**5**	**Yes**	**No**	**1**	**2**	**3**	**4**	**5**

J. Housing	Importance					Have you used this service before? (if yes,) →		Satisfaction				
	Not Very Important ←-----→ Very Important							Not Satisfactory←----------→ Satisfactory				
57.Improve living space	**1**	**2**	**3**	**4**	**5**	**Yes**	**No**	**1**	**2**	**3**	**4**	**5**
58.Provide sufficient choices of housing	**1**	**2**	**3**	**4**	**5**	**Yes**	**No**	**1**	**2**	**3**	**4**	**5**
59.Avoid too long distance from residence to service network	**1**	**2**	**3**	**4**	**5**	**Yes**	**No**	**1**	**2**	**3**	**4**	**5**
60.Provide sufficient transitional housing arrangement	**1**	**2**	**3**	**4**	**5**	**Yes**	**No**	**1**	**2**	**3**	**4**	**5**

K. Self Care	Importance					Have you used this service before? (if yes,)		Satisfaction				
	Not Very Important ←-----→ Very Important							Not Satisfactory←----------→ Satisfactory				
61.Improve ability of household management	**1**	**2**	**3**	**4**	**5**	**Yes**	**No**	**1**	**2**	**3**	**4**	**5**
62.Improve self-care skills	**1**	**2**	**3**	**4**	**5**	**Yes**	**No**	**1**	**2**	**3**	**4**	**5**
63.Improve ability of managing own property	**1**	**2**	**3**	**4**	**5**	**Yes**	**No**	**1**	**2**	**3**	**4**	**5**
64.Improve personal hygiene	**1**	**2**	**3**	**4**	**5**	**Yes**	**No**	**1**	**2**	**3**	**4**	**5**

L. Stress Management	Importance					Have you used this service before? (if yes,)		Satisfaction				
	Not Very Important ←-----→ Very Important							Not Satisfactory←----------→ Satisfactory				
65.Reduce anxiety	**1**	**2**	**3**	**4**	**5**	**Yes**	**No**	**1**	**2**	**3**	**4**	**5**
66.Reduce pressure of everyday life	**1**	**2**	**3**	**4**	**5**	**Yes**	**No**	**1**	**2**	**3**	**4**	**5**
67.Improve stress management skills	**1**	**2**	**3**	**4**	**5**	**Yes**	**No**	**1**	**2**	**3**	**4**	**5**

M. Leisure	Importance					Have you used this service before? (if yes,)		Satisfaction				
	Not Very Important ←-----→ Very Important							Not Satisfactory←----------→ Satisfactory				
68.Increase interest in leisure	**1**	**2**	**3**	**4**	**5**	**Yes**	**No**	**1**	**2**	**3**	**4**	**5**
69.Provide sufficient leisure opportunities	**1**	**2**	**3**	**4**	**5**	**Yes**	**No**	**1**	**2**	**3**	**4**	**5**
70.Develop appropriate leisure Arrangement	**1**	**2**	**3**	**4**	**5**	**Yes**	**No**	**1**	**2**	**3**	**4**	**5**

N. Education	Importance					Have you used this service before? (if yes,) →		Satisfaction				
	Not Very Important ←-----→ Very Important							Not Satisfactory←----------→ Satisfactory				
71.Provide sufficient opportunities of basic education	**1**	**2**	**3**	**4**	**5**	**Yes**	**No**	**1**	**2**	**3**	**4**	**5**
72.Provide sufficient opportunities of education and further studies	**1**	**2**	**3**	**4**	**5**	**Yes**	**No**	**1**	**2**	**3**	**4**	**5**

O. Care of Children	Importance					Have you used this service before? (if yes,) →		Satisfaction				
	Not Very Important ←-----→ Very Important							Not Satisfactory←----------→ Satisfactory				
73.Improve the skills of taking care of children	**1**	**2**	**3**	**4**	**5**	**Yes**	**No**	**1**	**2**	**3**	**4**	**5**

P. Treatment Compliance	Importance					Have you used this service before? (if yes,) →		Satisfaction				
	Not Very Important ←-----→ Very Important							Not Satisfactory←----------→ Satisfactory				
74.Improve the drug compliance	**1**	**2**	**3**	**4**	**5**	**Yes**	**No**	**1**	**2**	**3**	**4**	**5**

Q. Lifestyle	Importance					Have you used this service before? (if yes,) →		Satisfaction				
	Not Very Important ←-----→ Very Important							Not Satisfactory←----------→ Satisfactory				
75.Develop a structural daily life	**1**	**2**	**3**	**4**	**5**	**Yes**	**No**	**1**	**2**	**3**	**4**	**5**

Apart from the above, do you have any other opinions towards the rehabilitation needs?

_____

_____

_____

--- End of Part I ---

Part II: Rehabilitation Service

There are a total of 11 types and 31 items of rehabilitation service for mental illness patients. Please rate **the importance of each rehabilitation service to you** using the scale 1 to 5 with 1 being not very important and 5 being very important. Hence, please answer if you have used the service before. If yes, please rate **your level of satisfaction towards the service** using the scale 1 to 5 with 1 being not satisfactory and 5 being very satisfactory. You are not required to answer the part on your level of satisfaction if you have not used the service before.

A. Vocational rehabilitation	Importance					Have you used this service before? (if yes,) →		Satisfaction				
	Not Very Important ←-----→ Very Important							Not Satisfactory←----------→ Satisfactory				
1. Supported Employment*	**1**	**2**	**3**	**4**	**5**	**Yes**	**No**	**1**	**2**	**3**	**4**	**5**
2. Social Enterprises*	**1**	**2**	**3**	**4**	**5**	**Yes**	**No**	**1**	**2**	**3**	**4**	**5**
3. Sheltered Workshop	**1**	**2**	**3**	**4**	**5**	**Yes**	**No**	**1**	**2**	**3**	**4**	**5**
4. Selective Placement Division of the Labour Department	**1**	**2**	**3**	**4**	**5**	**Yes**	**No**	**1**	**2**	**3**	**4**	**5**
5. Day Hospital	**1**	**2**	**3**	**4**	**5**	**Yes**	**No**	**1**	**2**	**3**	**4**	**5**
6. Training and Activity Centre	**1**	**2**	**3**	**4**	**5**	**Yes**	**No**	**1**	**2**	**3**	**4**	**5**

B. Vocational rehabilitation	Importance					Have you used this service before? (if yes,) →		Satisfaction				
	Not Very Important ←-----→ Very Important							Not Satisfactory←----------→ Satisfactory				
7. Community Psychiatric Outreach Service*	**1**	**2**	**3**	**4**	**5**	**Yes**	**No**	**1**	**2**	**3**	**4**	**5**

C. Family Rehabilitation	Importance					Have you used this service before? (if yes,) ⟶		Satisfaction				
	Not Very Important ←-----→ Very Important							Not Satisfactory←----------→ Satisfactory				
8. Family self-help organization	**1**	**2**	**3**	**4**	**5**	**Yes**	**No**	**1**	**2**	**3**	**4**	**5**
9. Family Therapy*	**1**	**2**	**3**	**4**	**5**	**Yes**	**No**	**1**	**2**	**3**	**4**	**5**

D. Housing Service	Importance					Have you used this service before? (if yes,) ⟶		Satisfaction				
	Not Very Important ←-----→ Very Important							Not Satisfactory←----------→ Satisfactory				
10. Halfway House	**1**	**2**	**3**	**4**	**5**	**Yes**	**No**	**1**	**2**	**3**	**4**	**5**
11. Long Stay Care Home	**1**	**2**	**3**	**4**	**5**	**Yes**	**No**	**1**	**2**	**3**	**4**	**5**
12. Hostel for Single Persons	**1**	**2**	**3**	**4**	**5**	**Yes**	**No**	**1**	**2**	**3**	**4**	**5**
13. Private Hostel	**1**	**2**	**3**	**4**	**5**	**Yes**	**No**	**1**	**2**	**3**	**4**	**5**

E. Psychological Therapy	Importance					Have you used this service before? (if yes,) ⟶		Satisfaction				
	Not Very Important ←-----→ Very Important							Not Satisfactory←----------→ Satisfactory				
14. Psychological Therapy*	**1**	**2**	**3**	**4**	**5**	**Yes**	**No**	**1**	**2**	**3**	**4**	**5**

F. Medical Treatment	Importance					Have you used this service before? (if yes,) ⟶		Satisfaction				
	Not Very Important ←-----→ Very Important							Not Satisfactory←----------→ Satisfactory				
15. Psychiatric oral medication	**1**	**2**	**3**	**4**	**5**	**Yes**	**No**	**1**	**2**	**3**	**4**	**5**
16. Psychiatric depot injection	**1**	**2**	**3**	**4**	**5**	**Yes**	**No**	**1**	**2**	**3**	**4**	**5**

G. Self-management	Importance					Have you used this service before? (if yes,)		Satisfaction				
	Not Very Important ←-----→ Very Important							Not Satisfactory←----------→ Satisfactory				
17. Self-management education and training*	**1**	**2**	**3**	**4**	**5**	**Yes**	**No**	**1**	**2**	**3**	**4**	**5**

H. Social Rehabilitation	Importance					Have you used this service before? (if yes,)		Satisfaction				
	Not Very Important ←-----→ Very Important							Not Satisfactory←----------→ Satisfactory				
18. Social skill training	**1**	**2**	**3**	**4**	**5**	**Yes**	**No**	**1**	**2**	**3**	**4**	**5**
19. Leisure/ activity group	**1**	**2**	**3**	**4**	**5**	**Yes**	**No**	**1**	**2**	**3**	**4**	**5**
20. Clubhouse	**1**	**2**	**3**	**4**	**5**	**Yes**	**No**	**1**	**2**	**3**	**4**	**5**
21. Self-help organization	**1**	**2**	**3**	**4**	**5**	**Yes**	**No**	**1**	**2**	**3**	**4**	**5**

I. Social Welfare	Importance					Have you used this service before? (if yes,)		Satisfaction				
	Not Very Important ←-----→ Very Important							Not Satisfactory←----------→ Satisfactory				
22. CSSA Allowance/ Disability Allowance	**1**	**2**	**3**	**4**	**5**	**Yes**	**No**	**1**	**2**	**3**	**4**	**5**
23 Compassionate Housing	**1**	**2**	**3**	**4**	**5**	**Yes**	**No**	**1**	**2**	**3**	**4**	**5**

J. Emergency Service	Importance					Have you used this service before? (if yes,) ⟶		Satisfaction				
	Not Very Important ←-----→ Very Important							Not Satisfactory←----------→ Satisfactory				
24. Hotlines (e.g. suicide or family violence)	**1**	**2**	**3**	**4**	**5**	**Yes**	**No**	**1**	**2**	**3**	**4**	**5**
25. Emergency housing service	**1**	**2**	**3**	**4**	**5**	**Yes**	**No**	**1**	**2**	**3**	**4**	**5**

H. Social Rehabilitation	Importance					Have you used this service before? (if yes,) ⟶		Satisfaction				
	Not Very Important ←-----→ Very Important							Not Satisfactory←----------→ Satisfactory				
26. Qi-gong	**1**	**2**	**3**	**4**	**5**	**Yes**	**No**	**1**	**2**	**3**	**4**	**5**
27. Religion	**1**	**2**	**3**	**4**	**5**	**Yes**	**No**	**1**	**2**	**3**	**4**	**5**
28. Special/ supported education	**1**	**2**	**3**	**4**	**5**	**Yes**	**No**	**1**	**2**	**3**	**4**	**5**
29. Yoga	**1**	**2**	**3**	**4**	**5**	**Yes**	**No**	**1**	**2**	**3**	**4**	**5**
30. Cognitive Remedial Training*	**1**	**2**	**3**	**4**	**5**	**Yes**	**No**	**1**	**2**	**3**	**4**	**5**
31. Assertive Community Treatment	**1**	**2**	**3**	**4**	**5**	**Yes**	**No**	**1**	**2**	**3**	**4**	**5**

Apart from the above, do you have any other opinions towards each type of rehabilitation service?

_____

_____

--- End of Part II ---

Part III: Background Information

The following questions are about your background information. This information will allow us to place you in the group of people with similar background in our data analysis.

Sex: □ Male □ Female

Age: □ 18 – 25 Years □ 26 – 35 Years □ 36 – 45 Years □ 46 – 55 Years □ 56 Years or above

Education: □ Uneducated □ Primary educated □ Secondary educated □ Tertiary educated or above

□ Others, please specify:_____

Marital Status: □ Single □ Married □ Divorced □ Widowed

People Living in the Same Household： □ Family member(s), please specify: _____ □ Live alone □ Friend(s) □ Halfway House

□ Others, please specify:_____

Employment Status: □ Open employment, please specify:□ Security guard □ Distributor of flyers □ Waiter/ waitress □ Cleaner □ Salesperson

□ Clerk □ Courier □ Others, please specify:_____

□ Supported employment □ Day Training and Activity Centre □ Sheltered Workshop □ Currently unemployed

□ Others, please specify:_____

If currently under employment, your monthly salary is: □ $3,000 or below □ $3,001 – $5,000 □ $5,001 - $10,000 □ $10,001 or above

If currently unemployed, you source of income is: □ Earned by oneself □ Savings □ Family □ Disability Allowance □ CSSA Allowance

□ Others, please specify_____

Years of using mental health service: □ 2 years or below □ 2 – 5years □ 5 – 10 years □ 10 years or above

-- End of Questionnaire, thank you! --

Supported Employment

Supported employment aims at helping disabled persons with difficulties in obtaining employment by providing them with opportunities of **open employment** and supported services, as well as in-service follow up and counseling. Services include selecting employment, arranging interview with employers and accompanying the service user to job interview. After the successful recommendation of a job, the service provider will pay regular visits and liaise with the employer, service user, his/her family and the referral agency to provide in-service follow up service.

Social Enterprises

Majority of these social enterprises are created by non-profit making/ non-governmental organizations. Social enterprises are operated by business principles and aims at making profit to contribute to the society. The profit made will be used in helping the vulnerable, in promoting community development and in the investment of the social enterprise itself. Social enterprise emphasizes more on its community value instead of making the greatest profit.

Community Outreach Mental Rehabilitation Service

An outreach mental rehabilitation service provided by professionals (e.g. psychiatrist, nurse, occupational therapist, social worker, etc.) which mostly takes place in the household of the service users or in the community.

Family Therapy

Targeted at the family and using the family as a unit, family therapy is a type of group therapy using modes like verbal therapy and interaction. It aims at reducing the physical and psychological symptoms of individuals brought by the family, solving disputes among family members and reconstruct.

Psychological Therapy

Psychological therapy is provided by clinical psychologists. Using psychology principles, clinical psychologists help clients to solve problems in one's emotion, ideology and behaviour, e.g. apprehension, fear, depression, difficulty in getting along with others, etc. The aim of psychological therapy is to promote one's mental and physical well-being and improve one's ability of adapting to life.

Self-management Education and Training

Generally speaking, it includes all education and training which promotes one's mental health which aims at enhancing one's ability to live independently, avoiding recurrence and improving one's quality of life (e.g. healthy living style, medication management, stress management, building up of insight, etc.).

Clubhouse

In the clubhouse, rehabilitated patients can work voluntarily as life-long members and work side by side with other staff. It allows members to choose the job they like and their choices will be respected. Apart from developing their skills at work, working in the clubhouse also allows members to make the best use of their strengths. The recognition and respect of their ability explains why members are eager to go to the clubhouse everyday.

Cognitive remediation Therapy (CRT)

CRT uses multi-media computer programmes which comprise audio and animation elements and it aims at training the cognitive ability of the brain of mental illness patients step by step. It includes cognitive training on concentration, memorization, computation, problem solving, etc. This training enables the mental illness patients aware of their defects, and thus enhancing their daily function.

Appendix 8. Perceived Rehabilitation Needs Questionnaire (Schizophrenia) – [PRNQ – S]

香港精神分裂症患者康復需要問卷

簡介

此問卷旨在辨認香港精神分裂症患者的康復需要。調查所得的結果將協助制定香港公共政策及日後提供精神健康服務，並協助政府及志願機構根據服務使用者的需要更妥善地安排資源及提高服務質素。

本問卷分為三部份。第一部份將以各康復需要對您的重要性及您對各康復需要的滿足程度進行評分。第二部份將以您對現有各項康復服務的重要性及滿意程度進行評分。第三部份將問及您的背景資料，以便進行資料分析。

第一部份: 康復需要

我們將列舉一共 19 類 76 項精神病患者的康復需要。請就以下**各康復需要對您的重要性**進行評分，以 1 至 5 分為標準，請您圈出**各需要對您的重要性**，1 分代表非常不重要，5 分代表非常重要。然後就該項需要，再以 1 至 5 分為標準，評定現有服務**能否滿足您的需要**。以 1 至 5 分為標準，請圈出**您對各需要的滿足程度**，1 分代表未能滿足，5 分代表十分滿足。

1. 工作	重要性					曾否接受有關服務？(如回答是) →		滿意程度				
	非常不重要 ←----------→ 非常重要							→ 未能滿意 ←----------→ 十分滿意				
1. 增加工作動機	**1**	**2**	**3**	**4**	**5**	**是**	否	**1**	**2**	**3**	**4**	**5**
2. 提升就業機會	**1**	**2**	**3**	**4**	**5**	**是**	否	**1**	**2**	**3**	**4**	**5**
3. 改善與同事關係	**1**	**2**	**3**	**4**	**5**	**是**	否	**1**	**2**	**3**	**4**	**5**
4. 改善與上司關係	**1**	**2**	**3**	**4**	**5**	**是**	否	**1**	**2**	**3**	**4**	**5**
5. 提升工作技巧/能力	**1**	**2**	**3**	**4**	**5**	**是**	否	**1**	**2**	**3**	**4**	**5**
6. 延長工作的穩定性	**1**	**2**	**3**	**4**	**5**	**是**	否	**1**	**2**	**3**	**4**	**5**
7. 增加在職支援/輔導	**1**	**2**	**3**	**4**	**5**	**是**	否	**1**	**2**	**3**	**4**	**5**
8. 增加工作訓練的機會	**1**	**2**	**3**	**4**	**5**	**是**	否	**1**	**2**	**3**	**4**	**5**
9. 加強面試技巧	**1**	**2**	**3**	**4**	**5**	**是**	否	**1**	**2**	**3**	**4**	**5**
10. 樂意讓員工請假覆診	**1**	**2**	**3**	**4**	**5**	**不 適 用**						
11. 增加晉升機會	**1**	**2**	**3**	**4**	**5**	**不 適 用**						
12. 能夠得到合理工資	**1**	**2**	**3**	**4**	**5**	**不 適 用**						
13. 增加工種選擇	**1**	**2**	**3**	**4**	**5**	**不 適 用**						

2. 社會福利及保障	重要性					曾否接受有關服務？(如回答是)		滿意程度				
	非常不重要 ←----------→ 非常重要							→ 未能滿意 ←----------→ 十分滿意				
14. 提供足夠食物	**1**	**2**	**3**	**4**	**5**	**是**	否	**1**	**2**	**3**	**4**	**5**
15. 提供足夠交通費用	**1**	**2**	**3**	**4**	**5**	**是**	否	**1**	**2**	**3**	**4**	**5**
16. 提供足夠娛樂費用	**1**	**2**	**3**	**4**	**5**	**是**	否	**1**	**2**	**3**	**4**	**5**
17. 提供足夠藥物費用	**1**	**2**	**3**	**4**	**5**	**是**	否	**1**	**2**	**3**	**4**	**5**
18. 提供足夠綜援金額	**1**	**2**	**3**	**4**	**5**	**是**	否	**1**	**2**	**3**	**4**	**5**
19. 增加求助渠道	**1**	**2**	**3**	**4**	**5**	**不 適 用**						
20. 提供足夠社區援助	**1**	**2**	**3**	**4**	**5**	**不 適 用**						

3. 醫療服務	重要性					曾否接受有關服務？(如回答是)		滿意程度				
	非常不重要 ←----------→ 非常重要							→ 未能滿意 ←----------→ 十分滿意				
21. 提供足夠精神科專業人仕跟進	**1**	**2**	**3**	**4**	**5**	**是**	否	**1**	**2**	**3**	**4**	**5**
22. 增加社區康復資源	**1**	**2**	**3**	**4**	**5**	**是**	否	**1**	**2**	**3**	**4**	**5**
23. 加強了解病人心靈需要	**1**	**2**	**3**	**4**	**5**	**是**	否	**1**	**2**	**3**	**4**	**5**
24. 有足夠渠道獲得有關資訊	**1**	**2**	**3**	**4**	**5**	**是**	否	**1**	**2**	**3**	**4**	**5**
25. 避免經常轉換醫療人員保持關係穩定						**不 適 用**						
26. 增長診症時間						**不 適 用**						

4. 家庭	重要性					曾否接受有關服務？(如回答是)		滿意程度				
	非常不重要 ←----------→ 非常重要							未能滿意 ←----------→ 十分滿意				
27. 有足夠的生育及家庭計劃的認識	**1**	**2**	**3**	**4**	**5**	**是**	否	**1**	**2**	**3**	**4**	**5**
28. 增加家人對精神病的認識	**1**	**2**	**3**	**4**	**5**	**是**	否	**1**	**2**	**3**	**4**	**5**
29. 改善與家人關係	**1**	**2**	**3**	**4**	**5**	**是**	否	**1**	**2**	**3**	**4**	**5**
30. 得到家人精神上支持	**1**	**2**	**3**	**4**	**5**	**不 適 用**						
31. 避免家人期望過高	**1**	**2**	**3**	**4**	**5**	**不 適 用**						
32. 得到家人物質上支持	**1**	**2**	**3**	**4**	**5**	**不 適 用**						

5. 社交及親密關係	重要性					曾否接受有關服務？(如回答是)		滿意程度				
	非常不重要 ←----------→ 非常重要							未能滿意 ←----------→ 十分滿意				
33. 擴闊社交網絡	**1**	**2**	**3**	**4**	**5**	**是**	否	**1**	**2**	**3**	**4**	**5**
34. 增強社交動機	**1**	**2**	**3**	**4**	**5**	**是**	否	**1**	**2**	**3**	**4**	**5**
35. 改善社交技巧	**1**	**2**	**3**	**4**	**5**	**是**	否	**1**	**2**	**3**	**4**	**5**
36. 增強信心及改善與異性相處技巧	**1**	**2**	**3**	**4**	**5**	**是**	否	**1**	**2**	**3**	**4**	**5**
37. 學習正確的性知識	**1**	**2**	**3**	**4**	**5**	**是**	否	**1**	**2**	**3**	**4**	**5**

6.行為及衝動控制	重要性					曾否接受有關服務？(如回答是)		滿意程度				
	非常不重要 ←----------→ 非常重要							→ 未能滿意 ←----------→ 十分滿意				
38. 減少暴力行為	**1**	**2**	**3**	**4**	**5**	**是**	否	**1**	**2**	**3**	**4**	**5**
39. 減少自殺行為	**1**	**2**	**3**	**4**	**5**	**是**	否	**1**	**2**	**3**	**4**	**5**
40. 減少酗酒行為	**1**	**2**	**3**	**4**	**5**	**是**	否	**1**	**2**	**3**	**4**	**5**
41. 減少過度揮霍	**1**	**2**	**3**	**4**	**5**	**是**	否	**1**	**2**	**3**	**4**	**5**
42. 增強理財能力	**1**	**2**	**3**	**4**	**5**	**是**	否	**1**	**2**	**3**	**4**	**5**

7. 病徵管理	重要性					曾否接受有關服務？(如回答是)		滿意程度				
	非常不重要 ←----------→ 非常重要							→ 未能滿意 ←----------→ 十分滿意				
43. 增加對病徵的處理方法	**1**	**2**	**3**	**4**	**5**	**是**	否	**1**	**2**	**3**	**4**	**5**
44. 維持情緒穩定	**1**	**2**	**3**	**4**	**5**	**是**	否	**1**	**2**	**3**	**4**	**5**
45. 改善陽性及陰性病徵	**1**	**2**	**3**	**4**	**5**	**是**	否	**1**	**2**	**3**	**4**	**5**
46. 增加對精神病及其藥物的認識	**1**	**2**	**3**	**4**	**5**	**是**	否	**1**	**2**	**3**	**4**	**5**
47. 能夠定時覆診	**1**	**2**	**3**	**4**	**5**	**是**	否	**1**	**2**	**3**	**4**	**5**

8. 治療權利	重要性					曾否接受有關服務？(如回答是)	滿意程度
	非常不重要 ←----------→ 非常重要					→ 未能滿意 ←----------→ 十分滿意	
48. 能獲配合適的藥物	**1**	**2**	**3**	**4**	**5**	**不 適 用**	
49. 減少藥物的副作用	**1**	**2**	**3**	**4**	**5**	**不 適 用**	
50. 縮短首次排診時間	**1**	**2**	**3**	**4**	**5**	**不 適 用**	
51. 改善病人治療權益及選擇權	**1**	**2**	**3**	**4**	**5**	**不 適 用**	
52. 積極參加治療	**1**	**2**	**3**	**4**	**5**	**不 適 用**	

9. 歧視	重要性					曾否接受有關服務？(如回答是)		滿意程度				
	非常不重要 ←----------→ 非常重要							未能滿意 ←----------→ 十分滿意				
53. 減少被公眾歧視	**1**	**2**	**3**	**4**	**5**	**是**	否	**1**	**2**	**3**	**4**	**5**
54. 減少被家人歧視	**1**	**2**	**3**	**4**	**5**	**是**	否	**1**	**2**	**3**	**4**	**5**
55. 減少自我歧視及自卑感	**1**	**2**	**3**	**4**	**5**	**是**	否	**1**	**2**	**3**	**4**	**5**
56. 減少被排斥的機會	**1**	**2**	**3**	**4**	**5**	**是**	否	**1**	**2**	**3**	**4**	**5**

10. 住屋	重要性					曾否接受有關服務？(如回答是)		滿意程度				
	非常不重要 ←----------→ 非常重要							未能滿意 ←----------→ 十分滿意				
57. 改善居住空間	**1**	**2**	**3**	**4**	**5**	**是**	否	**1**	**2**	**3**	**4**	**5**
58. 提供足夠的住屋選擇	**1**	**2**	**3**	**4**	**5**	**是**	否	**1**	**2**	**3**	**4**	**5**
59. 避免居住地點距離服務網絡過遠	**1**	**2**	**3**	**4**	**5**	**是**	否	**1**	**2**	**3**	**4**	**5**
60. 提供足夠的居住過渡安排	**1**	**2**	**3**	**4**	**5**	**是**	否	**1**	**2**	**3**	**4**	**5**

11. 自理	重要性					曾否接受有關服務？(如回答是)		滿意程度				
	非常不重要 ←----------→ 非常重要							未能滿意 ←----------→ 十分滿意				
61. 改善家居管理能力	**1**	**2**	**3**	**4**	**5**	**是**	否	**1**	**2**	**3**	**4**	**5**
62. 改善自理技巧	**1**	**2**	**3**	**4**	**5**	**是**	否	**1**	**2**	**3**	**4**	**5**
63. 改善財物管理能力	**1**	**2**	**3**	**4**	**5**	**是**	否	**1**	**2**	**3**	**4**	**5**
64. 改善個人衞生問題	**1**	**2**	**3**	**4**	**5**	**是**	否	**1**	**2**	**3**	**4**	**5**

12. 壓力管理	重要性					曾否接受有關服務？(如回答是)		滿意程度				
	非常不重要 ←----------→ 非常重要							→ 未能滿意 ←----------→ 十分滿意				
65. 減少焦慮	**1**	**2**	**3**	**4**	**5**	**是**	**否**	**1**	**2**	**3**	**4**	**5**
66. 減少日常生活/工作壓力	**1**	**2**	**3**	**4**	**5**	**是**	**否**	**1**	**2**	**3**	**4**	**5**
67. 改善壓力管理技巧	**1**	**2**	**3**	**4**	**5**	**是**	**否**	**1**	**2**	**3**	**4**	**5**

13. 娛閒	重要性					曾否接受有關服務？(如回答是)		滿意程度				
	非常不重要 ←----------→ 非常重要							→ 未能滿意 ←----------→ 十分滿意				
68. 增加對娛閒的興趣	**1**	**2**	**3**	**4**	**5**	**是**	**否**	**1**	**2**	**3**	**4**	**5**
69. 提供足夠娛閒機會	**1**	**2**	**3**	**4**	**5**	**是**	**否**	**1**	**2**	**3**	**4**	**5**
70. 提供合適的娛閒安排	**1**	**2**	**3**	**4**	**5**	**是**	**否**	**1**	**2**	**3**	**4**	**5**

14. 教育	重要性					曾否接受有關服務？(如回答是)		滿意程度				
	非常不重要 ←----------→ 非常重要							→ 未能滿意 ←----------→ 十分滿意				
71. 提供足夠基本教育機會	**1**	**2**	**3**	**4**	**5**	**是**	**否**	**1**	**2**	**3**	**4**	**5**
72. 提供足夠的教育或進修機會	**1**	**2**	**3**	**4**	**5**	**是**	**否**	**1**	**2**	**3**	**4**	**5**

15. 兒童照顧	重要性					曾否接受有關服務？(如回答是)		滿意程度				
	非常不重要 ←----------→ 非常重要							未能滿意 ←----------→ 十分滿意				
73. 改善照顧兒童技巧	**1**	**2**	**3**	**4**	**5**	**是**	**否**	**1**	**2**	**3**	**4**	**5**

16. 治療遵從性	重要性					曾否接受有關服務？(如回答是)		滿意程度				
	非常不重要 ←----------→ 非常重要							未能滿意 ←----------→ 十分滿意				
74. 改善服藥規律	**1**	**2**	**3**	**4**	**5**	**是**	否	**1**	**2**	**3**	**4**	**5**

17. 生活模式	重要性					曾否接受有關服務？(如回答是)		滿意程度				
	非常不重要 ←----------→ 非常重要							未能滿意 ←----------→ 十分滿意				
75. 建立有規律的生活模式	**1**	**2**	**3**	**4**	**5**	**是**	否	**1**	**2**	**3**	**4**	**5**

除上述以外，請問您對康復需求有沒有其他意見？ _____

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--- 第一部份完 ---

第二部份: 康復服務

我們將列舉一共 11 類 31 項精神病患者的康復服務。請就以下各項康復服務**對您的重要性**進行評分，以 1 至 5 分為標準，請圈出**各需要對您的重要性**，1 分代表非常不重要，5 分代表非常重要。然後請填寫您曾否接受該項服務，如曾接受該項服務，請再以 1 至 5 分為標準，評定您是否滿意該服務。以 1 至 5 分為標準，請圈出**您對各服務的滿意程度**，1 分代表未能滿意，5 分代表十分滿意。如未曾接受該項服務，則無需填寫對該項服務的滿意程度。

1. 工作康復	重要性					曾否接受此服務?		滿意程度				
	非常不重要 ←----------→ 非常重要					(如回答是) ——→		未能滿意 ←----------→ 十分滿意				
1. 輔助就業*	**1**	**2**	**3**	**4**	**5**	**是**	否	**1**	**2**	**3**	**4**	**5**
2. 社會企業*	**1**	**2**	**3**	**4**	**5**	**是**	否	**1**	**2**	**3**	**4**	**5**
3. 庇護工場	**1**	**2**	**3**	**4**	**5**	**是**	否	**1**	**2**	**3**	**4**	**5**
4. 勞工處展能就業科	**1**	**2**	**3**	**4**	**5**	**是**	否	**1**	**2**	**3**	**4**	**5**
5. 日間醫院 (精神科)	**1**	**2**	**3**	**4**	**5**	**是**	否	**1**	**2**	**3**	**4**	**5**
6. 日間訓練及活動中心	**1**	**2**	**3**	**4**	**5**	**是**	否	**1**	**2**	**3**	**4**	**5**

2. 社區康復	重要性					曾否接受此服務?		滿意程度				
	非常不重要 ←----------→ 非常重要					(如回答是) ——→		未能滿意 ←----------→ 十分滿意				
7. 社區外展精神康復服務* (社康)	**1**	**2**	**3**	**4**	**5**	**是**	否	**1**	**2**	**3**	**4**	**5**

3. 家庭康復	重要性					曾否接受此服務?		滿意程度				
	非常不重要 ←----------→ 非常重要					(如回答是) ——→		未能滿意 ←----------→ 十分滿意				
8. 家庭自助組織	**1**	**2**	**3**	**4**	**5**	**是**	否	**1**	**2**	**3**	**4**	**5**
9. 家庭治療(Family Therapy)*	**1**	**2**	**3**	**4**	**5**	**是**	否	**1**	**2**	**3**	**4**	**5**

4. 住宿服務	重要性					曾否接受此服務?		滿意程度				
	非常不重要 ←----------→ 非常重要					(如回答是) ——→		未能滿意 ←----------→ 十分滿意				
10. 中途宿舍	**1**	**2**	**3**	**4**	**5**	**是**	否	**1**	**2**	**3**	**4**	**5**
11. 長期護理院	**1**	**2**	**3**	**4**	**5**	**是**	否	**1**	**2**	**3**	**4**	**5**
12. 單身人仕宿舍	**1**	**2**	**3**	**4**	**5**	**是**	否	**1**	**2**	**3**	**4**	**5**
13. 私營院舍	**1**	**2**	**3**	**4**	**5**	**是**	否	**1**	**2**	**3**	**4**	**5**

5. 心理治療	重要性					曾否接受此服務?		滿意程度				
	非常不重要 ←----------→ 非常重要					(如回答是) ——→		未能滿意 ←----------→ 十分滿意				
14. 心理治療*	**1**	**2**	**3**	**4**	**5**	**是**	否	**1**	**2**	**3**	**4**	**5**

6. 藥物治療	重要性					曾否接受此服務?		滿意程度				
	非常不重要 ←----------→ 非常重要					(如回答是) ——→		未能滿意 ←----------→ 十分滿意				
15. 精神科口服藥物	**1**	**2**	**3**	**4**	**5**	**是**	否	**1**	**2**	**3**	**4**	**5**
16. 精神科注射藥物	**1**	**2**	**3**	**4**	**5**	**是**	否	**1**	**2**	**3**	**4**	**5**

7. 自我管理	重要性					曾否接受此服務?		滿意程度				
	非常不重要 ←----------→ 非常重要					(如回答是) ⟶		⟶ 未能滿意 ←----------→ 十分滿意				
17. 自我管理教育及訓練*	**1**	**2**	**3**	**4**	**5**	**是**	**否**	**1**	**2**	**3**	**4**	**5**

8. 社交生活	重要性					曾否接受此服務?		滿意程度				
	非常不重要 ←----------→ 非常重要					(如回答是) ⟶		⟶ 未能滿意 ←----------→ 十分滿意				
18. 社交訓練小組	**1**	**2**	**3**	**4**	**5**	**是**	**否**	**1**	**2**	**3**	**4**	**5**
19. 娛閒活動/小組	**1**	**2**	**3**	**4**	**5**	**是**	**否**	**1**	**2**	**3**	**4**	**5**
20. 會社(Club house)	**1**	**2**	**3**	**4**	**5**	**是**	**否**	**1**	**2**	**3**	**4**	**5**
21. 自助組織	**1**	**2**	**3**	**4**	**5**	**是**	**否**	**1**	**2**	**3**	**4**	**5**

9. 社區福利保障	重要性					曾否接受此服務?		滿意程度				
	非常不重要 ←----------→ 非常重要					(如回答是) ⟶		⟶ 未能滿意 ←----------→ 十分滿意				
22. 綜援	**1**	**2**	**3**	**4**	**5**	**是**	**否**	**1**	**2**	**3**	**4**	**5**
23. 傷殘津貼	**1**	**2**	**3**	**4**	**5**	**是**	**否**	**1**	**2**	**3**	**4**	**5**
24. 恩恤住屋	**1**	**2**	**3**	**4**	**5**	**是**	**否**	**1**	**2**	**3**	**4**	**5**

10. 緊急服務	重要性					曾否接受此服務?		滿意程度				
	非常不重要 ←----------→ 非常重要					(如回答是) ⟶		⟶ 未能滿意 ←----------→ 十分滿意				
25. 電話熱線 (如自殺或家庭暴力	**1**	**2**	**3**	**4**	**5**	**是**	**否**	**1**	**2**	**3**	**4**	**5**
26. 緊急住所服務	**1**	**2**	**3**	**4**	**5**	**是**	**否**	**1**	**2**	**3**	**4**	**5**

11. 其他	重要性					曾否接受此服務?		滿意程度				
	非常不重要 ←----------→ 非常重要					(如回答是) ⟶		⟶ 未能滿意 ←----------→ 十分滿意				
27. 氣功	**1**	**2**	**3**	**4**	**5**	**是**	否	**1**	**2**	**3**	**4**	**5**
28. 宗教活動	**1**	**2**	**3**	**4**	**5**	**是**	否	**1**	**2**	**3**	**4**	**5**
29. 特殊教育	**1**	**2**	**3**	**4**	**5**	**是**	否	**1**	**2**	**3**	**4**	**5**
30. 瑜伽	**1**	**2**	**3**	**4**	**5**	**是**	否	**1**	**2**	**3**	**4**	**5**
31. 認知治療訓練*	**1**	**2**	**3**	**4**	**5**	**是**	否	**1**	**2**	**3**	**4**	**5**

除上述以外，請問您對現有各康復服務有沒有其他意見？ _____

_____

_____

_____

--- 第二部份完 ---

第三部份：背景資料

以下問題是關於您的背景資料，方便我們在分析研究結果時，將您的資料和其他與您背景相似的人士歸類：

性別： □ 男 □ 女

年齡： □ 18 – 25 歲 □ 26 – 35 歲 □ 36 – 45 歲 □ 46 – 55 歲 □ 56 歲或以上

教育程度：□ 未曾接受正式教育 □ 小學 □ 中學 □ 大學或以上 □ 其他，請註明：_____

婚姻狀況：□ 單身 □ 已婚 □ 離婚 □ 喪偶

與何人同住： □ 家庭成員，請註明：_____ □ 獨居 □ 朋友 □ 中途宿舍 □ 其他，請註明：_____

就業狀況： □ 公開就業，請註明：□ 保安員 □ 派傳單 □ 侍應 □ 清潔 □ 售貨員 □ 文員 □ 速遞 □ 其他，請註明：_____

□ 輔助就業 □ 日間訓練及活動中心 □ 庇護工場 □ 暫無職業 □ 其他，請註明：_____

如正在就業，月入： □ $3,000 或以下 □ $3,001 – $5,000 □ $5,001 - $10,000 □ $10,001 或以上

如暫無職業，主要收入來源： □ 自行賺取 □ 儲蓄 □ 家庭 □ 傷殘津貼 □ 綜援 □ 其他，請註明：_____

接受精神病服務年期： □ 2 年或以下 □ 2 – 5 年 □ 5 – 10 年 □ 10 年以上

--全問卷完，謝謝！--

輔助就業

輔助就業服務主要為在就業上有困難的殘疾人士安排**公開就業**機會及提供支援服務，並給予在職跟進及輔導。服務會提供就業選配、與僱主安排面試及陪同服務使用者前往面試。在成功介紹工作後會透過定期探訪及與僱主、服務使用者、其家人及轉介機構聯絡提供在職跟進服務。

社會企業

大多數是由非營利組織/非政府組織實施，社會企業透過商業手法運作，賺取利潤用以貢獻社會。它們所得盈餘用於扶助弱勢社群、促進社區發展及社會企業本身的投資。它們重視社會價值，多於追求最大的企業盈利。

社區外展精神康復服務

由專業人仕(如:精神科醫生, 護士, 職業治療師, 社工等)所提供的外展精神康復服務, 服務或訓練地點一般於服務使用者的家居或在社區進行。

家庭治療

家庭治療是以家人為單位及對象的一種團體治療，經由語言、互動等治療模式，其目的在消除個人因家庭所產生的生理或心理症狀，解決之間的衝突，重新建構

心理治療

由臨床心理學家所提供的心理治療, 臨床心理學家利用心理學的原理去幫助當事人解決各種情緒、思想、行為上的困擾，例如:過份憂慮、恐懼、抑鬱及與人相處困難等等。治療的最終目的是為促進身心健康，增加適應 生活的能力。

自我管理教育及訓練

泛指所有促進自我精神健康的教育及訓練, 從而提高獨立生活能力, 避免病發及改善生活質數. (如: 健康生活, 藥物管理, 壓力管理, 病悉感建立等) 。

會所 (Clubhouse)

會所的運作模式，讓精神病康復者能夠自願地以終身會員的身份參與會所工作，與會所職員並肩管理會所日常運作。會員可自由選擇自己喜歡的工作，會所亦尊重他們的選擇。會員在會所工作，不但可發展其工作技能，並可有機會從實際工作中發揮會員的優點。會員的才華被肯定、被尊重，是令會員每天都期待身處會所的重要元素。

認知矯正治療 Cognitive remediation Therapy (CRT)

CRT是運用語音及動畫等的多媒體電腦程式, 循序漸進地訓練精神病患者的腦部認知功能, 內容包括專注力,記憶力,計算,問題處理能力等基本腦部認知的訓練. 透過這些訓練, 精神病患者能改善認知缺陷, 從而提升日常生活的功能。

