User and Family-Centred Mental Health Services in Taiwan-
Exploring the Possibilities.

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Abstract

Global healthcare provision requires providers to supply efficient and cost-effective care, while continuously assessing user focused outcomes upon which to base subsequent improvements. However, the voice of the service user in mental health services is a relatively new concept in Taiwan. The aim of this research was to gain in-depth knowledge about the perspectives of users and providers of current Mental Health services in Taiwan and for these findings to inform recommendations for the development of user and family-centred mental health services in Taiwan.

In order to achieve these aims, a multi-method approach was used. A satisfaction survey using the Verona Service Satisfaction Scale was administered. This scale was firstly translated and culturally adapted to produce a version in traditional Chinese (VSSS-TC) following protocols developed by the EPSILON Research Group. A pilot study procedure was carried out to test face and content validity. In depth interviews to elicit the experience of users, carers, providers and policy makers were also used. This research was conducted under ethical approval within two hospitals in Taiwan.

A non-proportional sampling method was used for the survey data collection. The survey data were analysed by using SPSS software, and the results indicate that patients rate the highest level of satisfaction in 'Professional Skills and Behaviour Dimension' (m=3.82), whereas the lowest rate of satisfaction is 'Relative Involvement Dimension' (m=3.59). A purposive sampling approach was used to identify informants for qualitative interviews. The in-depth interviews with users, providers and three key informants were analysed by using a thematic analysis method. At the professional and policy making level, issues of stigmatisation, institutionalisation, and resource allocation, which influence service provision on different levels, as well as future expectations of mental health service in Taiwan were illuminated.

Taking cultural characteristics and the perspective of users, providers and policy makers into consideration, recommendations are derived from the study findings. These include: (1) enhancement of community mental health care provision; (2) enabling the user's voice to be heard; and (3) reforming mental health education of the public and service providers. Since only two hospitals were involved, the results of this study are not claimed to be representative of the Mental Health System of Taiwan. However, this project was designed to elicit preliminary insights as a first step to understand issues concerning user involvement in Taiwan, and to provide a platform for future research.

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Chapter One Introduction

The health-care market requires health care providers to supply efficient and cost-effective health care, while continuously assessing outcomes upon which to base continued care and any subsequent improvements. Investigating the user's view of the health service provision is of growing importance to both practice and research around the world. However, the mental health field is affected by many policies, standards and ideologies which are not necessarily directly related to mental health. In order to maximise positive effects when mental health policy is being formulated, the World Health Organization (2001) suggested the necessity of ensuring intersectional collaboration so that benefit is obtained from education programmes, health, welfare and employment policies, the maintenance of law and order, policies specifically addressing the young and the old, and housing, city planning and municipal services.

Mental and neurological disorders such as depression, schizophrenia, epilepsy and substance abuse, among others, cause immense suffering for those affected, amplify people's vulnerability, and can lead individuals into a life of poverty. Despite the worldwide availability of cost-effective treatments, WHO (2003) argue that the vast majority of people are left without access to the treatment they need. Instead of getting the help and support they require to lead productive lives, many people are subjected to stigma, discrimination and human rights violations, and are denied the basic life opportunities given to other citizens.

The World Health Organization (2003) highlights the fact that primary care, as well as community care, programmes have been evaluated and found to be the principal elements of Mental Health Services. Since the 1970s, there has been a politicised trend to extend the psychiatric services from hospitals into communities in Taiwan. Nevertheless, the Mental Health Services provided in the community to ensure that people with mental health problems receive the appropriate treatment and rehabilitation are still inadequate (Shiau, et al, 2005).

This chapter is the introduction to the Thesis. This study explores the level of users' satisfaction with current mental health services in Taiwan by acquiring in-depth knowledge of the experiences of service users, providers and policy makers in terms of using or providing the service in Taiwan. The perspectives of service users and providers are examined for similarities and differences, and the consequent implications for future mental health service improvement are discussed.

1.1 Research Questions and Aims

The aim of this research is to gain in-depth knowledge of the perspectives of service providers and users of the current Mental Health services in Taiwan. In order to meet this aim, the study involves in-depth interviews and administers a satisfaction survey instrument which has not previously been used in the Taiwanese context. The intention was to gain insights into the way in which a service user centred emntal health system can be developed, and to investigate its appropriateness to the culture of Taiwan.

Five objectives were devised to meet the aim of the study, and are as follows:

(1) To gain insight into Taiwan's policies, culture and practice of Mental Health Services

(2) To elicit Taiwanese Mental Health Service users' levels of satisfaction of the contemporary service provision

(3) To elicit Taiwanese Mental Health Service providers' views of contemporary service provision

(4) To explore and describe the issues facing the current mental health services in Taiwan from the perspective of participants

(5) To recommend strategies to develop user and family-centred mental health services appropriate to the Taiwanese context.

The objectives will be achieved by addressing the following questions:

(1) How do Taiwanese Mental Health Services differ from those provided in the West from a cultural, historical and policy development point of view?

(2) What is service users' level of satisfaction with current Taiwanese Mental Health Services?

(3) Does the current service meet mental health care needs from the perspective of users and providers?

(4) What is Mental Health Service providers' perspective of the current service provision?

(5) What is the nature of any relationship between the data generated through the satisfaction survey and that generated from the in-depth interviews?

(6) What is the potential of any insights gained for suggestion of future service development?

1.2 Overview of the Thesis

Figure 1-1: Structure of the thesis
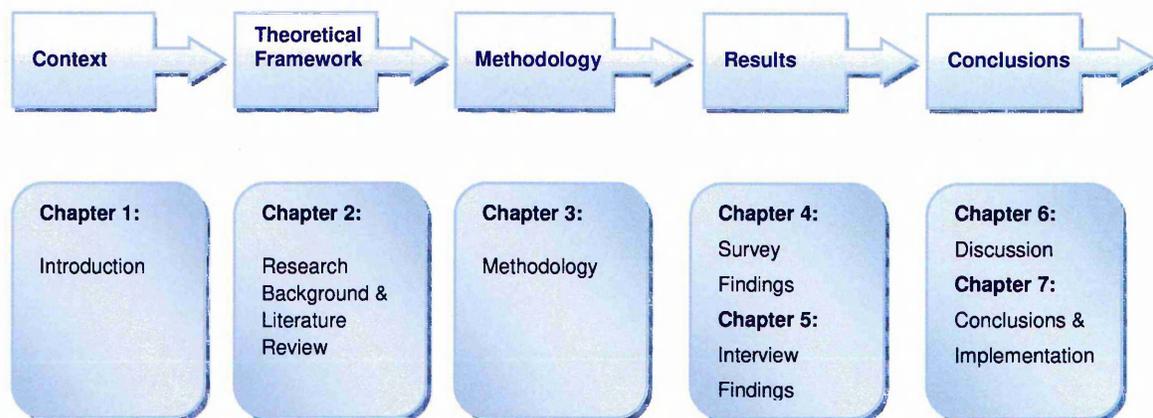
Chapter one introduces the aim and research questions of this study, and also illustrates the level of user involvement for participation in the current research. Definitions of the terminology used in the study are provided in Chapter One

Chapter Two provides the background of mental health service history and the current service provision in Taiwan. At the same time, this chapter stresses the importance of cultural influences on the experiences and help-seeking process of individuals with mental illness, and how stigma has developed as a consequence of the traditional Chinese cultural perspective.

Chapter Three outlines the methods used to address the study questions. The first section of the chapter details the triangulation research design of this study, which combines a quantitative satisfaction survey and qualitative in-depth interviews. The second section describes the three phase process of this study, and how the accounts were generated, along with the systems used for collecting and analysing the data.

The survey and interview findings and discussion are presented separately in Chapters Four and Five. The satisfaction survey findings and discussions are compared and contrasted between the two hospitals, and also the satisfaction rankings of all participants are given. Themes of key services users, and carers and service providers, are presented separately in Chapter five, along with the principal points from the perspectives of key informants.

In Chapter Six, discussion of three main issues, which emerge from the themes of the service users, carers and service providers, are expounded and critically reviewed, combined with the opinions of key informants.

The conclusions, main findings, and suggested implementation from the study are presented in Chapter Seven, along with issues, limitations, and recommendations for further research.

1.3 Users' Voices in this Study

User involvement in mental health service evaluation is considered to be essential if service provision is to be responsive to their needs (Hickey & Kipping, 1998). As Lindow and Morris (1995) argue, "User involvement is not an end in itself but is instead a means of enabling people to assert choices and have control over their daily lives."

However, service user involvement in mental health is a relatively new concept for healthcare professionals. Although mental health professionals are less familiar with the concept of service users as active participants in the research process, this is not a new idea in other disciplines (Telford & Faulkner, 2004).

In recent years, the voices of mental health service users have been acknowledged as being valid contributions to service development and provision (Campbell, 2001). Moreover, service users are increasingly viewed as being "experts by experience" (Faulkner, 1998), since they are specialists in the field of their own mental illness. Indeed, the value of involving such experts in the research process has not only been recognised, but has also been embodied in many user-led research initiatives (Townend & Braithwaite, 2002).

Although mental health services have been required to involve consumers and carers in the planning, delivery and evaluation of mental health services for over a decade in most Western countries, this has not yet happened in Taiwan. There is no literature or national health policies regarding the involvement of users and carers in healthcare practice or associated research, despite the fact that Hickey and Kipping (1998) claim that service user involvement in mental health is regarded as an indicator of a system being considered to be responsive to the needs of individual users and a discriminating public.

This study aims to gain in-depth knowledge of the perspectives of service providers and users of the current Mental Health Services in Taiwan. Service users' voices have not yet been heard in Taiwan, but attention is increasingly

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being paid to the need to involve services users in developing and delivering Mental Health Services in this context.

This study does not claim to be participatory research in terms of full user involvement. Rather, it involved mental health service users and carers in a 'consultative' role as described in Cornwall's (1996) model of users involvement and participation (see chapter three for research design). However, it can still be considered as being a first step in involving users in the planning, delivery, and evaluation of Taiwan's mental health services.

1.4 Terminology and the Writer's Voice

A survey was conducted to examine the satisfaction with mental health services of individuals suffering from mental illness. In order to continue to explore the experiences of service users and providers of Taiwan's mental health services, a qualitative interpretive study design was adopted, focusing on the available stories or narratives of the participants relating to their experience of using or providing the services.

• **Definition of 'Service Users and Carers'**

Whereas traditional definitions have sometimes only focused on current or past service users, who have direct experiences to impart, more inclusive definitions are preferred nowadays. Service user organisations in the UK give their own definitions. In 2003, the UK Shaping Our Lives National User Network suggested definitions and meanings as follows: a 'service user' can be seen as someone who has things 'done to them' or who quietly accepts and receives a service (Shaping Our Lives National User Network, 2003).

The definitions of 'Carers', according to Carers UK, are people *"who without payment, provide help and support to a relative, friend or neighbour, who could not manage to stay at home without their help, due to sickness, age, addiction or disability"* (Carers UK, 2009). At the same time, the leaflet, "A

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Commitment to Carers" defines the carer of a person suffering from a mental health problem as: ***"Someone who provides, or intends to provide, practical or emotional support to someone with a mental health problem. You may or may not live with the person you care for. You may be a relative, partner, friend or neighbour. You may be a young person but you now find yourself in the position of needing to support an unwell person".*** *(NSF Rethink, 2003)*

The use of both terms together, such as 'service users and carers' in used in accordance with INVOLVE's definition: ***"Service users and carers' are defined as patients and informal (unpaid) carers, such as parents, family members, or guardians; users of mental health services; mental illness individuals; members of the public who are the potential recipients of mental health promotion/service interventions."*** (Hanley, et al, 2003. pp I)

However, in order to maximise the service users' input to this research, the participants had current experience of mental health services network, i.e. they should be able to draw on a wide body of opinion, and be capable of providing a broad perspective in this research process. The criteria of the 'service users' in this research are therefore as follows:

- Individuals with mental health problems which affect their ability to cope with everyday living
- People who are at least 18 years old
- People who have receiving the mental health services in Taiwan for at least one year

● Definition of 'Service Provider'
The term, 'healthcare/service provider', is defined as any individual who provides health services, such as prevention, treatment, and management of illness, and preservation of mental and physical well-being to health care consumers/patients (Mosby's Medical Dictionary, 2009).

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A mental health care/service professional is a person who offers services for the purpose of improving an individual's mental health, or to treat mental illness. This broad category includes psychiatrists, clinical psychologists, clinical social workers, psychiatric nurses, as well as many other professionals. The definition of the 'service providers' used in this research is as follows:

- People who have worked in the mental health service field for at least three years

• Definition of 'Experience'

According to the definition from Collins English Distonary, **"experience is direct personal participation or observation; actual knowledge or contact"** or **"accumulated knowledge, especially of practical matters".** (Collins English Dictionary, 2003)

The influence of society and culture on the construction of how individuals express their experiences and feelings is one of the key sensitivities integrated within the study, alongside experiential, contextual and historical factors which act to shape feelings as individuals interact with each other and their world. 'Experience' is defined as being the apprehension of an object, thought, or emotion through the senses or the mind, or **"a personal knowledge derived from participation or observation"** (Roget's II: The New Thesaurus, 2003). However, 'user experience' represents the perception left in someone's mind following a series of interactions between people, devices, and events. Therefore, although there is no 'true' interpretation, people's experiences are very valuable, and they strengthen the outcomes of this study.

• Writer's Voice

The interpretive nature of this research, especially the qualitative inquiry and the constructionist philosophies which underpin it, are testament to my pivotal role

in shaping and presenting the findings a sense of coherence, and in keeping with a health science dissertation as the primary means of discourse of the health professionals for whom I write. Therefore, the key role of the researcher in this study in shaping the argument and research agenda was fulfilled in the following two ways:

1. By incorporating notes derived from a research diary and memos
2. By making a clear distinction between respondents' actual words and my interpretation of them throughout both the findings and discussion sections

Within the qualitative part of study, the researcher's influence is acknowledged and reflected upon in the discussion of findings. Thus, the qualitative interview findings represent the researcher's construction of what the participants created in the interviews, with a focus on developing a framework which can present a means of developing and improving future mental health service provision, underpinned by the experiences of the participants.

I used to be a psychiatric nurse, and am now involved in searching for an improved perspective towards current mental health service in Taiwan in order to improve our services delivery systems. My own experience of mental health services in the North of Taiwan is that little attention has been paid to the expression of service user experience regarding the service they have received. In my experience, mental health professionals often anticipate what the best for service users is instead for them to actually listening to what the users want. Therefore, in some important respects in terms of user experience in mental health services, this is akin to the ethnographer who understands, and also is a part of, Taiwanese culture. In order to do this, I must critically examine my frames of reference which I have internalised from my own culture. This is not only an intellectual endeavour but also a precondition for action via this research project.

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The best mental healthcare practice should move from being a list of 'the right things to do', to being viewed as a pattern generated from research evidence and the preferred practices of the people involved. Once the mental health service improvement has developed in this way, it will stand a much greater chance of being responsive to the values and cultures of the people experiencing it.

Chapter Two

The Mental Health Care System in Taiwan and cultural influences

The background to this study is presented in this chapter through a description of features of the healthcare system in Taiwan, followed by an introduction of the history of mental health service development in the context of current mental health service policies and policy implementation. Taiwan's cultural background has influenced perceptions of mental illness and service delivery in many ways. It is recognised that traditional Chinese culture has an effect on family relationships, beliefs and help-seeking behaviour which is also described. Problem identification and justification are drawn together in the final section of this chapter to address users' needs within mental health services in Taiwan.

2.1 Literature Searching Strategy

Studies and journal articles included in the literature review and throughout the thesis are research articles from the beginning of PhD study to March 2010 published in English and Chinese. The search strategy used the following sources:

• A literature search of electronic data was undertaken using MEDLINE (EBSCO), CINAHL plus, MEDLINE (CSA), LOP Journals (IOP), ASSIA, PsycINFO, Cochrane Library, Health Source: Nursing (EBSCO), Web of Science, PubMed, HighWire Press, and ScienceDirect (Elsevier).

• The literature search was also supplemented by using Google Scholar, and websites of organisations (for example: Department of Health, Executive Yuan, Taiwan, http://www.doh.gov.tw/EN2006/index_EN.aspx, World Health Organisation, http://www.who.int/en/).

• Hand searching of journals in Taiwan, such as The Journal of Nursing Research Taiwan, Taiwanese Journal of Psychiatric, Chinese Journal of Public Health, The Kaohsiung Journal of Medical Science (Taiwan), Journal of Social Work (Taiwan) and Journal of Mental Health (Taiwan).

The following search terms were used for each database, as appropriate: patient satisfaction scale/measurement; patient satisfaction; community-based/hospital-based mental health service; mental health service; patient/public/ user/ carer involvement; participatory research; mental health policy/professionals/welfare/education/reform/rehabilitation/resources; institutionalisation/deinstitutionalisation; Chinese culture context/influence; service users' perceptions/attitudes/views/unmet needs; service providers' perceptions/attitudes/views/ predicaments; stigma/ stigmatisation; mutual help; doctor/nurse-patient relationship.

2.2 Overview of the Healthcare Service in Taiwan

Taiwan is an island located in the Pacific Ocean near China. Covering a total of nearly 36,000 square kilometres, Taiwan is a long, narrow island separated from the Chinese mainland by the two hundred kilometre wide Taiwan Strait. Taipei is its capital city, and Taiwan has a population of just over 23 million. The major languages are Mandarin Chinese (official) and Min-Nan Chinese (Taiwanese), and the major religions are Taoism, Buddhism, and Christianity.

Figure 2-1: Map of Taiwan (Source from Guardian.co.uk. 2010)

In 1971, the Department of Health (DOH) was established directly under the Executive Yuan (Cabinet) in Taiwan. The restructuring of the two-level health administration indicated that health-related issues were being given priority (Figure 2-2). The Department of Health is responsible for the formulation of national health policies, health administration and guidance, and supervision and co-ordination of local public and private health organisations (Department of Health Taiwan, 2009d).

Figure 2-2: Current Health Administration System at the Department of Health in Taiwan. (DOH Taiwan, 2009d)
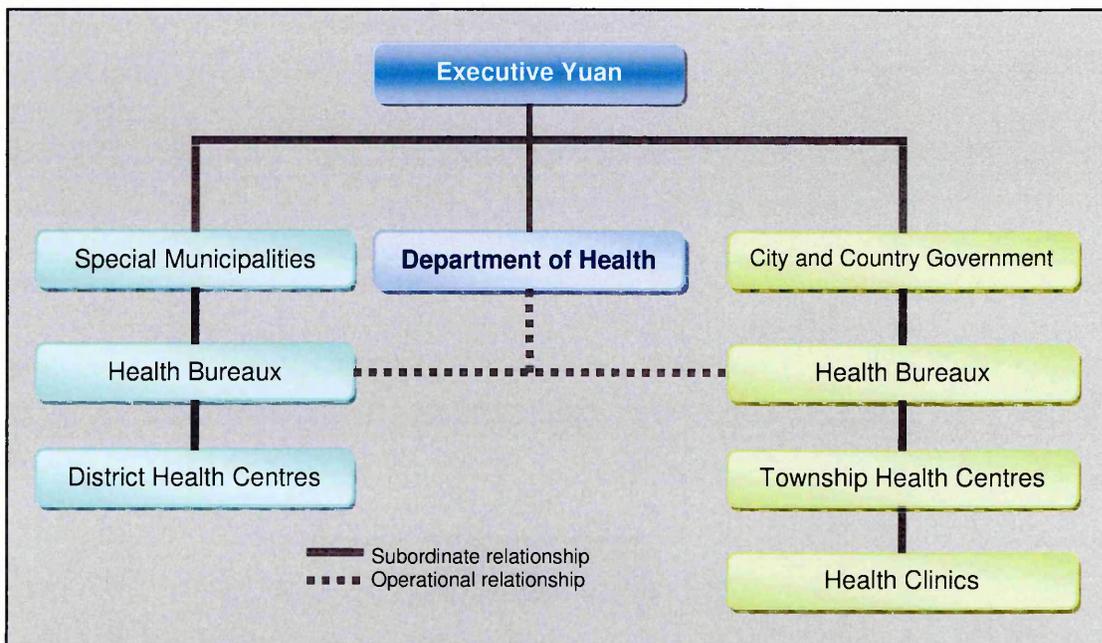
Taiwan's National Healthcare provides a system to improve the health of its people, and although public health officials and medical professionals face many challenges in serving Taiwan's 23 million population, they continue to make strides in the prevention and treatment of common illnesses. The health of Taiwan's population has improved considerably over the past several decades. For example, according to the Ministry of the Interior, between 1952 and 2006 (figure 2-3), the average life expectancy rose from 53.1 years to 74.6 years for males, and from 57.3 years to 80.8 years for females. The infant mortality rate also fell, from 44.7 per 1,000 live births in 1952 to 4.6 in 2006 (Taiwan Year Book 2006, 2007). The most recent health system problem is the need for long-term care because of the increasing number of older people in the population. The diet of Taiwanese people has improved in its variety and become more nutritious, leading to an overall increase in health, and to a reduction in the ten leading causes of death as shown in table 2-2 (Taiwan Year Book 2006, 2007).

Figure 2-3: Change in Ten Leading Causes of Death (1952 vs. 2006). Source from Taiwan Year Book 2006 (2007)
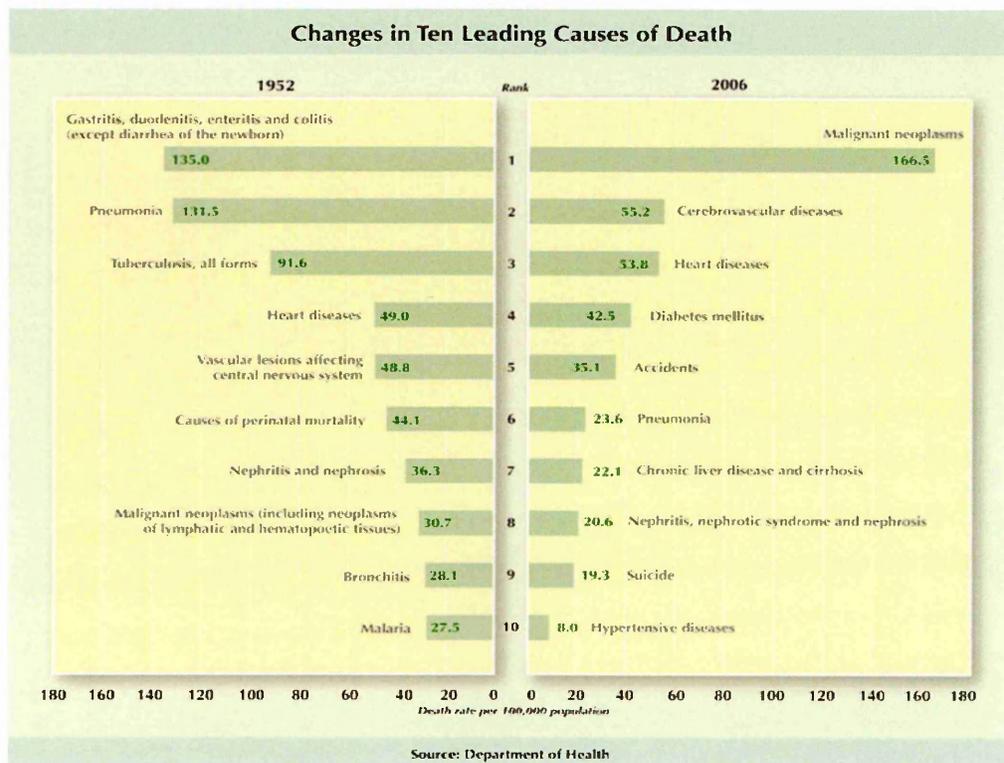
Taiwan has two types of hospital provision, public hospitals and private hospitals. Private hospitals are the major provider in terms of health care provision. Private hospitals, can be further subdivided into profit making and non-profit making hospitals and provide 65 per cent of all hospital beds The healthcare system in Taiwan has three characteristics, the first of which is a Closed System, which means that physicians are hired by hospitals on contract, and are allowed to practise medicine only at the hospital at which they are contracted. The second is free Choice of Physician and Hospital, which means that patients in Taiwan are free to choose a hospital for outpatient visits or emergency room services. They can go directly to a tertiary hospital to see a specialist without consultation or referral from a family physician. Medical care is therefore highly accessible, due to there being a sufficient number of hospitals and physicians, as well as the wide population coverage of the National Health Insurance Programme (Wu, 2005). The third characteristic is the hospital as a Multi-Product Firm which refers to hospitals that provide a wide variety of services, including out-patient clinics, in-patient hospitalisation, and emergency room treatment. Hospitals in Taiwan not only provide in-patient services, but also run an extensive out-patient clinic service. However, there is no functioning referral system run by a government organisation.

According to statistical data from the Taiwan Year Book 2009 (2010), there were 231,571 medical professionals working in Taiwan at the end of 2008, a ratio of 18.27 (including doctors of Chinese medicine) doctors and 4.86 dentists per 10,000 people. Medical professionals are trained at 11 medical schools and 35 paramedical colleges and junior colleges. In 2008, there were 515 hospitals and 19,659 clinics operating in Taiwan. There included government-run medical care institutions consisted of 80 hospitals and 461 clinics, including public hospitals, medical school hospitals, veterans' hospitals, military hospitals, hospitals' outpatient clinics, clinics affiliated with government institutions, and community clinics. Private healthcare institutions comprised of 435 hospitals and 19,198 medical and dental clinics, including private hospitals, hospitals affiliated with private medical schools, corporate hospitals and clinics, and private clinics. Therefore, the medical institutions in Taiwan provided a total of 152,901 beds in 2008, or 66.37 beds per 10,000 people (Taiwan Year Book 2009, 2010).

Hospital accreditation in Taiwan began in 1978 in order to evaluate hospitals for clerk and internship training (Wu, 2005). The Ministry of Education (MOE) and Department of Health (DOH) jointly conducted the accreditation, and a Medical Care Act was implemented by the government in 1986 (Department of Health Taiwan, 2004). As a consequence, the Central Health Administration Office was authorised to conduct hospital accreditation. Taiwan is the first country in Asia, and the fourth in the world, to conduct hospital accreditation (Wu, 2005). The accreditation is valid for three years, after which it is repeated, and there are currently 497 hospitals with a three-year accreditation qualification (Wu, 2005).

2.3 Taiwanese Mental Health Service Provision

In the past three decades, along with dramatic progress in economic development, the Taiwanese government has made many social reforms in response to increased demands for better social and human services for mental health service users. The Department of Health, Executive Yuan R.O.C. (Taiwan) resolved to provide better healthcare for the Taiwanese people, and it developed a National Mental Health Plan for a Medical Care Network as one of the 14 major projects of the Executive Yuan in the early 1980's (Yeh, 1992)

2.3.1 History and Origins of the Taiwanese Mental Health Service

The history of the Mental Health Service in Taiwan can be divided into four different stages, with a focus on the change from hospital-based services to community-based care. The four stages are as follows:

(1) Before 1970, the Psychiatric Department of the National Taiwan University Hospital (NTUH) was the only institution playing a major role in providing Mental Health Services. NTUH not only contributed to education, staff training, and psychiatry related research, but also built up a foundation of community mental health services for the future (Yeh, 1992).

(2) Between 1971 and 1980, the Department of Health made significant revolutionary changes to the organisation and provision of nation-wide services,

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which can be regarded as the beginning of a new era in the history of health administration in Taiwan. Mental hospitals traditionally provided the bulk of mental health services, and the hospitalisation of patients was mainly long term, with 42% of inpatients staying in hospital for more than 5 years. The quality of care in mental hospitals was low, except for a few selected government mental hospitals, such as Taipei City Psychiatric Centre (TCPC). However, the psychiatric hospitals not only provided hospital care but began to extend their care into the community, which supplied an integrated and continuous service to patients and their carers compared to previous service provision (Yeh, 1992).

(3) Between 1981 and 1990, Mental Health Services were expanded nationally, and health promotion and prevention were introduced as being the most important health policies of the Taiwanese government. At this stage, a 15 year National Mental Health Plan was proposed by the Executive Yuan, which emphasised the need to increase the psychiatric work force, improve the facilities, and promote quality of care (Yeh, 1992).

In order to provide better healthcare and a more evenly distributed medical service, and to balance medical resources, the Department of Health launched a 15-year project designated as the Establishment of a Medical Care Network in Taiwan in July, 1985. This three-phase project divided Taiwan into 17 medical care regions, each of which served as a basic unit for developing medical manpower, facilities, and an emergency care network. The three-phase project was concluded in 2000.

(4) After 1990, the mental health service provision moved from being "hospital-based" towards "community-based". In December, 1990, the "Mental Health Act" was publicly announced by the Department of Health, Executive Yuan, which covers (a) determination of the responsibility of each level of government for mental health services, (b) the establishment of a mental health administration and service delivery system, (c) the protection and treatment of severely disturbed patients, and (d) patients' right for treatment and social rehabilitation. This Act was a very clear expression of the government's intention to provide a range of services to enable patients to receive comprehensive and continuous care, and it also demonstrated the

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government's strong commitment to provide quality care for the mentally ill in a humane way (Department of Health, Taiwan, 2004).

In 1999 the DOH introduced a Medical Care Network for elderly care, the prevention and control of mental illness, long-term medical care services, and the rehabilitation of the physically and mentally impaired. In 2001, the "New Century Healthcare Network" was initiated by the government, and this was divided into two parts: general medical care services and medical services for particular groups (Department of Health, Taiwan, 2004).

2.3.2 Concept of the Original National Mental Health Plan

The National Mental Health Plan was implemented though regional planning. Taiwan was divided into seven catchment areas called Regions, each of which was responsible for providing comprehensive and continuous care for psychiatric patients. This was to be accomplished through developing and integrating all kinds of services, including inpatient treatment, day care services, emergency services, outpatient services, crisis intervention, and a variety of community care programmes, including home care, half-way houses, rehabilitation programmes, and sheltered workshops (Department of Health, Taiwan, 2004).

A government mental hospital providing good quality of care was assigned as a "Central Hospital" (also called "Nucleus Hospital") in each region to assist local health authorities in developing the regional mental health network. The roles of the Central Hospital were as follows:

(1)   To assist in developing psychiatric manpower and facilities
(2)   To innovate and demonstrate mental health programmes in the community
(3)   To co-ordinate all mental health services into comprehensive and continuous care
(4)   To promote the mental health education of the public
(5)   To assist with the improvement of the quality of care in private mental hospitals

Historically, community mental health services in Taiwan were only provided by hospitals, namely, psychiatric hospitals extended care into the community (Hsieh, 1989). The Central Hospital of the Region was responsible for developing community care programmes for the patients in each catchment area. It also provided training and supervision of local public health nurses so that they may effectively follow the patients into the community after their discharge from the psychiatric hospital.

Hsieh, (1989) proposed a plan to make governmental psychiatric hospitals the base for community mental health services, and the advantages of this plan were:

(1)   Community mental health services were integrated into the whole patient care system at the hospital, which ensured that patients were given continual aftercare.

(2)   The community programme was able to receive the support of the professional work force and facilities of the hospital.

(3)   The psychiatric hospital became community orientated, not isolated from society.

(4)   The psychiatric hospitals would be energised to provide treatment to actively help patients to return to the community, so that there would be no unnecessary institutionalisation.

However, this scheme had one disadvantage, i.e. the possibility of the stigma attached to mental hospitals causing obstacles. The community programmes innovated by the Regional Central Hospital were all located in the community, with their office separated from the hospitals. Regardless of whether the community mental health services were hospital-based or community-based, the most important thing was to provide continuous and comprehensive care for the mentally ill (Hsieh, 1989). However, it has been about two decades since the Department of Health launched the National Mental Health Plan, which focused on extending the services into the community, and the reality is that, not only are the care services for mentally ill patients in Taiwan still mainly hospital-based, but also community-based service provision and personnel are still limited.

2.3.3 Contemporary Mental Health Law in Taiwan

Taiwan's Mental Health Law was first promulgated and came into force on the 7th December, 1990, and this was the most important set of actions taken by the Central Health Authority during the 1980s in order to improve the nation's mental health programme. This Law represented an attempt to superimpose a uniform legal and institutional regime upon a system and pattern of usage which had developed over the previous 45 years. At the same time, the Law sought to shape a mental healthcare system suited for the challenges of the years to come. It consists of six chapters, which are as follows:

Chapter I : General Provisions

Chapter II : Mental Health System and Facilities

Chapter III: Protection and Medical Treatment

> Part 1: Protection of ill persons
>
> Part 2: Involuntary, Evaluation and Inpatient Treatment
>
> Part 3: Psychiatric Care
>
> Part 4: Medical Treatment Expenses

Chapter IV: The Right of Ill Persons

Chapter V : Penalties

Chapter VI: Supplementary Provisions (DOH, Taiwan Mental Health Law, 2007a):

In 1998, Dr. Yeh, a senior Professor in both the psychiatric clinical and academic areas, pointed out that the impact of the Law on the development of the nation's mental health programme had been significant in terms of the administration system in both central and local government. This had been accompanied by massively increased budgets, extended facilities, and modalities of treatment and care with an emphasis on the community. At the same time, there was improved quality of care through psychiatric training, research, and the accreditation of psychiatric hospitals and other care facilities, a respect of the rights of the mentally ill, and an increased awareness of the importance of mental health programmes as an integral part of the nation's

health and welfare administration by the Government and the public (Yeh, 1998).

One of the most unique features of this law is its emphasis on the family in cases of mental health, and the roles family members are expected, or even demanded, to play, which reflects Taiwanese culture. The Law requests that family members assist patients to seek treatment, and that they should be responsible for any damage to others (Salzberg, 1992). In terms of its effect on the basis of costs/benefits, emphasis on patients' rights, support to caregivers, and acceptability by the community, Taiwan is undoubtedly in great need of progressively developing a comprehensive and continuous care programme.

2.3.4 Mental Hospital Reform in Taiwan

For the past 200 years, psychiatry has struggled with the challenge of reforming the institutions which treat and care for people with mental health problems. This reform first appeared in Europe in the early 19th Century when England and France began to introduce state-run asylums, which were designed to free mental illness patients from abuse. After these asylums were introduced, they rapidly expanded in size, whereas they were originally planned to be fairly small. This was due to pressure from various aspects: economic, political and professional, and the great demand for services (Grob, 1994)

In Taiwan, the families of people with mental illness, especially parents, have to shoulder much of the burden of care, and their primary worry is often their inability to continue that care as they get older, because it is highly unlikely that other family members would undertake those responsibilities. This can also be viewed from a different perspective, which is that, due to lack of support from other family members and society, the parents may eventually collapse under the pressure of taking care of their mentally ill dependents. However, since the focus of present day psychiatry is "deinstitutionalisation" and "return to the community" , issues such as the readiness of the community to accept mentally-ill patients and their families, and the option of return to the community by people with mental illness still remain critical issues, which need to be resolved.

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For example, for the past 50 years, Yuli Veterans Hospital (YVH), a well-known asylum located on the north-eastern coast of Taiwan, has been the largest mental hospital for patients with chronic and severe mental illness. When the hospital was first established, it represented an unspoken humiliation for the psychiatric and mental health practices in Taiwan like the old asylum in the Western countries, and for patients with mental illness and their families. It was a symbol of hopelessness and despair. Yet, today it stands as an example of how an old, custodial hospital can be transformed into a very different institution (Lin, et al., 2009). The World Health Report, published by WHO in 2001, recommended that mental hospitals downsize their operations in order to shift patient care into community care programmes (World Health Organization, 2001), and currently, a fairly small number of hospitals in Taiwan have met the WHO's standards. Thus, to establish a mental health system which provides high quality care is still considered as being one of the greatest challenges for Taiwanese psychiatric services.

The YVH was established in 1957, and it was initially designated as a veterans-only hospital, devoted to the care and treatment of mental illness. The number of its patients kept increasing until it reached a peak of 4,060 in the 1960s. In the early days, because of its austere appearance, and with police regularly patrolling the institution, it was more like a prison than a hospital, but during the past few decades, Yuli town has significantly improved because of the contributions of many patients who participated in the town, and the industrial therapy programmes hosted by the hospital.The interaction between patients and the community is now friendly and mutually beneficial (Lin, et al., 2009).

Lin. et al. (2009) claim that YVH occupies an intriguing place in the development of psychiatry in Taiwan. When it was established, it was neglected because of its location and its patients, and it was not until 2000 that Taiwanese psychiatry began to recognise the achievement of YVH in helping institutionalised patients, who had long been regarded as 'difficult', with no hope of being reintegrated into the community. At present, YVH is one of seven nuclear mental hospitals responsible for mental health services within their respective catchment areas. Thus, the Yuli model clearly demonstrates the multiple ways that mental health system reform can be achieved, particularly in

the improvement of mental hospitals. In Taiwan, mentally-ill patients who heavily rely on mental health care and are regarded as being long-term residents of mental hospitals are a group which is often neglected by the system. Thus, it can be argued that the priority of mental health service improvement should be focused on the needs of people with long-standing illness, and solutions to shorten their hospital residency. This may imply that the task of community reintegration is particularly challenging for service providers and policy makers.

2.3.5 Community Mental Health Services

A balance of community-based and hospital-based mental health services has been shown to be the most effective form of comprehensive mental healthcare (Thornicroft and Tansella, 2004). Yet such a balance has only been achieved in a few high-income countries, where financial resources have been matched to the political will to increase community care (Saxena, et al., 2007). Although there is a trend toward community-based treatment, hospital-based care programmes are still considered to be necessary in Taiwan.

The economic situation and demographic composition of a community determine the lifestyle and experience of its residents, while their experiences affect their mental health (Yang, 2004). Mental Health status varies among communities, and Gans (1968) indicates that the differences in mental health status may be attributable to demographic variables, such as social status, ethnic background, family structure, and cultural factors. Yang (2004) indicates the influence of demographic variables on mental health in a community emphasises the fact that the sociality of individuals is the major factor which determines the differences in the distribution of mental health conditions among communities. This emphasises the fact that personal factors such as poverty, social-pressure endurance, and poor health determine the differences in the distribution of diseases among communities.

Schwab and Schwab (1978) believe that an individual's mental health is influenced by the social integrity of the community, and that a poorly integrated community causes stress to local residents. At the same time, because of a lack

of social support resources, the residents of these communities will suffer from stress which would influence their mental health and making it more likely that they will develop various mental disorders. A community study conducted in Kaohsiung (a city located in the South of Taiwan) showed that community experience was highly correlated with individuals' mental health. The lower the personal income, the less community support was received, and the higher the rate of low-income families, the poorer the mental health of its residents (Yang, 2004). It is therefore evident that an individual's mental health is affected by factors such as gender, education, career, economic conditions, and the condition of the neighbouring environment (Yang, 2004). Although this interaction is so complex that it is impossible to make it clear from the standpoint of a single variable, none of the variables should be ignored. With the change in demographic structure and an increase in the aging population, caring for those suffering from mental illness has become an important subject in the field of social medicine, and a long-term community-based care system will undoubtedly be the trend of future development.

De-institutionalisation is the mental health policy of many countries. Hannigan (1999) states that the successful of de-institutionalisation is depend on a number of key conditions, the first of that is the establishment of a comprehensive community support system. The second is an environment which allows the mentally ill to experience all of the rights of citizenship, as other individuals do, and the third is tolerance and non-discrimination from the public. According to the Department of Health in Taiwan, strengthening the community psychiatric rehabilitation programme has been one of its primary goals since 1985 (Department of Health Taiwan, 2004). However, this endeavour has proved to be fairly unsuccessful, given the fact that only 2,199 persons with mental illness were served by the community rehabilitation facilities in 2007 (Department of Health Taiwan, 2008). It is believed that one of the barriers to success is the social stigma towards mental illness. Currently, the media tend to link negative events, such as suicide, homicide, and disturbing behaviour to mentally ill individuals, and they are often portrayed as being an 'unexploded bomb' in society.

Shen (2007) reports on two community care programmes should provide a good example to Taiwan's Community Mental Healthcare system, one of which is the PACT (Programme of Assertive Community Treatment), and the other is ICM (Intensive Case Management). Both of these programmes aim to prevent unnecessary medical expenses caused by returning to hospital by means of Treatment in Community Living, rehabilitation treatment, social support, and rigorous follow-up.

In Taiwan, patients with mental health problems are disadvantaged in the use of psychiatric services, and this may due to the fact that most psychiatrists practise in hospitals rather than in local communities (Tseng, et al., 2008). Thus most of the care for mentally ill patients is provided by hospitals in urban or suburban areas with psychiatric outpatient departments. For mentally ill patients who live in remote areas of Taiwan, this centralisation of services and lack of a well-established community-based mental healthcare system may be critical factors in ability to access treatment. This is despite the fact that Taiwan's Mental Health Act launched in 1990 underlines the negative effects of limited access to psychiatric care by stating that health authorities should establish medical networks to deliver psychiatric care based on population demography and a fair distribution of medical resources. As Tseng et al (2008) state, the distribution of psychiatric health services remains uneven, partly for geographical reasons.

Taiwan's fast industrialisation and rapid growth during the latter half of the twentieth century has resulted in a vast number of the growing population migrating from rural urban areas. During recent decades, Taiwan has experienced significant economic growth, so much so that it has been called an "Economic Miracle", and it is now one of the industrialised developed countries. The improved economy has raised the awareness of better health services quality, and the money spent on improving the health system, especially mental health, has been greatly increased. However, although the funds for the health system have increased, the overall percentage of the total budget for healthcare allocated to it is still rather low in many Asian countries, including Taiwan where only around 3 percent of the total national budget is allocated to the health sector, of which less than 1 percent is spent on mental health (Department of

Health, Taiwan, 2009a). At the same time, mental health services are mainly based in urban areas. Even though the national health insurance programme is available to everyone, with the coverage increased from 59 percent in 1995 to 99 percent in 2008 (Bureau of National Health Insurance Taiwan, 2009), the role played by the welfare and insurance system is almost negligible. Thus, the financial burden rests upon the family carers.

According to the Department of Health in Taiwan, to ensure that mentally ill patients receive appropriate treatment and rehabilitation, and to protect their human rights, a vital four-part plan needs to be included in Mental Health Policy. Firstly, the responsibility of each level of government for mental health services must be determined, and secondly, a mental health administration and service delivery system must be established. Thirdly, the protection and treatment of severely disturbed patients must be reinforced, and last, but not least, the patients' rights for treatment and social rehabilitation must be emphasised (Department of Health, Taiwan, 2004).

Currently, there are no integrated psychiatric teams working in the public health stations (community-based healthcare) in Taiwan, who are able to provide a professional community mental health service, and although some Psychiatric Centres can provide community rehabilitation programmes focused upon crisis intervention, or developing patients' independent living skills and social competence in the community after being discharged from Psychiatric Centre, there is still a lack of professional psychiatric staff to deliver effective community mental health services. Another serious drawback is the lack of any adequate Mental Healthcare Network System to provide continued care. Consequently, this results in a relatively higher readmission rate to psychiatric hospitals than general hospitals in Taiwan.

Furthermore, the number of trained mental health professionals based in the community area is small compared to the population's needs and demands (Shiau et al., 2005). As a consequence, the pathway to care is long, and includes people who are not at the vanguard of knowledge about treatment for people with mental illness. However, long and time-consuming pathways to

care are not specific to Taiwan and can also be seen in many other societies (Lauber and Rössler, 2007).

2.4 Mental Health Policy and Policy Implementation

To develop special healthcare services for mental health, the Department of Health, in 2005, Executive Yuan reported in 2004 progress made to strengthen national mental health services and enhance mental healthcare system management (Department of Health, Taiwan, 2005), as follows:

(1) Expanding of psychiatric care facilities and ensuring quality of healthcare: however, areas are prohibited to have an excess of facilities, and a medical care development fund is set up to encourage areas lacking in facilities, such as community care, to establish them. An evaluation programme is required to assess healthcare quality for every healthcare provider organisation in Taiwan in order to provide a quality and patient-centred service.

(2) Establishment of a comprehensive mental health administration network system (Prevention, treatment, and rehabilitation): the Taipei City Psychiatric Centre and seven other core hospitals in the psychiatric care network are assigned to assist subordinate hospitals in establishing psychiatric emergency contact centres to provide convenient and accessible services for consultation and referral.

(3) Continuing efforts to foster specialised psychiatric care personnel: subsidies for training front-line mental health service staff and community mental health workforce are put in place.

(4) Establishment of suicide prevention plans: A selective suicide prevention scheme is required for each region of Taiwan.

(5) Implementing and revitalising the post-traumatic treatment system in the community, and establishing a Community Mental Health Centre based in every district of every city and county.

(6) Constructing mental health case management information systems in order to enhance community care service for long-term chronic psychiatric illness patients: integrating government and civil medical organisations to provide a comprehensive service.

(7) Strengthening mentally ill patients' social welfare service and improving the mental health educational service: to disseminate a positive concept of mental health to society in order to improve the public's view of mental health, and promote the improvement of de-stigmatisation.

The Department of Health in 2005 reported achievements in developing long-term care services and rehabilitation for the mentally and physically disabled within the four important areas of long-term care mental health services in Taiwan in the previous decade. These include:

(1)   The setting up of a long-term care service network to provide subsidies to 25 counties and cities for the establishment of long-term care management demonstration centres
(2)   The expansion of the nursing home system
(3)   The provision of guidance for public hospitals and nursing homes in the setting up and promotion of home care services and day care
(4)   The setting up of joint assessment centres for children with delayed development to promote early intervention and establish comprehensive care models.

There were two major noteworthy events for transforming mental health services in Taiwan: the Mental Health Law enacted in 1990, and National Health Insurance launched in 1995. These events significantly influenced the development of mental health services in Taiwan. The former represents great progress as the Mental Health Law codifies the protection of human rights, and calls for ethical practice from all mental health professionals, and was amended and further strengthened in July 2008 (Department of Health Taiwan, Official Online News, 2008). The National Health Insurance (NHI) is important, as it reimburses a wide range of medical expenditure on the treatment of mental

illnesses, including fees for psychiatric rehabilitation. Furthermore, the co-payment, which usually constitutes ten percent of the total medical expenditure, may be waived for people with severe mental illness, such as schizophrenia and bipolar affective disorder. Despite its growing financial deficit, there is no doubt that the NHI has made mental healthcare more affordable for every insured person (Bureau of National Health Insurance Taiwan, 2009).

According to Taiwan's report, 'Asia-Pacific Community Mental Health Development Project (AAMH, 2008)', there have been a number of studies over the past decades describing the prevalence rate of various mental disorders and different programmes have been launched by the Taiwanese government. However, studies about the outcome of these programmes are relatively lacking (Wu, et al., 2008). This report explicitly suggests that mental policy formulation should be based on the best evidence from robust data showing the effectiveness of any particular service. For instance, mental health authorities should implement outcome studies as part of the vertical integrative care programme for schizophrenic disorders, which is to be launched shortly (Wu, et al., 2008).

In terms of the evidence of efficacy and cost effectiveness of treatment in Taiwan, Tzeng, et al (2007) used the National Health Insurance database to demonstrate that patients with schizophrenia who utilised the redesigned care network had a better quality of life, lower family burden and a decreased length of hospital stay, but that their costs were higher than for standard care. However, Yeh (2007) found that the users of community mental health services cost less in terms of total medical expenditure.

In terms of the new mental health policy introduced by the Department of Health in Taiwan, the Committee of Psychiatric Service, DOH, has initiated a new mental health White Paper, *Healthy People 2020*, which contains a special chapter entitled 'Stress and Coping', in which mental health promotion is highlighted in the health policy for the first time (Department of Health Taiwan, 'Healthy People 2020', 2007b).

2.4.1 Funding Mechanisms - National Health Insurance System

In 1995, the Taiwanese government launched the National Health Insurance (NHI) programme, which offered a comprehensive, unified and universal health insurance programme to all citizens. This system of universal healthcare incorporated existing public health insurance plans, and extended coverage to eight million uninsured citizens, the majority of whom were children, students, stay-at-home parents, the elderly, and the disabled. When the NHI was launched in 1995, only 59 percent of Taiwan's population had health insurance, and those who did were covered by one of 13 different public health insurance plans. However, over 22 million people were enrolled in the programme in 2007, with coverage of 99 percent of the population (Bureau of National Health Insurance, 2009). The total national health expenditure for 2006 was NT$722.6 billion, equivalent to 6.1 percent of Taiwan's gross domestic product (GDP). The national health expenditure as a percentage of GDP increased from 4.9 percent in 1994 to 5.3 percent in 1995, and to 6.1 percent in 2006, which indicates that accessibility to medical care has increased since the inception of the National Health Insurance (Taiwan Public Health Report 2008, 2009).

The NHI system is a compulsory type of social insurance, and every person (those holding Republic of China (Taiwan) citizenship or from Hong Kong, Macao China or foreign citizens residing in Taiwan) who meets the eligibility criteria is obliged to enrol in the system and pay the premiums in accordance with their legal status, and may not suspend coverage. The NHI is operated on a Fee for Service (FFS) system, so that patients only need to pay a small proportion of the fee set by the Bureau of National Health Insurance (BNHI) for each medical service received, and the remainder of the service payment is covered by the BNHI. In order to prevent unlimited spending, the BNHI introduced "the Global Budget System" to modify the FFS mechanism. The global budget put an expenditure cap on each medical field (hospitals, western medicine, Chinese medicine, etc.). If the total services provided exceed the field's budget quota, the FFS reimbursement ratio starts to deflate, which shrinks the payment for each service performed (Taiwan Healthcare Reform Foundation, National Health Insurance System, 2008).

NHI benefits are comprehensive, and include inpatient care, ambulatory care, laboratory tests, X-ray examinations, prescription services, dental services, traditional medicine, and day care for the mentally ill and limited home care. In addition, four preventative services are covered: adult health examinations, prenatal examinations, checkups for babies, and Pap smear examinations. A number of more expensive treatments are also included under NHI, such as HIV and AIDS therapy and organ transplants (Bureau of NHI, 2009). National Health Insurance covers a comprehensive mental health service in Taiwan. This includes assessment, examinations (tests), consultations, general treatment, provision of prescription drugs or prescriptions, provision of therapy materials, nursing and provision of wards, psychotherapy, and rehabilitation treatment for in-patients and out-patients, occupational therapy and provision of home care services for rehabilitation services. In order to strengthen the rehabilitation of psychotic patients into their communities, the national health insurance of chronic psychosis rehabilitation also provides rehabilitation therapy in local rehabilitation centres (including sheltered workplaces), rehabilitation therapy at rehabilitation homes, and home care (Bureau of NHI, 2009).

However, the current system of the Taiwanese NHI emphasises hospital-based care and tends to ignore the psychological and rehabilitation domains of psychiatric care, as well as community-based care domains, for which there is still limited mental health coverage in NHI. This stimulates increasing psychiatric bed numbers instead of moving services toward the community area, which is an unusual trend in psychiatric services (Department of Health Taiwan, 2007b).

Chronically mentally ill patients can apply for two certificates from the local government social welfare system to reduce their individual expenditure; the Serious Accident and Disease Certificate and the Physically or Mentally Disabled Certificate. Statistic show that, by the end of 2007, a total number of 117,934 serious accidents and disease certificates in the Chronic Psychotic Disorder category were issued in Taiwan, which included 12,602 which were issued by the city government of Taipei (DOH Taiwan, 2008).

The financial burden of mental healthcare in Taiwan has been growing incessantly in recent years with an uneven distribution of the allocation of

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resources. The chronic sector of mental healthcare has expanded steadily, while the acute and community sectors are still undersupplied compared with demand, resulting in patients being detained in long-stay chronic wards. Therefore, the government states that the aim of the mental health policy should be to reduce expenditure, reallocate resources, and ensure quality of care (DOH Taiwan, 2007b).

2.4.2 Funding Mechanisms - Mental Health Expenditure

With regard to expenditure, mental healthcare accounts for only 0.0245 percent of the total annual government expenditure (DOH Taiwan, 2008). According to the statistical data provided by the Department of Health (2008), personal expenditure on mental healthcare was 26.871 million New Taiwan Dollars (NT dollars), which only accounted for 3.86 percent of the total annual expenditure on personal healthcare in 2007.

According to the table (Table 2-4) on the next page, In terms of the health expenditure of National Health Insurances over the past ten years (1999-2008), the healthcare expenditure of the NHI shows a gradual increase in mental health services, both for psychiatric hospital care and rehabilitation care between 1999 and 2008 (see Table 2-4 below). Until 2008, the health expenditure for mental health was just over NT 5 billion, which has increased from NT 3.5 billion in 1999.

Table 2-4: Health Expenditure of National Health Insurance, 1999-2008 (million NT Dollars) (Department of Health, Taiwan, 2009 a)

Year/Type		Psychiatric Hospital	Psychiatric Rehabilitations Institutions	Day Care Institutions	Residential Institutions
1999	Total	3,665	56	11	45
	%	1.26	0.02	0.00	0.02
	Outpatient	788	56	11	45
	Inpatient	2,877	-	-	-
2000	Total	6,422	50	15	36
	%	1.16	0.02	0.01	0.01
	Outpatient	776	50	15	26
	Inpatient	2,645	-	-	-
2001	Total	3,899	23	19	3
	%	1.26	0.01	0.01	0.00
	Outpatient	864	23	19	3
	Inpatient	3,034	-	-	-
2002	Total	3,831	63	19	44
	%	1.16	0.02	0.01	0.01
	Outpatient	895	63	19	44
	Inpatient	2,936	-	-	-
2003	Total	4,237	132	42	90
	% (Annual Rate)	1.23 (10.59)	0.04 (109.92)	0.01 (124.18)	0.03 (103.89)
	Outpatient	1,105	132	42	90
	Inpatient	3,133	-	-	-
2004	Total	4,695	194	69	125
	% (Annual Rate)	1.30 (10.80)	0.05 (47.02)	0.02 (64.69)	0.03 (38.80)
	Outpatient	1,216	194	69	125
	Inpatient	3,478	-	-	-
2005	Total	4,631	261	94	167
	% (Annual Rate)	1.24 (-1.36)	0.07 (34.22)	0.03 (35.86)	0.04 (33.32)
	Outpatient	912	261	94	167
	Inpatient	3,719	-	-	-
2006	Total	4,761	337	137	200
	% (Annual Rate)	1.23 (2.82)	0.09 (29.28)	0.04 (46.27)	0.05 (19.73)
	Outpatient	903	337	137	200
	Inpatient	3,858	-	-	-
2007	Total	4,681	444	215	229
	% (Annual Rate)	1.15 (-1.69)	0.11 (31.71)	0.05 (56.78)	0.06 (14.50)
	Outpatient	958	444	215	229
	Inpatient	3,722	-	-	-
2008	Total	4,787	470	237	234
	% (Annual Rate)	1.13 (2.27)	0.11 (6.01)	0.06 (10.02)	0.06 (2.24)
	Outpatient	937	470	237	234
	Inpatient	3,850	-	-	-

However, with the increase in health expenditure in terms of personnel and health facilities for mental healthcare in Taiwan has healthcare utilisation inevitably increased or not? The above table clearly shows that government policy and the National Health Insurance system is still paying more attention to conventional hospital care, instead of the contemporary community care model.

2.4.3 Characteristics of Mental Health and Service Organisations

According to the data from the Department of Statistics, Ministry of the Interior, there were more than 100 thousand psychiatric patients, accounting for 9.64 percent of the total population of disabled persons, and 0.43 percent of the total population, by the end of 2008 and this is still increasing (Department of Statistics, Ministry of the interior, 2009). Among psychiatric patients in 2008, there were slightly more male patients (51.42%) than female (48.58%) (See table 2-5 below) and the majority of them were aged between 30 to 64 years old (82.19%), with medium (57.59%) or mild (22.77%) psychiatric morbidity level (see table 2-6 below).

Table 2-5: Number of Psychiatric patients in Taiwan over the years (1999-2008) Department of Statistics, Ministry of the interior, 2009).

	Number of Psychiatric patients	Percentage of Total Population (%)	Male	Female
1999	48,464	0.22	27,178	21,286
2000	54,350	0.24	30,254	24,096
2001	60,453	0.27	33,504	26,949
2002	68,763	0.31	37,792	30,971
2003	75,832	0.34	41,345	34,487
2004	83,175	0.37	44,762	38,413
2005	87,039	0.38	46,309	40,730
2006	91,160	0.40	47,801	43,359
2007	97,127	0.42	50,282	46,845
2008	100,045	0.43	51,445	48,600

Table 2-6: Number of Psychiatric Patients with Different Morbidity Level in Taiwan (1999-2008) Department of Statistics, Ministry of the interior, 2009).

End of Year	Psychiatric Morbidity Level				Percentage of Total Disabled Population (%)
	Severe	High	Medium	Mild	
1999	1,600	12,474	26,880	7,510	7.47
2000	1,660	13,458	31,185	8,047	7.64
2001	1,674	14,394	35,673	8,712	8.02
2002	1,740	15,726	40,370	10,927	8.27
2003	1,795	16,755	44,755	12,527	8.81
2004	1,760	17,377	48,927	15,111	9.15
2005	1,700	17,327	51,053	16,959	9.28
2006	1,671	17,563	52,945	18,981	9.29
2007	1,658	17,833	56,201	21,435	9.52
2008	1,638	18,007	57,618	22,782	9.64

Regardless of further developments to shift the provision from hospital-based to community-based psychiatric care over the years, community mental health service provision in Taiwan is still limited. The number of psychiatric beds has been on the rise until 2009 according to the data provided by Taiwan's Department of Health (see table 2-7 below). The number of acute psychiatric beds in 1994 was 1,949, which increased to 6,595 at the end of 2008, and the number of chronic psychiatric beds in 1994 was 10,546, which had increased to 13,661 in 2008 (DOH, Taiwan, 2009 b). These statistics also show there were 2.86 acute psychiatric beds and 5.93 chronic psychiatric beds per 10,000 populations in Taiwan in 2008 (DOH, Taiwan, 2009 b). There has been a steady increase in the number of psychiatric beds, but this is mainly due to the lack of community rehabilitation facilities and the high burden of family care givers.

Table 2-7: Number of Psychiatric Beds in Hospitals and Clinics (1994-2008)
   (DOH, Taiwan, 2009b)

End of Year	Number of Acute Psychiatric Beds	Number of Chronic Psychiatric Beds
1994	1,949	10,546
1999	4,641	8,681
2004	5,868	11,644
2008	6,595	13,661

Before the 1970's, apart from a few acute treatment settings, mental healthcare provision by the government was limited to long-term sheltered institutions for mentally ill patients as a beginning of psychiatric care development in Taiwan. In 1977, the first two occupational sheltered workshops were established by two of the central psychiatric hospitals (Taipei and Changhua), followed by the establishment of the first rehabilitation home in the community. Those developments can be considered as being community service area for psychiatric patients. By the end of 2008, there were a total of nineteen psychiatric nursing homes which can serve up to 1,539 mentally ill patients, and one hundred and fifty-four psychiatric rehabilitation institutes which enable 6,809 patients to be accepted in the community in Taiwan, which increased over the years (see table 2-8 on next page).

Table 2-8: Number of Psychiatric Nursing Institutions and Institute for Psychiatric Rehabilitation in Taiwan (2000-2008) (DOH Taiwan, 2009b)

End of Year	Psychiatric Nursing House			Institute for Psychiatric Rehabilitation					
	Subtotal	Affiliated to Hospitals or Clinics	Free-Standing Psychiatric House	Day Care Institution			Residential Institution		
				Subtotal	Affiliated to Hospitals or Clinics	Day Care Institution	Subtotal	Affiliated to Hospitals or Clinics	Residential Institution
2000				15	10	5	30	9	21
2005				48	25	23	78	19	59
2008	19	11	8	64	28	36	90	16	74

Every mental healthcare service system in Taiwan is influenced by the government's policy. From the 1990s, the mental health sector at the Department of Health has promoted psychiatric prevention, which stresses "developing a service which is active in psychiatric treatment and rehabilitation, instead of passive in sheltered protection care", and as a result, community-based mental health service resources have increased. According to the data provided by the Department of Health, the number of psychiatric patients being accepted in community-based mental health institutes has doubled, as well as the ability of mentally ill individuals to receive service in the community being extended over the years since 2000 (see table 2-9 below).

Table 2-9: Number of Psychiatric Nursing Institutions and Institute for Psychiatric Rehabilitation in Taiwan (End of Year 2008) (DOH Taiwan, 2009c)

	Psychiatric Nursing House			Institute for Psychiatric Rehabilitation					
	Subtotal	Affiliated to Hospitals or Clinics	Free-Standing Psychiatric House	Day Care Institution			Residential Institution		
				Subtotal	Affiliated to Hospitals or Clinics	Day Care Institution	Subtotal	Affiliated to Hospitals or Clinics	Residential Institution
Total No. of Institutions	19	11	8	64	28	36	90	16	74
No. of Beds	1,539	1,178	361						
No. of Pts Allowed to be Accept				3,261	1,519	1,742	3,548	600	2,948
TOTAL	19 Institutes, 1,539 Beds			154 Institutes, 6,809 Patients Allowed to be Accept					

Table 2-10: Existing and required psychiatric treatment facilities in Taiwan (DOH Taiwan, 2009c)

Psychiatric treatment and rehabilitation facilities	Estimated need	
Acute Treatment Beds	Mentally ill patients 10%	6,900 beds
Chronic Rehabilitation Beds	Mentally ill patients 25%	17,250 beds
Long-Term Care Beds	Mentally ill patients 15%	10,350 beds
Day Care Bed Occupancy	One bed per 10,000 residents	2,300 people
Rehabilitation Centre Beds	One bed per 10,000 residents	2,300 people
Community Rehabilitation Centre	Two beds per 10,000 residents	4,600 people

From the government's point of view, these statistics demonstrate that, not only have the facilities have been improved, but also the quality of service. In addition, professional education and training programmes have been promoted within mental health services in Taiwan. However, data provided by Department of Health shows that there is still a gap between the existing and the required psychiatric facilities (DOH Taiwan, 2009c). Since there is a prevalence of psychiatric disease in 0.003 percent of the total population in Taiwan, the number of mentally ill people is estimated to be 69,000 in 2009. Thus, the current psychiatric facilities for Taiwan's mentally ill population have still not met the standard of the estimated need (See table 2-10 above).

2.4.4 Managing Resources to Delivery Effective Services

In 1985, the Department of Health launched its Mental Health Service programme by introducing the Mental Healthcare Network, which aimed to build up psychiatric hospitals, and increase psychiatric in-patient beds, as well as in the community. To date, although significant progress is being made to improve mental health services, limited resources in community provision, and clinical predicaments within practice still emerge.

Those working in mental healthcare have to seek a balance between the patient's treatment, patient's rights, safety issues and family concerns, needs,

public fear and awareness. However, the existing literature suggests that, in order to prevent or avoid the occurrence of violent behaviour, there has to be continued treatment and care for severe mentally ill patients (Shen, 2007). Mental healthcare services in the 21 century should emphasise the importance of medication and community care, and therefore, it should focus on compulsory treatment to prevent disturbed behaviour, and continue care through out-patient clinic services and community care centres.

Currently, the mental health service in Taiwan lacks an integrated and continuing care system, which includes acute and community care. This requires complex procedures and a sufficiently large workforce and budget from the government, to support mental health policies, and assist related organisations to put those policies into effect (Shen, 2007). Moreover, Shen (2007) points out that the Taiwanese government should strengthen mental health policies through the introduction of emergency psychiatric care network, as well as extending the community care system and referral service by establishing 24 hours emergency care centres in order to make a cautious assessment to recommend the appropriate treatment for severely mentally ill patients, and launch a suitable community care programmes.

The only research to test the ecology of Mental Healthcare in Taiwan was conducted by Li-Fang Chou, who was more interested in knowing the proportion of the population receiving various kinds of mental healthcare (Chou, 2006). Because such research of healthcare involves an extensive survey of a defined population over a period of time, relevant literature is also relatively scarce. Li-Fang Chou tests the utilisation of mental health services of the population by estimating the proportion of the population in Taiwan who received mental health services in 2001. Seven estimates were computed in the research from the 200,000 eligible people, and 170,393 people (92.6%) were found to have received health insurance benefits during that year. He then interpreted the utilisation of Mental Health Services of 10,000 people in Taiwan in 2001. Of those 10,000, 2559 had been given at least a psychotropic drug, 792 had been diagnosed with mental disorder, 201 had visited a psychiatric clinic, 58 had been issued with a certificate of chronic psychosis, 38 had visited the emergency department because of mental disorder, 20 were hospitalised to a

psychiatric ward, and 3 had received community psychiatric rehabilitation during the year (Figure: 2-11).

Figure 2-11: Yearly prevalence estimates of people receiving mental healthcare in 2001 (Chou, 2006)

→10,000 people

2559 receive a psychotropic drug

792 have a diagnosis of mental disorder

201 visit a psychiatric clinic

58 have a certificate of chronic psychosis

38 visit an emergency department because of mental disorder

20 are hospitalized to a psychiatric ward

3 receive community psychiatric rehabilitation
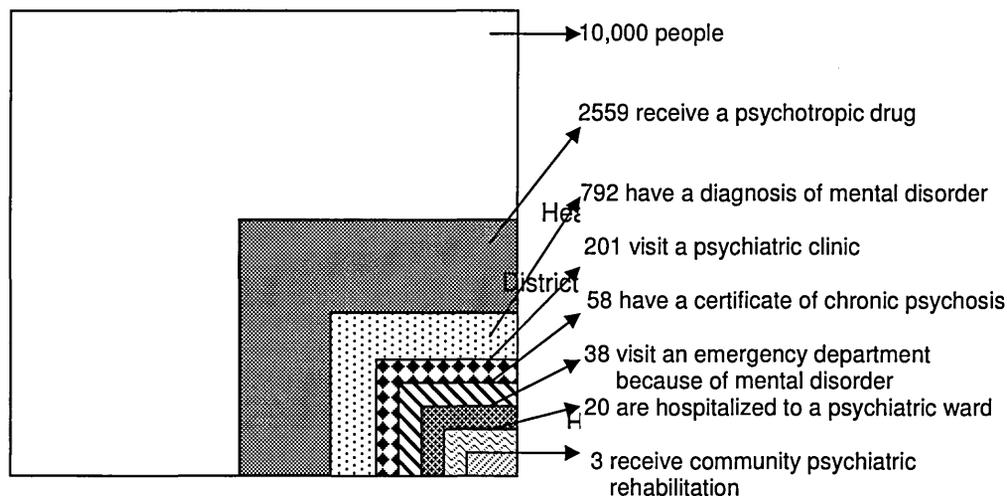
This research clearly indicates that community rehabilitation programmes are infrequently utilised by patients with mental disorders, since only 3 out of 10,000 people had received such programmes, even though 58 were registered with chronic psychosis. On the other hand, 20 in 10,000 people during the year 2001 had a psychiatric admission. The author suggests that this could infer that hospitalised patients may become more severely mentally ill due to lack of early intervention, and have a longer length of stay (Chou, 2006).

2.5 Issues Determining Current and Future Demand and Supply

Globalisation is an important worldwide economic and political phenomenon, and the challenges associated with it are complex. Due to the current financial crisis and economic recession, the majority of the Taiwanese population live in poverty. Unemployment and other factors such as frequent population migration, an aging population, and a decreasing birth rate, are resulting in the demographic structure change and the composition of the country, which has severe implications for healthcare demands.

2.5.1 Demographic Structure of Taiwan

According to the statistics of 2006, the gross population growth, birth, and fertility rates reached an all-time low in Taiwan (DOH Taiwan, 2007b). If the birth rate continues to fall and the mortality rate rises as the aging population increases, not only will the problem of population chasm and aging increase, but also other socio-economic problems will ensue.

In traditional Chinese culture, it is the family's responsibility to take care of the older people, but because of the social changes arising from the industrialisation globalisation, and the influence of various factors (decrease in the number of children, rising employment among women, increased divorce rate), a large number of families are unable to assume the responsibility of caring for all their older members. Therefore, when traditional family care becomes insufficient, there is an increasing dependence on institutional care (Tzeng, 1999). However, the quality of institutional care varies, and the associated expenses are high. Tzeng (1999) indicates that the concept of long-term care in the community has subsequently evolved; the former trend of a shift from family to institutional care has reversed, with the burden being placed again on family and the community.

As the number of older people in society increases, there is a gradual decrease in social productivity and competitiveness, and an increase in the demands on society to support the elderly. Addressing the mental health needs for older persons is becoming a greater challenge in Taiwan. The incidence of depression is high among older people, females, widows and widowers in Taiwan, those with memory problems or having difficulty in carrying out everyday activities, those suffering chronic diseases, and among less educated persons (Liu, Wang, and Teng, 1997). It seems that the mental health of the dependent elderly in particular, is closely related to the quality of their interaction with others and their relationship with their community. Yang (2004) highlights the need for more attention to be given to the correlation between participation in community activities and the prevention and treatment of depression among the elderly. The more community activities they take part in, the better mental health they enjoy. Gender is also strongly correlated with

participation in activities, possibly because in Taiwan men have more traditionally taken charge of matters outside the home, while home matters have traditionally been assigned to women. Women have been marginalised, and the notion that men take precedence over women is pervasive in Taiwanese culture (Yang, 2004).

2.5.2 Immigration

In recent years, new policies have opened up the labour market and stimulated changes to Taiwan's overall industrial structure, and social demands, the "marriage market", and an aging population. Statistics show that, by the end of March 2008, the number of authorised foreign workers in corporations or families in Taiwan was more than 365,000 (Employment and Vocational Training Administration, Council of Labour Affairs, Executive Yuan, Taiwan, 2008), and these were mainly persons from Southeast Asian countries such as Thailand, Indonesia, the Philippines, Vietnam, and Malaysia.

According to WHO report (Weekly Epidemiological Record, 1992), the suicide rate of immigrants is often higher than that of native residents, and this is probably related to mental health problems associated with immigration. Yet, the main motive for stimulating international labour migration is better economic benefits, job opportunities, and salaries. However, when foreign workers arrive they usually find a gap between expectations and the reality of life in a foreign country, which is a difficult disparity to overcome. The results of research of the mental health of foreign workers in Taiwan disclose a series of adjustment difficulties, including lack of opportunities for social participation, a feeling of being unwelcomed by the local society, poor working conditions, discrepancies between the present state and former expectations, unsatisfied sexual desires, different living customs, and an inability to make friends (Yang et al., 1999; Yang et al., 2000). In addition, since most foreign workers are engaged in low-status, low-paying, labour-intensive industries characterised by poor and dangerous working conditions, they undoubtedly also encounter troubles caused by inequality in the distribution of income.

Since the first Indonesian bride appeared in Taiwan 16 years ago, the number of people immigrating though marriage has grown steadily. Foreign brides in Taiwan mainly come from Mainland China and South-East Asian countries such as Vietnam, Indonesia, and Malaysia, and statistics show that, by the end of 2007, a total of 137,353 foreign brides had applied for permanent residency in Taiwan (Department of Statistics, Ministry of the Interior, Taiwan, 2008). Marriage should mark the beginning of a happy family life, but in the case of cross-cultural marriage, it can be the beginning of trouble and pain. A cross-sectional questionnaire survey was conducted among foreign pregnant women in Kaohsiung city, south of Taiwan, and the results of the survey showed that 10% of the interviewees had contemplated committing suicide. These suicidal thoughts were associated with a perceived lack of social support, family dysfunction, adverse life events, and domestic violence. The most stressful life events included troubled marital or interpersonal relationships and financial problems (Chu, et al., 2000).

2.5.3 Privatisation and Unemployment

Since Taiwan's entry into the WTO (World Trade Organisation) in 2002, the globalisation of the economy and its integration into international society means that Taiwan's unemployment rate is no longer a regional problem, but a problem of interregional balance. In recent years, the movement of enterprises out of Taiwan has impacted upon the country's unemployment rate. By January 2010, the number of unemployed people in Taiwan was 626,000, and the unemployment rate was 5.68% (Directorate-General of Budget, Accounting and Statistics, Executive Yuan Taiwan, 2010).

Mental health reflects the social status quo, and by applying a distress index, a summation of unemployment and the rate of inflation are used to estimate the influence of economic fluctuation on people's lives. The higher the unemployment rate, the lower the family income, and the higher the cost of living, the more stressful life will be. In Taiwan, traditionally the breadwinner of the family is usually male, so when unemployment increases, family incomes decrease. In addition to economic difficulties, unemployment also creates loss of self esteem and the active control of personal security state, and thus

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influences personal health (Yang, 2004). Therefore, the economic condition and unemployment rate of a country are closely related to the health of its citizens. Research conducted by Yang (2004) analysed the nature of different jobs, and its influence on the occurrence of depressive symptoms. The results showed that workload, salary, welfare, and interpersonal relationships are not significantly associated with employee depression. Instead, the main factors were lack of learning opportunities, impeded self-actualisation, job strain, and the challenges of work.

2.6 Cultural influences on Mental Health Services

What is culture? An integrated description was written by Helman (1994) in a book for healthcare professionals, as follows:

> *"Culture is a set of guidelines (both explicit and implicit) which individuals inherit as members of a particular society, and which tells them how to view the world, how to experience it emotionally, and how to behave in it in relation to other people, to supernatural forces or gods, and to the natural environment... And all cultures have elaborate ways of moving people from one social category into another (such as from "ill person" to "healthy person"), and also of confining people-sometimes against their will to the categories into which they have been put (such as "mad", "disabled" or "elderly")".*
> *(Helman, 1994, pp.2-3)*

Kleinman (1977) proposes that cultural background can influence the following aspects of mental well being: conception, perception, experience of symptoms, recognition and labelling, classification, treatment, and the course of mental illness. Therefore, it is pertinent to suggest that, in any discussion and evaluation of mental health services in Taiwan, it is essential to take cultural inferences into consideration.

Taiwanese culture is a blend of its distinctive Chinese heritage and western influence. Most Chinese families want to care for their relatives because they feel it is their duty to do so. Being a 'right and proper' person is central to the

social role within Confucian-based, Chinese society, and obligations and honour are extremely important to Chinese people (Holroyd, 2003). Traditionally, Taiwanese people view the family as being the essential basic unit of society which is more important than the individual. "Chia-Ho-Wan-Shih-Hsing", a popular Chinese proverb, means that a harmonious family can accomplish almost everything as long as every family member is willing to function as a part of the whole, rather than independently (Braun & Browne, 1998).

Traditional Chinese people believed that spirits and fate influenced their health (Chen, 2001). Some Taiwanese people's beliefs invoke the concept of 'karma' as a specific explanation of the causes of disability or disease. Under Buddhist belief, the soul exists externally, materialising in an endless succession of temporal existences in a variety of forms of life. Each violation of moral axioms causes 'seeds of revenge' in the form of misery in the new being. This brings social stigma, hence families may not want relatives or friends to know about a family member who is mentally disabled. They may feel inferior to other people, may not want to take part in social activities, and may gradually become isolated from society (Zhou, 2000).

Even so, the majority of Buddhists usually give a positive meaning to suffering. They believe that if people can tolerate all of the painful experiences caused by disease, they will receive a better reward in heaven after death. In addition, they believe that the accumulation of good deeds through compassion will enable them to reach a higher state of being in the world of eternal life (Sheng-Yen Master, 2000).

2.6.1 Complementary and Alternative Medicine among the Taiwanese People

For the past five thousand years, Chinese herbal medicines (CHMs) have played a critical part in Chinese culture, and in recent years, Western nations have also gradually adopted an open attitude toward traditional Chinese medicines. According to the WHO Traditional Medicine Strategy 2002-2005, more than 180 nations in the world have drawn attention to the importance of traditional medicines in their national medicine policy (World Health Organization, 2007).

Complementary and alternative medicine (CAM) refers to a large number of therapies, systems and techniques which exist outside the conventional medicine which is taught and delivered by the majority of medical institutions. When tracing the history of Western medicine, it is evident that it was in the 1960s and 1970s when therapies which used to be considered as being alternative to conventional care were given the term, "alternative medicine" (Mamtani and Cimino, 2002). As stated in a report by Integrated Healthcare in 1997, CAM therapies are widely used around the world, and in the industrialised nations, around 25 percent to 50 percent of people adopt alternative methods of treatment. Among the people who use CAM therapies, most do to alleviate pain or neurological and psychological problems. When referring to the use of CAM therapies for psychiatric disorders herbal supplements, acupuncture, and mind-body techniques such as the use of biofeedback, and meditation are the most common treatments (Zollman and Vickers, 1999). Acupuncture, a component of Traditional Chinese Medicine (TCM) has been integrated into the healthcare system in China for at least 2000 years. In Chinese society, Traditional Chinese Medicine, including Chinese herbal remedies and acupuncture, is the major CAM in comparison with western medicine.

In Taiwan, Traditional Chinese Medicine (TCM) includes Chinese medicine, acupuncture, and other traditional medical practices are an alternative to Western medicine. The committee on Chinese Medicine and Pharmacy under the DOH in Taiwan is the highest government agency overseeing the practice of traditional Chinese medicine. However, in traditional Asian societies, supernatural, religious, and magical approaches to illness and behaviour are also prevalent. This may be due to the fact that in these countries, many people hold the belief that most chronic, irreversible and relapsing stigmatised conditions are considered to be the result of sorcery, spiritual punishment or possession by spirits and demons.

Depression has been reported as one of the most common medical conditions associated with the use of CAM. Barnes, et al (2004) discovered that around 10 percent to 54 percent of people with probable, self-defined, or physician-diagnosed depression using CAM in the past 12 months (Barnes, et. al., 2004).

Research reviews on the use of complementary and alternative medicine among adult patients with depression in Taiwan found that nearly 70 percent of the participants used CAM to cope with their psychiatric symptoms. Participants with mild to moderate depression tended to use more CAM than participants with severe depression (Hsu, et al., 2008). Higher CAM use may also be a reflection of the easy access to and affordability of CAM therapies in Taiwan, as some are reimbursed by National Health Insurance (NHI) (Chen, et al., 2006). CAM is predominantly used for symptom relief, but also to improve general well-being, energy levels and quality of life.

Ng (1997) argues that traditional medicine and traditional healers are sought after, and there is strong resistance to and extreme delay in, seeking psychiatric help. Alternative medicine is therefore popular among patients in Taiwan, particularly psychiatric patients. Some of the previous studies regarding Taiwanese psychiatric patients focus on the use of folk medicine on patients with severe psychiatric disorders. Research by Wen (1998), which surveyed 599 psychiatric patients in Taiwan, revealed that 84 percent of the patients had used folk medicine previously. In the same study by Wen an 18-month follow-up analysis of psychiatric patients indicated that patients who believed in supernatural power as the cause of mental disorders had poor medication compliance and a bad prognosis. Furthermore, a survey investigating the reasons for hospital discharge of psychiatric patients showed that 20.8 percent of discharges against medical advice were due to the patients' decision to use folk medicine instead of modern medical treatment (Yang, et al, 1990).

Some researchers have set up hypotheses to investigate the reasons patients relinquish conventional treatment for alternative medicine, and why they choose a combination of both. Wen (1998) implies that the above hypotheses can be answered by two aspects, the first of which may be that patients may be dissatisfied with conventional treatment. Kessler et al (2001) suggested that other reasons may include the fact that anxious and depressed patients tend to prefer alternative medicine and a study by Brown (2001) indicates that alternative medicine may have a more significant therapeutic effect than conventional treatment for some people with anxiety and depression (Brown, 2001). Other reasons could be associated with the perceptions of the patients

and their families of what caused the mental disorder, with cultural factors being a pivotal to these beliefs.

2.6.2 Cultural Influence upon Beliefs and Help-Seeking Behaviour

In the past three decades most studies in psychiatric care have been conducted in Western countries, with little research being conducted elsewhere. Culture and healthcare systems vary from country to country, and findings from the West may not be generalised to the situation in Taiwan. Hence, the main objective of this part of the literature review is to elaborate on the Chinese cultural influences on the mental healthcare system. Regarding health care, Chinese culture maintains an integrated of the body and the mind. Due to a lack of knowledge of mental illness, moral judgments and supernatural attributions are usually associated with the mentally ill.

Cultural background can affect mental illness in the following aspects: conception, perception, the experience of symptoms, recognition and labelling, classification, and the treatment and course of mental illness (Kleinman, 1977). Apart from their cultural background, people with mental illness can often experience a negative response from society. This unfavourable social situation, termed as stigma, has become a popular topic in the last decade. Researchers, health policy makers, and the patients themselves and their families, have all expressed an interest in this topic (Raguram, et al., 2004).

Many Asian countries have undergone significant social and economic transformations in the past few decades. The increasing Gross Domestic Product (GDP) of many Asian countries can best reflect these transformations, and Taiwan is no exception, being one of the industrialised developed countries in Asia. The quality of life of Taiwanese people has considerably improved in most areas, with this being reflected in increased physical health and a longer life expectancy (Tseng et al., 2001). However, despite being westernised in many aspects, transitional habits, values and principles, and a strong sense of national pride still remain influential in Taiwanese culture.

In traditional Chinese societies, supernatural, religious, and magical approaches to illness are very common, and people who hold traditional beliefs tend to maintain that most chronic, irreversible and relapsing conditions are the result of being spiritually controlled or punished by spirits and demons (Kleinman, 1980). In the case of some severe mental illnesses, Ng (1997) illustrates that most patients have a two-stage help-seeking process. Firstly, the pre-diagnosis stage, which is often protracted and characterised by family concern and protectiveness, with the use of inter-familial resources, and finally, seeking outside help. In the first stage, traditional medicine and traditional healers are often sought and there is strong link between resistance and the extreme delay in seeking psychiatric help. Secondly, the post-labelling stage, which is mainly filled with despair and loss of tolerance. This may be followed by a series of hospitalisations, and may eventually end with rejection (Ng, 1997).

As previously mentioned, Chinese culture holds an integrated point of view of the body and the mind, and Yang (2005) claims that, due to a lack of knowledge of mental illness, moral judgment and supernatural attributions are usually related to mental illness in Chinese culture. A survey undertaken by Chang and Song in 1998, based on the caregivers of patients with mental illness in central Taiwan, revealed that psychosocial factors (61.2 percent) are considered to be the leading cause of mental illness. With biological factors being the second (19 per cent) and supernatural factors (15.7 per cent) came in third place. Western psychiatry is the primary treatment in Taiwan. However, mentally-ill patients and their families, commonly seek other resources such Chinese medicine or folk therapy as secondary treatments (Chang, 1998).

In order to understand the under-utilisation of the mental health service, cultural factors within individuals are important in determining service use. According to Lau and Takeuchi (2001), for Chinese people, there may be conflicts between cultural values and their expectations of psychotherapy or counselling. Traditional Chinese culture places a higher value on self-restraint than emotional expression, and individuals are expected to control and suppress their emotional problems. Thus, an open discussion of personal issues though a psychiatric counselling context may be unnatural to many Chinese people. Due to concerns of shame and 'loss of face' to them and their families, Chinese

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people may not seek counselling to avoid being stigmatised, since stigmatisation may have an effect on themselves and their families (Mak and Chen, 2006).

Culture not only shapes people's attitudes when they are seeking help from mental health professionals, but also influences the cognitive appraisal of their psychological problems. Mak and Chen (2008) claim that cultural differences are underpinned by lay beliefs about the etiology of mental illness. People with traditional cultural backgrounds, such as Asians, are more likely to attribute mental health problems to internal, personal causes, whereas counsellors influenced by Western psychotherapeutic approaches often perceive mental illness to have arisen from interaction between the person and the environment (Mallinckrodt, et al, 2005). This also implies that cultural differences can influence the efficacy of Western-based psychological treatments. In other words, in Chinese culture, psychological problems are regarded as personal failure, whereas Western-based trained counsellors tend to emphasise the influence of the environment. Therefore, it may be fair to suggest that, for mental health service providers, it is vital to understand the service user's etiological and cultural beliefs in order to provide more effective psychological treatment.

2.6.3 Cultural Effects on Stigma

From the traditional Chinese perspective, emotions are considered to be pathogenic factors which disturb the body's normal functions. Thus the expression of emotional extremes is often discouraged (Bond, 1993). In addition, Chen, et al (2005) found that ambivalence over emotional expression was predicated by some Chinese personality constructs such as 'face'. Individuals concerned about 'loss of face' care about their public image and are very conscious of how others judge them. Therefore, they may suppress the expression of distress to avoid losing face. As a result, it is very difficult for Chinese people to take the initiative in discussing personal problems and expressing emotions with counsellors (Mak and Chen, 2006).

Traditional societies are often located in rural areas, and tend to emphasise the group benefit more than the individual person. Compared to modern society, they may have a slower pace in social change and a society remains stable overtime. Due to the huge differences between traditional and modern societies, social tension may emerge when modern and traditional influences clash (Furr, 2005). Traditional societies are often characterised by familial orientation and group-centeredness, and thus, Samuma (1978) suggests that the stigma of mental illness can influence the entire familial or group system and the patients, their families and relatives being greatly affected by social discrimination in marriage, business and education. As a consequence, denial and somatisation are used to relieve the family of stigma, and to avoid public shame and social marginalisation (Lee, et al., 2005).

A Systematic Review by Lauber and Rössler (2007) examined the literature on stigma as affecting people with mental health illness in Asia. The review found that the most urgent problem of mental healthcare in Asia is the lack of personal and financial resources. Mental health professionals are mainly available in urban areas, which creating barrier for people with mental illness in rural communities to seeking help, and this contributes towards the stigmatisation of the mentally ill.

Psychological illness and disability is considered to be a serious threat to a family's social status. For example, mental illness can affect chance of marriage, and they fear that their children may also carry the genes in the family. Lee, et al (2005) pointed out that a collectivist culture, such as Chinese culture, does not protect psychiatric patients against familial stigma. The entire family takes up the shame and burden of having a mentally ill member throughout the course of the illness. In addition, they found that the powerful forces of stigma can possibly break the relationship of the inter-familial and social connections, and that, ultimately, families may abandon a member with a mental disorder. Such abandonment is especially distressing because unmarried adults are generally expected to live with their parents and siblings (Lee, et al. 2005). Hence, the family has to share the problems, and tries to resolve them by using their own resources (Ng, 1997).

2.6.4 Influences of Language

In the Chinese society, the term 'jing-shen-fen-lie-zheng' ('mind-split-disease') has been used to denote schizophrenia. Many Asian countries, where the Chinese writing system is used, adopt a similar translation. Chung and Chan (2004) initiated an investigation in China on the issue of the less pejorative name 'si-jue-shi-diao' ('dys-regulation of thought and perception') as a diagnostic label for the symptoms of schizophrenia. They found out that one indirect method for reducing the stigma is the use of politically correct labels to describe mental illness (Chung and Chan, 2004).

If a negative stereotype is associated with a label which is currently in use to describe mentally ill individuals, replacing the term with a more appropriate, less pejorative name may reduce prejudice and discrimination (Lauber and Rössler, 2007). Furthermore, there was a discussion in Japan about renaming the term 'schizophrenia', as research had revealed that the label of schizophrenia has a stigmatising effect, and the term, schizophrenia, influences a psychiatrist's decision to inform patients about their diagnosis. By changing the term to a less stigmatising one, information about schizophrenia to patients would be disclosed (Desapriya and Nobutada, 2002; Sato, 2006).

In 2002, The Japanese Society of Psychiatry and Neurology changed the term 'schizophrenia' for the disorder, 'Seishin Bunretsu Byo' ('mind-split-disease'), into a new term 'Togo Shitcho Sho' ('integration disorder'). A survey by Sato (2006), conducted seven months after the renaming, found out that the new term had replaced the old term in about 78 percent of cases, and the number of patients of informed of the diagnosis rose from 36.7 percent to 69.7 percent in three years. Simultaneously, 86 percent of psychiatrists in the area of Miyagi in Japan found the new term to be more acceptable when informing patients about the diagnosis, and that it was easier to explain the modern concept of the disorder to patients.

2.6.5 Role of somatisation

Psychological distress can be expressed through physical complaints. This is termed the 'somatisation of psychiatric disorders' and is not uncommon in Asia, including Taiwan. Since somatisation is one of the priorities of the 'first filter' challenge for professionals, putting it as a priority can assist patients to accept their mental health problems and seek appropriate care from mental health professionals (Ng, 1997). However, Ng (1997) implies that, in the process of help seeking, there may exist numerous culturally determined barriers, such as stigma. In the research, Ng (1997) highlights the fact that somatisation may also explain why mentally-ill patients primarily approach general practitioners, rather than mental health professionals, in the first place.

2.7 Problem Identification and Conclusion

The World Health Organisation (2003) highlights the fact that primary care, as well as community care programmes, are the principal elements of Mental Health Services. However, in many countries, services for people with mental disorders remain minimal and do not measure up to these principles. Community-based care is not available in 37 percent of all countries. Certain essential psychotropic drugs are not available at primary care level in almost 20 percent of countries, with a marked variability within and between countries. Approximately 70 percent of all people have access to less than one psychiatrist per 100,000 of the population (WHO, 2003). Despite a widespread recognition of the importance of national mental health policies, data collected by the WHO reveals that 40.5 percent of countries have no mental health policy, and that 30.3 percent have no programmes (WHO, 2001). According to the statistics, there were 2.65 acute psychiatric beds and 5.71 chronic psychiatric beds per 10,000 people in Taiwan in 2006 (DOH Taiwan, 2007b).

The healthcare market requires healthcare providers to supply efficient and cost-effective healthcare, while continuously assessing outcomes upon which to base continued care and any subsequent improvements. The healthcare provider now sees clients with complex health problems in ambulatory settings, and increasing numbers of chronically ill, poor, and older clients are also seen in the community. Beebe (1990) points out that the promotion of shorter hospital

stays has caused patients with serious illnesses to require continued treatment through outpatient services. Interventions provided in the outpatient setting can be an effective means of decreasing patients' stress, improving service function, and increasing understanding of coping with chronic mental illness. Thus, it also contributes to the overall cost reduction by decreasing hospitalisation rate (Beebe, 1990).

In Taiwan, there has been a trend to extend the psychiatric services from hospitals to communities since the 1970s (Yeh, 1992). The legislation of mental health law in 1990 further promoted the development of the community psychiatry service as an important health policy (Yeh, 1992). Along with the increase of practice in community psychiatry, the needs of patients and their families have also become a new focus of research (Tsui, et al. 1998). To improve the clinical service to mentally ill patients in Taiwan, a comprehensive, integrated, convenient to access, and reliable service system is essential to meet patients' needs.

In addition to providing excellent rehabilitation programmes, a successful community psychiatric rehabilitation centre should optimise the use of case management and acquire resources across various areas of operation. Since it is not possible for purely hospital-based or purely community-based rehabilitation services to completely fulfil this aim, community mental health services are not yet fully developed in Taiwan.

Due to the low availability of community mental healthcare in Taiwan, there is high impact on families. However, despite the shortage of community mental healthcare, traditional methods can serve as critical treatment, and these practices are generally provided by traditional healers or religious personnel in temples and other religious centres. Compared to modern treatments, the traditional methods of treatment may be more acceptable to certain patients and their families (Dave, 2002). In Taiwan and other parts of Asia, the problem that most old asylums are situated far from the communities and general hospitals is yet to be resolved.

When seeking to understand the under-utilisation of exiting mental health services, cultural factors within individuals and families cannot be ignored. Culture not only shapes attitudes toward help-seeking behaviour, but also influences the cognitive appraisal of psychological problems. Therefore, simply adopting western-based mental health research findings may not be appropriate for the Taiwanese context, and it is crucial to take cultural factors into account as well.

Alongside rapid socio-economic change, there is political transformation in Taiwan, and this can influence the public's perceptions and attitudes to mental illness. This chapter addresses a considerable range of topics, including an examination of traditional beliefs, regional and cultural aspects about the nature of disease, and the cause and the treatment of mental illness. Lauber and Rössler, (2007) point out that Asia is different from other parts of the world in terms of culture, and this can be viewed from two perspectives. Firstly, there may be a different cultural understanding of health and healthcare, and secondly, this could be due to the absence of integrated mental health provision in some areas.

The government's policies and plans demonstrate a very clear expression of the drive by the government to provide a whole range of services which enable patients to receive comprehensive and continuous care, in the least restrictive environment appropriate to their needs. It also demonstrates that the government has a strong commitment to provide quality care for the mentally ill in a humane way. However, even though the available research is limited, there is still a big gap between the provision and the demand of mental health services in Taiwan, and the question of what the patient thinks of the service is unanswered.

There is a lack of literature about the views of those using the service, and the 'voices' of front-line service providers, either in general health services or in the mental health service system in Taiwan. Although the "Ordinary Patients' Satisfaction Survey" is implemented in most of the Hospitals in Taiwan each year, as required by the independent body of "Taiwan Joint Commission on Hospital Accreditation", this is done in order to meet the requirement and

receive the executive hospital accreditation according to the Taiwan Quality Indicator Project (TQIP). However, these kinds of survey only ask about users' satisfaction with, and opinion of, the services provided in hospitals, categorised in the Cornwall (1996) model of participation within the consultation level of participation in the research. Therefore, this may indicate that user involvement in Taiwan is not a feature of the healthcare organisation or a priority of the government's policies. In the meantime, the "Human Rights" issue is widespread among Taiwanese society in that people should be able to express what they want and how they want it as human beings, especially when mentally ill patients are labelled as a minority group compared to the larger population. Therefore, users of mental health services in Taiwan will be invited to participate in this research project in order to inform methods of involving users in developing and evaluating mental health services in Taiwan in the future.

Chapter Three

Methodological Approaches

This study employs a design which uses mixed methods to explore the perceptions of both service users and staff of the Taiwanese Mental Health services provided in two hospitals in Taiwan. The study utilises a satisfaction survey administered to service users and in-depth interviews with service users, front-line staff and key informants with respect to policy development.

3.1 Research Questions

The aim of this research is to gain in-depth knowledge of the perspectives of service providers and users of the current Mental Health services in Taiwan. In order to meet this aim, the study will conduct in-depth interviews and a satisfaction survey instrument which has not been previously used in the Taiwanese context. The intention is to gain insights into the way in which a service user and family-centred system can be developed, and to investigate its appropriateness to the culture of Taiwan within the country's Mental Health System.

The objectives will be achieved by addressing the following research questions:

(1) How do Taiwanese Mental Health Services differ from those provided in the West from a cultural, historical and policy development point of view?

(2) What is service users' level of satisfaction with current Taiwanese Mental Health Services?

(3) Does the current service meet mental health care needs?

(4) What is Mental Health Service providers' perspective of the current service provision?

(5) What is the nature of any relationship between the data generated by means of the satisfaction survey and that generated from the in-depth interviews?

(6) What is the potential of any insights gained to form a user and family-centred service?

3.2 Methodology

The intentions of this study are complex in that they are concerned with human problems and the study utilises more than one method of data collection. This field of interest has not previously been explored from a Taiwanese perspective. The goal of social science research is to understand the complexity of human behaviour and experience (Bowling and Ebrahim, 2005). The tasks to understand, describe, and explain the reality of this complexity is limited by the methods selected by the researcher. Specific research methods enable the researcher to describe, understand, and explain the complexity of living by providing various perspectives. Creswell (2003) suggest that different methods are best designed for particular types of questions. By combining and increasing the number of research strategies used within a particular project, researchers are able to broaden the dimensions, and hence the range, of the project. By using more than one method within a research project, researchers are able to obtain a more complete picture of human behaviour and experience, and increase the scope of comprehensiveness of the study (Creswell, 2003).

The aim of this study is to elicit service users and service providers' views of Mental Health Services in Taiwan. Therefore, it is important to recognise the strengths and weaknesses of the different types of methods which can be used in this research project. The choice of a particular methodology is a fundamental decision when designing a research study to answer the research questions which have been established for the project.

Patient satisfaction is a central concern of this study, and a survey instrument is employed within it. However, Williams (1994) mentions that patients are not always satisfied with their experiences, giving rise to the need for more in-depth explorations - in the case of this study, qualitative interviews. Wensing and Elwyn (2003) contend that qualitative methods can be used to examine experiences in more depth, and Schers, et al. (2001) agree that qualitative approaches are particularly useful for exploring patients' views in areas which have not been previously studied.

3.2.1 Methodological Triangulation

Triangulation was originally used in Health and Social Sciences research by quantitative psychologists, Campbell and Fiske (1995). Methodological triangulation involves the use of more than one research method, or source of data, in the study of social phenomena. There are three rationales given for using methodological triangulation: **confirmation, "abductive inspiration" or "retroduction", and completeness** (Risjord et al, 2002).

The first, and most controversial rationale in terms of the underpinning ethos of qualitative research, is **confirmation**. In social research, data are triangulated for the purpose of confirmation in order to enhance the reliability and validity of the findings. Risjord, et al. (2002) suggest that, by using a triangulation strategy, quantitative and qualitative findings may corroborate each other, support a more robust conclusion, and strengthen the evidential support for hypotheses more than either source of data could do alone. The second rationale, called **"abductive inspiration"**, is the use of one method to generate ideas which are tested by another method, and it is very similar in meaning to the critical realist concept of **"retroduction"** (McEvoy and Richards, 2006). In other words, Risjord et al. (2002) indicate that a qualitative investigation can help to organise quantitative data which has already been gathered, or can illustrate new ways of approaching the phenomenon. This rationale bears some importance to the present study in that data arising within the satisfaction survey suggests areas to be further explored in the interviews. The final rationale for triangulation is **completeness,** McEvoy and Richards (2006) suggest that quantitative and qualitative data may be triangulated for the purpose of completeness in order to obtain complementary perspectives, and a greater level of detail than that which could be obtained by using either data source. Risjord, et al. (2002) also emphasise the fact that methods can complement each other, providing a richness or detail which would be unavailable from one method alone. This is also of interest in the present study.

Theorists agree that there are differences between qualitative research and quantitative research, but deny that these differences stand in the way of confirmation. Existing literature seems to contain two main contrasting ideas, one of which is that both methods have different strengths and weaknesses (Duffy, 1987). Qualitative research tends to focus on a small group of

participants, and for this reason, it may be difficult to generalise the conclusions, since qualitative results can only be applied to new situations when the context is taken into account. However, Risjord et al. (2002) argue that engaging triangulation with a quantitative methodology can increase the researcher's confidence that the conclusions can apply to another or a larger population. Because quantitative and qualitative methods compensate for each other's weaknesses, a combination of methods can increase the researcher's confidence in the whole study. Although the scope of the present study does claim that the findings might be generalised to a large population, it is anticipated that they will illuminate a field which is, as yet, unexplored.

A second argument proposed by theorists is that triangulation helps to eliminate bias (Duffy, 1987), since both qualitative and quantitative research is subject to bias and because the bias occurs in different ways. The use of both methods enhances the researcher's confidence that all biases have been identified. When the quantitative and qualitative results diverge, the results of one can be used to refine the questions of the other. If the results of the methods converge, then the researcher can be more confident that social desirability bias is not present (Risjord, et al. 2002). Therefore, the use of the triangulation method increases confidence in the results of this research project to a higher degree than the use of either method alone. In this study, the quantitative and qualitative data collection was not concurrent. The survey instrument was administered first, and the data collected helped to form the agenda for the in-depth interviews. Where data collection using different methods is concurrent (see figure 3-1 on the next page), the priority would be equal between the two methods but, in the practical application of collecting data with this project, priority was given to the quantitative approach, and the qualitative sample was derived as a subset of the larger quantitative sample. A concurrent strategy usually integrates the results of the two methods during the interpretation phase (Creswell, 2003), with this being planned for the present study. Creswell (2003) suggests that this interpretation can either note the convergence of the findings as a way of strengthening the knowledge claims of the study, or explain any lack of convergence which may result.

Figure 3-1: Concurrent Triangulation Strategy (Creswell, 2003)
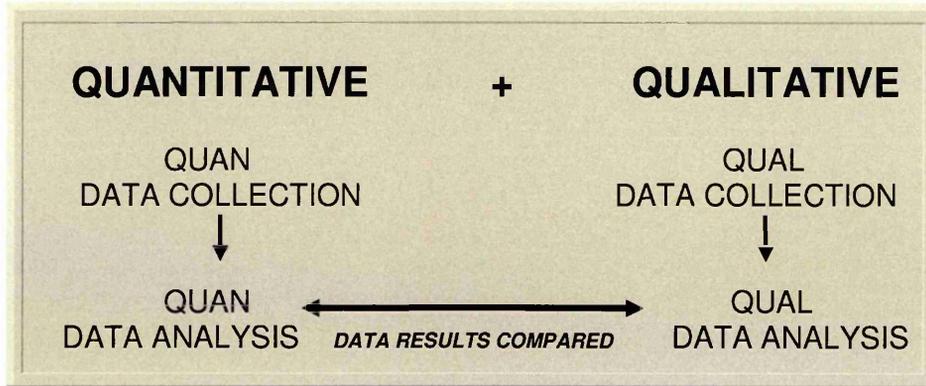
3.2.2 Methods of Measuring Patients' Views

Unlike the Taiwanese context to date, Western society recognises the importance of incorporating the views of users when developing services, and healthcare professionals use a range of methods to identify the views of patients and the general public (Wensing and Elwyn, 2003). Some examples are questionnaires to assess patients' needs before a consultation with the clinician, shared decision making, focus groups with patients to include their views in clinical guidelines, and surveys of patients to provide feedback to care providers or to the public (Wensing, 2000).

Wensing and Elwyn (2003) state that the methods used to determine patients' views can be divided into three types, namely measures of preferences, evaluations by users, and reports of health outcomes (Table 3-2 on next page).

Table 3-2: Types of measures used to determine patients' view (Adapted from Wensing and Elwyn, 2003)

	DEFINITIONS	METHODS
Preferences	**Preferences** are ideas about what should occur in healthcare systems. Preference is often used to refer to individual patients' views about their clinical treatment, and term priorities are used to describe the preferences of a population.	Qualitative methods give the greatest scope for expressing different preferences, such as individual interviews and focus groups. Quantitative methods for eliciting preferences ask individuals to rate, rank, or vote for different types of care or attributes of care providers, which include surveys and consensus methods
Evaluations	**Evaluations** are patients' reactions to their experience of health care, whether the process or outcome of their care was good or bad.	Questionnaires surveys used to ask for evaluations of health care in terms of satisfaction or dissatisfaction. Some questionnaires measure preferences and experiences and derive evaluations from the two by calculating difference or ratio scores. Qualitative approaches are particularly useful for exploring patients' views in areas that have not been previously studied and can be used to examine patients' experiences in more depth.
Reports	**Reports** represent objective observation observations of organisation or process of care by patients, regardless of their preferences or evaluations.	Reports reflect patients' observations, but they do not necessarily imply a patients' perspective on the quality of care. Patients' reports, in some situations, are the most accurate method of observation. (e.g. patient's pathway through different healthcare institutions.)

Wensing and Elwyn (2003) argue that it is an ethical and legal rule that patients should be informed and involved in their health care, at least to a minimal standard. Many patients, in Western societies at least, appear to wish to take part in the decision making process (Guadagnoli and Ward, 1998). When the research aim is to include patients in decision making, it is crucial that this is a process of involvement, rather than its outcome. For instance, Edwards et al, (2001) suggest that shared decision making can be evaluated in terms of information delivered about treatment options, checking understanding and preferences, and making shared decisions. Patient involvement can also result in better processes and outcomes of care. For example, it can make clinicians more responsive to patients' preferences, contribute to a better implementation of clinical guidelines, improve safety by engaging patients in processes, and result in better satisfaction with overall care. Patients can be seen as being co-producers of healthcare, because their decisions and behaviour influence healthcare provision and its outcomes (Wensing and Elwyn, 2003).

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Research into the area of satisfaction with mental health services has been obstructed by the widespread use of many non-standardised methods, and therefore, direct comparison between studies is usually not possible. Ruggeri (1994) suggests that most studies have used instruments that have little or no data to support their validity or reliability, and investigators have frequently designed their own instruments for specific studies. As a result, findings cannot be generalised. In addition, although satisfaction has been demonstrated to be a multi-dimensional concept (Ware et al, 1978), instruments have often been limited to a few broad items, which only measure approximately one or two dimensions of mental health care. Thus, they may not only fail to detect dissatisfaction, but are also unable to detect the reasons for such dissatisfaction.

3.2.3 Involving Users in Healthcare Service

There is a growing body of literature to describe how users of services can become involved in shaping the planning and delivery of services. Pilgrim and Waldron (1998) capture the spirit of service user involvement in research in the context of planning mental health services: ***"The aim is to take service users beyond the role of passive suppliers of opinion, to a role of active negotiators for change"***. Hanley et al. (2003) highlight the active nature of public involvement in research: "Doing research *with* or *by* the public, rather than to, about, or for the public." User involvement is often introduced into policy and practice as something which intrinsically reduces the inequality between service users and professionals. However, much of the existing research which discusses user involvement in mental health services has identified four major areas of concern (McDaid, 2009), as follows:

1. The capacity of services users to participate
2. Their lack of participation skills
3. The need for a positive organisational culture
4. The need for arenas of participation

Literature on the involvement of users identifies users' lack of competency as being a barrier to participation (Rose et al. 2004), and recommends increasing

various types of skills. Linhorst (2006) interprets this skill deficiency as being a consequence of mental illness, rather than the result of social inequality.

> *"The inability to acquire and perform skills is one manifestation of severe mental illness, and it is just as much a part of the illness as symptoms such as delusions, mania, or depressed mood"*
> (Linhorst, 2006 p.66)

Users or carers can influence health services in many ways, and Simpson and House (2003) indicate that user and carer involvement is intrinsically worthwhile. They emphasise that

> *"Improvements can be made to services as a result of involvement, leading to better relations between users or carers and staff, and perhaps increased job satisfaction among those working in the service."*
> (Simpson and House, 2003 p.89)

Therefore, user and carer involvement should be integrated within service, as well as during the process of planning and delivering a mental health service.

3.2.4 Participatory Research

Participatory research aims to bring to the forefront the life experience and implicit knowledge of participants (Macauley, et al., 1999). The participatory approach invites the participation of stakeholders in research and, in doing so, acts to recognise the role of professional power in the research process and challenges it. Participatory methods are characterised as a means of generating information to fill the gap between those who collect information for developing services, and those who are intended to benefit from those services (Macauley, et al., 1999). Moreover, Macauley, et al. (1999) indicate that participatory research is about creating a balance between developing valid generalisable knowledge which benefits the community being studied, and improves research protocols by incorporating the knowledge of community members. Participatory research is gaining increasing importance as a research strategy in health, and it is also being increasingly recognised that professionals need to draw on a broad evidence base in order to make informed and effective decisions (Keen, 1995).

Participatory research is often mistakenly characterised as being a particular methodological approach favouring qualitative techniques. However, Truman (1999) argues that it is equally possible to conduct quantitative research within the participatory paradigm. The underlying principles behind qualitative research are based on, and emphasise, research participants and researchers collaborating as equals, by sharing power in the decision making, and by drawing upon each others' respective knowledge and insights (De Koning and Martin, 1996). Whilst the underlying principles of participation can provide clear benefits to healthcare evidence and evaluation, the reality of user participation with the health service provision is less straightforward. Dullea and Mullender (1999) suggest that the merits of any individual participatory research study should be judged on the levels of participation achieved.

As an alternative to linear models of participation, Cornwall (1996) proposes a more complex model of participation (see Table 3-3 below).

Table 3-3: Models of participation, Source Adapted from Cornwall (1996, p.96)

Co-option	Token; representatives are chosen, but no real action	On
Compliance	Tasks are assigned, with incentives; researchers decide agenda and direct the process	For
Consultation	Users' opinions asked, researchers analyse and decide on a course of action	For/with
Cooperation	Users work together with researchers to determine priorities; responsibility remains with researchers for directing the process	With
Co-learning	Users and researchers share their knowledge to create new understanding and work together to form action plans with researcher facilitation	With/by
Collective active	Users set their own agenda and mobilize to carry it out, in the absence of outside researchers or facilitators	By

Cornwall's model describes different modes of user involvement, and explores ways in which the researcher relationship influences the types of knowledge created. The model demonstrates how research involves the kinds of levels of participation of users, but that the levels of participation vary within different contexts.

Cornwall's' stage of 'consultation' (Cornwall, 1996: p. 96) best reflects the nature of service user participation in this study. Cornwall describes 'consultation' as people participating by being consulted or by answering questions. External agents (researcher) define problems and information-gathering processes, and therefore control analysis. Such a consultative process does not concede any share in decision-making, and professionals are under no obligation to take on board people's views. In this study users were taken to ask open questions and gather information from the participants as they saw fit to disclose. However in keeping with Cornwall's definition, the analysis was entirely the researcher's responsibility.

In summary, participatory research can provide an important means by which users can be involved in the creation of evidence. However, the nature of participation is both contextual and contingent (Truman and Raine, 2001). Truman and Raine (2001) also suggest that, to understand participation in research, it is necessary to move beyond assessment of how much user participation has taken place, and rather explore the opportunities and constraints for user participation within the given research context.

3.2.5 Patient Satisfaction Research

Patient satisfaction is an important variable in the evaluation of psychiatric services, which complements the measurement of other outcome variables, and it is suggested that satisfaction is strongly linked to the effectiveness of the care provided. In contrast, dissatisfaction is frequently the reason why patients decide to discontinue psychiatric care (Ware et al, 1978). Simultaneously, there is also some criticism of satisfaction surveys, particularly in mental health research, and this will be discussed later in this section.

● Use of Patient Satisfaction Surveys

Satisfaction surveys are subjective and patient-orientated measures, and are used by services to provide information about service outcomes (e.g. bed usage, hospitalisation costs) of mental health service users and providers. They are often locally developed idiosyncratic tools (with minimal relevance to the quality

of clinical care), with inadequate regard paid to their methodological accuracy, especially their validity and reliability (Sitzia, 1999). Consequently, although apparently sensitive to local agendas, they have limited generalisability, and no meaningful comparative inter-site and inter-services analyses (Powell et al. 2004).

Patients' satisfaction with the care they receive in hospital has risen at the same time as growing concern about the future development of healthcare services in many countries. A survey of more than 80,000 inpatients in 169 trusts in England, which was undertaken by the NHS watchdog body, the Healthcare Commission in 2006, found that 92% of the respondents rated their care as excellent, very good, or good. The previous year (in 2005) this percentage was 90% (Cole, 2006). Nearly four out of five patients (79%) said they were always treated with dignity and respect. However, this survey also highlighted continuing concerns among patients about the cleanliness of wards, poor communication, and lack of information on discharge (Cole, 2006). Patient satisfaction surveys often report remarkably high levels of contentment or satisfaction with health services. However, Cohen et al (1996) suggest that the choice of wording may be one possible reason for underestimating patients' dissatisfaction with certain elements of the service. Therefore, they suggest a cross calibration of satisfaction surveys as a method of improving the reliability of the results. Gavin et al (1996) also recommend that patients should help to decide the wording and design of questionnaires. While it is important to make questionnaires easily understandable, it should be patients who determine the dimensions used to assess the quality of service, rather than research staff or those who provide the service.

Whilst the service user's voice is being encouraged in multiple forums in the Western world, particularly in satisfaction research (especially using survey methods), it is primarily heard as a commentary on the services provided. Broadly speaking, the service user satisfaction survey has emerged as the method of choice when accessing the views of a relatively large number of people about the provision of health and social care services. Fitzpatrick (1991) outlines three reasons why health professionals should take service user satisfaction seriously, the first of which is that it is an important outcome

measure, often predicting users' concordance with their treatment, and improvements in their state of health. Secondly, it is an increasingly useful assessment of consultation and communication (e.g. success at giving information), and thirdly, it can be used to select alternative methods of service provision (e.g. arrangements for out-of-hours care). Additionally, satisfaction surveys can provide a rich source of local feedback on service user development, including moral, political and clinical issues, which many professionals ignore (Fitzpatrick, 1991).

Rea (1999) outlines a "*double-barrelled rationale*" for the continuation of service user satisfaction research. On the one hand, the requirement of basic needs service planning demands sensitivity to the users' perspective, so that local population assessments of service satisfaction can be fed into the quality assurance audit loop. On the other hand, government emphasis on service users' evaluation will be required as much as an assessment of local services' ability to maintain community and clinical services. As a result, community-based services can only achieve this goal if they are responsive to service users' views, not only in terms of their needs, but also in the ability of the services to fulfil them in ways which are acceptable, as well as effective. Satisfaction research can help to identify those areas of service delivery which require improvement (Powell et al. 2004).

• Critique of Satisfaction Surveys

Satisfaction surveys often take the form of self-administered questionnaires, which, in general, have the advantage of being more easily standardised and economical, in that they can be efficiently administered to a large population. However, Peat et al. (2002) also indicate that the response rate to self-administered questionnaires may be low, and the use of these types of questionnaire does not provide an opportunity to clarify the responses. There are some primary criticisms of satisfaction surveys in mental health research, one of which is that, after years of disempowerment, service users tend not be readily critical of the services they receive. Powell et al., (2004) suggest that this is compounded by the fear that future service access will be jeopardised by expressing dissatisfaction, and the suspicion that nothing will change as a

consequence of complaining. However, Powell, et al. (2004) argue that, while satisfaction surveys appear not to be the optimum method of obtaining user views, their limitations do not indicate that their value should be totally negated. That accepted, methodological concerns still exist regarding the use of satisfaction surveys as a measure of healthcare quality. As Richards suggests, if mental health services are to be shaped by users' views, then *"methodologically sound ways of obtaining their views and encouraging people to come forward and present them are needed"* (Richards,1999, p.277)

Even where proven and sound ways of eliciting views are implemented, satisfaction ratings are regularly very high (the so-called *halo effect*) with minimal variability, which makes meaningful analysis problematic (Elbeck and Fecteau, 1990). Moreover, these high ratings are often contradicted by more critical evaluations when service users are enabled to explore their experiences in more depth.

Lebow (1983) proposes that response rates are notoriously low, which means that non-response bias is a significant problem, and this is especially the case when asking people with severe and enduring mental health problems, to use self-completion questionnaires. Without a representative sample by which to generalise survey findings, one of the risks which may bias future services is the significant differences among populations of service users (e.g. those most satisfied with the service are unlikely to be critical of it).It has also been argued that satisfaction scales are modelled on biomedical psychiatry's measuring instruments, which objectify satisfaction as a *'thing'* and ignore the complexity of users' subjective appreciation of services (Crawford and Kessel, 1999).

The extent of service change brought about by satisfaction surveys compared with other means of eliciting users' views has been questioned. The UK Coronary Heart Disease Collaborative claim that intensive interviews with patients and carers create far more valuable ideas for service change than traditional patient satisfaction surveys (Mahoney, 2003). A recent systematic review reported that there is evidence to support the notion that involving patients has contributed to changes in the provision of services across a range

of different settings. However, the effects on the use of services, quality of care, satisfaction, or health of patients, are not known (Crawford et al., 2002). Finally, Powell et al (2004) claim that, given the limitations of the resulting data, the cost effectiveness of undertaking a satisfaction survey at the expense of service provision is not only questionable, but also ethically suspect.

Typically these surveys show minimal regard to the complex, multi-dimensional theoretical construct of satisfaction which has cognitive expectations and an affective evaluation component. Therefore, Powell et al (2004) emphasise that whether one is 'satisfied' with a service depends as much on one's personal expectation of that service as it does upon one's direct experience of it. However, it has to be acknowledged that the vast majority of research measuring patients' satisfaction uses a patient satisfaction scale. Only a few researchers have developed a conceptual framework of service quality and patient satisfaction. Raftopoulos, et al (2002) argue that the measurement of patient satisfaction lacks conceptual accuracy, since it reflects dimensions considered important by researchers and not by respondents. In fact, it can be argued that it only measures what researchers consider as being the quality of care.

Perhaps the most consistent predictor of satisfaction is the patient's age, with older people being far more overtly satisfied with healthcare than younger people (Raftopoulos, 2005). This can be attributed to the notion that elderly patients give socially favourable answers, and are not willing to challenge professional authority. It is, therefore, difficult to distinguish between a true correlation and the fact that the density of the problem relates to the importance of the service provided.

While acknowledging the limitation of satisfaction surveys, their use is seen as having some value nevertheless, and this research project combines a satisfaction survey with qualitative interviews in order to obtain more in-depth information of users' and providers' experience from participants in Taiwan.

3.3 Study Methods

In order to address the research aim and objectives, multiple methods were used to gain a greater understanding of a particular phenomenon, and this can be seen from a number of different perspectives. This research project was conducted in three main phases (Figure 3-4).

Phase one was the early exploratory stage of related literature, reviewing and identifying issues in developing the research concept via discussions with Taiwanese mental health professionals. These discussions confirmed the relevance of the main research questions, which formed the basis of the interview guides used in the qualitative interviews, and the fundamental element of searching for a suitable survey questionnaire.

Phase two was the stage of preparation of the survey and interview instruments. This process tested the validity and reliability of a survey questionnaire which aimed to measure patients' satisfaction with the mental health service via pilot work, and developed a topic guide for in-depth interviews.

Phase three was the main study stage, which integrated both the quantitative survey and qualitative interview methods which determined and interpreted the findings of this project.
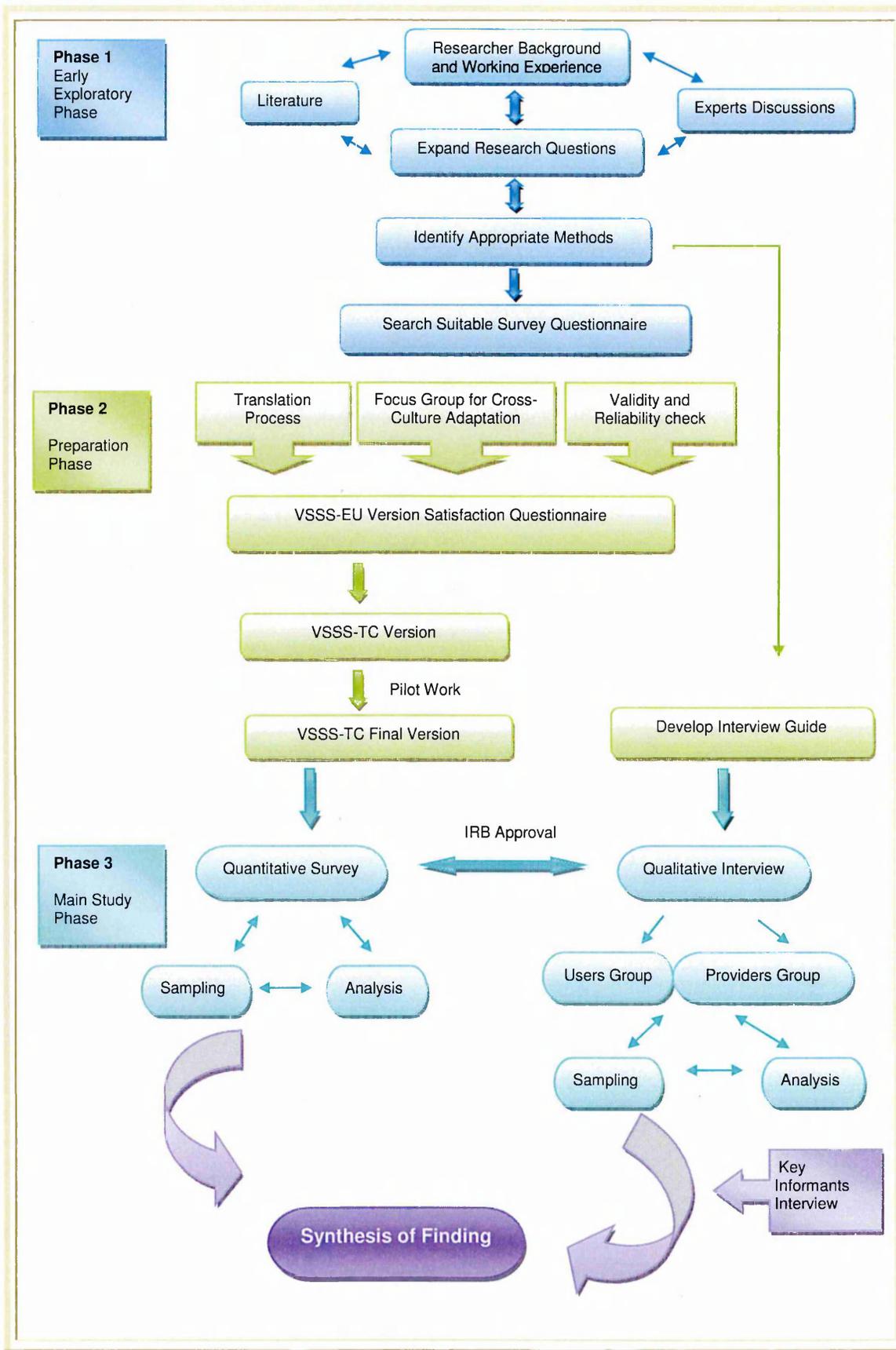
Figure 3-4: Overview of the three phases of the research project.

3.3.1 Quantitative Method: Questionnaire Survey Design

Most healthcare research studies use questionnaires to collect social demographic characteristics, previous and current illness symptoms and treatments and the exposure of particular subjects. A questionnaire has the advantage over other measurement tools in that it is simple and cheap to administer, and can be used to collect information about past, as well as present, phenomena (Peat, et al., 2002).

• Instrument Selection

To identify a suitable and existing measure of patient satisfaction in this research, it was essential to search for a users' satisfaction questionnaire. The terms: "Patient Satisfaction scale", "Mental Health Service measurement" , "Service Satisfaction scale" were used. The databases searched related to the subjects of Health/Social Care (CINAHL, MEDLINE, ASSIA, Health Source: Nursing, National Library for Health, PubMed, Web of Science, ScienceDirect).

Eleven validated survey questionnaires designed to measure mental health service satisfaction were identified. These were then sorted using pre determined criteria namely suitable setting, questionnaire length, extent of previous usage in healthcare research, and cultural context. The identified questionnaires include the Client Satisfaction Questionnaire (CSQ-8 and -18 versions) (Williams, et al., 1998), Hospital Care Questionnaire (Hendriks, et al., 2004), Satisfaction Scales (Brannan, et al., 1996), Satisfaction Data (Greenberg and Rosenheck, 2004), Patient Satisfaction Scale (PSS) (Bjorngaard, et al., 2007), Medical Interview Satisfaction Scale (MISS-21) (Meakin and Weinman, 2002), Munich Patient Satisfaction Scale (MPSS-24) (Moller-Leimkuhler, et al, 2002), Inpatient treatment Survey-Patient Version (ITS-P) (Hackman, et al., 2007), Inpatient Evaluation of Service Questionnaire (IESQ) (Meehan, et al., 2002), Patient's Perspective on Information Questionnaire (PPIQ) (Perreault, et al., 2006), and Verona Service Satisfaction Scale (VSSS) (Ruggeri, et al., 2000). Each questionnaire or scale is described in the table 3-5 below with the concept of the research to which they were applied.

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Table 3-5: Compare objectives and contents of different satisfaction questionnaires.

Name of the instrument	objectives	contents
Client Satisfaction Questionnaire (CSQ-8 and CSQ-18 versions)	This is a structured interview guide with closed-end questions that are used to ask about mental health service users' experience of receiving the services.	Covers three conceptual dimensions: **(1)** service modality and organization (7 items on the functioning of the clinic and mental health resources available in their region), **(2)** difficulties for which patients were consulting (three items), and **(3)** information on treatment (eight items on psychosocial treatment and medication).
Hospital Care Questionnaire, Satisfaction Scales	This scale is a self-administered 55-items version of scale used to assess overall satisfaction with hospital care.	covering 12 aspects of care: **(1)** admission procedures (3 items), **(2)** nursing care (5 items), **(3)** medical care (5 items), **(4)** other disciplines (3 items), **(5)** information (6 items), **(6)** patient autonomy (2 items), **(7)** emotional support (2 items), **(8)** hotel care (6 items), **(9)** recreation facilities (3 items), **(10)** miscellaneous aspects (5 items, e.g., rules and regulations), **(11)** ease of access to the hospital (4 items), and **(12)** discharge and aftercare (4 items).
Satisfaction Scales	This scale is a self-report questionnaire and used to measure satisfaction with children's mental health services.	Cover nine separate modules. Each module focuses on a different type of service: **(1)** intake and assessment, **(2)** outpatient therapy, **(3)** inpatient hospital/residential treatment centre, **(4)** case management, **(5)** day treatment, **(6)** therapeutic group home, **(7)** therapeutic family home, **(8)** after-school services, and **(9)** in-home counselling.
Satisfaction Data	This scale is address satisfaction with general health service delivery.	Containing 71 questions used to create nine subscales **(1)** co-ordination of care, **(2)** sharing of information, **(3)** timeliness and accessibility, **(4)** courtesy of staff, **(5)** emotional support, **(6)** attention to patient preferences, **(7)** family involvement, **(8)** transition to outpatient status, and **(9)** overall quality of care.
Patient Satisfaction Scale (PSS)	This questionnaire is a multilevel scale and was designed to provide information on several aspects of care in collaboration with the user organization,	Contains six items representing different aspects of patient satisfaction with the therapeutic relationship: **(1)** sufficient time for

	Mental Health Norway for testing patient satisfaction in the community mental health centres.	contact/dialogue, **(2)** clinicians' ability to listen and understand, **(3)** follow-up of planned interventions, **(4)** respect for patient's view/opinions, **(5)** cooperation among clinicians, and **(6)** influence on treatment.
Medical Interview Satisfaction Scale (MISS-21)	It is a modified questionnaire from Medical Interview Satisfaction Scale (MISS-29), which was developed in the USA to assess patient satisfaction with individual doctor-patient consultations. It has been used in studies of a British general practice population for assessment of patient satisfaction with individual consultations.	This questionnaire was produced with four subscales: **(1)** communication comfort, **(2)** distress relief, **(3)** compliance intent, and **(4)** report.
Munich Patient Satisfaction Scale (MPSS-24)	The initial version of MPSS was developed with the aim to have a comprehensive instrument of patient satisfaction that assesses general as well as differentiated aspects of in-patient treatment which are potentially relevant for treatment satisfaction from the patients' viewpoint.	Covering the following domains: **(1)** professionals skills and behaviour, **(2)** information and communication, **(3)** psychopharmacological therapy, **(4)** other therapeutic services, **(5)** autonomy of the patient, **(6)** relatives' involvement, **(7)** characteristics of the ward, and **(8)** overall evaluations. Followed with reduction to 99-items version then 72- items version, and the last version is a 24-items MPSS version of high internal consistency and reliability questionnaire.
Inpatient treatment Survey-Patient Version (ITS-P)	It is used to determine satisfaction with in-patient care and consumer perspective on several aspects of care process.	Contains 16 items with five categories of **(1)** medication, **(2)** illness management, **(3)** substance use, **(4)** the importance of outpatient care, and **(5)** living skills. The questions are related to how much effort the staff made in teaching patients about 16 different problem areas and this questionnaire also contains a series of questions about whether the relatives participated in care and had contact with the treatment team.
Inpatient Evaluation of Service Questionnaire (IESQ)	This scale was designed to gain understanding of the factors underpinning patient satisfaction in the inpatient setting.	This 20 scaled items containing three key dimensions, including: **(1)** social domain, which incorporates staff-patient relations, and a technical domain which includes **(2)** satisfaction with environment, and **(3)** satisfaction with treatment. In addition to the 20 scaled items, the IESQ comprises two open-ended

		questions in order to elicit comments on aspects of the hospital stay, which can allow for identification of particular aspects not covered by the scaled items.
Patient's Perspective on Information Questionnaire (PPIQ)	In the first subscales (importance), is to assess patients' perspectives on the importance of different components of information received in psychiatric outpatient services. In the second subscale (satisfaction), is in order to evaluate satisfaction with information received on psychiatric outpatient services.	This scale is an 18 items scale covering three aspects of measuring outpatient psychiatric services, which includes: **(1)** information on service modality and organization, **(2)** information on difficulties for which patients were consulting, and **(3)** information on treatment.
Verona Service Satisfaction Scale (VSSS)	It is a setting-specific, validated multidimensional scale for measuring patients' satisfaction of mental health services. It has been used in a growing number of studies performed in many countries in the world. The detail of VSSS is illustrated in the next section.	Cover seven dimensions: **(1)** overall satisfaction, **(2)** professionals' skill and behaviour, **(3)** information, **(4)** access, **(5)** efficacy, **(6)** types of intervention, and **(7)** relatives' involvement.

The above instruments were selected from fifteen questionnaires related to measuring patients' satisfaction: CSQ-8 or CSQ-18 was designed for interviewing patients with experience; the Hospital Care Questionnaire Satisfaction Scale and Satisfaction Data were designed to assess overall satisfaction with general hospital care, and therefore, they are not suitable for psychiatric care; Satisfaction Scale was used to measure satisfaction with children's mental health service, and is not suitable for adult patients; PSS, MISS-21, and MPSS-24 were similar questionnaires which were designed to examine therapeutic-patient relationships, and are not suitable to test overall satisfaction and different aspects of patients' satisfaction with psychiatric care; ITS-P and IESQ were designed only to measure the satisfaction with inpatient care. However, PPIQ was devised for assessing patients' perspectives of receiving outpatient psychiatric services.

To meet the aims as being the optimum measure for this research project, the Verona Service Satisfaction Scale (VSSS) was selected. The VSSS is a validated questionnaire intended to measure satisfaction with mental health services. Some of the key factors detailed in the next section led the researcher

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to choose the VSSS for this survey, and these make it an appropriate instrument for testing patients' satisfaction with Mental Health services in Taiwan.

• Verona Service Satisfaction Scale (VSSS)

The Verona Service Satisfaction Scale (VSSS) (Ruggeri and Dall'Agnola, 1993) is a questionnaire intended to measure patients' satisfaction with mental health services. It is a setting-specific, validated, multi-dimensional scale. After identifying that VSSS as the most suitable questionnaire to meet the aims and objectives of the this study, the researcher obtained authorisation from Professor Ruggeri to use the VSSS-EU in English version (See Appendix I for the permission letter to use VSSS questionnaire in this study and Appendix II for the detail of developing the original VSSS. Also to see Appendix III for the original English Version of VSSS-EU questionnaire).

The European version of the Verona Service Satisfaction Scale (VSSS-EU) was specifically developed for the EPSILON Study of Schizophrenia, a comparative, cross-national, cross-section study of the characteristics, need for care and quality of life, caregiver burden, patterns of care, associated costs, and satisfaction levels of people with schizophrenia in five European countries. The VSSS-EU is a reliable instrument for use in comparative cross-national research projects, as well as in routine clinical practice in mental health services across Europe (Ruggeri et al., 2000). The VSSS-EU has been developed from the Italian VSSS-54 patient version, and it has been produced in five European languages (Danish, Dutch, English, Italian, and Spanish). The process of conversion did not merely follow the traditional procedure (translation and back-translation), but used a focus group methodology to culturally adapt the concepts underlying the instrument. This process was mirrored in the Japanese context by a Japanese researchers' group during the translation of the instrument (Knudsen et al., 2000).

The VSSS-EU is designed for self-administration, and it can be completed without prior training. Questionnaire administration takes 20-30 minutes. In the

questionnaire, subjects are asked to express their overall feeling about their experience of the mental health service they have been receiving.

in the last dacade, the VSSS has been used to assess outcome in the perspective of the patients in several settings and intervention studies (Ruggeri et al.,2006a). Therefor, the VSSS has proved to be a senstive and useful tool that identifies strengths and weeknesses of service provision in many different settings. Here are the key factors of VSSS-EU being selected for the optimum measure for this project, which are summarised below:

- It is a mental health setting-specific instrument which can be easily used in all mental health clinical settings
- It is a validated multi-dimensional scale for measuring patients' satisfaction with mental health services
- It has been developed and improved over two decades, and has been used internationally, being translated into various languages, including Japanese, which indicates that the instrument is suitable for use in a Asian context
- It covers a wide range of services provision in the scale
- It is designed to be self-administered questionnaire and can be completed without prior training

● **Verona Service Satisfaction Scale-EU Questionnaire Translation**

Mental health measurement instruments and psychological tests are usually developed and tested for content, validity and reliability in one country or language exclusively. Some of these instruments are then used in different language and cultural settings, but often without attention being given to the necessary cross-national and cross-cultural adaptation. This section therefore are: (a) describes the process of transferring VSSS-EU satisfaction survey instruments from the English language and culture to the Chinese Traditional language and Taiwanese culture; (b) describes the strategies identified from European Psychiatric Services: Inputs Linked to Outcome Domains and Needs (EPSILON) Study for the translation and cross-cultural adaptation and then used to develop a Traditional Chinese Version of the VSSS (VSSS-TC)

questionnaire; and (c) describes the impact the applied methods had on the development of the instrument.

Sartorious and Kuyken (1994) identify four alternative approaches to the translation of instruments from a source to a target language, depending on the degree of conceptual overlap between the source and the target culture: (a) an ethnocentric approach with a 100% conceptual overlap between source and target culture; (b) a pragmatic approach with considerable conceptual overlap (for example in a European context); (c) an emic plus etic approach: some degree of conceptual overlap (An "etic" is an item with a shared meaning and equivalence across cultures and an "emic" is an item of relevance to some subset of the cultures under study); and (d) Translation impossible: no conceptual overlap.

The cultural sensitivity issue is significant when using measurement to assess the satisfaction with services. Cultures differ with respect to expectations of feedback about public and private services. In some countries where 'consumerism' is firmly established, frank verbal or written feedback may be freely given. However, is a generally known phenomenon that direct negative feedback in Chinese cultures is considered to be impolite, and complaints may only be shared with intimate peers or family. Therefore, direct and challenging questions also may be culturally inappropriate in the Chinese context. Methods of requesting patient feedback must take into account prevailing cultural norms, and seek to ensure the use of appropriate methods to assess patients' beliefs and opinions.

Measures validated in one culture may not be appropriate in others, and a simple translation of questionnaire items does not guarantee that they will have the same meaning across cultures. Sartorius and Kuyken (1994) indicate that the aim of translation is to maintain, as far as possible, the semantics of the linguistics, as well as the conceptual, and the technical equivalence between the versions of the instruments in the source and target languages. They go on to explain that 'semantic equivalence' means retaining a similar meaning to that intended by the source, as well as the target version. 'Conceptual equivalence', which refers to the need to obtain an identical meaning for concepts which may

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have different cultural understandings between the source and the target culture. Finally, 'technical equivalence' refers to both the technical features of the language, and their relationship to the socio-cultural context. The three translation elements and culture-related equivalences are key issues in the proper translation of instruments.

In consideration of the conceptual overlap between English and Chinese, the emic plus etic approach was used to translate the instrument from the source to the target language in this research. The English Version of VSSS-EU had to be translated into Traditional Chinese to conduct the survey in Taiwan, and the following method was utilised. A protocol developed by the EPSILON Study Group for the translation and cultural adaptation of the outcome measured instruments was adopted. The procedure for each step in the translation process is shown below (Knudsen, et al., 2000). Also, see Table 3-6 for the complete timetable of the VSSS-TC translation procedures for this project.

Two focus groups took place during the translation process in compliance with the protocol developed by the EPSILON study group. The participants in this 'Focus Group' in the translation process should include mental health service providers, such as psychiatrists, nurses, psychologists, and social workers, according to the protocol developed for the translation and cross-cultural adaptation of the instrument used in the EPSILON study group (Knudsen et al., 2000). However, it was not possible to find such professionals from Taiwan who were studying or working in the UK. As a result, translation process of the VSSS questionnaire to suit the Taiwanese cultural translation was adapted from the original protocol, and the main task for the participants in the focus group was translation wording, cultural adaptation, and clarifying the meaning of concepts in the questionnaire from the public point of view. The translation processes used are detailed below:

(A) Translations from the English version (which was provided by Professor Ruggeri) into the Traditional Chinese were made by a translator whose first language is Traditional Chinese and the second, English:

This process was undertaken by myself. And having received written authorisation from Professor Ruggeri, the researcher then translated the English Version of VSSS-EU into Traditional Chinese Version (first version of VSSS-TC).

(B) A focus group discussed the first translation (constituency shown below). This led to a revision of the translation and a list of disputed translation items:

The first small-scale focus group met to discuss language and culture-related issues in the first version of the questionnaire translation. Members were two Taiwanese students who were resident and studying in the UK. Due to the location distance between the three of us (the researcher, and the two participants), the focus group was held via an Online Conference System. The issues pertaining to the linguistic and cultural influence were discussed, and subsequently, a revised (second) version of the VSSS-TC was produced.

(C) The translated instrument was then back-translated into English by a different translator to the researcher, whose native language was English, and whose second language was Traditional Chinese, the target language:

Finding a translator to do the back translation process was difficult, since most translators whose second language was Mandarin, could understand the spoken Chinese language and written documents in Simplified Chinese, but not written documents in Traditional Chinese (In Taiwan, the official *Spoken Language* is Mandarin. However, the official *Written Word* is Traditional Chinese). However a suitable translator was found among the student body of a local university, enabling the back-translation process to be undertaken by a professional translator who both spoke Mandarin and could understand documents written in Traditional Chinese.

(D) The back-translation was compared with the original English version, and this led to another revision of the translation and a list of disputed items to be considered in a further focus group:

Having received the back-translation version of VSSS, the researcher examined the list of disputed items to be raised in the next Focus Group. There were some items in the back-translation version which carried slightly different meanings or wording compared to the original VSSS-EU. Therefore, this led to another revision (third Chinese version) of VSSS-TC for discussion the translation and cultural issues by the Focus Group.

(E) The third version was discussed between the researcher and focus group members. Inappropriate and impossible items and sentences were revised, which led to the final version of the questionnaire before piloting:

The Focus Group was held on the 28th of June 2006. The second Focus Group included eight members who are Taiwanese students and studying a postgraduate course in Sheffield Hallam University or University of Sheffield in different subjects, which included the researcher as a moderator (group leader), a Master's Student who was studying translation, and the remainder were Master's students in Sheffield Hallam University. The Focus Group activities consisted of three main tasks: (1) discussing the translation adequacy and cultural adaptation process between the last two revisions (Second and Third) of VSSS-TC, the original VSSS-EU, and the back-translation version, including the problems raised during the translation process; (2) discussing the applicability of the VSSS-TC instrument; and (3) the concepts of the construct (please see Appendix II for more detail).

Table 3-6: Summary of the VSSS-TC Questionnaire Translation Process

PROCEDURES	COMPLETED DATES
(a) Translated into Traditional Chinese	25/March/2006
(b) First Focus Group discussed the first translation (revision of the translation)	31/May/2006
(c) Looked for a translator to do the back-translation work	05/June/2006
(d) Back-translated into English by translator, who is an undergraduate student studying East Asian Studies in Sheffield University	12/June/2006
(e) Back translation compared with the original version (another revision of translation)	17/June/2006
(f) 2 hour Focus Group (Constituted of eight postgraduate students) to discuss the topics including: translation adequacy, instrument applicability, and the concepts of the constructs	28/June/2006

This results in a Traditional Chinese Version of VSSS （VSSS-TC）which was converted for this project from English into Traditional Chinese by accurate translation and back-translation process into Chinese. Then, cross-cultural applicability using a Focus Group was checked, and finally, an assessment was made in the next section of the validity and reliability of the instrument.

• Verona Service Satisfaction Scale-TC Questionnaire Validity

Validity refers to the degree to which the research reflects the concept the researcher is attempting to measure. In other words, validity is an assessment of whether or not an instrument measures what it aims to measure (Bowling and Ebrahim, 2005).

Face and content validity tests of the Chinese version of the VSSS were implemented through a pilot study. Face validity is concerned with how a measure or procedure appears. It refers to the researcher's subjective assessment of the presentation and relevance of the questionnaire (Bowling and Ebrahim, 2005). In addition, because face validity pertains to how respondents and other users of the test perceive it, it should be judged by them rather than by experts in the field (Stereiner and Norman, 2003). The question which needs to be addressed in terms of face validity is: do the questions appear to be relevant, reasonable, unambiguous and clear? However, content validity refers to judging the extent to which the content of the instrument appears to logically examine, and comprehensively include, all aspects of what it sets out to measure (Bowling and Ebrahim, 2005). Streiner and Norman (2003) states that a measure which includes a representative sample of the target behaviour lends itself to more accurate inferences with data.

To test content validity, the VSSS-TC was distributed together with details of the research project at the beginning of the data collection period via e-mail to five psychiatric professionals, who had worked in the Mental Health field for more than five years in Taiwan. Participants included a Psychiatric Attending Physician, two Senior Social Workers, a Senior Nurse, and a Psychiatric Head Nurse. Having gathered the suggestions and opinions as detailed in table 3-7

from the five experts, some of alterations were made according to recommendations, and the final version of the Verona Service Satisfaction Scale Traditional Chinese Version of questionnaire was generated to use in the pilot study of this project (suggestions from the five experts are shown below in table 3-7). Apart from some of the suggestions which related to the original VSSS-EU design for measuring patients' perspective of mental health services, such as the direction of the five-point Likert scale, which remained in their original form, the others were adjusted according to the recommendations.

Table 3-7: Five professional suggestions for testing the VSSS-TC content validity

1. Some of the terms should be changed to meet the situation in Taiwan.
2. Too many questions look similar, such as asking same related questions about behaviour, manner of different staff.
3. Q1 should add "overall" to make it clear.
4. The wording of Q10, 14, 18, 28, and 39 needs to be changed.
5. Q54 wording should be changed to be suitable for patients in Taiwan.
6. Should not only mention "Negative opinion", but also "Positive opinion" in Patient Information Sheet.
7. Suggest changing the wording from "Do you feel..." to "I feel ...., I think...".
8. Suggest changing option 3 from "No idea" to "Mixed feeling".
9. Wording of Q15 should be changed to "during the night time or weekend" in order to have the same meaning of the original VSSS's term of "after hours".
10. Feel a bit confused about the use of the term, "the recipient of psychiatric services", need to make it clear for patients to understand.
11. In Taiwan, the role of Psychologist and Clinician in Mental Health Services are easily confused by patients. Therefore, this needs to be clarified in the questionnaire.
12. Is it necessary to present the 5-point Likert scale with alternate directionality?
13. Some medical terminology has still been used in the questions.

● **The Verona Service Satisfaction Scale-TC Question Items**

After the process of translation and the focus group for cross-cultural adaptation, the final 70 items of the questionnaire were structured as follows:

- 49 items in part one regarding satisfaction with separate assessment for psychiatrist/ paychologists and social workers/ nurses performances and general service satisfaction questions .

- 14 items in part two regarding the question around service intervention

- 7 demographic items, four of which have been found in the literature to influence satisfaction (age, gender, number of admissions, length of time using the service), and three others (marital status, current occupation, educational level) (please see Appendix IX for more detail)

At the end of the questionnaire, an additional and optional question was added about the willingness of the respondent to participate in an in-depth interview.

Items 1 to 40 (of 49 items) are based upon the assumption that the patient has a close caring relative, who is often in contact with the service, or that the patient is cared for by a multidisciplinary team. These items are also assessed separately in terms of the performance of psychiatrist/psychologists and social workers/nurses. If any of these items were not applicable, the researcher assisting the VSSS-TC administration wrote "N.A." against them.

The purpose of items 41 to 54 is to identify the types of intervention which are not provided by the locations where patients are being treated, and also to consider the corresponding inapplicable items in order to avoid patients' misunderstanding. The manual of using VSSS as an instrument to evaluate mental health service suggests that researchers should be cautious when deleting items, because from this point of view, the VSSS can provide interesting information about the under-provision of care also could invalidate the questionnaire (Ruggeri, et al. 2003).

• Pilot Work in Taiwan

A pilot study is a small version of the definitive study, and it is conducted before the actual investigation is undertaken in order to inform, refine or modify the research tools. New questionnaires do not emerge fully-validated; they have to be created or adapted. In fact, every aspect of a survey has to be tested at the pilot study stage to make sure that it works as planned for the individual research purpose (Oppenheim, 1992). However, sometimes questionnaires can be borrowed or adapted from other research, the task remains of ensure that this will work with the target population and will yield the requisite data (Oppenheim,1992).

Pilot studies are useful for a number of reasons, which include determining the adequacy of the sampling frame, assessing non-response rates, evaluating the suitability and effectiveness of the selected data collection method, and establishing the adequacy of the questions. Oppenheim (1992) claims that

piloting can help researchers, not only with the wording of questions, but also with procedural matters such as the design of a letter of introduction or covering letter, the order of question sequences, and the reduction of non-response rates. Researchers should also realise from the beginning that pilot work is expensive and time-consuming, but that avoiding or skimping on pilot work is likely to prove even more costly (Oppenheim, 1992).

The pilot study of the Chinese Version of the VSSS-TC validity and usability of this project was conducted after receiving the IRB approval from Suburban Specialised Psychiatric Centre (SSPC) (Please see Appendix VI and Appendix VII for the certificate of IRB approval). A convenience sample was used for the pilot, which consisted of patients who were enrolled through the out-patient clinic at SSPC in a psychiatric attending physician's clinic over a period of two visits. With the patient's consent, the researcher stayed in the room with the psychiatrist while the patients (with or without their families) discussed their treatment with the doctor. At the end of the session the doctor asked them if they might be willing to participate in this study. If so, the participants were taken to a separate room away from the clinic and given oral information about the study, and their written consent was obtained. They were also asked to give oral feedback to the researcher regarding the completion of the questionnaire to test its face validity and reliability.

This method, of utilising a doctor to recruit patients, for the pilot test and also for the main data collection period within the setting of out-patient clinic at Psychiatric centre enabled obtaining as many returned completed questionnaires as possible. Although this is not a orthodox and acceptable way of collecting data within the UK regulation context, it is acceptable and commonly used in Taiwan contexts. As a doctor is seen as an authorative figure in Chinese culture, a greater result will be achieved if patients are asked by a doctor, rather than any other professional staff, to participate in the study.

● **Pilot Work for Testing Face Validity**
A total of 15 participants took part in the pilot study. The average time taken for completing the questionnaire was 17 minutes (less than the average 20-30

minutes quoted in the VSSS-EU manual of questionnaire administration). However, this may have been because of the relative high functionality of patients in the out-patient clinic. Following the pilot, the participants provided feedback on experience of completion, and subsequent modifications were made to the VSSS-TC, as shown below in table 3-8 in order to reduce the risk of confusion. Minor modifications were also made to the wording of some of the questions, which led to the final version of the VSSS-TC, which was used for the main survey.

Table 3-8: Modifications made to the VSSS-TC according to patients' suggestions

SUGGESTIONS FROM PATIENTS	MODIFICATIONS TO THE VSSS-TC
1. Some of the questions look similar to me.	1. Stressed different details of the question to patient when completing questionnaire.
2. Not very clear about how to complete the second part of the questionnaire.	2. Changed the layout of second part of the questionnaire to make it easier to follow.
3. Not too sure about sub-question number 7 in the second part of the questionnaire (Q41-Q54). Does it mean "Don't know" or "Not Sure".	3. Changed the second part of the questionnaire (sub-question number 7) to "Not Sure", to make it clear for participants.
4. Some of the terms used in the questions are not very clear to me because they are specialised terms.	4. Changed those specialised terms to more understandable words.
5. I have been using the service for a long time, and have been to other hospitals before. I am not sure if I need to rank service satisfaction in the past or present.	5. Stressed the term "the satisfaction level within the past year" to patients in the beginning of the section.

3.3.2 Survey Data Collection

This survey was conducted in two hospitals in one of the majory city in Taiwan, between the data collecting period of the 17th of January to 26th of April, 2007:

(A) Urban General Hospital Psychiatric Unit (UGHPU): Including the day care Centre and the out-patients clinic.

(B) Suburban Specialised Psychiatric Centre (SSPC): Including the out-patients clinic, two acute wards, two in-patient rehabilitation wards, day care centre, two half-way house residential services, and out-patients clinic.

In order to collect data from various psychiatric settings, those two hospitals in Taiwan were chosen. The characteristics of the Two hospitals will stated in Chapter four.

● **Administration of the Verona Service Satisfaction Scale-TC**

The VSSS-TC is designed for self-administration and can be completed without prior training. In cases of cognitive deficit, mental symptoms obstruction, and low level of literacy, the researcher assisted the patients by reading through the items with them. Special care were taken to guarantee confidentiality and anonymity and, in the case of assisted administration, to stress the independence of the researcher from the clinical team. The questionnaire administration took an average of 20-30 minutes, depending on the condition of the participant.

● **Survey sampling**

The ideal way of sampling is by a random selection of a target population, as in probability sampling. However, the reality of this project means that this is not possible. The oppoosite of probability sampling is *non-probability sampling*, and simply means sampling without using random selection methods.

Therefore, an non-proportional sampling method was used for the survey data collection. Quota sampling of the non-probability method is equivalent to stratified sampling. Like stratified sampling, the researcher first identifies the strata and their proportions as they are represented in the population. Non probability sampling is an sampling method where some elements of the population have no chance of selection. It involves the selection of elements based on assumptions regarding the population of interest, which forms the criteria for selection. Then convenience, or judgment, sampling is used to select the required number of subjects from each stratum (Kinnear and Gray, 2008).

This differs from stratified sampling, where the strata are filled by random sampling. Since this research aimed to explore the perception of users of Mental Health Services, it was necessary to avoid false results that might be obtained from participants with severe psychopathology. Consequently, non-proportional Quota sampling was applied with several conditions, which included *'used the services for more than 1 year'*, *'will be able to understand the questions'*, and *'without any severe psychopathology obstruction'* being implemented in the sampling method.

Hence, because the selection of elements is non-random, non-probability sampling does not allow the estimation of sampling errors. These conditions place limits on how much information a sample can provide about the population. Information about the relationship between sample and population is limited, making it difficult to extrapolate from the sample to the population (Kish, 1995).

The initial sampling strategy was purposive, aiming to include various types of wards and sections of the Psychiatric Department, whilst simultaneously generating different users' experiences, and their likelihood of expressing their views of the services. However, the practical way of collecting the survey sample in an unfamiliar environment was for the researcher to approach the patients through a member of the staff (nurse practitioners or a psychiatrist in the wards). It was recognised that there were a number of significant benefits in asking nurse practitioners and/or psychiatrists to search the lists for suitable participants for the researcher to approach them to ask if they were willing to participate, as the staff were able to target those known to be eligible for inclusion. The researcher advised participants that the study was independent of the hospital and would not affect their treatment.

A total of 210 mental health service users (patients who had used the mental health services for more than one year) were identified, who were willing to participate in the quantitative part of the study during the period of data collection (17th January-26th April, 2007). Table (3-9) indicates the numbers of returns obtained of survey questionnaires for the two hospitals in Taiwan.

Table 3-9: Detail of data collection places

Collecting place	No. of patient available on average during visiting	returned Questionnaire	valid Questionnaire	No. of visit by researcher
UGHPU Day Care	44	30	25	3
UGHPU OPD	20-30	33	32	11
UGHPU total		*63*	*57*	
SSPC (Acute ward a)	33	14	12	3
SSPC (Acute ward b)	33	4	4	1
SSPC Day Care	160	25	24	2
SSPC (Rehab ward a)	31	6	6	1
SSPC (Rehab ward b)	45	33	31	2
SSPC (Half-Way Home a)	34	15	14	1
SSPC (Half-Wat Home b)	31	24	23	2
SSPC OPD	20-40	46	39	6
SSPC total		*167*	*153*	
TOTAL		**230**	**210**	

* UGHPU: Urban General Hospital Psychiatric Unit
  SSPC: Suburban Specialised Psychiatric Centre

Table 3-9 shows the number of patients in the wards who participated for the questionnaire survey, and the returned and valid questionnaires. During the period of collection, the main influences of the ratio of returned questionnaire was reflected in the level of help given by healthcare professionals. I received a great deal of help and assistance from staff, who encouraged patients to participate in this survey in the day care centre in Urban General Hospital Psychiatric Unit, and Rehabilation ward b with Half-Way Home b in Suburban Specialised Psychiatric Centre. Thus, the rate of return was over 80% of the number of patients in those wards with the assistance of the staff from those units, which had an advantage effects on the data obtained. The staff from those wards told me that, because some of them were studying for a Master's degree in Taiwan, they understood how difficult it was to collect data in an unfamiliar environment.

3.3.3 Qualitative Method: Interview Design

Qualitative research is distinct from quantitative research. Qualitative research of this paradigm is orientated to understanding human nature, and as such, the researchers get close to the research subjects. This research method has major strengths, since by using it, it is possible to understand how healthcare can really affect an individual. It can provide vital information about attitudes and satisfaction, and this type of information can then be used to improve healthcare (Bassett, 2004).

An important way of collecting data for qualitative research is in-depth interviews. Kvale (1996) describes how anthropologists and sociologists have long used informal interviews to obtain information from their informants. Sociologists and psychologists have talked with subjects in order to obtain background knowledge for conducting quantitative questionnaire studies and laboratory experiments. However, in recent decades, qualitative interviews have been increasingly employed as a research method in their own right, with an accompaying expanding methodological literature and theoretical development on how to conduct this form of research vigorously.

Using qualitative interviews as a research method involves a challenge to renew and enrich the conceptions of knowledge and research in the social sciences (Kvale, 1996). The qualitative research interview is not a new method added to the existing quantitative field of methods, producing qualitative texts rather than quantitative data, but it reflects alternative conceptions of the subject matter of social science. Kvale (1996) emphasises the fact that qualitative research involves alternative concepts of social knowledge, of meaning, reality, and truth in social science research, because the basic subject matter is no longer objective data to be quantified, but meaningful relationships to be interpreted.

Interviewing is the most widely used method of data collection in qualitative research in Healthcare. This is party because interview data can be analysed in a variety of ways, which means that interviewing is a method of data collection which is compatible with several aims of data analysis. Another reason claimed by Willig (2008) for the popularity of interviews is that they are somewhat easier to arrange than other forms of qualitative data collection.

There is a growing interest in the qualitative method of interviews as an alternative to standardised interviews, which are well-established as a research technique. Murphy and Dingwall (2003) emphasise the fact that, judging from the contents of health study journals, qualitative interviews seem to be synonymous with qualitative research and in this research design are part of a triangulation method. This made it possible to obtain complementary perspectives and a greater level of detail than could be obtained from using the satisfaction survey alone (Crosby, et al., 2006). To achieve the aim of this study, and also in order to answer research questions stated in the beginning of this Chapter, in-depth interview technique were considered the optimum method to obtain insights of individual participants' perspectives.

Qualitative interviews aim to fully cover the topic being discussed, explore what people say in as much detail as possible, and uncover new areas or ideas which were not anticipated at the outset of the research. Qualitative interviews attempt to be interactive and sensitive to the language and concepts used by the interviewees, and also attempt to achieve a flexible agenda. Britten (2000) claims that qualitative interview studies address different questions than those addressed by quantitative research. Therefore, it is important that interviewers confirm their understanding of respondents' meanings as opposed to drawing on their own assumptions.

Patton (1987) indicates that good questions qualitative interviews are open-ended, neutral, sensitive and clear to the interviewees. He lists six types of questions which may be asked: those based on behaviour or experience, on opinion or value, on feelings, on knowledge, on sensory experience, and those asking about demographic or background detail (see Table 3-10).

Table 3-10: Types of Questions for Qualitative Interview (Patton, 1987: p118, 119)

►BEHAVIOUR OR EXPERIENCE
►OPINION OR BELIEF
►FEELINGS
►KNOWLEDGE
►SENSORY
►BACKGROUND OR DEMOGRAPHIC

Interviewing requires careful preparation and planning. Therefore, the researcher needs to think about who is to be interviewed and why, how to recruit participants, how to record and transcribe the interview, what style of interviewing to use, and what kind of information will obtained from participants. The seven stages of interview method suggests by Kvale (1996) were implemented though-out the process.

● Seven Stages of Interview Research

Kvale (1996) suggests that the course of an interview investigation goes through seven stages, from the original idea to the final report. These include *thematic plan, design, interview, transcription, analysis, verification, and report.* In order to provide some structure to an open and flexible interview study, Kvale (1996) emphasises a linear progression through the seven stages of an interview inquiry. Each step of the qualitative part of this research project is briefly examined below, with some key issues which had to be taken into consideration:

1. Thematic Plan

The purpose of the investigation and the concept of the topic were formulated before the interview procedure began. This contained three key questions, as follows:

- Why?: clarifying the purpose of the study, which is to understand the different perceptions of mental health services in Taiwan.
- What?: obtaining pre-knowledge of users' satisfaction with the mental health services and all related subjects via a review of the literature and a discussion with professionals.
- How?: acquiring knowledge of different techniques of interviewing and analysis, in particular the use of in-depth interviews with a topic guide, followed by using a thematic analysis to interpret the data.

2. Design

This consisted of the overall planning and preparation of the methodical procedures for obtaining the required knowledge. I took all of the seven stages into consideration before beginning the in-depth interview procedure. Additionaly descrbed by Kvale (1996) the moral implications of the study, such as ethical issues during the data collection period had to be addressed. This included following the regulations to apply for Ethical Approval from the IRB (Institutional Review Board) team in Taiwan.

3. Interviews

At this stage I took the consideration of the sample size for conducting qualitative interviews, bearing in mind with the limitation of cost and time. The interviews were based on the three different interview topic guides prepared (for service users, carers, and the other for service providers), and the interview data were the raw material for the later process of thematic analysis. Therefore, the quality of the original interview was considered as being decisive for the quality of the analysis, verification, and reporting of the interviews.

4. Transcription

This was the stage of preparing the interview raw material for analysis. All interviews were recorded using a digital recorder, and then transcribed. Transcriptions of all of the interview data made the interview conversations accessible for analysis by taping the oral interview interaction, transcribing the tapes into written Chinese text, and then analysing the interviews.

5. Analysis

At this stage, Thematic Analysis (Boyatzis, 1998) was selected as being the most appropriate method of analysis of interviews data. The analysis involved organising the interview texts, condensing the meanings into forms which could be presented in a relatively short space, and working out the implicit meanings of what was said in the interview. Therefore, extensive and critical interpretation

of the meaning of the interview statements was essential for the analysis of the interview data.

6. Verification

Verification of knowledge is commonly discussed in social sciences in relation to the concepts of reliability, validity, and generalisability. Validity means whether or not an interview study investigates what is intended to be investigated (Kvale, 1996). At this stage, the main emphasis was on the validation of the interview data, by seeking assistance with understanding the data, and verifying the practical issues of the analysis. A third study supervisor, Dr. Ning Tang, whose first language is Chinese, was available during the period of the analysis to check the validity of the interview data, and she also assisted with locating a professional translator to translate the quotes from Traditional Chinese into English.

7. Report

Reporting involves communicating the methods applied in accordance with the scientific and research criteria and the findings of the study. It is not only re-presenting the views of the interviewees, but is accompanied by the researcher's perceptions in the form of interpretation. It is also important to take the ethical aspects of the investigation into consideration when writing an interview report, such as the confidentiality of interviewees.

• In-depth Interviews

In-depth interviews tend to be relatively long in duration, and commonly involve one-on-one, face-to-face interactions between an interviewer and an informant, with the aim of building the kind of intimacy which is common to mutual self-disclosure (Johnson, 2001). In-depth interviews also tend to involve a greater expression of the interviewer's self than do some other types of interview, as well as a personal commitment on the part of participants which spans several interview segments.

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As the name implies, in-depth interviews seek "deep" information and understanding, and Johnson (2001) indicates that there are four meanings to the word "deep". Firstly, deep understandings are held by real-life participants during everyday activity, events, or locations. The interview seeks to achieve the same deep level of knowledge and understanding as the participants, which means to check and explore whether or not the understanding of one participant is shared by the others. Secondly, deep understanding goes beyond superficial explanations and others' understanding of culture, activities, events and places. It begins with commonsense perceptions, explanations, and understanding of some lived cultural experience, and aims to explore the contextual boundaries of that experience, to uncover what is usually hidden from ordinary view to produce a more reflective understanding. Thirdly, deep understanding can reveal how the researcher understands common assumptions, practices, and ways of talking, and fourthly, deep understanding allows the researchers to grasp and clearly express the multiple views of perspectives on, and meanings of, some activity, event, place or cultural object.

In-depth interviews have certain advantages over survey research in terms of individual experiences. For example, a survey might produce data concerning the number and demographic characteristics of people with a chronic illness and also about population perspectives, but it tells us little about the experience of individual living with chronic illness or the kinds of services people believe to be the most appropriate to meet their needs as they perceive them. Therefore, I considered that the best way to gain access to the experience of health and illness from people who are already disempowered by their illness is the in-depth interview method. Corbin and Morse (2003) clearly outline the advantages of in-depth interviews, and a summary is shown below:

- They are cost-effective ways to collect a great deal of rich data within a short time frame.
- They are useful when exploring complex research areas that the researcher knows little about.
- They can address 'how' and 'why' questions from the participants' perspective, and allows researchers to explore and to interpret that information regarding how participants give meaning to their experiences.

- They are flexible, and allow the researcher to follow the lead of the interviewee in terms of how they construct particular phenomena, and then explore emergent themes, and thus, gain new insights.
- They allow the researcher the opportunity to seek ongoing informed consent.
- They can enable the exploration of health and illness, both from the perspective of the health professional and the research perspective.
- They give informants more power during the interview to propose what they want to discuss.

• Creating the Topic Guide for In-Depth Interviews

The goal of an interview is to deeply explore the respondent's points of view, feelings and perspectives, and in this sense, in-depth interviews yield information. However, an interview guide is an essential tool for conducting semi-structured format of in-depth interviews in order to guide the interview and ensure that all aspects are covered. An interview guide indicates the topics which need to be covered in the interview, and it contains an outline of the topics to be addressed, with suggested questions. Although the interview contains pre-planned questions to ask the interviewee, the researcher must allow the questions to flow naturally, based on information provided by the respondent, as suggested by Kvale (1996). Most qualitative interviewers will have a list of core questions which define the areas to be covered, based on the objectives of the study. Unlike quantitative interviews, which are based on highly structured questionnaires, the order in which the questions are asked will vary, as will the questions designed to probe the interviewees' meanings (Patton, 1987).

Kvale (1996) suggests that each question in the interview guide can be evaluated in terms of both a thematic and dynamic dimension. Thematic is defined as the relevance of the question to the research theme, and dynamic is defined as the interpersonal relationship with the interview. A good interview question should provide thematics for knowledge construction, and dynamics to promote a good interview interaction. Therefore, both thematic and dynamic dimensions were taken into account by researcher to design three topic guides

for the interviews, with the aim of allowing interviewees to talk feely, while still obtaining rich interview data.

However, the popularity of interviews as a method of data collection has given rise to debate. Potter and Hepburn (2005) draw attention to the fact that much qualitative analysis of interview-generated data pays no attention to the many contextual features of the interview material, and instead takes such data at 'face-value'. Therefore, it is important to reflect on the meaning and experience of the interview for both the interviewer and the interviewee, and to take care not to assume that the interviewees' words are simple and direct reflections of their thoughts and feelings (Willig, 2008)

In keeping with the aims and the objectives of this research design, three versions of the in-depth interview guide were designed, two for mental health services users, including one for patients and one for carers, and another for mental health services providers, namely professional staff. The interview guides were created from the working experience of the researcher and suggestions made during discussions with experts, as well as by taking the Client Satisfaction Questionnaire (CSQ-8) (Williams, et al., 1998) as resources, and suggestions for designing interview questions indicated in Kvale's book entitled InterViews (1996). (See Appendix IV for CSQ-8 and Appensix V for the three versions of the Interview Guide, namely Services Users', Carer's, and Providers').

3.3.4 Interview Data Collection

Qualitative interviewing is based around conversation (Kvale, 1996), with an emphasis on the researcher asking questions and listening, and the respondents answering. Warren (2001) indicates that the purpose of most qualitative interviewing is to derive interpretations, not facts or laws, from respondents' talk. Interviews were therefore used to explore and describe the issues in the exprience of mental health service process from the perspective of participants.

In qualitative research, exploring the range and nature of views experience is important. Because of resource constraints it is more practical to purposively sample respondents to capture qualitative data. Respondents are chosen because they have particular features or characteristics which will enable detailed exploration of this research objectives. A non-probability sampling technique was used to identify respondents for qualitative interview. One of the examples of non-probability sampling is 'Purposive sampling' (Warren, 2001), which is when the researcher chooses the sample based on who he or she believes to be appropriate for the study. This is primarily used when there is a limited number of people who have expertise or volunteer in the area being researched. However, the consequence is that an unknown portion of the population is excluded (e.g., those who did not volunteer).

The survey respondents were asked to indicate in the questionnaire whether or not they would be willing to participate in an individual interview, and if so, they were advised to leave a contact number so that I could contact them to explain the in-depth interview, and answer their questions about the interview process, and ask them if they would like to participate. At the time of sampling the interview cases, the eligibility of each potential participant was then re-checked with the hospital staff (nurse practitioners or psychiatrist), and a location was arranged for the interview of the patient or carer. A date and time convenient to the patient or carer was also scheduled for the interview.

Carers' viewpoints are frequently different from those held by health professionals (Campbell et al., 2004). Furthermore, Cleary, et al. (2005) claim that carers' and consumers' perspectives of consumers' needs may be dissimilar, which can make the collaborative development of care plans particularly challenging. Therefore, it was essential to obtain carers' perceptions of the mental health services in Taiwan at the same time.

A total of nine respondents were selected, including seven patients and two carers (the patients and carers were not necessarily related to each other). The condition of the mental health of selected interviewees was taken into consideration, including informing them about the topic to be discussed, and

asking them to speak clearly, etc. According to the aim and objectives of this research, in order to obtain the opinions, not only of the mental health service users, but also of service providers, a total of six interviewees were selected from the psychiatric department in the hospital and community mental health service, who were willing to participate in an individual interview. A doctor, nurse, social worker, psychologist, occupational therapist, and occupational workshop manager were selected from each category. All of the interviews were recorded using a digital recorder, and then transcribed by the researcher.

In terms of the sampling issue in qualitative research, Rubinstein (1994) contends that there are no hard and fast rules about sampling numbers. Because, in fact, the adequacy of the sample size in qualitative research is linked to the unfolding conceptual consistency of the data and the thematic pattern saturation. It is difficult to know beforehand how many informants will be needed to learn about a particular subject matter, and sufficiency is suggested by saturation of the data.

● **Conducting the Interviews**

Kvale (1996) proposes that an "Interview Guide" indicates the topics and their sequence in the interview. The guide can include some rough topics to be covered, or it can be a detailed and planned process of carefully worded questions. The topic guide of a loosely-structured, in-depth type of interview will contain an outline of topics needing to be covered, with some suggested questions (Kvale, 1996). Three sets of Interview Guides were conducted before the interview, for the services users, carers and for the service providers (see Appendix V for details of Interview Guide).

Having identified each service user interviewees, I made a list in order to ascertain with each of ward manager (Head Nurse or Doctor) which of them would be able to understand the questions and express their feelings, after which I contacted those who were appropriate via telephone or in person to arrange a one hour interview session. When I initially communicated with them, I explained the purpose of the research, and gave them some rough idea of

what the interview was about. I then gave them some time to make sure that they were willing to participate in the research.

A total of 15 semi structured interviews (Topic Guide for depth interview) were scheduled, in order to gain their perspectives through narrative and the formation of the participants' stories. All of the in-depth interviews began with small talk to help the interviewee relax and then informed consent, using a **Participant Information Sheet** was obtained with a form for the interviewee to sign. The Consent Form included information such as the interviewer's name, contact details, the project aims, allowing the interview to be audio taped, allowing the participant to withdraw from the study without giving any reason, confirming that all of the data would be kept by the researcher only, etc. This was followed by simple questions, intended to 'get the ball rolling', and not move so quickly into the issues of the key interview questions, as Johnson (2001) suggests.

• Interview Data Analysis -Thematic Analysis

A thematic analysis is a foundational method for qualitative analysis. This is a process which is used with qualitative information. It is not another qualitative method, but a process which can be used with most of these. Holloway and Todres (2003) identify 'thematising meanings' as one of a few shared generic skills of qualitative analysis. Therefore, it is not a specific method, but a tool to use within different methods.

One of benefits of a thematic analysis is its flexibility, and its compatibility with both essentially independent theories and construction paradigms within research (Braun and Clarke, 2006). Given the advantages of the flexibility of thematic analysis, Braun and Clarke (2006) stress that it is important for researchers to be clear about not trying to limit this flexibility. However, although thematic analysis is already widely used, there is no clear agreement about what it is and how it should be done. Braun and Clarke (2006) argue that it can be seen as being a very poorly "branded" method. In other words, it does not exist as a "named" analysis in the same way that other methods do (e.g. narrative analysis, grounded theory).

A thematic analysis is a process for encoding qualitative information when the encoding requires an explicit "code". This may be a list of themes, a complex model with themes, indicators, and qualifications which are causally related, or something in between these two forms (Boyatzis, 1998). Boyatzis (1998) also indicates that a theme is a pattern found in information where a minimum number of facts describes and organises possible observations, and a maximum number of facts interprets certain aspects of the phenomenon. Coffey and Atkinson (1996) propose that *"Coding can be thought about as a way of relating our data to our ideas about these data" (pp. 27)*. They emphasise the fact that coding provides many benefits to an organisation in terms of processing and analysing qualitative information. However, in short, coding is the process of defining what the data are all about (Charmaz, 1995).

Thematic analysis aims to identify themes within the data, and it is more inductive than a content analysis. Ezzy (2002) argues that, since the categories into which the themes will be sorted are not decided prior to coding the data, these categories are "induced" from the data. The use of thematic analysis involves three distinct stages, as follows:

Stage I: is deciding on sampling and design issues

Stage II: is developing themes and codes

Stage III: is validating and using the codes (Boyatzis, 1998)

Within these three stages, there are different ways to develop thematic codes. However, for this research project, Data-driven code development was used in analysing the interview data. Data-driven codes are constructed inductively from raw information, as they appear in the words and syntax of the raw information. It is suggested that the task of the researcher is to interpret the meaning after obtaining the findings, and to construct a theory after discovering the results. Boyatzis (1998) suggests that the results are more highly reliable because a data-driven code is highly sensitive to the context of the raw information. This increases with the use of a data-driven approach rather than a theory-driven approach. The process of developing a code inductively with a data-driven code mode step by step is shown below.

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Stage I : Sampling and Design Issues

The steps in developing a code inductively using thematic analysis require criteria-referenced material. The material to be coded must represent a sub-sample of two or more specific samples used in the research. In this study, the raw information collected from those two sub-samples is the basis for developing the code. With a data-driven, inductive approach to thematic analysis, the first stage not only involves sampling and designing the study, but also requires the selection of sub-samples (Boyatzis, 1998).

The theoretical meaning of the criteria variables and criteria sampling will determine the likelihood of developing a code which can be validated in future studies. Selecting an appropriate criterion selection and sampling will determine the quality of the coding, and subsequently, the quality of the findings. The criterion of this research design was to describe satisfaction with the mental health service provision in two hospitals, both from the perspective of the service providers and the service users. Therefore, this divide would be the criterion variable, and would result in forming two criterion groups, namely service users, carers, and service providers.

Stage II: Developing Themes and a Code

There are five steps involved in inductively developing a code:

- **Step 1: Reducing the Raw Information**
  Read and listen to the raw material for each sample to be analysed. Paraphrase or summarise each piece of data and information, then create outline items for each transcript. The in-depth review of the material for each sub-sample should provide close familiarity with the raw information.

- **Step 2: Identifying Themes within Samples**
  Compare all of the summaries to determine the similarities between the pieces of information within each sub-sample separately, looking for similarities or patterns, and then repeat this process for the other sub-samples.

- **Step 3: Comparing Themes across Sub-samples**

  Compare the themes which can be identified as "similar within each group". The aim of doing this is to reduce the raw information into smaller "packets", which will contain most of the energy of the raw information and be more manageable than the complete raw material.

- **Step 4: Creating a Code**

  Construct a set of statements which differentiate the two sub-samples, and then return to the raw information and re-read the material while attempting to determine the presence or absence of each of the preliminary themes. It is important to keep the objective or research phenomenon in focus, since this is essential in forming a theme and converting it into a code (Boyatzis, 1998).

Stage III: Validating and Using the Code

Using the code or coding development process involves two steps, as follows:

- **Step 1: Coding the Rest of the Raw Information**

  Apply a reliable code to the entire sample.

- **Step 2: Validating the Code Statistically or Qualitatively**
- The validation of the entire sample is a cross-check. This step is intended to compute the statistical significance of the coded raw information to determine the type of validity sought.

Boyatzis (1998) emphasises that a good thematic code is one which captures the qualitative richness of the phenomenon. A good code will also have the maximum probability of producing high inter-rate reliability and validity. Therefore, a good thematic code should have five elements, as follows:

(1) A label (or a name)

(2) A definition of what the theme concerns

(3) A description of how to know when the theme occurs

(4) A description of any qualifications or exclusions to the identification of the theme

(5) Examples, both positive and negative, to eliminate possible confusion when looking for the theme

The qualitative interview data results are presented in Chapter five with suggestions from above to make the theme clearer and more understandable.

3.4 Ethical Implications of this Study

3.4.1 Ethical Issues

The primary ethical issue concerns *"how to protect the specific individuals who have assisted him or her in the research, as individuals"* (Johnson, 2001 p.116). There is one traditional ethical principle which needs to be respected, and researchers must do whatever is necessary *"to protect the research subjects"* (Johnson, 2001 p.116). There are several different ways in which what is required of the researcher, can be interpreted. For example, Johnson (2001) claims that one interpretation of this ethical principle is that the researcher would be obliged to take whatever steps are necessary to protect the individuals who have co-operated in the research from any misuse of the information they shared in the interview. To protect participants' details, it is common practice for researchers to themselves code interview records and keep them securely in a different location from where the research was conducted. Johnson (2001) points out that in-depth interviewing commonly elicits highly personal information about specific individuals, which can include participants' personal feelings and reflections, as well as their perceptions of others. It also may include expressions of private knowledge about some setting or public service issues. Therefore, collecting this kind of information raises some specific ethical issues.

Another issue concerning the protection of research informants is that researchers should avoid causing harm to the reputation or social standing of their informants' in terms of their profession, occupation, community, or relationships. Johnson (2001) states that predicting future consequences of this kind is highly problematic, and it is extremely difficult to assess the risk of harm with any certainty. Gubrium and Holstein (1995) point out that another issue

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which relates to the protection of informants is whether or not a research report will play a role in "de-privatising" their lived experience. The risk of this is also very difficult to assess, and so it is reasonable to expect different individuals to reach different judgments.

Having taken all of the ethical issues into consideration, the *"Ethical Guidelines for research with human beings"*, set by the British Psychological Society (BPS, 2006) in the UK, are summarised in Table 3-11. These were followed during the data collection to the end of this research. The BPS guidelines are regulations, and they from part of the Code of Conduct to which all professional personnel should adhere.

Table 3-11: Ethical guidelines for research with human beings. Source: Adapted form British Psychological Society (2006).

Ethical guidelines for research with human beings
1. Investigators must always consider ethical implications and psychological consequences for research participants.
2. Investigators should inform participants of the objectives of the research and gain their informed consent.
3. Withholding information or misleading participants is unacceptable, and intentional deception should be avoided.
4. Participants must be fully debriefed, so they can complete their understanding of the nature of the research.
5. Investigators must emphasise the subject's right to withdraw from participation at any time.
6. All data obtained must be treated as confidential unless otherwise agreed in advance.
7. Investigators must protect participants from physical and mental harm during or arising from the investigations.
8. Studies based on observation must respect the privacy and psychological well-being of the people studied.
9. Investigators must exercise care in giving advice on psychological problems.
10. Investigators share responsibility for ethical treatment, and should encourage others to rethink their ideas if necessary.

Key ethical principles were applied to all aspects of this study. The patients' consent was required for participation, in the first instance to perform an audit of their computerised records, and in the second, to include data obtained from the returned patient satisfaction survey, and thirdly for the in-depth interview by

signing a consent form. Patients were assured that confidentiality and anonymity would be maintained throughout the study. Since the survey data and the interview transcript data for this research were stored on a computer, secure data management was required. This was achieved by the use of anonymous coding, which was applied to the sample before typing to the computer. All printouts and questionnaires were kept secure throughout the study in a locked cupboard. However, there is no standard procedure at the Sheffield Hallam University regarding the time period of keeping data. Having discussed this with the university ethics committee, it was agreed that the data should be safely stored for at least 10 years.

3.4.2 Applying for Ethical Approval from the Local Institutional Review Board

In Taiwan, the study protocols must be reviewed and approved by an IRB (Institutional Review Board), to ensure the protection of human research subjects, before the patients are recruited. The appropriate and independent operation of IRB is a critical issue for the effective protection of human subjects, and ethics committees have become a global feature of health research over the past 40 years. The 1975 version of the *Declaration of Helsinki* first suggested that ethics committees be created to review proposed research (Edwards et al., 2004). Today, all of the international guidelines relating to health research advocate an ethical review, and ethics committees are an almost worldwide phenomenon (Hyder et al., 2004).

From 1996 onwards, The Department of Health, Executive Yuan in Taiwan announced a wide range of clinical standards related to ethical issues in clinical research, and guidelines were adopted from ICH E6 Guidance for Industry (E6 Good Clinical Practice: Consolidated Guidance, 1996). However, on the 12th of November 2002, The Department of Health in Taiwan announced further guidelines for the Operation of Independent Ethics Committees within organisations (JIRB, 2006). These guidelines stated that Independent Ethics Committees (IEC) should be independent bodies (review boards or committees) which are composed of medical professionals and non-medical members, whose responsibility it is to ensure the protection of the rights, safety and well-

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being of human subjects involved in a trial and other research, and to provide public assurance of that protection. The function of the committee is the review and approval of trial or research protocols, to determine the suitability of the investigator, facilities, and the appropriateness of methods and material to be used in obtaining an informed consent document of the research (JIRB, 2006).

In order to carry out data collection process of this research project within the two hospitals in Taiwan, it was essential to apply for IRB approvial from both hospitals. An Institution Review Board (IRB) was established at both Urban General Hospital and Suburban Specialised Psychiatric Centre in 2005. The regulations require the ethical approval of undertaking individual research projects in hospitals by an Independent Ethics Committee. However, this process took a long time (Table 3-12 and 3-13 shows the process of applying for IRB Approval in two hospitals).

Table 3-12: Process of application to the IRB committee in Urban General Hospital

DATES	PROCESS
20/05/2006	Contacted the Education and Research Department, and received information regarding an application to implement the research project in the hospital
27/08/2006	Application was submitted to the IRB
24/10/2006	Attended and presented at the first IRB meeting
20/11/2006	Received the comments of the first meeting from the IRB committee
01/12/2006	Attended and presented at the second IRB meeting
29/12/2006	Received the comments of the second meeting from the IRB committee, and submitted modified contents according to comments (been labelled as a "Fast Verification Process")
08/01/2007	Received the confirmation of IRB approval via E-mail
15/01/2007	Received the formal approval document giving by the IRB
17/01/2007	Data Collection officially started

Table 3-13: Process of application to the IRB committee in Suburban Specialised Psychiatric Centre

DATES	PROCESS
20/05/2006	Contacted the Education and Research Department, and received information regarding how to apply for permission to implement the research project in the hospital
09/10/2006	Application was submitted to the IRB, labelled as "Fast Verification Application"
04/11/2006	Received comments from two of the IRB committee members
09/11/2006	Modified the contents according to the comments and submitted to the IRB committee
13/12/2006	Received the confirmation of IRB approval via E-mail
15/12/2006 & 20/12/2006	Pilot study sample collected in Out-Patient Clinic
20/12/2006	Received the formal approval document giving by the IRB
17/01/2007	Date Collection officially started

In line with the suggestions from the process of applying for IRB approval, a list of comments and the modifications being made are shown below in table 3-14.

Table 3-14: List of comments from both IRB committees

URBAN GENERAL HOSPITAL	
IRB committee's comments	Modifications
1. No indication of the diagnosis of the patient will be included in this project.	1. The condition of the patient who will be included in this project is indicated in the consent form and application document.
2. Ensure that every patient who is willing to participate in the survey is authorised to do so by their Doctor.	2. Cases from the out-patient clinic will be assigned by the Doctor, and those from the Day Care Centre will be assigned by the Head Nurse.
3. Need to find a Co-Host researcher who works in the psychiatric department to be included in the application.	3. The Co-Host of the research project was arranged, who was the Head Nurse of the Day care unite, and the details formally added into the application and consent form.
4. Need to delete any words shown on the consent form or in the questionnaire which may affect patients' emotions during the survey.	4. Words which may affect patients' emotions were deleted from the consent form were amended. * (see note)
5. Be clear about all of the procedure	5. Clearly indicate the process of

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when approaching a patient.	approaching a participant in the application.
6. Need to adjust some wording within the questionnaire, and indicate the average time needed to complete it in the consent form.	6. Questionnaire wording was adjusted to meet the requirement, and the average time (20 minutes) needed to complete it was added to the consent form.
7. Need to provide a gift for users and providers who participate in this survey and interview.	7. Gifts for the participants who completed the questionnaire and the interviewees were prepared (please see photos in Appendix IX).

SUBURBAN SPECIALISED PSYCHIATRIC CENTRE	
IRB Committee's comments	**Modifications**
1. The heading of this application needs to be modified in order to achieve the results of this project.	1. The heading was changed to meet the requirement.
2. Not very clear about the type of patient to be included in this survey and interview.	2. The condition of patients who will be included in this project is indicated in the consent form and application document.
3. Need to add more information regarding the validity and reliability of the questionnaire in the application.	3. Information about the Validity and Reliability of the questionnaire was added to the application form.
4. Need to verify the type of facilities the hospital can provide.	4. The facilities of the hospital were verified, e.g. interview room.
5. Be clear about the sample size of the survey.	5. An indication of the sample size in the main data collection is added to the application.
6. Need to be clear about the new system of case managers who are working in the psychiatric field.	6. Information about the new system of the role of case managers in Taiwan will be added to the proposal.

* The urban general hospital (UGH) research committee suggested that the VSSS-TC should be changed to remove words panel members felt could be emotionally upsetting for service users. However during the Ethical Approval meeting to discuss the study and their recommendations, the researcher explained the need to maintain the questionnaire as originally devised and then translated in order to protect validity and reliability. This stance was successfully argued and the recommendation withdrawn.

The Institutional Review Board (IRB) at each of the two hospitals approved this study. Written and oral information was then provided to all mental health professionals, service users, carers, and community workshop managers. The preparation of the data collecting period in each settings at both hospitals will be presenting the detail in the next section of undertaking the main study.

Participation in the study was voluntary, and participants could withdraw at any time without giving a reason and without jeopardising their employment, treatment or care. All service users provided written informed consent before completing the questionnaire, and all staff, service users and carers gave written consent for in-depth interviews to be recorded, to ensure that the confidentiality of specific information obtained from individuals was not shared with other participants or staff. Participants were regularly reminded of my role as a researcher during the data collection period. All names used in reports of the findings are pseudonyms, and some other identifying information was also changed in order to maintain anonymity.

3.5 Summary and Conclusion

Selecting a pragmatic and interpretive triangulation research approach to the study of the evaluation and exploration of mental health services in Taiwan from different perspectives has enabled the researcher to benefit from the influence of several interpretive quantitative and qualitative research paradigms and their respective methodological strategies. This has also enabled the researcher to broaden the interpretive opportunities and theoretical feelings in the analysis, whilst trying to maintaining flexibility of design to best accommodate the research questions and aim.

A questionnaire survey can offer the perceptions of users' evaluation of the current mental health services provision, whilst semi-structured interviews with users and providers can offer insights into the respondents' experiences and how they make sense of the phenomena. It is not the intention of this study to generalise the findings to the whole population, but a reflexive and rigorous approach to the study design and conduct is proposed.

Chapter Four

Findings from the Quantitative Survey of Services Users

The aim of this chapter is to present the findings from the survey of the VSSS-TC to measure patients' satisfaction with the Mental Health Services in two hospitals in one of the major city in Taiwan. The chapter is divided into four parts; the first describes the characteristics of the respondents. This is followed by a breakdown of the respondents by location, namely by Urban General Hospital Psychiatric Unit (UGHPU) and Suburban Specialised Psychiatric Centre (SSPC). In the second part, the results obtained on individual questions and seven dimensions of VSSS-TC questionnaire are reported, and in the third part, comparisons with the Part Two questionnaire, (interventions provided by the two locations and participants' satisfaction with the interventions offered). The final section contains a discussion of the results, which describes and contrasts current mental health service provision from the perspective of the users.

4.1 Statistical Results of Pilot Work

Of the 15 pilot study respondents, (who were subsequently included in analysis of the main survey sample) six were male, nine were female. The majority of pilot study respondents were unmarried. Eight were school leavers, and seven were undergraduate students (details shown in table 4-1). Only one was a student, one was retired, six were unemployed, and seven were employed. Five had used mental health services for less than three years, two had used them for between three and five years, two had used them for between five and seven years, one had used them for between seven and ten years, and five had used them for more than ten years. However, in terms of the number of times being hospitalised in the Psychiatric ward, four had never been hospitalised and the majority of pilot study respondents had been hospitalised during the period they had used the Mental Health Services in Taiwan.

Table 4-1: Summary of socio-demographic characteristics of the 15 pilot respondents

	Gender	age	marital status	job status	education level	length of time for using service (years)	number of times hospitalized
1	Male	51-60	unmarried	unemployed	school leaver	over 10	once
2	Female	under 21	unmarried	employed	undergraduate	5-7	never
3	Female	41-50	married	unemployed	undergraduate	1- <3	once
4	Female	21-30	unmarried	unemployed	school leaver	1- <3	never
5	Female	31-40	unmarried	unemployed	technology college	5- <7	third times or over
6	Female	21-30	unmarried	employed	school leaver	1- <3	once
7	Female	31-40	married	employed	school leaver	1- <3	once
8	Female	31-40	unmarried	employed	undergraduate	7- <10	third times or over
9	Male	31-40	married	unemployed	technology college	over 10	twice
10	Female	21-30	unmarried	student	undergraduate	1- <3	once
11	Male	31-40	unmarried	employed	school leaver	3- <5	twice
12	Male	31-40	unmarried	unemployed	school leaver	over 10	third times or over
13	Male	51-60	unmarried	retirement	school leaver	over 10	never
14	Male	31-40	unmarried	employed	school leaver	over 10	third times or over
15	Female	41-50	married	employed	technology college	3- <5	never

As previously described in Chapter Three, the English Version of the VSSS-EU was tested for acceptability, content validity, sensitivity and test-retest reliability in the original EPSILON Study (Ruggeri et al., 2000). The VSSS-EU was translated into Traditional Chinese including a developed translation protocol. The pilot study involved conducting a reliability test on the version of VSSS-TC. In view of limitations of cost and time, only one reliability test was performed after collecting the pilot study sample, and **Cronbach's α** was used to check the internal consistency of the whole questionnaire and the different dimensions. Internal Consistency involves testing for homogeneity, which is the extent to which the items within a dimension relate to that dimension. Cronbach's alpha produces an estimate of reliability based on all possible correlations between all of the items within the scale (Cronbach, 1951).

Table 4-2: Reliability test for each dimension (Cronbach's Alpha)

	OVERALL SATISFACTION	PROFESSIONAL'S SKILL AND BEHAVIOUR	INFORMATION	ACCESS	EFFICACY	TYPE OF INTERVENTION	RELATIVE'S INVOLVEMENT
Number of Items	3	24	3	2	8	17	6
Cronbach's Alpha	.880	.962	.755	.444	.914	.564	.790

Cronbach's Alpha therefore gives the degree to which items exhibit a positive correlation (internal consistency above 0.7 is considered adequate). Table 4-2 demonstrates the Cronbach's Alpha values for the pilot sample of the VSSS-TC dimensions, Cronbach's Alpha ranged from 0.444 (Access dimension) to 0.962 (Professional's Skill and Behaviour dimension). The Access dimension, which consisted of just two items (costs of service and physical layout) measured different constructs, and therefore, the EPSILON study reported it as a special case when testing internal consistency. Dimensions constituted by a higher number of items are expected to have higher Cronbach's Alpha values, and although this was true of the dimension Professionals' Skills and Behaviour ($\alpha=0.962$), it was not for the Types of Intervention dimension ($\alpha=0.564$). The EPSILON Study report found the same results, stating that types of Intervention dimension can not be expected to have high internal consistency due to the wide range of different interventions explored by the questionnaire (Ruggeri et al., 2000). Therefore, the Chinese version of the Verona Service Satisfaction Scale demonstrated adequate reliability.

4.2 Survey Data Coding and Analysis

Non-parametric methods of analysis were used to analyse the quantitative data. Non-parametric statistics are referred to as distribution-free methods, since they do not rely on assumptions that the data has been drawn from a given probability distribution. In other words, non-parametric tests require few, if any,

assumptions about the shapes of the underling population distribution. Another reason for using these tests is that they allow for the analysis for nominal (categorical), as well as ordinal (ranked), data. Non-parametric tests are also useful when small samples are applied, and when the data does not meet the stringent assumptions of the parametric technique. (Pallant, 2007)

The quantitative questionnaire data was collected, and then coded using the methods of item scoring given in the VSSS manual. It was then analysed using SPSS for Windows v.16.01 to obtain the overall satisfaction level of the population surveyed, and to compare their different perspectives of the Mental Health Services in Taiwan (See Appendix VIII for coding book). The VSSS-TC mean score is obtained by summing the values of all items (if all items were applicable) and dividing by 63 (for full details of VSSS-TC item scoring please see the Appendix IX). If some items are not applicable, a global score is obtained, by summing up the values of all of the items and dividing by the number of the items assessed. A mean rank is obtained for each dimension of the questionnaire. To obtain the VSSS-TC total means score, if some items are not applicable, each dimension score is obtained by summing up the values of all of the items and dividing by the number of items assessed.

Patients' socio-demographic, service utilisation and clinical characteristics were compared using Chi-Square, Fisher exact test and Kruskal-Wallis Tests, where appropriate. Descriptive statistics were used to describe the distribution of the demographic features and patients' satisfaction. The correlation between the levels of satisfaction and other variables were calculated using the Mann-Whitney U test (Ruggeri, et al., 2006b). The **Chi-Square Test** for independence is used to determine whether or not two categorical variables are related. It compares the frequency of cases found in one variable category with different categories of another variable. However, according to Siergel and Castellan (1988) mentioned in their book of the 'Nonparametric Statistics for the Behavioural Sciences', if the smallest expected frequency is less than five, use the **Fisher exact test** p-value statistics. The **Mann-Whitney U Test** is used to

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test for differences between the continuous measures of two independent groups, and this test is a non-parametric alternative to the t-test for independent samples. A Mann-Whitney U test actually compares the medians instead of comparing the means of two groups (as in the case of a t-test). The *Kruskal-Wallis Test* is the non-parametric alternative to a one-way between-groups analysis of variance. It allows for a comparison of the score of some continuous variables of three or more groups. It is similar in nature to the Mann-Whitney U test, but it allows for the comparison of more than two groups (Pallant, 2007).

4.3 Characteristics of Respondents

Of the 230 returned questionnaires from patients, 210 were valid questionnaires. They were collected from two different types of hospitals; a Suburban Specialised Psychiatric Centre based on the outskirts of city within an Urban General Hospital Psychiatric Unit. Table 4-3 shows the data collection locations and the percentage of the cases sampled. Respondents came from two hospitals: the Urban General Hospital Psychiatric Unit (UGHPU) including day care centre, and out-patient clinic; Suburban Specialised Psychiatric Centre (SSPC), including out-patient clinic, acute ward, in-patient rehabilitation ward, day care centre, and half-way house services.

Table 4-3: Numbers surveyed by location

	NUMBER (N)	PERCENTAGE OF TOTAL SAMPLE (%)
UGHPU (Day Care)	25	11.9
UGHPU OPD (Out-Patient)	32	15.2
SSPC (Acute ward a)	12	5.7
SSPC (Acute ward b)	4	1.9
SSPC (Day Care)	24	11.4
SSPC (Rehab ward a)	14	6.7
SSPC (Rehab ward b)	23	11.0
SSPC (Half-Way Home a)	31	14.8
SSPC (Half-Way Home b)	6	2.9
SSPC OPD (Out-Patient)	39	18.6
Total	210	100.0

* UGHPU: Urban General Hospital Psychiatric Unit
* SSPC: Suburban Specialised Psychiatric Centre

4.3.1 Characteristics of the Two Hospitals used for the survey

The **Urban General Hospital** was established in 1976 as a General Hospital within a city of Taiwan. In 1990, it was recognised as being a Class I Teaching Hospital by the Department of Health, Taiwan, under the category of regional hospitals. This hospital stresses the holistic approach towards meeting patients' physical, psychological, and social wellbeing with the role of interdisciplinary medical provider. At the time of data collection in 2007, the Psychiatric Department of the Hospital A were proving a range of services in a Day care unit (45 beds) and out-patient clinic. In contrast, **Suburban Specialised psychiatric Centre** is one of five Psychiatric Service Network systems in Taiwan, and is the Government owned Psychiatric Centre with residential setting in a city of Taiwan, which provides an extensive range of psychiatry-related services. The number of psychiatric Beds in SSPC include 780 general beds (Medical: 18, Acute: 471, and Rehabilitation: 291) and 506 special beds (day care: 490 and emergency: 16). The main areas of service delivery are as follows:

1. Medical treatment for adults, children, teenagers, and the elderly
2. Clinical service and hospitalisation for drug addicts/alcoholics
3. Early hospitalisation and rehabilitation of psychiatric patients
4. Day-time hospitalisation of psychiatric patients

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5. Community rehabilitation of psychiatric patients and occupational treatment

6. Professional physical and mental examinations, mental treatment and psychiatric treatment and counselling

4.3.2 General Characteristics of Respondents

Of the 210 respondents, 27.1 per cent (n=57) were from Urban General Hospital Psychiatric Unit (UGHPU), and 72.9 per cent (n=153) were from Suburban Specialised Psychiatric Centre (SSPC). Of the total 210 respondents 50.5 per cent (n=106) were male and 49.5 per cent (n=104) were female.

Table 4-4: Characteristics of the total number of respondents divided into two groups (UGHPU and SSPC)

	Total Sample (n=210) N (%)	UGHPU (n=57) N (%)	SSPC (n=153) N (%)	significance level p-value (Fisher exact test)
Gender				
Male	106 (50.5)	28 (49.1)	78 (51.0)	0.877
Female	104 (49.5)	29 (50.9)	75 (49.0)	
Age				
under 21 age	5 (2.4)	1 (1.8)	4 (2.6)	
21-30 age	26 (12.4)	43(5.3)	23 (15.0)	
31-40 age	80 (38.1)	22 (38.6)	58 (37.9)	0.334
41-50 age	65 (31.0)	21 (36.8)	44 (28.8)	
51-60 age	30 (14.3)	8 (14.0)	22 (14.4)	
over 60 age	4 (1.9)	2 (3.5)	2 (1.3)	
Marital Status				
married	53 (25.2)	31 (54.4)	30 (19.6)	
unmarried	141 (67.2)	30 (52.6)	110 (71.9)	*0.021*
divorce	16 (7.6)	3 (5.3)	13 (8.5)	
Employment Status				
student ⎤	8 (3.8) ⎤	1 (1.8) ⎤	7 (4.6) ⎤	
out of work ⎬ unemployed	76 (36.2) ⎬ 108(51.4)	19 (33.3) ⎬30(52.6)	57 (37.3) ⎬ 78(51.1)	
housewife ⎦	24 (11.4)⎦	10 (17.5)⎦	14 (9.2) ⎦	
office holder ⎤	5 (2.4) ⎤	2 (3.5) ⎤	3 (2.0) ⎤	
businessman ⎥	8 (3.8) ⎥	2 (3.5) ⎥	6 (3.9) ⎥	0.582
labourer ⎥	7 (3.3) ⎥	0 (0.0) ⎥	7 (4.6) ⎥	
self-employ ⎬ employed	12 (5.7) ⎬ 85(40.5)	4 (7.0) ⎬ 23(40.4)	8 (5.2) ⎬ 62(40.4)	
service industry ⎥	39 (18.6) ⎥	11 (19.3) ⎥	28 (18.3) ⎥	
others ⎦	14 (6.7) ⎦	4 (7.0) ⎦	10 (6.5)⎦	
retirement	17 (8.1)	4 (7.0)	13 (8.5)	
Educational Level				
primary school or under	13 (6.2)	7 (12.3)	6 (3.9)	
junior high school	29 (13.8)	6 (10.5)	23 (15.0)	
senior high school	87 (41.4)	20 (35.1)	67 (43.8)	0.971
technology college	43 (20.5)	12 (21.1)	31 (20.3)	
undergraduate	31 (14.8)	9 (15.8)	22 (14.4)	
postgraduate or above	7 (3.3)	3 (5.3)	4 (2.6)	

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The characteristics of the total number of respondents divided into the two locations; UGHPU and SSPC are shown in table 4-4. The reason for dividing them by location is because the two settings provide services to people who are institutionalised and for those living in the community respectively. Therefore, comparing the characteristics of the two groups could provide information about the patient populations in each setting. By using chi-square to compare two groups, there were no significant differences in gender (p=0.877) (see Figure 4-5 of a tree diagram), age (p=0.334) (see Figure 4-6 below of three pie chart), employment status (p=0.582) (see Figure 4-7 of a tree diagram and Figure 4-8 of pie chart below) and level of education (p=0.971) (see Figure 4-9 below of three pie chart) between the two groups.

Figure 4-5: Gender of respondents overall and by location
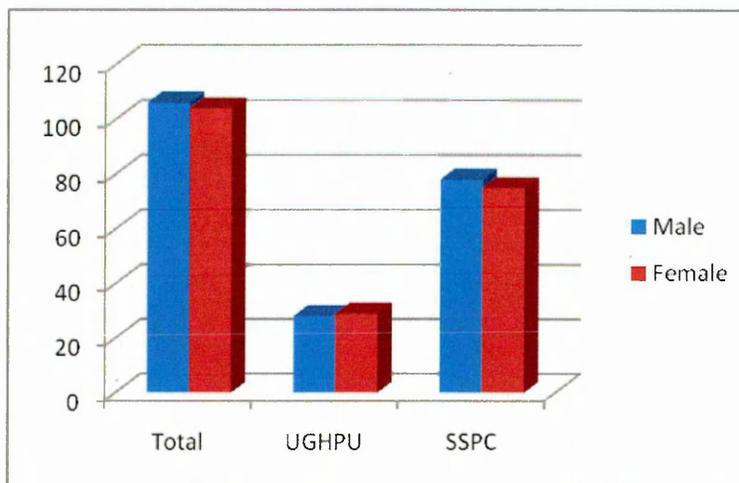
The bar chart shown in Figure 4-5 compares the gender of respondents. It shows that 106 (50.5 per cent) were male and 104 (49.5 per cent) were female. As shown in the diagram, the gender breakdown was similar between the two locations; [49.1 per cent (n=28) male and 50.9 per cent (n=29) female respondents from the UGHPU, and 51 per cent (n=78) male and 49 per cent (n=75) female respondents from the SSPC (p=0.877)].

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Figure 4-6: Age of respondents overall and by location
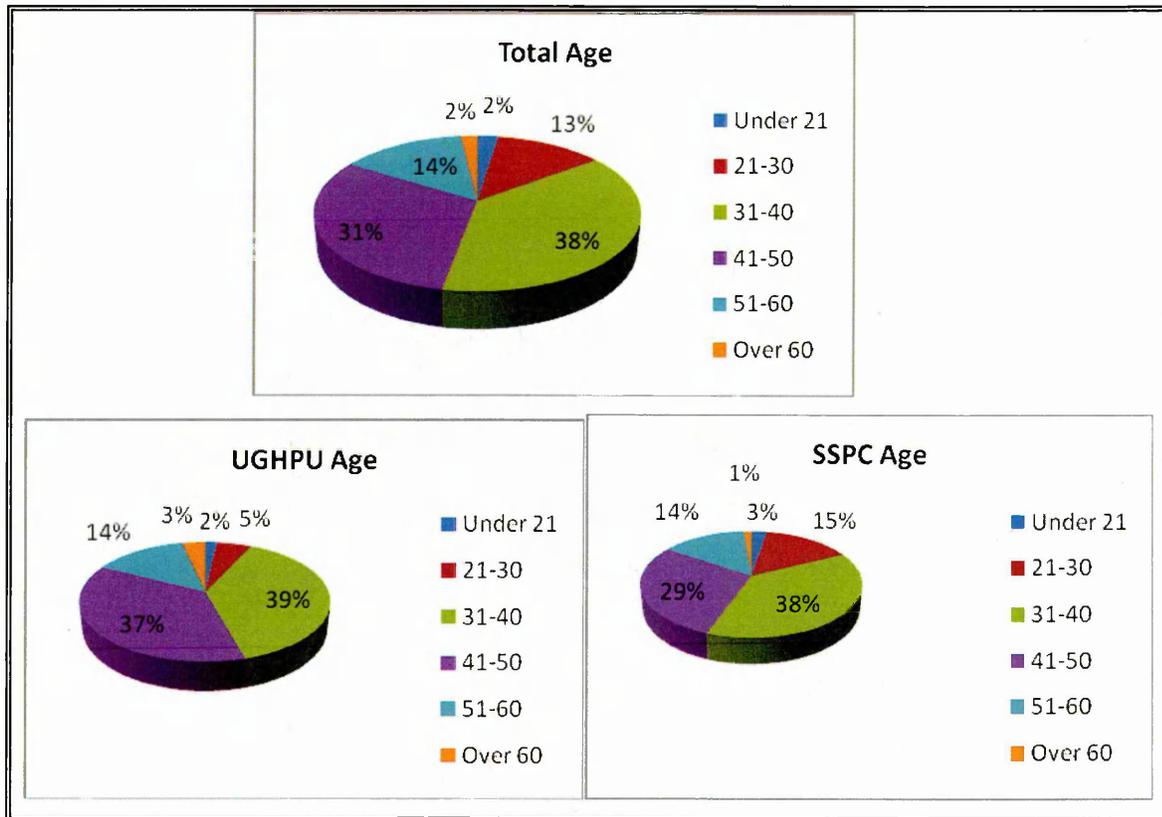
The respondents' ages are shown in the pie charts above (figure 4-6). The majority were aged to 40 years old (n=80, 38.1 per cent), and the remainder were in the 41-50 age group (n=65, 31 per cent). As shown in the pie charts, the age breakdown across the two locations was similar (p=0.334).

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Figure 4-7: Employment Status of respondents overall and by location
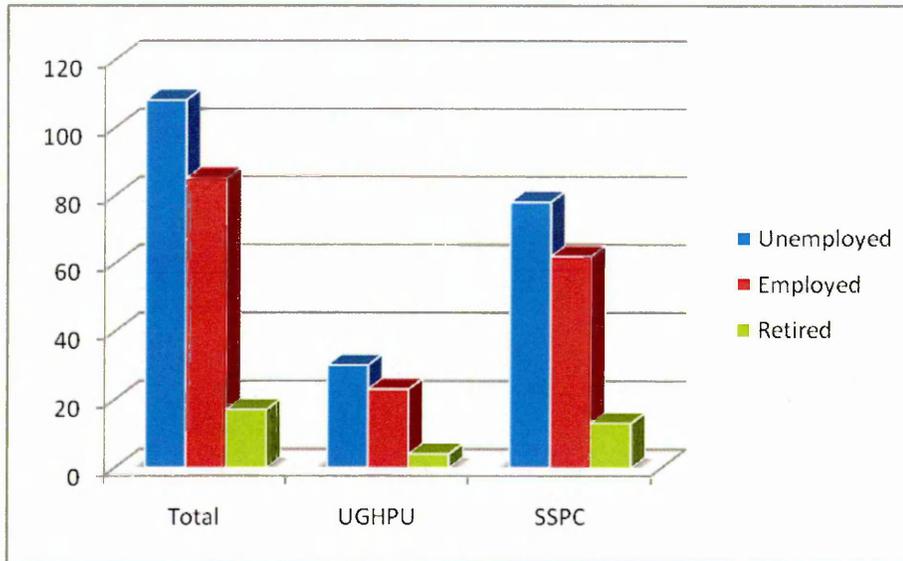
Figure 4-8: Employment Status of the respondents overall and by location
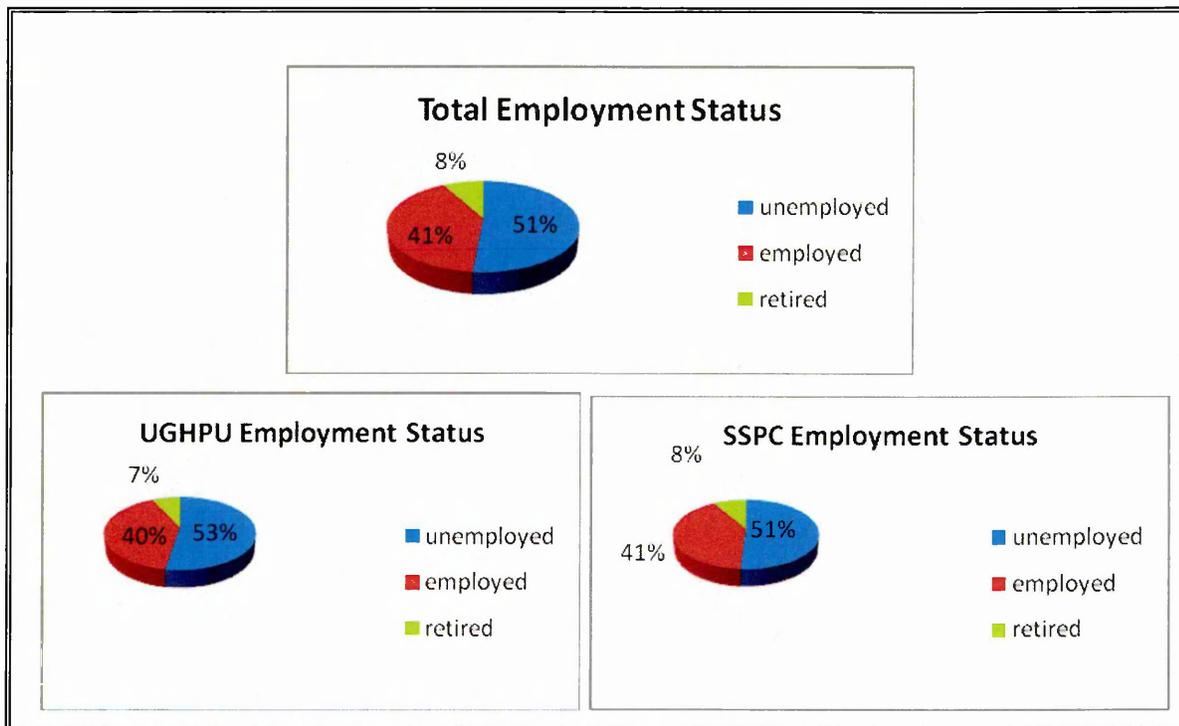
Figure 4-7 presents the self reported employment status of respondents. The majority were unemployed (n=108, 51.4 per cent), which includes those designated as being 'out of work' (n=76, 36.2 per cent), 'housewife' (n=24, 11.4 per cent), and 'student' (n=8, 3.8 per cent). However, 40.5 per cent of

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respondents were employed (n=85), which included the groups in 'service industry' (n=39, 18.6 per cent), 'other employment' (n=14, 6.7 per cent), 'self-employed' (n=12, 5.7 per cent), 'businessman' (n=8, 3.8 per cent), 'labourer' (n=7, 3.3 per cent), and 'office holder' (n=5, 2.4 per cent). A minority were retired (n=17, 8.1 per cent). As it can be seen from the pie chart in Figure 4-8, employment status was equivalent across locations (p=0.582).

Figure 4-9: Educational Level of the respondents overall and by location
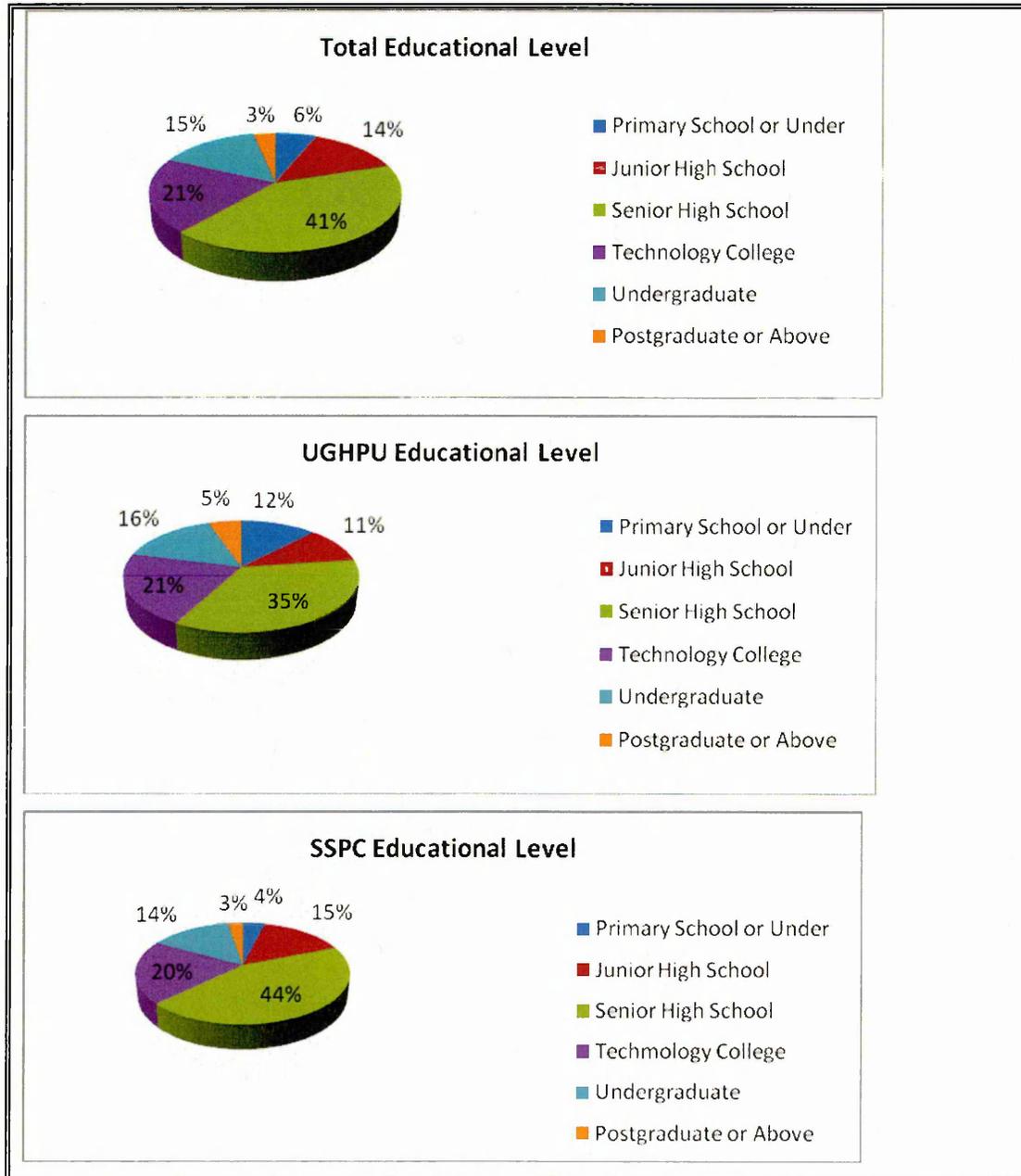
Figure 4-9 shows the self reported educational level of respondents. The majority had graduated from senior high school (n=87, 41.4 per cent), and the remainder had graduated from technical college (n=43, 20.5 per cent). In general, the respondents' educational levels formed a similar pattern across two groups (p=0.971).

Figure 4-10: Marital status of respondents overall and by location
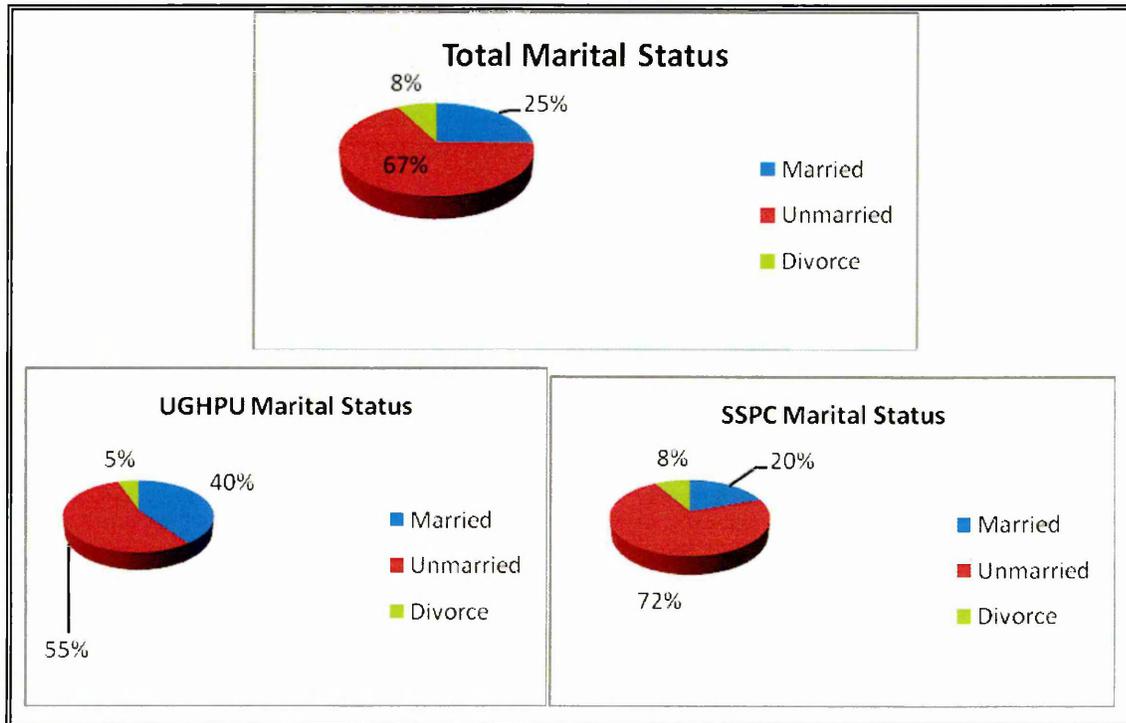
However, there was a significant difference in the marital status (p=0.021) between the two groups with respect to marital status, with more services users in the urban General Hospital Psychiatric Unit (UGHPU) group being married. Figures 4-10 presents the marital status of the total respondents and by location. Of those participants from the UGHPU, 23 were married (40.4 per cent) and 31 were unmarried (54.4 per cent). Although the majority of the respondents in the Urban General Hospital Psychiatric Unit were also unmarried (n=31, 54.4 per cent), the percentage of married respondents (n=23, 40.4 per cent) was much higher than for those attending the Suburban Specialised Psychiatric Centre (SSPC). The majority of the respondents who attended the SSPC were

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unmarried (n=110, 71.9 per cent) , which suggests that there were more unmarried mentally ill patients long stay in the Suburban Specialised Psychiatric Centre than in Urban General Hospital Psychiatric Unit.

4.3.3 Respondents ' History of using psychiatric services

The length of time the respondents reported using psychiatric services is shown in table 4-9 below. There was no significant difference in the length of time using the service between hospital type (Urban General Hospital Psychiatric Unit and Suburban Specialised Psychiatric centre) p=0.538. However, there was a significant difference in the number of previous hospitalisations (p<0.0005) (see Table 4-11).

Table 4-11: Respondents' Reported History of Service Use

	Total Sample (n=210) N (%)	UGHPU (n=57) N (%)	SSPC (n=153) N (%)	significance level p-value (Fisher exact test)
Length of time for using service 1-3 years 3-5 years 5-7 years 7-10 years over 10 years	59 (28.1) 21 (10.0) 26 (12.4) 23 (11.0) 81 (38.6)	20 (35.1) 6 (10.5) 8 (14.0) 6 (10.5) 17 (29.8)	39 (25.5) 15 (9.8) 18 (11.8) 17 (11.1) 64 (41.8)	0.538
Number of time to be hospitalized never once twice third times or over	36 (17.1) 51 (24.3) 27 (12.9) 96 (45.7)	26 (45.6) 12 (21.1) 4 (7.0) 15 (26.3)	10 (6.50) 39 (25.5) 23 (15.0) 81 (52.9)	*<0.0005*

Table 4-11 and figure 4-12 show the number of times respondents reported having been hospitalised. There were significant differences in reported numbers of hospitalisations between the two groups (p<0.0005), with service users in the Urban General Hospital Psychiatric Unit being less frequently admitted to a psychiatric ward, while patients in the Suburban Specialised Psychiatric Centre had a history of more frequent admissions. The majority of respondents (n=81, 52.9 per cent) who had been hospitalised three times or more were from the group in the Suburban Specialised Psychiatric Centre, and

only 10 respondents (6.5 per cent) had never been previously hospitalised. The majority of respondents in the Urban General Hospital Psychiatric Unit group attending the day unit (n=26, 45.6 per cent) had never been admitted to a psychiatric hospital and only 15 (26.3 per cent) had been previously been hospitalised for psychiatric care three times or more.

Figure 4-12: Respondents' Reported on the Number of times hospitalised
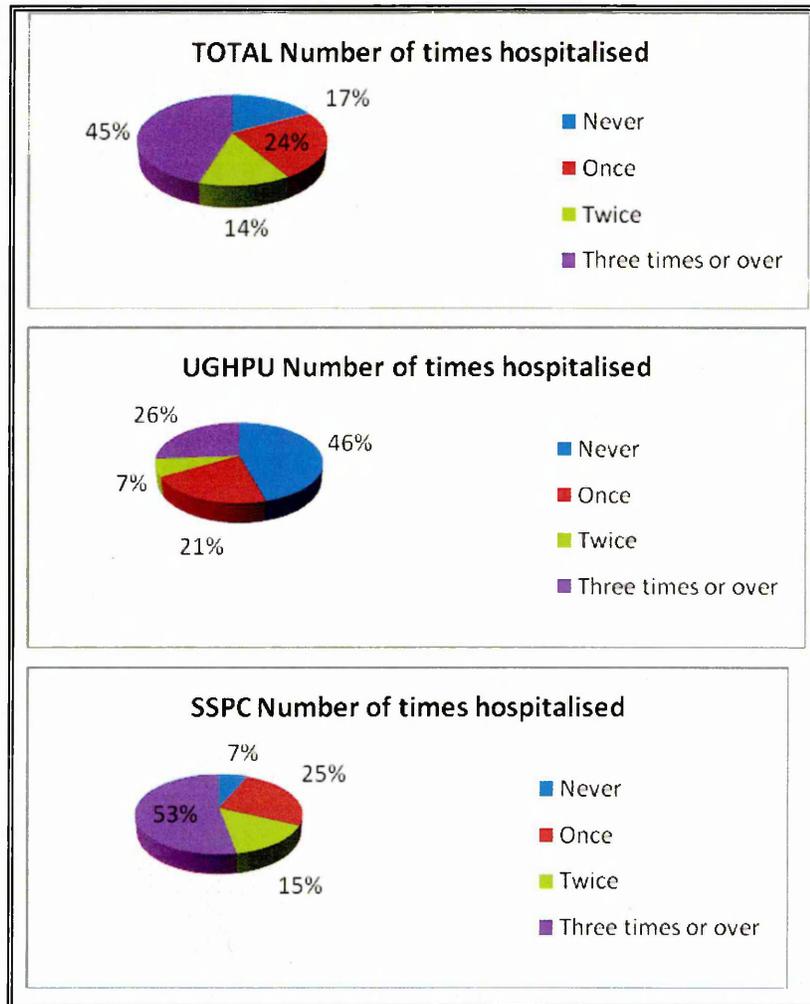
When comparing respondents' service user history with the length of time of using the service, there was no significance difference emerged between respondents from each location (p=0.538) (see Figure 4-13 pie charts below). The majority of the respondents had used some form of psychiatric service

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either between 1 or 3 years (n=29, 28.1 per cent) or for over 10 years (n=81, 38.6 per cent), with the data from both locations revealing a similar trend.

Figure 4-13: Respondents' Reported on the Length of time of using the services
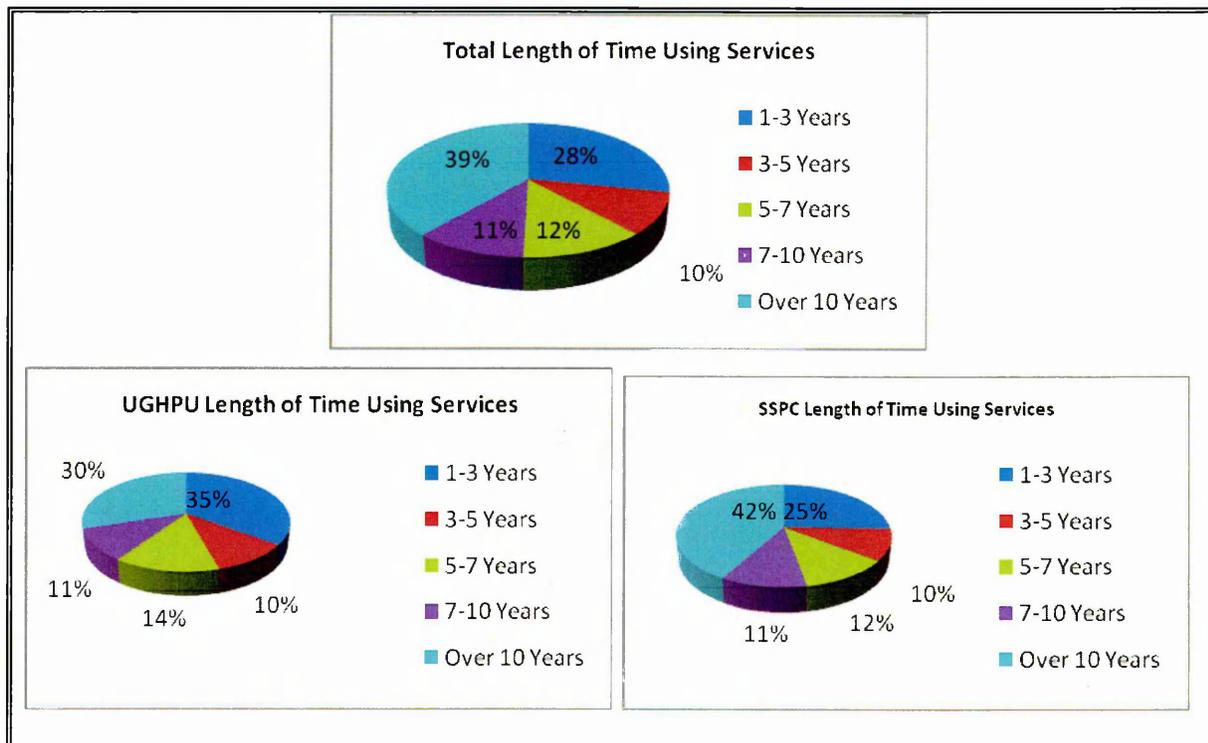
4.3.4 Summary

Analysis of the data provided by the 210 survey respondents shows several interesting features, as follows:

- 69.1 per cent of the respondents were aged between 31 and 50 years.
- 74.8 per cent of the respondents were single. There were significant differences (p=0.021) between the two hospital types, with more single service users in the Suburban Specialised Psychiatric Centre (80.4 per cent).
- 51.4 per cent of respondents were unemployed, with no significant differences between the two hospital types.
- 61.4 per cent of respondents had a low level of education (had never been to college or university).

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- 62 per cent of the respondents had been using mental health services for more than 5 years, with no significant difference between the two hospital types.

- The majority of the all respondents (45.2 per cent) had been hospitalised because they had exhibited symptoms of mental illness three times or more. There were significant differences between the two hospital types ($p<0.0005$), with the services users in the Urban General Hospital Psychiatric Unit never being hospitalised (45.6 per cent), whereas 52.9 per cent of the services users in the Suburban Specialised Psychiatric Centre were more frequently hospitalised.

4.4 VSSS-TC Reported Satisfaction

This section reports the findings of the survey of service users' satisfaction by location, and also compares the scores obtained for each individual question on the VSSS-TC. The reported results also include a comparison of the total score with the seven different dimensions of the scale. Also compares two different hospital types by satisfaction level to enable the researcher to determine whether or not there is any statistical difference between the two groups.

4.4.1 Comparison of means by the total and seven dimensions of the total sample

The Boxplot in Figure 4-14 gives the distribution of the mean scores of VSSS-TC between the two hospital types (UGHPU vs. SSPC). Boxplots are used to compare the distribution of scores. The length of the box is the variable's inter-quartile range and contains 50 per cent of cases, and the line across the inside of the box represents the median value. The whiskers protruding from the box go out to the variables' smallest and largest values. Outliers are cases (with ID number attached) of scores which are quite different from the remainder of the sample, either much higher or lower (Pallant, 2007). In Figure 4-14, the distribution of scores on the mean score of VSSS-TC for the two locations is

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very similar, with only two outliers (Code Number 117 and 132) outside the range in the group from the Suburban Specialised Psychiatric Centre.

Figure 4-14: Distribution of mean score of VSSS-TC between the two hospitals types (UGHPU vs. SSPC)

Mean score of VSSS-TC

Hospital type
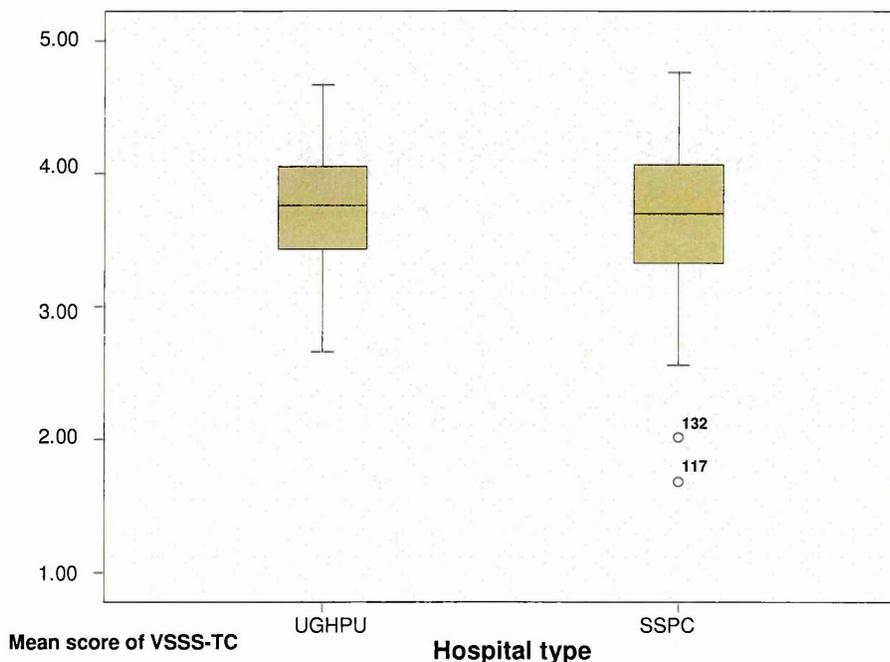
The two outliners of the Boxplot above were given code numbers 117 and 132. They were both are male, were both resident on the same chronic ward in the Suburban Specialised Psychiatric Centre, and had been hospitalised three times or more in the past. Respondent number 117 had used the services for less than 3 years, and ranked all of the questions as 'unsatisfied' (very dissatisfied, mostly dissatisfied, and mixed). Respondent number 132 had used the services for 5 years, and ranked only 3 questions as 'mostly satisfied', and the remainder 'dissatisfied'. Only those two outliners had moved away from the centre of distribution of VSSS-TC mean scores.

In order to detect the capability of the mental health service in two of the hospitals in Taiwan to provide satisfaction care, the researcher measured mean satisfaction scores in the various satisfaction dimensions and in the VSSS totals

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score. Table 4-15 gives the mean and standard deviation of the total score of the VSSS-TC and seven dimensions. The mean describes the average of the data, and the standard deviation measures the spread of the data about the mean value (Pallant, 2007). This is useful when comparing sets of data which may have the same mean, but a different range. The standard deviation is a statistic which tells how tightly all of the various samples are clustered around the mean in a set of data. When the samples are tightly bunched together, the standard deviation (SD) is small, and when they are spread apart, a relatively large standard deviation will be indicated.

Table 4-15: Comparison of the Means and Standard Deviations of the total score and seven dimensions of the VSSS-TC questionnaire of 210 samples.

	Mean	Standard Deviation	Minimum	Maximum
Total Score of VSSS-TC	224.76	35.31	106.00	300.00
Overall Satisfaction	3.78	0.72	2.00	5.00
Professional Skills and Behaviour	3.82	0.61	1.63	4.96
Information	3.61	0.74	1.00	5.00
Access	3.74	0.84	1.00	5.00
Efficacy	3.74	0.65	1.50	5.00
Type of Intervention	3.60	0.51	2.12	4.82
Relative Involvement	3.59	0.69	1.00	5.00

In table 4-15, the highest mean score with small number of standard deviation was for the Professional Skills and Behaviour dimension (m=3.82, SD= 0.61), and the lowest mean was in the Relatives' Involvement dimension (m=3.59, SD=0.69). By comparing the standard deviation with the mean score of the VSSS-TC obtained from the satisfaction ranking on four dimensions, which included 'type of intervention' (SD=0.51), 'professional skills and behaviour' (SD=0.61), 'efficacy' (SD=0.65), and 'relatives' involvement' (SD=0.69) were considerably more clustered around the mean. In contrast, within the ranking of the other three dimensions which contained 'overall satisfaction' (SD=0.72), 'information' (SD=0.74), and 'access' (SD=0.84), these were rather more spread apart from the mean.

4.4.2 Comparison of the means scores and seven dimensions by Hospital Type

The results of using a Mann-Whitney U test to compare the total 'mean score' and 'seven dimensions' with the two hospital types' are shown in table 4-16. The Mann-Whitney U Test is used to test for differences between two independent groups on continuous measures. This test is the non-parametric alternative to the t-test for independent samples. Instead of comparing the means of the two groups, as in the case of a t-test, the Mann-Whitney U test actually compares the medians. It converts the scores on the continuous variable into ranks across the two groups, and then evaluates whether or not the ranks of the two groups differ significantly (Pallant, 2007).

Table 4-16: Comparison of Hospital types with the total mean score of the VSSS-TC and the seven dimensions scores.

	Hospital type	N	Mean Rank	Median	Significance level (Mann-Whitney Test)
Mean Score of VSSS-TC	UGHPU	57	111.10	3.76	
	SSPC	153	103.42	3.69	0.42
	Total			3.70	
Total Score of VSSS-TC	UGHPU	57	105.16	222.00	
	SSPC	153	105.63	222.00	0.96
	Total			222.00	
Overall Satisfaction Score	UGHPU	57	115.54	4.00	
	SSPC	153	101.76	3.67	0.14
	Total			4.00	
Professional Skills and Behaviour Score	UGHPU	57	113.50	3.88	
	SSPC	153	102.52	3.80	0.24
	Total			3.84	
Information Score	UGHPU	57	106.77	3.67	
	SSPC	153	105.03	3.67	0.85
	Total			3.67	
Access Score	UGHPU	57	108.14	4.00	
	SSPC	153	104.52	4.00	0.70
	Total			4.00	
Efficacy score	UGHPU	57	111.04	3.88	
	SSPC	153	103.44	3.75	0.42
	Total			3.75	
Type of Intervention Satisfaction Score	UGHPU	57	109.47	3.71	
	SSPC	153	104.02	3.65	0.56
	Total			3.65	
Relative Involvement Score	UGHPU	57	99.38	3.50	
	SSPC	153	107.78	3.60	0.37
	Total			3.50	

Table 4-16 shows the results of application of the Mann-Whitney U test, which revealed no significant differences in the mean scores, total scores, and seven dimensions of the VSSS-TC between hospital type, i.e. overall satisfaction score from Psychiatric Unit in Urban General Hospital (median=4.00, n=57) and Suburban Specialised Psychiatric Centre (median=3.67, n=153). Although, the result shows that the median rank of the VSSS-TC in the UGHPU is higher than the median in the SSPC. There is no significant difference when comparing the seven dimensions between the two hospital types. The median rank is higher for the UGHPU than the SSPC for four of the dimensions, which include overall satisfaction, professional skills and behaviours, efficacy, and type of intervention. The medina rank reports the same compare between the two location in two dimensions, which were information (median= 3.67) and access (median= 4.00). The only median is that is greater for those respondents who were mostly in-patients from Suburban Specialised Psychiatric Centre is for the relatives' involvement dimension (medina= 3.60).

4.4.3 Comparison of the means of VSSS-TC individual items

Descriptive statistics were used to compare service satisfaction in the survey data of individual questions. This allowed the researcher to build a better understanding of service satisfaction in every direction. Although non-parametric methods of analysis should have been applied throughout the survey data, non-parametric descriptive statistics comparing Median and Inter Quartile Range (IQR) do not show as much exquisite detail of data as parametric methods when comparing Mean and Standard Deviation (SD) (see Appendix XII for more detail). Therefore, the researcher adopted parametric methods to compare the Mean and SD of satisfaction scores on total satisfaction, seven dimensions (table 4-15) and individual questions (table 4-17), which methods also referenced resources from Professor Ruggeri's study using the same instrument (Ruggeri, et al., 2007).

However, it could still be disputed as to whether or not the results agreed between the two (Mean and Median). Therefore, *Cronbach's Alpha* coefficient was tested on the VSSS of 63 items as an indicator of internal consistency

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between the two sets of results. Ideally, a reliability coefficient of 0.70 or higher is considered to be "acceptable". With the result of **0.960** of the reliability Cronbach's α test, it can be said that the two sets of results do agree with each other (see Appendix XII for more detail).

Table 4-17: Comparison of the means and standard deviation of individual items

INDIVIDUAL ITEMS WITH DIMENSIONS	MEAN	STANDARD DEVIATION
The Overall Satisfaction (3 items)		
Q11 Amount of help	3.88	0.928
Q20 Kinds of service offered	3.66	0.895
Q21 Service general sense	3.80	0.827
The Professional's Skills and Behaviour (24 items)		
Q2 Behaviour and manners of reception staff	3.90	0.912
Q3a Professionalism of Psychiatrists	**4.05**	**0.916**
Q3b Professionalism of Psychologists	3.78	0.965
Q5a Ability of Psychiatrists	3.95	1.013
Q5b Ability of Psychologists	3.62	0.941
Q6a Personal manner of Psychiatrics	**4.00**	**0.968**
Q6b Personal manner of Psychologists	3.76	0.943
Q7 Punctuality of the professionals	**4.03**	**0.966**
Q10 Confidentially and respect for patient's right	3.85	1.000
Q16a Thoroughness of Psychiatrists	**4.00**	**0.938**
Q16b Thoroughness of Psychologists	3.78	0.913
Q17 Referring to general practitioner or other specialists	**3.45**	**0.964**
Q18 Cooperation between service providers	3.82	0.873
Q22a Professional competence of Nurses	3.92	0.855
Q22b Professional competence of Social worker	3.66	0.954
Q25a Personal manner of Nurses	3.91	0.837
Q25b Personal manner of Social worker	3.70	0.908
Q28 Nurses knowledge patients medical history	3.61	0.938
Q33 Instruction on what to do between visit	3.73	0.926
Q35a Thoroughness of Nurses	3.92	0.917
Q35b Thoroughness of Social worker	3.77	0.895
Q37a Ability of Nurses	3.82	0.905
Q37b Ability of Social worker	3.64	0.924
Q40 Continuity of care	3.85	0.908
The Information (3 items)		
Q12 Explanation procedures and approaches used	3.61	0.907
Q19 Publicity on mental health services offered	3.63	0.909
Q29 information on diagnosis	3.59	0.995
The Access (2 items)		
Q4 Appearance, comfort level and physical layout	3.79	0.940
Q8 Cost of service	3.69	1.092
The Efficacy (8 items)		
Q1 Helping patient deal with problems	3.94	0.916
Q9 Attaining well-being and preventing relapses	3.79	0.921
Q13 Helping to relieve symptoms	3.85	0.820
Q24 Helping patient improve knowledge of his problems	3.76	0.871
Q26 Improving relationship between patient and relative	3.66	0.996
Q31 Helping to establish good relationship outside family	3.56	1.007
Q34 Helping to improve capacity to look after themselves	3.80	0.947
Q38 Helping patient improve abilities to work	3.60	0.949
The Types of Intervention (17 items)		
Q14 Response to crisis during office hours	3.63	0.961
Q15 Response to emergencies during nights weekend	**3.49**	**0.955**
Q39 Help for discomfort of side effects from medications	3.75	1.047
Q41 Medication prescription	3.89	0.929
Q42 Individual rehabilitation	3.56	1.040
Q43 Individual session	3.72	1.026
Q44 Compulsory treatment in hospital	3.33	1.116
Q45 Family session	**3.43**	**1.075**
Q46 Living in sheltered accommodation	3.49	0.938

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Q47	Recreational activities in the service	3.84	0.944
Q48	Group session	3.78	0.972
Q49	Shelter work	3.51	1.001
Q50	Informal admission to hospital	3.76	0.907
Q51	**Practical help by the service at home**	*3.43*	**0.983**
Q52	Helping in obtaining welfare benefits	3.98	0.982
Q53	**Help to find open employment**	*3.18*	**1.094**
Q54	Recreational activities outside the service	3.45	0.974
The Relative's Involvement (6 items)			
Q23	Recommendations about how relative could help	3.56	0.890
Q27	Helping relative improve understanding of patient's problems	3.51	1.022
Q30a	Ability of Psychiatrists to listen to relative	3.81	0.891
Q30b	Ability of Psychologists to listen to relative	3.51	0.929
Q32	Information to relative about diagnosis and prognosis	3.49	0.950
Q36	Helping relative to deal better with patient's problems	3.62	0.922

When looking at individual items, table 4-17 compares the means and standard deviation obtained from analysis of responses to 63 individual questions in the VSSS-TC. The mean describes the central location of the data, and the standard deviation describes the spread. The highest mean with small standard deviation was found in Q3a Professionalism of Psychiatrists (m=4.05, SD=0.916), and the lowest mean was in Q53 Help to find employment (m=3.18, SD=1.094).

Four questions had a mean ranking of more than 4, indicate of greater overall satisfaction of the services, all in the section of the 'Professional skills and behaviour dimension': Q6b 'Personal manner of Psychologists' (m=4.00, SD= 0.968); Q16a 'Thoroughness of Psychiatrists' (m=4.00, SD=0.938); Q7 'Punctuality of professionals' (m=4.03, SD=0.966); Q3a Professionalism of Psychiatrists (m=4.05, SD=0.916). And there were five individual questions with a mean ranking of less than 3.5, which represents the most dissatisfied part of the services, which included: Q15 'Response to emergencies during nights and weekends' (m=3.49, SD= 0.955); Q17 'Referring to general practitioner or other specialist' (m=3.45, SD= 0.964); Q45 'Family sessions' (m=3.43, SD=1.075); Q51 'Practical help by service at home' (m=3.43, SD=0.983); Q53 'Help to find employment' (m=3.18, SD=1.094).

4.4.4 Comparison of means, total scores and seven dimensions of different grouping variables

A Kruskal-Wallis Test is a non-parametric alternative to a one-way between-groups analysis of variance. It allows for a comparison of the score of continuous variables for three or more groups. It is similar in nature to the Mann-Whitney U test, but allows a comparison of more than two groups (Pallant, 2007). The scores are covered with a means ranking for each group to compare.

Table 4-18: Comparison of the significance level of p-value with mean score, total score and seven dimensions of different grouping variables

GROUPING VARIABLE/ SIGNIFICANCE P-VALUE	GENDER	AGE	MARITAL STATUS	EMPLOYMENT STATUS	EDUCATIONAL LEVEL	LENGTH OF TIME FOR USING SERVICE	NUMBER OF TIME TO BE HOSPITALIZED
Mean score	0.342	0.295	0.699	0.553	0.391	0.754	0.677
Total score	0.147	0.061	0.705	0.541	0.783	0.707	0.679
Overall satisfaction	0.721	0.525	0.372	0.183	0.235	0.732	0.443
Professional skills and behaviour	0.470	0.429	0.791	0.403	0.311	0.525	0.350
Information	0.472	0.346	0.165	0.273	0.569	0.360	0.156
Access	0.466	0.063	0.436	*0.034*	0.296	0.083	*0.009*
Efficacy	0.882	0.294	0.390	0.537	0.776	0.755	0.467
Type of intervention	0.139	0.365	0.803	0.413	0.186	0.493	0.854
Relatives involvement	0.879	0.690	0.872	0.867	0.594	0.543	0.591

As shown in table 4-18, for "gender", the Kruskai-Wallis Test revealed no statistically significant difference in the satisfaction level between groups for each of the seven dimensions of the scale. However, males tended to give a higher ranking than females for most dimensions, except for the 'relatives' involvement' dimension (males' mean ranking=104.78; females' mean ranking=106.14). In the grouping variable 'age', analysis revealed no statistically significant difference in the satisfaction level of the total score of the VSSS-TC across age groups (p=0.06). However, the older age group (over 51 yrs) recorded a higher mean ranking (m=122.17). Also in the grouping variable of marital status, the test revealed no statistically significant difference in the level of satisfaction between married or single respondents upon the mean score, total score and seven dimensions.

The Kruskai-Wallis test revealed a statistically significant difference in the level of satisfaction with employment status (p=0.034), compared to the 'access' dimension for the employment status grouping variable. Respondents who worked in service industry (retail, transport, distribution, and food services, as well as other service-dominated businesses), were found to have the highest mean ranking in the 'access' dimension (m=128.79), followed by those who were retired (m=125.26).

Table 4-18 also shows that there is no statistically significant difference in satisfaction between respondents with different levels of educational attainment. However, the respondents with the lowest level of education tended to give a highest overall score (m=122.69), and also for three out of seven dimensions ('overall satisfaction', m=142.42; 'information', m=133.27; 'type of intervention', m=140.65).

The Kruskai-Wallis test revealed no statistically significant difference in the satisfaction level between 'length of time using the service' on the mean score, total score, and seven dimensions. Nevertheless, respondents who had been using the service for more than 7 years tended to gave a higher ranking in the total score (m=116.48 in 7-10 years group), and also gave a high ranking in three of the dimensions ('information', m=117.09 in the 7-10 years group; 'access', m=119.19 in the over 10 years group; 'type of intervention', m=110.96 in the 7-10 years group).

In the grouping variable of 'number of times hospitalised', the test revealed a statistically significant difference in the satisfaction level with the 'access' dimension across different groups (p=0.009). 'Once' (m=115.43) and 'three times or more' (m=114.29) groups recorded a higher mean ranking than the other two groups. The respondents who had never been hospitalised tended to have a more highly ranked total score (m=120.22) as well as in three out of seven dimensions ('professional skills and behaviour', m=122.15; 'efficacy', m=120.00; 'type of intervention', m=113.03). This indicates that respondents who has never been hospitalised were satisfied with hospital-based community mental health services that they had received.

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4.4.5 Summary

Patient satisfaction has always been an important issue for healthcare policy makers and providers, and many previous studies have used measures of patient satisfaction as a quality improvement tool for healthcare providers. Furthermore, following increased levels of competition and an emphasis on consumerism, patient satisfaction has become an important measurement for monitoring the performance of health policies (Jatulis, et al., 1997).

Analysis of data from the reported satisfaction ranking of 210 survey respondents using several non-parametric tests produced numerous interesting results, as follows:

- The highest satisfaction ranked was in the dimension of 'Professional skills and behaviour' (m=3.82) whereas the lowest was in the 'Relatives' involvement' dimension (m=3.59).

- The highest satisfaction ranking of individual questions was 'Professionalism of Psychiatrists' (m=4.05), and the lowest one was 'Help to find employment' (m=3.18).

- Comparing the means of 63 individual questions, only four questions had a mean ranking above 4, and these were related to the satisfaction ranking associated with the doctor.

- Older age groups recorded a higher satisfaction ranking, and employed respondents also gave a higher satisfaction ranking.

- Comparing the mean score within seven dimensions by hospital type, there were no significant differences between the groups. However, satisfaction ranking levels were higher in six out of the seven dimensions from the respondents from the Urban General Hospital Psychiatric Unit group.

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In summary, application of the 63-items Traditional Chinese version of the VSSS has captured the satisfaction of a sample of patients with the mental health services in two of the hospitals in Taiwan. Although, there were no statistically significant differences between results obtained from analysis of survey results obtained from the two hospitals, some indications have been provided about how the different styles of service provision within each setting translate into patient satisfaction. The respondents from the Psychiatric Unit in Urban General Hospital tended rate services they had received more highly. This may be due to the fact that the respondents in Urban General Hospital Psychiatric Unit were only from the hospital-based community service, such as out-patients setting, out-patient clinic, and day care centre, and therefore may have been less severely ill and more connected to the community

The respondents gave a higher satisfied ranking to questions related to their interaction with medical staff. It may suggest that Chinese cultural issues in the doctor-patient relationship are correlated with authority. Society has a deep respect for doctors, which is reflected by the high status of doctors in Chinese culture. Consequently, is common for the family to ask the doctor to make the treatment decision. Cong (2004) highlights the fact that patients and family members of traditional Chinese society tend to believe doctors, and hope that they will help them to make treatment decisions. Moreover, similar results have been found in many other satisfaction surveys. The findings of research conducted by Tung and Chang (2009) in which they measured a total of 1,910 patients satisfaction with general primary care in Taiwan, showed that 'doctor's technical skills' and 'doctor's interpersonal skills' were critical factors in patients' satisfaction with a clinic.

The results of this data show that users attributed most dissatisfaction to the services which are supposed to help them to find employment when they leave hospital. This issue is clearly important element in improving mental health services in the future in order to meet patients' needs.

4.5 Part Two Questions: Service Provision and Satisfaction

This section reports the findings of analysis of satisfaction with the intervention provision in the two hospitals, with the results being compared across both locations. The results are compared between the Psychiatric Unit in Urban General Hospital and the Suburban Specialised Psychiatric Centre to enable the researcher to determine whether or not there is a statistical difference between the two groups in terms of the provision of intervention.

Items Q41 to Q54 on the survey instrument consist of three questions, as follows:

- **Question A**: "Did you receive intervention x within the last year?" (Yes/no/don't know)
- If the answer is "yes" the subject is asked (**Question B**) his/her rating of intervention on a 5-point Likert scale (1=very dissatisfied; 5= very satisfied).
- If the answer is "no", he/she is asked **Question C**: "Do you think you would have liked to receive intervention x?" (6=no, 7=don't know, 8=yes).

4.5.1 Results of Analysis Provision of Intervention Services

Table 4-19 lists the numbers and percentages of the respondents who reported receiving interventions and conversely those who did not. Four areas of service interventions were reportedly not received by over 50 per cent of the respondents. These were the 'provision of sheltered accommodation' (Q46), 'home visiting services' (Q51), 'help finding employment' (Q53), and 'providing non-hospital related leisure activities' (Q54).

Over 80 per cent of all respondents reported that they had not received the option of sheltered accommodation after being discharged from hospital, whereas only 13 per cent of the respondents had received this service, which shows an obvious lack of service provision in terms of providing sheltered

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accommodation. Around 77 per cent of the respondents' reported lack of assistance from service providers to help them to find employment or provide them with home visiting care, and 71 per cent of the respondents indicated that inadequate leisure activities were offered. However, it must also be appreciated that a proportion of respondents will not require each of these interventions; for example those already living in the community will not require sheltered accommodation.

Table 4-19: Respondents reports of intervention provision (Q41-Q54)

INTERVENTION PROVISION (Q41-Q47)	Q41	Q42	Q43	Q44	Q45	Q46	Q47
Not Provided Count(%)	0(0)	73(34.8)	30(14.3)	91(43.3)	96(45.7)	181(**86.2**)	72(34.3)
Provided Count(%)	210(100)	137(**65.2**)	180(15.7)	119(56.7)	114(54.3)	29(13.8)	138(**65.7**)
Intervention Provision (Q48-Q54)	Q48	Q49	Q50	Q51	Q52	Q53	Q54
Not Provided Count(%)	50(23.8)	110(52.4)	93(44.3)	162(**77.1**)	55(26.2)	163(**77.6**)	149(**71**)
Provided Count(%)	160(**76.2**)	100(47.6)	117(55.7)	48(22.9)	155(**73.8**)	47(22.4)	61(29)

However, in contrast, good intervention provision was reported by services users in four areas, which included 'help to improve the capacity to cope with social and working life (Q42)', 'provision of hospital related leisure activities (Q47)', 'provision of group psychotherapy (Q48)', and 'help to obtain welfare benefits or exemptions (Q52)'. 65.2 per cent of all respondents indicated that they received help with learning to cope with their lives and making arrangements to join in with leisure activities in the hospital. 76 per cent of the respondents had been provided with group psychotherapy sections, and 73 per cent of them received welfare benefits or exemptions via help from services providers.

4.5.2 Comparison of Provision of interventions across the two locations

The results in Table 4-20 were obtained by applying Chi-square tests to explore the relationship between the two hospital types (Psychiatric Unit in Urban General Hospital and Suburban Specialised Psychiatric Centre) in terms of intervention provision. Chi-square is used when wanting to explore the relationship between two categorical variables (Pallant, 2007), each of which can have two or more categories. This test compares the observed frequencies or proportions of cases which occur in each category, with the values which would be expected if there was no association between the two measured variables (Pallant, 2007). This is based on a cross-tabulation table, with cases classified according to the categories in each variable.

Table 4-20: Results of the application of a Chi-square to reports of service intervention provision by location (Q41-Q54)

INTERVENTION PROVISION	Q41		Q42		Q43		Q44		Q45		Q46		Q47	
	UGHPU/SSPC		UGHPU/SSPC		UGHPU/SSPC		UGHPU/SSPC		UGHPU/SSPC		UGHPU/SSPC		UGHPU/SSPC	
Not Provided Count %	0 (0)	0 (0)	31 (54.4)	42 (27.5)	12 (21.1)	18 (11.8)	39 (68.4)	52 (34.0)	42 (73.7)	54 (35.3)	55 (96.5)	126 (82.4)	29 (50.9)	43 (28.1)
Provided Count %	57 (100)	153 (100)	26 (45.6)	111 (72.5)	45 (78.9)	135 (88.2)	18 (31.6)	101 (66.0)	15 (26.3)	99 (64.7)	2 (3.5)	27 (17.6)	28 (49.1)	110 (71.9)
Significance Level P-value (Chi-square)	nil		*<0.0005*		0.137		*<0.0005*		*<0.0005*		*0.016**		*0.003*	

INTERVENTION PROVISION	Q48		Q49		Q50		Q51		Q52		Q53		Q54	
	UGHPU/SSPC		UGHPU/SSPC		UGHPU/SSPC		UGHPU/SSPC		UGHPU/SSPC		UGHPU/SSPC		UGHPU/SSPC	
Not Provided Count %	28 (49.1)	22 (14.4)	41 (71.9)	69 (45.1)	38 (66.7)	55 (35.9)	52 (91.2)	110 (71.9)	28 (49.1)	27 (17.6)	52 (91.2)	111 (72.5)	46 (80.7)	103 (67.3)
Provided Count %	29 (50.9)	131 (85.6)	16 (28.1)	84 (54.9)	19 (33.3)	98 (64.1)	5 (8.8)	43 (28.1)	29 (50.9)	126 (82.4)	5 (8.8)	42 (27.5)	11 (19.3)	50 (32.7)
Significance Level P-value (Chi-square)	*<0.0005*		*0.001*		*<0.0005*		*0.005*		*<0.0005*		*0.007*		0.084	

UGHPU: Urban General Hospital Psychiatric Unit

SSPC: Suburban Specialised Psychiatric Centre

* Fisher exact test p-value for samples is small (less than 5)

Table 4-20 above is a two by two table of a Chi-square test for independence, which indicates that there were statistical significant associations between service provision and hospital type for Q42 ('coping with social and working life', $p<0.0005$), Q44 ('compulsory treatment', $p<0.0005$), Q45 ('family meeting with therapist', $p<0.0005$), Q46 ('sheltered accommodation', Fisher exact test $p=0.016$), Q47('leisure activities in hospital', $p= 0.003$), Q48 ('group psychotherapy', $p<0.0005$), Q49 ('sheltered work', $p=0.001$), Q50 ('voluntary admission to hospital', $p<0.0005$). Q51 ('practical help at home', $p=0.005$), Q52 ('welfare benefits or exemptions', $p<0.0005$), and Q53 ('open employment', $p=0.007$).

However, there was no significant association between intervention provision and hospital type in Q43 ('meeting with therapist', $p=0.137$) and Q54 ('leisure activities outside hospital', $p=0.084$). Therefore, from the results of each part two questions, the significant difference between the two hospitals groups indicate that the respondents from the Suburban Specialised Psychiatric Centre reported a higher percentage of receiving more services than those respondents from the Urban General Hospital Psychiatric Unit on eleven out of fourteen different interventions. Q41 asks about access to prescribed medication, and since all of the respondents were prescribed with medication, no statistics were computed.

4.5.3 Results of Satisfaction Ranking of total Respondents with the Provision of intervention services

Descriptive statistics was used to compare service satisfaction with the provision of intervention. Table 4-21 on the next page lists the number and percentage of respondents who ranked their satisfaction with the provision of intervention services.

Table 4-21: Results of part two questions regarding the satisfaction level of the total respondents with the provision of services (Q41-Q54)

Satisfaction Level (Q41-Q47)		Q41	Q42	Q43	Q44	Q45	Q46	Q47
Very Dissatisfied	Count (%)	5 (2.6)	5 (2.5)	5 (2.5)	13 (6.9)	9 (4.8)	2 (1.2)	1 (0.5)
Mostly Dissatisfied	Count (%)	8 (4.2)	35 (17.5)	24 (11.8)	38 (20.1)	35 (18.4)	40 (23.1)	21 (10.7)
Mixed	Count (%)	49 (25.8)	37 (18.5)	40 (19.7)	30 (15.9)	35 (18.4)	10 (5.8)	37 (18.8)
Mostly Satisfied	Count (%)	71 (37.4)	90 (45.0)	87 (42.9)	89 (47.1)	87 (45.8)	113(65.3)	88 (44.7)
Very Satisfied	Count (%)	57 (30.0)	33 (16.5)	47 (23.1)	19 (10.0)	24 (12.6)	8 (4.6)	50 (25.3)
Satisfaction Level (Q48-Q54)		Q48	Q49	Q50	Q51	Q52	Q53	Q54
Very Dissatisfied	Count (%)	4 (2.0)	5 (2.6)	3 (1.6)	5 (2.8)	2 (10.0)	3 (1.6)	1 (0.6)
Mostly Dissatisfied	Count (%)	18 (8.9)	34 (17.9)	19 (9.9)	39 (21.8)	18 (9.0)	72 (39.1)	40 (24.4)
Mixed	Count (%)	44 (21.9)	33 (17.4)	31 (16.2)	19 (10.6)	32 (16.0)	13 (7.1)	21 (12.8)
Mostly Satisfied	Count (%)	88 (43.8)	96 (50.5)	105 (55.0)	106 (59.2)	78 (39.0)	81 (44.0)	88 (53.7)
Very Satisfied	Count (%)	47 (23.4)	22 (11.6)	33 (17.3)	10 (5.6)	70 (35.0)	15 (8.2)	14 (8.5)

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The results given in table 4-21 indicate that the intervention most respondents were satisfied with was 'helping to obtain welfare benefits or exemptions' (Q52), with over 74 per cent of the respondents reporting being 'mostly satisfied' or 'very satisfied'. The next most highly ranked category was 'voluntary admission to hospital' (Q50), with 72.3 per cent of respondents reporting being satisfied with this intervention. This was followed by 70 per cent of the respondents reporting that they were satisfied with 'providing leisure activities in hospital' (Q47). In contrast, the most reporting dissatisfied aspect of intervention services (mostly dissatisfied with very dissatisfied) was 'helping to find employment' (Q53), with 40.7 per cent of the respondents being dissatisfied with this intervention. The second and third most often reported dissatisfied interventions were 'compulsory treatment' (Q44) with 27 per cent reporting being dissatisfied, and 'providing leisure activities outside hospital' (Q54) with 25 per cent of respondents reporting dissatisfaction.

4.5.4 Comparison of Satisfaction Rankings with the Provision of intervention services between the Two Hospitals

Table 4-22 on the next page, shows an application of the Fisher exact test to compare the relationship between the two hospital types (Urban General Hospital Psychiatric Unit and Suburban Specialised Psychiatric Centre) regarding satisfaction with the provision of intervention services.

Table 4-22: Comparison of the satisfaction level between the two hospital types in part two questions (Q41-Q54)

SATISFACTION LEVEL Q41-Q47		Q41		Q42		Q43		Q44		Q45		Q46		Q47	
		UGHPU	SSPC	UGHPU	SSPC	UGHPU	SSPC	UGHPU	SSPC	UGHPU	SSPC	UGHPU	SSPC	UGHPU	SSPC
Very Dissatisfied	Count	0	5	0	5	0	5	1	12	0	9	0	2	0	1
	%	(0)	(3.3)	(0)	(3.4)	(0)	(3.4)	(2.0)	(8.6)	(0)	(6.3)	(0)	(1.5)	(0)	(0.7)
Mostly Dissatisfied	Count	2	6	10	25	9	15	11	27	10	25	4	36	6	15
	%	(3.5)	(3.9)	(18.9)	(17.0)	(16.1)	(10.2)	(22.0)	(19.4)	(21.7)	(17.4)	(9.3)	(27.7)	(11.8)	(10.3)
Mixed	Count	12	37	5	32	9	31	5	25	5	30	0	10	7	30
	%	(21.1)	(24.2)	(9.4)	(21.8)	(16.1)	(21.1)	(10.0)	(18.0)	(10.9)	(20.8)	(0)	(7.7)	(13.7)	(20.5)
Mostly Satisfied	Count	25	66	31	59	26	61	31	58	28	59	37	76	29	59
	%	(43.9)	(43.1)	(58.5)	(40.1)	(46.4)	(41.5)	(62.0)	(41.7)	(60.9)	(41.0)	(86.0)	(58.5)	(56.9)	(40.4)
Very Satisfied	Count	18	39	7	26	12	35	2	17	3	21	2	6	9	41
	%	(31.6)	(25.5)	(13.2)	(17.7)	(21.4)	(23.8)	(4)	(12.2)	(6.5)	(14.6)	(4.7)	(4.6)	(17.6)	(28.1)
Significance Level P-value (Fisher exact test)		0.169		0.390		0.945		*0.047*		*0.042*		*0.003*		0.768	

SATISFACTION LEVEL Q48-Q54		Q48		Q49		Q50		Q51		Q52		Q53		Q54	
		UGHPU	SSPC	UGHPU	SSPC	UGHPU	SSPC	UGHPU	SSPC	UGHPU	SSPC	UGHPU	SSPC	UGHPU	SSPC
Very Dissatisfied	Count	0	4	1	4	1	2	0	5	0	2	0	3	0	1
	%	(0)	(2.7)	(2.0)	(2.8)	(2.0)	(1.4)	(0)	(3.8)	(0)	(1.4)	(0)	(2.2)	(0)	(0.8)
Mostly Dissatisfied	Count	8	10	11	23	7	12	11	28	6	12	17	55	10	30
	%	(15.4)	(6.7)	(22.4)	(16.3)	(14.3)	(8.5)	(23.4)	(21.2)	(11.5)	(8.1)	(36.2)	(40.1)	(25.0)	(24.2)
Mixed	Count	8	36	5	28	4	27	1	18	4	28	2	11	4	17
	%	(15.4)	(24.2)	(10.2)	(19.9)	(8.2)	(19.0)	(2.1)	(13.6)	(7.7)	(18.9)	(4.3)	(8.0)	(10.0)	(13.7)
Mostly Satisfied	Count	28	60	28	68	31	74	34	72	32	46	27	54	25	63
	%	(53.8)	(40.3)	(57.1)	(48.2)	(63.3)	(52.1)	(72.3)	(54.5)	(61.5)	(31.1)	(57.4)	(39.4)	(62.5)	(50.8)
Very Satisfied	Count	8	39	4	18	6	27	1	9	10	60	1	14	1	13
	%	(15.4)	(26.2)	(8.2)	(12.8)	(12.2)	(19.0)	(2.1)	(6.8)	(19.2)	(40.5)	(2.1)	(10.2)	(2.5)	(10.5)
Significance Level P-value (Fisher exact test)		0.470		0.771		0.528		0.052		*0.001*		0.581		0.845	

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The Chi-square tests requires that the expected frequencies in each cell should not be too small. If they are too small, the test may not be properly or meaningful. Therefore, Siegel and Castellan (1988) recommendations that if the smallest expected frequency is less than 5, use the Fisher exact test.

When the Fisher exact test was applied to the data, significantly different associations were revealed with the satisfaction level between locations for Q44 ('compulsory treatment', p=0.047), Q45 ('family meeting with therapist', p=0.042), Q46 ('sheltered accommodation', p=0.003), and Q52 ('welfare benefits or exemptions', p=0.001). There were no significant associations for in Q41 ('prescribed medication', p=0.169), Q42 ('coping with social and working life', p=0.390), Q43 ('meeting with therapist', p=0.945), Q47 ('leisure activities in hospital', p=0.768), Q48 ('group psychotherapy', p=0.470), Q49 ('sheltered work', p=0.771), Q50 ('voluntary admission to hospital', p=0.528), Q51 ('practical help at home', p=0.052), Q53 ('open employment', p=0.581), and Q54 ('leisure activities outside hospital', p=0.845).

Q44 asked about compulsory treatment; with the satisfaction level being higher for those from the Urban General Hospital Psychiatric Unit than in the Suburban Specialised Psychiatric Centre; 66 per cent of all respondents from the General Hospital Psychiatric Unit were satisfied and 53.9 per cent of respondents from the Suburban Specialised Psychiatric Centre were satisfied with the compulsory treatment. However, 28 per cent of all respondents from the SSPC were dissatisfied with this aspect.

Q45 asked about meetings with the family and the therapist. The satisfaction level of respondents from the Urban General Hospital Psychiatric Unit (UGHPU) was higher than those from the Suburban Specialised Psychiatric Centre (SSPC) (p=0.042); 67.4 per cent of all respondents from the UGHPU were satisfied with the service provided in terms of meetings between family and therapist. However, only 55.6 per cent of the respondents from the SSPC were satisfied. Q46 asked about sheltered accommodation. The satisfaction level of respondents from the UGHPU was 90.7 per cent, in contrast to the SSPC, where there only 63.1 per cent of the respondents were satisfied.

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Q52 asked about obtaining welfare benefits or exemptions. The satisfaction level of respondents from the Urban General Hospital Psychiatric Unit was 80.7 per cent, which was higher than the 71.6 per cent of respondents from the Suburban Specialised Psychiatric Centre who were satisfied with this aspect.

The findings regarding satisfaction with part two question of the four service interventions were statistically significantly different between the two hospital types; the respondents reported a higher percentage of service satisfaction with the Urban General Hospital Psychiatric Unit than the Suburban Specialised Psychiatric Centre in terms of all fourteen part two intervention provision questions.

4.5.5 Summary

Part two questions in the VSSS-TC questionnaire focuses on the provision of interventions, not only asking whether or not the intervention services were provided, but also asking the respondents to rank their satisfaction level with the interventions they received. The following are some of the highlights from this section of the findings:

- Over 50 per cent of the respondents reported that they '*did not receive'* services in all four areas, which could indicates that there is an inadequate provision of these services:

    (1) Sheltered accommodation

    (2) Home visiting services

    (3) Finding employment

    (4) Leisure activities outside the hospital

    However some of these might not have been relevant to users in certain situations

- Over 60 per cent of the respondents reported that they '*received'* intervention services in the following four areas, which indicates that these are better provided services:

    (1) Help to cope with social and working life

(2) Leisure activities in hospital,

(3) Group psychotherapy

(4) Helping with obtaining welfare benefits or exemptions

- Respondents from the Suburban Specialised Psychiatric Centre reported that they received more intervention services than in the Urban General Hospital Psychiatric Unit.
- The intervention that most respondents were satisfied with was help in obtaining welfare benefits or exemptions. The intervention that was most frequently reported as being unsatisfactory was help in finding employment.
- Respondents from the Urban General Hospital Psychiatric Unit reported higher level of satisfaction in all areas of intervention provision than those from the Suburban Specialised Psychiatric Centre.

Analysis of eleven out of thirteen questions in part two of the questionnaire reveals a statistically significant difference between the two locations, in that respondents from the Suburban Specialised Psychiatric Centre received more intervention services than those from the Urban General Hospital Psychiatric Unit. This clearly indicates that the Suburban Specialised Psychiatric Centre provides a wider range of services compared to the Urban General Hospital Psychiatric Unit. However, the findings also indicate that respondents from the Urban General Hospital Psychiatric Unit were more satisfied with the provision of fewer intervention services than those respondents from the Suburban Specialised Psychiatric Centre who received a wider range of services.

4.6 Discussion of the Satisfaction Survey Findings

The main objective of a user satisfaction survey is to identify users' satisfaction with services so that areas for improvement can be identified. Satisfaction is an indicator of the relationship between users and services, and it can also be related to both the risk of dropping out of the healthcare system and compliance with treatment (Tung and Chang, 2009). Comparison of users' satisfaction with

healthcare in different settings can produce more general information to improve the quality of the service. Not only can it attempt to measure satisfaction with different types of service provision, but it also may be able to identify unsatisfactory aspects.

The aim of this survey was to examine users' satisfaction with mental health services within two different types of psychiatric provision in Taiwan, the capital city of Taiwan. It involved comparing service provision and satisfaction from the perspectives of user attending a psychiatric day centre and out-patient clinic located within a Urban General hospital with most people institutionalised within a suburban specialised psychiatric centre also with some respondents from out-patient clinic setting, where very few community-based care interventions are provided. The researcher would expect to find some differences from examining these very different populations. However, the findings were different from those expected. One possible explanation might be due to those respondents have more integration by people attending the day centre and out-patient clinic.

The VSSS was adapted and used to measuring patient's satisfaction with mental health services in these different settings. The 63-item traditional Chinese version of the Verona Service Satisfaction Scale appeared to capture most contents relevant to the concept of satisfaction with psychiatric diagnoses by the psychiatric services in Taiwan.

Although the two groups of samples' characteristics did not differ by age, gender, educational level, and employment status, there was one significant difference in the users' marital status between the two groups, in that more users in the Suburban Specialised Psychiatric Centre were unmarried. A possible explanation for this difference is that most of the respondents from the Psychiatric Centre were institutional in-patients with more serious symptoms.

Users surveyed from both locations had been users of mental health service for a similar time, but there was an important difference in the length of time of hospitalisation. While the length of time using the mental health service did not

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significantly differ between the two groups, but the length was shorter for those respondents from the Urban General Hospital Psychiatric Unit (UGHPU). Moreover, a higher percentage of users from the Suburban Specialised Psychiatric Centre (SSPC) were more frequently hospitalised while the majority of respondents from the UGHPU had never been hospitalised in any psychiatric ward with a psychotic diagnosis in Taiwan. Possible explanation might be due to that Specialised Psychiatric Centre provides more residential services for patients, while Urban General Hospital Psychiatric Unit only provides services of day care unit and psychiatric out-patient clinic.

Analysis of the social demographic characteristics of respondents overall revealed that most of them were single, had a low level of education, were unemployed, and were in and out of hospital many times. This could be an indicator of the inadequate provision of mental health services which have not promoted community integration. Moreover, a comparison of the characteristics of respondents by location revealed that more unmarried mentally ill patients were in the Suburban Specialised Psychiatric Centre, and these people also had a high level of re-admission into psychiatric care, which may be the result of a lack of the provision of services in the community.

With respect to survey respondents reported lower satisfaction level regarding relatives' involvement, some early studies in western societies which assessed the needs of the families of adults with mental illness consistently found that families need information about their relative's illness, coping strategies, support, understanding of the illness, and assistance with problem-solving (Winefield and Harvey, 1994). More recent research has found that family psycho-education models which last for nine months and provide information about mental illness, emotional support, problem-solving skills, and crisis intervention, reduce the relapse and re-hospitalisation of persons with mental illness, and improve the well-being of their family member (McFarlane, et al., 2003).

One of the most striking findings in this survey was that, despite the poor provision of services, respondents from the Urban General Hospital Psychiatric Unit tended to be more satisfied with the services they received. Moreover, the

respondents who had never been hospitalised tended to give a higher ranking of satisfaction compare to those respondents who had been hospitalised previously. One possible explanation for this may be that the respondents in Urban General Hospital were all day patients and were therefore not institutionalised, but it could also indicate that the service practice differs between different service settings.

Satisfaction with the professional skills and behaviour, particularly of doctors, tended to be high among users in both hospitals, which could be attributed to traditional Chinese culture, where society deeply respects doctors. The lowest satisfaction ranking was with helping to find employment and this result was also confirmed by the thematic analysis of the interview findings with regard to the users' financial problems when they live in the community by themselves, which will discuss later in the Chapter six.

This assumption is supported by the respondents' opinions about the kind of intervention they did not receive and also the interventions with lower satisfaction rankings. This may not apply to all respondents' situation, such as those who used the out-patient service and lived at home. However, despite the fact that they did not need those services, the majority of respondents said that they did not know about the service to assist with the provision of sheltered accommodation, and would like to receive help to find employment. In contrast to the inadequate service provision reported by users, better service intervention provision with a higher satisfaction ranking was given to providing group psychotherapy and help in obtaining welfare benefits or exemptions support. This may indicate that mental health services provided by both hospitals have better quality of service in relation to those areas.

The major findings obtained in this survey study are that, after taking into account a comprehensive set of measures which include patients' socio-demographics characteristics, and the type of intervention provided for them, there was a significant effect on users' service satisfaction which was not directly linked to the differences in the intervention service being provided. Users from the Suburban Specialised Psychiatric Centre setting, who were in

and out of hospital many times, were more prone to expressing lower levels of satisfaction with the care they received.

It is difficult to say whether these findings reflect a lowering of efforts and enthusiasm of service staff when they are providing care for patients with chronic and enduring disorders. Another explanation may be supported by discussion of a previous study by Ruggeri, et al. (2007) which used the same instrument to measure users' satisfaction. Their findings indicated a more pessimistic view of long-term patients who perceive their own condition as being substantially unchanged, despite having received a number of long-lasting treatments. This finding, however, highlights the importance of mental health services keeping a clear focus on long-term patients who generally display increased levels of disability and a consequent wide range of social and health needs.

The lower satisfaction among those users who have been provided with services by the Suburban Specialised Psychiatric Centre, which resembles an asylum, could also be tackled within the recovery model or discharging plan of mental healthcare where mental health services support users with the overall aim of social inclusion. According to the findings by Ruggeri, et al. (2007), the role of the mental healthcare services for those who still need their support for a very long time should be upon promoting goals which are meaningful for the patients themselves.

Chapter Five

Qualitative Interview Findings and Discussion

5.1 Introduction

The aim of the qualitative interviews used in this research project was to, explore people's experiences in detail, and to uncover new areas or ideas which were not anticipated at the outset of the research. The findings of the in-depth interviews with nine service users and carers (Group A) and six service providers (Group B) and an additional three key informants at the end of the data collection are presented in this chapter. The findings are presented in themes representing the main issues which emerged within the two groups of interviews, and the perspectives of the three key informants are also presented. Each theme demonstrates a pattern found within the interviews and is described with the name (label), the concept, and sub-themes which underpin the structure of the key themes. To support the evolving arguments of the selection of the themes, quotations are used to support the interpretation of each theme. Each quote is attributed by a fictitious surname for each participant.

5.2 Service Users' and Carers' Interviews

5.2.1 Service Users' and Carers' Characteristics

Nine individuals were recruited to Group A, which consisted of Mental Health Service users and carers. These included seven patients and two carers. The group consisted of eight females and one male, with a mean age of 44.8 years, and a mean time of using the mental health service of 13.3 years. The method of sampling was purposive, specifically sampling from different ward environments within two hospitals, which has been discussed in Methodology Chapter Three. Three participants were selected from the Day Care Centre in Urban General Hospital Psychiatric Unit (UGHPU), with two participants chosen from two different In-Patient Rehabilitation wards, while the other two participants were selected from a Half-Way House in the Suburban Specialised Psychiatric Centre (SSPC). The two carers, both of whom have a family

member suffering from mental health problems. One carer was recruited from each of the two hospitals mentioned above. See Table 5-1 for a summary of the service users' characteristics.

Table 5-1: Summary of users' and carers' characteristics
(Each participant is labelled with a fictitious surname, and all of the selected surnames are common family names in Taiwan)

NAME	ORIGIN	GENDER	AGE	YEARS FOR USING SERVICES	OCCUPATION PAST/PRESENT
Ms. Chang	UGHPU DC	Female	50	8	Nurse/ School Assistant
Ms. Chao	SSPC Rehab	Female	27	6	Part-time job/ Assistant in the Hospital
Ms. Wang	UGHPU DC	Female	42	20	Receptionist/ Assistant in the Hospital
Ms. Chen	UGHPU DC	Female	49	14	Sales/ nil
Ms. Lin	SSPC Half-Way	Female	57	24	Teacher/ nil
Mr. Liu	SSPC Half-Way	Male	36	9	nil/ Assistant in Post Office
Ms. Wu	SSPC Rehab	Female	47	16	Teacher/ Assistant in the Hospital
Mrs. Guo	UGHPU DC	Female	60	13 (Carer)	Typist / House wife
Mrs. Lee	SSPC Rehab	Female	36	10 (Carer)	Teacher

*UGHPU: Urban General Hospital Psychiatric Unit
SSPC: Suburban Specialised Psychiatric Centre

5.2.2 Conducting Service Users' and Carers' Interviews

Seven interviews were conducted with psychiatric patients in their original ward's consulting room at the patients' request. As for the two carers' interviews, one was conducted in a public place outside the hospital at the participant's request, since this was deemed to be the most convenient time and place, while the other was conducted in a consulting room inside the hospital. All of the participants consented to having the interview recorded. After a review of the purpose of the interview, and having obtained written consent, several questions were asked within a topic guide (See Appendix V), which had been created for the service users' interviews. The interview guide was intended to be used flexibly, in order to promote the generation of natural links and explanations in the users own words. Furthermore, users' stories were allowed to unfold naturally, in keeping with qualitative approaches (Holstein and Gubrium, 1995)

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Most interviews in this project lasted one hour on average, and participants reported the fact that the interview had given them an opportunity to talk freely about their experiences and feelings about the service, which they did not normally have the chance to do, since most of their conversations within the service would be centred on the symptoms of their illness. This suggests that a supportive element of interviewing in cases of mental illness could promote interviewees to feel valued, and allow them to feel as if they are contributing to the improvement of future services (Potter and Heburn, 2005).

5.3 Findings: Service Users' and Carers' Themes

For the ease of interpretation, and to ensure that the health services in Taiwan are clearly illustrated from different perspectives, services users' and providers' themes are presented separately. The main themes are described in this Chapter and discussed more theoretically in the light of the literature in Chapter Six.

5.3.1 Overview and Introduction of Services Users' and Carers' Themes

The key themes presented in this section are presented in diagram 5-2. Each theme has a descriptive theme label, and each theme has several sub-themes which support the development of the key themes. The main issues are inter-related and links between the key themes from both groups are discussed in the next Chapter.

The fundamental element of the interviews with the service users and carers was the expression of their experiences of using the Mental Health services in Taiwan. After undertaking a thematic analysis of the raw data, three key themes were uncovered, namely aspects of experiencing the service, dealing with life, and fears and hopes for the future.

Experiencing the service represents an interpretation of being cared for within the psychiatric institution. This key theme is emphasised in two areas: experiencing help and experiencing difficulties.

The second key theme, dealing with life, elaborates their general experience of life as a person or carer of someone labelled as having a mental health problem by the outside world. This theme covers experiences of being stigmatised and being disadvantaged by society, and also includes experiences of how to cope with the world outside the institution. The third key theme, fears and hopes for the future, describes some of the users' sense of comfort when staying within the institution. At the same time, others wish to go back home and live independently, but have fears regarding how they might cope within the current financial and social welfare system.

Figure 5-2: Key themes and sub-themes of service users' and carers' group

Experiences of using Mental Health Services

Three Key Themes

Dealing with Life
(Life generally as Mental Health service user)

- Self help and family influences
- Being different
- Being disadvantaged

Experiencing the Services
(Life in the institution)

Experiencing Difficulties
- Environment and facilities
- Personal experiences with staff
- Financial problems

Experiencing Help
- Understanding of their own illness
- Available support
- Mutual help

Fears and hopes for the Future

- Comfort of staying in the institution
- Wanting to rejoin life
- Individual needs

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5.3.2 Key Theme: Experiencing the Services

This theme contains two sub-themes: **experiencing help** and **experiencing difficulties** with the services provided by institutions, which can also be displayed as the positive and negative sides of their experience. Both sub-themes contain a further three sub-themes to support the concept of the key theme. Under the sub-theme of experiencing help, three more sub-themes were added, namely, understanding their own illness, available support, and mutual help, while under the other sub-theme of experiencing difficulties, another three sub-themes were constructed, namely, environment and facilities, personal experience of staff, and financial problems.

• Experiencing Help

The extent to which services users and carers experience help when staying in the institutions includes the kind of support they receive, how they feel that life in a sheltered environment influences their understanding of their own illness, why life in the hospital environment makes them feel as if their behaviour is as normal when they compare themselves with other patients, what kind of support they receive to enhance their working and self-care ability and what kind of welfare support can make their life easier. Also discussed was how this support can stabilise their lives and help them to cope better with the life in hospital or community environment, how they experience the consideration shown to them by the healthcare profession, not only within the hospital, but also the follow up services after being discharged into the community.

▪ Sub-theme: Understanding their illness

Many users (patients) described their understanding of their own illness by narrating its course. Some service users had received information from service providers and there seem to be a pattern of the longer they had been in contact with services, the better they understand their illness. Ms. Wu has been using the service for sixteen years, and she became aware that she needed mental health treatment after having been hospitalised for the first time:

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> I insisted that I was in a normal state, but I wondered why I had to be taken to hospital. I had the sense that I was not willing to go to hospital. I thought I was not at a pathological state and I had no idea why I should be under the confinement.... After that, I had to admit that I was ill, I had to be treated, and it could not be overlooked! I was getting along well with the doctor... [Ms. Wu]

However, Ms. Chao has been using the service for six years, and at the beginning of her illness, she insisted that her situation was due to some disturbance by evil spirits. However, recent years of continuous treatment have made her realise that the solution to stabilising her illness is though ongoing treatment from the service:

> At that time, we did not know there was a psychiatric clinic, thus we did not go to see the doctor... I repelled the psychiatric clinic. I thought there was no need for me to accept any treatment since I did not get any disease. I thought I had met something unclear, such as ghosts... I lacked the knowledge of psychiatric disease and I did not know that I must keep taking pills. Then I thought I had recovered and stopped taking pills. But the uncomfortable feelings re-emerged again. [Ms. Chao]

Service users also mentioned that they have received support from the service regarding gaining knowledge of their own illness. Before they knew anything about psychiatry and their illness, they often refused to seek help from the mental health service. Ms. Chao particularly stated that, once she had comprehended the nature of her illness, it really made a lot of difference to her willingness to receive help from the services:

> I had been thinking of ghosts in relation to my illness in the beginning. I still didn't know what auditory hallucination was, until he (doctor) told me that I was ill. Yes, the help is... is that my condition began to improve from that time, and it was in November that I knew, so my knowledge about Psychiatric department was also limited. [Ms. Chao]

The present study participants described their understanding what was happening to them through folklore and this delayed their seeking help. The relationship between help-seeking behaviour and cultural inference is evident in prior studies, and this effect in terms of treatment needs and seeking mental health professional help can also be found among Chinese people across various Asian countries, including Hong Kong, Taiwan, Mainland China and Singapore (Chen & Mak, 2008). A study conducted by Lin (2002) in Taiwan found that people tended to depend on themselves to deal with problems of

mental illness, rather than asking for help from others, particularly professionals. If they could not resolve their own problems over a long period of time, they were inclined to experience shame, blame, negative emotions and embarrassment, after which they then may have considered seeking help from others. Help-seeking behaviour depended on factors such as the level of familiarity, professional knowledge and competence (Lin, 2002).

▪ Sub-theme: Available support

Some of the users maintained that the flexibility of mental health services enabled them to control the illness in their own way. Ms. Chang has been a patient of the Psychiatric Day Care unit for more than five years, and since she does not live near the hospital, she only comes to the Day Care Centre once a week:

> When I felt ill or had some problems, I would tell them my symptoms, and they always took care of me.... it is far away from my home,.. if I can't come, it is flexible. [Ms. Chang]

Mr. Liu, who has been living in the hospital for more than nine years, has a part-time job outside the hospital. He describes the service as being flexible enough to suit everyone:

> I go out to work. Therefore, I can't participate in all the activities of the hospital... Everyone has his different condition,... we are staying in a ward like half-way home, therefore can suit everyone's situation for their own good. [Mr. Liu]

Some users explained how the hospital acts as a shelter to help them to deal with the psychological pain caused by psychotic symptoms. Ms. Chao, who has been using the service irregularly for six years, did not realise that she needed the service to help her to control her illness until recently:

> Yes, thanks for the shelter environment, I have transformed into this present situation as I'm sitting here now. This shelter environment prevents me from making errors... Yes, the most important one is this, the shelter environment, right, shelter environment like OT. It is OT as well as a working place, and the ward is a ward, and it also has someone to lock the door and to protect you. This is sheltered environment, under that condition, doctor's help is limited, and one should fight with the disease by himself. [Ms. Chao]

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However, Mrs Lee, a carer, stressed the fact that a sheltered environment like the hospital could give her sister a safer place to live as a mentally ill patient. She mentioned that she used to wonder why her sister's behaviour differs between life in the hospital and outside in the community although under the same medication, then she figured out that it could be the effect of a sheltered environment and professional care:

> Because of her condition, the patients there were different from other people in the outer world, thus, under that environment, she felt sheltered. In the hospital, regardless of the mistakes she made or her abnormal behaviour, she would think that it was rationality and staff will take care of her and accept her behaviour. And she was stable under that environment.... [Mrs Lee]

In terms of the support received to enhance their working ability, users explained how the service helps them by referring them to the different stages of the training programme to suit their individual needs:

> They encourage us to work. Of course, it doesn't matter is it's inside or outside the hospital, if we are able to, the work will be introduced to us according to everyone's situation. In this way, we have some income sources. [Ms. Lin]

> If he feels that you are in stable condition, then he will ask the OT to arrange some work for you to do. Gradually, you feel you are part of the society, and you also have the room in the hospital. Even if you don't work outside, the hospital will hold some activities, which may make you feel better. [Mr. Liu]

> Then she worked in the hospital, responsible for packing drugs. In fact, she had done many different jobs, and the function of her brain is all right, just like everyone else. [Mrs Kuo]

Two users explained how the service helped them to enhance their self-care ability. They had both been using the service for more than ten years, and have been through the stage of acute illness and are now in the rehabilitation ward in the Suburban Specialised Psychiatric Centre. Ms. Lin indicated that she received special support on a rehabilitation programme because of other medical conditions. Mr. Liu also stated that he followed the rehabilitation programme, which has led to a great improvement:

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> They really helped me a lot with my health... they also care about our diet, exercise and daily life. They required us to bathe, wash hair, wash clothes, and care about personal hygiene. They pay attention to our self-care; meanwhile, they also take good care of us. [Ms. Lin]

> The hospital has a set regime in its recovery system. As long as you do what you are told to do according to it, you will have some improvement. For example,...when I was just arrived in the hospital, I didn't care about personal hygiene, then the nurse asked me to take a bath, and made me feel like a normal person. [Mr. Liu]

Some of the users gave an account of the welfare support they received. Ms. Chen mentioned free bus rides and subsidies she received every month, while Ms. Wu said that the Occupational Therapy (OT) work and training she obtained not only stabilised her daily regular pattern, but also gave her some cash to spend:

> Work helps me live regularly and maintain good personal relations to some extent, your original function will not become degenerated, and you may have more interactions with other people. I love my job, because it's selective, not everyone has the chance to do it. [Ms. Wu]

> She told us the government would offer us handicapped subsidies which we could receive each month. She helped us go through all the formalities and the certificate for moderately disabled people were distributed to us, and then we got 4,000 Yuan for each month. [Ms. Chen]

> I was guided to apply for low income households, so the government pays money which was initially at my own expense; I only need to pay for meal fees here. If you held a 'Catastrophic Illness Card', then you don't need to pay any fee at all. [Mr. Liu]

Moreover, users stated that the support provided by the mental health service, such as daily activity, group therapy and OT training programmes have made their lives significantly more stable. As a carer, Mrs. Kuo thought that the support from the day care centre has meant that her daughter has a daily life as an office worker, just like other working people:

> She goes to mental hospital every day just like a normal office worker rather than a patient, she works here in the daytime、 gets off work after punching out and stays at home at night, all the environments are familiar to her. [Mrs. Kuo]

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However, Ms. Chang described the work training programme she received can make her have things to do during day time:

> The advantage is that we don't have to work hard endlessly from early morning till late night; we can have quality sleep and enjoy our life without pressure every day. Although the assistant work is low-paying, we can kill time through it and earn a sense of pride from it... [Ms. Chang]

Several researchers indicate that a therapeutic relationship is of importance in psychotherapy as well as in mental health care in general. For example, a study undertaken by Johansson & Eklund (2003) established that the quality of a helpful relationship, including the patients feeling understood by the professional staff, is counted as, and constitutes, good psychiatric care. Studies in which a therapeutic alliance is described as being empathic, warm, supportive, accepting, cooperative and reciprocated, engage the creation of hope and the possibility for a patient to obtain emotional release (Frank & Gunderson, 1990; Hougaard, 1994).

▪ Sub-theme: Mutual help

Users and carers elaborated on the fact that mutual help from other patients staying in the same institution can make them feel that they are not alone. Mr. Liu indicated that the friends he met in the same ward offered him understanding and they all helped each other:

> It is very nice for us to make friends with other patients, sometimes we have quarrels with others because of different personalities, but we can understand and forgive each other immediately after making an apology, most time we live in harmony. [Mr. Liu]

As a carer, Mrs. Lee expressed the idea that her sister's condition was far more stable inside the hospital than in the outside community. Therefore, she believed that allowing her sister to be in the same environment with other mentally ill patients was beneficial to her:

The patients there are different from other people in the society, and then in fact, under that environment, she feels sheltered. So, in that place, regardless of the mistakes she made or her abnormal behaviour, she would think that it was rationality. And she was stable under that environment, apart from taking medicine. [Mrs. Lee]

Mutual help is one of the self help activities, which Helgeson & Gottlieb (2000) suggest is worth focusing on because their distinct theoretical rationale underpins the existence of other mentally ill individuals. From a theoretical point of view, mutual help can be classified as the potential benefits of socially supportive interactions, especially if patients utilise the support of people who have experienced similar difficulties, and who can therefore easily empathise with them. In addition, Borkman (1990) stresses that mutual help actually possesses 'experiential knowledge', in contrast to the 'professional knowledge' of service providers. A number of benefits would be expected from such supportive interactions, such as a feeling of being more understood and less isolated and learning more effective ways of coping with difficulties (Helgeson & Gottlieb, 2000).

• Experiencing Difficulties

Alongside these positive experiences of service users, other issues of a more negative nature were mentioned. Negative experiences expressed should be considered as areas of dissatisfaction with the mental health services users have received during their lives in institutions, including the kind of environmental issues they can recall, their disaffected personal experiences with medical staff regarding hospital regulations, the kind of financial problems they were facing, and how the hospital systems limited their choice of continued care.

▪ Sub-theme: Environment and Facilities

Issues surrounding the environment and facilities available were cited as problematic by some service users.

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Ms. Chang compared the psychiatric ward facilities between the private and public hospitals, and said that, not only were the facilities rather poor in the public psychiatric hospital, but also the professionalism of the staff. Ms. Wang complained that the group therapy in the day care centre was not useful for her, but she felt compelled to make the daily visit because her family wanted her to do it. Also as a caregiver, Mrs. Lee made some statements about a disrespectful situation in one of the private sanatoriums, which she noticed when she visited her sister:

> If you have ever been to a private sanatorium, I think you'll find that a pubic hospital is quite different from a private one... the private one is like a cuckoo's nest, everything is gathered together, and the centralised management is very convenient.......You should respect everyone, even if they are mentally ill. [Mrs. Lee]

> * "Cuckoo's nest" is a term of expression, which used in Taiwan to describe an old psychiatric sanatorium.

Ms. Chao has been using the service for six years, and she complained about the lack of choice of suitable activities for her and her family to participate in, such as a family group therapy:

> My father and I, we both think that some activities are just held in form of hospital regulations, but we don't think that really help.... some family members want to take part in some activities. But after they participated in the activities, they found that they didn't get any help. [Ms. Chao]

Ms. Lin has been using the service for more than twenty years, and had stayed in one of the rehabilitation wards in Suburban Specialised Psychiatric Centre for six years until the time of the interview. She expressed her feeling of a lack of freedom in the hospital:

> Though it seems that you are free on Saturday and Sunday in the recovery ward, however...it would be better that if there are no time limitations on weekends,... your freedom seems to be a little bit restricted. [Ms. Lin]

▪ Sub-theme: Personal experiences with staff

More than half of the users complained about the psychiatric staff during interviews. Their complaints included being treated disrespectfully, a lack of professionalism among nurses, lack of opportunity for discussion, and poor information related to medication and treatments provided by doctors. Ms. Chang specifically mentioned her dissatisfaction with the service regarding discussing medication treatment with the doctor. She complained that no one gave her a chance to discuss it, or even inform her about the side effects of the new medicine she was been prescribed. She found it really difficult to endure the experience of having her medical prescription changed by the doctor. Ms. Wang, explained how she has been treated by a doctor in the out-patients clinic in the past, when she felt that the doctor was only interested in the medication treatment rather than her feelings:

> I doubted that if he realised what I really needed, what kind of help I needed. That was out-patient treatment. I wondered if during the past 10 years that the doctor in neurology department had any interest in this, or in me, I felt they were just careless over their work. [Ms. Wang]

Ms Chao also described her experience of lack of attention from a doctor when she was staying in the hospital. She wanted to discuss her illness and treatment, and felt that the doctor had only given perfunctory attention to her situation:

> The symptom did not disappear. Then I conveyed my concerns to the doctor, he always said he would observe again, but there was no news afterwards. So, I did not know what to do. Such situation occurred frequently, then eventually I…I would not like to reveal anything to the doctor. [Ms. Chao]

Meantime, Ms. Chao complained about the nursing staff, mentioning that professional nurses should be kind and professionally behaved. She gave an example of her experience in the previous stay of a psychiatric ward in the same hospital:

> I think the nurses were not professional enough, … nurses should take care of patients, and they should be very kind; but the nurses here were ferocious. I think nurses themselves should have some good manners, and have their own professional virtue at some point. They should not be talking all the time. …. we

patients always discussed privately the inappropriate and terrible behaviours or responses towards us when a certain nurse was angry. [Ms. Chao]

Ms. Wu also expressed her resentment toward one of the nurses during a previous stay in the acute ward, where she was treated disrespectfully and accused of breaking the regulations, which she did not admit to doing:

> I think she didn't respect human rights...I was bound on the bed for 5 hours, Then I called them from time to time, but they didn't answer me. I had no choice but to urinate on the bed, at that time I felt very...disrespected, I even had a bad impression, for it seemed that they were punishing me....... I did not commit any monstrous crime, but she tied me like this, that made me feel nonhuman. [Ms. Wu]

She also cited the lack of professionalism of the nursing staff in terms of patient confidentiality and respect. After her condition had stabilised, she was transferred to a chronic ward where she was being trained as an assistant. She complained that nurses, as a professional staff working in a psychiatric hospital, should understand the symptoms of mental illness and should respect mentally ill patients, rather than just sneering at them:

> They considered me as a worker rather than a patient, so they said anything without evading me.... They would laugh at patients who had just been hospitalised. I thought as nurses were engaged in this spiritual service, they should respect their patient, and they should know why she had such behaviour. It was her illness. If they didn't have such perceptions, how did they gain the qualification to work as nurses in neurology department? [Ms. Wu]

Nursing people with mental health problems provides many challenges for mental health nurses and their 'performance' in the context of multi-professional and interagency team working. Goodwin and Gore (2000) states that this type of nursing work can induce strain, which staff unwittingly fail to recognise, but which can significantly affect the patient's experience of the service. In clinical practice, Tummey (2006) confirms that it can often be a feature of the nursing role that the impact of mental illness on behaviour causes patients to distance themselves from contact with the mental health service. Given that mental health nurses' role, possibly more than many other healthcare professionals, usually involves a significantly longer period of time in direct personal contact

with the patients, then it is perhaps essential that their 'performance' is seen to embrace empathic elements which demonstrate and foster commitment and active involvement (Handsley and Stocks, 2009).

Several studies have shown that negative attitudes about mental illness are widespread in the general population (Corrigan, 2004; Bordieri and Drehmer, 1986; Wahl, 1999). Furthermore, stigmatising views seem not only to be limited to the general population or in the context of social relationships with friends, relatives or employers, but also occur in contact with mental health professionals (Schulze, 2007).

▪ Sub-theme: Financial problems

Two of the users made statements about the inadequate salary they earned when participating in the job training programmes. Ms. Wang, who has been in a day care unit for about two years, has had two regular jobs within the hospital, while Mr. Liu, who has stayed in the same rehabilitation ward for six years, has had a formal part-time job outside the hospital for the past four years. However, even with these regular jobs, they complained that the salary was not enough to make a living. However, they also said that it is still better to support themselves rather than having no income at all:

> I have had the job for about two years, although I thought the wage is not satisfactory, totally about 3000 yuan a month. [Ms. Wang]

> In the aspect of wages, it is calculated by quantity, not by time. Thus the monthly wages is about 8000 Yuan, even 10000 Yuan. It is a better job compared to the one in the hospital. The money is less when working in the hospital. If you do want to do other jobs, you need to make an effort. [Mr. Liu]

▪ Theme Summary

The essence of this theme was the experiences of the users and carers of their lives in the institutions. Accounts of the help experienced by the users strongly identify with the environmental influence on the individual patient's behaviour and symptoms, how patients made sense of their feeling of safety in the hospital, and the flexibility of the services to suit them, all of which, they

believed, helped them to control their illness. Simultaneously, carers described how patients behave differently inside the hospital and outside in a community setting, because the hospital setting provides a place for them to be themselves as a mentally ill people. They know that the staff in the institutions understand and accept their illness, and that they will provide a safer environment with suitable facilities for them. On the other hand, from the patients' point of view, once they realise that the treatment provided by the services can actually stabilise their uncomfortable symptoms, they are willing to stay in the service and receive a continuing care programme.

However, at the same time, some service users and carers identified some negative experiences. In essence, the accounts of complaints from users the using mental health service strongly related to poor facilities and disrespectful attitudes and lack of professionalism by the staff. From the patients' point of view, they expected staff to show their professionalism by displaying warmth and kindness toward the patients, and although this may only reflect the experience of a few interviewees in certain situations, it was a strong theme in their accounts.

Despite the complaints with the services in the previous theme, users still expressed satisfaction with a lot of the support they receive from the mental health service, which enhances their being able to work and their self-care abilities. This stabilises their lives in hospital or, after being discharged into the community with the rehabilitation programme, the welfare system supports their daily cost of living and they are taken care of by front-line services providers. Another issue concerns the financial problems experienced by mental health in-patients undertaking occupational job training. They complain that their income is far less than the average salary, which contributes greatly to their dissatisfaction with the service.

5.3.3 Key Theme: Dealing with Life

This key theme centres on how patients cope with the outside world, and with their lives generally as mental health services users in Taiwan. It covers three

main sub-themes, which generally describe the situations they face within current society. The sub-themes include the descriptions of users and carers of the total process from understanding their own illness in the beginning, followed by the perspectives of users and carers of the stigmatisation they experience in society. Also discussed in the interviews with the effect of being labelled as a 'disadvantaged minority group' in society, this disrupts their lives in many ways and deprived them of their human rights.

▪ Sub-theme: Self help and family influence

This theme mainly relates to patients' and their families' understanding of their illness, which influences their choice of treatment from mental health services. It includes how they narrated their story from the beginning of their course of illness; how they gained knowledge about their own illness; the process of how their family developed an understanding of mental illness, and the fact that sometimes they continue to find accepting the patient's symptoms difficult, and the way those issues affect the timing of seeking help from the service.

All nine interviewees talked about processes of self-help, and some spoke of their families' understanding of the different levels of knowledge of their mental illness. This usually affected the timing of seeking of treatment from mental health service at the beginning of the illness. Three users mentioned that, when they discussed their symptoms with their parents (such as hallucinations), they always received a scared and unconvinced reaction from their parents, and were forbidden to discuss the issue ever again. Ms. Chao, Ms. Wang and Ms. Lin all encountered reactions such as these from their parents, which resulted in them being afraid to talk about their situation and feelings with their families:

> I did not talk about this with my family, because my parents could not believe that there was someone talking to me when I was alone. In fact, they are normal people... Thus families could not accept what they had not heard....., my parents felt that it was impossible to accept the hallucination. And now they have realised that I had been ill for years. [Ms. Chao]

> I have spoken to my father about this, his reaction was intense. He could not accept it... Since then, I did not mention this matter any more. [Ms. Wang]

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I came back home and told my parents that my illness had relapsed. My mother could not accept the fact. And my father brought me to a psychiatric clinic to see the psychiatric doctor. [Ms. Lin]

In Ms. Wu's case, she delayed her opportunity of early treatment for her mental illness due to her ex-husband's understanding of her symptoms, which he believed was purely the influence of evil spirits:

At the beginning, I did not know what had happened. At that time, my ex-husband took me to the temple to use folk custom therapy. It turned out to be useless. [Ms. Wu]

At the same time, two carers mentioned their knowledge of their family member's course of illness, which affected their understanding and choice of treatment. In the early stage of the illness, the family members did not understand what was wrong with the patient because they had no knowledge of psychiatric signs and symptoms.

Mrs. Kuo described what had happened when her sister found out there was something wrong with her daughter. Mrs. Kuo had no idea about mental illness, and so was unable to believe it:

My younger sister detected such abnormal behaviour of my daughter. My sister knew something about psychiatric disease. At that time, I gave a negative response...It was impossible! I was shocked and could not accept it... [Mrs. Kuo]

Mrs. Lee explained how her family first thought her sister's difficulties stemmed from relationship problems before realising the issues were a symptom of mental illness. Her family actually went through a stage of searching around before they discovered her sister needed help from mental health services:

At the very beginning; we thought that she had some problems in aspects of interpersonal relationships. However, through repeated observations, we found there was something wrong. It was not the problems simply related to the external world. [Mrs. Lee]

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In Chinese society, family caregivers play a significant role in the treatment of mentally ill patients because of Chinese cultural expectations and obligations. A report by Tung and Beck (2007) states that, in Taiwan, the average duration of providing care for a mentally ill family member is 9.7 years. Furthermore, more than ninety percent of family caregivers live with their mentally ill family members in order to take care of their relatives while they are not in institutions, because China has a collective society, which relies on family when making important decisions (Chang, 2001). Research shows that making a decision to seek mental health care in a Taiwanese family is not made by the individual alone, but usually a result of family influence.

It is also suggested that, in Chinese culture, there is increased family involvement in cases of mental illness, and the participation of key family members tends to be persistent and intensive (Lin, et al. 1982). This kind of influence affects health-seeking behaviours in terms of asking for help from mental health professionals. Research also implies that family members with mental illness often seek assistance from traditional healers before receiving treatment from modern medicine (Wen, 1998).

▪ Sub-theme: Being Different

This sub-theme illustrates the perspectives of public stigmatisation towards mental illness from the users' point of view, and in their stories, they described how they felt normal inside the hospital, but in reality, they were regarded as disabled people by the community. As a result they were discriminated against by the public, and even by their own relatives.

A great many users felt they were being discriminated against. Some of them have been labelled as "lunatics" by other people, and others feel they have unequal opportunities when looking for employment. Two carers shared the same impression of society's discrimination.

Ms. Chang experienced being called a "madwoman" by a family member and mentioned the fact that the law was doing no favours to mentally ill patients. Furthermore, she mentioned the issue of human rights:

> People who are mentally ill will feel marginalised or discriminated against. So there will... will be some problems around their human rights. It seems that the problem has remained a long time. I feel marginalised... a kid, relatives, call me 'crazy woman (in Taiwanese dialect)', something like this. Maybe we will be untenable both on the matter of law and human rights. [Ms. Chang]

Ms. Wang was looking for a job outside hospital because she had been told that she could be discharged from the day care unit if she could find a job. However, she felt that her appearance made it difficult for her to find a job because of discrimination:

> I knew that he just turned me down politely in this way... Maybe he judged me by my appearance...he didn't trust in my ability. [Ms. Wang]

Ms. Wu experienced her aunt refusing to take her to see a doctor in the psychiatric hospital because the aunt had a fear of visiting a 'dreadful' mental hospital. She used a metaphor to compare her situation with her life staying in the hospital and living in the community:

> I used to be a patient just when I came to hospital, and nobody knew I was a patient when I was outside the hospital. So, I felt respected, and was regarded as a normal person within the community. Take car for an example, just as I have a new car, but something is wrong with the vehicle parts. In this case, I would have the parts changed. However after that, I can drive a good car out, right? But now, I am an abandoned car (ha), which stays in the abandonment field (ha), right? [Ms. Wu]

The two carers both mentioned society's stigmatisation of people with mental illness, especially the totally erroneous belief that mentally ill people committed serious crimes, which was perpetrated by the public media:

> I can feel the discrimination towards these patients, and their future.... The government and the media bring a lot of misunderstanding, you see, the news reports are all negative, reporting killing which is always related to the people who are mentally ill. [Mrs. Kuo]

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At present, the society's general view about intellectual handicap, mental handicap and other diseases are not the same. Actually, this is still a wrong concept and an exclusion from society of people who are mentally ill. To be honest, I feel that this is a big problem, and a sudden change is impossible. [Mrs. Lee]

Enacted stigma refers to directly experienced social rejection, devaluation or discrimination such as not obtaining employment, reduced access to housing or to interpersonal rejection. However, felt stigma includes the experience of shame of having a mental illness and the fear of encountering enacted stigma (Lundberg, et al 2009).

A study among family members of people with mental illness in China (Phillips, et al., 2002) reported that stigma had a moderate to severe effect on the lives of 60 percent of patients, and on the lives of another 26 percent of family members. They pointed out that the effect of stigma on patients and family members was significantly greater if the patient had high levels of ability to express emotion and was highly educated, and also if he or she had more severe symptoms and the family lived in an urban area.

▪ Sub-theme: Being Disadvantaged

Two users used the term, 'disadvantaged', to describe their treatment by the public. Ms. Lin stated that as a mentally ill patient she was calling for help when she was trying to deal with her illness. However, in reality, nobody was willing to lend her a hand. Ms. Chang also stressed the lack of human rights for mentally ill patients, and how this made her feel she had to be less than honest about revealing her condition and this made her feel guilty:

> Ah ...I'm just aware of this problem, and I'm afraid if I write down that I have psychiatric illness, he will then ask me more... that seemed to be cheating, but I wanted to protect myself; ...it is just the question of human rights. Though I knew my symptoms, I was afraid of being discriminated and misunderstood. I felt I was conscienceless; it seemed that I had lied. [Ms. Chang]

> The reality is that we are really lacking help. We need help to solve some problems. So when we are faced with reality problems, we are helpless and can not get help from others. That is to say people like us are a "disadvantaged minority group". [Ms. Lin]

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A study by Lauber & Rössler (2007) investigated the influence of stigma on people with mental illness in Asian countries, pointing out that basis of stigmatisation is to make them feel as if they are different, or behave in a 'different, unusual way', e.g., strange, unpredictable, even dangerous or violent. Families of individuals with mental illness face a range of practical and emotional stressors, and social disapproval. Devaluation is the most important concern of services providers in the analysis of the quality of service provision (Chiu, et al., 2006). Data from China shows that much of the family burden is related to stigma, and to a lack of mental health and rehabilitation services, the consequences of which include the social isolation of families, and a great many other difficulties experienced by mentally ill individuals, including financial hardship, resulting from difficulties in gaining employment when in competition with others (Tseng, et al., 2003).

▪ Theme Summary

How users and carers made sense of the conception of theirs, or their family member's, illness in this account is predominately a combination of the experience and the impact of the symptoms in terms of dealing with life in general. To conclude this theme relating to self-help and the family's influence on the approach to mental illness in the beginning, the family understanding certainly influences the patient's timing for access to treatment and eliciting help from the psychiatric services. Once families learn more about mental illness and are willing to accept that their relative needs professional help, continuing treatment can begin.

However, in terms of dealing with their lives in current society, society's attitudes towards mentally ill people are also an issue, which is the focus of users' experiences of being discriminated against. The impact of discrimination on their lives is significant, since it disrupts their day-to-day living in many ways, emotionally and psychologically, and not only are patients concerned for

themselves, but also the impact of discrimination on their families. In summary, the feeling of being discriminated against by the public, as well as the law not, in their view, doing enough to protect their human rights, greatly affects mental health service users. In addition, the lack of public education regarding mental illness is a great disadvantage for users, especially as unhelpful information can be broadcast to the public by the mass media, which is a major drawback. These issues were the main reason for users' dissatisfaction, because they relate to public acceptance, and employment equality at outside the hospital. The data in this study suggest that users live with a frustratingly negative self-image, are stigmatised by the public, which impacts on their day-to-day life. These issues influence patients' willingness to be de-institutionalised, and cause an erosion of a positive sense of their current and future selves.

5.3.4 Key Theme: Fears and Hopes for the Future

This theme reveals the expectations of service users and carers of the future mental health services in Taiwan. For example, in some cases, they said they would feel more comfortable staying in the institutions rather than facing the outside world. However, under certain conditions, users indicated they may eventually wish to go back into the community to take up their lives with family and society. The next section will discuss the issue of this unmet demand in current service provision.

▪ Sub-theme: Comfort of staying in the institution

Some users want to be hospitalised for the rest of their lives because they feel more secure staying in the institutions than going back into the community. Ms. Lin explained that, if she was discharged from the hospital, she would need to find good employment or she would face financial difficulties, particularly as she had no relatives to support her. She did however indicate a half-way solution that could help:

> Because I'm in poor economic condition, I need a high-salary job, a suitable job I'm
> competent for. Though I live in hospital, I can go out to work in the day and come
> back at night, and ... [Ms. Lin]

Ms. Wu and Mr. Liu had the same feeling about the security of the hospital facilities, and appreciated the regular lifestyle of the paid work training programme. As a result, they want to stay in the hospital permanently:

> While in hospital, there are larger spaces and better equipment... Otherwise why there are some people who have been here for 10 or even 20 years (laughter), we all do not want to leave hospital... I feel good here, pretty satisfied with present regular life which is good for health. [Mr. Liu]

> It's impossible for me to work outside, so my own aim is to stay here as long as I'm allowed to stay. My main hope is that I can live here for ever, for the facilitates here are good and the doctors and nurses here treat me well, so I mean...in such an organization...because I'm in such a poor health condition, I won't go out of here easily ...[Ms. Wu]

Mrs. Lee, as a carer, claimed that, at present, the best way to keep her younger sister in a stable condition is for her to remain in an institution. Meanwhile, Ms Wang held the same opinion that the hospital had a positive influence on her sister, and being there has allowed her sister to feel less worried and anxious about social relationships with others:

> We couldn't provide her such companionship, so, that is to say, we need such a place, because of its system and its environment of shelter... According to her experience, only hospital is the best for her. So, the pressure appears under that situation. For other patients, it makes no difference; however, for others...for her, the situation is like this. [Mrs. Lee]

Despite the security a hospital can offer to mentally ill patients, finance has always been the crucial issue as to whether or not they can stay in the institution for a longer period of time. Being single at the moment, Ms Lin expressed her concern that her financial situation may not allow her to leave the hospital and live independently:

> We have no income at all, and there is only little financial assistance... the little salary is far from being enough to support ourselves... we have no other choice, it is free for us to live and eat in hospital because people like us in such a poor health condition are rejected by their families. [Ms. Lin]

Some of the previous studies regarding the rights of mental patients indicate that the general population tends to favour measures which restrict the rights and freedoms of people with mental illness. Such measures include the compulsory hospitalisation of people with mental illness, and that people with mental illness should not be issued with a driver's licence (Lauber et al., 2002). Moreover, Lauber & Rössler (2007) affirm that self-stigma occurs when mentally ill patients internalise stereotypes regarding them as people with severe mental disability and therefore incompetent, this may generate a loss of self-esteem, diminished self-efficacy, and a hesitancy to participate in society.

▪ Sub-theme: Wanting to rejoin life

Although there was only one out of the seven participants spoke about wanting to go back to a community setting after being discharged from hospital, this was a theme worthy of attention. Ms. Chao described how she and other people she knew in the hospital wanted to go home when they were able. However, she still found it a dilemma when thinking of going back into the community versus staying on in the hospital. She reckoned that participating in the rehabilitation programme in the community would be her first step in preparing to go back into the community:

> So I hope that I can go to the rehabilitation Centres, such as Wen-shan Workshop to get well, which is also my family's hope. To get well in that kind of place is my aim for the future.... People living here like us have a common hope of we all want to go home. [Ms. Chao]

From the carers'perspective, Mrs. Kuo and Mrs. Lee emphasised the fact that, for their relatives, going back into the community was the only and best eventual option. However, lack of resources and facilities in the community still remained as obstacles which needed to be overcome:

> And for the other aspects, there should be more professional institutions in the community. Among these institutions I think the Psychiatric Centre is the best one, then what about the others? So I think some facilities need to be enlarged in the community, and it will get better. [Mrs. Kuo]

> There're no such things in other hospitals, maybe it's because of the resource being distributed unevenly... Maybe the reason is that there are not so many

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facilities in the community settings... The real reason is either because it hasn't been made full use of, or because it is really not widespread enough. [Mrs. Lee]

There are many problems patients that may encounter in the future in order to return to society. As a key carer and a parent, Mrs. Kuo's main concern is her daughter's ability to be financially independent. She considers that it would be beneficial if the services provided more help in this regard:

> As for the economic problems, we can organize a fund organization or something else, namely specific institutions. Because the patients like them are not so financially available like us! They do not think about too much about their futures. [Mrs. Kuo]

- **Sub-theme: Individual needs**

Five users indicated that they would find it helpful to receive tailored services to meet thier individual needs, and Ms. Wang and Ms. Lin wanted to know what the mental health service can offer them from a long-term perspective:

> I don't know what I'm doing now, with no aims... They give me medicine to take but don't let me know what they are doing, what their aim is. The short-term, mid-term, and long-term plan is taking medicine all my life. [Ms. Wang]

> My future plan, of course, is to work outside hospital. Step by step... At present the most helpful thing would be to tell us explicitly that what we do is right, and make us clear up ourselves, our problems, and what this would remedy our the case. [Ms. Lin]

As the carer of her daughter, Mrs. Kuo expects a comprehensive programme from the mental health service, providing a wide range of future care plans to suit individual needs instead of restricting their future lives:

> I feel that many aspects for the patients can be improved! (Ha-ha) What I expect is that she can recover well. What I want to do is only to offer her the scope in which she can develop very well. So I think Government should provide multi-space which have a range of opportunities therapies available for them to improve themselves, right? I hold the idea that we need not restrict them to work or study just because he is a patient. [Mrs. Kuo]

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▪ Theme Summary

The above data may imply that what patients would like of future mental health services carries a strong relationship with the issues they may encounter in their lives, which can range from financial problems to difficulties in the community environment. For mentally ill patients, the fear of financial problems can be worsened due to aging and the progression of the disease.This may mainly be associated with the patients' insecurity about their ability to work, and the insuffiency of individually tailored community programmes from service providers that would continue their rehabilitation. The research also shows that patients' expressed needs about services are highly associated with their personal experience, their evaluation of their current ability to live and work in society, and their interaction with front-line service professionals. As for the expectation of life outside hospitals, these are mainly defined by the patients themselves, since they tend to be linked to the level of their emotional wellbeing and their motivation for wanting to reintegrate into the community.

5.3.5 Key issues from Services Users' and Carers' themes

Although data from service users and carers were collected separately, in individual interviews, the degree of overlap and inter-relatedness of themes across the interviews is evident. For instance, patients who wish to remain hospitalised typically related their feeling of being different to other people, and issues of working ability and related financial problems. As in the text, those issues were consistently echoed in the carers' accounts. Therefore, four core ideas were identified, which represent the central issues of the key themes. Those issues are discussed with core ideas arising from service providers' themes in more detail in the Chapter Six, The core ideas arsing from the service user and carer accounts are as follows:

- The level of understanding of the illness affects the choice of treatment
- The influence of public stigmatisation
- Welfare system and financial problems of mental health service users
- Problems of being de-institutionalised

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5.4 Service Providers' Interviews

5.4.1 Characteristics of Service Providers

Mental Health Service Providers group comprised six service providers. These were a Psychiatrist; a Head Nurse; a Psychologist; a Social Worker; an Occupational Therapist and a Sheltered Workshop Manager. All six participants were female, with a mean age of 36 years, and a mean length of time working as a Mental Health Professional of 9.2 years. The sampling was purposive to include participants from both hospitals. Four agreed to participate were from Suburban Specialised Psychiatric Centre (SSPC), while the remaining two were from Urban General Hospital Psychiatric Unit (UGHPU). See Table 5-3 or the summary of the Group B: service providers' sample characteristics.

Table 5-3: Summary of Service Providers Sample Characteristics
(Each participant was labelled with a fictitious surname, and all
selected surnames are common family names in Taiwan)

NAME	ORIGIN	GENDER	YEARS OF WORKING IN THE SERVICES	PROFESSIONAL
Ms. Tsai	SSPC	Female	14	Psychiatrist
Ms. Yang	UGHPU	Female	9	Head Nurse
Ms. Chiu	SSPC	Female	8	Psychologist
Ms. Huang	UGHPU	Female	3	Social Worker
Ms. Guo	SSPC	Female	12	Occupational Therapist
Ms. Sung	SSPC	Female	9	Occupational Workshop Manager

*UGHPU: Urban General Hospital Psychiatric Unit
SSPC: Suburban Specialised Psychiatric Centre

5.4.2 Conducting Service Providers' Interviews

Five Interviews were conducted in private at participants' place of work at their request, with the remaining one carried out in a public place, which was outside the interviewee's apartment. After reviewing the purpose of the interview and having obtained written consent, several questions were posed according to the topic guide, which had been created specifically for the service providers'

interviews. As the interviewing process was intended to be flexible and to promote the generation of natural links and explanations in the service provider's own words, the interviewer allowed the interviewee's narrative to unfold naturally where this was relevant to the broad topic area.

The interviews lasted for an average of one hour. Participants offered the view that their interview offered a channel which gave them the opportunity to freely discuss their experiences, feelings and frustrations when trying to balance the provision of services to meet most patients' needs, while having to adhere to laws and policies.

5.5 Findings: Service Providers' Themes

The aim of this research is to form a complete picture of the current mental health service in Taiwan. Thus, it is vital to gather and analyse data, not ony from the patients' perspective, but also that of the front-line service providers.

5.5.1 Overview and Introduction of Service Users' and Carers' Themes

The key themes presented in this section are presented in diagram 5-4. Each theme has a descriptive label. The key themes uncovered were Facing Deficiencies; Managing Resources; and Challenges for the Future. A few of the sub-themes emerged as the principle ones to support the key themes. The principle sub-themes are also presented in diagram 5-4.

The fundamental element of the interviews with the service providers was the expression of their experiences of providing mental health services in Taiwan. After undertaking a thematic analysis of the raw data, three key themes involving all aspects of service providing experiences were discovered (see diagram 5-4). The first key theme was labelled as Facing Deficiencies, which revealed the participants' experiences of confronting deficiencies and difficulties under current mental health policies when providing services to mental health users. This theme also included a core element of the deficiency theme which

emerged from the current state of service provision, which was interpreted using the conceptual label of the 'disadvantaged helping the disadvantaged'.

The second key theme was labelled as Managing Resources, which illustrated their experience of understanding, and thus maximising, the use of limited resources. The third key theme was labelled as Challenges for the Future, which covered issues such as how to meet users' needs to improve mental health services in the future from the service providers' point of view.

Figure 5-4: Key themes and sub-themes of service providers' group

Experiences of Providing Mental Health Services

Challenges for the Future

- Challenges for the Organisation
- Expanding the services into Community
- Public education
- The need of increasing professional staff

Three Key Themes

Managing Resources

- Service resources allocation
- Making links with limited resources

Facing Deficiencies

- Emerging conflicts
- Difficulties and frustrations
- The Disadvantaged help the disadvantaged

5.5.2 Key Theme: Facing Deficiencies

This theme is mainly about the front-line service providers' perceptions and experiences of the current deficiencies of the Mental Health policies, which were perceived as being unable to meet service users' needs. These can be found in certain situations, such as the difficulty of policy implentation. For example, there appeared to be always a conflict between service policies and patients' needs. Moreover, the providers' perspective of how the public views mentally ill people was considered to affect the users' right to receive a better quality service and thought to hinder providers from implementing services in practice that users need.

▪ Sub-theme: Emerging Conflicts

This sub-theme describes the difficulties that are faced by clinicians when faced by decisions regarding the best treatments for patients in the face of limited resources. In the interviews, service providers expressed feelings of conflict when in clinical practice. As Dr. Tsai stated, of all the mentally ill patients, abused women and children, and patients with financial problems, proved to be the most vulnerable groups and there were too many to be helped:

> Even there are policies and law regarding this, but it still can not settle the issues on the abused women and children. I feel helpless to these... Unfortunately the reality is that the community will ignore the existence of such kind of people, so they are very miserable. There is too many of this kind of cases. [Dr. Tsai]

Since the Psychiatric Unit is always being treated as a 'disadvantaged unit', Dr Tasi and Head Nurse (HN) Ms. Yang, both mentioned the tension between gaining hospital benefits and delivering individual care plans for patients. Dr. Tsai and Ms. Yang also brought in the issue of the values of individual practitioners:

> Doctors must ask why we should help mark out it. A rehabilitation home will compete with our own business... They will feel that a rehabilitation home will affect the benefits of the hospital. That will be a very big conflict! But I think that it depends on one's position--what do you care about or what do you not care about? [Dr. Tsai]

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> The hospital would take the hospital's interests into account, whereas our psychiatric department thought of it from the position of our patients. [NH Ms.Yang]

HN Ms. Yang described an incident of a clash between the National Health Insurance regulations and the provision of better prescriptions for patients:

> According to the regulations made by Health & Care Bureau, doctors can not use the first-line drugs to treat their patients or the improved drugs in the first instance. On the one hand, doctors worry about that this drug will be cut (deleted) by health insurance, On the other hand, once the problem appears, it will be exacerbated without treatment. The hospitals should assume the risk. [NH Ms. Yang]

Apart from the situations mentioned above, the community workshop manager, Ms. Sung, and HN Ms. Yang mentioned another area of disagreement, both of them stating that conflicts may also exist in Occupational Community Workshops and private rehabilitation homes with respect to the distribution of resources:

> I do not know how to deal with the problem of sharing of the benefits. I think this is very difficult to negotiate such a business interest in this aspect. [Workshop manager Ms. Sung]

> Basically, Community Rehabilitation Centers belong to the public sector units, so we will not be so much concerned about the so-called revenue. However, many of the rehabilitation homes are privately financed, so they will be very concerned about that part of this income... We have recently encountered such a situation. [HN Ms. Yang]

Policies which adversely affect clinical care have gained domination in many countries since the 1980s (Green & Bloch, 2001), and there is a dilemma between the interference of beneficial principles of psychiatrists' financial interests and patients' needs. Hopital income may vary according to the treatment provided, which could lead to a risk that doctors might make decisions based on economic factors rather than clinical ones. Furthermore, research by Hillman, et al. (1989) shows that if psychiatrists' conflicts over costs and treatments are recognised by patients, this may disintegrate the trust of an effective relationship. At the same time, clinicians argue that this kind of conflict prevents them from working to provide better services to meet patients' needs (Green & Bloch, 2001).

▪ Sub-theme: Difficulties and Frustrations

In addition to feelings of frustration, service providers equally mentioned the dilemmas they are facing when offering better quality of service in the current climate. These dilemmas include feelings of hopelessness about current services and their distress about the high re-admission rate and issues of institutionalisation.

Both Dr. Tsai and social worker, Ms. Huang, refered to the dilemma facing them in their day to day work:

> I feel that there are some problems not covered by the Psychiatric Department. Such as: the surrounding environment has great impact on many symptoms of psychiatric patients. However, psychiatrists often have no way to alleviate this fact. [Dr. Tsai]

> I also try to find certain reason to do the social work. If you can not give a reason to persuade yourself about the effectiveness of the work, then, why do you ask the patients to do it outside? Is it for the value of life? Is it really important for a patient to live independently? Do you think that it is important or it really is a truth? What benefits does he get from independence? [SW Ms. Huang]

Three of the front-line service providers talked about their feelings of hopelessness when fighting to raise funds from hospital organisations, and how to take different levels of policies and patient's benefits into consideration in their clinical practice, and how in their view these policies could impact negatively on the quality of care they could provide:

> When I strive for this piece of land, I am really facing a big challenge... However the hospital in reality assesses the departments by the standard of making money. On the one hand you need to consider the operation of hospitals, and it will limit your choices. On the other hand, some policy which will benefit patients cannot be executed, because you have to calculate the cost of Hospital. [HN Ms. Yang]

> Because we are the first-line staff, we have more time to contact with patients. If the policy coming down based on decisions of the upper layers, there is no way to change it. So we cannot do anything without the permission of upper layers, or what we do will result in lowering our grade of performance from A to B. [OT Ms. Guo]

> We should understand and be able to measure the capacity of what we can do for patients' sake on our own under current circumstances. In fact, we have to stop if we can't do. [Sheltered Workshop Manager Ms. Sung]

Moreover, social worker (SW) Ms. Huang and occupational therapist (OT) Ms. Guo mentioned thier frustration with the de-institutionalisation movement and service policies:

> It really makes us feel sad to see a sick man stay here for 8 years. More often than not, a person is discharged from here in good condition but soon returned just because of some factors beyond control in the outside environment, which makes us feel sad. [SW Ms. Huang]

> And then the next question is: where to go? Back to career places or home. This is often the biggest frustration to us. [OT Ms. Guo]

> It is really.about lack of money! I also feel very powerless. Using the resources outside to take care of patients usually costs more than the family members can do by themselves. The resources should be spent on the people in real need, but just in fact very few of patients meet the criteria. [SW Ms. Huang]

> Take the processing industry in the hospital as an example... that is because some patients need some repetitive work, and some repetitive actions of the operation. If there is something here they can do, they will feel meaningful, including the salary. Although he can get just a little pay that is an encouragement...Otherwise they think that it is unnecessary to do it. I really feel frustrated. [OT Ms. Guo]

The issues of high re-admission rates and patients being institutionalised have become more complex owing to the lack of responsible organisations and personnel in the community to implement integrated mental health care programmes. Ms. Sung brings up the high costs of readmission due to the community environment not being conducive to enabling the maintenance of mental wellbeing of discharged patients:

> He/ she will get sick again and return to the hospital, which will severely consume the hospital resources and lead to higher costs. So it is necessary to make these patients know that it is not so bad to live in the community and get along well with other community members [Sheltered Workshop Manager Ms. Sung]

Previous studies suggest that negative social reactions toward mental illness often lead to lost opportunities for social relationships, education, employment and housing (Mueller et al., 2006). Consequently, certain pressure should be put on service providers to provide better quality of mental healthcare aimed at rehabilitation, because the stigma of mental illness and discrimination against

mental patients are believed to be significant obstacles to the development of mental health recovery, and the promise to those suffering from mental illness to enjoy a better quality of life (Lauber & Rössler, 2007).

- **Sub-theme: The 'Disadvantaged help the Disadvantaged'**

Both Dr. Tsai and Head Nurse Ms. Yang described their patients as a disadvantaged minority in today's society, while at the same time mental health professionals can be seen as a disadvantaged group in the healthcare system due to perceived lack of resource being allocated to mental health services. They indicated that, if the government could relocate funding, the situation would be greatly improved:

> The Psychiatric section is a disadvantaged group! So in terms of the whole Psychiatric section, how to change the current situation, which can begin from the media, from health education. Because of the environment, psychiatric services can not go into the community, rather than he has really no way to do so. [Dr. Tasi]

Four out of the six services providers mentioned the term 'public stigmatisation' in the interviews, as mentally ill patients were being discriminated against by the public. Social Worker Ms. Huang and OT Ms. Guo argued that the reason for the public stigmatisation of patients mainly related to the negative images and exaggerated incidents broadcast by the media:

> Even if they are specialized in physical and psychological barriers groups, they still do not understand the people with mental disorder... So it is more difficult for us to carry out health education or find some cooperative agency for the people with mental disorder as in other disabilities. [SW Ms. Huang]

> When they go to work, they face the pressure, and then there are some negative reports outside to our patients, some people who hold negative ideas or social prejudice can not accept such patients.... People cannot fully understand the mental patients... news reports about the establishment of a half-way home of community rehabilitation centre for the mental patient was protested against by the local people, not everyone accepts it. [OT Ms. Guo]

Sheltered Workshop Manager Ms. Sung stated that stigmatisation actually came from the public's misunderstanding of mental disorder:

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There is a problem that to what extent the public understands mental illness... they seem to think them like terrorists. In fact, mental patients are so not so terrible, they usually do not hurt others but harm themselves. [Ms. Sung]

▪ Theme Summary

The theme of Facing Deficiencies emphasises the complexities and difficulties experienced by clinical workers while attempting to provide a better quality of mental health services. Evidence can be found when service providers experience limitations in service policies to meet patients' needs. This limitation may lead front-line professionals focusing narrowly on the government or hospital's policies only, which may further negatively influence patients' rights to receive better and integrated services. Thus, it may be fair to imply that the impact of policies can conflict with the regulations of the National Health Insurance system and give rise to conflicts between organisations when battling for benefits .

Another key element when providing services are directly associated with how the implementation of the Mental Health Service is affected by the public's stigmatisation of mentally ill patients. The public has a tendency to have a distorted and negative perception of individuals with mental disorder, and thus, a long-term goal of the service providers participating in this study is to eliminate all negative comments about mental illness as a part of addressing the stigma associated with mental illness.

In order to fulfil the Physically and Mentally Disabled Citizens Protection Act launched at June, 1998, the Council of Labour Affairs in Taiwan actively provides services for the disabled to improve their employability, eliminate employment obstacles, protect their employment rights and benefits, and enhance their equality in employment (Council of Labour Affairs, Taiwan, 2010). Allowances are provided by the government to incentive employers in order to promote the quota employment of the disabled to ensure their rights and benefits in employment.

At the stage of analysing the data, key issues emerged from the interviews with both services users and carers, and providers. The key issues identified will be discussed in the next section, along with the interviews of the three key informants. It is hoped that, by cross-examining data from different perspectives, a panoramic picture of the current situation and future challenges for the mental health service in Taiwan may be obtained .

5.5.3 Key Theme: Managing Resources

This theme is primarily about service providers' knowledge and experience of managing service related resources. Three issues will be discussed under this theme, the first of which is the resource allocation between urban and rual areas. The second is the lack of resources service providers find in the current system, and the third is to determine the most ideal way to combine welfare policies and regulations to provide the best services for patients.

▪ Sub-theme: Service resource allocation

Following up issues about resources mentioned in his interview, Dr. Tsai was asked about the ideal way to allocate resources. She proposed that a cost-effective analysis should be executed when distributing resources:

> What I do depends on a number of resources, and the role which I play... effects how I make the cost-effective-analysis. Where is the most meaningful that I allocate capital, and get the greatest effect. Although I have an ideal, I shill have to evaluate how to allocate the resources most efficiently. [Dr. Tsai]

Head Nurse Ms. Yang and Social Worker Ms. Huang highlighted the limitations they found when they were trying to allocate resources:

> It is difficult to ask the hospital to give us some cooperation, and even very difficult to ask the hospital to give us a Sheltered store... The hospital will consider the problem. If our Psychiatric Department can not bring the profit,... I face a big challenge. So I think that that is the difference between the polyclinic system and specialised Psychiatric hospital, such as our hospital compare with specialised psychiatric centre. [HN Ms. Yang]

There are some positive policies and resource allocation... there is a policy that the more patients disabled in body or mind the corporation hire*, the more money the corporation will get... Now these patients still have continued to work. The patients can get work, meanwhile hospitals can get money. [HN Ms. Yang]

People with mental illness were accepted into the project only 5 or 6 years ago... the accepted people with mental disorder only get the allowance which in fact can not afford the cost of the service which they need. The Executive Government has recently marked out that "big warmth planning", which mainly aims at the long-term care of the aging population. The planning will also benefit to the people with mental disorder. [SW Ms. Huang]

*"People with Disabilities Rights Protection Act", amended date at July, 2009 to protect persons with **disabilities** include those who have long-term physical and mental have the right to work.

Three out of the six service providers in this research revealed concern about a lack of resources in various ways, such as the mechanism of community service provision, the access to complementary services, and the gap between urban and rural areas of provision:

Community services in Taiwan are the most lacking of resources, and most of the money has been spent on hospital resources. Very little money can be spent in the community. [Dr. Tasi]

I think there is a lack of complementary services. Actually, most people do not need 24-hour care... There are many strict rules to be classed as a low-income family... I had a deep feeling about the gap between urban and rural areas... I wanted to do some meaningful work, but it's difficult because of the large geographical area... I think the most important thing is that there are not enough resources. Local governments cannot grant enough resources to psychiatric services. That is the probable reason. [SW Ms. Huang]

Ms. Guo as an occupational therapist mentioned that patients with special talents, such as excellence in literature or art, would find that resources provided to them are only available for what is seen as 'productive' rather than 'expressive' work.

People like him have some talent to do artistic creation. However, the people we introduced are the lack of some advanced specialty. We can let the patients have chances to work by their specialties under special conditions. There is very few in this aspect.... As far as I know, the policy has been implemented for some years, but the disable still work by their labor. There is no way to assist some special cases. [OT Ms. Guo]

▪ Sub-theme: Making links with limited resources

The quotations below demonstrate that service providers have attempted to make the most of their efforts to link different resources in order to provide better service for patients. The purpose of service providers to pool their resources is to encourage patients to go back into their community settings, and this can best be achieved by applying funding to set up a sheltered store, building a complete programme for an occupational training scheme, and working towards diminishing the public stigmatisation of mentally ill patients:

> The Labor Bureau already agreed the application and gave us appropriate funds to set up the sheltered store*... But the subsidies are so limited that there is certain gap between the subsidies and the money we need... This is why we make our great efforts to recommend the advantage to the hospital. And that it will give some help to the hospital marketing. [HN Ms. Yang]

> This is a small step we do.... Sheltered stores* will find resources. Public health centre which was a clinic at the beginning is, now renamed the Community Mental Health Center. We can make use of the store to link patients who are necessarily coming here... This is the marketing—let people outside come here, and let local patients go outside to work. Because we have no experience of social work and no initiative about data of it, we also need to go outside to find out how the other rehabilitation institutions are run. [SW Ms. Huang]

> After the patients have experienced certain number of hours of work, and we think their performance is OK, and they can go into the employment market to compete with others... It depends on their behaviors. [Workshop Manager Ms. Sung]

> * Sheltered store: A store which located inside the hospital or in the community area. Staff working in this kind of store is mentally ill people who are under occupational training programmers. Usually, some of the goods or food they are selling is made by themselves.

The service providers described some of the resources they provide to service users being based on NHI and Government welfare policies, and these are beneficial to patients. However, they also agreed that some regulations may result in unequal resource allocation among users:

> The confirmation of the application of Certificate of Chronic has its own standard. You will be regarded as a severe chronic patient if you conform to diseases... Different certificate for the physical disability and mental disorder will be offered to different patients. Each patient belongs to certain grade, and will obtain different benefits in accordance with the different grades used by the city and there are differences among counties... [NH Ms. Yang]

Although the law has endowed us the business scope of an independent implementation, but under the system of health and insurance, the government did not give us this right. If we want to be independent and treat the patient ourselves, the expenses of the project must be paid by ourselves. [Psychologist Ms. Chiu]

Basically we are public sector unit so we will not be so concerned about the so-called revenue. Since many of the rehabilitation homes are privately financed, they will be very concerned about that part of this income... Nowadays the main problem is that if the hospitals should accept the regulation, or if the Government should force hospitals to accept the regulation. I do not know. [Workshop Manager Ms. Sung]

▪ Theme Summary

This theme consists of aspects of interviews with service providers, aiming to explain their strategy of pooling their resources in order to help patients to go back into a community setting (i.e. to set up sheltered workshops or sheltered stores). The data demonstrate service providers' understanding of a variety of resources in order to provide better services. They clearly recognise the necessity of being able to deal with diverse problems when they are encountered, and as a result, each professional member of staff possesses a different set of skills and knowledge to organise the resources. Issues such as service provision facing obstacles when service professionals try to manage resources based on the restrictions and regulations of the National Health Insurance were also revealed under this theme.

Resource allocation of healthcare in most countries tends to be incremental, influenced more by historical and political patterns than rational decision-making (O'Shea, et al., 2008). In particular, previous studies claim that high technological clinical interventions tend to receive more funding than personal and community care programmes, particularly in relation to mental health, and as past studies suggest, funding for mental healthcare does not match patients' needs in Taiwan. When spending occurs, it tends to be largely distributed to support hospital-based psychiatric care, which indicates that resources in the community service area are very limited (Shiau, et al., 2005).

Research strongly suggests that the policies of policy makers regarding the allocation of resources to mental health services are influenced by their

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attitudes toward people with mental illness and treatment efficacy (Corrigan, et al., 2004). For instance, legislators who are prejudiced about people with mental illness can block funding for mental health services which could promote independent living and recovery goals. Similar findings are obtained by Skitka and Tetlock (1993), who argue that legislators and other government officials play major roles in health services through their decision making process when allocating public resources. This clearly pressurises front-line mental health service providers to make the most of helping patients with limited resources.

5.5.4 Key Theme: Challenges for the future

The main idea underlying this theme is to underpin the future challenges which front-line service providers may confront when trying to improve services to their ideal standards. These challenges include the fact that organisations need to have multi-functional policies to suit the needs of different users, and of increasing the of workforce in the mental healthcare system in order to provide better service quality.

▪ Sub-theme: Challenges for the Organisation

Four of the providers, (Psychiatrist Dr. Tsai, Psychologist Ms. Chiu, Social Worker Ms. Huang, and Sheltered Workshop Manager Ms. Sung) recommended that the priority for any organisation's future plans should be the improvement of the community mental healthcare system:

> They plan to establish two psychiatric consultancy centres for each community health centre, one in the charge of a clinic psychologist and the other, a consultant psychologist... Now it has stepped into the 2nd year's plan... What we expect in the future is the response of Department of Health Bureau, but it still largely depends on how the officials in charge of Department of health bureaus evaluate the policy... [Psychologist Ms. Chiu]

> I wanted to challenge this structure in order to make the qualified people lead the team to communities or medicine safety, for mental illness usually lasts for a long time and every stage should be guided or controlled by different staff but not always by doctors. This phenomenon embarrasses both the doctors and us. So from the very beginning, we want to challenge the structure. [SW Ms. Huang]

> I have not found that any public establishment is like Rehabilitation home (Half-way home). Even if Rehabilitation home is established inside the hospitals, therefore, they are again being institutionalized. So it is necessary to establish them in

communities or organize as much daily activity as we do in the community workshop. [Sheltered Workshop Manager Ms. Sung]

HN Ms. Yang noted that the challenge for front-line service providers is to expand the services to more regions with limited resources while following national and local policies. Ms. Guo, as an OT, suggested that a " human-centred care" healthcare management, which provided a natural and safer environment for chronic mentally ill patients, would be the fundamental challenge of the future:

> We can do it with much effort or little. Without going against the hospital regulations, we can extend our service, some special service, so that the patients could have more room to develop. That's to say, we begin with the limited resources, and then extend the program under the guidance of hospital regulations. [HN Ms. Yang]

> I think this is what the human-centred management should be. For the safety concerns of the emergency case, we have to keep them in a hospital environment, so we try to offer them adequate equipment such as indoor equipment or public equipment. However, when it comes to something like natural environment, we can not meet the requirement for fear that some patients will run into danger or run away or something else. [OT Ms. Guo]

A study conducted by Song et al (2006), which targeted a group of mentally ill patients in a long-term institution in Taiwan with the potential of rehabilitation, suggested that the patients certainly had the ability to gain social capital by making connections with other people in the community. This finding was further supported by Anthony (1993), who has been promoting rehabilitation programmes to facilitate consumer recovery in western countries for the past two decades. However, from the patients' perspective, long-term hospitalisation provides a protected environment for them, whereas the community may not be a friendly place. Although patients may face difficulties in the community, with professional support, they could still make their way in the community using their inherent ability (Anthony, 1993).

These challenges may increase the burdens of healthcare providers, hence certain fundamental principles must be addressed in the mental health system. It is crucial for the system to expend resources efficiently, so that the policies not only maximise effectiveness, but fairness in treating individuals can also be

achieved (Green & Bloch, 2001). Sabin (1995) further argue that clinicians should serve as stewards of resources and work for justice in their organisations to protect patients' rights and interest. By adapting the improved clinical practice principle, clinicians can create a balance between efficiency and fairness.

- **Sub-theme: Extending the services into the Community**

In the interviews, four out of the six service providers indicated that it is essential to strengthen and extend mental health service provision from hospital-based to community-based care. However, the lack of trained mental health staff in the community area, and personnel occupied in follow up and referral programmes in the community remained a critical issue:

> This means when patients return to the community after discharge out of the hospital, the community needs some special people to track or follow them... However this part now is really a shortage! We often find not long after patients get out of the hospital, they have to be admitted to hospital again (haha) because of irregular medicine, so there will be such a problem. [HN Ms. Yang]

> There are small establishments you can go such as Care Centres, or Sheltered stores, or day-care in the community... The problem in the community is lack of ability of tracking patients... The function of follow-up is usually referred to the community clinics, or to the head of the district. Yet they need re-educating, and the tracking quality is not very good. [SW Ms. Huang]

> Community is involved in the whole aspects of the cases. In terms of the situation of dealing with cases, exclusive of the so-called administrative business, rehabilitation treatment of a case can be more complete in the community... After the acute symptoms of the patient have stabilized, the role played by the community is the largest... [Sheltered Workshop Manager Ms. Sung]

> I think it is an inevitable trend for the rehabilitation patients to come into the community, and I think the function of the community should be increased. [OT Ms. Guo]

It has been demonstrated that comprehensive and co-ordinated community care is beneficial to the successful long-term prognosis of mental illness, and that poor community care will increase the cost of treatment because of the increase in the rate of re-hospitalisation (Rothbard, et al., 1998). Shen et al (2006) indicate that there is growing evidence of the negative consequences of poor community mental healthcare in Taiwan, where insufficient supply and

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inadequate quality still remain long-term unresolved problems of the community psychiatric care delivery system. Unlike hospital care, few professionals are equipped to work in community-based care, and little professional training or preparation for community psychiatric care has been developed (Shiau et al., 2005).

▪ Sub-theme: Public education

This theme predominantly consists of issues, concerning service providers' views on how the public evaluation of mentally ill people can affect the their right to receive better quality services; secondly, how public stigmatisation can prevent providers from implementing services in the community, and thirdly, a discussion of how to seek solutions to redefine the public view of patients, and what can be done to educate the public in this respect.

Social Worker Ms. Huang and OT Ms. Guo noted that the reason for public stigmatisation of mentally ill individuals mainly stems from the negative images and exaggerated incidents broadcast by the media. Hence service providers emphasised the importance of national and local government to provide a multiplicity of mental health related education to the public in order to rectify the distorted images of mental disorder relayed by the media:

> In the past the declaration of the news there are a lot of mental disease people make the community feel that the patients are just like an unexploded bomb in the area, which is because mental illness are not known or tracked, they do not know how to do with it... Because the media for the mental-impaired persons do not really understand, they will often link criminal personality with the mental patients, so in fact a wide range health education will really need much of the funding. [SW Ms. Huang]

> That is to say we help the community have more understanding about the business of clinic psychologist and more clear awareness of the boundaries of psychologists and doctors... Let them know more clearly what clinical psychological counselling is, and what psychological services are, clinical psychology may not be seen in the community, that is what its meaning really is. [Psychologist Ms. Chiu]

> We should make the whole society understand the significance of rehabilitation of the mental patient, and how to accept them; I think the re-education is needed. [OT Ms. Guo]

> I think the police officers will feel very helpless when they face the mental patients, that is to say, they do not know how to deal with them, because they would fear

facing patients with mental illness... If you want the Government to do more for this so-called mental illness, it is right choice to have a correct advocacy for the patients! [Sheltered Workshop Manager Ms. Sung]

Some research investigates education programmes related to mental illness stigma and suggests that participation in these kinds of programmes could lead to improved attitudes about people with mental problems (Corrigan, et al., 2001). More literature related to this topic will be discussed in the chapter six.

▪ Sub-theme: Need of an increased workforce

Two of the service providers raised the problem of an inadequate workforce in the mental healthcare area, which has resulted in an unequal distribution of staff:

> So the system needs improvement and to become more uniform. Another point is the configuration of staff... This is also a policy-related problem. [HN Ms. Yang]

> We adopt the criterion of 1 to 20, which is also required by Department of Health, that is, one full-time case manager for 20 students*... If one more case is in bad condition, the case manager will cry for help. Yes, if proportion is slightly adjusted, it will be much better. [Sheltered Workshop Manager Ms. Sung]

> * Mental illness patients in the sheltered workshop are called by professional staff as 'student' instead of 'patient'.

▪ Theme Summary

The community mental healthcare programme is generally regarded as a treatment to enhance patients' work and self-care ability. However, due to the public's current attitude to mental disorder, the programme cannot be fully implemented. It is believed that, by requiring national and local governments to reinforce multi-disciplinary mental health educational schemes, the public will gradually transform its views of mental illness.

The vision of front-line service providers is to combine the provision of an integrated care programme with the broad principles of chronic mental illness management, for example, to transform hospital-based care into community-based care. This vision originates from the desire to revise current mental healthcare policies as discussed in this theme. This theme reveals that service

providers are able to provide a wider range of services in hospitals or sheltered workshops, the purpose of which is to support and advise patients about experience and coping with their illness. However, after discharging patients into a community setting, many constraints may arise, which may hinder the continuation of care. Such constraints may come from organisational and contextual settings, shortage of psychiatric-trained staff and a lack of agencies in the community.

The challenges for providing better services in the future and the various problems and concerns which service providers may encounter were also addressed under this theme. The key role of front-line service providers in extra-medical intervention is to act as a co-ordinator of other health-professionals and to seek the best support for patients within the limits of organisational resources at all times. During the interviews, the majority of service providers considered that the priority of future challenges should be to expand the service from a hospital to a community setting, since they all regard community mental healthcare service as the most effective way to treat chronic mental illness. In order to face this challenge the participants suggested that, it is vital for hospitals to have a multi-disciplinary team and an adequate workforce.

5.5.5 Key issues from Services Providers' themes

The degree of overlap and inter-relatedness from the service provider interviews has resulted in the emergence of key issues, for instance, the lack of resource in the community, which is related to public stigmatisation of people with mental illness. In the interview of service providers, extending the mental health service to the community and enforcing supportive policies and re-education programmes from the government, the problem of intitutionalisation can be significantly improved. Four core ideas are identified which have an inter-relationship with the key themes emerging from the interviews. Those issues are discussed with core ideas from the service users' and carers' core ideas in more detail in the Chapter six discussion. The core ideas arising from the service provider themes are as follows:

- Managing resources to meet different needs
- Importance of shifting services into community-based Mental Health Services
- Influence of public stigmatisation and the need for mental health education
- Problems of deinstitutionalisation

5.6 Key Informants' Interviews

5.6.1 Conducting Key informants' Interviews

Interviews were conducted with three key informants, and since the researcher was not in Taiwan, a telephone interview method was conducted to collect the data. The three key informants included a Mental Health policy maker at the Department of Health, Executive Yuan, a Mental Health policy maker at the Department of Health, Local City Government, and a senior researcher in the mental health research area in Taiwan.

Interviews with the three key informants were arranged via email to schedule a suitable time for the interviewees. Three individual telephone interviews were conducted between the 18th August and the 25th of September, 2008, and the three informants consented to have the telephone interviews recorded. After a review of the purpose of the interview, several questions were asked according to a topic guide (See appendix X), which had been created for the key informant interviews by drawing on findings from the service users and carers and the service providers.

5.6.2 Findings: Key informants' interviews

A summary of each key informant's interview is shown separately below. Four main topics were discussed, which related to the findings from the interviews with the service users, carers and providers. However, a comparison and discussion of the experiences of the service users, carers, and providers will be presented in Chapter Six.

5.6.2.1 Interview summary with a policy maker at the Department of Health, Local City Government

Regarding the fundamental elements of an integrated mental health service in Taiwan, this interviewee mentioned that mental health law should cover the entire mental health service network, including every aspect of the service provision. Secondly, the mental healthcare work force should be allocated equally for hospital-based and community-based care. Then, thirdly, public health education should be provided as the first stage of intervention in the community in relation to mental health primary prevention issues, such as psychological empowerment, interpersonal relationships, and self-exploration

In terms of the problem to the high re-admission rate and institutionalisation in Taiwan, he suggested that the main problem lies in how the government allocates its limited resources. There is a movement towards de-institutionalisation worldwide. However, we cannot simply copy these policies from western countries, because we have a different situation in terms of environment, resources, and values. Simultaneously, there is a big gap between the resources for psychiatric hospitals and community care provision, particularly in terms of the national budget arrangement for healthcare expense. The other problem is the difficulty in breaking the long-outdated structure of the nucleus of psychiatric hospitals, which still dominates most of the mental health resources from the government.

Stigmatisation is one of the must discouraging factors in implementing mental health policies. The reason for it, he emphasized, is mainly due to the terms being used by the media to describe people who suffer from mental illness,

such as 'unexploded bombs' and 'devils of humans'. Due to their understanding of mental illness, mental health professionals would have the maximum acceptance of mentally ill patients. Therefore, he suggested that if the public also had an initial understanding of mental illness, the chances of them accepting a community rehabilitation centre being set up in their neighbourhood would be greater.

Regarding the future challenges, government policy should focus on the intervention services in the second stage of prevention. Therefore, they can re-allocate mental health professionals into the community area of provision in order to balance the quality of the care provided. The government should also set a high standard of targets to be achieved by service providers. However, there is always a dilemma in the current situation, and we always feel frustrated and lonely in our role of implementing policies for local government.

5.6.2.2 Interview with a policy maker at the Department of Health, Taiwan National Government

In terms of the current deficiency, Taiwan's mental health service has now moved from its stage of "institutional care" into community care. However, he believes that how to move service provision into community care is a real challenge for the government. At the moment, there are sufficient acute beds, (more than six thousand in total). Therefore, the government is now focusing on setting up adequate mental health rehabilitation programmes and organisations in the community area.

The government has also distributed a budget to the Mental Rehabilitation Association in order to establish non-governmental social groups, such as Fountain House, for mentally ill individuals. He emphasized that this kind of social group functions as a social club, which not only provides a platform for them to communicate with each other and with government, but also gives an opportunity for the public to understand more about mental illness.

A long-term healthcare plan is the future focal point of the Department of Health. However, it is not possible to simply bring western research evidence into the Taiwanese context, and thus, the government needs an integrated plan to improve services, such as a "long-term 10 year plan". Regarding the main deficiency of the imperfection of the social welfare system in terms of mental health service is due to a limited national budget, along with other supportive elements. However, although "government resource is limited, civil power is limitless".

In terms of stigmatisation, he believes that partly due to the cultural influence, mentally ill individuals are still in a critical stage of being stigmatised. From the public's point of view, mentally ill patients are equal to 'unexploded bombs' due to information disseminated by the media. Therefore, public stigmatisation is the main obstacle to moving patients back into community settings. Therefore, putting the emphasis on to strengthening the mental health education of the younger generation will enable the public to understand mental illness more.

In relation to the problem of institutionalisation in Taiwan, this is due to limited resources in the community. Therefore, he had impression that some non-governmental agencies provided by religious groups, such as "Lung-Fa-Tang", were established three decades ago and still exists in order to provide shelter for the mentally ill. At the same time, the overstay rate in Taiwan is high, due to inadequate resources in community service provision and the fear of the process of re-hospitalisation of service users. However, if the public can accept mentally ill patients in the community and have proper knowledge of mental health, for instance by accepting Yuli Veterans Hospital's reform programme (see Chapter two for more detail), mentally ill patients will have a better quality of life under the protection of the "Mentally Disabled Citizen Protection Act".

Regarding the future challenges for Taiwanese Government to improve the quality of mental health service, he suggested that firstly, there is a need to improve the quality of service in mental health institutions. Secondly, mental institutions are essential, and therefore, the government should provide a diversified mental health service provision, suitable for Taiwan's cultural context.

Thirdly, emphasis needs to be placed on health education in the government's prevention programme, and finally, better social welfare needs to be provided, as well a revision of the related protection law.

5.6.2.3 Interview with a senior researcher, a Superintendent of TSYR-HUEY Mental Hospital

In relation to the current deficiencies, he stressed that firstly, there is insufficient national budget from the government to support the provision of community mental health services. Only three per cent of the budget goes to mental health care annually from the total amount of National Insurance Budget, and as we all know, "where there is money, there is a way". Secondly, the workforce allocated to community service provision is inadequate. Thirdly, the family structure has changed gradually over the years, and therefore, it is difficult for families to take care of their mentally ill family members after they are discharged from hospital. Finally, hospitals' own benefit consideration is the main impediment to the downsizing of psychiatric hospitals. However, folk healing remains a strong tradition in Taiwan.

Regarding the situation of stigmatisation, although the 'Physically and Mentally Disabled Citizen Protection Act' was introduced by the government in 1998 to protect the civil rights of people with illness, and also to prevent the media from using discriminating terms against patients, the public is still unwilling to accept patients with mental illness due to misunderstandings and fear. Thus, he suggested that to develop a mental health education programme with an anti-stigma movement would enhance the public's acceptance of mentally ill individuals. At the same time, changing the term used for mental disorder diagnosis as Japan did should be the first stage of anti-stigma movement. At the same time, the power of non-governmental societies, such as the Mental Rehabilitation Association, should encourage patients to speak out and fight for their civil rights.

In terms of the problem of institutionalisation in Taiwan, he believes this is due to the lack of service provision in community areas, because the current

national insurance funding mechanism still favours the hospital-based care system and the traditional structure of those Central Hospitals, which is very difficult to break. At the same time, there are not enough professional workers working in community mental health services, and if there is no money, how is it possible to improve the quality of community mental health services?

Regarding the future challenges for providing the quality of mental health service in Taiwan, he suggested that hospital-based and community-based care should be carefully combined in order to provide a better quality of healthcare, because of our social and cultural background. Since modern western medicine co-exists with traditional Chinese treatment in Taiwan's culture, folk therapy should also not be forgotten.

We should not only move the budget from hospitals to the community, but we also need to keep the money to support hospital care, and then seek other sources of money to put into the community healthcare system. He also mentioned that national human rights' issues in a country which are actually reflected by their mental healthcare quality can also be an indicator.

5.7 Conclusion

This chapter presented themes drawn from interview data about the experiences of service users, carers and service providers in terms of receiving and providing mental health services in Taiwan. Furthermore, the findings are illuminated by three key informants' perspectives of the current provision of mental health services. The themes of the findings were presented separately.

The issues raised in this chapter indicate growing evidence of the negative consequences of the current mental healthcare in Taiwan, including several unsolved problems of the healthcare delivery system, especially in the community-based care sector, which have existed for a long time, such as

insufficient supply and inadequate quality. Therefore, it seems that people with mental illnesses and their families are underserved and overwhelmed by gaps in the services. Thus, it is urged that, since the needs of disabled people of various kinds, degrees, ages, causes of mental disability, and education are different, more attention should be paid to such differences to make good and effective use of resources. However, without clear and strong national-level policies to guide and support the development of mental healthcare, the existing services cannot meet the immense needs of this disadvantaged population.

Furthermore, the lack of integration among public and private sectors, as well as health and social welfare sectors, is failing to deliver effective community psychiatric care. In contrast to hospital care, few professionals are devoted to community-based mental healthcare and little professional training or preparation for community psychiatric care has been developed in Taiwan. Assisting people with mental illness to live in the community is an important paradigm shift from psychiatric in-patient treatment, but to date it has not been well prepared for in Taiwan. An integrated discussion of this study's findings will be presented in the next chapter, along with three main issues which emerged from the process of analysing the three sets of interview data.

Chapter Six

Discussion of Study Findings

This chapter discusses the findings of the research, which firstly explores the experiences of service users, carers and providers, as well as the opinions of key informants. This is followed by the three main issues emerging from the process of analysing the three sets of interview data, together with discussed in the light of relevant literature. The second section combines the key findings from the three different perspectives (service users, providers, and key informants) and discusses the perceived problems and gaps within the provision of mental health services. The last section concludes with the key findings of this research, and then draws attention to the development of future mental health services in the next chapter.

During the last few decades an increasing interest in the consumer perspective on psychiatric care has developed around the world. Furthermore, patients' satisfaction with care has been focused on by those who plan psychiatric services as well as by researchers who want to investigate what brings about patient satisfaction (Ruggeri and Dall'Agnola, 1993). There is a documented relationship between better treatment outcomes and higher satisfaction with care (Ruggeri, 1994). However, satisfaction surveys of mental health services routinely generate high levels of apparent satisfaction, but conversely non-compliance with treatment continues to be a major issue. Ries, et al. (1999) indicated the reason for this might be that the satisfaction measuring methods in use tend to disregard factors of dissatisfaction and most studies concerning satisfaction have used questionnaires as a means of collecting data. Those data can be somewhat superficial and therefore more in-depth studies are needed to further investigate and characterise this phenomenon.

It is not only important to understand the levels of satisfaction with mental health services and their relation with other factors, but more specifically what brings it about and what creates a better quality services for users, which is the motivation for this study. Satisfaction is a vague term, which can be conceptualised in several ways and be approached from various different perspectives. The present study augmented the measurement of users' satisfaction via survey with in-depth interviews with service users, providers, and policy makers in order to elicit deeper perspectives on the current mental health service in Taiwan.

6.1 Exploring the experiences of service users, carers and providers of mental health services and three key informants

This section focuses on the similarities and differences between the perspectives of services users, carers and providers of mental health services in Taiwan. In addition, the opinions of three key informants are included to illustrate the perspective; two of the key informants are policy makers. The other key informant who specialised in related research. Since the primary goal of this study was to explore the different experiences and perspectives of those involved in current mental health services in Taiwan, it is important to explore the three sets of interview data to address the research questions.

The service users and carers' group expressed some positive experiences of using the mental health services in Taiwan. The members of this group indicated that the system helped users to: understand their own illness and provided support to meet the needs of users and carers while staying in the institutions. Despite a few negative experiences and patients' future insecurities, they considered that most of their experiences of using the service to be positive and satisfactory. However, the service providers who were interviewed argued that, in spite of the government's policies and law in terms of the

psychiatric facilities and available resources in the last decade, a great many improvements still need to be made to benefit people with mental health problems. The interviews with service providers mainly focused on the current deficiencies and frustrations they were facing, and elicited their views on improving service quality in order to meet user needs.

According to the findings presented in the previous chapter, two sets of core ideas are identified from the key themes of the interview data. One set of core ideas is summarised from service users' and carers' themes, while the other set is gathered from service providers' themes.

Core ideas from service users and carers themes are as follows:

- The level of understanding of the illness affects the choice of treatment
- The influence of public stigmatisation
- Welfare system and financial problems of mental health service users
- Problems of being de-institutionalised

Core ideas from service providers themes are as follows:

- Managing resources to meet different needs
- Importance of shifting services into community-based Mental Health Services
- Influence of public stigmatisation and the need for mental health education
- Problems of deinstitutionalisation

Distillation of the key themes and identified core ideas across the data sets resulted in the identification of three major issues:

- The phenomenon of stigmatisation of mental illness in Taiwanese society;

- Problems of deinstitutionalisation and the adequate provision of community mental health services;

- The current social Welfare system and how this impacts on the financial situation of individuals with mental illness.

6.1.1 The Phenomenon of Stigmatisation of Mental Illness in Taiwanese Society

A strong thread running through the themes of this study is the stigma experienced by service users and their carers. In this study, a number of people stated that they were discriminated against even by their own relatives. This is a factor that hugely affects patients' self-confidence, and put them in a disadvantageous situation for example, in seeking employment. Both users and carers offered reasons why psychiatric patients were being stigmatised by the media, since the mass media in Taiwan tend to draw a link between mental illness and serious criminals and 'psychopaths', and used the terms 'precarious bomb' or 'unexploded bomb' to label people in the community with mental illness. Both users and carers agreed that the current law in Taiwan is totally inadequate to protect and preserve the rights of people with mental illness in society.

From the perspective of policy makers, stigmatisation can be a very disturbing and discouraging factor when implementing mental health policies into practice. This may be mainly due to the exaggerated and distorted term 'unexploded bomb' used by the media to refer to patients with mental illness. One policy maker from the Department of Health in the government of a Local City indicated that, if people had initial understandings of mental illness, the chance of them accepting a community rehabilitation centre in their community would be greater. However, when discussing this issue with his educated friends, the

majority were still refusing to consider welcoming patients with mental illness into their surrounding communities. Both policy makers and the researcher who were interviewed emphasised the need for mental health education for the younger generation, indicating that this would not only enable them to have a better understanding of mental illness, but also offer them knowledge about prevention, treatment and rehabilitation.

Stigma refers to the negative effects of a label placed on any group, such as a racial or religious minority, or in this case, those who have been diagnosed as being 'mentally ill'. In terms of mental illness, stigma is not just about using inappropriate words or actions. It is also about disrespectful exclusion, and the use of negative labels to identify a person who is experiencing such an illness. Stigma results in discrimination and it forms a barrier for individuals with mental illness and their families against seeking professional help. From Goffman's perspective, stigma is a powerful discrediting and tainting social label which radically changes the way individuals view themselves and the way others view them (Goffman, 1963). As Goffman noted, stigma is not merely an attribute, but it also represents a language of relationships. Goffman defines stigma as an **"attribute that is deeply discrediting"** and that reduces the bearer *"from a whole and usual person to a tainted, discounted one"* (Goffman, 1963, p.3).

Front-line mental health service providers reported a dilemma of trying to provide a quality service whilst being in disadvantageous positions in the current hospital system. They claimed that the Psychiatric Department of a hospital has always been known as being the less profitable sector, and this has resulted in it being quite difficult for psychiatric services to gain sufficient funding and support from the hospital to provide better services. In addition, the negative images and exaggerated incidents broadcast by the mass media to the public play a major role in causing public stigma to their patients. Along with the unsupportive regulations of the current government laws and policies, these issued work against the development of services.

According to previous studies, public conceptualisation of the 'mentally ill' can have a significant influence on both service users and providers (Corrigan, 2004). Thus, finding solutions to the phenomenon of stigma in current society have become a vital issue. According to the opinions of the service providers and the three key informants in this research, a public health educational programme may be an ideal initial start. However, the senior researcher who participated in this study indicated that, although the 'Physically and Mentally Disabled Citizen Protection Act' was introduced by the government in August 1998 to protect the civil rights of people with illness and to prevent the media from using discriminating terms against patients, the situation of the anti-stigmatisation movement has not had notable impact in the past decade (Law and Regulations Database of Republic of China, 2009). However, the senior researcher suggested that an 'anti-stigma movement' could emerge as a powerful force in the development of mental health education, and a non-government, non-profit, grass roots and self-help organisation called 'The Alliance for the Mentally Ill of Republic of China, Taiwan (TAMI)' was established, with the aim of supporting families and friends of people with mental illness, and to persuade the government to protect these minority groups.

The findings clearly indicated that the impact of discrimination on service users' lives is significant. Their day-to-day lives are affected emotionally and psychologically in many ways. Furthermore, not only are patients affected by discrimination, but also their families. Stigmatisation is a well-known fact, and one which has great impact on individuals with mental illness. This situation is common to both the Eastern and Western worlds. 'Anti-Stigma programmes' exist in contemporary Western countries to solve the issue of stigma. For instance, a new four-year ground-breaking programme called *'Time to Change – Stigma Shout'* was launched to combat the growing problem of mental health stigma and discrimination in England in 2008 (Rethink, 2008).

Despite the anti-stigma movement, Corrigan (2004) highlights the fact that stigma is one of several factors that affect the decision to accept treatment,

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since people avoid being labelled as individuals with mental illness and who are therefore associated with mental health care. In addition, some studies suggest that patients diagnosed with psychosis are more harshly judged by the public than patients with affective disorders, such as depression or anxiety (Pescosolido, et al, 1999). People labelled with mental illness are more severely stigmatised than those with other health conditions (Corrigan, et al., 2000). Stigma can harm people with mental illness in several ways, and stereotyping, prejudice, and discrimination can take precious life opportunities from people who are labelled as being mentally ill (Corrigan, 2004). There is sufficient evidence to suggest that people with mental illness frequently confront difficulties when attempting to secure a decent job or find a suitable housing, due to prejudice and stigma prevalent in the community (Corrigan, 2004; Bordieri and Drehmer, 1986; Wahl, 1999).

Rost et al. (1993) indicate that rural residents with depression in the West are more likely to experience negative views (i.e. stigma) than urban residents. In Chinese society, Phillips et al. (2002) found that people with schizophrenia living in the more urbanised areas of China were also greatly impacted by stigma in their everyday lives. Because of their difficulty in achieving the minimum living standards expected by city dwellers, they felt socially inferior. Therefore, stigma can discourage users from seeking psychiatric care services both rural and urban area.

A negative impact can also be experienced by individuals with mental illness when trying to access the general health care systems. Druss and his colleagues (2002) completed a study indicating that people labelled as being mentally ill are less likely to receive benefit from the depth and breadth of available physical health care services than people without these illnesses. However, in fact, this is reflected in Taiwanese society as well.

6.1.2 Problems of Deinstitutionalisation and Community Mental Health Service Provision

Deinstitutionalisation is the process of replacing long-stay mental health institutions with less isolated community mental health services for those individuals with mental disorder or related disability. In the 19th century, there was a large expansion in the number and size of asylums in Western industrialised countries, and although these were initially based on the principles of 'moral treatment' for mental disorders, asylums gradually became overstretched, un-therapeutic, isolated in location and neglected in terms of social and clinical practices (Wright, 1997). The first community-based alternatives were suggested and tentatively implemented in the 1920s and 1930s in the UK, and although the number of asylums kept increasing until the 1950s, the movement of deinstitutionalisation came to the fore in various Western countries in the 1950s and 1960s (Wright, 1997).

In Taiwan, there are number of residential care services, such as half-way houses and long-stay care homes, and sheltered workshops where discharged patients. In addition, a number of communities have launched services, such as Community Rehabilitation Day Care Units and Community Mental Health Centres, to facilitate patients' re-integration into the community. Nevertheless, according to the findings of this study, it is clear that mental health service deinstitutionalisation programmes are still posing many and varied challenges for mental health policy makers and front-line service providers.

In this study, service users expressed their desire to remain in an institution. This seemed partly due to the financial difficulties of living in the community combined with being discriminated against. Compared to living in the outside world, they feel comfortable and safe in the institution, and therefore, most service users wished to stay where they were. However, the financial difficulties of patients and the lack of comprehensive community mental health services were the carers' major concerns. They wished that the healthcare organisations could provide customised services to meet various demands.

However, the service providers interviewed described being frustrated at seeing some patients continually coming and going in the psychiatric institution, as in the term 'revolving door'. The main reason for deinstitutionalisation programmes failing to be fully launched in Taiwan is the shortage of resources and fully-trained staff in the provision of community mental health services (Shiau, et al, 2005). Although, there was a desire to provide good quality services to meet users' needs; the required good referral systems and community support organisations are still inadequate in Taiwan in the view of front-line service providers and key informants.

According to the key informants' opinions in this study, the senior researcher used the term *"where there is money, there is a way"*, to illustrate the problem. The inadequacy of deinstitutionalisation in Taiwan was raised by the senior researcher, who believed that this is due to the lack of service provision in the community, partly because the current national health insurance funding mechanisms still favour primary hospital-based care. The mental health policy maker in a Local City Government considered that there was a big gap between the resources in the psychiatric hospital and community care provision, particularly in terms of the national budget arrangements for healthcare expenditure. In addition, there are difficulties in breaking the long-outdated structure of the nucleus psychiatric hospitals known as the "Central Hospital", which still dominates the majority of mental health service arrangement and resource allocation.

One of the key informants for this study is a policy maker in the National Government's Department of Health. He indicated that the tendency of mental health service provision in Taiwan was to shift from hospital-based to community-based mental health care. However, he pointed out that barriers to the deinstitutionalisation process have led to insufficient resources in the community. He also cited a study which has pointed out that there was a 24.4

per cent overstay rate in acute beds in hospital after the implementation of Taiwan's national Health Insurance (NHI) in 1995 (overstay was defined as a hospital stay of over 30 days) (Wu, et. al., 1998). Two reasons have been suggested to explain this phenomenon, one of which refers to inadequate resources in the community, and the other cites the fearful and toilsome process of the hospitalisation of users (Wu, et. al., 1998).

The senior researcher also mentioned this predicament, and gave four reasons for it. The first of which is that the government provides insufficient budget to support the provision of community mental health services. Secondly, there is an inadequate workforce in the community mental health services area, and thirdly, families are less able to take care of patients after discharge due to a gradual change having taken place in family structures, such as nuclear family structure, and those families in Taiwan need double-salaries to support the household expenditure under current economy situation. Finally, there is an obstruction to the psychiatric hospital downsizing process, which has arisen from these hospitals considering how this might impact negatively on their own revenue. According to the interview with a policy maker working in the Department of Health in Taiwan, the current policy of extending services into community areas is via a pilot scheme of 'case manager' mode in managing available resources, with a follow-up service for mentally ill persons in the community in an attempt to alleviate the insufficient number of public health nurses.

However, in terms of the future and long-terms plans of service users and carers, from the interview findings in this study, only one user in the interviews expressed a wish to go back into the community, which could point to the others experiencing fear and disappointment while living under the current mental health community service provision.

A high readmission rate among persons discharged from in-patient psychiatric treatment may reflect the fact that the community lacks adequate accommodation for such patients, and can be used as an indicator of the inadequacy or inappropriateness of community-based healthcare (Thornicroft, et al., 1992). A wide range of psychiatric readmission rates has been reported in Western literature, and the reported rates have ranged from 10 percent readmission within one month after hospital discharge to as high as 47 percent within one year (Klinkenberg and Calsyn, 1996). However, data on the readmission of psychiatric patients in Asian societies is limited.

Lin and Lee (2009) used a registry-based cohort design to estimate the short-term readmission rate – within 60 days – among 1,813 patients discharged from a psychiatric hospital between November 2003 and October 2005 in north-western Taiwan. They discovered that the readmission rates were 6 percent within 14 days, 9 percent within 30 days, and 12 percent within 60 days. In addition, patients who received a scheduled ambulatory follow-up ran a significantly higher risk of readmission within 60 days, and those who attended community rehabilitation programmes were significantly less likely to be readmitted. In terms of patients with schizophrenia, those who had a hospital stay longer than 60 days had a significantly increased risk of readmission within 14 and 30 days. Although the readmission rate is not substantially high in Taiwan, service providers and mental health policy makers is clear an exploration of the significance of rehospitalisation of psychiatric patients, and specific forms of aftercare and types of services which can ensure that discharged psychiatric patients remain in community care settings could be helpful.

In order to examine the relationship between home-to-hospital distance and the admission rates of psychiatric facilities in the Western context, Sohler and Clapis (1972) evaluated the length of psychiatric stay. They found that longer distances from psychiatric facilities were associated with longer lengths of stay. A more recent study undertaken by Miclutia et al. (2007) argues that patients who live in rural areas could find it difficult to access psychiatric care, and that,

when they are eventually admitted to hospital, they may stay longer because prompt readmission may not be possible. This is reflected in the Taiwan context. A study investigating the relationship between the travel distance and the length of stay in hospitals in Taiwan revealed a longer stay in psychiatric facilities of index admission by 9.3 days between remote and non-remote regions (Tseng, et al., 2008).

The deinstitutionalisation movement has become worldwide over the past several decades, and a number of studies from Western countries suggest that mentally ill patients can re-enter the community if there is a well-organised system of care to address their mental health needs (Lesage, et. al., 2000). This movement towards community re-integration is predicated on the continuity of psychiatric care from the hospital to the community. However, Shiau, et al. (2005) point out that continuity of psychiatric care is suboptimal in the national policies of many developing countries, which includes Taiwan. Evidence albeit from a decade ago, for the negative impact of poor community care in Taiwan comes from a national survey in 1997, in which 54.2 per cent of 2,349 in-patients with schizophrenia were re-hospitalised within one year of being discharged (Hwu, 1997). Further research found that half of the psychiatric patients discharged from hospital do not receive regular follow-up appointments, and 30 per cent had poor medication adherence (Tsai and Chen, 1996).

Although those studies were conducted more than a decade ago in Taiwan and more recent work is lacking, anecdotal evidence suggests that little has changed. In contrast with experience from Western studies, mentally ill patients in Taiwan seem not to be prepared to live in the community under the current situation. Meanwhile, research done by Tzeng, et al (2004) in Taiwan suggests that, in making health insurance policy, the authorities should increase funding to community-based programmes before downsizing acute care facilities, and provide incentives to institutions, conducting community-support programmes.

A main indication of approaches to deinstitutionalisation is a decrease in the total number of conventional psychiatric hospital beds (Leff, 1993). However, evidence shows that the number of psychiatric beds has been rising in Taiwan over the past decade (Department of Health, Taiwan, 2009c). The Statistical Annual Report of Medical Care Institutions Status and Hospitals Utilization from the Department of Health in Taiwan shows that there were 4,641 acute psychiatric beds and 8,681 chronic psychiatric beds in total in the year 1999, which had then increased to 6,012 acute psychiatric beds and 12,544 chronic psychiatric beds by the year 2005. The newly-updated statistical report in February 2009 from the Department of Health shows that there were 6,455 acute psychiatric beds and 13,644 chronic psychiatric beds in total in Taiwan, which indicates that the there is little evidence of deinstitutionalisation in Taiwan, according to the definition of deinstitutionalisation being indicated by the number of available acute beds.

6.1.3 The Impact of the Social Welfare System and Financial Situation upon People with Mental Illness

Financial problems among mental health in-patients undergoing occupational job training were discussed in the service users' and carers' interviews. Patients complained that the income received from occupational job training was far less than the average salary, which made them feel dissatisfied with this service. Also, this was one of the reasons that they were afraid to leave the institution and live in the community by themselves under the current welfare system provided by the government. This issue is related to poor employer acceptance and employment inequality within the societal environment outside the institutions.

From the service policy maker's point of view, the main deficiency of the national social welfare system is the 'budget', along with other contributing elements, such as the operational system between national and local

government levels, and resources in the community. However, a study done in Taiwan, proposed that the main issues are due to problematic relationship between the assessment process within the work training programme of those mentally-disabled individuals and the allowance from the government. This was exacerbated by inadequate professionalism of staff and diversification of services in community provision (Shiau et al., 2005). The other issues raised by the Bureau of Employment and Vocational Training in Taiwan in 2007 included long standing stigma against people with mental illness, perceived self-disgrace, symptoms interfering the ability to work consistently, and difficulties in interpersonal and social skills, which result in the predicament of difficultly in finding employment (Bureau of Employment and Vocational Training, ROC Taiwan, 2007).

Data supplied by the World Health Organization (2004) indicates that one in four people can expect to experience a significant episode of mental illness during their lifetime. Therefore, a major challenge for mental health professionals and policy makers in many countries is to ensure that mental health needs receive a fair share of societal or collective attention, and that those preventive interventions, treatments and services to meet these needs receive their fair share of the available health system funding.

Data from the Directorate-General of Budget, Accounting and Statistics, (Executive Yuan, ROC, Taiwan, 2010) states that there is a budget of around 450 billion New Taiwan dollars provided to the National Health Insurance (NHI) system every year by the Central Government of Taiwan. This occupies just over one-fifth of the total Central Government General Budget. However, healthcare expenditure for all psychiatric disorders combined represent only less than three per cent of NHI's budget at the present time, which was pointed out in this study by the senior researcher. The policy maker in the Department of Health at Local City Government also indicated that the central government budget for the mental health sector was extremely small compared to Western

countries, and this amount of healthcare expenditure is even projected to increase gradually in the West.

According to 'The Disabilities Discrimination Act' in 1995 (Law and Regulations Database of Republic of China, 2009), the definition of disabled people is 'people with difficulties or limits to fulfilling functional needs when participating in social or production activities due to their physical or mental disabilities are certified as disabled by the Executive Yuan authority of national General Health and Mental Hygiene Department'. Simultaneously, the 'Physically and Mentally Disabled Citizens Protection Act', which has been amended to 'People with Disabilities Rights Protection Act' in 2007 (Law and Regulations Database of Republic of China, 2009), this Act includes 'Mental disability' within 16 different categories of disabilities. However, since those Acts were implemented around ten years ago to include people with mental disability, there still little evidence to show that disabled persons have equal rights in Taiwan's healthcare system and current social welfare support.

In relation to job retention for workers with psychiatric disabilities in a supported employment programme, 'The Enforcement Regulations of the Vocational Training Act' promulgated by the Executive Yuan, ROC Taiwan in March, 1996 and modified in December, 2000 (Council of Labour Affairs, Executive Yuan, Taiwan, 2000), clearly provided an incentive for employers to engage disabled workers in their companies. However, in interviews in this study, service providers stated that from their experience those employers consistently hired physically-disabled persons rather than mentally-disabled individuals. They reported feeling frustrated about providing progressive services in the context of unsupportive policies and powerlessness to change this situation.

Mental disorders are not only highly prevalent medical conditions but they are also highly disabling. Measured by years lived with disability and by premature death in disability-adjusted life years (DALYs), psychiatric and neurological

conditions accounted for over 13 per cent of the global disease burden in the year 2001(WHO, 2001).

In terms of the social burden, the impact of mental disorders on communities is large and manifold. There is the cost of providing care, the loss of productivity, and some legal problems associated with some mental disorders. This includes the misperception of violence being a feature of the behaviour of individuals with mental disorders. One way to measure the social burden of disability caused by chronic disorders is the Global Burden of Disease (GBD) methodology. According to the World Health Report 2001 (WHO, 2001), the global burden of neuropsychiatric disorders is estimated to increase from 11.5 per cent of the world's total Disability Adjusted Life Years (DALYs) to 15 per cent by the year 2020 (WHO, 2001). The definition of DALYs by World Health Organization is the sum of years of potential life lost due to premature mortality and the years of productive life lost due to disability (WHO, 2009).

It is well documented in Western literature that comprehensive and coordinated community care is beneficial for the successful long-term prognosis of mental illness (Ryu, et al., 2006), and poor community care will increase the cost of treatment because of an increase in re-hospitalisation rates (Rothbard, et al., 1998). There is growing evidence for the negative consequence of inadequate community care in Taiwan (Lai, Lee and Shuen, 2006; Shen, et al., 2006). Shiau et al. (2005) clearly state that several unsolved problems of community psychiatric care delivery systems in Taiwan have existed for a long time, such as people with mental illness and their families being underserved and overwhelmed by huge gaps in the provision of services.

In addition to the direct burden of mental illness, lost opportunities have to be taken into account. For example, families in which a member is suffering from a mental disorder have to make a number of adjustments and compromises which prevent other members of the family from achieving their full potential in work, social relationships and leisure (Gallagher and Mechanic, 1996). Families

often have to set aside a major part of their time to look after a mentally-ill relative, and suffer economic and social deprivation because a mentally-ill person is not fully productive.

6.2 Synthesis of Key Findings on Different Perspectives towards Mental Health Service in Taiwan

This study investigated patients' satisfaction ranking of the current mental health services they receive, and simultaneously explored the opinions of service users, carers, providers and policy makers in terms of their experience of using or providing those services. It is a methodological triangulation research, using the Verona Service Satisfaction Scale (VSSS) as a survey instrument to measure patients' satisfaction, and employing in-depth interviews centring on the users' and carers' experience of receiving, as well as the providers' experience of providing, psychiatric care in Taiwan, along with the perspectives of the key informants on related issues. The description and analysis of the quantitative data were based on a variable-orientated technique, and a thematic analysis was used for the qualitative data analysis. In addition to this explorative and comparative analysis, the findings from each group can also 'stand-alone'. Thus, the conclusions are presented in two sections, namely perspectives of service users and carers, and perspectives of service providers.

Although the informants in this research study were selected as a convenience sample, the results reveal a range of perspectives of mental health services between services users, providers, and policy makers.

6.2.1 Service Users' and Carers' Perspectives

The group of service users and carers expressed ambivalence in terms of their experience of staying in an institution and living in the community. This

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ambivalence is probably more due to stigmatisation and the difficulty of dealing with everyday life by patients, and through the care given by carers. It is evident that service users and carers of both hospitals, whether from out-patient units or in-patient wards, rely heavily on hospital-based psychiatric healthcare for providing a service. Moreover, the survey findings demonstrate that the participants are generally satisfied according to the measure used with the current hospital-based mental health services they receive.

Psychiatric disorders impose a significant burden on developed and developing countries (Jenkins, et al. 2002). According to a World Health Organization report on mental health (WHO, 2001), the disability caused by mental and neurological disorders is high in all regions of the world. The social-economic impact of mental disorders is wide ranging and long lasting, including the cost of supporting the dependents of people with mental illness. Psychiatric disorders impose a range of costs on individuals, families and communities as a whole. However, although part of this social-economic burden is evident and measurable, other parts are almost impossible to measure. The World Health Report (WHO, 2001) highlights the fact that among the measureable components of the economic burden, are health and social service needs, such as lost employment and reduced productivity, the impact on families and caregivers, levels of crime and public safety, and the negative impact of premature mortality (WHO, 2001).

Although persons who suffer from mental illness have the right not to be blamed and to live and recover in the community, the findings of the present study suggested that mentally-ill individuals encountered social adversity and illness-related difficulties in their attempts to live in the community. Furthermore, patients' social disadvantage adds to the impact of the illness and hampers their community adaptation.

6.2.2 Service Providers' and Policy Makers' Perspective

Despite users' and carers' desire for hospital-based service prevision, service providers and policy makers made clear statements that community-based mental health service should be considered as a priority development for current and future service provision. The service providers and policy makers, who acted as key informants in the interviews for this study agreed with the government's policies. The findings of this study clearly reveal one common main theme of what constitutes better psychiatric care, namely the establishment and distribution of balanced hospital-based and community-based mental health services.

A study conducted by Wing and Brown (1970) looking at patients with schizophrenia demonstrated how the effect of under-stimulating social environments and the length of stay in psychiatric hospitals resulted in negative symptoms. This study influenced psychiatric hospital reform and promoted the idea of community mental health services in the UK. A later study conducted by Curson et al. (1992) in the UK, showed de-institutionalisation as an advanced development. However, de-institutionalisation has yet to become fully engaged in Taiwan. This is in contrast to many Western countries that over the past two or three decades have been trying to establish community mental health services and have gradually decreased the number of psychiatric beds (Leff, 1993).

From the perspective of the service providers and key informants, much of the previously research published in the Western countries has demonstrated that community-based psychiatric care has positive effect on patient outcomes resulting in a better quality of life for mentally-ill patients. Moreover, the results clearly indicate that a well-balanced mental health service is essential, and it seems important to develop a training programme for staff working in community-based psychiatric care. Shiau et al. (2005) stressed that, in contrast to hospital care, few professionals are devoted to community psychiatric care

and little professional training or preparation for community psychiatric care has been developed in Taiwan.

Shiau et al (2005)'s findings are reflected in the current study where participants indicated an inadequacy in numbers of properly of trained mental health staff in community service provision and highlighted this as a deficiency along with lack of follow up and referral services for mental health patients in the community.

Numerous mental health care policies and strategies have been launched by the government in order to shift the healthcare system into community settings, the so-called deinstitutionalisation movement in Taiwan. However, the number of psychiatric beds steadily increased until 2009, according to data provided by Taiwan's Department of Health. The number of acute psychiatric beds in 1999 was 4,641, and then this increased to 6,455 in 2009 with a growth rate of 39 percent. The number of chronic psychiatric beds in 1999 was 8,681, which increased to 13,644 in 2009 with a growth rate of 57 percent (Deportment of Health, Taiwan, 2009b).

Recently, no relevant nationwide cross-section survey has been conducted in Taiwan to examine the characteristics of the psychiatric in-patient and out-patient population in order to interpret and analyse the overall phenomenon of mental health care service usage in Taiwan. Nevertheless, the deinstitutionalisation process has been cited since the 1990s in community mental health policy, and social rehabilitation facilities have been established in several districts across Taiwan in line with the new mental health law, which was amended in 2007. Data provided by the Department of Health in Taiwan (2009c) supports the view of two key informants' who indicated that various programmes have been put in place, although the resources allocated for those programmes were viewed as insufficient to date.

6.3 Conclusion

During the past four decades, Taiwan has experienced significant economic development. The Taiwanese government has delivered many social reforms in response to increasing demands for better social and human services for mental health. In recent years, in order to develop special healthcare services for mental illness individuals, the Department of Health under Executive Yuan (2005) reported the progress made to strengthen the current national mental health services (Department of Health, Taiwan, 2005). However, the question of whether the reformed mental health services have met user's needs and what are the experiences of users and their families? This study aimed to address this question.

The conclusion of this chapter is that the participants in this study revealed negative consequences within current mental health care in Taiwan. Several unsolved problems within the system, especially in the community-based care sector of care, have existed for a long time, such as insufficient supply and inadequate quality. Therefore, in the context of this study, people with mental illness and their families report being underserved and overwhelmed by gaps in the services. Although this study does not claim to generalise to a larger population, it can be suggested that from this research finding, since the needs of people with disabilities of different kinds, and degrees with causes, and different age and education status, more attention needs be paid to those deficits in order to make good and effective use of resources. However, without clear and strong national-level policies to guide and support the development of mental health care, the existing services cannot meet the needs of the population.

In addition, a lack of knowledge of mental disorders and stigma remain major barriers to care, according to the great amount of research addressed in the

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previous discussion. Factors which are direct barriers to care, including financial considerations, also preclude treatment. In terms of issues of accessibility, there is limited availability or even a lack of availability of services in some area in Taiwan. Furthermore, a lack of integration among public and private sectors, as well as health and social welfare sectors, has failed to deliver effective community psychiatric care. In contrast to hospital care, few professionals are devoted to community-based mental health care and little professional training or preparation has been developed in Taiwan for community psychiatric care. Helping people with mental illness to live in the community is an important paradigm shift from the traditional psychiatric treatment. However, this has still to be realised in Taiwan.

To summarise, the findings of this study reveal that the perspective of the service providers and policy makers in terms of the development of national mental health policies and service provision in Taiwan does not match the needs of users and carers. The findings emphasise the importance of the incorporation of psychiatric care principles in every service provision. However, there were some variations in the findings, one of which was that the users with mental illness expressed ambivalence regarding the institutionalised care. One conclusion of this research may be that the implementation and development of mental health services in Taiwan may require integrated strategies. This is a significant task and one which makes great demands on service providers, and requires maximum utilisation of service resource distribution. The phenomena described in this study will be recognised by readers from across the globe perhaps occurring at a greater or lesser according to levels of industrialisation and the pace of social change. However, what this study has aimed to achieve is describe this from the perspective of the Taiwanese context and offer solutions that are culturally sensitive and specific.

Chapter Seven

Conclusion and Recommendations

The research design used for this study combined a quantitative satisfaction survey and qualitative in-depth interviews to describe and explore the experiences of service users, carers and providers in using or providing mental health services. More specifically, the research sub-aims were to describe the nature of these experiences, to explore how the experiences might be constructed, and to compare and contrast the views of users, providers and related policy makers with regard to the mental health services in Taiwan. The purpose of studying the opinions of service users and service providers was to indentify any similarities and differences, and to take key informants' opinions into consideration of recommendations for future service development.

Within each section, the findings of the study have been evaluated and discussed in terms of what they contribute to the body of knowledge about the subjective experiences and clinical provision of mental health services in the Taiwanese context. The strengths and limitations of this study, and suggestions for future research, are presented at the end of this chapter.

7.1 Research Implementation and Recommendations

Mental health policy is increasingly a focus for long overdue attention in many countries, including Taiwan. This is partly due to the gradually heightened impetus within the mental health field itself from service users, their families and mental health professionals, and partly because of conventional general health sector reforms that have failed to pay attention to a significant portion of the health services (Yang, 2004). Mental health care systems are extremely complex, being comprised of many different agencies which inevitably come into contact with people with mental illness, and the interfaces and patient-flows through the system have inevitable consequences for the rest of the system.

For example, it is very difficult to resettle people with severe mental illness in the community if the stigma surrounding people with mental illness is not tackled through public education in schools and communities.

Regarding healthcare policy implementation, Jenkins, et al. (2002) suggested that stakeholders' agreement on strategy is desirable but may not be achieved, and that a communications exercise may be necessary to engage them. Different stakeholders may require different approaches in terms of health care. Professionals and national government officials in the mental health care sector may need information on proven effectiveness and epidemiology. Historically, human rights and ethical arguments have also been of great importance in moving mental health services forward. Therefore, as the aim of this study is to obtain the views of service users and carers, there are particularly important given that they are directly affected by the implementation of strategy and also have personal experience of those aspects of the current mental health system that are working well.

A growing body of evidence in the Western world has consistently shown that mental health professionals and service users have different perceptions of needs (Slade, et al., 1998; Wiersma, et al., 1998). It has been found that patients and staff disagree on both the presence of a need and on whether a need has been met or not. Moreover, a research group led by Professor Ruggeri (Lasalvia, et al., 2000) pointed out that, while staffs tend to identify more need in areas related to clinical aspects, patients tend to report more need in social life and in domains related to everyday issues. Therefore, this is a critical point in terms of mental health care delivery, and every effort should be made by services to implement strategies which aim to increase the consensus between professional staff and service users. Furthermore, it may be that the result of better service staff-patient agreement can help to improve treatment outcomes, not only on patient-rated scale, but also clinician-rated dimensions (Lasalvia, et al., 2008).

Given the nature of the research methodology, the similarity of the participants and the small sample size, it is difficult to make too many general statements about implications for practice. To understand the extent of transferability of the findings, it is important to remember that all the participants from the questionnaire survey and in-depth interviews were either from a Urban General Hospital Psychiatric Unit or a Suburban Specialised Psychiatric Centre, and they all live in the city or county of that district. It could be argued that the findings of this study are, therefore, less applicable to those patients and services outside the administrative district.

However, as identified in Chapter Six, this research contributes to the existing literature about mental health services and the impact of stigmatisation. In addition, there are some specific new findings that are derived from the Taiwanese context:

• Users' satisfaction with the mental health services is not directly linked to service interventions they receive, and users are not fully informed about what choice of services is available.

• People with mental illnesses and their families are underserved by what is provided and overwhelmed by gaps in the services, especially the inadequate resources in the community mental health sector, contributing to difficulties in delivering a de-institutionalisation programme.

• Service users' and carers' expectations do not match those of service providers and policy makers with respect to how improvement of mental health services is provided. The main different is that the survey indicates a satisfaction with institutionalised care and hospital-based community care, this is reiterated in the interviews with most people wanting to stay in the institution unless things in the community can be addressed and service providers considering community care is the goal for future mental health service development.

According to the findings of this research, three main issues can be identified as recommendations for implementing a user and family-centred mental health service in Taiwan. These are: to enhancing community mental health care provision, to enable the user's voice to be heard to inform this enhancement, and reforming mental health education of the public and service providers. These recommendations respond to the key factors taken from this study which have the potential to influence mental health service system delivery in Taiwan. The research also highlights the importance of a service user-centred system in the development of a more comprehensive mental health service to meet the users' needs. In addition, the findings suggest that mental health institutions should provide continuous care according to each patient's individual characteristics, should work to improve or expand services, and should refer patients to the most appropriate community model.

7.1.1 Enhancement of Community Mental Health Care Provision

According to Taiwan's Mental Health Law (Department of Health, Taiwan, 2007a), the government is responsible for a well-established community mental health care system; however, community-based services have been neglected for several decades (Shiau, et al., 2005). As mentally ill patients are discharged from in-patient facilities, most of them and their families are left isolated and receive care not completely meet their needs (Chang and Song, 1998; Shiau, et al., 2005). This is because the public sector is not placing importance on caring for this vulnerable population, and they have been forced to rely on themselves. In addition, this research confirmed with previous study findings that patients in Taiwan did not obtain adequate care to assist them to cope with their illness in a community environment. Because of the lack of access to community-based care, mentally ill persons could become unstable, and consequently the public would have negative impressions of their strange behaviour, psychotic symptoms and poor functioning (Hsu and Tai, 1991). This of course would exacerbate the stigmatisation of this unfortunate group.

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In 1997 the Department of Health in Taiwan claimed to begin implementing 'community-based mental health services'. However, evidence from previous research, as discussed in other chapters, suggests that policy after policy has continually failed to achieve this goal. Without clear and strong implementation of national-level policies to guide and support the development of community psychiatric care, the existing insufficient and fragmented services cannot meet the needs of this population in Taiwan.

According to the theme of World Health Day 2001 - "Stop Exclusion, Dare to Care" - there is no justification for excluding people with a mental illness from our communities. Community care is recommended because of its cost-effectiveness and respect for human rights. Several studies suggest that mentally ill patients can re-enter the community successfully and live independently within a well-prepared and organised mental health care system (Lesage, et al., 2000; Ryu, et al., 2006). According to previous research in Taiwan, a lot of psychiatric patients suffer from long-term illness and live at home, during which time they lack a good support system and are faced with impeded daily activity (Chen, Yin and Tsai, 1999). They frequently need to be hospitalised, thus greatly increasing the medical costs of psychiatric care. Although those mentally ill individuals comply with OPD (Out-Patient Department) follow-up, they still have unmet mental health needs from psychiatric services (Chen, Yin and Tsai, 1999).

Community-based mental health systems of care might create a platform for quality interventions to be developed and organised. However, this research found that mentally ill patients in Taiwan were encumbered by numerous difficulties as they tried to live in the community. Getting a 'shameful' illness and having unmet needs for community care have forced them into social disadvantage. At the same time, they have to manage several difficulties

caused by the illness, such as denying the illness, living with the difficulties of the illness and adapting to change more limited level of function.

Severe and persistent is one of the characteristics of mental illness and many studies have indicated that community-oriented mental health care seems to be a distant hope for mentally ill patients, families and psychiatric professionals in Taiwan. Interventions from the government at both individual and societal levels are needed to tackle the difficulties found in this research. For example, anti-stigma action on a broad level that comprehensively integrates sectors might diminish the long-existing social stigma surrounding mental illness in Taiwan. In addition, the establishment of an organised community care delivery system will favour mentally ill patients and their families. At the same time, it is imperative to refine Taiwanese national policies to support the community psychiatric care system and to recruit more mental health care professionals to such systems.

At the individual level, more culturally adapted care models which suit individual needs have to be developed and empirically validated, particularly by front-line psychiatric professionals, such programmes should be assist this population and their caregivers who are living with the illness in the community. Finally, alliance groups of patients and family members, with information exchanges and mutual support, would promote competence.

However, according to the data from 'The living situations of the mentally ill and their needs within social welfare in Taiwan, 2004', provided by the Health and Social Division in the Taiwan Provincial Government, of the 70,000 psychiatric patients in 2004, 50.7 per cent of them were living with their family, 16.7 per cent were in hospital-based institutions, 2.1 per cent were in community-based residential institutions and 5.3 per cent were living alone (National Policy Foundation, 2009). Those patients who have better drug compliance and who use regular out-patient follow-up services have improved their quality of life, and those individuals who live alone without family, service systems and social

support are living under difficult conditions and are seen as a burden on society (National Policy Foundation, 2009).

Culture is a major variable impacting upon the conceptualisation, development and administration of mental health systems. Culture includes the beliefs, values, symbolic meanings and normative behavioural practices of a specific human group. Cultural belief systems inform us of whether deviant behaviours are identified and classified as illness, and they also inform us about the concepts of etiology and cure and the designation of appropriate healers. Lefley (1994) highlights the fact that in any cultural system, moral concepts of mental illness, help-seeking paths and utilisation patterns are intermeshed with the organisation and structure of service delivery systems. Therefore, belief systems, value orientations, religious and medical practices, social organisation and family structure influence the modes of developing and delivering services to persons identified as needing interventions.

In Buddhist thinking, suffering is the consequence of previous misdeeds. Thus, mental illness may be perceived as punishment for misdeeds perpetrated by the patients themselves, or their family members. Within this orientation, mental illness is a shameful label for Chinese people with mental illness and their family members. (In Buddhism, people have three lives, namely, the previous, the present and the future. A man in this life may become an animal in the next life because of his misdeeds) Being influenced by such beliefs, family members of clients with mental illness, especially those in rural areas where traditional belief still prevails, family members may feel reluctant to disclose, or even admit to, their relative's mental illness.

Buddhist beliefs, which include an entrenched belief in reincarnation, have made the public's conception of mentally ill persons and their families highly negative. In this study, the patients and their families expressed feeling hurt by negative public attitudes. Public misconception and stigma against mental

illness have left mentally ill persons and their families with feelings of blame and exclusion and driven them into a socially disadvantaged corner (Ng, 1997). In addition, such stigma also hinders patients and their families from accepting the illness, seeking help, getting access to appropriate treatment and rehabilitation, and reintegrating into the community.

Moreover, because of religious beliefs and stigma both patients and their families may not be aware of their right to live in the community and may consider their problems as being the result of their unavoidable fate rather than the failure of the mental health system provided by the national and local sector. An old Chinese saying that translates as "do not wash dirty linen in public", means that families are encouraged to keep their mentally ill relative a secret and care for them by themselves rather than seeking help. In contrast to the individualistic orientation of Western culture, traditional Asian culture puts much more emphasis on family bonds and views the family as an essential component of the value system (Lee, et al., 2005). This collectivistic value orientation compels families to provide physical and emotional support as well as bearing the negative impact of illness and stigma. This means that parents and other family members have to help their mentally ill relative to battle with the impact of illness and resulting stigma without the support of an effective service.

7.1.2 Enabling the User's Voice to be Heard

This study, involved service users, and thus gave voice to a previously silenced group - the mentally ill. There are many ways in which the voice of mental health service users is beginning to be heard, and research can play its part. By systematically collecting user testimonies, mainstream psychiatry might be confronted with the flaws in its practice.

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Much user involvement takes the form of campaigning. These campaigns for rights and dignity are undertaken by users and survivors themselves. The modern user movement developed first in the USA and in the Nordic countries. According to Rose (2008), these campaigns were not particularly radical, but it was clear that the authorities saw the service users as a threat because it was not conceivable to them that 'patients' could negotiate rationally. However, research such as the present study can provide service users with a platform from which they can speak and that allows their voices to reach the public and the government.

It is important to explore at the views of service providers and policy makers regarding the mental healthcare service move from 'hospital' to 'care in the community', which may be one of the drivers that can change the social position of mental health service users. People with mental health problems are no longer locked up in closed institutions; some may find themselves in positions which enable a critique of the dominant practices within mental healthcare systems. Therefore, according to the findings of this study, this author suggests that government should provide opportunities for service users to explore their experiences and views of future service development.

Obstacles to mainstreaming mental health issues to become part of social policy include negative public attitudes, inter-professional tensions, and a mental health system operating against a backdrop of continuous political and organisational change. However, according to a report on Taiwan from the 'Asia-Pacific Community Mental Health Development Project', links between the statutory service and the voluntary sector make public participation possible. Local people are now allowed to contribute to service planning and innovation-related projects. For instance, the alliance between the John Tong Foundation (founded in 1984) and the Taiwanese Association against Depression (established at 2001), as well as the set up of the Mental Health Foundation (2002) are two other examples of organisations which address public education and aim to change public attitudes (Wu, et al., 2008).

In terms of 'speaking out', there are some organisations in Taiwan, such as Mental Rehabilitation Association organised by the public Corporation Aggregate in every major city. In these Association, the mentally ill are representing themselves, and are rational negotiators, speaking for themselves and on behalf of a group who have been profoundly mistreated at the hands of society and service professionals, and at the same time providing and developing skills in self-management of mental health problems and mutual support. However, these Associations are still publically funded, and without enough financial support from the government it is very difficult for them to organise sufficient and effective action to change the social position of mentally ill individuals.

It is suggested that national and local government should provide an adequate allowance to such associations in order to decrease public stigmatisation and increase public awareness of mental health. This might also improve the function and purpose of the Mental Rehabilitation Association in terms of issues such as restoration of full civil rights to people detained or treated by the psychiatric service system.

7.1.3 Reforming Mental Health Education of the Public and Service Providers

In order to achieve a goal of decreasing public stigma associated with mental illness, two areas should be focused on, the first of which is the media's role when broadcasting mental illness related news, since the media bear a great responsibility for informing society. The second area of focus is improvement to law and policies, since the current regulations are generally unsupportive, and often position mentally ill patients as an excluded minority in society.

The recommendation to enhance public health education and ensure implementation of mental health policy is based on the reasons listed below.

First, this supports a population mental health approach rather than one primarily focusing on individuals, in which all psychiatric patients and families with a member who has a psychiatric disability should have access to information and support. Second, it emphasises that mental health education is created within everyday settings, such as schools, community and family. Third, it embraces a social view of mental health, promoting the utilisation of strengths within families and communities, and emphasising societal factors that may influence mental health (e.g. public understanding), rather than looking solely at individual risk and protective factors.

Research confirms that anti-stigma programmes can considerably reduce the negative societal attitudes and behaviours that prevent patients from seeking care. Corrigan and Penn (1999) identify three approaches, protest, education and contact, all which may decrease the stigmatisation experiences of people with mental illness. They believe that pressure groups could send two messages. The first is to pressure the media to stop reporting inaccurate representations of mental illness. The second is to ask the public not to believe the negative views about mental illness in the media. However, even if protest achieves the aim of diminishing negative attitudes towards mental illness; it is suggested that at the same time it can fail to promote positive ones. This may be the reason why education offers better opportunities in providing more detailed information about mental illness to the public as suggested by key informants in this research. Research has suggested that the public's positive attitudes towards patients with mental illness have notably increased after the launch of educational programmes (Corrigan, et al., 2001). It is believed stigma could be further eliminated when the general public has actual contact with people with mental illness who are able to hold down jobs or act as good neighbours in the community (Corrigan and Penn, 1999).

Mental illness is often a long-term condition that the person lives with daily and tries to make progress with, despite their vulnerability. The positive effects of educational intervention for the public in terms of the attitudes about, and

understanding of, mental health or psychiatric signs and symptoms should not be ignored. From stakeholder's interview in this research confirmed that, in order to improve the service provision in the community area and reduce the public stigma, the government should be encouraged to embrace public mental health education through a public health policy approach in framing the development of promotion, prevention and early intervention strategies.

The collectivistic value orientation in Taiwan also means "family bond", which represents a dual force: family care and family burden (Lin, et al., 2008). This research also found that caregivers are not equipped with adequate knowledge about mental illness. Providing carers with an educational programme on mental illness management is extremely urgent.

Mental health promotion and mental illness prevention strategies in the community can be used to improve the health outcomes of families and patients with psychiatric disability. For example, in accord with the eastern culture of family orientation, services could be focused to be more inclusive of family members, embedding notions of meaningful and valued roles, and also building connections between services in everyday life in the community.

Research done by a government organisation of Research, Development and Evaluation Commission, Executive Yuan in Taiwan to evaluate the utilisation of mental health resources in Taiwan demonstrates that the majority of the users attend out-patient services provided at hospitals, and only few utilise community rehabilitation service and home-care services. The reason for low rates of utilisation was mainly due to the users not knowing about community-based services and organisations (Research, Development and Evaluation Commission, 1995). Although these figures are from fifteen years ago, according to key informants' opinion, frequent hospitalisation and increased medical costs remain a problem. Therefore, the current mental health service in Taiwan is still in a state of limited resources with low utilisation.

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The Taiwanese style of "silent communication" relies on an implied understanding between the people of that culture. According to Chen and Starosta (1998), while communication serves as a carrier of culture, what, where, and how we should talk is regulated by our culture. Thus, culture not only conditions our thinking, but is also manifest in our communication patterns. Ma (1992) reports that the Chinese are much less explicit in showing their emotions when they are communicating. In addition, the study indicated that a major difference in the communication style between the Chinese and the Americans is that the Chinese tend to be less confrontational and direct (Yang, 1978). However, when communication and relationships are allied with pressures on preserving harmony, this can create an additional strain on patients and families. Therefore, the cultural impact on 'speaking out' in Taiwan could be one of the obstructions to establishing a channel for service users and carers.

Mental health education for the workforce in the community mental health service area is equally important. Mental health education and training programmes are a vital gateway for the promotion of knowledge about mental disorder, and the improvement of knowledge of mental disorders and related issues, an informed work force can promote and provide the services to users and work towards the integration of all the local agencies and resources into a complete healthcare service network. Attitudinal changes and areas of focus for future community mental health service development are the primary goal and the first stage in shifting services into the community arena.

Therefore, it is very important to understand the behaviour of individuals suffering from mental health problems and their utilisation of psychiatric care. With increasing recognition of the high prevalence of mental disorders, their disabling nature, and the distress they cause for individuals and families, it may seem surprising that the majority of people with psychiatric disorders remain untreated or, if they make contact, do not stay in care (Mechanic, 1996).

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Globally, only a small percentage of people with mental health problems ever receive formal treatment, and even fewer people are treated by specialised mental health professionals (Kohn, et al. 2004).

7.2 Research Strengths and Limitations

• Strengths

In terms of strength of study design, the unique focus of this study was to combine quantitative and qualitative research methods in order to understand the mental health service in Taiwan from different perspectives. A survey at the preliminary stage investigated users' satisfaction level with current mental health service provision. This was combined with in-depth exploration through interviews of a diversity of experience of services on the part of users and the providers. The field of health research seem particularly keen on this structure of combining qualitative and quantitative research methods, given the pragmatic nature of the discipline coupled with the complexity of many factors that influence health and health care (Bowling and Ebrahim, 2005).

The mix of users and provider participating and in-depth interviewing techniques to clarify themes through to theme saturation proved to be the particular strength of this study. Analysis of interviews led to the uncovering of important issues, particularly user-relevant experiences, which had not been previously documented in relation to the service user's view in Taiwan. The decision to sample from two different hospitals in the same region of Taiwan resulted in a diverse sample from which it was possible to compare user satisfaction levels with different type of service provision in the survey data. In clinical practice, the patients from the Psychiatric Unit within the Urban General Hospital (UGHPU) were likely to have received less resource from service and may be less able to acquire an integral discharge plan compare to patients in Suburban Specialised Psychiatric Centre (SSPC), and collecting data from different mental health service setting may influence personal experiences.

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In terms of strength of research methods, the qualitative part of the study provided the researcher with an opportunity to look at the topic in more depth. It allowed the researcher to tap into the perspectives and interpretations of participants. In this way, it facilitates the generation of genuine insights and new understandings. Qualitative research methods of data collection and analysis may be thought of as ways of listening, and their strength may be said to lie in their sensitivity to diverse forms of expression. Unlike much quantitative analysis, which tends to discard 'outliers', qualitative research pays attention to exceptional cases and idiosyncrasies in order to gain a more complete understanding of a phenomenon. In addition, qualitative research tends to be open-ended in the sense that the research process is not predetermined or fixed in advance. As a result, unjustified assumptions, inappropriate research questions, false starts, and so on can be identified, and the direction of the research can be modified accordingly (Willig, 2008).

Building on these study findings, the use of a triangulation research design may provide additional detail about the nature of the process of users' experience as they actually experience variable circumstances. Regarding the healthcare professionals' experiences, the most notable difference between the two hospitals in this study was the tendency of the professional staff from the same hospital to focus upon their own particular local deficits in terms of the lack of services and resources such as insufficient financial support from government. This suggests that the context and particular resources available to psychiatric department or psychiatric hospital may impact upon the view about how services can be developed at that site.

The study was able to assess not only service user views of current mental health services in Taiwan, but also service provider and policy maker perspectives as well. In the interviews with services providers, they were open and frank in their descriptions of personal frustration and disgruntlement about

the service they were providing, both as an individual and as a psychiatric department. The interviews could have been viewed as a means of airing concerns with current service provision, anticipating that findings may reach a wider audience through publication.

Most studies on satisfaction with care methodology are based on different ratings or surveys with pre-defined items. However, the methodology used in the present study added qualitative in-depth perspective and a focus on experiences of using and providing the services. This revealed a difference between the experiences and expectation of service users and those of providers and policy makers for future service development. Such as the users wish to staying in institution, however, service providers and policy makers aiming to enhance services in community area. This present study is to be considered as exploratory within its field and there is correspondingly little supporting or comparative research work in Taiwan; therefore, the findings of this study should to be regarded as a first step to further study.

● **Limitations**

There were some limitations in this study. In terms of research method, it is unfortunately the case that its main focus on qualitative methods of interview may mean that it does not carry the same influence in the science-dominated field of mental health as quantitative research (Risjord, et al., 2002). Without revisiting the epistemological arguments outlined in Chapter Three regarding the strengths and limitations between quantitative and qualitative research methods, it is fair to say that what have been captured are only the subjective experiences of using and providing the services of a small number of people. In fact, it is the relating of subjective experiences that is its strength, but in positivist thinking this would be seen as a limitation. Other data sources could have been gathered (i.e. interviews with users' families and case managers, case notes, etc.), but the stated purpose of this research was to allow the participants to tell their own stories. Issues of validity, triangulation and

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trustworthiness have been achieved not by going outside participants' experience but by returning to it via the transcripts and discussion with supervisors.

One significant factor is the transferability of this research. This is particularly true given the criteria for service user participant selection. The research needed service users who could understand the questions and who were able to express their feeling and experiences to take part in the satisfaction survey and in-depth interview. Therefore it would be difficult to generalise the findings to all users with mental health problems in Taiwan. In addition, as has been stated in a previous chapter regarding participant selection for interviews, due to the limitation on data collection time and limited financial resources, there was only one carer from each mental health setting where the researcher was permitted to collect data. This is a limitation of this study.

Additional possible limitations of this study are volunteer bias, sample selection, and geographic location. Since this study utilised volunteer participants on an availability basis, it is possible that the findings may not represent the whole community from both mental health service settings. A small number of participants in quantitative interviews as well as in qualitative survey data are always an issue. The researcher is dependent to a large extent on who is able to participate, and in this case was subject to a wide range of influences, such as the level of helpfulness of psychiatric ward staff, patients' condition and the time available. Therefore, only seven patients using hospital-based service and six professionals participated in interviews. It may well be the case that being a mental health service user in a community-based mental health service setting brings a very different experience of identity, mental health services, and employment opportunity.

7.3 Future Research and Dissemination

● **Future Research**

The body of literature on the views of mental health service from users and providers in Taiwan is still small and further work would be a helpful contribution in this important area. The concept of comparing and integrating the views of service users, providers and policy makers is not described elsewhere in Taiwan and further research may help develop further mental health provision. The view from service users is also an important aspect of this within this research. Further exploration of the experiences of individuals with mental illness would be an important way forward for future development in improving mental health services.

The sample for this research was small and demographically similar. A more diverse sample would be of interest and important for future research. The research only focused on the experiences of the people using specific context bound mental health services and the professionals who provide the services, and future research could explore this from the viewpoint of carers, and also users in different service settings. Longer term studies could explore users and carers' experiences of using the services and dealing with their lives from different regions of Taiwan.

● **Dissemination**

There is a great deal of material published on mental health user involvement, the deinstitutionalisation movement and improvements in service delivery, but most studies are based in western countries and there are only a few indications on research or study that it is impacting on mental health practice in Taiwan, especially related to user involvement. This research has used the service users' perceptive to impart some important messages about how people with mental health problems feel about dealing with their life and what kind of

support services can provide that would be meaningful to them. This research offers a unique contribution to the limited literature in Taiwan and dissemination would convey some important messages for service users, mental health professionals and policy makers.

One of the key drivers of the research methodology was to hear users' experiences in their own voice. Therefore, this research can offer mental health practitioners and policy maker's help in working with people with mental health problems to improve and reform the services. Listening to the participants' stories of their experiences has taken the researcher back to her days in practice in Taiwan few years ago. Then research would have been viewed as being well intentioned but falling short of offering anything that made a significant impact. The researcher hopes that now this study can provide some important messages for practitioners in their work to provide services and for policy makers in planning and improving the mental health service delivery system.

In my experience there is an absence of simple guidance about how to configure services in line with practice based on the evidence of mental health service user experience in Taiwan. Even where it does exist, it is often overtaken by immediate and necessary tasks which are inevitably prioritised. Therefore, the researcher will try to adjust this new perspective by presenting at conferences and lectures aimed at professionals and policy makers. Simultaneously, the researcher intends to disseminate the research in Taiwan from the following ways:

► Publishing articles in academic journals.

► Write for service user and mental health professional publications.

►Seek to join and contribute to regional/national networks and conferences on related subjects.

• Reflection on clinical practice

The findings of this research have implications for government policy makers who have the power to allocate resources to and future mental healthcare development, as well as clinical psychiatric nurses and other mental healthcare providers who care for mentally ill patients and their primary family caregivers. Most people with mental illness have difficulty in adjusting and coping with their everyday life in the community. It can cause stress to both the family caregiver and the mentally ill patients and lead to an increase in the number of hospitalisations, which results in a heavy burden on government's healthcare budget. Designing and implementing tailored interventions to enhance mental health service provision might decrease the number of hospitalisations and improve public awareness of mental health related issues.

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List of Appendices

Appendix Ⅰ : Letter from Prof. Ruggeri of giving permission to use VSSS

Dipartimento di Medicina e Sanità Pubblica
Sezione di Psichiatria e Psicologia Clinica
Università di Verona

Policlinico "G.B. Rossi", Piazzale L.A. Scuro 10
37134 Verona, Italia

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Web page: www.psychiatry.univr.it

*WHO Collaborating Centre
for Research and Training in Mental Health
and Service Evaluation*

Michele Tansella
Professore di Psichiatria

Verona, 16/06/2005

Dr. Yung-Chieh Ching(Jade)

Sheffield Hallam University

The Centre for Health & Social Care Research

Dear Dr. Ching,

as you requested, I am pleased to send you the VSSS for service Providers. Permission to use this instrument is given provided the following procedure is followed:
permission applies to not-for-profit use of instruments only, and they are not to be copied (by those to whom they have been sent) to other centres. No alterations of the instrument are allowed and the copyright remains to the authors.
For more detailed information, please see the paper by Ruggeri et al. Development, internal consistency and reliability of the Verona Service Satisfaction Scale-European Version, British Journal of Psychiatry (2000), 177 (suppl. 39).
Best regards.

X **Prof. Mirella Ruggeri**
Associate Professor of Psychiatry,
Department of Medicine and Public Health,
University of Verona,
Section of Psychiatry and Clinical Psychology, Ospedale Policlinico,
37134 Verona, Italy.
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Web page of our section: http://medicina.univr.it/~psymed/index.html

Servizio Universitario di Psichiatria di Verona-Sud, DSM di Verona

Regione del Veneto
- Azienda Ospedaliera di Verona
- Azienda ULSS N. 20 di Verona

- Clinica Psichiatrica, Policlinico "G.B. Rossi", 37134 Verona   Tel. 045 8074952
- Centro di Salute Mentale, via S. Giacomo 51, 37135 Verona   Tel. 045 584222
- Comunità Alloggio, via Tunisi 11, 37134 Verona   Tel. 045 580527
- C.T.R.P. "Casa Raldon", via Pinzon 9, 37050 Raldon,
  S. Giovanni Lupatoto (VR)   Tel. 045 8731833
- Centro per la Prevenzione, Riabilitazione e Promozione Sociale,
  via Caccia 6 B, 37136 Verona   Tel. 045 502533

Appendix Ⅱ : VSSS Questionnaire Development

The process of development of the VSSS took the following steps. First, an 82-item version was developed with a set of 37 items cross-setting for health services and a set of 45 items specific for mental health services. The former group of items involves aspects meant to be relevant to both medical and psychiatric settings, and has been derived from the Service Satisfaction Scale (SSS-30) (Ruggeri & Greenfield, 1995). The latter group of items involve aspects relevant specifically to mental health settings, particularly in community-based services, such as social skills and types of intervention (e.g. admissions, psychotherapy, and rehabilitation) and has been developed by the authors of the VSSS.

VSSS-82, with versions for patients and relatives, was then tested for acceptability, content validity, sensitivity and test-retest reliability in 75 patients and 75 relatives (Ruggeri & Dall'Agnola, 1993). Factor analysis has been performed (Ruggeri et al, 1996). Combination of results obtained in the validation study and factor analysis has given origin to the intermediate (VSSS-54) and the short version (VSSS-32), two reliable instruments that can be easily used in everyday clinical settings.

To date the VSSS has been translated into various languages (English, French, Spanish, Portuguese, German, Dutch, Danish, Greek and Japanese), and it has been used in a growing number of studies performed in many sites around the world.

The VSSS-EU was specifically designed for community-based mental health services run by multidisciplinary teams of psychiatrists, psychologists, social workers, and nurses. These services are assumed to have various treatment options (e.g. hospitalisation, day-care, rehabilitation, psychotherapy, home help, outpatient visits) available within the service or provided by various services which closely co-operate.

Conceptually, the items in VSSS-EU cover seven dimensions: Overall Satisfaction, Professionals' Skills and Behaviour, Information, Access, Efficacy, Type of Intervention and Relative's Involvement. While the first five dimensions have already been investigated by some other authors in previous studies (Ware, 1983), the last two dimensions examine domains which have not previously been assessed systematically and have been specifically developed for the VSSS.

Each dimension of the VSSS-EU is made up of a certain number of items that cover various aspects of satisfaction with services:

1. **The Overall Satisfaction** dimension: covers general aspects of satisfaction with mental health services. It is measured by 3 items seen at (Q11, 20, 21).

2. **The Professionals' Skills and Behaviour** dimension: covers various aspects of satisfaction with the professionals' behaviour such as technical skills, interpersonal skills, co-operation between service providers, respect for patients' rights, etc. Psychiatrists, psychologists, nurses and social workers are assessed in separate items. It is measured by 3 items (Q12, 19, 29).

3. **The Information** dimension: covers aspects related to satisfaction with information about services, disorders and therapies. It is measured by 24 items (Q2, 3a, 3b, 5a, 5b, 6a, 6b, 7, 10, 16a, 16b, 17, 18, 22a, 22b, 25a, 25b, 28, 33, 35a, 35b, 37a, 37b, 40).

4. **The Access** dimension: covers aspects related to satisfaction with service location, physical layout, and costs. It is measured by 2 items (Q4, 8).

5. **The Efficacy** dimension: covers aspects related to satisfaction with overall efficacy of the service and service efficacy on specific aspects such as symptoms, social skills and family relationships. It is measured by 8 items (Q1, 9, 13, 24, 26, 31, 34, 38).

6. **The Type of Intervention** dimension: covers various aspects of satisfaction with mental health care, such as medicine prescription, response to emergency, psychotherapy, rehabilitation, domiciliary care, admissions, housing, recreational activities, work benefits, etc. It is measured by 17 items (Q14, 15, 39, 41-54).

7. **The Relative's Involvement** dimension: covers various aspects of patient's satisfaction with help given to his/her closest relative, such as listening, understanding, advice, information, help coping with the patient's problems, etc. It is measured by 6 items (Q23, 27, 30a, 30b, 32, 36).

The VSSS-EU is designed for self-administration and can be completed without prior training. Questionnaire administration takes 20-30 minutes. In the questionnaire, subjects are asked to express their overall feeling about their experience of the mental health service they have been attending. For items 1-40 satisfaction ratings are on a 5-point Likert scale (1=terrible, 2=mostly unsatisfactory, 3=mixed, 4=mostly satisfactory, 5=excellent), presented with alternate directionality to reduce stereotypic response (The VSSS-EU Manual). Items 41-54 consist of three questions; first the subject is asked if he/she has received the specific intervention (Question A). If the answer is "yes" he/she is asked his/her satisfaction on a 5 point Likert scale (1=terrible; 5=excellent) (Question B). If the answer is "no", he/she is asked Question C about his/her's desire of receiving the intervention (6=no, 7=don't know, 8=yes). These questions allow measurement of the subjects' satisfaction both on interventions provided and on the professionals' decision not to provide an intervention.

Appendix Ⅲ: Original Verona Service Satisfaction Scale EU English Version

DEPARTMENT OF MEDICINE AND PUBLIC HEALTH
SECTION OF PSYCHIATRY AND CLINICAL PSYCHOLOGY
UNIVERSITY OF VERONA

WORLD HEALTH ORGANIZATION
COLLABORATING CENTRE FOR RESEARCH
AND TRAINING IN MENTAL HEALTH

VERONA SERVICE SATISFACTION SCALE (VSSS-EU)[1][2]

PATIENTS

THE QUESTIONNAIRE ASKS ABOUT YOUR EXPERIENCE OF THE COMMUNITY MENTAL HEALTH SERVICES OFFERED LOCALLY, DURING THE LAST YEAR

It is very important that you answer **truthfully**; please express your opinion **whatever it is**. We are especially interested to know about your **criticisms** and about **problems** you have had with the services.

All your answers will be treated **confidentially**.
Your answers will not be discussed with the professionals working in the service or your relatives.

Please feel free to ask the researcher for help if a question is not clear or if you encounter any problem in filling in the questionnaire.
Please red the questions very carefully and take your time before answering.
It is very important that every answer expresses your true opinion.

1   M. Ruggeri & R. Dall'Agnola (1993). The development and use of the Verona Expectations for Care Scale (VECS) and the Verona Service Satisfaction Scale (VSSS) for measuring expectations and satisfaction with community-based psychiatric services in patients, relatives and professionals. *Psychological Medicine*, 23, 511-523. Items from n. 1 to n. 21 and n. 23, 29, 39, as well as the two open questions, have been translated, or modified, with the permission of the authors, from the Service Satisfaction Scale-30 or derived instruments [Greenfield T.K. & Attkisson C.C., (1989). Steps toward a multifactorial satisfaction scale for primary care and mental health services. *Evaluation and Program Planning*, 12, 271-278].

2   Ruggeri M., Lasalvia A., Dall'Agnola R. *et al.* (2000). Development, internal consistency and reliability of the Verona Service Satisfaction Scale – European Version. In *Reliable outcome measure for mental health service research in five European countries: the EPSILON Study* (ed. G. Thornicroft, T. Becker, M. Knapp, H.C. Knudsen, A. Schene, M. Tansella & J.L. Vázquez-Barquero). *British Journal of Psychiatry* 177 (suppl. 39), 41-48.

3   Address requests to: Prof.ssa Mirella Ruggeri, Dipartimento di Medicina e Sanità Pubblica, Sezione di Psichiatria e Psicologia Clinica, Istituto di Psichiatria, Università di Verona, Ospedale Policlinico G.B. Rossi, Piazzale L.A. Scuro 10– 37134 Verona – Italia; Phone: +39 045 8074441 Fax: +39 045 585871

IN THE FOLLOWING PAGES WE ASK YOU ABOUT YOUR EXPERIENCES IN USING THE LOCAL MENTAL HEALTH SERVICES DURING THE LAST YEAR.

Please mark the answer which best describes your overall impression in using the local mental health services during the last year.
You can use one of these options:

1. Terrible

2. Mostly dissatisfied

3. Mixed

4. Mostly satisfied

5. Excellent

> Please choose the answer which is the best description of your experience in using the local mental health services over the **last year**:
>
>
> ### WHAT IS YOUR OVERALL FEELING ABOUT THE ...

1. effect of services in helping you deal with your problems

1.Terrible   2.Mostly <u>dis</u>satisfied   3.Mixed   4.Mostly satisfied   5.Excellent

2.behaviour and manners of reception or secretarial staff on the telephone or when you meet them

5.Excellent   4.Mostly satisfied   3.Mixed   2.Mostly <u>dis</u>satisfied   1.Terrible

3a.professional knowledge and competence of psychiatrists

1.Terrible   2.Mostly <u>dis</u>satisfied   3.Mixed   4.Mostly satisfied   5.Excellent

3b.professional knowledge and competence of psychologists

5.Excellent   4.Mostly satisfied   3.Mixed   2.Mostly <u>dis</u>satisfied   1.Terrible

4. the appearance, comfort level and physical layout of the facilities (e.g. the waiting rooms and the offices)

1.Terrible   2.Mostly <u>dis</u>satisfied   3.Mixed   4.Mostly satisfied   5.Excellent

5a. ability of psychiatrists to listen to and understand your problems

5.Excellent   4.Mostly satisfied   3.Mixed   2.Mostly <u>dis</u>satisfied   1.Terrible

5b. ability of psychologists to listen to and understand your problems

1.Terrible   2.Mostly <u>dis</u>satisfied   3.Mixed   4.Mostly satisfied   5.Excellent

> *Please read the questions very carefully and take your time before answering.*
> *It is very important that every answer expresses your true opinion*

Please choose the answer which is the best description of your experience in using the local mental health services over the **last year**:

WHAT IS YOUR OVERALL FEELING ABOUT THE ...

6a. personal manner of psychiatrists

5.Excellent   4.Mostly satisfied   3.Mixed   2.Mostly dissatisfied   1.Terrible

6b. personal manner of psychologists

1.Terrible   2.Mostly dissatisfied   3.Mixed   4.Mostly satisfied   5.Excellent

7.punctuality of the professionals when you come for an appointment

5.Excellent   4.Mostly satisfied   3.Mixed   2.Mostly dissatisfied   1.Terrible

8. cost of the service to you (e.g. prescription charges)

1.Terrible   2.Mostly dissatisfied   3.Mixed   4.Mostly satisfied   5.Excellent

9.effectiveness of services in helping you to attain wellbeing and preventing relapse

5.Excellent   4.Mostly satisfied   3.Mixed   2.Mostly dissatisfied   1.Terrible

10.confidentiality and respect for your rights

1.Terrible   2.Mostly dissatisfied   3.Mixed   4.Mostly satisfied   5.Excellent

11.amount of help you have received

5.Excellent   4.Mostly satisfied   3.Mixed   2.Mostly dissatisfied   1.Terrible

12.explanations of specific procedures or approaches used

1.Terrible   2.Mostly dissatisfied   3.Mixed   4.Mostly satisfied   5.Excellent

Please read the questions very carefully and take your time before answering.
It is very important that every answer expresses your true opinion

Please choose the answer which is the best description of your experience in using the local mental health services over the **last year**:

WHAT IS YOUR OVERALL FEELING ABOUT THE ...

13.effect of services in helping to relieve symptoms

5.Excellent   4.Mostly satisfied   3.Mixed   2.Mostly dissatisfied   1.Terrible

14. response of the service to crises or urgent needs during office hours

1.Terrible   2.Mostly dissatisfied   3.Mixed   4.Mostly satisfied   5.Excellent

15.arrangements made for after hours emergencies

5.Excellent   4.Mostly satisfied   3.Mixed   2.Mostly dissatisfied   1.Terrible

16a.thoroughness of psychiatrists

1.Terrible   2.Mostly dissatisfied   3.Mixed   4.Mostly satisfied   5.Excellent

16b.thoroughness of psychologists

5.Excellent   4.Mostly satisfied   3.Mixed   2.Mostly dissatisfied   1.Terrible

17. appropriateness of referrals to your GP or other specialist if needed

1.Terrible   2.Mostly dissatisfied   3.Mixed   4.Mostly satisfied   5.Excellent

18.cooperation between service providers (if you are treated by more than one professional)

5.Excellent   4.Mostly satisfied   3.Mixed   2.Mostly dissatisfied   1.Terrible

19.publicity or information about available mental health services

1.Terrible   2.Mostly dissatisfied   3.Mixed   4.Mostly satisfied   5.Excellent

---

Please read the questions very carefully and take your time before answering.
It is very important that every answer expresses your true opinion

> Please choose the answer which is the best description of your experience in using the local mental health services over the **last year**:
>
>
> **WHAT IS YOUR OVERALL FEELING ABOUT THE ...**

20.kinds of service offered

5.Excellent   4.Mostly satisfied   3.Mixed   2.Mostly <u>dis</u>satisfied   1.Terrible

21. in an overall, general sense, the service you have received

1.Terrible   2.Mostly <u>dis</u>satisfied   3.Mixed   4.Mostly satisfied   5.Excellent

22a.professional knowledge and competence of nurses

5.Excellent   4.Mostly satisfied   3.Mixed   2.Mostly <u>dis</u>satisfied   1.Terrible

22b.professional knowledge and competence of social workers

1.Terrible   2.Mostly <u>dis</u>satisfied   3.Mixed   4.Mostly satisfied   5.Excellent

23.recommendations made to your closest relative about how they could help you

5.Excellent   4.Mostly satisfied   3.Mixed   2.Mostly <u>dis</u>satisfied   1.Terrible

24. effectiveness of the service in helping you to improve your knowledge and understanding of your problems

1.Terrible   2.Mostly <u>dis</u>satisfied   3.Mixed   4.Mostly satisfied   5.Excellent

25a. personal manners of nurses

5.Excellent   4.Mostly satisfied   3.Mixed   2.Mostly <u>dis</u>satisfied   1.Terrible

25b. personal manners of social workers

1.Terrible   2.Mostly <u>dis</u>satisfied   3.Mixed   4.Mostly satisfied   5.Excellent

> *Please read the questions very carefully and take your time before answering.*
> *It is very important that every answer expresses your true opinion*

Please choose the answer which is the best description of your experience in using the local mental health services over the **last year**:

WHAT IS YOUR OVERALL FEELING ABOUT THE ...

26. effectiveness of the service in improving the relationship between you and your closest relative

5.Excellent   4.Mostly satisfied   3.Mixed   2.Mostly dissatisfied   1.Terrible

27. effectiveness of the service in helping your main carer (relative or friend) improve their understanding of your problems

1.Terrible   2.Mostly dissatisfied   3.Mixed   4.Mostly satisfied   5.Excellent

28. nurses' knowledge about you and your medical history

5.Excellent   4.Mostly satisfied   3.Mixed   2.Mostly dissatisfied   1.Terrible

29. how information was given to you about your problem (diagnosis) and what to expect (prognosis)

1.Terrible   2.Mostly dissatisfied   3.Mixed   4.Mostly satisfied   5.Excellent

30a.ability of psychiatrists to listen to and understand the worries your main carer (relative or friend) may have about you

5.Excellent   4.Mostly satisfied   3.Mixed   2.Mostly dissatisfied   1.Terrible

30b.ability of psychologists to listen to and understand the worries your main carer (relative or friend) may have about you

1.Terrible   2.Mostly dissatisfied   3.Mixed   4.Mostly satisfied   5.Excellent

31. effectiveness of the service in helping you establish good relationships with people outside your family (e.g. friends, neighbours, colleagues at work, etc.)

5.Excellent   4.Mostly satisfied   3.Mixed   2.Mostly dissatisfied   1.Terrible

Please read the questions very carefully and take your time before answering.
It is very important that every answer expresses your true opinion

Please choose the answer which is the best description of your experience in using the local mental health services over the **last year**:

WHAT IS YOUR OVERALL FEELING ABOUT THE ...

32.how information was given to your main carer (relative or friend) about your problem (diagnosis) and what to expect (prognosis)

1.Terrible   2.Mostly dissatisfied   3.Mixed   4.Mostly satisfied   5.Excellent

33. instructions about what to do on your own between appointments; the clarity, practicality etc. of recommendations

5.Excellent   4.Mostly satisfied   3.Mixed   2.Mostly dissatisfied   1.Terrible

34. effectiveness of the service in helping you to improve your self-care (e.g. take care of your personal hygiene, your diet, your room)

1.Terrible   2.Mostly dissatisfied   3.Mixed   4.Mostly satisfied   5.Excellent

35a.thoroughness of nurses

5.Excellent   4.Mostly satisfied   3.Mixed   2.Mostly dissatisfied   1.Terrible

35b.thoroughness of social workers

1.Terrible   2.Mostly dissatisfied   3.Mixed   4.Mostly satisfied   5.Excellent

36.effectiveness of the service in helping your main carer (relative or friend) deal better with your problems

5.Excellent   4.Mostly satisfied   3.Mixed   2.Mostly dissatisfied   1.Terrible

Please read the questions very carefully and take your time before answering.
It is very important that every answer expresses your true opinion

Please choose the answer which is the best description of your experience in using the local mental health services over the **last year**:

WHAT IS YOUR OVERALL FEELING ABOUT THE ...

37a. ability of nurses to listen to and understand your problems

1.Terrible   2.Mostly dissatisfied   3.Mixed   4.Mostly satisfied   5.Excellent

37b. ability of social workers to listen to and understand your problems

5.Excellent   4.Mostly satisfied   3.Mixed   2.Mostly dissatisfied   1.Terrible

38.effectiveness of the service in helping you to improve your ability to work

1.Terrible   2.Mostly dissatisfied   3.Mixed   4.Mostly satisfied   5.Excellent

39. help you have received for side effects from medications (if occurred)

5.Excellent   4.Mostly satisfied   3.Mixed   2.Mostly dissatisfied   1.Terrible

40.continuity of care (seeing the same staff) you have received

1.Terrible   2.Mostly dissatisfied   3.Mixed   4.Mostly satisfied   5.Excellent

Please read the questions very carefully and take your time before answering.
It is very important that every answer expresses your true opinion

Please choose the answer which is the best description of your experience in using the local mental health services over the **last year**:

WHAT IS YOUR OVERALL FEELING ABOUT THE ...

41. in the last year, have you been prescribed medication?

YES (if you answered YES, please answer the following question):
- What is your overall feeling about this/them?

1.Terrible
2. Mostly unsatisfactory
3. Mixed
4. Mostly satisfactory
5. Excellent

NO (if you answered NO, answer the following question):
- Do you think you would have liked to receive this/them?

6. NO   7.DON'T KNOW   8. YES

42. in the last year, did you receive help from staff to improve your capacity to cope with your social and working life (e.g. going to public offices, doing housework, getting on with your family and others)?

YES (if you answered YES, please answer the following question):
- What is your overall feeling about this/them?

5. Excellent
4. Mostly satisfactory
3. Mixed
2. Mostly unsatisfactory
1.Terrible

NO (if you answered NO, answer the following question):
- Do you think you would have liked to receive this/them?

6. NO   7.DON'T KNOW   8. YES

Please read the questions very carefully and take your time before answering.
It is very important that every answer expresses your true opinion

Please choose the answer which is the best description of your experience in using the local mental health services over the **last year**:

43. in the last year, did you have the opportunity to meet alone, on a regular basis, with your therapist (e.g. in order to help you understand your problems and/or change your behaviour in some way)?

YES (if you answered YES, please answer the following question):
- What is your overall feeling about this/them?

1.Terrible
2. Mostly unsatisfactory
3. Mixed
4. Mostly satisfactory
5. Excellent

NO (if you answered NO, answer the following question):
- Do you think you would have liked to receive this/them?

6. NO   7.DON'T KNOW   8. YES

44. in the last year, did you have compulsory treatment in a psychiatric hospital?

YES (if you answered YES, please answer the following question):
- What is your overall feeling about this/them?

5. Excellent
4. Mostly satisfactory
3. Mixed
2. Mostly unsatisfactory
1.Terrible

NO (if you answered NO, answer the following question):
- Do you think you would have liked to receive this/them?

6. NO   7.DON'T KNOW   8. YES

Please read the questions very carefully and take your time before answering.
It is very important that every answer expresses your true opinion

Please choose the answer which is the best description of your experience in using the local mental health services over the **last year**:

45. in the last year, did you have meetings with your family and therapist (with the aim of improving/changing the relationships between family members)**?**

YES (if you answered YES, please answer the following question):
- What is your overall feeling about this/them?

1. Terrible
2. Mostly unsatisfactory
3. Mixed
4. Mostly satisfactory
5. Excellent

NO (if you answered NO, answer the following question):
- Do you think you would have liked to receive this/them?

6. NO   7. DON'T KNOW   8. YES

46. in the last year, did you have a place in sheltered accomodation (e.g. foster home/family placement scheme, group home, hostel with staff available for help)**?**

YES (if you answered YES, please answer the following question):
- What is your overall feeling about this/them?

5. Excellent
4. Mostly satisfactory
3. Mixed
2. Mostly unsatisfactory
1. Terrible

NO (if you answered NO, answer the following question):
- Do you think you would have liked to receive this/them?

6. NO   7. DON'T KNOW   8. YES

Please read the questions very carefully and take your time before answering.
It is very important that every answer expresses your true opinion

Please choose the answer which is the best description of your experience in using the local mental health services over the **last year**:

47. in the last year, did you have the opportunity to take part in leisure activities organized by the mental health services?

YES (if you answered YES, please answer the following question):
- What is your overall feeling about this/them?

        1.Terrible
        2. Mostly unsatisfactory
        3. Mixed
        4. Mostly satisfactory
        5. Excellent

NO (if you answered NO, answer the following question):
- Do you think you would have liked to receive this/them?

6. NO   7.DON'T KNOW 8. YES

48. in the last year, did you have group psychotherapy (e.g. meetings of a group of patients with one or more therapists with the aim of improving the patients understanding of their problems and/or changing their behaviour)?

YES (if you answered YES, please answer the following question):
- What is your overall feeling about this/them?

        5. Excellent
        4. Mostly satisfactory
        3. Mixed
        2. Mostly unsatisfactory
        1.Terrible

NO (if you answered NO, answer the following question):
- Do you think you would have liked to receive this/them?

6. NO   7.DON'T KNOW 8. YES

Please read the questions very carefully and take your time before answering.
It is very important that every answer expresses your true opinion

Please choose the answer which is the best description of your experience in using the local mental health services over the **last year**:

49. in the last year, did you have any sheltered work?

YES (if you answered YES, please answer the following question):
- What is your overall feeling about this/them?

        1.Terrible
        2. Mostly unsatisfactory
        3. Mixed
        4. Mostly satisfactory
        5. Excellent

NO (if you answered NO, answer the following question):
- Do you think you would have liked to receive this/them?

6. NO   7.DON'T KNOW 8. YES

50. in the last year, did you have any voluntary admission to a psychiatric hospital?

YES (if you answered YES, please answer the following question):
- What is your overall feeling about this/them?

        5. Excellent
        4. Mostly satisfactory
        3. Mixed
        2. Mostly unsatisfactory
        1.Terrible

NO (if you answered NO, answer the following question):
- Do you think you would have liked to receive this/them?

6. NO   7.DON'T KNOW 8. YES

Please read the questions very carefully and take your time before answering.
It is very important that every answer expresses your true opinion

Please choose the answer which is the best description of your experience in using the local mental health services over the **last year**:

51. in the last year, did you have practical help at home from the service (e.g. companionship, home help, etc.)?

YES (if you answered YES, please answer the following question):
- What is your overall feeling about this/them?

        1.Terrible
        2. Mostly unsatisfactory
        3. Mixed
        4. Mostly satisfactory
        5. Excellent

NO (if you answered NO, answer the following question):
- Do you think you would have liked to receive this/them?

6. NO   7.DON'T KNOW 8. YES

52. in the last year, did you have help from the service obtaining welfare benefits or exemptions (e.g. Disability Allowance, Council Tax, etc.)?

YES (if you answered YES, please answer the following question):
- What is your overall feeling about this/them?

        5. Excellent
        4. Mostly satisfactory
        3. Mixed
        2. Mostly unsatisfactory
        1.Terrible

NO (if you answered NO, answer the following question):
- Do you think you would have liked to receive this/them?

6. NO   7.DON'T KNOW 8. YES

Please read the questions very carefully and take your time before answering.
It is very important that every answer expresses your true opinion

Please choose the answer which is the best description of your experience in using the local mental health services over the **last year:**

53. in the last year, did you have help from the service finding open employment?

YES (if you answered YES, please answer the following question):
- What is your overall feeling about this/them?

1. Terrible
2. Mostly unsatisfactory
3. Mixed
4. Mostly satisfactory
5. Excellent

NO (if you answered NO, answer the following question):
- Do you think you would have liked to receive this/them?

6. NO   7.DON'T KNOW   8. YES

54. in the last year, did you receive help from the service to join in leisure activities separate from the mental health services (e.g. sports clubs, adult education, etc.)?

YES (if you answered YES, please answer the following question):
- What is your overall feeling about this/them?

5. Excellent
4. Mostly satisfactory
3. Mixed
2. Mostly unsatisfactory
1. Terrible

NO (if you answered NO, answer the following question):
- Do you think you would have liked to receive this/them?

6. NO   7.DON'T KNOW   8. YES

Please read the questions very carefully and take your time before answering.
It is very important that every answer expresses your true opinion

PLEASE, WRITE YOUR COMMENTS

The thing I have liked most about my experience of local mental health services is:

....

....

....

....

....

....

The thing I have disliked most about my experience of local mental health services is:

....

....

....

....

....

....

THANK YOU VERY MUCH FOR YOUR HELP

Appendix IV: The Client Satisfaction Questionnaire (CSQ-8)

1. How are the services that you have received?
   - Excellent ; Good ; Regular ; Poor
2. Did you receive what you want from the service class?
   - No, definitely not ; No ; Yes, generally ; Yes, definitely
3. To what extent do you think our programme has helped you to resolve your problems?
   - All of it ; Most of it ; Only some of it ; None
4. If your friend needed a similar help, would you recommend our porgramme to your friends?
   - NO, definitely ; No, I don't think so ; Yes, I think so ; Yes, definitely
5. How satisfied from the quantity of help that you have received?
   - No satisfied at all ; Indifferent or not satisfied moderately ; mostly satisfied ; very satisfied
6. Those services that you have received have they helped to treat better to your problems?
   - Yes, they helped me a lot ; Yes, they helped me something ; No, it didn't help really ;   No, they helped things get worse
7. In general, how satisfied with the services have you received?
   - Very satisfied ; Mostly satisfied ; Indifferent or satisfied moderately ; Not very satisfied
8. IF you needed help again, would you return to our programme?
   - No, definitely ; No ; Yes, generally ; Yes definitely

Please leave your comments.

1.) What I like the most about he centre is:
2.) If you could change to other centre what would it be?

Appendix Ⅴ: Topic Guide for Service Users and Providers and Interview Process

(A) For Service Users

• Over all, how do you think of the mental health service you have been received in Taiwan?

• What kind of service you are satisfied with?

• & why are you satisfied with that services?

• What kind of service you are dissatisfied with?

• & why are you dissatisfied with that services?

• what are the main reasons that you are satisfied/dissatisfied?

• Do you think what kinds of mental health services provided in Taiwan are not enough?

• From your point of view, what are the main elements do you think that will create a comprehensive Mental Health Service?

• As a service users, what kinds of services do you want to be provided in the mental health service in Taiwan?

• From your experience with mental health service you have been received in Taiwan, which part of service do you think is/are the must useful for you? (Out-patient department, Day centre, In-patient ward, rehabilitation centre etc.)

• Have you experienced a conflict between what you wanted and what they really can provided in the services?

(B) For Service Providers

• Over all, how do you think of the mental health service being provided in Taiwan?

• What kind of service you have been provided that you are satisfied with?

• & why are you satisfied with this services?

• What kind of service you have been provided that you are dissatisfied with?

• & why are you dissatisfied with this services?

• What kind of service do you think that the mental health service should be provided to the public, which means there are not enough at the moment?

• What kind of resources for the mental health service in Taiwan do you think are sufficient/ insufficient?

• As a service provider, what are the main elements do you think that will create a comprehensive Mental Health Service?

• How do you think of "care co-operation"? Do you think it is important or not?

• If you have the power to transform & improve the service, what are you going to do?

• Have you experienced a conflict between what you wanted to provide and what really you can do for the service users?

Interview process

(1) Choose interviewees

Interviewees will be chosen from services user's survey responds, who are willing to participate in individual in-depth interview. From services providers, researcher will ask all the staffs during the staff meeting (should include: Dr. Senior Nurse, Social Worker, Psychologist and Occupational Therapist).

(2) Room arrangement

Room will be booked for participants to have a quiet and safe place to do the interview.

(3) Initial introduction:

    (a) Informed Consent

- Purpose of study

- Who is carrying out the interviews

- Why/how have they been chosen

- Their role in the study

- Degree of anonymity and confidentiality

    (Use of data, data storage arrangements)

- Participation is voluntary

    (Entitlement to withdraw compliance)

  (b) Permission to record

(4) The topic guide

  (a) A list of topics for service users

  (b) A list of topics for service providers

  (C) A memory Aid (Objective of study; general & specific areas of research)

(5) Closing the interviews

  (a) End on a positive note

  (b) Thank and affirm confidentiality

Appendix VI: Certificate of IRB Approval from the Urban General Hospital
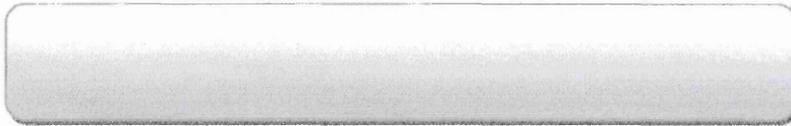
252 WU HSING STREET
TAIPEI, TAIWAN,
TEL: (02) 2737-2181

June 8, 2007

CERTIFICATE

To whom it may concern :

RE : User Involvement in mental Health Service in Taiwan-Exploring the Possibilities.

Principle Investigator : Hsiu-Ju Chang (Assistant Professor)

Collaborating principal investigator: Yung-Chieh Ching

Sequence No. : #TMUHIRB 20061001

This study was approved by the Institutional Review Board of _____ _____ on Dec. 1, 2006 and will be effective till Nov. 30, 2007.   The Institutional Review Board performs its functions according to written operating procedures and complies with GCP and with the applicable regulatory requirement.
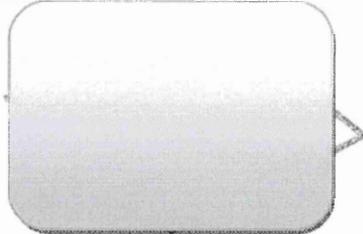
Fei-Peng Lee, M.D.

Fei-Peng Lee, M.D.
Chairman, Committee of IRB,

Wu, Chih-Hsiung, M.D.

Wu, Chih-Hsiung, M.D., Ph.D.
Superintendent,

Appendix Ⅶ: Certificate of IRB Approval from the Suburban Specialised Psychiatric Centre

同意函

中華民國 95 年 12 月 19 日

計畫名稱： 台灣精神醫療服務系統之調查與評價－從醫療服務提供者與接
受者之不同角度透視研究(本會編號：TCHIRB-951006-E)

計畫主持人：陳映燁醫師（松德院區）

上述計畫業經本院九十五年度第十次人體試驗委員會審查通過，特此證明。
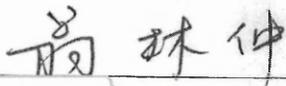
翁林仲 _____ 人體試驗委員會主任委員

CERTIFICATE

Date：2006/12/19

The project entitled "User involvement in Mental Health Service in Taiwan Exploring the possibilities." submitted by investigator Ying-Yeh Chen has been approved by Institutional Review Board of the
(Above study is approved by the TCHIRB on Dec. 13, 2006 and valid till Dec. 12, 2007.Since the constitution and operation of the review board are formulated according to the guidelines of ICH-GCP. The IRB will have to review each clinical research case annually. Please send us your Midterm Report one month before the expiry date.)

Lin-Chung Woung, MD, DMSc
Chairman
_____ Institutional Review Board
The Committee is Organized and operates in accordance with ICH-GCP regulations and guideline.
本委員會組織與運作皆遵守 ICH-GCP 規定

Appendix Ⅷ: Coding Book

NUMBER	SUBJECT	ABBREVIATION	CONTECT
1	Identification	id	1-200
2	Data collection place	dcp	**1**=TMUH11W(DC); **2**=TMUHOPD; **3**=TCH5C(ACUTE); **4**=TCH5D(ACUTE); **5**=TCHDC; **6**=TCH7H(SUBACUTE); **7**=TCH8H(SUBACUTE); **8**=TCH6F(REHAB); **9**=TCH6A(REHAB); **10**=TCHOPD
3	Sex	sex	**1**=male; **2**=female
4	Age	age	**1**=under 20 age; **2**=21~30 age; **3**=31~40 age; **4**=41~50 age; **5**=51~60 age; **6**=over 61 age
5	Marriage	marr	**1**=married; **2**=unmarried; **3**=divorce; **4**=others
6	Current Job	job	**1**=student; **2**=await job; **3**=retirement; **4**=housewife; **5**=office holder; **6**=farmer; **7**=businessman; **8**=laborer; **9**=self-employ; **10**=service industry **11**=others
7	Education	edu	**1**=primary school or under; **2**=junior high school; **3**=senior high school; **4**=technology college;

			5=undergraduate; **6**=postgraduate or above **7**=others
8	Length of time for using the service	leng	**1**=under 1 year; **2**=1~3 years; **3**=3~5 years; **4**=5~7 years; **5**=7~10 years; **6**=over10 years
9	Number of time to be hospitalized	hosp	**1**=never; **2**=once; **3**=twice; **4**=third times or over
10	Part one Questions	var1~var40	**1**=very dissatisfied; **2**=mostly dissatisfied; **3**=mixed; **4**=mostly satisfied; **5**=very satisfied
11	Part two questions	var41~var54	**1**=very dissatisfied; **2**=mostly dissatisfied; **3**=mixed; **4**=mostly satisfied; **5**=very satisfied; **6**=no; **7**=not sure; **8**=yes

Appendix Ⅸ: Verona Service Satisfaction Scale Item Scoring

Items from number 1 to number 40 in VSSS-TC are rated on the following 5-point Likert scale:

1= Dissatisfied

2= Mostly dissatisfied

3= Mixed

4= Mostly satisfied

5= Very satisfied

Items from number 41 to number 54 consist of three questions:

·Question A: "Did you receive the intervention x in the last year?" (yes/no/don't know).

·If the answer is "yes", the subject is asked his/her rating of intervention on a 5-point Likert scale (1=Dissatisfied; 5=Very satisfied) (Question B).

·If the answer is "no", he/she is asked Question C: "Do you think you would have liked to receive intervention x?" (6=no, 7=don't know, 8=yes).

For each item, answers to the three questions can be (a) treated separately or (b) collapsed into a single rating.

(a) Where answers are treated separately:

·Answers to Question A give a profile of the type of interventions provided. The following re-coding strategy was used.

 - rating from 6 to 8 =0 (intervention not provided)

- rating from 1 to 5 =1 (intervention provided)

·Answers to Question B (ratings 1 to 5) assess satisfaction with interventions provided.

·Answers to Question C (rating 6 to 8) assess satisfaction on under-provision of care according to the patients views. In this case, rating 6 is give the profile of interventions not provided but also not wanted. Rating 8 is instead giving the profile of interventions not provided but wanted.

(b) In order to collapse ratings obtained in question A, B, and C into a single rating, the following re-coding was made:

  - rating 6 = 4

  - rating 8 = 2

  - rating 7 = missing

This rating is representing overall satisfaction with the management of the intervention, whether the intervention has been provided or not.

VSSS-TC mean dimensions' scores are obtained by summing up all items values and then dividing by the number of items in each dimension as follows:

·Overall satisfaction (3 items)

(Item: 11 + 20 + 21)/ 3

·Professionals' Skills and Behaviour (24 items)

(Item: 2 + 3a + 3b + 5a + 5b + 6a + 6b + 7 + 10 + 16a + 16b + 17 + 18 + 22a + 22b + 25a + 25b + 28 + 33 + 35a + 35b + 37a + 37b + 40)/ 24

·Information (3 items)

(Item: 12 + 19 + 29)/ 3

·Access (2 items)

(Item: 4 + 8)/ 2

·Efficacy (8 items)

(Item: 1 + 9 + 13 + 24 + 31 + 34 + 38)/ 8

·Types of Intervention (17 items)

(Item: 14 + 15 + 39 + 41 + 42 + 43 + 44 + 45 + 46 + 47 + 48 + 49 + 50 + 51 + 52 + 53 + 54)/ 17

·Relative's Involvement (6 items)

(Item: 23 + 27 + 30a + 30b + 32 + 36)/ 6

Appendix X: Topic Guide for Three Key Informants Interviews

(1) Regarding mental health services in Taiwan

What are the fundamental elements of an integrated mental health service in Taiwan?

Your opinions on the current mental health service settings?

What are your opinions on the policy tendency of moving services into community settings? What the outcomes of implementing those kinds of policies are at the present time?

What your experiences of being a mental health policy maker in the national/local government are?

(2) Regarding high re-admission rate and problem of institutionalised

What your opinions on high re-admission rate and the problem of institutionalised are?

What kinds of policies that national or local government are launched to solve those problems?

(3) Regarding stigmatisation

What your opinions on 'Stigmatisation' and 'Discrimination' towards mentally ill individuals are? How to solve these kinds of problems?

What kinds of policies that national or local government are launched to reduce this kind of situations?

How to change public perception and knowledge on mentally ill?

(4) Regarding future challenge to improve mental health services

What government should do next to improve the services in order to meet user's needs?

What is the future development of mental health services?

What kinds of services area that you think is the most important principal that government have to consider to improve it?

Appendix XI: Gifts for the participants

Gift for respondents of survey questionnaire: A set of portable chopsticks and spoon

Gift for every interviewee: NT$100 gift voucher

Appendix XII: Compare Mean (SD) with Median (IQR) on the individual items of VSSS

INDIVIDUAL ITEMS WITH DIMENSIONS	MEAN	STANDARD DEVIATION	MEDIAN	IQR
The Overall Satisfaction (3 items)				
Q11 Amount of help	3.88	0.928	4	2
Q20 Kinds of service offered	3.66	0.895	4	1
Q21 Service general sense	3.80	0.827	4	1
The Professional's Skills and Behaviour (24 items)				
Q2 Behaviour and manners of reception staff	3.90	0.912	4	2
Q3a Professionalism of Psychiatrists	4.05	0.916	4	2
Q3b Professionalism of Psychologists	3.78	0.965	4	2
Q5a Ability of Psychiatrists	3.95	1.013	4	2
Q5b Ability of Psychologists	3.62	0.941	4	1
Q6a Personal manner of Psychiatrics	4.00	0.968	4	2
Q6b Personal manner of Psychologists	3.76	0.943	4	1
Q7 Punctuality of the professionals	4.03	0.966	4	2
Q10 Confidentially and respect for patient's right	3.85	1.000	4	1
Q16a Thoroughness of Psychiatrists	4.00	0.938	4	2
Q16b Thoroughness of Psychologists	3.78	0.913	4	2
Q17 Referring to general practitioner or other specialists	3.45	0.964	3	1
Q18 Cooperation between service providers	3.82	0.873	4	2
Q22a Professional competence of Nurses	3.92	0.855	4	1
Q22b Professional competence of Social worker	3.66	0.954	4	1
Q25a Personal manner of Nurses	3.91	0.837	4	0
Q25b Personal manner of Social worker	3.70	0.908	4	1
Q28 Nurses knowledge patients medical history	3.61	0.938	4	1
Q33 Instruction on what to do between visit	3.73	0.926	4	1
Q35a Thoroughness of Nurses	3.92	0.917	4	2
Q35b Thoroughness of Social worker	3.77	0.895	4	1
Q37a Ability of Nurses	3.82	0.905	4	1
Q37b Ability of Social worker	3.64	0.924	4	1
Q40 Continuity of care	3.85	0.908	4	2
The Information (3 items)				
Q12 Explanation procedures and approaches used	3.61	0.907	4	1
Q19 Publicity on mental health services offered	3.63	0.909	4	1
Q29 information on diagnosis	3.59	0.995	4	1
The Access (2 items)				
Q4 Appearance, comfort level and physical layout	3.79	0.940	4	1
Q8 Cost of service	3.69	1.092	4	2
The Efficacy (8 items)				
Q1 Helping patient deal with problems	3.94	0.916	4	2
Q9 Attaining well-being and preventing relapses	3.79	0.921	4	1
Q13 Helping to relieve symptoms	3.85	0.820	4	1
Q24 Helping patient improve knowledge of his problems	3.76	0.871	4	1
Q26 Improving relationship between patient and relative	3.66	0.996	4	1
Q31 Helping to establish good relationship outside family	3.56	1.007	4	1
Q34 Helping to improve capacity to look after themselves	3.80	0.947	4	2
Q38 Helping patient improve abilities to work	3.60	0.949	4	1
The Types of Intervention (17 items)				
Q14 Response to crisis during office hours	3.63	0.961	4	1
Q15 Response to emergencies during nights weekend	3.49	0.955	3	1
Q39 Help for discomfort of side effects from medications	3.75	1.047	4	2
Q41 Medication prescription	3.89	0.929	4	2
Q42 Individual rehabilitation	3.56	1.040	4	1
Q43 Individual session	3.72	1.026	4	2
Q44 Compulsory treatment in hospital	3.33	1.116	3	1
Q45 Family session	3.43	1.075	3	1
Q46 Living in sheltered accommodation	3.49	0.938	3	1
Q47 Recreational activities in the service	3.84	0.944	4	2
Q48 Group session	3.78	0.972	4	1
Q49 Shelter work	3.51	1.001	4	1
Q50 Informal admission to hospital	3.76	0.907	4	2
Q51 Practical help by the service at home	3.43	0.983	3	1
Q52 Helping in obtaining welfare benefits	3.98	0.982	4	2
Q53 Help to find open employment	3.18	1.094	3	1
Q54 Recreational activities outside the service	3.45	0.974	3	1

The Relative's Involvement (6 items)				
Q23 Recommendations about how relative could help	3.56	0.890	4	1
Q27 Helping relative improve understanding of patient's problems	3.51	1.022	4	1
Q30a Ability of Psychiatrists to listen to relative	3.81	0.891	4	1
Q30b Ability of Psychologists to listen to relative	3.51	0.929	3	1
Q32 Information to relative about diagnosis and prognosis	3.49	0.950	3	1
Q36 Helping relative to deal better with patient's problems	3.62	0.922	4	1

Reliability Statistics between

mean and median

Cronbach's Alpha	N of Items
.960	2