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THE PURPOSES AND FUNCTIONS OF LIVING SKILLS CENTRES ACCORDING TO STAFF AND CLIENTS:

A Study on Living Skills Centres in New South Wales

A thesis submitted in partial fulfilment of requirements for the award of the degree of

MASTER OF SCIENCE (HONOURS)

UNIVERSITY OF WOLLONGONG

by

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GRADUATE SCHOOL OF HEALTH AND MEDICAL SCIENCES
UNIVERSITY OF WOLLONGONG
1995

ABSTRACT

Living Skills Centres (LSCs) are part of the community mental health service. These centres use psychosocial rehabilitation as their operational framework. LSCs aim to provide rehabilitation and support so that clients with mental illness can live in the community and function at their optimal performance level. As there was limited literature documenting this unique service, the focus of this investigation was to explore how clients and staff perceived the characteristics and benefits of the service. A two part survey research design was used. The initial, exploratory data were gathered through semi-structure interviews from which a questionnaire survey was developed. Seven staff and six clients in three Sydney LSCs were interviewed. The data was used to identify existing issues and phenomena in the service and to design the questionnaire. Three hundred and thirty questionnaires were sent to randomly selected LSCs in Sydney and rural areas as well as to a few community mental health teams who acted as a comparison sample. One hundred and fourteen of the 330 sets of questionnaire were completed and returned. The results of both the semi-structured interviews and the questionnaires were analysed and compared. The findings indicated that the staff and clients' perceptions of the purpose and function of the LSCs did not deviate notably from those originally identified when the centres were set up. However, the purpose and function were perceived differently in terms of how they were described and prioritised. Clients tended to perceive that the LSCs met their needs in the areas of social support, recreation and constructive use of

time. Although staff agreed with this perception, they also viewed the LSCs as serving a broader purposes of providing support and resources for clients to live in the community and opportunity to rebuild their self-confidence and self-esteem. Community mental health staff were more likely to see the LSCs as having limited functions, which primarily were maintenance and recreation. Clients found the LSCs helpful to them in rebuilding self-confidence, making friends and using time constructively during the day. Both staff and clients agreed that the most important factor in assisting clients to achieve goals in the centres was a good relationship between staff and clients. Besides an increase in staffing, facilities and space, the clients identified the need for more specialised programmes to match their levels of ability or functioning. However, the staff was more concerned about having a clearly defined role and direction for the centres within the community mental health services. A non-anticipated phenomenon that emerged from the investigation was job stress and a sense of frustration among the LSC staff. This might have been one of the reasons for high staff turnover in the centres. However, with further improvement and research, the LSCs could still continue to make an important contribution to mentally ill clients' independent community living and quality of life.

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Last, but not least, I like to thank my family, Vivian and Velda for their support, tolerance and patience during the course of my study.

To

my parents who have taught me the sense of responsibility to

family, work and friends

For me, if I didn't come here (the Living Skills Centre), I wouldn't see a soul because I live on my own....Mix with people, talk over our problems with others.

[Living Skills Centre offers] a variety of activities.... You get self-esteem from doing a job and you get self-esteem from socialising, you get self-esteem from achieving, doing things, and just being with your friends.

Comments of two clients who were attending the Living Skills Centres

....I think it [the purpose of Living Skills Centre] is extremely broad, and it has to cater for each individual. I think the purpose is to give people a sense of respect, acknowledgment and understanding of their illness; to provide a venue where people feel that they are not isolated, that they can learn from others and from staff more about what they are going through.... What we are trying to achieve is to give people a quality of life...

A quote from the coordinator of a Living Skills Centre

Living Skills Centres are not client-centred but group-centred. People do not have personal programme, [treatment] goals or objectives. They are just put together as a group and minded for the day.

A written comment of a staff member of a community mental health team

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CHAPTER ONE

Introduction and background:

A review of literature

CHAPTER ONE:

Introduction and background – A review of literature

1.1 OVERVIEW OF THE STUDY

Disability in the chronically mentally ill population is a complex phenomenon with a variety of antecedents. The process of deinstitutionalisation of clients suffering from mental illness has helped to alleviate many problems associated with institutional care, such as dependency and violations of individual rights. However, deinstitutionalisation created an increased number of chronically mentally ill people in the community who have limited access to mental health services and are lacking skills to survive independently.

The New South Wales Department of Health (1983) carried out an inquiry to investigate the health services provided for people with chronic mental illness. The results of the investigation indicated the need for a change of focus, i.e., from hospital-based intervention to a community oriented approach. Implementation of this change of emphasis brought about an increase in community resources and facilities. One type of community facilities that has been developed in the past decade are the Living Skills Centres (LSCs). The general aims of the centres are: to promote community adjustment and prevent readmissions to psychiatric hospitals for people who are dependent on

the system; to increase each person's effectiveness in daily living skills, social skills and interpersonal relationships; to educate clients and their families; and to establish and widen a social network and support system for clients (Life Skills Forum, 1985)

The LSCs are a major element in the psychosocial rehabilitation process and function as part of the community mental health services. The purpose of this investigation was to contribute to the body of knowledge about psychosocial rehabilitation for chronically mentally ill people through 1)examining whether or not the LSCs are perceived as helping clients to live in the community; 2) investigating any discrepancy of perceptions of the purposes and functions of LSCs between the clients and the staff; and 3) scrutinising any discrepancy between clients' needs and staff perception of their needs in the LSC settings.

1.2 COMMUNITY MENTAL HEALTH

1.2.1 Concept of mental health and illness

Although in all parts of human life, the mental health of an individual is seen as a vital component of adaptation and growth, the term mental health covers a broad spectrum of concerns. People who have been called "mentally ill" have been appearing throughout history - to be feared, marvelled at, ignored, banished, sheltered, laughed at, pitied, or tortured (Wilson & Kneisl, 1983). What is mental illness? Certainly the definition of mental illness is varied within and across different cultures. Actually, by definition, culture is one of the largest determinants of all behaviour, normal as well as abnormal, therefore, to the extent that one finds different cultural patterns of normal behaviour, one should expect to find culturally determined differences in abnormal behaviour (Cochrane, 1983). An obvious example, as commonly known, is the way in which the concept of mental health and illness of the East is different from the West.

There is no universal agreement on what constitutes insanity in different cultures. Perhaps a major problem is the fact that psychiatry itself is very much a Western discipline (Cochrane, 1983). The evidence from anthropological studies indicates that the idea of the cultural determinants of normal and abnormal were first made apparent. For example, Chinese have been generally reluctant to define mental health problems in highly individualised psychiatric terms. Lin (1982) concluded, from a review of literature, that minor mental disorders among Chinese show that the phenomenology of Chinese depression differs greatly from that in the West and is characterised by somatisation.

Marsella (1979), like some of the anthropologists, investigates to see whether the behaviour that is regarded as symptomatic of mental illness in the West exists in other cultures and, if it does, to see whether it is also recognised there as indicating psychopathology. He found that depression in one form or another is probably the most common mental illness found in Western society and yet appears hardly to exist in some non-Western cultures. Not only is the concept not available in various languages such as Chinese, Japanese, Malay, and North American Indian languages, but the very symptoms that are regarded as indicative of depression (feelings of hopelessness, irrational guilt, worthlessness and apathy) do not appear to exist in some other cultures (Marsella, 1979)

There also appears to be very strong cultural determinants of prognosis and outcome too. Schizophrenia is perhaps the only concept which seems to have an almost universal acceptance (Murphy et al, 1963) and there is a relatively uniform rate of it across different cultures - sometimes estimated at between 0.5 percent to 1 percent of the adult population. Nevertheless, it has not always carried the stigma associated with the concept of schizophrenia in the West. In their study on schizophrenia in Britain and Mauritius, Murphy and Raman (1971) discovered that although both countries had very similar incidence rates for the illness, the prognosis for Mauritian patients was far better than for those in Britain. Although treatment in Mauritius was probably behind treatment in Britain in terms of availability of new drugs, Mauritian schizophrenics were far less likely to relapse and be readmitted to hospital than were British schizophrenics. They concluded that this difference was attributed to the fact that the concept of schizophrenia in

Britain implies a lifelong disability with periods of remission whereas in Mauritius the concept is much more equivalent to a physical infection in Britain, i.e. one has the disorder then is cured. Indeed, it has been found that generally prognosis of schizophrenia is far better in Third World countries than in the West (World Health Organisation, 1979).

On the other hand, mental illness is also defined differently at different times based on dominant social attitudes of the time and the philosophical ideas about humanity at the time. Sometimes contemporary attitudes have their roots centuries earlier. The evolution of the concept of mental health and illness has, in a historical sense, also influenced the development of mental health services. This has been well documented in the Western history (Kisker, 1977; Wilson & Kneisl, 1983).

In preliterate cultures, mental and physical suffering were not distinguished from each other, and both were attributed to forces acting outside the body. Consequently medicine, magic, and religion were not distinct disciplines. All were variously directed against some mortal or superhuman force that had malevolently inflicted suffering on another, thus they dealt with spirits of torment through exorcism, magical ritual and incantation. In the Ancient Greek and Roman times, supernatural forces were blamed as a cause of mental suffering and there was no treatment. However, Hyppocrates (4th Century B.C.) maintained that psychiatric illnesses were caused mainly by disturbances of body humours - blood, black bile, yellow bile and phlegm. These four humours resulted from the combination of the four basic qualities in nature - heat, dryness, moisture and cold, respectively. He

saw personality reach an optimal level when the appropriate interaction of internal and external forces had been achieved. Conflict between the forces indicated an excess of body humour, which then had to be removed by purging. Thus, for the first time mental illness was treatable by physicians with the purging of humours.

In the Medieval period, until the Renaissance, the definition of mental illness returned to magic, mysticism, demonology and madness was seen as a dramatic encounter with secret powers. Some, mostly women, were identified as witches and were tortured and killed. This was a result of the writings and directives of monks who wrote about the problems of the mind attributing it to the devil. Any unknown disease or illness or abnormal behaviour was thought to be caused by witchcraft, and the devil was destroyed by burning its host.

During the Classical Age of 15th Century, people with mental illness were confined in asylums for the insane. They were seen to have a right to be fed, but they were then morally constrained and physically confined. Huge asylums were built to contain and confine the mad, the poor, and other social deviants. People who were considered "insane" had no rights and could be locked away permanently. Asylums typically had cells and equipment for restraint such as stakes, irons, shackles and cages.

The Eighteenth and Nineteenth Centuries is also known as the Enlightenment period when the great changes generated by the Renaissance, in the form of the reappearance of scientific method, emphasis on individual dignity, and the political belief in liberty and the rights of man were reflected in this period with an emerging concern for mental patients. The devil was no longer seen as the

cause of mental illness. The emphasis was placed, once again, on anatomy and physiology, and the physical treatment of mental patients was stressed by physicians. Examples of some of the techniques were: bloodletting, purgatives, dousing patients in ice cold water, or using other methods to put them in near shock or using a spinning chair that rendered people unconscious.

The age of enlightenment also had positive benefits for people with mental illness, in that there was an interest in reform and moral improvement. Pinel (1745-1826) is one of the most influential historical figures in this regard. While he was superintendent of two asylums for the insane, mentally handicapped, and criminals in France, he instituted programs of reform where the inmates were released from chairs and stakes, fed well, living conditions were made light and airy, and they were treated with kindness. Similar reforms were also carried out by Quakers in England and this commenced the moral treatment movement which sowed the seed for modern approach to the care of people with mental illness.

Finally, to discuss the concept of mental illness in contemporary society, one may also find that there are markedly differing ways of speaking about mental normality and abnormality. Piligrim & Rogers (1993) identify six perspectives: the lay view, psychiatry, psychoanalysis, psychology, legal framework and sociological perspective. These expert perspectives on mental health and illness all have a certain persuasiveness, but equally, each encounters some credibility problems. Piligrim and Rogers (1993) comment that the illness and legal frameworks emphasise discontinuity (people are ill/disordered or they are not) whereas the other perspectives tend to emphasise continuity. It is a matter of

opinion whether a continuous or discontinuous model of normality and abnormality fits the knowledge of people's conduct and whether one or other is morally preferable. The traditional psychiatrist might argue that, unlike the psychoanalyst, they do not see abnormality everywhere. The psychoanalyst might argue that the pervasive condition of mental pain connects us all in a common humanity.

Sociologists are in an ambivalent relationship to psychiatry and have been seen as oppositional by those inside clinical psychiatry - "anti-psychiatry" or "critics of psychiatry". They claim the stress of poverty and social disorganisation pushes vulnerable individuals into psychosis (Faris, 1944; Dunham, 1957, 1964). Furthermore, they blame the labelling of mentally ill and see labes as significantly altering the person's identity and social status (Garfinkel, 1956). The labelled persons are stripped of their old identity and it is replaced by a new one. Part of such a process then leads them to internalise the new identity ascribed to them. Nonetheless, sociologists have not only contributed to an expanded theory of aetiology, in tracing the social causes of mental illness, but have also set up competing ways of conceptualising mental abnormality.

1.2.2 Background: A brief account of the development of psychiatric/mental health services in the 20th Century.

In his autobiography written in 1908, "*A Mind that Found itself*", Beers exposed his experience of brutalities in the psychiatric hospitals while he was undergoing treatment of his emotional disturbance (Dain, 1980). His story shocked the nation. He talked about his experience as a victim of cruelties, and his observation of fellow patients being subjected to indifference, lack of consideration, humiliation and inhuman restraints. Later he became the secretary of the National Committee for Mental Hygiene, in the United States. This marked the beginning of the *Mental Hygiene Movement* in the United States. Hospital treatment and care for the mentally ill people were significantly improved. However, abuses and injustice in the psychiatric hospitals were still being reported (Kisker, 1977), probably due to the lack of understanding about mental illness.

At the turn of the century, neuroscientists that were involved in the care and treatment of the mentally ill were convinced that it was a disorder of the brain. People with mental illness were housed in asylums and isolated from the community. There was little hope that inmates could be rehabilitated, cured, or released from these institutions.

In the 1920s psychiatrists and other mental health practitioners, began to be influenced by the thinking of Sigmund Freud. Although Freud emphatically stated that people with schizophrenia and other serious mental illnesses would not benefit from his approach, psychiatrists began to link mental illness in

adults with childhood trauma and poor parenting. Since psychoanalysis was ineffective in the treatment of those suffering from serious mental illness, a number of biological treatments were developed. These included prefrontal surgery (Monitz, 1936; Freeman & Watts, 1950); insulin shock (Sakel, 1938); and electroconvulsive therapy (Cerletti & Bini, 1938).

Treatment of mental illness came to a turning point in the late 1950s with the introduction of psychotrophic drugs. Despite the severity of the side effects of these drugs, they produced obvious and significant effects in controlling psychotic symptoms, such as hallucinations and delusional thinking, and in alleviating the symptoms of depression. Thus, the use of drugs has not only dominated the treatment of mental illness since the 1950s, it also has opened the doors of the asylums and made it possible for many mentally ill people to live and receive treatment outside the hospital environment. However, a significant number of the people with mental illness did not respond well enough to the new drugs to be discharged from the hospital environment. They continued to live in the mental hospitals, which traditionally encouraged dependency and conformity to the hospital regime. Mental health professionals saw the need to develop new approaches for caring for the hospitalised mentally ill. As a result, programs such as the therapeutic community, milieu therapy and group therapy were introduced as into the hospital environment. These programs marked the beginning of the pre-deinstitutionalisation era. During this time, there also was a blossoming of theories, such as behaviourism, existential humanism, neo-Freudism and transactional analysis, etc., which

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attempted to explain the aetiology of mental illness and suggest alternate treatment approaches. Furthermore systematic, scientific studies began to be valued as important tools to understand human behaviour and the human mind.

Legislative changes and concern for civil rights of people with mental illness, particularly those who were treated in public psychiatric hospitals, became the significant events in the 1960s. In the United States the Community Mental Health Act of 1963 mandated the development of community mental health centres to support people who were discharged from state hospitals. At the same time the rise of the anti–psychiatry movement (Szasz, 1961), which saw the system of psychiatric care as a form of socio-political and intellectual control, and the legal system, which narrowly defined instances in which people with mental illness could receive treatment, including drug therapy, against their will, effectively sabotaged the intent of the Community Mental Health Act. Psychiatrists, influenced by Szasz and Laing, decided that treating the "worried well" was an effective means of reducing the incidence of mental illness. As a result, few of people discharged from the large state institutions received services and support (Fuller, Wolfe & Flynn, 1988). There was an increase in the homeless population in urban areas and a significant number of them were deinstitutionalised clients from the psychiatric hospitals (Bachrach, 1984 & 1986). They lived in poverty and easily became the victims of abuse or exploitation. This gave rise to the concerns about human rights among mentally ill people.

The development of mental health care in Australia evolved slightly later than the events described in the United States; however, it followed a similar path. Prior to the 1960s, persons with mental illness were locked up in large psychiatric hospitals, such as Callan Park Hospital, which was built in 1897. Conditions in this hospital were described vividly by an occupational therapist who worked there:

> *Wards were separated into 'female' and 'male' and only one ward on each side of the campus had open doors. In other wards every door was locked, caging people into incredibly cold and unpleasant rooms or into the courtyard, where there was no access to their rooms, toilets or other facilities. Many were tied up in straight jackets and tied to their chairs. Others roamed aimlessly with nothing to do.*
> *Patients had few, if any, personal possessions nor had they any control over their lives....They were stripped of their independence, autonomy and individuality....Few had any visitors as family and friends often rejected them once they were admitted to a psychiatric hospital* (Weir, 1991, p.186).

In 1961, a Royal Commission into conditions at the Callan Park Hospital (McClemens, 1961) led to changes in psychiatric hospital care in New South Wales. These changes also spread to other states. Additional staff were employed, wards renovated, doors unlocked, and therapeutic programmes were

introduced. Open days were organised for the public to have a glimpse of the inside of the hospital at last (Weir, 1991).

The Community Mental Health Movement began in Australia in the early 1970s. An increased number of alternate accommodations and community services were set up to provide alternate care or follow-up service for mentally ill people. The purpose of these services was to prevent rehospitalisation.

From the beginning of 1980s, mental health service delivery has taken another turn. Community involvement is encouraged in the care of mentally ill people. Many voluntary or community organisations work independently of, though in close parallel to, the public mental health services, such as GROW, Schizophrenia Fellowship and Alcoholics Anonymous. Some of these were founded by current or past sufferers of mental illness and serve as self-help organisations. At the same time, there is a rise of a consumer movement where clients and their carers are empowered to fight for a fair share of decision making regarding mental health services delivery. The momentum of this movement continues to grow.

Since the McClemen Report of 1961, there have been a series of inquiries and commission reports on mental health services, though they might be politically motivated. These include the Richmond Report of 1983; the Tolkien Report of 1991, and the Burdekin Report of 1993. Recommendations were made and some of them have been or are being carried out by the federal and state governments along with allocation of more funding and resources. These recommendations and funds have been instrumental in changing mental

health service delivery in Australia from a hospital-based orientation to a community-based, consumer-focused orientation.

1.2.3 The target population of community mental health services: people with serious mental illness

With the advances in diagnostic technology and increased public awareness of mental health, the incidence of mental illness appears to be on the decline (Der, Gupta & Murray, 1990). However, mental health practitioners still are concerned about the large number of people with severe mental illness, whose positive symptoms of schizophrenia are well controlled by neuroleptics, but whose negative symptoms of schizophrenia continue to impair their abilities to cope effectively with every day life. In studies on prognosis of people with schizophrenia it is suggested that even with state-of-art treatment, approximately 40 percent of the persons with schizophrenia will experience a relapse within one year and 75 percent within five years of discharge from inpatient care (Talbott, 1981; Hogarty, 1984).

The magnitude of deficits in social and living skills also have been well documented in persons with chronic mental illness. A study by Sylph, Ross and Kedward (1978) found that more than 50 percent of a sample of chronic psychiatric patients had major functional deficits in social and personal areas. Two studies of schizophrenic patients also found that both discharge and remission rates were significantly higher among patients who had higher levels

of social and living skills (Linn, Klett & Caffey, 1980; Farkas, Rogers, and Thurer, 1986).

Goldman & Manderscheid (1987) define the serious mentally ill population encompassing persons who experience:

> *certain mental or emotional disorders (organic brain syndrome, schizophrenia, recurrent depressive and manic depressive disorders, and paranoid and other psychoses, plus other disorders that may become chronic) that erode or prevent the development of their functional capacities in relation to three or more primary aspects of daily life-personal hygiene and self-care, self-direction, interpersonal relationships, social transactions, learning, and recreation* (p.13).

They are either still living in the large psychiatric institutions or having been deinstitutionalised into the community to cut hospital costs. Often, they are found to be homeless, vulnerable to stress, at risk of malnutrition, abusing drugs or alcohol and unable to master the basic skills for daily community living and employment. The "revolving-door syndrome" of going in and out of institutions may be seen as a way of coping and finding shelter in a world where they do not have the skills to survive.

In summary, despite the fact that they are not an homogenous group in terms of diagnosis and medical condition, people with severe mental illness tend to share some common problems or impairments which include: 1) lack of a

continuing sense of competence, and mastery over their own lives; 2) lack of ability to attend to self maintenance; 3) impaired role functioning, i.e. inability to perform tasks to fulfil valued roles; 4) impaired ability to use time productively; 5) impaired ability to acquire sufficient material resources or negotiate their due entitlements with public or community agencies for help with life's basic necessities; 6) impaired ability to withstand stress, which leads to vulnerability exploitation and inability to respond appropriately to change; 7) difficulty in establishing or maintaining interpersonal relationships and a social support system; and, 8) increased vulnerability to health problems due to poverty, poor nutrition and health habits (such as excessive nicotine and caffeine intake), and neglect (Gibson, 1987; Jacobs, Crichton & Visotina, 1989).

With all these problems facing people with severe mental illness, one may question whether they are perceived as "untouchable", "hopeless" and "incurable" cases? Fortunately, research studies indicate otherwise. A review of five (5) recent long-term outcome studies, by Harding and colleagues (Harding, Zubin, & Strauss, 1987) found that a half or more of the cohorts that had been hospitalised in one state mental hospital had significantly improved or recovered at 20, 30 or 40-year follow-up periods. The authors suggest that improved intervention programmes might interrupt the possibility of a self–fulfilling chronicity prophecy and contribute to a significant improvement in functioning and quality of life for many people with severe mental illness. This finding is supported by Beiser and co-workers (1985) when they compared

outcomes in an area with good intervention programs to an area with poor intervention programs.

Anthony & Liberman (1986) summarised the current research findings and maintain that: 1) severely mentally disabled persons can learn skills; 2) skills of person with mental illness are positively related to measures of rehabilitation outcome; 3) skill development interventions improve the mentally disabled person's rehabilitation outcome; and, 4) environmental resource development also improves client's rehabilitation outcome.

1.2.4 Deinstitutionalisation and quality of life

The deinstitutionalisation movement signified a turning point in the history of care of the mentally ill. The asylum approach to deliverery of mental health services is no longer a viable model. The driving force that has fuelled the deinstitutionalisation movement is the awareness of the limitations and disadvantages of institutionally based care which reinforces dependency, encourages adoption of the sick role, lacks choices, and leads to separation from society (Macklin, 1993).

There is a body of research supporting the positive effects of caring for mentally ill persons in the community. A four-year follow-up study was carried out by Dicky and colleagues (1981) on 27 chronic mentally ill clients who were discharged from hospital to community directly or to a transitional mental health centre. The results indicated that clients tended to move from hospital to

community residence, and once they were in the community, their time spent in the hospital dropped dramatically.

Furthermore, though there is still a lack of conclusive evidence, more and more studies indicate that care in community settings for people with schizophrenia or other chronic mental illness tends to be cheaper than care in hospital settings (Weisbrod, Test & Stein, 1980; Fenton, Tessier & Struening. 1982; Hoult, Reynolds, Charbonneau-Powis, et al, 1983; Hoult, Rosen & Reynolds, 1984; Hafner & Heiden, 1989; Knapp & Beecham, 1990; Knapp, et al, 1990). A recent study by Dean and colleagues (1993) also suggests that community-based service is at least as effective as the hospital-based service for people with acute, severe psychiatric illness. Additionally, community based care is preferred by relatives. Also, community based interventions seem to be effective in keeping people in long term contact with psychiatrists.

However, there is little conclusive evidence that placement in the community guarantees a better quality of life for the clients. Studies of assertive community treatment programs (Marx, Test & Stein, 1973; Mulder, 1985; Bond, Miller, et al, 1988; Jerrel & Hu, 1989), which included subjective quality-of-life measures, have not found significant differences between experimental and control subjects, with the exception of Stein and Test's study (1980).

However, Stein and Test's (1980) findings are supported in a longitudinal study carried out by Okin and Pearsall (1993) on clients' perceptions of their quality of life after discharge. After an 11-year follow-up, a

majority of the clients who still were living in non-institutional settings perceived that their quality of life outside the hospital had improved in several ways. These include the extent of their social networks, the quality of their living environment, and their capacity to meet basic needs.

Additionally, Pinkney and associates (Pinkney, Gerber & Lafave, 1991) investigated patients' perceptions of their quality of life one year after discharge from the hospital psychiatric rehabilitation program. Fifty-five subjects were interviewed by using the Client's Quality of Life (QOL) Instrument. Ninety-six percent felt that their quality of life had improved as a consequence of leaving hospital. It was found that most people had the necessary maintenance skills to live in community settings. They showed appropriate behaviours and were able to integrate themselves into the large community without difficulty. The study also indicated that the subjects tended to use outreach support services provided by the hospital to help them in the transition to community living.

Although the study by Pinkney and associates (1991) suggests that psychiatric rehabilitation is an effective method of preparing people for community living, the study is not without faults. Shepherd (1992) indicates that the results are almost too good to be true and suggests that rater bias could have influenced the findings. Shephard also infers that studies which use the QOL instrument as an outcome measure may lose the concept of quality in the process of measurement. He suggests the use of qualitative research approaches, which deal with a rich amount of raw data, that is analysed for

trends and commonalties, as an alternative to imposing a rigid, quantitative framework (p.267).

1.2.5 Community-based rehabilitation and its development in Australia

The Community Mental Health Movement postulates that it is preferable for treatment to be provided in the least restrictive environment i.e. the local community where the client lives. Thus, community based intervention is seen as more humane than hospital based treatment because it facilitates re-integration into society, and provides choices and consumer-focus intervention (Stein, & Test, 1980; Dickey, et al, 1981). It also is estimated that at any one point in time, only about two percent of mental health clients will be treated in a hospital and the remaining ninety eight percent will be treated in the community (Grant & Lapsley, 1993).

The concept of the community as the ideal locus for rehabilitation services has grown as model programmes have developed and flourished. Examples of these programs include the Fountain House model in New York City (Beard, Prospst & Nalamud 1982), the Center House of Boston (Greb, 1983) and Horizon House of Philadelphia (Cnann, et al, 1982). These programmes demonstrated that persons with mental illness could experience successful rehabilitation outcomes outside the hospital environments.

Although the movement toward community based care was initiated in the United States in the early 1960s, it was not adopted in Australia until the 1970s. Community health centres were set up to provide follow-up services to

mentally ill persons discharged from hospital. However, there was a lack of resources and funding, staff were overworked with large caseloads and there was not sufficient training for in community based care for staff, who were recruited primarily from hospitals.

The first LSC was established in 1977 to provide outreach and offer skills training in vivo. It also provided a venue for people to meet each day to seek support from staff and each other (Weir & Rosen, 1988; Weir, 1991). In addition, the first controlled study on community mental health service – crisis intervention and extended hours services, was carried out by Hoult and colleague in 1979 in New South Wales. Results indicated positive outcomes for the community-based intervention.

With the increase in consumer power, international trends of mental health practice and social pressure, politicians became aware of the issue and instigated legislation to support the process of change from an institutional to a community oriented approach. Health care policies developed in the last decade and outlined below have provided a specific framework for this transition: first, the Richmond Report of 1983 challenged the existing provision of services and provided impetus for reforms in mental health care. The resounding recommendation was that "services be delivered primarily on the basis of a system of integrated community based networks, backed up by specialist hospital or other services as required" (Richmond, 1983, p.21).

Secondly, the Mental Health Act, 1990 (N.S.W.) established a legal definition of mentally ill and mentally disordered persons. It provided strict

guidelines for the scheduling of persons with mental illness for hospitalised treatment and outlined the patient's legal rights. It also emphasises the importance of providing treatments and rehabilitation in as least restrictive environment as appropriate.

Thirdly, the National Mental Health Policy of 1992 (Australian Health Ministers, 1992) recommended that: 1) psychiatric hospitals should be closed and replaced with a mix of general hospital, residential and community support services; 2) early intervention should be emphasised; 3) preventative activities should be implemented; 4) community education programmes aimed to inform the general public about mental disorders and promote understanding and support for the mentally ill and their care givers should be instituted; and 5) extra respite care places should be provided for persons who care for people with disabilities at home (Macklin, 1993).

Recently, the Human Right and Equal Opportunity Commission Report (1993) on the mentally ill condemns the inadequacy of accommodation and follow-up service for deinstitutionalised clients. It strongly recommends an integrated and comprehensive mental health care service for the rehabilitation of mentally ill persons. This service should not only involve the Health Department, but other private, state and federal organisations. If the recommendations of these reports are to be implemented, more funding and resources will be allocated to upgrade and expand community mental health services.

1.2.6 Psychosocial rehabilitation

Although the terms 'psychiatric rehabilitation' and 'psychosocial rehabilitation' are regarded as synonymous terms in this literature review, psychosocial rehabilitation emerged from the psychosocial movement that developed in the 1970s (such as the Fountain House). The definition of psychosocial rehabilitation as commonly known states (IAPSRS, 1985):

> *[T]he process of facilitating an individual's restoration to an optimal level of independent functioning in the community.... while the nature of the process and the methods used differ in different settings, psychosocial rehabilitation invariably encourages persons to participate actively with others in the attainment of mental health and social competence goals. In many settings, participants are called members. The process emphasises the wholeness and wellness of the individual and seeks a comprehensive approach to the provision of vocational, residential, social/recreational, education, and personal adjustment services.* (p.iii)

The philosophy of psychosocial rehabilitation emphasises common sense and practical need satisfaction and usually includes vocational, social, leisure, residential and educational services aimed at teaching the essential skills of community living (Peterson, Patrick & Rissmeyer, 1990, p.468). It uses assessment and intervention techniques based on social learning theory,

behavioural principles, client-centred therapy and human resource development, and life span developmental psychology.

On the other hand, psychiatric rehabilitation evolves from the concept of physical rehabilitation where an interdisciplinary intervention brings about restoration of function and role performance (Solomon & Flexer, 1993). It is suggested that the focus of the psychiatric rehabilitation practitioners should be on remediating disabilities and compensating for handicaps (Frey 1984). Rehabilitation should proceed from a four-stage framework for understanding the nature and consequences of disease (Liberman, 1988):

1. **Pathology**. The pathology in schizophrenia is still poorly understood, although brain–imaging techniques are revealing intriguing leads for structural and functional abnormalities in certain brain regions. Genetic studies also reveal that some of the mental disorders, e.g., schizophrenia and manic depression, seems to be genetically linked (Kaplan & Sadock, 1989; Lawn & Meyerson, 1993). The psychobiological abnormalities in the nervous system caused by defective genes or trauma or diseases, can produce deficiencies in cognitive, attentional, and autonomic functions, and in regulation of arousal and information processing (Ross, 1988).
2. **Impairments**. The examples of impairments experienced by people with mental illness include: thought disorder and speech incoherence, delusions, hallucinations, anxiety, depression, loss of concentration or memory, distractibility, and apathy and anhedonia.

3. **Disability.** Disability can be defined as inability or limitation to perform roles and tasks expected of an individual within a social environment due to existing impairments (Frey, 1984), for examples poor self–care skills, social withdrawal and seclusiveness, abandonment of family responsibility and work incapacity. However, not every impairment results in a disability.
4. **Handicap**. Handicap occurs when a person's disabilities place him or her at a disadvantage relative to others in society, for examples, social stigma, discrimination and general neglected by society.

Thus, it is important to remove social stigma and discrimination from mental illness, as well as use medical treatment to control the pathological condition or minimise the impact of impairments of mental illness on the persons. On the other hand, the aim of psychiatric rehabilitation also focuses on the strengths of the individual, promotes rejuvenation of lost skills, teaches new and more effective living skills, compensates functional deficits, enhances interpersonal relationships and assists in developing supportive social networks (Macklin, 1993, p.90).

The original psychosocial rehabilitation model excluded medical management. However, currently medical management is an integral part of the rehabilitation process (Lawn & Meyerson, 1993), with the client perceived as an actively informed coequal participant. As the differences between the two rehabilitation models have been minimised, they are being used interchangeably in literature as well as in this thesis.

To understand the assumptions that underpin the psychiatric rehabilitation, one needs to understand the Vulnerability-stress-competence Model of mental disorders (Liberman, 1988) (Figure 1.1). Research findings indicate that appearance or exacerbation of psychotic symptoms and associated disabilities may occur in susceptible individuals when:

1. underlying psychobiological vulnerability factors are triggered, which is more likely in the absence of optimal antipsychotic medication;
2. stressful life events intervene that exceed the individual's coping skills and competencies in social and instrumental roles;
3. the individual's social support network weakens or diminishes; and,
4. coping and problem-solving skills atrophy as a result of disuse, reinforcement of the sick role, or loss of motivation.

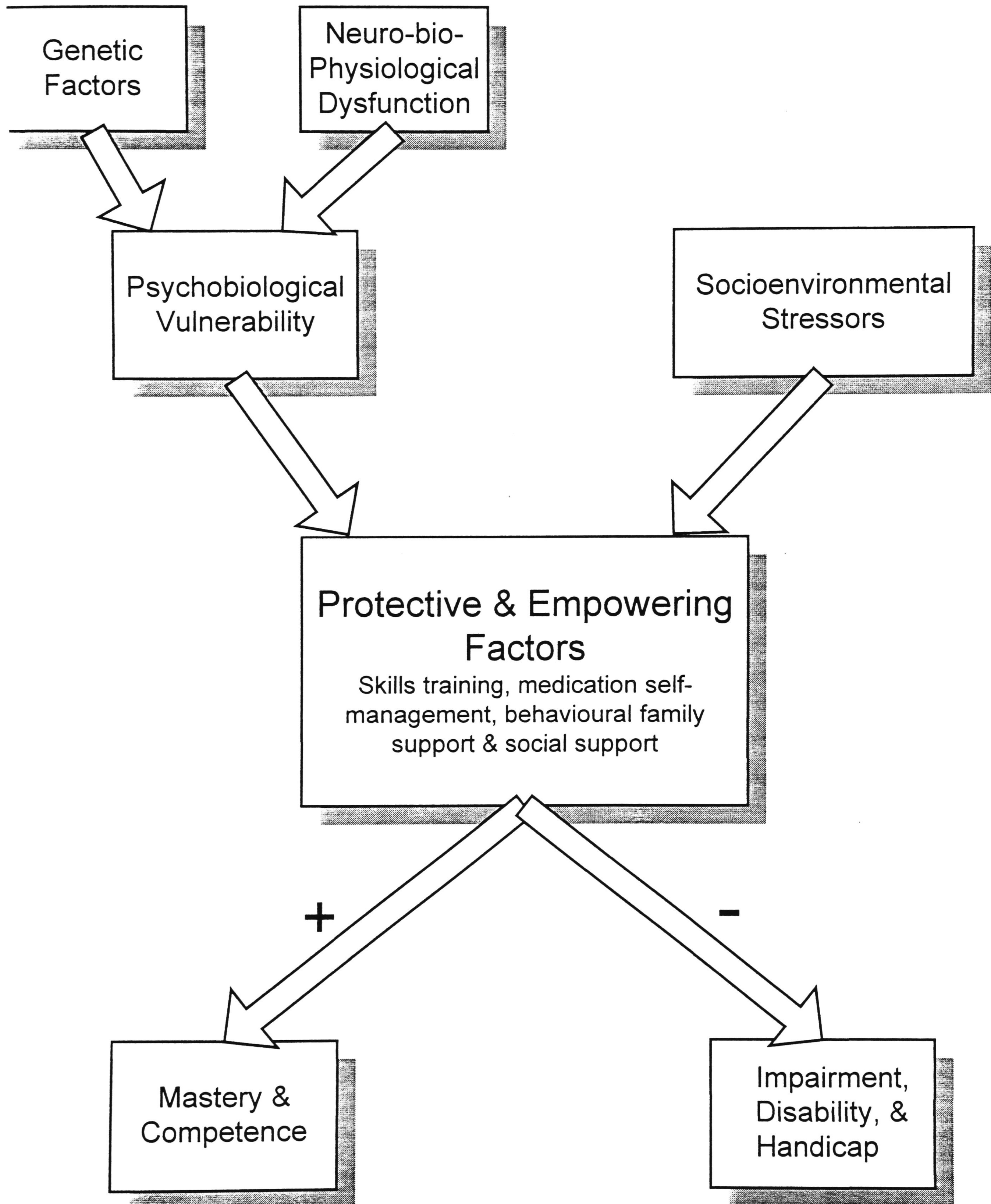
Therefore, vulnerability and stressors are moderated in their impact on impairment, disability, and handicap by the presence and action of protective factors. Primary protective factors are coping and competence exercised by individuals, families, natural support systems, and professional treatment.

The vulnerability-stress-competence model highlights the role of specific psychosocial interventions in developing personal and familiar coping skills, and interpersonal and vocational competence as protective factors in the course of mental disorders. It is believed that experience of efficacy, control, self-determination, self-esteem, goal clarity and motivation are directly related to

skills and knowledge. Skills training approaches have shown much promise and empirical efficacy (Paul & Lentz, 1977; Liberman, 1984; Anthony & Liberman, 1986). Carkhuff (1981) further states that "skills are observable and measurable, replicable and teachable, and therefore, achievable." (p.151).

Furthermore, to maximise the function and achievement potential of an individual, the task and level of potential function of the competence based programmes need to be determined by individual, and not by the mental health practitioner. Thus, the therapeutic process should revolve around responding to priorities or appropriate goals as perceived and set by individual clients and assisting clients in the identification or modification of their life priorities at different stages of treatment. Enhancement of an individual's coping ability through skills training leads to successful coping, which then leads to attainment of social and emotional goals which define adjustment and competence. However, some studies suggest that without a continued skills maintenance programme, clients will tend to lose their skills six to twelve months after stopping the training program (Brady, 1985; Falloon, 1978).

Figure 1: Vulnerability-stress-competence Model



Adapted from Liberman, 1988

In summary, a model psychosocial rehabilitation programme for people with severe mental illness should include the following components:

1. Assessment of each individual's functional ability and their environmental demands;
2. Involvement of clients and carers in assessment and intervention;
3. Promotion of clients' personal strengths;
4. A sequenced individual management plan with observable, measurable and specific objectives;
5. A program for teaching living skills;
6. A normalised environment of intervention, i.e. least restrictive, informal settings, rather than formal clinical institutions;
7. A "here and now" orientation of service delivery;
8. Assessment and modification of the environment to enhance social support;
9. Assertive follow-up and establishment of procedures to prevent clients from dropping out from the system during the process of changing from one health care environment to another;
10. Adopting case management principles, as well as a multidisciplinary team approach in which staff are trained specifically for working in the area of mental health;
11. Evaluation which is undertaken in client's own environment; and
12. Involvement of community support groups in policy making and planning.

1.2.7 The Living Skills Centres

LSCs have been set up as one of the elements of the community mental health services for mentally ill people in New South Wales since the Richmond Report of 1983. However, the first LSC was established in 1977 (Weir & Rosen, 1988). By 1990, there were more than fifty LSCs in New South Wales (Weir, 1991), and new centres are still being established. All these centres are adopting a multidisciplinary approach for rehabilitating clients with mental illness, particularly chronic and deinstitutionalised clients. They are staffed primarily by nurses, occupational therapists, psychologists and social workers.

The original purposes of the LSCs were: to promote community adjustment and prevent readmission to psychiatric hospital; to develop opportunities for normalisation; and to work co-operatively with clients and their families in the rehabilitation process. In vivo training, case management and client-oriented approach are some of the intervention principles. The main areas of focus include pre-vocational and vocational programs, family therapy, client education (including consumer's rights and medication management), social skills training, daily living skills and leisure programs (Life Skills Forum, 1985; Weir and Rosen, 1989).

As the mental health services have evolved and changed since the establishment of first Living Skills Centre, one may wonder if there are any changes in the purposes and functions of the current LSC service which are different from its original? How effective are these services in facilitating community tenure for people with mental illness? After an extensive literature

search, there seems to be a lack of published information or research studies on different aspects of the rehabilitation services that would provide answers to the above questions. Hall and Ryan of The University of New South Wales were commissioned by the Health Department to conduct an extensive review of the role and operations of living skills centres in New South Wales in 1991, which should have answered some of the questions posed above. Although some of the findings from their review were presented to the Life Skills Forum in 1992 and 1994, to the author's knowledge, the results of this review still are not officially available to the public.

1.3 CONSUMER AND MENTAL HEALTH SERVICE DELIVERY

1.3.1 Consumer satisfaction

Client satisfaction information is often ignored while developing protocols or making changes to improve the quality of services (Prager & Tanaka, 1980; Vouri, 1987; Prehn, Mayo & Weisman, 1989). The common reasons for this omission include: 1) clients lack the scientific and technical knowledge necessary to adequately assess quality of care; 2) clients may be in a physical or mental state which makes them incapable of passing "objective" judgement; 3) health professionals and clients may have different goals for care; and 4) client satisfaction can not be measured as there is no absolute definition of "quality" (Vouri, 1987). However, these reasons were challenged by others, particularly the sociologists who see these are excuses of health care professionals to maintain control over their activities (Sommers & Sommers, 1962; Vouri, 1987).

In addition, due to the shortage of health funding and insufficient manpower and resources, client-oriented approaches to service provision often have to give way to the service-oriented approach. Westbrook (1993) maintains that although health care professionals are educated about the importance of evaluating their work, the role of patients in the evaluation of services largely has been ignored.

However, the steady increase in concern for consumer satisfaction in the community reflects two profound philosophical changes (Vouri, 1987). First, with increase of community participation and consumerism, quality assurance

activities in the health care industry are no longer seen as elitist endeavours aimed at raising the quality of work of health care providers. Social accountability is being introduced; therefore, the goal of quality assurance is no longer excellence at any cost, but rather, optimal quality. Quality is no longer an absolute ideal, but a functional concept. Second, social and behavioural sciences consider subjective experiences and objective assessments to be equally valid measures. Perceptions of wellness are not based purely on objective external findings, but also depend on the person's subjective feelings that significantly influence the course and outcome of intervention (Vouri, 1985).

1.3.2 Consumer-focus of service delivery in mental health

The assessment of client satisfaction with various aspects of mental health services is an important issue to health care professionals. First, client satisfaction not only influences the pursuit and use of the services, but also is a significant factor in compliance with intervention and its eventual success or failure. In an early study on clients' satisfaction with psychiatric hospital treatment and their opinions on further improvement required to the service, Gordon, Alexander and Dietzan (1979) concluded that clients' satisfaction *per se* can not be the major goal of the health services, as their views could be unrealistic and at variance with the observations of others. Nevertheless, they maintain that the path to improved welfare and treatment may be facilitated by clients' satisfaction or at least by an awareness of clients' opinion since clients

are in a strategic position to offer observations and are the experts in the role of psychiatric client (Gordon, et al, 1979).

Second, two significant consumer movements have emerged as major influences in the development of mental health care and in community resources development for the chronically mentally ill. One is the consumer/client movement, such as Schizophrenia Fellowship and GROW, and the other is family and carer movement, for example, the Association of Relatives and Friends of the Mentally Ill. Their importance is in providing mutual support to each other and in their articulate, moving presentations to health professionals, policy makers, and politicians, on their experiences with and perceptions of the needs of mentally ill individuals and their families. Their interest is in improving the quality of treatment as well as increasing access to normative roles and to community services and resources (Hatfield & Lefley, 1987).

A typical example of this type of consumerism is the establishment of The National Consumer Advisory Group (NCAG) in 1992, which was formed to provide an ongoing mechanism for consumer input into mental health policy decision making processes, particularly in relation to the implementation of the Plan in accordance with the Mental Health Statement of Rights and Responsibilities of 1992. As clients assume an active role in treatment planning, they become collaborators or partners rather than passive recipients of care. Thus, the once conflictual relationship between the provider sector and the consumer movement appears to be evolving into an alliance (Anagnos, et al. 1993)

The Mental Health Consumer Outcomes Task Force (1991) in its report to the Australian Health Ministers maintained that:

> *Mental health services exist to meet the needs of consumers and for the promotion of mental health. In the past, people with mental health problems and mental disorders have had limited say and, in some cases, little choice about the nature and form of services they received. These decisions have generally rested with health and welfare professionals and service administrators. Voluntary mental health organisations have played a role in the dissemination of information and the provision of support, care and advocacy.*
>
> *Current thinking about health acknowledges the vital importance of promoting and protecting as well as restoring mental health. To ensure that this broader understanding of health is reflected in programs and policies, there needs to be national co-operation by public, private and voluntary sectors, and between consumers, carers, members of the community and service providers.* (p.viii)

Thus, it is clear that the focus of psychiatric rehabilitation intervention should be the clients and not a one-way process which is dominated by health professionals. Client and carer needs have to be incorporated in planning and evaluation of interventions. This can happen through client and carer empowerment.

1.3.3 Measurement of consumer satisfaction in mental health service

Although the literature on client satisfaction with mental health services is extensive, it is neither cohesive nor conclusive. Kalman (1983) points out that it is difficult to define and quantify client satisfaction because it is a composite of many variables. An individual's expectations, experiences, personality, attitudes, psychodynamics, perceptions, and values all act in concert to determine the state of mind that researchers label "satisfaction".

A review of literature indicates that there is no standard methodology to measure client satisfaction (Kalman, 1983). Thus, it is difficult to compare findings from different satisfaction studies. Personal interview (Gordon, et al 1979), letters from clients (Eisen & Grob, 1979), telephone survey (Denner & Halprin, 1974; Frey, 1985), and satisfaction scales (Glenn, 1978) are some of the methods commonly used. Other methods include picture tests (Brady, et al, 1959) and multiple-choice questions (Gove & Fain, 1973).

One common approach to elicit client opinion is through client satisfaction surveys. The survey can be in the form of questionnaires, suggestion boxes, focus groups, interviews, consumer hotlines, informal visits with clients by nonclinical staff or by staff from other units. They serve to provide important information to health care providers about the quality of their service. This information is specially useful in programme planning and evaluation in quality assurance activities. Ideally, client feedback alerts health professionals to their needs, concerns and perceptions of the intervention. Health professionals can then modify their behaviour accordingly and improve

their overall quality of care. Interestingly, studies consistently report a high degree of satisfaction with mental health services (Nguyen & Attkisson, 1981; Kalman, 1983; Lebow, 1983; Elbeck & Fecteau, 1990; Levois, Morphy, 1991). However, some question the validity of client satisfaction surveys and the methods currently being used.

Kalman (1983) suggests that the tendency towards conformity and overrating of success with programmes is related to the clients' involvement with the interviewing staff or programme from which they may seek treatment. Very often, client participation in the evaluative process is restricted merely to that of respondent. They have not been involved in instrument development and data collection. Nelson and Neiderberger (1990) agree that client satisfaction surveys established by professionals run the risk of not reflecting what is really important to the client. Furthermore, clients often are hesitant to disclose what they really think or feel because of their sense of dependency on the services being provided and because of previous negative experiences in communication with professionals. This hesitancy to share opinions or ideas may limit the validity of the information obtained from the evaluation. Sabourin, Bourgeois, Gendreau, and Morval (1989) further support this belief through their studies. They find that client reports of satisfaction are significantly related to socially desirable responses. This behavior may invalidate the evaluation findings.

The current method of evaluating client satisfaction seems to be unsatisfactory due to the many problems that exist with present studies and results. Therefore, alternate methods of collecting information are needed.

Elbeck and Fecteau (1990) proposed that problems with validity should not be regarded as a reason to abandon the collection and use of satisfaction data, but rather as a reason to develop new methods of collecting and interpreting data. A study by Morrell-Bellai and Boydell (1992) on consumer participation in paid employment concluded that clients want to be included in all stages of the research project. However, as mentioned earlier, client satisfaction information is seldom used for the development of protocols or for making changes to improve the quality of services. Nelson and Niederberger (1990) maintain that without client consultation or involvement in the design of satisfaction surveys, these instruments may not provide a true representation of client satisfaction. Thus to ensure relevance and ongoing effectiveness of services it is emphasised that client involvement in the entire process of survey development and administration is warranted (Gordon, et al, 1979; Elbeck & Fecteau, 1990; Nelson & Niederberger, 1990; Boydell & Everett, 1992).

Several approaches of client involvement in the process of satisfaction survey have been suggested which include: "participatory research"; joining as a member of the quality assurance committee and focus group. In "participatory research" clients are recruited as co-researchers (Everett & Steven, 1989). This type of research is seen as holistic, naturalistic and acknowledges the subjectivity of human behaviour (Lord, Schnarr & Hutchinson, 1987). In Campbell's study (1991), a client researcher in California conducted a state wide survey of client, staff, and family satisfaction with mental health services. She concluded that there is a major shift in the types and nature of questions

developed when clients are responsible for conceptualising and conducting programme evaluation and research. As a result, a broader repertoire of questions are addressed. Everett and Steven (1989) identified that reducing the power differential between professionals and clients results in a more reciprocal relationship which empowers those involved by allowing clients to discover their own strengths and abilities.

Anagnos and co-workers (1993) also reported success in involving community volunteers and consumers in the quality assurance review of clinical programs. In addition to participating in the site visits to clinical programmes, they had specific responsibility for interviewing programme clients to generate consumer satisfaction data that could be used in evaluation of clinical services. However, it was noted that this type of effort required substantial staff support.

Wilson, Mahler and Tanzman (1990), summarised reports from both professional and client-operated organisations and found several benefits to employing clients as co-researchers. They found that the clients provided valuable insights related to treatment strategies. They were motivated and dedicated to the job and were found to be empathic and sensitive workers. Pratt and Gill (1987) further suggested that the use of client interviewers may encourage the participation of respondents. Morrell-Bellai & Boydell (1992) found that the interviewees felt more comfortable when interviewed by a peer. In addition, they reported that the clients' experience of being employed as an interviewer can lead to an increase in clients' confidence in their own abilities as

well as provide them with new and marketable skills (Morrell-Bellai & Boydell, 1992).

Another benefit of involving clients in the quality assurance process, through joining in as a committee members, is to minimise discomfort or dissatisfaction for predetermined protocols, such as fire drills and unavoidable intensive treatment technology (Prehn, Mayo & Weisman, 1989).

In another study of the use of clients in the assessment of care, Elbeck and Fecteau (1990) used a focus-group method to generate attributes of ideal care from the client's viewpoint. A group of 50 client-generated items were rated for importance by a second group of inpatients on locked units of a psychiatric hospital. Factor analysis and mean importance ratings were used, as well as identified interpersonal relations with staff as a key factor of client satisfaction and a seven-item measure of satisfaction was designed based on this key factor. It was concluded that the idiosyncratic concerns of various service settings and their clients likely to be most clearly addressed by applying the focus-group method in those locales. This approach would yield satisfaction scales that were tailored to reflect the unique perspective of the particular client population being served (Elbeck & Fecteau, 1990).

1.3.4 Consumer and staff dissatisfactions: Discrepancy of perceived goals and needs between staff and clients

In the recent inquiry reports and policy papers in Australia, the importance of meeting consumers' needs by health service delivery agents has

been emphasised (National Mental Health Policy, 1992; Human Rights & Equal Opportunity Commission, 1993; Macklin, 1993). However, studies indicate that there are often discrepancies between clients' needs and staff perceptions of their needs; and, between health professions' goals for the clients and services which actually are delivered (Kielhofner, 1982). In her ethnographic studies, Estroff (1991) learned that clients are concerned with issues such as sexuality, happiness, warmth, intimacy and privacy rather than management of illness.

Furthermore, clients and mental health professionals often disagree on clinical issues. A review of literature suggests that both professionals and clients believe that mental health professional and clients differ in their perceptions about: the relevance of treatment services; client priorities; client problem areas; the value of treatment provided; and, the desired treatment outcome (Larsen et al, 1979; Prager & Tanaka, 1980; Kalman, 1983; Lynch & Kruzich, 1986; Capponi, 1990; Elbeck & Fecteau, 1990; Law et al, 1990; Estroff, 1991; Boydell & Everett, 1992; Everett & Nelson, 1992). Prager and Tanka (1980) in their review of the literature conclude that a number of studies indicated "a fundamental lack of agreement between the helper and the helped in such key areas as problem definition and perception of what 'rehabilitation' and 'getting better' meant." (p.32).

In his review of client satisfaction studies, Kalman (1983) notes that there is also a discrepancy between the reported satisfaction of clients and the expectations and predictions about client satisfaction from within mental health professions. Clients are more pleased with treatment and much less bothered by

or displeased with research, teaching and commitment than what are expected them to be. In addition, Lynch and Kruzich (1986) concluded from a study on barriers in using mental health services that clients tended to focus on financial issues and clinicians on issues of treatment resistance. Furthermore, in the consumer literature there is often a strong emphasis on: hope, courage, the need for encouragement and being given a chance, involvement, and overcoming fear of illness.

Finally, the Human Rights & Equal Opportunity Commission (1993) comments, from a consumer's perspective, that there are two shortcomings in the Living Skills programmes which reflect an inability to meet client needs:

> *First, unless the Centre succeeds in integrating its clients with local social, recreational, community or work activities, an important social outlet is lost when they have progressed as far as they can with the Living Skills programs. The second problem referred to was that in some Living Skills programs the groups are geared for those clients with the greatest difficulties. This means those who are less disabled often become bored.* (Human Rights & Equal Opportunity Commission, 1993, p.321)

1.4 SUMMARY AND STATEMENT OF PROBLEM

To summarise, there was evidence indicating that:

a) The concept of mental health and illness varies within and across different cultures, and as it evolves with time, it influences the development of mental health services;

b) Community treatment is preferable to hospital treatment for the chronically mentally ill;

c) There are contradictory findings in the study of client quality of life upon discharge from institution to the community.

d) There appears to be insufficient literature or studies on the different aspects of Living Skills Centre as one of the community mental health services;

e) There is a re-focus on client/consumer-oriented service delivery in psychiatric rehabilitation i.e. providing services to achieve the goal of meeting client's needs/demands.

f) A discrepancy in perception of needs and service provision between staff and clients seems to exist.

g) Quantitative studies do not adequately reflect consumer satisfaction and their perceptions of quality of life.

h) The psychosocial rehabilitation model provides the foundation for the current rehabilitation process for people with mental illness.

i) Consumers' involvement in the development and implementation of consumer satisfaction surveys will improve their validity.

j) Clients' involvement in programme planning and implementation will not only influence their pursuit and use of the service, but also their compliance with the identified interventions.

1.5 RESEARCH QUESTIONS

The following are the research questions that were generated from the literature review for this study.

a) What client needs can be met by the LSC programmes?

b) What differences are observable between staff and client perceptions of the purposes and functions of the LSCs?

c) To what extent have the LSC programmes been perceived as improving clients' quality of life in the community?

d) What do clients perceive as the factors that will help them achieve program goals in the LSCs?

e) To what extent are clients satisfied with the LSCs' programmes?

1.6 OVERALL AIMS OF THE STUDY:

The overall aims of this study were:

a) To identify which client needs of community living can be met by the LSC programmes ;

b) To investigate staff and client perceptions of the purposes and functions of the LSCs;

c) To identify staff and client perceptions of the factors that will facilitate clients' attainment of programme goals in the LSCs.

d) To investigate improvement in community living among the clients who have attended the LSC programmes as perceived by staff and clients; and

e) To investigation client satisfaction with the living skills programmes and future improvements required for the centres.

CHAPTER TWO

An exploratory study on Living Skills Centres

CHAPTER TWO:

An exploratory study on Living Skills Centres: Semi-structured interviews of staff and clients

2.1 INTRODUCTION

Since the establishment of the first LSC in 1977, the health care industry has gone through further changes, particularly in the area of mental health, e.g. The Tolkien Report, 1991; Mental Health Act (N.S.W.), 1990, The Burdekin Report on the Human Right issues among the people with mental illness and the National Mental Health Policy. One may wonder how changes impact on the LSCs. Are there any changes in the purposes and functions of the LSC service? However there seems to be little published literature and few studies provide answers to the above questions.

2.2 AIMS

As there was insufficient literature to guide development of an instrument to answer the research questions posed in the previous chapter, the investigator used a qualitative approach to explore current issues or phenomena pertaining in the service in order to identify problems or hypotheses that could guide further study. Patton (1980) explains that the purpose of qualitative research is explore unknowns. Schmid (1981) expands on this definition by stating that qualitative research aims to understand the meaning of human behaviour in social and cultural settings. Qualitative research is based on the assumptions that: 1) human behaviour is influenced by the physical and psychological context or environment in which it occurs; and, 2) human behaviour goes beyond that which can be observed; it lies in the perspective and meanings held by the individuals in a context.

Due to a variety of constraints, it was not possible to use a participatory approach that involved subjects in designing the questionnaire. However, an attempt was made to develop a "user-friendly" survey instrument. The previously described, qualitative, semi-structured interviews of subjects were used to generate concepts, question items and words/phrases that were relevant and valid for both the subjects and the field of study. This approach also served to assure content validity of the questionnaire items.

2.3 METHODOLOGY:

2.3.1 Overview of the research design

The semi-structured interviews were conducted between May and June, 1994. In interviewing subjects, the researcher used an open-ended questionnaire on the perceived purposes and services of LSCs (refer to Appendices II & III: Semi-structured Questionnaire for interview [Clients & Staff]). Participants were encouraged to freely express any feelings, perceptions or experiences related to LSC services. All interviews were recorded on audio-cassette tapes and later transcribed by a trained transcriber. This was followed by a content analysis of the responses.

2.3.2 Subjects

Subjects were approached through informal channels and personal networks. Subjects were either staff currently working in a LSC or clients attending a LSC. A total of seven (7) staff and six (6) clients from three (3) LSCs in the Sydney Metropolitan area were interviewed.

2.3.3 Data collection

Prior to data collection, the co-ordinators of the three (3) LSCs were contacted by phone to confirm their willingness to participate in the study. At that time, the purpose and methodology of the study also were explained. In addition, it was requested that the centre co-ordinators asked the staff and clients if they would consider being interviewed. Final arrangements were made regarding the date, time and place for the interviews with each centre.

Prior to the commencement of each interview, the subject was once again informed the purpose of the interview. A consent form to release the transcript of the interview was read and signed by the subject before recording commenced (refer to Appendix VII: Interviewee's release form). Questions were asked based on the prepared questionnaire. However, subjects were reminded again that they were free to express any issues or thoughts regarding the LSC and were assured that what was said would remain confidential. If subjects came up with interesting or unexpected themes and concepts during the interview, these ideas were explored through the use of additional questions.

Interviews were recorded using an audio-tape recorder. Tapes were sent to a trained transcriber to transcribe the content. A hard copy of each interview was printed out and checked by the researcher by listening to the tape. Any omissions or transcribing errors were then corrected. A revised copy of the transcripts was sent to each subject for verification or corrections of the interview content. After further adjustments and corrections, the final hard copy of each interview then was used for data analysis.

2.3.4 Content analysis

A method of dimensional content analysis was adopted where existing dimensions, emerging themes and categories were identified through reading the transcripts repeatedly. Temporary hypotheses were formulated from the classes of data. The researcher then returned to the transcripts again looking for disconfirmation, qualification or confirmation of those hypotheses.

2.4 RESULTS

2.4.1 Demographic Data

Subjects were 7 staff and 6 clients from three LSC in Sydney Metropolitan area.

Table 2.1 Interviewees' Data

	STAFF	CLIENTS
Number (n=13)	7	6
Gender	4 x Male 3 x Female	4 x Male 2 x Female
Position	3 x Nurses 2 x Occupational Therapist 2 x Psychologist	
Date of first admission to mental health care		1 x Less than 1 year ago 2 x 1 – 5 years ago 2 x 6 – 20 years ago 1 x More than 20 years ago
First time working in LSC	5 x YES 2 x NO	
Date of first attendance at LSC		2 x Less than 6 months ago 3 x 6 months – 5 years ago 1 x 6 – 10 years ago
Date commenced working in LSC	3 x Less than 1 year ago 2 x 1 – 2 years ago 2 x 3 – 5 years ago	

2.4.2 Reasons for referral

Table 2.2 Referring persons and reasons given to clients for attending Living Skills Centres

REFERRED BY	2 x Psychiatrist 1 x Psychologist 1 x Treating doctor 2 x Nurses
REASONS FOR REFERRAL	* 3 x Things to do during the day and meeting people Other reasons (1 x): * Rehabilitation * To learn about illness & cooking and budgeting, etc. * Reason not given

Most of the clients were referred either by psychiatrists or nurses. The reasons given by the referring persons to the clients for attending a LSC tended to not contain great details:

Something to do during the day

To mix with people

This client quoted the explanation he had received from the referring person, *"It was mainly a place to come along, be occupied and joining in the activities and different groups and things to help me getting through this sort of...problem that I have at the moment"*

However, all the staff felt that knowledge about the purposes and functions of LSCs varies among the referring agents. A majority of the staff felt that the referring agents did not have a clear understanding of the purposes of LSCs.

For examples, the following are the comments given by the staff:

I think some do, but I don't think the majority fully understand the purposes of what we are trying to achieve.

There are some that have perhaps ideas that were perhaps years down the track of what living skills [centre] were like. Then there are people that are new, most of the new people do to check it out. People that have been there for a long time and might occasionally refer somebody but really just don't know how much people can benefit from coming here.

We have had difficulties with that. We had to do a presentation in order to try and educate them to what we are doing because there was a lack of knowledge about what we did and what we are doing.

2.3.3 Perceived purposes of Living Skills Centres

Table 2.3 The perceived purposes of Living Skills Centres

STAFF	CLIENT
* 4 x Provide a venue for socialisation/ prevent loneliness	* 4 x Socialising/ meeting people
* 4 x Rehabilitation into community	* 3 x Things to do for the day
* 2 x To reach an optimal level of functioning/ maximise abilities	* 3 x Problem solving
* 2 x Provide support	* 2 x Prevent loneliness
* 2 x Promote and maintain independence	* 2 x Teach ADL/basic living skills
* 2 x Provide activities	* 2 x Rehabilitate back to community
Other (1 x):	* 2 x Education on illness
* Prevent hospitalisation	* 2 x Help people to live as close to normal life/role
* Acquire skills for productive life	* 1 x Develop work skills
* Give people a quality of life	* 1 x Getting support
* Give clients a sense of respect, acknowledgement and understanding of illness	
* Help client to come to term with deficits	
* Provide activities	
* Assessment & referral to other community services	
* Provide a " kick start" for client	

Interestingly, Clients perceived the purposes of the LSC according to what they had received or benefited from. They tended to express their perceptions in concrete, "layman" terms. More than half of them see the LSC as a place for "socialising", "meeting people". Half of the clients stated, "Things to do during the day" and assisting them "problem solving". Other perceived purposes include: "Learn how to budget", "Teaching people how to cook and clean", "Rehabilitate back to community", "learn a lot about schizophrenia and manic depression", "Prevent loneliness", develop work skills and "help people to live as close to normal life".

Examples from the interviews are:

> *[It offers] a variety of activities.... You get self esteem from doing a job and you get self esteem from socialising, you get self esteem from achieving, doing things, and just being with your friends....*

> *For me, if I didn't come here (LSC), I wouldn't see a soul because I live on my own....Mix with people, talk over our problems with others.*

However, staff perceived the purposes in terms of goals or outcomes that they wished to help the clients achieve. They tended to express in professional "jargon."

More than half of the staff saw the LSCs as providing a venue for people to meet (socialisation), to prevent loneliness, and to rehabilitate clients into the community. Other common perceived purposes include: "Prevent

hospitalisation", "To reach an optimal level of functioning", "To maximise abilities", "Help clients to come to term with deficits", "Provide a kick start [for client]" and " Give people a quality of life".

The following quote effectively represents the staffs' perceived purposes of the LSCs:

> *....I think it [the purpose of LSC] is extremely broad, and it has to cater for each individual. I think the purpose is to give people a sense of respect, acknowledgement and understanding of their illness to provide a venue where people feel that they are not isolated, that they can learn from others and from staff more about what they are going through....What we are trying to achieve is to give people a quality of life....I think the priority is giving those persons (clients) independence, hopefully to give them some sort of stepping stone so that they can think about what they want in their life that is productive for them....[for examples] perhaps social networking, seeing how others have managed their illnesses and so forth.*

2.4.4. Services provided as identified by the subjects

Table 2.4 Services provided by the Living Skills Centres as perceived by the staff and clients

STAFF	CLIENT
* 4 x Education on illness & management * 4 x Pre/vocational training * 4 x Therapeutic groups * 3 x Assessment * 3 x Provide program based * 2 x Drop–in centre/socialisation * 2 x ADL & IADL training * 2 x Supportive work program * 2 x Liaise with outside community/services * 2 x Individual therapy – incl. counselling on client's need/interest Other (1 x): * Social Skills Training * Physical activity/sports * Collaborative Therapy * Outings	* 3 x Supportive work * 3 x Therapeutic groups * 3 x Education e.g. on illness * 3 x Cooking * 2 x Sports/physical exercises * 2 x Outings Other (1 x): * Horticulture course with TAFE * Stress management * Expressive art and diet * Budgeting

As another example of the differences in service description between clients and staff, the following responses are clients' examples of services provided by the LSCs. These responses are categorised as follows:

1) Supportive work programme; 2) Courses run with other community organisation; 3) Therapeutic groups - stress management, cooking, discussion; 4) Education on illness and management of symptoms; 5) Physical exercises - sports, outings; and, 6) Activities of daily living (ADL) and instrumental activities of daily living (IADL) training.

The examples given by staff include the above, plus:

"Drop-in centre"; social skills training; Assessment; collaborative therapy; and individual therapy - including counselling.

2.4.5 Activities that clients like most or least

Table 2.5 Activities that clients like most or least

ACTIVITY MOST LIKED	1 x Table games, snooker 1 x Outings 1 x "Knowing your illness" education 1 x Meeting people 1 x Aerobic exercise/Dieting 1 x "All are good, no particular one"
ACTIVITY LEAST LIKED	1 x Gardening 1 x Craft 1 x Washing/cleaning up 1 x Creative art 1 x A few fellow clients 1 x None

The results of this question showed no consistent pattern among the clients. It seemed that the activity that clients liked most or least depended on their personal interest and/or experience.

2.4.6 Clients' satisfaction with the Living Skills Centre's programmes

Table 2.6 Clients' level of satisfaction with the Living Skills Centre's programmes

SATISFACTION **(Scale 1 – 10)**	2 x Rank 9 – 10 3 x Rank 6 – 8 1 x No response

Clients were asked to rank their satisfaction with the LSC's service by using a 10 point-likert scale, where 1 is very dissatisfied to 10 - very satisfied. The results indicated that two of them ranked the centre between 9 to 10; and three ranked between 6 - 8.

2.4.7 Further Improvements of the Living Skills Centres

Table 2.7 Further improvements required for the Living Skills Centres as perceived by the staff and clients

STAFF	CLIENT
Structural:	**Programme:**
* 5 x More space	* 3 x Centre opens more days and/or longer hour, incl. weekend
* 4 x More staff, incl. psychologist, vocational officer	* 2 x Metal/woodwork workshop
* 2 x More mobile treatment team	* 2 x Setting up work program
Programme:	**Other:**
* 3 x Better LSC's practice models and direction	* 2 x Better access/ transportation
Other:	
* 3 x To rename LSC	
* 2 x Sharing resources and ideas	
* 2 x State-wide standardised assessment on client	

Staff and clients were asked to suggest what further improvements were required by the LSCs in order to meet clients' needs. The suggested improvements were categorised as structural, such as space and staffing, and programme. The table only showed suggestions that were given by more than 20% (1) of the subjects of that group. It appeared that staff were more concerned about structural improvement while clients saw improvement in

programming as more important. This is another example of discrepancy in the perceptions of needs between staff and clients.

These findings can not be generalised to all LSCs; however, that was not the purpose of this qualitative study. The findings has helped to increase the knowledge about LSCs and an understanding of the issues which exist in the service. This study, using semi-structured interviews, has generated many questions and hypotheses for further research. Some of those questions, as listed below, were addressed in the questionnaire survey. Questions not addressed in the questionnaire are discussed in the Conclusion:

1. Does discrepancy in the perception of the purposes and functions of LSC, as well as treatment goals exist between staff and clients?
2. If such discrepancies exist, what are their characteristics? To what extent have these discrepancies affected the rehabilitation process?
3. What are the factors which will facilitate clients' attainment of intervention goals in the LSCs?
4. To what extent are the LSCs perceived as effective in rehabilitating or reintegrating people with mental illness into the community?

Furthermore, the results of this exploratory study have helped to develop appropriate questions and items to be included in the questionnaire. Subjects' commonly used words or phases were incorporated in order to make the questionnaire more "user-friendly" and valid.

CHAPTER THREE

A questionnaire survey on the purposes and functions of the Living Skills Centres according to staff and clients

CHAPTER THREE:

A questionnaire survey on the purposes and functions of the Living Skills Centres according to staff and clients

3.1 AIMS

In order to address the questions raised from the qualitative exploratory study and to further understand the perceived purposes and functions of LSCs according to staff and clients, a questionnaire survey was conducted. The aims of the survey were:

1. To investigate whether discrepancy in the perception of the purposes and functions of LSCs, as well as treatment goals generally exists between staff and clients;
2. To describe the characteristics/nature of any discrepancy;
3. To identify whether the factors perceived will facilitate client's attainment of intervention goals in the LSCs;
4. To investigate to what extent the LSCs are being perceived as effective in rehabilitating or reintegrating people with mental illness into the community;
5. To compare those perceptions of staff and clients who were currently in the LSCs with those who were not; and
6. To investigate any relationship between the discrepancy and rehabilitation outcome.

3.2 METHODOLOGY

3.2.1 Overview of research design

A cross-sectional survey by self-report questionnaire was employed as the methodology to investigate the perception of purposes and functions of Living Skills Centre according to staff and clients. The targeted subjects for this study were staff and clients who were working/attending the Living Skills Centres at the time of the survey. For the purpose of constructing the questionnaire, informal semi-structured interviews, which were described in the last chapter, were conducted with a small sample of staff and clients of three Living Skills Centres in Sydney Metropolitan area. Results and feedback from the exploratory study were incorporated whilst designing the questionnaire. Though two separate sets of questionnaire was developed for staff and client subjects, they both contained some identical questions so that comparison of data could be carried out during analysis (refer to Appendices IV & V: Survey Questionnaire for clients & staff).

3.2.2 Subjects

Random selection was made of ten (10) Living Skills Centres, or similar facilities, in Sydney metropolitan area and four (4) from the rural areas of New South Wales. The selection was based on a list supplied by the Life Skills Forum, N.S.W., which is made up of most of the Living Skills Centres in New South Wales. Staff and clients of those centres were invited to participate in this survey. For ease of identification in this study, this group of subjects was called the LSC group.

A comparison sample, non-LSC group, was also used which consisted of staff and clients, who were not working/attending a Living Skills Centre at the time of survey. Subjects for the non-LSC group were recruited by the use of a convenience sampling method through the directors or team leaders of several nominated community mental health teams. The client subjects were currently receiving other services from the community mental health teams. Both the LSC and non-LSC groups used the same questionnaire for staff and clients.

3.2.3 Procedure

The selected LSCs and community mental health teams were first informed by a letter regarding the survey about to take place and their agreement sought for participation (Refer to Appendices XI & XII). Then, they were phoned a few weeks later to confirm their participation. If human ethics approval for the study was required by individual LSCs or the research committee of the area health board to which the LSC belonged, a formal application was then submitted. (Example of such application is found in Appendix X.) Once approval had been given, questionnaires were either delivered in person or by mail to the centres or the community mental health teams. The reasons to deliver in person were three fold: 1) to ensure questionnaire was collected safely; 2) to answer any queries about the questionnaire; and 3) to save postage.

A trial-run of the questionnaire was conducted with a few staff and clients of a LSC. Comments and feedback were received regarding wording of the questions and structure of the questionnaire. Based on the results, further revision of content on the questionnaire was made.

Due to distance, time constraints as well as delays and difficulties in obtaining approvals from a few randomly selected LSCs, the researcher was only able to deliver the questionnaires to five out of those ten selected metropolitan LSCs in-person. Mailing method was used to send questionnaires to the rest of the subjects. The questionnaires were sent together with an introduction letter, (refer to Appendix XIII), and a self-addressed, return freepost envelope. A reminder note, (refer to Appendix XIV), was also sent to those selected LSCs and community mental health teams when they had not responded by returning the questionnaire 6 weeks after posting.

The returned questionnaires were collated and coded to be analysed by using the SPSS-Windows statistical package. As the data were mainly in nominal scale or ordinal scale, analysis by means of frequency counts, descriptive statistics and non-paramatric tests was adopted. All percentages in this report have been rounded up to the nearest whole numbers, thus the sum of the percentages may not be equal to 100 percent. Furthermore, prior to the statistical testings, the following adjustments had been applied to those ranking responses:

1. all the original rankings had been recoded into 3 different rankings, i.e.:

Rank 1 - 3	-	1
Rank 4 - 6	-	2
Rank > 6	-	3

2. Those responses which were a tick without a rank number have been replaced by the ranking values of medians-of-nearby-points.

3.3 RESULTS

3.3.1 Number of questionnaire received:

Three hundred and thirty (330) questionnaires were personally delivered or sent (120 for staff and 210 for clients). One hundred and fourteen questionnaires were received, of which 55 were from staff and 59 from the clients. The overall response rate was 35%, with staff 46% and clients 28% respectively, which was low as expected for questionnaire survey, particularly returns from country LSCs and the non-LSC group. However, there were good responses from those randomly selected LSCs which were visited by the researcher and the response rates were 68% and 70% of the total returns from staff and clients, respectively

Table 3.1 Response rate of the questionnaire survey

	LSC Group	Non-LSC Group	Total Questionnaire Sent	Total Questionnaire Received	Response Rate
STAFF	22	33	120	55	46%
CLIENT	49	10	210	59	28%
Total	81	43	330	114	35%

3.3.2 Regrouping of subjects

At the stage of sorting the data from the returned questionnaires, it was found that a few "corrupted" questionnaires were received, i.e. responses were not expected to be found in that group. The following Table illustrates the problem:

Table 3.2 Subjects who were currently working in or attending Living Skills Centres

	LSC Group		Non-LSC Group	
	Staff	Client	Staff	Client
YES	18	48	8	2
NO	4	1	25	8

There were four staff and one client of the LSC group not currently working in/attending a LSC. On the other hand, there were eight staff and two clients of the non-LSC group currently working in/attending a LSC. Since these "corrupted" responses provided invaluable information, the researcher chose to include the data for analysis. It was decided to swap those in the LSC group with the non-LSC group as convenient samples. However, they would be excluded from analysis when comparison was carried out between randomly selected LSC staff and clients.

3.3.3 Summaries of data after "regrouping"

3.3.3.1 STAFF

3.3.3.1.1 Current work settings

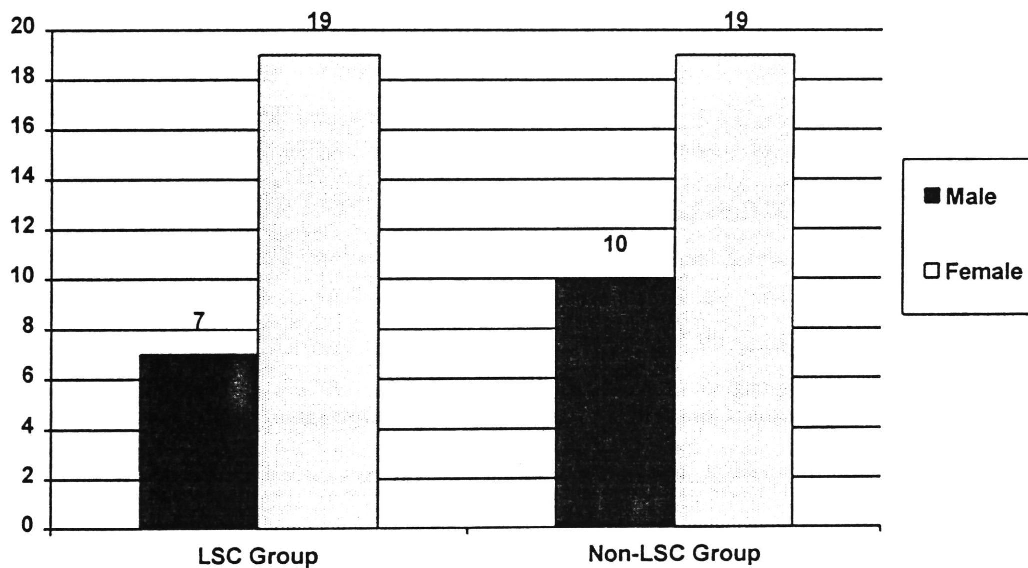
Among the fifty five (55) staff who had responded to the questionnaire, 26 of them were currently working in a LSC whilst the other 29 subjects were in a non-LSC setting but were still working in other community mental health services.

Table 3.3 Staff's current work settings

STAFF (N =55)	Working in a LSC setting - LSC Group	Working in a non-LSC setting - Non-LSC Group
	26 (47%)	29 (53%)

3.3.3.1.2 Sex distribution

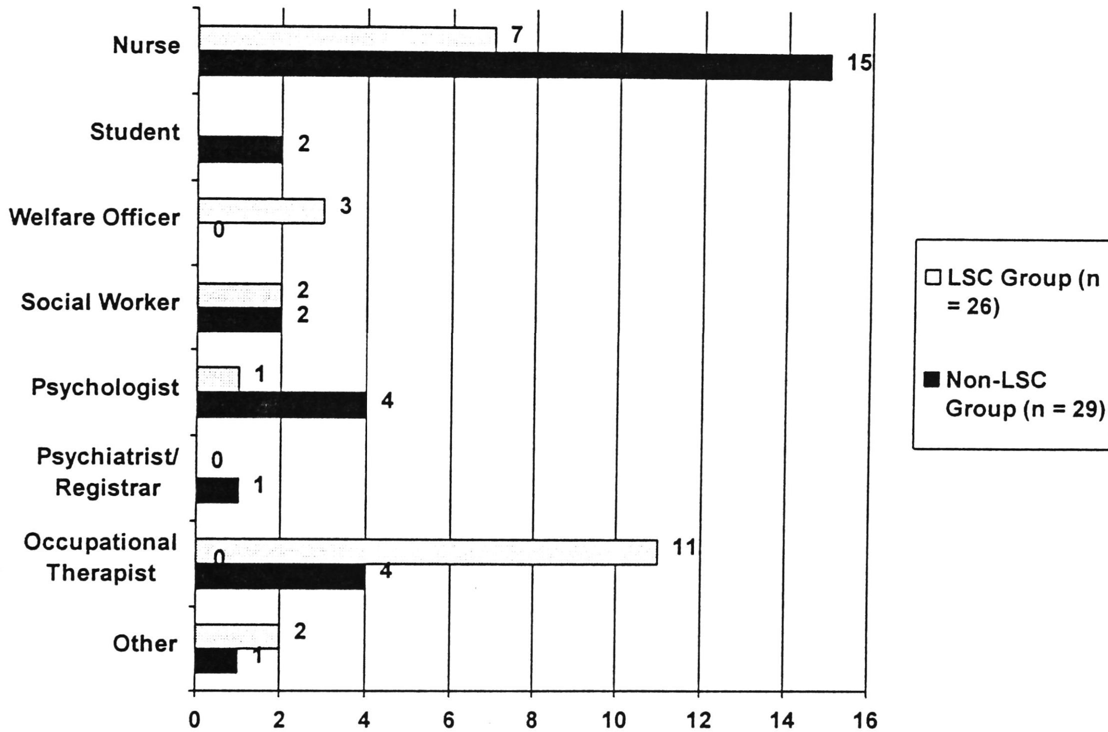
Figure 3.1 Sex distribution of staff



Nearly 75% of staff who worked in LSCs and over 60% of staff who worked in non-LSC settings were female.

3.3.3.1.3 Profession

Figure 3.2 Staff's professions



Over 40% of LSC staff in this survey were occupational therapists and nearly 30% of them were nurses. These figures appeared to represent the two major health care professional groups operating most of the LSCs in New South Wales. Over 50% of non-LSC staff who participated in this survey were also nurses.

3.3.3.1.4 Position

Table 3.4 Staff's positions at work

STAFF	LSC Group n = 26	Non-LSC Group n = 29	Total N = 55
Team leader		5 (17%)	5 (9%)
LSC/ Community Centre In-charge	6 (23%)	2 (7%)	8 (14%)
Staff of the Centre/CMH team	**20 (77%)**	**20 (69%)**	**40 (73%)**
Visitor/student		2 (6%)	2 (4%)

A majority of staff who participated in the survey were staff members either of the LSCs or the Community Mental Health teams, with nearly 80% in the LSC group and 70% in the non-LSC group.

3.3.3.1.5 Years of work experience in mental health/psychiatry

Table 3.5 Staff's years of work experience in mental health/psychiatry

STAFF	LSC Group (n = 26)	Non-LSC Group (n = 29)	Total N = 55
Less than or equal to 1 year	**8 (31%)**	6 (21%)	14 (25%)
2 - 5 years	4 (15%)	7 (24%)	11 (20%)
6 - 10 years	**8 (31%)**	6 (21%)	14 (25%)
11 - 15 years	3 (12%)	4 (14%)	7 (13%)
16 - 20 years	3 (12%)	5 (17%)	8 (14%)
More than 20 years		1 (3%)	1 (2%)
Average years of work experience	**6.92 years (S.D.= 5.99)**	**8.41 years (S.D.= 6.87)**	**7.73 years (S.D. = 6.45)**

S.D. = Standard Deviation

Over 30 % of LSC staff either had less than one year of working experience in mental health or had between 6 to 10 years of experience. The working experience among the staff in the non-LSC group appeared to be more

evenly spread out. The average years of work experience in mental health among the LSC subjects was 6.9 years, which was 2 years less than the mean of the non-LSC subjects.

3.3.3.1.6 Previous experience in Living Skills Centres

Table 3.6 Staff's previous experience in Living Skills Centres

STAFF	LSC Group n = 26	Non-LSC Group n = 29	Total N = 55
YES	**9 (35%)**	**4 (14%)**	**13 (24%)**
If 'Yes'			
Less than or up to 1 year	4 (45%)	1 (25%)	5 (38%)
2 - 5 years	3 (33%)	1 (25%)	4 (30%)
6 - 10 years	2 (22%)	1 (25%)	3 (23%)
NO	17 (65%)	25 (86%)	42 (76%)

Only a small number of LSC group (9) and non-LSC group (4) staff had previous experience in a LSC, 35% and 14%, respectively. Most of them worked in those LSCs for less than 5 years.

3.3.3.1.7 Years of working experience in Living Skills Centres

Table 3.7 Staff's years of work experience in Living Skills Centres

Less than or up to 1 year	**12 (46%)**
2 - 5 year ago	9 (35%)
6 - 10 years ago	3 (12%)
No response	2 (8%)
Mean = 2.85 years	**S.D. = 2.61**

For staff who were working in a LSC at the time of the survey, nearly 50% had been working there for less than one year. The average years of work experience in a LSC was 2 years and 9 months.

3.3.3.1.8 Major referring agents/persons to Living Skills Centres

Table 3.8 Major referring agents/persons as stated by the Centres' staff

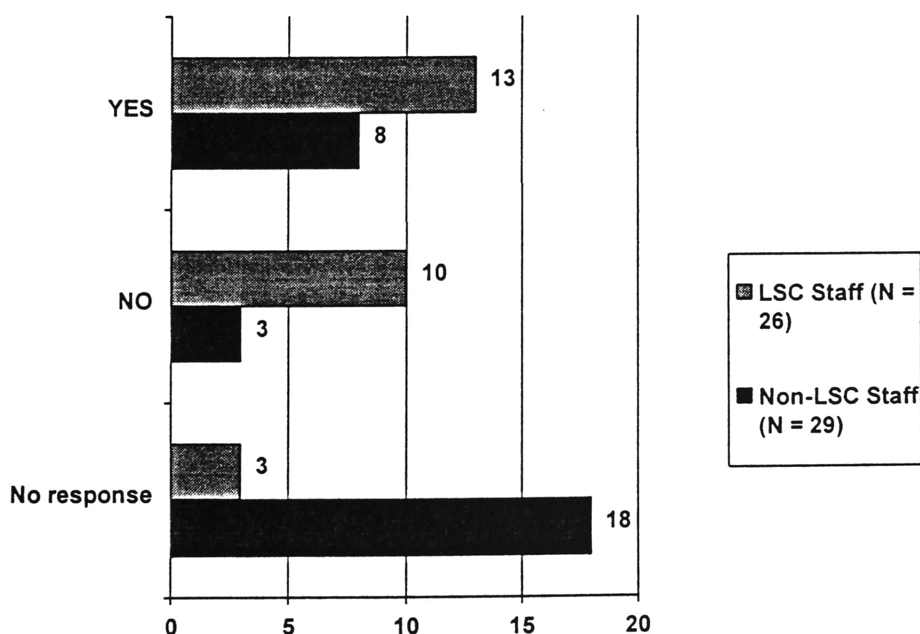
	n = 30*
Staff member of community mental health team	**24 (80%)**
Staff of psychiatric hospital	2 (7%)
Self	1 (3%)
No response	3 (10%)

* n is the total number of staff subjects who were currently working or previously worked in a LSC.

Eighty percent of staff who responded to this question stated that their referrals were mainly coming from staff members of community mental health team.

3.3.3.1.9 Referring agents' understanding of the purposes of Living Skills Centres

Figure 3.3 Referring agents' understanding of the purposes of Living Skills Centres as perceived by staff



Fifty percent (13) of LSC staff stated that the referring agents did understand the purposes of the LSCs.

3.3.3.1.10 The preferred methods to advise referring agents/persons about Living Skills Centres

Table 3.9 The preferred methods to advise referring agents/persons about Living Skills Centres as perceived by staff

Staff - LSC GROUP (n = 10)	**Frequency**	**Rank 1**	**Rank 2**	**Rank 3**	**TOTAL Rank 1 - 3**
Sending information pamphlets	**10**	3	4	1	**8 (80%)**
Writing letter	8	0	0	2	2 (25%)
Regular Open Day	9	2	2	1	5 (56%)
Attachment to the Centre for a period of time	9	6	1	1	**8 (89%)**
Regular Phone Call	8		1	4	5 (63%)
Other	2	1	1		2 (100%)

Among LSC staff (n = 10) who claimed that the referring agent did not understand the purposes of the LSCs, the two most preferred methods of advising the referring agents were: 1) sending information pamphlets; and 2) arranging them to attach to the Centre for a period of time.

3.3.3.1.11 Clients' understanding of the purposes of the Living Skills Centres when being referred

Table 3.10 Staff's perceptions of Clients' understanding of the purposes of the Living Skills Centres whilst referred

Staff	**LSC Group n = 26**	**Non-LSC Group n = 29**	**Total N = 55**
YES	1 (4%)		1 (2%)
NO	3 (12%)		3 (5%)
PARTLY UNDERSTAND	**18 (69%)**	10 (35%)	**28 (51%)**
I AM NOT SURE	1 (4%)	1 (3%)	2 (4%)
NO RESPONSE	3 (12%)	18 (62%)	21 (38%)

Nearly 70% of LSC staff perceived that clients partly understood the purposes of the LSC at the time when they were referred. Over 50% of all staff subjects perceived the same.

A *Chi-square test* for between group differences proved to be significance. There was also a greater association between the two variables, Work-setting (CENTRE) and Referring-agent's-understanding (REFERUND) *(chi-square value = 15.557, df = 2, p < 0.01, Cramer's V = 0.53182).*

A *Chi-square Test* was also used to find out whether the between group differences were significant as this variable (REFERUND) was crosstabulated with other variables: Profession (PROF), Position (POSITION), Sex (SEX) and Years-of-experience (YEAREXP). Results indicated that the differences were not significant either because the significant levels, p values, were greater than 0.05 or there were more than 25% of cells with expected frequency less than 5.

When a multivariable crosstabulation test was carried out between those variables with CENTRE as the control variable, the results indicated no differences were significant.

3.3.3.1.12 Perceived value of Living Skills Centres within mental health services

Table 3.11 Staff's perceptions of how Living Skills Centres being valued by other community mental health staff

	LSC Staff n = 26	Non-LSC Staff n = 29	Total N =55
Being valued more than other services	0	0	0
Being valued as much as other services	11 (42%)	5 (17%)	16 (29%)
Slightly being undervalued	6 (23%)	4 (14%)	10 (18%)
Generally being undervalued	6 (23%)	1 (3%)	7 (13%)
No response	3 (12%)	19 (66%)	22 (40%)

Over 40% of LSC staff felt that the LSC service was being valued as much as other services by community mental health teams. However, there was also slightly high proportion of them felt the service being undervalued by the teams. None of the staff who had responded to this question felt the LSC service being valued more than other services.

The following findings were obtained after applying the *Chi-square test* for group differences:

a) Between group

The difference was significant and there was a weak association between the variable CENTRE and LSCVAL. (*Chi-square value = 17.747, df = 3, p < 0.01, Cramer's V = 0.56804)*

b) Within group

I. Target group (n = 26) - The difference was not significant. (*Chi-square value = 5.0769, df = 3, p value is greater than 0.05).*

II. Control group (n = 10) - The difference was significant. *(Chi-square value = 26.5862, df = 3, p < 0.01).*

III. Total group (N = 55) - The difference was significant. (*Chi-square value = 9.6545, df = 3, p < 0.05)*

A *Chi-square Test* was also used to find out whether the differences were significant as the variable, Perceived-LSC's-value (LSCVAL) was crosstabulated with PROF, POSITION, SEX when comparing staff who were currently working in LSCs to those who were not. Results indicated none of the differences were significant.

When a multivariable crosstabulation test was carried out between those variables with CENTRE as the control variable, no result reached significance.

3.3.3.1.13 Discrepancy in goal setting

Table 3.12 Staff's perceptions of the discrepancy in goal setting in Living Skills Centres between staff and clients

	LSC Staff **n = 26**	**Non-LSC Staff** **n = 29**	**Total** **N = 55**
ALWAYS	1 (4%)		1 (2%)
SOMETIMES	**17 (65%)**	7 (24%)	24 (44%)
RARELY	3 (12%)	2 (7%)	5 (9%)
NEVER	2 (8%)	1 (3%)	3 (5%)
No response	3 (12%)	19 (66%)	22 (40%)

Sixty five percent of LSC staff found that the goals that they set for their clients in LSCs were sometimes different from the clients' own goals of attending the centres.

The results from a *Chi-square test* for between groups and within group differences indicated the differences failed to achieve significance

A *Chi-square Test* was also used to find out whether the differences were significant as the variable, Goal-setting (GOALDIF), was crosstabulated with PROF, POSITION, SEX when comparing LSC to non-LSC staff. Results indicated no differences reached significance.

3.3.3.1.14 Perceived purposes of Living Skills Centres

Table 3.13 Staff's perceptions of the purposes of Living Skills Centres for persons with mental illness

{Some of responses were a tick without giving a rank. This table shows frequency count only}

	LSC Staff (n = 26)	**Non-LSC Staff (n = 29)**
1. Prevent hospitalisation	23 (88%)	23 (79%)
2. Provide support and resources to live in the community	**25 (96%)**	**27 (93%)**
3. Assist and support family/carer to manage client's illness	22 (85%)	25 (86%)
4. Supervise daily medications	16 (61%)	21 (72%)
5. A convenient venue for staff to monitor client's progress	18 (69%)	22 (76%)
6. A place to engage in activities instead of being home alone or having nowhere to go	**25 (96%)**	**28 (97%)**
7. A place for making friends and socialising	**25 (96%)**	**27 (93%)**
8. Prepare for and assist in employment	22 (85%)	25 (86%)
9. Provide opportunities to rebuild self-confidence and self-esteem	**26 (100%)**	**28 (97%)**
10. Rebuild one's natural character	1 (4%)	2 (7%)
11. Education/ understanding illness	1 (4%)	
12. Other	2 (8%)	1 (3%)
13. I don't know		1 (3%)

* *Figure in italic and bold = Number of responses with no ranking given in that item.*

More than 90% of both LSC group and non-LSC group subjects thought the following four functions were the purposes of the LSC: 1) providing opportunities to rebuild self-confidence and self-esteem; 2) a place for making friends and socialising; 3) a place to engage in activities instead of being home alone or having nowhere to go; and 4) providing support and resources to live in the community. Surprisingly, nearly the same proportion of subjects in both groups responded to each of these four items.

A *Chi-square test* for between group differences of each item failed to achieve significance, except item 1 *(Chi-square values = 9.831, df = 2, p <0.01).* There was also no significant correlation between the variable CENTRE and each purpose item (PURPOS_X) where correlation coefficients, r values, were less than 0.5. The Kendall's tau-b test was carried out and the results indicated a high degree of disagreement in ranking of each item between the two groups.

Table 3.14 Results of the Kendall Test on the degree of agreement on the ranking orders of perceived purposes between the LSC and non-LSC staff

STAFF	**Kendall's tau-b test**
1. Prevent hospitalisation	0.438
2. Provide support and resources to live in the community	0.166
3. Assist and support family/carer to manage client's illness	0.146
4. Supervise daily medications	0.028
5. A convenient venue for staff to monitor client's progress	-0.061
6. A place to engage in activities instead of being home alone or having nowhere to go	-0.348
7. A place for making friends and socialising	-0.195
8. Prepare for and assist in employment	-0.320
9. Provide opportunities to rebuild self-confidence and self-esteem	-0.158

Those responses without a rank number were ranked using values of **medians-of-nearby-points.**

Table 3.15 Comparison of the first three ranking orders on the perceived purposes of Living Skills Centres between LSC and Non-LSC staff

	LSC Staff (N = 26)					**Non-LSC Staff (N = 29)**				
Ranking	**n***	**R1**	**R2**	**R3**	**M**	**n***	**R1**	**R2**	**R3**	**M**
1. Prevent hospitalisation	23	3	2	5	5	23	4%	4%		6
2. Provide support and resources to live in the community	**25**	**56%**	**28%**		**1**	**27**	**41%**	**15%**	**15%**	**2**
3. Assist and support family/carer to manage client's illness	22	9%	9%	14%	5	25		4%	4%	6
4. Supervise daily medications	16				8	21		10%		9
6. A convenient venue for staff to monitor client's progress	18				7	22		4%	4%	7
7. A place to engage in activities instead of being home alone or having nowhere to go	25	4%	12%	12%	4	**28**	**21%**	**18%**	**11%**	**3**
8. A place for making friends and socialising	25	12%	8%	8%	4	**27**	**22%**	**18%**	**11%**	**3**
9. Prepare for and assist in employment	22			9%	7	25	4%	8%	4%	5
10. Provide opportunities to rebuild self-confidence and self-esteem	**26**	**23%**	**23%**	**31%**	**3**	**28**	**29%**	**32%**	**32%**	**2**
11. Rebuild one's natural character	1		100%			2				
12. Education/ understanding illness	1					0				
13. Other	2		50%	50%	2.5	0				

*** n** is the total number of subjects who had ranked the answer, i.e. excluding those who ticked the answer or made no response.
M = Median rank

Most of the staff (over 90%) in both groups ranked the purposes items, "provide support and resources to live in the community" and "provide opportunities to rebuild self-confidence and self-esteem", as very important purposes of the LSCs, with ranking order between the first to third level of importance. However, about

50% of non-LSC staff (n = 28 and 27, respectively), as compared to less than 30% of LSC staff (n = 25), regarded the purposes, "a place to engage in activities instead of being home alone or having nowhere to go" and "a place for making friends and socialising" also as the very important purposes of the LSCs.

3.3.3.1.15 Perceived services of Living Skills Centres

Table 3.16 Staff's perceptions of the services of Living Skills Centres

{Some of responses were a tick without giving a rank. This table shows frequency count only}

	LSC Staff (N = 26)	**Non-LSC staff (N = 29)**
1. Supportive work programme and work skills training/Prevocational programme	19 (73%)	24 (83%)
2. Daily living skills training in the centre	22 (85%)	25 (86%)
3. In-vivo Daily living skills training	19 (73%)	23 (79%)
4. Assertive/social skills training	21 (81%)	25 (86%)
5. Provide opportunities to make friends and socialise	22 (85%)	**27 (93%)**
6. Provide opportunities for leisure activities	22 (85%)	**27 (93%)**
7. Provide programmes for client to spend time constructively during the day	22 (85%)	**27 (93%)**
8. Liaise with other community agents to assist client to live in the community	**24 (92%)**	25 (86%)
9. Provide education on medications and symptoms management to client and family/carer	21 (81%)	**27 (93%)**
10. Provide opportunities for group discussion to share problems and set goals	**23 (88%)**	**27 (93%)**
11. Case management		1 (3%)
12. Provide different level of activities to meet individual needs		1 (3%)
13. Support case management & client in goal setting and problem solving	2 (8%)	
14. Other		1 (3%)
15. I don't know		1 (3%)

* *Figure in italic and bold = Number of responses with no ranking in that item.*

Over 90% of non-LSC staff thought the LSC services should provide the following: 1) opportunities to make friends and socialise; 2) opportunities for

leisure activities; 3) programmes for clients to spend time constructively during the day; 4) education on medications and symptoms management to client and family/carer; and 5) opportunities for group discussion to share problems and set goals. In contrast, the only service item, that was agreed by over 90% of LSC staff to be one of the LSC's services, was "liaising with other community agents to assist client to live in the community."

A *Chi-square test* for between group differences of each item revealed that differences are non-significant. There was also no significant correlation between the variable CENTRE and each service items (SERVIC_X) where correlation coefficients, r values were less than 0.5. The Kendall's tau-b test was also carried out and the results indicated a high degree of disagreement in ranking of each item between the two groups.

Table 3.17 Results of the Kendall Test on the degree of agreement on the ranking orders of perceived services of Living Skills Centres between LSC and non-LSC staff

STAFF	Kendall's tau-b test
1. Supportive work programme and work skills training/Prevocational programme	-0.145
2. Daily living skills training in the centre	-0.072
3. In-vivo Daily living skills training	0.089
4. Assertive/social skills training	0.150
5. Provide opportunities to make friends and socialise	-0.088
6. Provide opportunities for leisure activities	-0.248
7. Provide programmes for client to spend time constructively during the day	-0.134
8. Liaise with other community agents to assist me to live in the community	0.311
9. Provide education on medications and symptoms management to client and family/carer	0.219
10. Provide opportunities for group discussion to share problems and set goals	-0.141
14. Other	-0.128

Those responses which were a tick without a rank number have been replaced by the ranking values of **medians-of-nearby-points.**

Table 3.18 Comparison of the first three ranking orders on the perceived services of Living Skills Centres between LSC and Non-LSC staff

	LSC Staff N = 26					**Non-LSC Staff N = 29**				
Ranking	**n***	**R1**	**R2**	**R3**	**M**	**n***	**R1**	**R2**	**R3**	**M**
1. Supportive work programme and work skills training/Prevocational programme	19	5%	21%	16%	7	24	12%	20%	4%	4.5
2. Centre-based daily living skills training	**22**	**27%**	**18%**	**5%**	3.5	**25**	**36%**	**4%**	**16%**	3
3. In-vivo Daily living skills training	19	11%	21%	11%	5	23	9%	17%	4%	6
4. Assertive/social skills training	21	5%	19%	19%	4	24	8%	16%	8%	4
5. Provide opportunities to make friends and socialise	22	14%		18%	5	27	7%	15%	11%	5
6. Provide opportunities for leisure activities	22	5%			7	27	7%	4%	19%	6
7. Provide programmes for client to spend time constructively during the day	22	18%	9%	14%	4	**27**	**30%**	**7%**	**15%**	3
8. Liaise with other community agents to assist me to live in the community	24	12%	4%	21%	4.5	25	8%	4%	8%	7
9. Provide education on medications and symptoms management to client and family/carer	21	10%		5%	6	27	4%	7%	7%	7
10. Provide opportunities for group discussion to share problems and set goals	23	9%	18%	13%	6	27	15%	15%	15%	4
11. Case management						1			100%	
12. Provide different level of activities to meet individual needs						1	100%			
13. Support case management & client in goal setting and problem solving	2	100%								
14. I don't know						1	100%			

* **n** is the total number of subjects who had ranked the answer, i.e. excluding those who ticked the answer or made no response. **M = Median rank**

Among the service item that were ranked by majority of the staff in both groups, it was revealed that:

1. Over 50% of staff in both groups, (n =22 for LSC staff; n=25 for non-LSC staff), ranked "daily living skills training in the centre" as one of the very important services that should be provided by the LSCs.
2. More than 50% of those non-LSC staff (n = 27), as compared to only about 41% of LSC staff (n = 22), ranked the service item, "provide programmes for client to spend time constructively during the day" between the first and third level of importance. The median ranking of the non-LSC staff on this service was 3 while the LSC's staff's was 4.

3.3.3.1.16 Perceived improvements in client's quality of life in community

Table 3.19 Staff's perceived improvements in client's quality of life in community

STAFF {Subjects could tick more than one answer}	**LSC Group** **N = 26**	**Non-LSC Group** **N = 29**
1. Able to make friends and socialise	**23 (89%)**	**23 (79%)**
2. Somewhere to go to spend time constructively	**22 (85%)**	**22 (76%)**
3. Able to learn skills to live in the community	20 (77%)	17 (59%)
4. Able to get help to prevent readmission to hospital	19 (73%)	12 (41%)
5. Able to get assistance and training for employment	11 (42%)	15 (52%)
6. Able to help the family/carer to cope with my mental illness	13 (50%)	15 (52%)
7. Able to help me to cope with my family/carer	13 (50%)	13 (45%)
8. Able to get assistance to live in group home	7 (27%)	11 (38%)
9. Able to comply taking medications	9 (35%)	7 (24%)
10. Able to learn how to manage symptoms	19 (73%)	17 (59%)
11. Able to gain self-confidence and self-esteem	**24 (92%)**	**21 (72%)**
12. Increase motivation to do things		
13. Increase life satisfaction		
14. Other		
15. Very little influence on my quality of life in the community		1 (3%)
16. I don't know	1 (4%)	2 (7%)

The following three improvements in client's quality of life were perceived by a large proportion of staff in both groups that the LSC had helped: 1) able to make friends and socialise; 2) somewhere to go to spend time constructively; and 3) able to gain self-confidence and self-esteem. The following three improvements were also perceived by over 70% of LSC staff that the LSC had helped: 1) able to learn skills to live in the community; 2) able to get help to prevent readmission to hospital; and 3) able to learn how to manage symptoms.

A *Chi-square test* for between group differences proved to be non-significant. An exception was Item 4, "able to get help to prevent readmission to

hospital", *(chi-square value = 5.60034, df = 1, $p < 0.05$)*. Correlation between the variable CENTRE and each Improving-client's-quality-of-life item (IMPROV_X) was shown to be non-significant as the correlation coefficient, r value was less than 0.5.

3.3.3.1.17 Perceived factors that assist clients to achieve their goals in Living Skills Centres

Table 3.20 Staff's perceived factors that assist clients to achieve their goals in Living Skills Centres

{Some of responses were a tick without giving a rank. This table shows frequency count only}

Staff	LSC Staff N = 26	Non-LSC Staff N = 29
1. Good relationship with centre's staff	**25 (96%)** ***2***	**25 (86%)**
2. Self motivation *[client's]*	19 (73%)	**25 (86%)**
3. Adequate staffing and facilities	21 (81%) ***1***	24 (83%)
4. Able to set own goals of rehabilitation	**22 (85%)** ***1***	23 (79%)
5. Staff motivation and dedication	**23 (88%)** ***1***	23 (79%)
6. Good liaison between centre and other community agents	19 (73%) ***1***	23 (79%)
7. Case manager assigned for each client in the centre	21 (81%) ***1***	23 (79%)
8. Varieties of programmes and activities in the centre	**22 (85%)**	**26 (90%)**
9. Opportunities to practice learned skills outside the centre	19 (73%) ***2***	22 (76%)
10. Case manager for overall management of client's rehabilitation	2 (8%)	1 (3%)
11. Develop clear goals of centre in collaboration with clients		1 (3%)
12. Other	1 (4%)	
13. I don't know		1 (3%)

** Figure in italic and bold = Number of responses with no ranking in that item.*

"Good relationship with centre's staff" was seen by the LSC staff as the most important factor that would assist a client to achieve his/her goals in the LSC while the non-LSC group saw "varieties of programmes and activities in the

centre" as the most important factor. Other factors that were perceived by 85% or more staff in the LSC group included: 1) able to set own goals of rehabilitation; 2) staff motivation and dedication; and 3) varieties of programmes and activities in the centre. Over 85% of non-LSC staff agreed on the factors including: 1) good relationship with centre's staff; and 2) client's self motivation.

A *Chi-square test* for between group differences of each item proved to be non-significant. There was also no significant correlation between the variable CENTRE and each of the Goal-achievements (GOALAC_X) where correlation coefficients were less than 0.5. The Kendall's tau-b test was also carried out and the results indicated a high degree of disagreement in ranking of each item between the two groups.

Table 3.20 The results of Kendall Test on the degree of agreement on the ranking orders of perceived assisting factors between LSC and Non-LSC staff

STAFF	Kendall's tau-b test
1. Good relationship with centre's staff	0.100
2. Self motivation	0.046
3. Adequate staffing and facilities	-0.285
4. Able to set own goals of rehabilitation	0.032
5. Staff motivation and dedication	-0.111
6. Good liaison between centre and other community agents	0.196
7. Case manager assigned for each client in the centre	-0.024
8. Varieties of programmes and activities in the centre	0.042
9. Opportunities to practice learned skills outside the centre	0.121
10. Case manager for overall management of client's rehabilitation	0.5

Those responses which were a tick without a rank number have been replaced by the ranking values of **medians-of-nearby-points.**

Table 3.22 Comparison of the first three ranking orders of perceived assisting factors between LSC and Non-LSC staff

STAFF	LSC Staff N = 26					Non-LSC Staff N = 29				
Ranking	n*	R1	R2	R3	M	n*	R1	R2	R3	M
1. Good relationship with centre's staff	23	30 %	9%	22 %	3	25	28 %	8%	12 %	4
2. Self motivation	19	47 %	11 %	5%	2	25	32 %	20 %	8%	2
3. Adequate staffing and facilities	20	10 %	10 %	5%	5	24	25 %	8%	17 %	3.5
4. Able to set own goals of rehabilitation	21	14 %	24 %	24 %	3	23	17 %	17 %	17 %	3
5. Staff motivation and dedication	22	9%	18 %	14 %	5	23	9%	26 %	13 %	4
6. Good liaison between centre and other community agents	18		17 %	6%	5	23	4%	9%	4%	6
7. Case manager assigned for each client in the centre	21	19 %	10 %	10 %	4	23	4%	13 %	22 %	4
8. Varieties of programmes and activities in the centre	22	8%	14 %	14 %	5	26	19 %	4%	4%	5
9. Opportunities to practice learned skills outside the centre	14	14 %		14 %	6	22	5%	9%	14 %	7
10. Case manager for overall management of client's rehabilitation	2			50 %	3	1				
11. Develop clear goals of centre in collaboration with clients						1	100 %			
12. Other	1					1	100 %			

*** n is the total number of subjects who had ranked the answer, i.e. excluding those who ticked the answer or made no response.**
M = Median rank

About 60% of staff subjects in both groups who had ranked the factors (n = 19 and 21 for LSC staff; n = 25 and 23 for non-LSC staff, respectively), "self motivation (client's)" and "able to set own goals of rehabilitation", as the two most important factors. Fifty percent of the non-LSC staff (n = 24), as compared to only 25% of LSC staff (n = 20) perceived adequate staffing and facilities in the LSCs was

one of the most important factors. On the other hand, 61% of LSC staff (n = 23), compared to less than 50% of non-LSC staff (n = 25), regarded good relationship with centre's staff as one of the most important factors.

3.3.3.1.18 Perceived future improvements required for Living Skills Centres

Table 3.23 Staff's perceived future improvements required for Living Skills Centres

{Some of responses were a tick without giving a rank. This table shows frequency count only}

STAFF	LSC Staff N = 26		Non-LSC Staff (N = 29)
1. More staff	19 (73%)	*1*	**19 (65%)**
2. More facilities and space	20 (76%)	*1*	18 (62%)
3. Better informed about the centre prior attending	14 (54%)		16 (55%)
4. Better liaison with other community resources/ services	**21 (81%)**	*2*	18 (62%)
5. Better defined role and direction for the centre within the community mental health service	**21 (81%)**	*1*	**23 (79%)**
6. More specialised services to meet the needs of clients of different levels of ability/ functioning	**22 (85%)**	*2*	**23 (79%)**
7. Better access to public transports	9 (35%)	*1*	16 (55%)
8. Have more activities	6 (23%)	*2*	11 (38%)
9. Not to have too many activities	4 (15%)		7 (24%)
10. More autonomy to choose activities	11 (42%)	*2*	15 (52%)
11. Change to a more appropriate name for the centre	4 (15%)		12 (41%)
12. Abolish the centre and replace it with other services	3 (11%)		9 (31%)
13. Providing help to be independence to live away from home			
14. Reorganise service based on community team rather than specialised services	1 (4%)		
15. Other			3 (10%)
16. No further improvement required			1 (3%)
17. I don't know			3 (10%)

* *Figure in italic and bold = Number of responses with no ranking in that item.*

The three future improvements of LSC that had the highest frequency counts (over 80%) of the LSC staff were: 1) more specialised services to meet the

needs of clients of different levels of ability/functions; 2) better defined role and direction for the centre within the community mental health service; and 3) better liaison with other community resources or services. While the non-LSC staff agreed with the first two, the third one with highest frequency was " more staff"

A *Chi-square test* for between group differences of each item failed to achieve significance. There was also no significant correlation between the variable, CENTRE and each improvement item (IMPROV_X) where r < 0.5. The results of Kendall's tau-b test, however, indicated a high degree of disagreement in ranking of each item between the two groups.

Table 3.24 Results of the Kendall Test on the degree of agreement on the ranking orders of the perceived future improvements between LSC and Non-LSC staff

STAFF	Kendall's tau-b test
1. More staff	0.309
2. More facilities and space	-0.083
3. Better informed about the centre prior attending	0.150
4. Better liaison with other community resources/ services	0.148
5. Better defined role and direction for the centre within the community mental health service	-0.015
6. More specialised services to meet the needs of clients of different level of ability/ functioning	0.074
7. Better access to public transports	-0.024
8. Have more activities	-0.274
9. Not to have too many activities	-0.239
10. More autonomy to choose activities	0.038
11. Change to a more appropriate name for the centre	0.105
12. Abolish the centre and replace it with other service	0.293

Those responses which were a tick without a rank number have been replaced by the ranking values of **medians-of-nearby-points.**

Table 3.25 Comparison of the first three ranking orders of the perceived future improvements between LSC and Non-LSC staff

STAFF	**LSC Staff N = 26**					**Non-LSC Staff N = 29**				
Ranking	n*	R1	R2	R3	M	n*	R1	R2	R3	M
1. More staff	**18**	**33%**	**11%**	**22%**	**3**	19	32%	5%		4
2. More facilities and space	**19**	**26%**	**21%**	**16%**	**2.75**	**18**	**33%**	**22%**	**17%**	**2**
3. Better informed about the centre prior attending	14	7%	14%	14%	4.5	16		12%	25%	6
4. Better liaison with other community resources/ services	19	5%	5%	37%	**3**	18		11%	33%	4.5
5. Better defined role and direction for the centre within the community mental health service	**20**	**30%**	**30%**	**5%**	**2**	**23**	**35%**	**13%**	**22%**	**3**
6. More specialised services to meet the needs of clients of different level of ability/ functioning	**20**	**20%**	**35%**	**20%**	**2**	**23**	**22%**	**30%**	**13%**	**2**
7. Better access to public transports	8	12%	12%		7	16	12%		6%	6.5
8. Have more activities	6				9	11	18%			6
9. Not to have too many activities	4				11	7				10
10. More autonomy to choose activities	9				5	15		7%	13%	7
11. Change to a more appropriate name for the centre	4	25%			6.5	12	8%	17%		8.5
12. Abolish the centre and replace it with other service	3	33%			7	9				12
13. Providing help to be independence to live away from home										
14. Reorganise service based on community team rather than specialised services	1									
15. Other						3	33%			6
16. No further improvement required						1	100%			2
17. I don't know						3	100%			

* **n** is the total number of subjects who had ranked the answer, i.e. excluding those who ticked the answer or made no response.
M = median rank

Over 65% of staff in both groups who ranked the items, (n = 20 for LSC staff; n = 23 for non-LSC staff), agreed that the most important future improvement of LSCs included "better defined role and direction for the centre within the community mental health service" and "more specialised services to meet the needs of clients of different levels of ability/functioning".

More than 60% of staff in both groups, (n = 19 for LSC staff, n = 18 for non-LSC staff), also regarded having more facilities and space in the centre as one of the most important future improvements. On the other hand, 66% of LSC staff (n =18), compared to less than 40% of non-LSC staff (n = 19), perceived having more staff as one of the priority for future improvement.

3.3.3.1.19 Importance of Living Skills Centres in improving client's quality of life in the community

Table 3.26 Staff's perceived level of importance of Living Skills Centres in improving client's quality of life in the community

STAFF	LSC Staff N = 26	Non-LSC Staff N = 29	Total N = 55
Most important	9 (35%)	9 (31%)	18 (33%)
Just as important as other services	15 (58%)	18 (62%)	33 (60%)
I am not sure	1 (4%)	1 (3%)	2 (4%)
Not as important as other services	1 (4%)		1 (2%)
Not important at all		1 (3%)	1 (2%)

Nearly 60% of staff of both groups perceived the LSC was just as important as other services in improving the quality of life of person with mental illness in the community. Thirty-five percent and thirty-one percent of LSC staff and non-LSC

staff, respectively, perceived the LSC was most important in improving client's quality of life.

A *Chi-square test* proved the within group differences to be significant (*Chi-square values: Target group = 21.3846, df = 3; Control group = 27.1379, df = 3; Total = 74.0, df = 4, $p < 0.01$).* However the same test failed to achieve significance in terms of the differences between the two groups.

3.3.3.2 CLIENTS

3.3.3.2.1 Current treatment setting

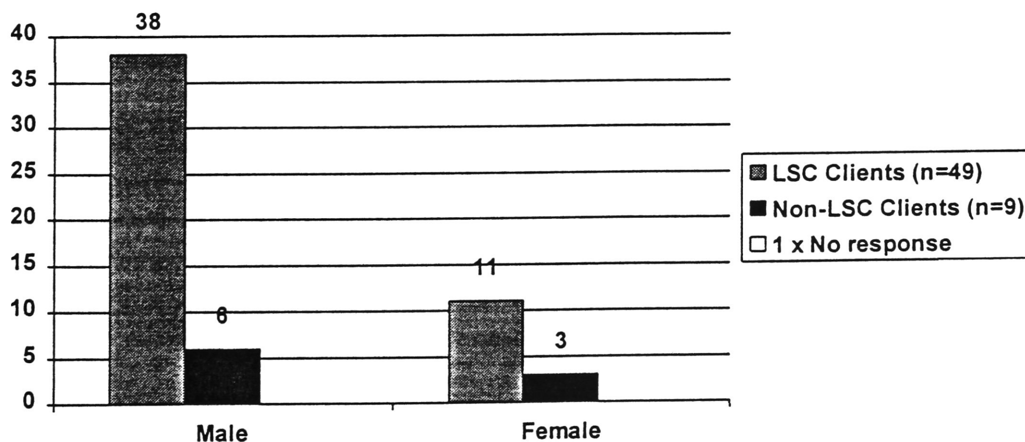
Among all the client subjects (N = 59), eighty-five percent of them were attending LSCs at the time of the survey. Probably due to the small number of non-LSC clients (n = 9), when LSC clients data was compared with non-LSC clients data, the statistical tests for the differences between two groups failed to achieve significance.

Table 3.27 Clients' current treatment settings

Number of clients currently attending LSC	Number of clients currently not attending
85% (50)	15% (9)

3.3.3.2.2 Sex distribution

Figure 3.4 Sex distributions of clients



Over 75% of LSC clients and nearly 70% of Non-LSC clients were male.

3.3.3.2.3 Age

Table 3.28 Age distributions of clients

CLIENTS	LSC CLIENTS	NON-LSC CLIENTS
Less than 21 years old		
21 - 30 years old	9 (18%)	1 (11%)
31 - 40 years old	**17 (34%)**	**5 (56%)**
41 - 50 years old	**16 (32%)**	**1 (22%)**
More than 50 years old	7 (14%)	2 (11%)
No response	1 (2%)	
Average Age	**40.46 years old S.D. = 9.51**	**41 years old S.D. = 9.82**

The average age of clients in both groups was nearly the same. The majority of the subjects (nearly 70%) were between the age of 31 to 50.

3.3.3.2.4 Birth places

Table 3.29 Birth places of clients and their parents

CLIENTS		LSC CLIENTS N = 50	NON-LSC CLIENTS N = 9	TOTAL N = 59
FATHER	AUSTRALIA	**30 (66%)**	4 (44%)	37 (63%)
	OVERSEAS	15 (30%)	5 (56%)	20 (34%)
	No response	2 (4%)		2 (3%)
MOTHER	AUSTRALIA	**31 (62%)**	4 (44%)	35 (59%)
	OVERSEAS	15 (30%)	5 (56%)	20 (34%)
	No response	4 (8%)		4 (7%)
CLIENT	AUSTRALIA	**41 (82%)**	6 (67%)	47 (80%)
	OVERSEAS	9 (18%)	3 (33%)	12 (20%)

More than 60% of clients in the LSC clients reported that their parents were both born in Australia, as compared to 44% of those in the non-LSC group. Over

80% of LSC clients and nearly 70% of clients in the non-LSC group were born in Australia.

3.3.3.2.5 Accommodation

Table 3.30 Types of accommodation where clients live

CLIENTS	LSC CLIENTS N = 50	NON-LSC CLIENTS N = 9	TOTAL N = 59
FAMILY	16 (32%)	5 (57%)	21 (36%)
FRIEND	2 (4%)		3 (3%)
GROUP HOME	6 (12%)	1 (11%)	7 (12%)
ALONE	22 (44%)	2 (22%)	24 (41%)
BOARDING HOUSE	1 (2%)		1 (2%)
NURSING HOME	1 (2%)		1 (2%)
HOSTEL	1 (2%)		1 (2%)
OTHER	1 (2%)		1 (2%)
No response		1 (11%)	1 (2%)

Over 75% of clients in both group were reported to be either living alone or with families.

3.3.3.2.6 Years of mental illness

Table 3.31 Years of mental illness among the clients

CLIENTS	LSC CLIENTS N = 50	NON-LSC CLIENTS N = 9	TOTAL N = 59
Less than 1 years ago	3 (6%)		3 (5%)
1 - 5 years ago	3 (6%)	2 (22%)	5 (9%)
6 - 10 years ago	12 (24%)	4 (44%)	16 (27%)
11 - 15 years ago	9 (18%)	1 (11%)	10 (17%)
16 - 20 years ago	7 (14%)	1 (11%)	8 (14%)
More than 20 years ago	11 (22%)		11 (19%)
No response	5 (10%)	1 (11%)	6 (10%)
Mean	**14.18 years ago S.D. = 9.19**	**13.0 years ago S.D. = 9.47**	**14.0 years ago S.D. = 9.15**

Subjects might have had mental illness or have been seeing a private psychiatrist prior to the first admission to the mental health service. Most of the clients (over 75%) in both groups appeared to have at least a 5 years history of mental illness with the average 14 years and 13 years among the LSC clients and the non-LSC clients, respectively.

3.3.3.2.7 Previous attendance at Living Skills Centre

Table 3.32 Clients' previous attendance at Living Skills Centres

CLIENTS	LSC CLIENTS N = 50	NON-LSC CLIENTS N = 9
YES	21 (42%)	1 (11%)
NO	29 (58%)	7 (78%)
No response		1 (11%)

3.3.3.2.8 Years of attending Living Skills Centre

Table 3.33 Clients' periods of attendance at Living Skills Centres

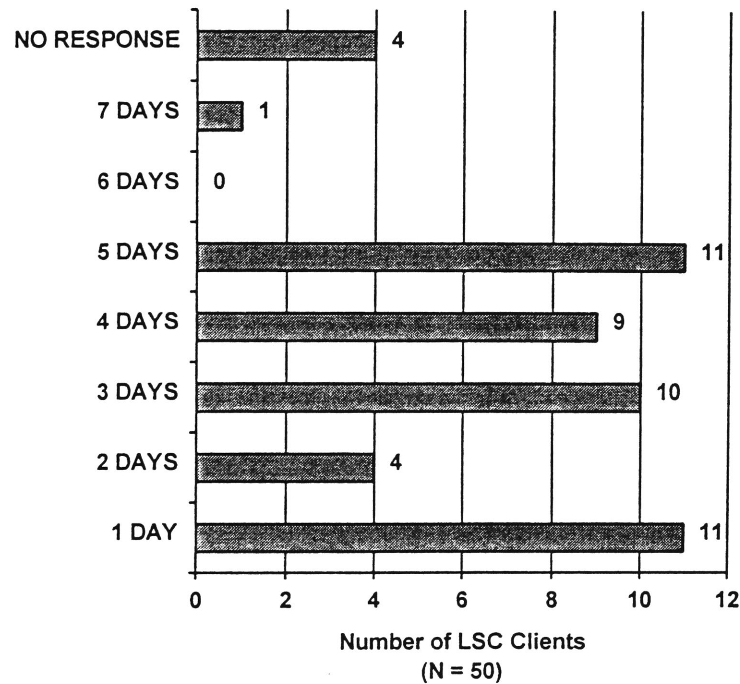
CLIENTS	LSC CLIENTS N = 50	NON-LSC CLIENTS N = 9
Less than 1 year ago	5 (10%)	
1 - 5 years ago	21 (42%)	
6 - 10 years ago	10 (20%)	
11 - 15 years ago	2* (4%)	
16 - 20 years ago		
More than 20 years ago	10* (21%)	1* (100%)
No response	2 (4%)	8 (80%)

* Some clients might have misinterpreted community (mental health) centre as LSC. Though the first formal LSC was established in 1977, most of the LSCs were established in the 1980s.

At the time of survey, over 50% of clients in the LSC group had been attending the LSCs for up to 5 years.

3.3.3.2.9 Days of attendance at Living Skills Centre

Figure 3.5 Number of days (per week) of attendance at Living Skills Centres by clients



On average, clients attended the LSCs 3 days a week, (Mean = 3.2 days and Standard Deviation = 1.6 days).

3.3.3.2.10 Referring agents/persons

Table 3.34 Clients' referring agents/persons to Living Skills Centres

	LSC CLIENTS N = 50
Case manager*	22 (44%)
other community mental health team member	8 (16%)
Psychiatric hospital	11 (22%)
Psychiatrist	3 (6%)
family doctor	2 (4%)
self	1 (2%)
Other	1 (2%)
No response	2 (4%)

* "Case manager" was not being clearly defined and might have been confused with other categories by the client subjects.

60% of clients, who were attending the LSCs, were either referred by their case manager or staff members of the community mental health team.

3.3.3.2.11 Reasons given for referring to Living Skills Centres

Table 3.35 Reasons given for referring to Living Skills Centres as reported by the clients

	LSC CLIENTS N = 50
Yes	**32 (64%)**
No	6 (12%)
Can't remember	8 (16%)
No response	4 (8%)

Table 3.36 The frequency counts of reasons given for referring to Living Skills Centres as reported by clients

(If YES, What were the reasons given for attending LSC?)	**LSC CLIENTS N = 50***	**LSC CLIENTS n = 32****
1. Prevent readmission to hospital	17 (34%)	14 (44%)
2. Obtain training and support to live in the community	14 (28%)	12 (38%)
3. Obtain assistance in managing mental illness	**20** (40%)	**16** (50%)
4. Obtain medications	2 (4%)	2 (6%)
5. Make friends and socialise with other people	**22** (44%)	**18** (56%)
6. Have something to do, instead of being home alone or having no where to go during the day	**22** (44%)	**18** (56%)
7. Obtain training or assistance in finding job	7 (14%)	7 (22%)
8. Doctor's instruction / recommendation		
9. Other		
10. I can not remember	3 (6%)	

* Percentage of LSC clients who chose this answer. A few subjects claimed reasons were not given also responded to this question.

** **Number of client subjects who claimed that reasons were given when referred to LSC**

Over 60% of clients stated that reasons for the referral were given when they were referred to the LSC and more than 50% of them stated the reasons given included: 1) to make friends and socialise with other people; 2) to have something to do, instead of being home alone or having no where to go during the day; and 3) to obtain assistance in managing mental illness.

3.3.3.2.12 Referring agents' understanding of the purposes of Living Skills Centres

Table 3.37 Referring agents' understanding of the purposes of Living Skills Centres as perceived by clients

	LSC CLIENTS N = 50	NON-LSC CLIENTS N = 9
Yes	**36 (72%)**	1 (11%)
No	3 (6%)	
I am not sure	10 (20%)	3 (33%)
No response	1 (2%)	5 (56%)

Over 70% of LSC clients perceived that the referring agents did understand the purposes of the LSCs.

3.3.3.2.13 Preferred methods of being informed about the purposes of Living Skills Centres prior to attendance

Table 3.38 Clients' preferred methods of being informed about the purposes of the Living Skills Centres prior to attendance

LSC Clients	Rank 1	2	3	4	5	6	7	No ranking given	Total
Received information pamphlets	2% (1)	4% (2)	8% (4)	6% (3)	10% (5)	20% (10)	2% (1)	2% (1)	54% (27)
A letter from the centre	4% (2)	2% (1)	12% (6)	12% (6)	8% (4)	10% (5)		8% (4)	56% (28)
Visit the centre	10% (5)	16% (8)	8% (4)	8% (4)	8% (4)			14% (7)	**64% (32)**
Trial period at the centre	10% (5)	6% (3)	8% (4)	8% (4)	8% (4)	10% (5)		8% (4)	**58% (29)**
Phone call from centre staff	14% (7)	8% (4)	8% (4)	4% (2)	14% (7)	2% (1)		6% (3)	56% (28)
Clear explanation by referring person/agent	28% (14)	8% (4)	4% (2)	8% (4)		6% (3)		16% (8)	**70% (35)**
Informed by relatives/friends	4% (2)								4% (2)
Other							2% (1)		2% (1)

The most preferred methods, by the LSC clients (70%), of being informed about the purposes of the centres before attending was a clear explanation by referring person/agent. The other more preferred methods included visiting the centres and having a trial at the centres.

3.3.3.2.14 Most/Least liked activities in Living Skills Centres

Table 3.39 Clients' most liked activities in Living Skills Centres

	LSC CLIENTS N = 50
Crafts	4 (8%)
Sports	7 (14%)
Discussion/ Verbal group	6 (12%)
Living skills training	3 (6%)
Art/Painting	4 (8%)
Socialising/ Making friends	5 (10%)
Work program	2 (4%)
Woodwork	1 (2%)
Outings	8 (16%)
Relaxation/ Stress Management	1 (2%)
Other	4 (8%)
No response	5 (10%)

There seemed to be no consistent pattern observed when comparing the least liked to the most liked activities in the LSCs. However, clients tended to come up with more preferred activities than non-performed activities.

Table 3.40 Clients' least liked activities in Living Skills Centres

	LSC CLIENTS N = 50
Crafts	2 (4%)
Sports	4 (8%)
Discussion/ Verbal group	6 (12%)
Living skills training	2 (4%)
Art/Painting	3 (6%)
Socialising / making friends	
Work program	2 (4%)
Woodwork	
Outings	1 (2%)
Relaxation/ Stress Management	
Other	8 (16%)
No response	22 (44%)

3.3.3.2.15 Discrepancy in goal setting

Table 3.41 Clients' perceptions of the discrepancy in goal setting between clients and staff at Living Skills Centres

	LSC CLIENTS N = 50	NON-LSC CLIENTS N = 9
All are different	11 (22%)	
Some are different	14 (28%)	
Very few are Different	8 (16%)	
No different	14 (28%)	1* (11%)
No response	3 (6%)	8 (89%)

* Previously attended LSC.

Fifty percent of LSC clients thought their own goals of attending the LSCs were different from the goals set by the staff. However, nearly 30% thought their goals were not different from the staff's goals.

3.3.3.2.16 Satisfaction with Living Skills Centres' services

Table 3.42 Clients' levels of satisfaction with Living Skills Centres' services

	LSC CLIENTS N = 50	NON-LSC CLIENTS N = 9
Very Satisfied	**22 (44%)**	
Satisfied	**14 (28%)**	**1**
I am not sure	4 (8%)	
Dissatisfied	1 (2%)	
Very Dissatisfied	1 (2%)	
No response	8 (16%)	

More than 70% of LSC clients were either satisfied or very satisfied with the LSC's services.

3.3.3.2.17 Perceived improvements in clients' quality of life in community

Table 3.44 Clients' perceived improvements in their quality of life in community

{Subjects could tick more than one answer}	LSC CLIENTS* N = 50
Able to make friends and socialise	**25 (50%)**
Somewhere to go to spend time constructively	**26 (52%)**
Able to learn skills to live in the community	17 (34%)
Able to get help to prevent readmission to hospital	20 (40%)
Able to get assistance and training for employment	13 (26%)
Able to help the family/carer to cope with my mental illness	8 (16%)
Able to help me to cope with my family/carer	10 (20%)
Able to get assistance to live in group home	6 (12%)
Able to comply taking medications	9 (18%)
Able to learn how to manage symptoms	14 (28%)
Able to gain self-confidence and self-esteem	24 (48%)
Increase motivation to do things	1 (2%)
Increase life satisfaction	1 (2%)
Other	2 (4%)
Very little influence on my quality of life in the community	5 (10%)
I don't know	2 (4%)

* Percentage of LSC clients who chose this answer.

Fifty percent of LSC clients claimed the LSC had helped to improve their quality of life in the community by having ability to make friends and socialise and having somewhere to go to spend time constructively.

3.3.3.2.18 Main reasons for not attending Living Skills Centres

Table 3.44 Main reasons for clients not to attend Living Skills Centres

	LSC CLIENTS * n = 50	NON-LSC CLIENTS n = 9
Never been referred	4	
Not interested	3	2
Not sure about the purposes of LSC	2	2
Not able to get to the centre	2	1
Don't like the program	1	1
Never been told such service exists	2	1
Don't need such service		1
Employed/ Back to work	1	
Medical condition/ too sick	1	
Other	2	1
No response	32	

* Those in the LSC group who responded to this question might imply that the reason they did not attend LSC in the past or the reason why they occasionally did not turn up at LSC.

The reasons given by those who had never attended LSC (n = 9) included: 1) not interested; 2) not sure about the purposes of LSC; 3) not able to get to the centre; 4) did not like the programme; 5) never been told such service exists; and 6) did not need such service.

3.3.3.2.19 Perceived purposes of Living Skills Centres

Table 3.45 Clients' perceived purposes of Living Skills Centres

{Some of responses were a tick without giving a rank. This table shows frequency counts only}

	LSC CLIENTS N = 50			NON-LSC CLIENTS N = 9		
Prevent hospitalisation	**36**	**(72%)**	***8***	4	(44%)	***1***
Provide support and resources to live in the community	31	(62%)	***7***	3	(33%)	***1***
Assist and support family/carer to manage client's illness	22	(44%)	***2***	3	(33%)	***1***
Supervise daily medications	22	(44%)	***2***	2	(22%)	
A convenient venue for staff to monitor client's progress	29	(58%)	***6***	2	(11%)	
A place to engage in activities instead of being home alone or having nowhere to go	**40**	**(80%)**	***8***	7	**(78%)**	***1***
A place for making friends and socialising	**36**	(72%)	***8***	5	**(56%)**	
Prepare for and assist in employment	23	(46%)	***3***	4	(4 4%)	***1***
Provide opportunities to rebuild self-confidence and self-esteem	32	(64%)	***8***	5	**(56%)**	***1***
Rebuild one's natural character	1	(2%)	***1***			
Education/ understanding illness	1	(2%)	***1***			
Other	1	(2%)	***1***			
I don't know	1	(2%)		2	(22%)	

** Figure in italic and bold = Number of responses with no ranking given in that item.*

Eighty percent of LSC clients and nearly 80% of the non-LSC clients perceived the LSCs as a place to engage in activities instead of being home alone or having nowhere to go. More than 70% of LSC clients also saw the centres serve the purpose of preventing hospitalisation and being a place for making friends and socialising. More than 55% of the non-LSC clients thought the LSC having the purpose of being a place for making friends and socialising, and providing opportunities to rebuild self-confidence and self-esteem.

The Kendall's tau-b test was also carried out and the results indicated disagreement in ranking of each item between two groups.

Table 3.46 Results of the Kendall Test on the degree of agreement on the ranking orders of perceived purposes between LSC and Non-LSC clients

Client	**Kendall's tau-b test**
1. Prevent hospitalisation	0.073
2. Provide support and resource to live in the community	0.167
3. Assist and support family/carer to manage client's illness	-0.216
4. Supervise daily medications	-0.071
5. A convenient venue for staff to monitor client's progress	-0.036
6. A place to engage in activities instead of being home alone or having nowhere to go	-0.071
7. A place for making friends and socialising	-0.230
8. Prepare for and assist in employment	-0.298
9. Provide opportunities to rebuild self-confidence and self-esteem	0.144

* **n** is the total number of subjects who had ranked the answer, i.e. excluding those who ticked the answer or made no response.

Table 3.47 Comparison of the first three ranking orders of the perceived purposes of Living Skills Centres between LSC and Non-LSC clients

	LSC CLIENTS N = 50					NON-LSC CLIENTS N = 9				
Ranking	n*	R1	R2	R3	<u>M</u>	n*	R1	R2	R3	<u>M</u>
1. Prevent hospitalisation	**28**	**50%**	**14%**	**14%**	**1.5**	3	33%		33%	3
2. Provide support and resource to live in the community	24	29%	17%	25%	2.5	2			50%	5
3. Assist and support family/carer to manage client's illness	20	15%		5%	5	2	50%			2.5
4. Supervise daily medications	20	5%	5%	10%	6	2	50%			4.5
6. A convenient venue for staff to monitor client's progress	23	4%	13%	4%	5.5	1				
7. A place to engage in activities instead of being home alone or having nowhere to go	**32**	**34%**	**13%**	**31%**	**3**	7	**71%**	**14%**		1
8. A place for making friends and socialising	**28**	**39%**	**18%**	7%	**2**	**5**	**40%**	**60%**		2
9. Prepare for and assist in employment	20	5%	10%	10%	6	3			33%	3
10. Provide opportunities to rebuild self-confidence and self-esteem	24	13%	13%	25%	3.25	4		25%		5

* **n** is the total number of subjects who had ranked the answer, i.e. excluding those who ticked the answer or made no response.
<u>M</u> = Median rank

For those LSC clients who had ranked the items (n = 28) on perceived purposes, nearly 80% of them perceived preventing hospitalisation as the most important purpose of the LSCs. Over two-third of LSC clients and more than 85% of non-LSC clients who had ranked the items (n = 32 and 28 for LSC; n = 7 and 5 for non-LSC, respectively) agreed that "a place to engage in activities instead of being

home alone or having no where to go" and "a place for making friends and socialising" were two of the very important purposes of the LSCs.

3.3.3.2.20 Perceived services of Living Skills Centres

Table 3.48 Clients' perceived services of Living Skills Centres

{Some of responses were a tick without giving a rank. This table shows frequency counts only}

	LSC CLIENTS N = 50	**NON-LSC CLIENTS N = 9**
1. Supportive work programme and work skills training/Prevocational programme	**58% (29)** *7*	44% (4) *1*
2. Centre-based daily living skills training	**64% (32)** *6*	33% (3)
3. In-vivo Daily living skills training	46% (23) *3*	33% (3)
4. Assertive/social skills training	54% (27) *7*	22% (2)
5. Provide opportunities to make friends and socialise	**66% (33)** *6*	**56% (5)**
6. Provide opportunities for leisure activities	54% (27) *5*	44% (4)
7. Provide programmes for client to spend time constructively during the day	54% (27) *3*	**78% (7)** *1*
8. Liaise with other community agents to assist me to live in the community	42% (21) *5*	33% (3) *1*
9. Provide education on medications and symptoms management to client and family/carer	50% (25) *5*	33% (3) *1*
10. Provide opportunities for group discussion to share problems and set goals	54% (27) *6*	44% (4)
11. Case management	8% (4) *1*	
12. Provide different level of activities to meet individual needs		
13. Support case management & client in goal setting and problem solving		
14. I don't know	2% (1) *1*	11% (1)

* *Figure in italic and bold = Number of responses with no ranking in that item.*

Nearly 60% of LSC clients stated the following services should be provided by the LSC: 1) opportunities to make friends and socialise; 2) centre-based daily living skills training; and 3) supportive work programme and work skills training.

However, nearly 80% of non-LSC client subjects thought LSC should provide

"programmes for clients to spend time constructively during the day". More than 55% thought the LSC should provide "opportunities to make friends and socialise."

The Kendall's tau-b test was also carried out and the results indicated disagreement in ranking of each item between two groups.

Table 3.49 Results of the Kendall Test on the degree of agreement on the ranking orders of perceived services of Living Skills Centres between LSC and Non-LSC clients

CLIENTS	Kendall's tau-b test
1. Supportive work programme and work skills training/Prevocational programme	-0.199
2. Daily living skills training in the centre	-0.049
3. In-vivo Daily living skills training	-0.087
4. Assertive/social skills training	0.066
5. Provide opportunities to make friends and socialise	-0.081
6. Provide opportunities for leisure activities	-0.238
7. Provide programmes for client to spend time constructively during the day	-0.128
8. Liaise with other community agents to assist me to live in the community	-0.141
9. Provide education on medications and symptoms management to client and family/carer	0.051
10. Provide opportunities for group discussion to share problems and set goals	-0.175

Those responses which were a tick without a rank number have been replaced by the ranking values of **medians-of-nearby-points.**

Table 3.50 Comparison of the first three ranking orders of perceived services of Living Skills Centres between LSC and Non-LSC clients

Client	LSC CLIENTS N = 50					NON-LSC CLIENTS N = 9				
Ranking	n*	R1	R2	R3	M	n*	R1	R2	R3	M
1. Supportive work programme and work skills training/Prevocational programme	22	55%	14%		**1.5**	3	67%	33%		**1**
2. Daily living skills training in the centre	**26**	**27 %**	**31 %**	**8%**	**2**	3	33%		33%	3
3. In-vivo Daily living skills training	20	20%	10%	15%	4	3	33%		33%	4
4. Assertive/social skills training	20	20%	5%	25%	3	2	50%			4.5
5. Provide opportunities to make friends and socialise	**27**	**37 %**	**11 %**	**22 %**	**2**	**5**	**20%**	**40 %**	**20 %**	**2**
6. Provide opportunities for leisure activities	22	23%	27%	14%	2	4	50%		50%	2
7. Provide programmes for client to spend time constructively during the day	24	17%	13%	17%	4	**6**	**33%**	**33 %**		**2**
8. Liaise with other community agents to assist me to live in the community	16	25%	6%		5	2	50%			3.5
9. Provide education on medications and symptoms management to client and family/carer	20	30%	10%		4	2	50%			5.5
10. Provide opportunities for group discussion to share problems and set goals	21	29%	5%		4	4	50%	25%		**1.5**
11. Case management	3	33%			8					

* **n** is the total number of subjects who have ranked the answer, i.e. excluding those who ticked the answer or made no response.
M = Median rank

A majority of clients in both groups, who ranked the item, perceived "supportive work programme and work skills training/Prevocational programme" as the most important service of the LSCs. However, there were less than 50% of the clients in both groups ranked the services. On the other hand, over 66% of the Sydney clients and non-LSC clients (n = 26 and 27, respectively) perceived that "daily living skills training in the centre" and "opportunities to make friends and

socialise" were the second most important services of the LSCs. A similar proportion of the Country clients perceived "opportunities to make friends and socialise" and "programmes for clients to spend time constructively during the day" as the second most important services of the LSCs.

3.3.3.2.21 Factors assisting clients to achieve their goals in Living Skills Centres

Table 3.51 Clients' perceived factors that assist them to achieve their goals in Living Skills Centres

{Some of responses were a tick without giving a rank. This table shows frequency counts only}

	LSC CLIENTS N = 50			NON-LSC CLIENTS N = 9		
1. Good relationship with centre's staff	**37**	**(74%)**	***9***	7	**(78%)**	***1***
2. Self motivation	**30**	**(60%)**	***5***	4	(44%)	***1***
3. Adequate staffing and facilities	22	(44%)	***5***	**5**	**(56%)**	***1***
4. Able to set own goals of rehabilitation	29	(58%)	***6***	**5**	**(56%)**	
5. Staff motivation and dedication	28	(56%)	***7***	3	(33%)	
6. Good liaison between centre and other community agents	20	(40%)	***2***	2	(22%)	
7. Case manager assigned for each client in the centre	**30**	**(60%)**	***7***	4	(44%)	***1***
8. Varieties of programmes and activities in the centre	27	(54%)	***5***	3	(33%)	***1***
9. Opportunities to practice learned skills outside the centre	22	(44%)	***3***	**5**	**(56%)**	
10. Case manager for overall management of client's rehabilitation						
11. Develop clear goals of centre in collaboration with clients						
12. Other	1	(2%)	***1***			
13. I don't know	2	(4%)	***1***	1	(11%)	

* *Figure in italic and bold = Number of responses with no ranking in that item.*

Over 70% of clients in both groups claimed that a good relationship with the Centre's staff was needed for clients to achieve their goals in the LSC. The other two factors perceived by LSC clients (60%) as needed to help them achieve

their goals were: 1) self motivation; and 2) case manager assigned for each client in the centre. Over 55% of non-LSC clients thought adequate staffing and facilities, being allowed to set own goals of rehabilitation and having opportunities to practice learned skills outside the centre were important.

The Kendall's tau-b test was also carried out and the results indicated disagreement in ranking of items between two groups.

Table 3.52 Results of the Kendall Test on the degree of agreement on the ranking orders on perceived assisting factors between LSC and Non-LSC clients

CLIENTS	**Kendall's tau-b test**
1. Good relationship with centre's staff	-0.027
2. Self motivation	-0.060
3. Adequate staffing and facilities	-0.018
4. Able to set own goals of rehabilitation	-0.055
5. Staff motivation and dedication	0.288
6. Good liaison between centre and other community agents	0.244
7. Case manager assigned for each client in the centre	-0.053
8. Varieties of programmes and activities in the centre	0.062
9. Opportunities to practice learned skills outside the centre	-0.414

Those responses which were a tick without a rank number have been replaced by the ranking values of **medians-of-nearby-points.**

Table 3.53 Comparison of the first three ranking orders on the perceived assisting factors between LSC and Non-LSC clients

	LSC CLIENTS N = 50					NON-LSC CLIENTS N = 9				
Ranking	n*	1	2	3	<u>M</u>	n*	1	2	3	<u>M</u>
1. Good relationship with centre's staff	**28**	**46 %**	**18 %**	**11 %**	**1.5**	**6**	**33 %**	**33 %**	**17 %**	**2**
2. Self motivation	**25**	**48 %**	**12 %**		**2**	3		33%	33%	3
3. Adequate staffing and facilities	17	41%		12%	3	4		25%	25%	3.5
4. Able to set own goals of rehabilitation	23	22%	17%	17%	3	**5**	**60 %**			**1**
5. Staff motivation and dedication	21	38%	10%	19%	2.5	3	33%			4
6. Good liaison between centre and other community agents	18	22%	11%	6%	4	2				7.5
7. Case manager assigned for each client in the centre	23	43%		22%	3	3	33%	33%		**2**
8. Varieties of programmes and activities in the centre	22	18%	18%	9%	3.5	2	50%			4
9. Opportunities to practice learned skills outside the centre	19	26%	11%	5%	4	**5**	**60 %**		**20 %**	**1**
10. Case manager for overall management of client's rehabilitation										
11. Develop clear goals of centre in collaboration with clients										
12. Other	6	100 %				1	100 %			

* n is the total number of subjects who had ranked the answer, i.e. excluding those who ticked the answer or made no response.
<u>M</u> = Median rank

Among factors ranked by over 50% of the clients, 75% of the clients in both groups perceived "good relationship with centre's staff" as the most important or second most important factor in assisting them to achieve their goals. While LSC clients perceived the second most important factor was "self motivation", non-LSC clients perceived "able to set own goals of rehabilitation" and "opportunities to practice learned skills outside the centre" as the most important factors.

3.3.3.2.22 Perceived future improvements required for Living Skills Centres

Table 3.54 Clients' perceived future improvements required for Living Skills Centres

{Some of responses were a tick without giving a rank. This table shows frequency counts only}

	LSC CLIENTS N = 50	NON-LSC CLIENTS N = 9
1. More staff	**26 (52%)** *2*	4 (44%) *1*
2. More facilities and space	**26 (52%)** *2*	3 (33%) *1*
3. Better informed about the centre prior attending	14 (28%) *1*	3 (33%) *1*
4. Better liaison with other community resources/ services	15 (30%) *1*	2 (22%)
5. Better defined role and direction for the centre within the community mental health service	20 (40%) *1*	2 (22%) *1*
6. More specialised services to meet the needs of clients of different levels of ability/ functioning	**27 (54%)** *5*	**6 (67%)** *1*
7. Better access to public transports	17 (34%) *4*	2 (22%)
8. Have more activities	19 (38%) *3*	4 (44%) *1*
9. Not to have too many activities	12 (24%) *1*	1 (11%)
10. More autonomy to choose activities	16 (32%) *1*	3 (33%)
11. Change to a more appropriate name for the centre	13 (26%)	2 (22%)
12. Abolish the centre and replace it with other service	8 (16%) *1*	1 (11%)
13. Providing help to be independence to live away from home		
14. Reorganise service based on community team rather than specialised services		
15. Other	1 (2%)	
16. No further improvement required	8 (16%) *1*	1 (11%)
17. I don't know	3 (6%) *1*	2 (22%)

** Figure in italic and bold = Number of responses with no ranking in that item.*

Over 50% of LSC clients and over 65% of non-LSC clients thought that a future improvement required for the LSC was "more specialised services to meet the needs of clients of different levels of ability/functioning. Over 50% of LSC clients saw that the LSC should have more staff, facilities and space.

The Kendall's tau-b test was also utilised and the results indicated disagreement in ranking of items between two groups. An exception was that they were likely to agree that clients should be given more autonomy in choosing activities.

Table 3.55 Results of the Kendall Test on the degree of agreement on the ranking orders on perceived future improvements between LSC and Non-LSC clients

CLIENTS	Kendall's tau-b test
1. More staff	-0.185
2. More facilities and space	-0.080
3. Better informed about the centre prior attending	-0.305
4. Better liaison with other community resources/ services	-0.187
5. Better defined role and direction for the centre within the community mental health service	-0.273
6. More specialised services to meet the needs of clients of different level of ability/ functioning	-0.137
7. Better access to public transports	-0.248
8. Have more activities	-0.449
9. Not to have too many activities	-0.406
10. More autonomy to choose activities	**-0.502**
11. Change to a more appropriate name for the centre	-0.187
12. Abolish the centre and replace it with other service	0.205

Those responses which were a tick without a rank number have been replaced by the ranking values of **medians-of-nearby-points.**

Table 3.56 Comparison of the first three ranking orders on the perceived future improvements between LSC and Non-LSC clients

	LSC CLIENTS N = 50					NON-LSC CLIENTS N = 9				
Ranking	n*	R1	R2	R3	<u>M</u>	n*	R1	R2	R3	<u>M</u>
1. More staff	**24**	**67%**	**4%**	**4%**	**1**	3	33%		67%	3
2. More facilities and space	**24**	**50%**	**33%**	**8%**	**1**	2	50%	50%		**1.5**
3. Better informed about the centre prior attending	13	23%	15%	15%	3.5	2	50%		50%	**1**
4. Better liaison with other community resources/ services	14	29%	14%	14%	3	2	50%		50%	2
5. Better defined role and direction for the centre within the community mental health service	19	26%	26%	16%	3.25	1	100%			
6. More specialised services to meet the needs of clients of different level of ability/ functioning	22	32%	5%	36%	3	**5**	**60%**	**40%**		**1**
7. Better access to public transports	13	15%	8%		5	2	50%		50%	2
8. Have more activities	16	6%	12%	12%	4	3	100%			
9. Not to have too many activities	11			9%	9	1	100%			
10. More autonomy to choose activities	15	13%		13%	4	3		67%		2
11. Change to a more appropriate name for the centre	13	8%	8%	23%	6	2	50%			2.5
12. Abolish the centre and replace it with other service	7				11	1				
15. Other	1	100%								
16. No further improvement required	7	86%		14%						
17. I don't know	2	100%				2	100%			

* **n** is the total number of subjects who had ranked the answer, i.e. excluding those who ticked the answer or made no response.
<u>M</u> = median rank

Less than 50% of clients in both groups ranked the items. Over 75% of the LSC clients perceived the most important improvement for the LSCs was to have

more staff, facilities and space while all of the non-LSC clients regarded "more specialised services to meet the needs of clients of different level of ability/ functioning" as the most important improvement.

3.3.3.2.23 Importance of Living Skills Centres in improving client's quality of life

Table 3.57 Clients' perceptions of the importance of Living Skills Centres in improving their quality of life in the community

	LSC CLIENTS N = 50	NON-LSC CLIENTS N = 9	TOTAL N = 59
Most Important	**28 (56%)**	2 (22%)	**30 (51%)`**
Just as important as other service	13 (26%)	2 (20%)	**15 (25%)**
I'm not sure	5 (10%)	3 (33%)	8 (14%)
Not as important as other service		1 (11%)	1 (2%)
Not important at all		1 (11%)	1 (2%)
No response	4 (8%)		4 (7%)

Over 55% of LSC clients saw the LSC as the most important service in improving their quality of life. Nearly 80% of clients thought the LSC was either most important or just as important as other services in improving their quality of life.

3.3.4 Further Comparisons of Data

Subjects were divided into the following groups: LSC staff, non-LSC staff, LSC clients, non-LSC clients, Sydney LSC clients, country LSC clients, subjects with LSC experience and subjects without LSC experience for further comparison. Selected summaries of results are discussed below and more summary tables are attached in Appendix I.

3.3.4.1 *Staff and Clients in Living Skill Centre*

3.3.4.1.1 Sex distribution

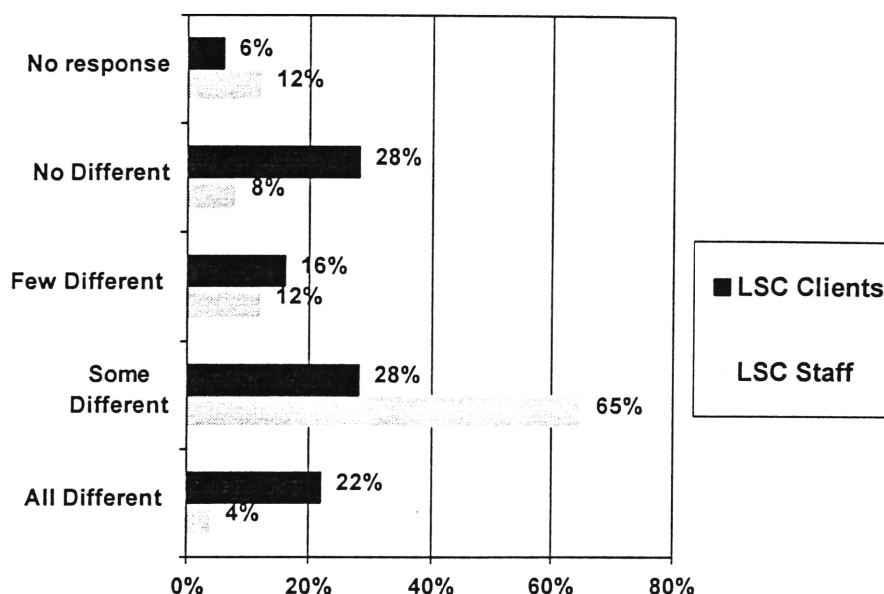
Table 3.58 Sex distribution of Living Skills Centre's staff and clients

LSC	**Staff** **N = 26**	**Client** **N = 50**
MALE	7 (27%)	38 (76%)
FEMALE	19 (73%)	11 (22%)
No response		1 (2%)

Interestingly, a majority of staff (73%) working in the LSCs were female whilst 76% clients who were attending the centres were male.

3.3.4.1.2 Discrepancy in goal setting

Figure 3.6 Comparison of the perceptions of discrepancy in goals setting in Living Skills Centres between staff and clients

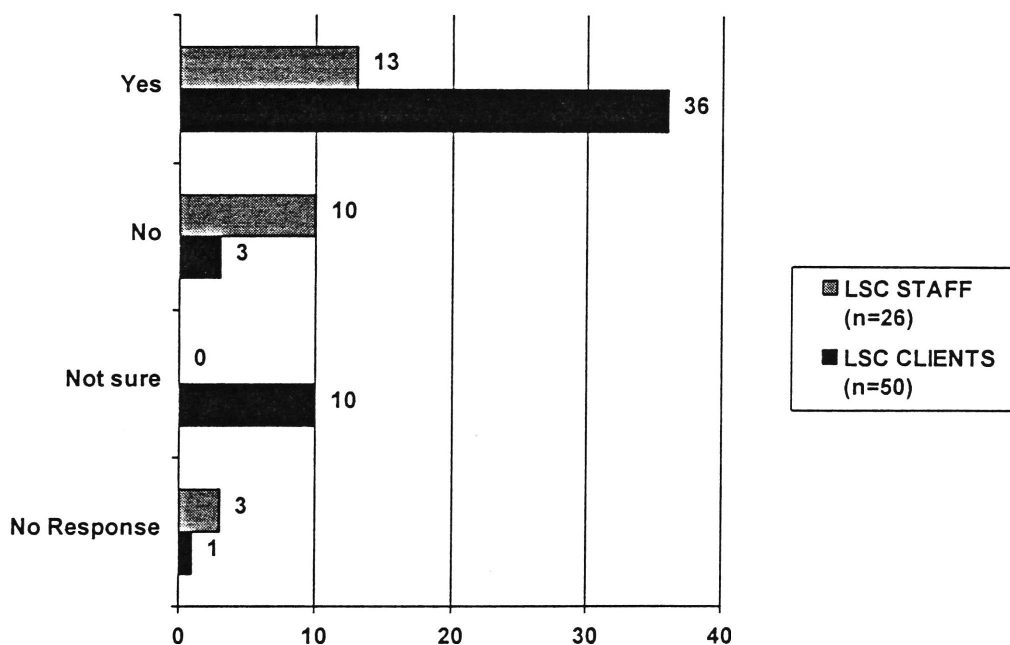


A majority of LSC staff (65%) felt that the goals they set for their clients were sometimes different from client goals. On the other hand, nearly 30% of LSC clients thought some of their goals of attending the centre were different from the ones set by the staff. There was also the same proportion of clients felt that their goals were the same as the staff's. Nearly 70% of LSC staff, compared to 50% of LSC clients thought the goals were either some or all different between the two groups.

A *Chi-square test* for between group differences proved to be significant (Chi-square value = 15.014, df = 5, $p < 0.05$), but more than 50% of cells had expected frequency of less than 5. Therefore, this significant finding could not be accepted.

3.3.4.1.3 Referring agents' understanding of the purposes of Living Skills Centres

Figure 3.7 Comparison of the perceptions of referring agents' understanding of the purposes of Living Skills Centres between staff and clients



Twenty percent more of the LSC clients (over 70%) than the LSC staff (50%) claimed that the referring agents/persons did understand the purposes of the LSCs.

A *Chi-square test* for between group differences proved to be significant (*Chi-square value = 19.978, df = 3, p < 0.01)*. However, the expected frequency in 50% of the cells were less than 5. Thus, this significant finding could not be accepted.

3.3.4.1.4 Perceived improvements in client's quality of life in community

The LSC staff, except two, perceived that the LSCs had helped to improve clients' quality of life by assisting them to gain self-confidence and self-esteem whilst less than half of the LSC clients agreed with this perception. The difference

between the two groups was statistically significant. Over 85% of staff perceived the LSCs had helped in improving clients' quality of life by being able to make friends and socialise, and having somewhere to go to spend time constructively whilst only about 50% of the clients agreed with this perception. The differences between the two groups in these two items also were statistically significant. Nearly 75% of LSC staff, as compared to about 35% of the clients, perceived that the centres had helped by assisting clients to gain skills to live in the community and prevent readmission to hospital. Ten percent of the clients felt that the LSC had little influence on their quality of life in the community.

3.3.4.1.5 Perceived purposes of Living Skills Centres

All the LSC staff , as compared to 64% of the LSC clients, perceived the purposes of the centres should be providing opportunities to rebuild self-confidence and self-esteem. Over 95% of staff, as compared to less than 80% of clients, perceived that the purposes of LSCs were to provide a place to engage in activities instead of being home alone or having nowhere to go, and a place for making friends and socialising. Nearly all the staff and only about 60% of clients thought the LSCs should be providing support and resources for clients to live in the community.

A *Chi-square test* for between group differences failed to reach significance. The Kendall's tau-b test was also utilised and the results indicated disagreement in ranking of items between the two groups.

In considering the items that were ranked by over 60% of LSC staff, it was revealed that:

1. 84% of staff (n = 25) thought providing support and resources for clients to live in the community was the highest priority (median ranking = 1);
2. 77% of staff (n = 26) thought provision of opportunities to rebuild self-confidence and self-esteem was also a high priority;
3. Three purposes which had been ranked highly by over 60% of the LSC clients (n = 28, 28 and 32, respectively), with median ranking 1.5, 3 and 2 respectively. They were: a) preventing hospital; b) provision of a place to engage in activities instead of being home alone or having nowhere to go; and c) provision of a place to make friends and socialise; and
4. Clients perceived item 7 and 8 as more important purposes of LSCs than staff perceptions (with median ranking 2 and 4, respectively).

3.3.4.1.6 Perceived services of Living Skills Centres

A *Chi-square test* for between group differences of each item indicated that the difference was not significant, except with item 5 and 6, "providing opportunities to make friends and socialise" and "providing opportunities for leisure activities", (chi-square value = 8.357, df= 2, $p<0.05$; and chi-square value = 22.474, df =2, $p<0.001$, respectively). The Kendall's tau-b test was also carried out and the results indicated disagreement in ranking of items between the two groups. An exception is item 6, "providing opportunities for leisure activities", with Kendall's tau-b value equal to 0.647, which indicated that there was agreement between the two groups over this LSC service.

Ninety percent of LSC staff, as compared to less than 50% of LSC clients, perceived the following services should be provided by the centres: 1) providing opportunities for group discussion to share problems and set goals; and 2) liaising with other community agents to assist clients to live in the community. Other services valued by 85% of staff included: 1) centre-based daily living skills training; 2) provide opportunities to make friends and socialise; 3) provide opportunities for leisure activities; and 4) provide programmes for client to spend time constructively during the day.

The three services most highly valued by the clients, with the highest frequency counts - 66%, 64% and 58% respectively, were: 1) providing opportunities to make friends and socialise; 2) daily living skills training in the centre; and 3) supportive work programme and work skills training/prevocational programme.

Fifty percent of staff (n = 22) and 66% of clients (n = 26), who ranked the service items, ranked the service of daily living skills training in the centre between first to third level in importance. The median ranking for staff was 3.5 while for client's it was 2. In addition, 70% of those clients (n = 27), as compared to only 30% of the staff (n = 22), also ranked the service of providing opportunities to make friends and socialise highly. Although less than 50% of clients had ranked the service item, "supportive work programme and work skills training/prevocational programme", nearly 70% of them regarded it as the most important service of LSCs.

3.3.4.1.7 Perceived factors that assisting clients to achieve their goals in Living Skills Centres

Nearly 90% of staff perceived good relationship with client and own motivation and dedication as the factors that assisted clients to achieve their goals in the Centres, as compared to 74% and 56% of clients respectively. More than 80% of staff, compared to less than 60% of clients, also perceived the following factors as important in assisting clients to achieve their goals: 1) setting own goals of rehabilitation; 2) case manager assigned for each client in the centre; and 3) varieties of programmes and activities in the centre.

A *Chi-square test* for between group differences of each item indicated that the difference was not significant. The results of Kendall's tau-b test indicated disagreement in ranking of items between the two groups.

Among those factors that were ranked by over 60% of subjects in both groups, it was revealed that:

1. Over 60% of the LSC staff (n = 23 and 19, respectively) and more than 70% of those clients (n = 28 and 25, respectively), ranked "good relationship with centre's staff" and "(client's) self motivation" between the first and third level of importance;
2. Over 60% of the LSC staff (n = 21) and over 50% of the clients (n = 23) had also ranked highly the factor, "(client's) able to set own rehabilitation goals", though only less than 50% of the total LSC clients ranked the factor; and,
3. Less than 50% of the clients (n = 23) had ranked the item, 65% of them, as compared to less than 40% of the staffs (n = 21) regarded the factor, "case

manager assigned for each client in the centre" as the most important factor in assisting them to achieve their rehabilitation goals.

3.3.4.1.8 Perceived future improvements required for Living Skills Centres

More than 80% of LSC staff, comparing to 54% of clients, suggested that a future improvement of the LSCs would be to provide more specialised services to meet the needs of clients of different levels of ability/functioning. On the other hand, nearly 80% of staff, as compared to less than 50% of clients, perceived that future improvements should include: 1) better liaison with other community resources/services; and 2) better defined role and direction for the centre within the community mental health service.

Other future improvements that were identified by more than 50% of client subjects, and over 70% of staff were more staffing and more facilities and space in the LSCs.

A *Chi-square test* for between group differences of each item failed to achieve significance. The results of Kendall's tau-b test indicated disagreement in ranking of items between the two groups. An exception was item 12, "abolish the centre and replace it with other services", (Kendall's tau-b value = 0.509), which indicated greater agreement between the two groups on this factor.

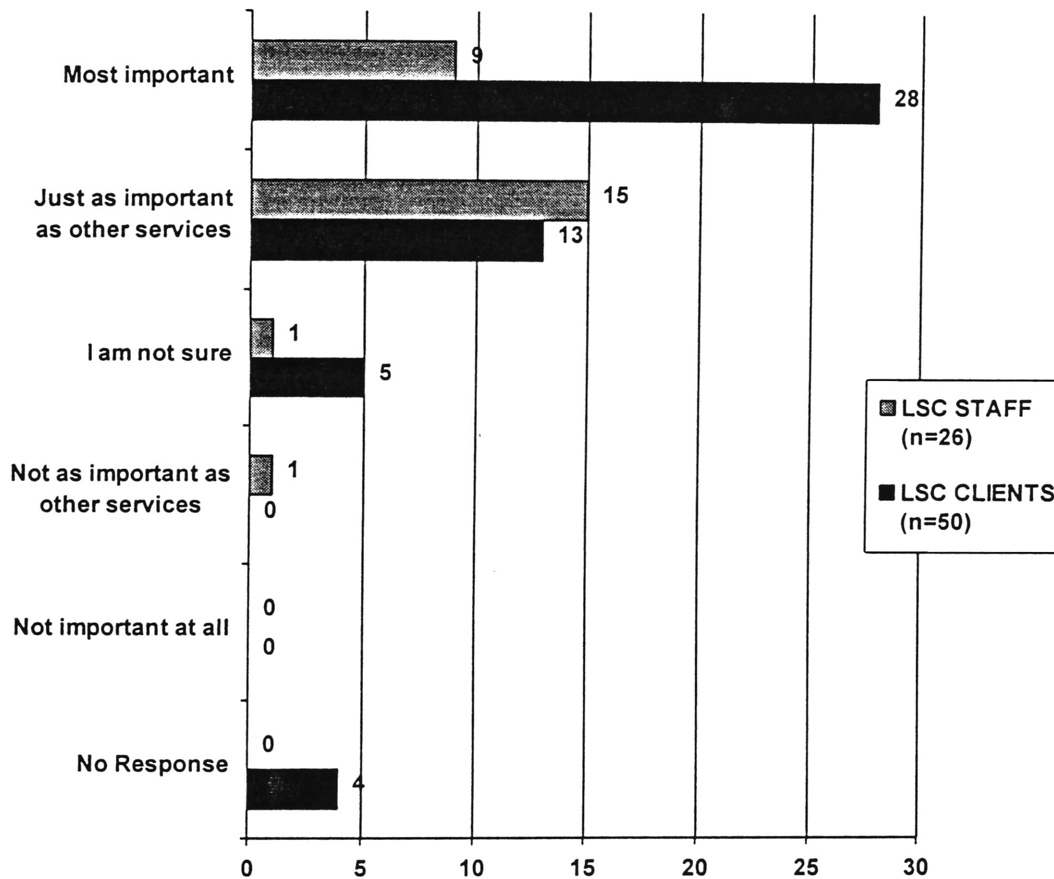
Among future improvements ranked by both groups, it was noted that:

1. "more staffing" and "more facilities and space" were perceived both by staff and clients (first and third level of importance) as future improvements; and,

2. Over 65% of staff and clients perceived improvements like, "better defined role and direction for centre with the community mental health service" and "more specialised services to meet the needs of clients of different levels of ability/ functioning" as importance. However, less than 50% of clients ranked these two items.

3.3.4.1.9 Importance of Living Skills Centres in improving client's quality of life

Figure 3.8 Comparison of the perceptions of the importance of Living Skills Centres in improving clients' quality of life between staff and clients



Nearly 60% of LSC clients, as compared to less than 35% of LSC staff, thought the LSC was most important in improving their quality of life. However, over 60% of staff, compared to less than 30% of client subjects, perceived the LSC service was just as important as other services.

3.3.4.2 *Staff and Clients in LSC*
(excluding the "corrupted" responses)

The results of the comparison of LSC staff and clients with and without the "corrupted" responses indicated that there were no major differences. The summary of results was similar to the analysis above which contained the "corrupted" responses.

3.3.4.3 *Clients in Sydney's LSCs and those in Country LSCs*
(Excluding those "corrupted" responses)

Among the clients from the randomly selected LSCs, thirty-seven (37) of them came from Sydney centres and 11 from the Country. Obviously, more males than females responded to the questionnaire in both kind of the settings.

Those clients who attended the Country LSCs tended to be older than those attending the Sydney LSCs as the average age was 41 and 38, respectively. However, all of them in both groups were between the age of 31 and 50.

3.3.4.3.1 Years of mental illness

Table 3.59 Years of mental illness among client subjects of randomly selected Living Skills Centres

CLIENTS	RANDOMLY SELECTED LSC IN SYDNEY	RANDOMLY SELECTED LSC IN COUNTRY
Less than 1 years ago	2 (5%)	
1 - 5 years ago	2 (5%)	3 (27%)
6 - 10 years ago	9 (24%)	4 (36%)
11 - 15 years ago	8 (21%)	1 (9%)
16 - 20 years ago	6 (16%)	
More than 20 years ago	6 (17%)	2 (18%)
No response	4 (11%)	1 (9%)
Mean age	**13.2 years ago**	**10.8 years ago**

Clients who attended the Country LSCs appeared to have shorter history of mental illness as compared to clients in Sydney LSCs, with the average years of mental illness 11 years and 13 years respectively.

3.3.4.3.2 Accommodation

Table 3.60 Types of accommodation where the clients of randomly selected Living Skills Centres lived

CLIENTS	RANDOMLY SELECTED LSC IN SYDNEY	RANDOMLY SELECTED LSC IN COUNTRY
FAMILY	12 (32%)	4 (36%)
FRIEND	2 (5%)	
GROUP HOME	3 (8%)	3 (27%)
ALONE	16 (43%)	4 (36%)
BOARDING HOUSE	1 (3%)	
NURSING HOME	1 (3%)	
HOSTEL	1 (3%)	
OTHER	1 (3%)	

Clients in both types of settings lived with their family or alone. A significant proportion of Country LSC clients lived in group homes.

3.3.4.3.3 Previous experience in Living Skills Centres

Table 3.61 Previous experience in Living Skills Centres among clients of randomly selected centres

CLIENTS	RANDOMLY SELECTED LSC IN SYDNEY	RANDOMLY SELECTED LSC IN COUNTRY
YES	14 (37%)	5 (45%)
NO	23 (63%)	6 (55%)

Over 50% of clients in both settings did not attend other LSCs prior to the current one.

3.3.4.3.4 Days of attendance at Living Skills Centre

Table 3.62 Days of attendance (per week) at Living Skills Centres among clients of the randomly selected centres

CLIENTS	RANDOMLY SELECTED LSC IN SYDNEY	RANDOMLY SELECTED LSC IN COUNTRY
1 day	2 (5%)	9 (82%)
2 days	4 (11%)	
3 days	9 (24%)	
4 days	9 (24%)	
5 days	9 (24%)	1 (9%)
6 days		
7 days	1 (3%)	
No response	3 (8%)	1 (9%)
Mean	**3.7 days S.D. = 1.32**	**1.4 days S.D. = 1.26**

The Sydney clients attended an average of nearly four days per week, as compared to Country clients who attended only one and a half day per week.

3.3.4.3.5 Discrepancy in goal setting between staff and clients

Table 3.63 Comparison of the perceptions of discrepancy in goal setting in Living Skills Centres between Sydney and Country clients of the randomly selected centres

Client goals verse staff goals	RANDOMLY SELECTED LSC IN SYDNEY N = 37	RANDOMLY SELECTED LSC IN COUNTRY N = 11
All are different	9 (24%)	2 (18%)
Some are different	12 (32%)	1 (9%)
Very few are Different	5 (14%)	2 (18%)
No different	9 (24%)	5 (46%)
No response	2 (5%)	1 (9%)

A *Chi-square test* for between group differences proved to be non-significant. Despite this fact, the results indicated obvious variations between the two groups.

Two-thirds of Sydney clients felt that their goals were different from the staff's goals. However, nearly the same proportion of Country clients thought that there were no difference or very few differences between their goals and the ones set by the staff.

3.3.4.3.6 Referring agent's understanding of the purposes of Living Skills Centres

Table 3.64 Comparison of the perceptions of referring agent's understanding of the purposes of Living Skills Centres between Sydney and Country clients of the randomly selected centres

CLIENTS	RANDOMLY SELECTED LSC IN SYDNEY N = 37	RANDOMLY SELECTED LSC IN COUNTRY N = 11
Yes	23 (62%)	11 (100%)
No	3 (8%)	
I am not sure	10 (27%)	
No response	1 (3%)	

A *Chi-square test* for between group differences proved to be non-significant. A significant proportion of Sydney LSC clients (27%) were not sure whether the referring agent understood the purposes of LSCs when they were referred.

3.3.4.3.7 Reasons given for referring to Living Skills Centre

Sixty-five percent and 55% of Sydney and Country clients, respectively, stated that reasons for the referral were given when they were referred. Over 50% of clients in both groups stated that the reasons given included: "making friends and socialise with other people" and "having something to do, instead of being home

alone or having no where to go during the day". Over 70% of the Sydney clients thought they were also given the reason of obtaining assistance in managing mental illness.

3.3.4.3.8 Perceived improvements in client's quality of life

Over 50% of the Sydney clients thought the LSC had helped to improve their quality of life by having somewhere to go to spend time constructively and being able to gain self-confidence and self-esteem. Over 50% of Country clients thought the LSCs had helped by being able to make friends and socialise. However, a *Chi-square test* for between group differences of each item failed to achieve significance.

3.3.4.3.9 Preferred methods of informing about the purposes of Living Skills Centres prior to attendance

A *Chi-square test* for between group differences of each item proved to be non-significant, except item 2, "a letter from the centre", *(chi-square value = 5.341, df = 1, $p < 0.05$).* The results of Kendall's tau-b test indicated disagreement in ranking of items between the two groups.

It was noted that the most preferred method of informing potential clients the purposes of LSCs prior to their attending by the Sydney LSC clients was a clear explanation by referring person/agent. The Country LSC clients perceived visiting the centre as the best method.

3.3.4.3.10 Perceived purposes of Living Skills Centres

The Kendall's tau-b test was carried out and the results indicated a high degree of disagreement in ranking of each item between the two groups. An exception was Item 2, "providing support and resources to live in the community", where the Kendall's test value was 0.653, which indicated that the two groups tended to agree on the ranking.

Over 75% of the clients in both groups who had ranked the item, (n = 22 for Sydney clients; n = 8 for Country clients), perceived one of the most important purposes of the LSCs was a place to engage in activities instead of being home alone or having nowhere to go. Seventy-five percent of Country clients who ranked (n = 8) also perceived that being a place for making friends and socialising was also one of the most important purposes of LSCs. On the other hand, 85% of Sydney clients who ranked the perceived purposes (n = 20) regarded preventing hospitalisation as the most important purposes of LSCs, with the median ranking equal to one.

3.3.4.3.11 Perceived services of Living Skills Centres

The results of Kendall's tau-b test indicated a high degree of disagreement in ranking of perceived services between the two groups. Although less than 50% of Sydney LSC clients ranked all the items, over 70% of them perceived the following services as the most important ones to be provided by the LSCs: 1) supportive work programme and work skills training/prevocational programme; 2) daily living skills training in the centre; 3) provide opportunity to make friends and

socialise; and 4) provide opportunity for leisure activities. (Median rankings for these items ranged from 1.5 to 2).

On the other hand, more than 65% of the Country LSC clients who had ranked the centres' services, (n = 8 and 6, respectively), perceived the following services as the most important services to be provided by the LSCs: 1) provide opportunities to make friends and socialise; and 2) provide education on medications and symptom management to client and family/carer.

3.3.4.3.12 Factors assisting clients to achieve their goals in Living Skills Centre

Over 75% of the clients in both groups who ranked the factors (n = 20 for Sydney LSC clients; n = 6 for Country LSC clients) agreed that a good relationship with the centre's staff was the most important factor in assisting them to achieve their rehabilitation goals in the centres. On the other hand, the factors, "able to set own goals of rehabilitation" and "staff motivation and dedication", were valued by more than 75% of Country LSC clients (n = 6), who ranked the items, as two important factors. In addition, the Kendall's tau-b test was carried out and the results indicated a high degree of disagreement in ranking of each item between the two groups.

3.3.4.3.13 Perceived future improvements required for Living Skills Centres

Less than 50% of Sydney LSC clients ranked the future improvement items. However, a majority of clients in both groups, who ranked the items, perceived more staffing, and more facilities and space as the most important future improvements

required for the LSCs. On the other hand, the Kendall's tau-b test was utilised and the results indicated a high degree of disagreement in ranking of each item between the two groups

3.3.4.3.14 Importance of Living Skills Centres in improving client's quality of life

Table 3.65 Comparison of the perceptions of the importance of Living Skills Centres in improving client's quality of life between Sydney clients and Country clients of the randomly selected centres

	RANDOMLY SELECTED LSC IN SYDNEY N = 37	RANDOMLY SELECTED LSC IN COUNTRY N = 11
Most Important	23 (62%)	5 (46%)
Just as important as other service	9 (24%)	4 (36%)
I'm not sure	2 (5%)	1 (9%)
Not as important as other service		
Not important at all		
No response	3 (8%)	1 (9%)

Over 60% of Sydney clients and nearly 50% of Country clients perceived the LSCs to be the most important service in improving their quality of life.

3.3.4.4 *Subjects with LSC experience (past or current) and those with no LSC experience*

Comparison was carried out between the staff and clients groups, who were previously and/or currently associated with the LSCs (N = 81), and those who had no LSC experience (N = 33). A *Chi-square test* was used for testing the significance of between group differences of each item, the results generally failed to achieve significance. However, the variations were still obvious between two groups. The Kendall's tau-b test was also utilised and the results indicated a high degree of disagreement in ranking of the items between the two groups

Table 3.66 Number of subjects with and without Living Skills Centre experience

	With LSC experience	**Without LSC experience**
Staff	30 (37%)	25 (76%)
Client	51 (63%)	8 (24%)
Total	81	33

Table 3.67 Sex distribution of subjects with and without Living Skills Centre experience

	LSC experience N = 81	**No LSC experience N = 33**	**TOTAL N = 114**
MALE	**46 (56%)**	**16 (49%)**	61 (53%)
FEMALE	34 (42%)	17 (51%)	52 (46%)
No response	1 (1%)		1 (1%)

3.3.4.4.1 Perceived purposes of Living Skills Centres

Eighty-five percent of LSC subjects and 97% of non-LSC subjects, the highest frequency counts in both groups, thought one of the purposes of LSCs was

to provide a place for clients to engage in activities instead of being home alone or having no where to go.

Those perceived purposes on which over 75% of subjects agreed were:

1) Subjects with LSC experience: " a place for making friends and socialising" and "providing opportunities to rebuild self-confidence and self-esteem"; and
2) Subjects with no LSC experience: "prevent hospitalisation", "providing support and resources to live in the community', "assist and support family/carer to manage client's illness", "a place for making friends and socialising", "prepare for and assist in employment", and "provide opportunities to rebuild self-confidence and self-esteem".

Among those purposes items that had been ranked by over 60% of the subjects in both groups, it was revealed that:

1. 78% of LSC subjects, compared to 68% of non-LSC subjects, perceived one of the most important purposes of LSCs was to provide support and resources to clients living in the community;
2. 97% of LSC subjects compared to 67% of non-LSC subjects ranked the purpose of "a place to engage in activities instead of being home alone or having nowhere to go" between first to third level of importance;
3. Over 50% of the subjects in both groups perceived "a place for making friends and socialising" as one of the very important purposes of LSCs;
4. 65% of LSC subjects, compared to 87% of non-LSC ranked "provide opportunity to rebuild self-confidence and self-esteem" between first to third level of importance; and

5. 65% of LSC subjects (n = 53), compared to just 12% of non-LSC subjects (n = 24) perceived the purpose of "preventing hospitalisation" as one of the very important purposes served by the LSCs.

3.3.4.4.2 Perceived services of Living Skills Centres

Nearly 90% of subjects with no LSC experience, as compared to 67% of subjects with LSC experience, thought the LSCs should provide programmes for clients to spend time constructively during the day. About 80% of subjects with no LSC experience, compared to less than 70% of subjects with LSC experience perceived that the LSCs should provide services, such as: 1) providing opportunities for group discussion to share problems and set goals; 2) providing education on medications and symptoms management to client and family/carer; 3) providing opportunities to make friends and socialise; 4) providing opportunities for leisure activities.

Among those service items ranked by over 50% of subjects in both groups, it was revealed that:

1. 52% of subjects with LSC experience (n = 44), compared to 42% of subjects without LSC experience (n = 24), ranked the service of "supportive work programme and work skills training/prevocational programme" between the first and third level of importance;
2. 56% of LSC subjects (n = 50) and 61% of non-LSC subjects (n = 26) perceived the service "daily living skills training in the centre" as one the very important service, with median rankings 2.5 and 3 respectively;

3. 51% of LSC subjects (n =54), compared to 41% of non-LSC subjects (n = 27) ranked the service "provide opportunities to make friends and socialise" as one the very important services, with median rankings of 3 and 3.5 respectively; and,
4. 60% of non-LSC subjects (n = 28), compared to 32% of LSC subjects (n = 51), ranked the service "provide programmes for client to spend time constructively during the day" between the first and third level of importance, with the median ranking at 4.

3.3.4.4.3 Perceived factors that assist clients to achieve their goals in Living Skills Centres

Over 80% of subjects in both groups perceived that having a good relationship with the centre's staff was one of the factors that could assist clients to achieve their goals in the LSCs. Over 75% of subjects with no LSC experience, as compared to about 65% of subjects with LSC experience, perceived the following factors that could assist clients to achieve their goals: 1) client's self motivation; 2) adequate staffing and facilities; 3) being allowed to set own goals of rehabilitation; and, 4) varieties of programmes and activities in the centre.

Among the factors that were ranked by 50% of subjects in both groups, it was noted that:

1. A similar proportion of subjects (over 50%) in both groups had ranked the following factors between the first and third level of importance in assisting clients to achieve their goals in the LSCs: 1) good relationship with centre's staff; 2) self motivation (client's); 3) able to set own goals of rehabilitation; and, 4) staff motivation and dedication; and,

2. 53% of LSC subjects (n = 47), compared to 34% of non-LSC subjects (n = 23) ranked the factor "Case manager assigned for each client in the centre" between the first and third level of importance.

3.3.4.4.4 Perceived future improvements required for Living Skills Centres

Sixty-five percent of subjects with LSC experience and over 75% of subjects with no LSC experience perceived one of the future improvements of the LSCs should be having more specialised services to meet the needs of clients of different levels of ability/functioning.

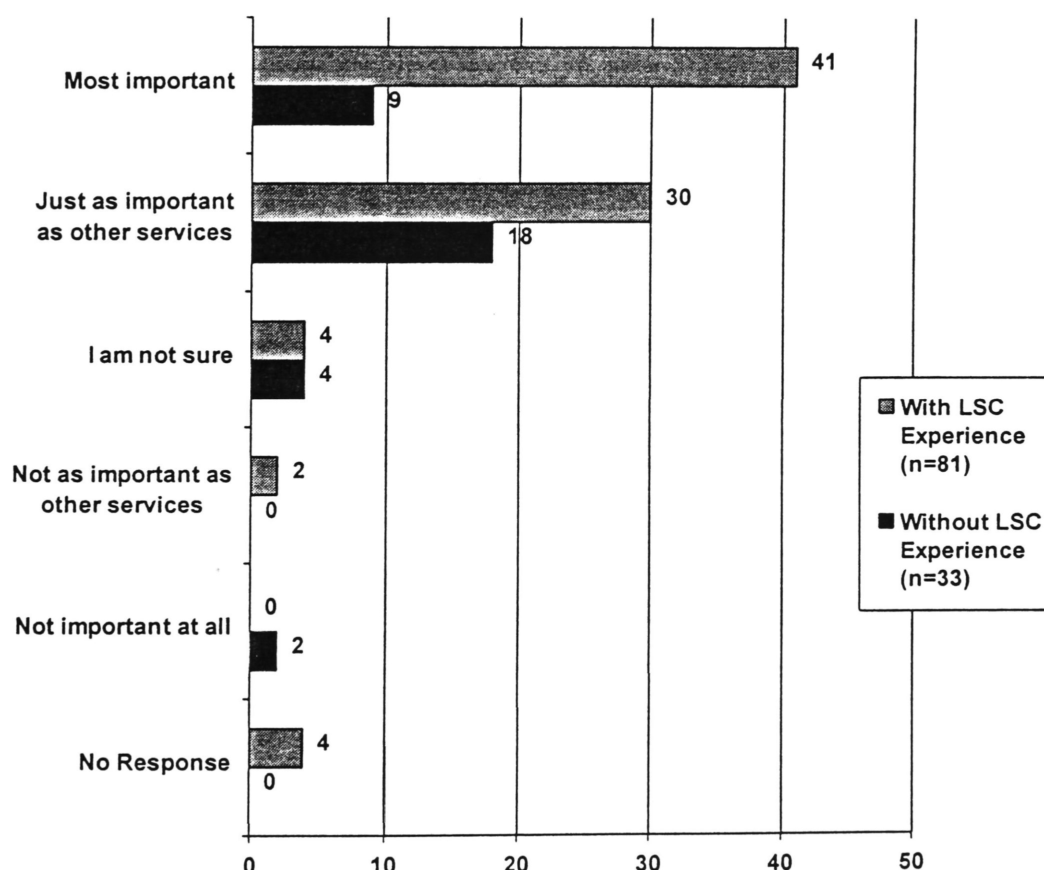
Among those future improvement items that were ranked by over 50% of subjects in both groups, it was revealed that:

1. Nearly 70% of LSC subjects (n = 45), compared to approximately 48% of non-LSC subjects (n = 19) perceived more staffing as the most important for future improvement required for the LSCs;
2. Nearly 90% of LSC subjects (n = 46) and over 75% of non-LSC subjects (n = 17) ranked "more facilities and space" between the first and third level of importance future improvements required for the LSCs;
3. A similar proportion (65 and 66%, respectively) of subjects in both groups ranked "Better defined role and direction for the centre within the community mental health service" between the first and third level of importance, with median ranking at 2; and,
4. 74% of LSC subjects (n = 46), compared to 65% of non-LSC subjects (n = 24), ranked "More specialised services to meet the needs of clients of different levels

of ability/ functioning" between the first and third level of importance, with median rankings of 3 and 2 respectively.

3.3.4.4.5 Importance of Living Skills Centres in improving client's quality of life

Figure 3.9 Comparison of the perceptions of the importance of Living Skills Centres in improving client's quality of life between subjects with and without LSC experience



Over 50% of subjects with LSC experience, compared to less than 30% of subjects with no LSC experience, perceived the LSCs as the most important service in improving clients' quality of life in the community. On the other hand, over 50% of subjects with no LSC experience, compared to less than 40% of subjects with LSC

experience, perceived the LSCs as just as important as other service in improving client's quality of life.

A *Chi-square test* for between group difference indicated the difference was significant *(chi-square value = 13.697, $df = 4$, $p < 0.05$)*

3.3.5 Correlation Tests

The Spearman Correlation Coefficient test was utilised on selected variables of different groupings of subjects. The following are summaries of the findings:

1. All Staff

The Spearman test was carried out on variables: YEAREXP, Years-working-in-LSC (YEARWK), GAOLDIF, IMPQOL and LSCVAL, all correlation coefficient values (r) were less than 0.5, except there was a significant correlation between the variables GOALDIF and LSCVAL, i.e. r = 0.7454.

2. All Clients

The Spearman Correlation Coefficient test was carried out on variables: 1st-Admission (AD1ST), Age (YOB), Years-attending-in-LSC (YATLSC), Days-attending (DAYAT), Satisfaction-with-LSC (SATISFY), Goal-difference (GOALDIF) and IMPQOL. All correlation coefficient values (r) were less than 0.5.

3. LSC Staff

Correlation coefficient values of variables: YEAREXP, YEARWK, GOALDIF, IMPQOL and LSCVAL were all less than 0.5

4. LSC Clients

Test on the variables, AD1ST, AGE, YATLSC, DAYAT, SATISY, GOALDIF and IMPQOL, indicated all correlation coefficient values (r) were less than 0.5.

5. Non-LSC Staff

Results of the test on variables, YEAREXP, YEARWK, GOALDIF, IMPQOL and LSCVAL, proved that all correlation coefficient values (r) were less than 0.5. An exception was a very high correlation between GOALDIF and LSCVAL, where correlation coefficient, (r) was = 0.915, (N=29).

Among those non-LSC staff who had responded to the relevant questions (N=10), there was a high negative correlation between LSCVAL and IMPQOL, with r = -0.9045. Within these samples, there was also a greater correlation between the variables: GOALDIF and YEAREXP, with r = 0.602. However the significant level of p values was greater than 0.05. That means the correlation between these two variables was likely to have happened by chance.

6. Non-LSC Clients

The Spearman Correlation Coefficient test was carried out on variables: AD1ST, AGE, YATLSC, DAYAT, SATISFY, GOALDIF and IMPQOL, all correlation coefficient values (r) were less than 0.5. However, there was an exemption in that there was a slight correlation between the variables AD1ST and SATISFY, with r value = 0.5635, but the significant level, p value was greater than 0.05. Thus the correlation was likely to have happened by chance.

7. Subjects with and without LSC Experience

The test result indicated that there was no significant correlation between the two variables: GOALDIF and IMPQOL in these two groups, where correlation coefficients (r) was less than 0.5.

3.3.6 Summaries of qualitative comments

At the end of the questionnaire, subjects were asked to comment on any aspects of the LSC service that had not been covered in the questionnaire. An analysis of content was carried out to identify the common themes among those responses. All those comments were categorised into the following themes:

3.3.6.1. Perception of the purposes and functions of the LSC

Staff who were currently working in the LSC did not make a lot of additional comments. If they did, they tended to see the functions of LSC positively, for example:

> *It is] Commonly reported by clients that LSC is most important to their well-being. Most clients attend of their own accord, and any break in programme is met with extreme disappointment and worry about their own mental health during the break.*

Staff were also concerned that the LSC service had been used by people other than those who were mentally ill.

> *Clients attending [are] not "mentally ill" but brain damage[d] clients, developmentally disabled, alcoholic, street people. [It is] hard to turn them away and they can influence those with mental illness. [Other] more appropriate services should be provided for them in the community.*

One of staff from a rural centre commented on its operational model saying:

We operate in a rural area. Most of the psychosocial rehabilitation aspects are done by case manager. This radically alters the way in which our rehabilitation functions. The case manager also operate the "living skills centre". I think the clients get what they need which is mainly socialisation.

On the other hand, staff who were not working in the LSC tended to see it serve a specific or restricted purpose only. The following are some of the examples:

LSCs are uniquely a N.S.W. concept and are always evolving.
LSCs are not recognised enough by other services.
Opportunities for earning money in LSC raises client's self-esteem.

The LSC in the local area tends to provide diversional activities and outings, which in my opinion is insufficient to do more towards improving the quality of life of person with mental illness....My impression is that LSCs are perceived as [maintenance] centres for clients who do not fit into the Commonwealth Rehabilitation Services, Skills Share Scheme and other work preparation programmes.

LSCs are not client-centred but group-centred. People do not have personal programmes, [treatment] goals or objectives. They are just put together as a group and minded for the day.

These centres are but one of many places of transition as the clients could understand their illness and take responsibility for their lives.

Clients who were using the LSC service tended to comment on the benefits they had gained from the service, such as:

[We are able to] attend movies or theatres more often and interact with the community more.

We feel sanctuary or asylum in such institutions is important. This, as well as, love are/were very important in my recovery.

I would like to obtain employment through LSC.

They also gave few general positive comments on the LSC service. For examples, *"It is very satisfying.", "[I] enjoy LSC and think it is good.", "LSC are very good."*

One of the clients, who was not attending a LSC commented on purpose of the service as providing *"[s]omewhere to go instead of getting into trouble."*

3.3.6.2 Future improvements for the LSCs' services

Many comments from the subjects were concentrated on suggesting future improvements of the services. Staff who were working in the LSC thought that there should be better integration with related services and more bilingual workers in the centres, for example:

Could be more involved with graded supervised housing if it was available.

Physical health needs to have adequate attention.

After these centres there needs a more specialised employment centre for people with history of major mental illness.

More skilled bilingual staff and training.

One of the staff also suggested that there should be a balance between functional skills training programmes and programmes aimed at improving quality of life. The same staff member further maintained, *"Management need a clear theoretical model of psychosocial rehabilitation. My experience is that they don't [and] so [they] are swayed by budgets and [glamour]."*

Another LSC staff member recommended that there should be more emphasis on motivating those clients who could not initiate attendance to the centre, and a more intensive approach should be adopted, which should include offering transportation to and from the centre.

Suggestions made by non-LSC staff appeared to cover a wider aspect of the service. The following are some of the examples:

Specialised and varied programmes are required to deliver a therapeutic service.

Timing in implementing certain activities is, in my view, important. For example, outdoor activities should be limited on cold and chilly days. Clients should be assessed at least once every fortnight on performance....If unsatisfactory, clients would be suggested to take up other unexpected field of activities.

In my opinion, they [LSCs] should be geared to help people regaining minimal skills needed for community living, to prepare them for on-going treatment programmes if possible. [The service] needs to be better integrated into other services.

One of the non-LSC staff recommended a more radical change to the delivery of LSC services. The staff member suggested that a successful centre needs to be client-focused, even in the management level. The staff member further suggested that the name - 'LSC' should be replaced and clients should truly own the centre and it should be privately owned.

On the other hand, suggestions made by clients, particularly those who were attending LSCs, appeared to be varied but concrete and practical. They could be categorised into the following sub-themes:

a) More varieties of programme

More camping holiday[s] and a social club.....[They should be] run and formally organised by people with mental illness.

More theatre excursions.

More group therapy with trained psychotherapist[s] for people who have just been discharged from hospital.

It is important that expression of feelings be an important priority in planning of living skills centres' programmes.

b) More resources

[More] recreation facilities such as snooker table and swimming.

Larger centre with transport facilitates.

Improving staff/client ratio and need more focus on leisure and entertainment.

c) Improving service delivery

[LSC] should help people who had been sick to move out and away from family pressure. Staff should assist the client in aspects of 'job search', education, accommodation, not just [stuck with] housing commission or government services, but the private [services too].

I think there should be more communication between clients and health workers and no mind games [among] clients.... Why should sick people talk about their problems first? Why don't health workers approach sick people first because sick people won't come to them first.

I think that living skills [centre] should cater to all levels of people's sickness and functioning. [It should] provide opportunities for all who attend to break away from the centre and enjoy a productive life or quality living. The focus should be on making the mental illness a small part of their lives so that they can get on with living.

CHAPTER 4

Summaries and Discussion

CHAPTER 4

Summaries and Discussion

The research design of purposive survey, which adopted a combination of semi-structured interviews and a questionnaire survey, was found to be an appropriate method of addressing the research questions. Since another aim of the study was to examine client satisfaction with the LSC service, participatory research, which has been identified as the best method of studying consumer satisfaction (Everett & Steven, 1989; Lord, Schnarr & Hutchinson, 1987), was adopted. However, due to budget and time constraints, it was not feasible for the researcher to involve the subjects in all aspects of the survey. Nevertheless, the exploratory study using semi-structured interviews of staff and clients provided valuable insights, in terms of content and language, for the construction of the questionnaire. In addition, this research design also helped to identify existing issues and phenomena in the LSC service which might not have been revealed if only a mail survey had been used. Another important benefit of using both qualitative and quantitative methodology was that the qualitative data, both from the exploratory study and the written comments on the questionnaire, could be used to examine some of the findings of the survey. Therefore, by using this research design, one could adopt a more "holistic" view as well as having an increased understanding and sensitivity to the specific issues or problems revealed.

The researcher conducted both studies as a person independent and unassociated with the LSC service. This approach minimised the problem of conformity and overrating of the service and the clients, as described by Kalman (1983). This, together with the anonymity of subjects, appeared to result in reliable answers from the subjects.

4.1 Response rate of the study

Since the subjects in the exploratory study were recruited by invitation, the LSC staff and clients who had accepted the invitation, co-operated with the interviews. Due to time and financial constraints, the questionnaire survey was not conducted with a comprehensive sample of subjects from both the LSC and non-LSC groups. Despite the efforts made by the researcher to encourage better response by way of personal visit, phone call and follow-up reminder, the overall response rate of the questionnaire survey was considered to be low (as indicated in Table 3.1). Only those LSCs visited by the researcher showed a good response rate of around 70 percent. In addition, LSCs that were not on the Life Skill Forum's list were excluded from the study. Thus, the skewed responses might have distorted the results as the returned questionnaires might not represent the typical LSC.

The inclusion of a non-LSC group was for the purpose of identifying differences in perceived function and effectiveness of the LSC service between the two groups. However, they were recruited by convenient sampling method through the researcher's personal network. The response rate of this group was generally considered to be low, in particular there were only a few returned questionnaires from the non-LSC clients. These factors may explain why, as the total sample size was relatively small, some of the differences within and across the two groups were statistically insignificant.

4.2 Verification of phenomena by the questionnaire survey

Despite the response rate problem as mentioned in **section 4.1**, the questionnaire survey did not only validate some of the phenomena which emerged in the exploratory study, it also provided some answers to the questions raised in the study. The findings are summarised and discussed according to the following themes: 1) the characteristics of staff working in the LSCs; 2)the characteristics of clients attending the LSCs.; and 3) discrepancies in the perception of purposes and functions of LSCs.

4.2.1 The characteristics of the staff working in the Living Skills Centres

Based on the findings from the survey, the characteristics of staff who worked in the LSCs were as follows:

a. They are most likely to be female (73%);
b. Professionally, they were either nurses or occupational therapists (70%), and are working as a staff member of the centres (77%);
c. They had been working in psychiatry/mental health for less than seven years with 30% of them working in this area for less than one year;
d. Most did not have previous experience working in LSCs (65%) and nearly half of them had been working in LSCs for less than one year, with the average time spent in the centres being less than 3 years;
e. Most clients were said to be referred by the community mental health team;

f. Most likely they think the referring persons did understand the purposes of the LSCs (50%). However, they were not sure about the clients, as they thought the clients partly understood the purposes of the LSCs prior to their referral (69%);

g. The method they preferred to educate the referring persons/agents about the purposes of the LSCs was to send information pamphlets or have them spend a period of time at the centres (80%); and,

h. As compared to other services, the LSC staff thought their service was being valued as much as any other service. Some staff considered that LSCs are undervalued by other the community mental health team staff. None of them thought the services were being valued more than other services.

Some of the above responses revealed in the survey verified the impressions and perceptions described in the exploratory study, i.e. not many of the staff had previous LSC experience, and they had a relatively short working history in the LSCs. However, two of the above findings differ from the exploratory study, i.e. : 1) most of the staff thought the referring agents did understand the purposes of the centres; and, 2) a significant number of staff felt the LSC service had been valued similarly when compared with other services.

4.2.2 The characteristics of clients attending the Living Skills Centres

The characteristics of clients who attended the LSC, as indicated in the study were:

a. They were most likely to be male (76%);

b. They were between the ages of 31 and 50 (66%) with the average age of 40.5 years;

c. They were born in Australia (82%), and most likely, their parents were too (over 60%);

d. They were living either with their families or alone (76%)

e. They had a relatively long history of mental illness (more than 10 years), with an average of 14 years;

f. They were likely to have not attended any other LSCs previously (58%), with a current attendance of less than five years (54%);

g. They attended the centres, on an average of three days per week and most likely attended between three to five days (60%);

h. They usually were referred either by their case managers or other community mental health team members (60%);

i. They felt that they had been given the reasons for attending the LSCs by the referring persons (64%). The reasons tended to be: "making friends and socialising with other people" and "having something to do, instead of being home alone or having no place to go during the day" (both 44%);

j. They felt the referring persons did understand the purposes of LSCs and clearly explained the purposes of the LSCs (70%). Many had a trial visit prior to their formal attendance to the centres (64%); and,

k. They either were satisfied or very satisfied with the services provided by the LSC (70%).

Some of the above LSC client characteristics also are similar to the findings from the exploratory study. They are the following: 1) they were most likely to have a long history of mental illness, i.e. over 5 years; 2) they did not have any previous LSC experience; 3) they claimed the reasons for the referral were socialising, making friends and having something to do; and, 4) they were satisfied with the LSC service. The last findings seems to be consistent with previous studies on satisfaction with mental health services, in that clients tend to report a high degree of satisfaction (Elbeck & Fecteau, 1990; Kalman, 1983; Morphy, 1991).

4.2.3 Discrepancies in the perception of the purposes and functions of Living Skills Centres

Based on the results of the questionnaire, although statistically the differences in perceived purposes and functions of the LSCs largely were non-significant, there were obvious variations in the perceptions of the LSCs purposes and services among two groupings of staff and clients. Generally, the perceived purposes and functions of the LSCs, according to staff and clients, did not deviate much from the broad, original purposes of LSCs as described in the literature, i.e. to promote community adjustment and prevent readmission to psychiatric hospital; to develop opportunities for normalisation; and to work co-operatively with clients and their families in the rehabilitation process (Life

Skills Forum, 1985; Weir & Rosen, 1989). The differences between staff and clients' perceptions were in terms of priorities of those purposes and functions. The nature and characteristics of these discrepancies in perceptions, as well as answers to some of the research questions raised earlier, are discussed under the following headings:

1. Differences in rehabilitation goal setting;
2. Differences in the perceived purposes of the LSCs;
3. Differences in the perceived services of the LSCs;
4. Differences in the perceived functions of the LSCs in improving clients' quality of life in the community;
5. Differences in the perceived importance of the LSCs in improving clients' quality of life;
6. Differences in the perceived factors that assisted clients in achieving their goals in LSCs; and,
7. Differences in the perceived future improvements required for LSCs.

4.2.3.1 *Differences in rehabilitation goals*

Although statistically the differences in rehabilitation goals between LSC staff and clients were non–significant, the variations were obvious. LSC staff thought that the goals that they set only differed in some instances from their clients' goals of attending the centres. However, a majority of the clients

saw their goals were different from those set by the staff, which ranged from few differences to being totally different.

Among the LSC clients, statistically, there appeared to be no correlation between the perception of differences in goal setting and level of satisfaction with the LSCs' services. There also was no relationship between the perception of differences in goals and the perceived importance of the LSCs in improving their quality of life in the community. Clients who were attending the LSCs seemed to accept the situation and continued to feel that the service benefited them in certain ways. Examples of their comments on the LSC service are:

> *[We are able to] attend movies or theatres more often and interact with the community more.*

> *We feel sanctuary or asylum in such institutions is important.*

> *It is very satisfying.*

> *[I] enjoy Living Skills Centre and think it is good.*

> *[S]omewhere to go instead of getting into trouble.*

On the other hand, among staff, there was a significant correlation between perceived goals and perception of how the LSC is valued by others.

Staff who thought there were few differences in goals between staff and clients reported that the LSC service was less valued by the non-LSC mental health staff. However, this significant correlation could not be found in the LSC staff or non-LSC staff group alone. The possible explanation for this occurrence could be due to statistical errors resulting from a low response rate from non-LSC staff.

4.2.3.2 *Differences in the perceived purposes of Living Skills Centres*

Regarding the perceived purposes of LSCs, there was no significant difference between LSC staff and non–LSC staff, at least in a statistical sense. Most of them (more than 90%) thought the purposes of LSC were:

1. Provision of support and resources to live in the community
2. Provision of opportunities to rebuild self–confidence and self-esteem;
3. A place to engage in activities instead of being home alone or having nowhere to go; and,
4. A place for making friends and socialising.

In particular, the first two purposes were identified by the majority of staff in both groups as most important. Additionally, a high proportion of staff (over 85%) perceived that LSCs also had two other purposes: assisting and supporting family/carers to manage clients' illness, and preparing for and assisting clients in employment.

Clients perceived the purposes of LSCs in the following order of importance:

1. A place to engage in activities instead of being home alone or having nowhere to go;
2. A place for making friends and socialising; and,
3. Prevent rehospitalisation.

LSC clients agreed with non-LSC clients in perceiving the purpose of "A place to engage in activities instead of being home alone or having nowhere to go" as most important. However, they differed in the priorities they gave to other purposes. In addition, Sydney LSC clients rated preventing rehospitalisation as more important than the Country LSC clients.

When comparing LSC staff's perceptions with LSC clients', a majority of subjects in both groups agreed that LSC was a place to engage in activities instead of being home alone or having nowhere to go. They also agreed that it was a place for making friends and socialising, and receiving assistance in preventing hospitalisation. However, they differed in the level of importance accorded to these purposes.

In addition, it was found that 50% more of the LSC staff than clients thought that the LSCs also had the following purposes including provision of support and resources for clients to live in the community; assisting and supporting family/carers to manage clients' illness; preparing for and assisting in employment; and provision of opportunities to rebuild self-confidence and self-esteem.

Similar to the findings in the exploratory study, the results from the survey verified that the staff chose the items described in broad and abstract terms. The clients selected the purpose items which were described in more practical and concrete words.

4.2.3.3 *Differences in the perceived services of Living Skills Centres*

A similar high proportion of LSC staff and non-LSC staff perceived that the following services should be provided by the LSCs: 1) providing opportunities to make friends and socialise; 2) providing opportunities for leisure activities; 3) providing programmes for clients to spend time constructively during the day; and 4) providing education on medications and symptoms management to clients and family/carers. The order of importance of these services between the two groups also was similar.

In contrast, the services which were perceived by a high proportion of clients (LSC and non-LSC) as preferred LSCs' services were: 1) providing opportunities to make friends and socialise; 2) daily living skills training in the centre; 3) providing programmes for client to spend time constructively during the day; and, 4) supportive work programmes and work skills training/prevocational programmes.

On the other hand, regarding the most important services of LSCs, Sydney clients tended to differ from Country clients. Sydney clients perceived the supportive work programmes and work skills training/prevocational

programmes as more important than Country clients, who thought provision of education on medications and symptoms management to them and family or carer was important. Perhaps this is a reflection of the differences in values of LSC staff in the two geographical areas. As one of the Country LSC staff wrote:

> *We operate in a rural area. Most of the psychosocial rehabilitation aspects are done by case manager. This radically alters the way in which our rehabilitation functions. The case manager also operates the 'living skills centre'. I think the clients get what they need, which is mainly socialisation.*

Subjects without LSC experience were more likely to think the LSCs serve a diversional purpose and maintain the well being of consumers, i.e. provision of programmes for clients to spend time constructively during the day. This phenomenon also emerged when comparing LSC clients with non–LSC clients. As perceptions are influenced by many factors, this finding indicates that exposure to the LSC setting would change perceptions of the service. Perhaps this can explain why the LSC staff preferred to educate the referring persons/agents by arranging an experience at the centres and the clients preferred to have a trial attendance period before making a decision as to whether or not to attend the centre's programme..

4.2.3.4 *Differences in perceiving the improvements in clients' quality of life by the Living Skills Centre services*

Over 70% of staff, with higher proportion in the LSC staff group than non-LSC staff group, agreed that the LSC services had helped clients to improve their quality of life in the following aspects: 1) to gain self–confidence and self–esteem; 2) to make friends and socialise; 3) to have somewhere to go to spend time constructively. Interestingly, none of the staff thought the LSC services had helped clients increase their motivation to do things or increase life satisfaction. Most of the staff also agreed that LSCs did not assist clients in the area of medication compliance.

Among all the service items on the questionnaire, there were three items where the highest proportion of responses by LSC clients (about 50%) matched the staff's choices. Nearly all the LSC clients agreed with the staff that the LSC did not help in the area of increasing motivation to do things, life satisfaction in general, and medication compliance.

The clients who thought the LSCs did not increase their life satisfaction did not differ in perceived importance and satisfaction with LSC services, i.e. there was no significant correlation between these three variables. In addition, there was a statistically significant difference, in that more staff than clients perceived the LSCs as assisting clients in gaining skills needed to live in the community and preventing readmission to hospital. It appears that staff tended to perceive the benefits of LSCs broadly and felt that they were achieved over a long period of time. Clients tended to perceive the benefits of the service in

terms of more immediate experiences, such as making friends and social outings or activities.

4.2.3.5 *Differences in the perceived importance of Living Skills Centres in improving clients' quality of life*

Although there was no statistically significant difference between staff and clients' perceptions, over 60% of all staff, compared to less than 30% of clients, rated services provided by the LSCs as important as other services in improving the quality of life of a person with mental illness, living in the community. However, nearly 60% of clients, as compared to only about 30% of staff perceived that the service was the most important among all the services in improving their quality of life. A high proportion of both Sydney LSC clients (62%, N = 37) and Country LSC clients (46%, N = 11) also rated LSC as the most important service in improving quality of life.

Interestingly, those non-LSC staff, who thought LSC service was valued more by others, tended to perceive it to be less important than other services in improving clients' quality of life. One explanation for this finding is that it may result from a statistical error as the sample was quite small (N = 10). Another explanation is that they valued the service highly but realised that it was one of several services responsible for improving clients' quality of life in the community.

On the other hand, people who had associated with LSCs tended to perceive them more positively, i.e. the most important service in improving

client's quality of life. As discussed in **Section 4.2.3.3**, it appears that once people had experience with an LSC, their perceptions of the service changed. Therefore, it would be logical to adopt the method of informing potential clients and non-LSC staff about LSC services through actual experiences at the centres.

4.2.3.6 *Differences in the perceived factors that assist clients*

Among all the items listed on the questionnaire, the factor perceived by the greatest proportion of the staff and clients as most important in assisting clients in achieving their goals in LSCs was a good relationship between staff and clients. The other important factors influencing goal achievement that were perceived by a high proportion of staff and clients included: 1) staff's motivation and dedication; 2) clients being able to set their own rehabilitation goals; 3) a case manager assigned to each client in the centre; 4) a variety of programmes and activities in the centre; and, 5) client self motivation. In all these cases, the differences in the proportion of responses between these two groups were proved to be statistically non–significance.

4.2.3.7 *Differences in the perceived future improvements required for Living Skills Centres.*

Approximately 80% of the LSC staff perceived that the most important future improvements in LSCs were: 1) better defined role and direction for the centres within the community mental health service; and, 2) more specialised services to meet the needs of clients of differing levels of ability/functioning.

The third most improvement was more facilities and space for the centres. The LSC staff also thought of having better liaisons with other community resources/services. The non-LSC staff perceived another important improvement, which was additional staff for the centres. The qualitative comments written by the staff regarding future improvements of the LSCs included the following:

> *Could be more involved with graded supervised housing if it was available*

> *Physical health needs to have adequate attention*

> *More skills, bilingual staff, and training.*

> *Management needs a clear theoretical model of psychosocial rehabilitation.*

> *Specialised and varied programmes are required to deliver therapeutic services.*

> *In my opinion, they [LSCs] should be geared to help people regain minimal skills needed for community living, to prepare them for on–*

going treatment programmes if possible. [The service] needs to be better integrated into other services.

Despite the fact that a smaller proportion of clients, compared to staff, responded to this question, the greatest proportion of clients in both settings agreed with the staff's perceptions. They perceived that one of the important improvements at the centres should be more specialised services to meet the needs of clients with different levels of ability/functioning. Particularly, the non-LSC clients saw it as the most important improvement. Consistently, people with or without LSC experience also perceived this as a needed improvement. Over 50% of LSC clients, and less than 50% of non-LSC clients, perceived that having more staff, facilities, and space would be another important improvement for the LSCs. On the other hand, there appeared to be fewer clients (less than 40%) than staff (over 80%) concerned about the need for LSCs to have a better defined role and direction within the community mental health services. Content of the qualitative comments written by clients was varied, but specific. The following are some examples:

More camping holiday and a social club....[They should be] run and formally organised by people with mental illness.

More theatre excursions. [More] recreation facilities such as snooker table.

Improving staff/client ratio and more focus on leisure and entertainment.

It is important that expression of feelings be a high priority in planning of living skills centre's programmes.

[LSC] should help people who had been sick to move out and away from family pressure. Staff should assist the client in aspects of 'job search', education, accommodation, not just housing commission or government services, but the private [services] too.

4.3 <u>Further discussion</u>

Although it was obvious that there were discrepancies in the perceptions of staff and clients, clients continued to attend the centres because they found the service benefited them. As one of the staff commented:

> *Most clients attend of their own accord, and any break in programme is met with extreme disappointment and worry about their own mental health during the break.*

In addition to the current literature, the results from this exploratory study and the qualitative comments have the potential to answer questions related to the reasons why clients continued to attend LSCs. These reasons include: 1) differences in focus and expectations of the service always have existed between clients and health professionals; 2) insufficient community mental services programmes to meet their needs, particularly in the areas of social support and recreation; and, 3) a preference for interacting with other mentally ill people and staff who understand their situations and illnesses.

Perhaps it can assumed that discrepancy in treatment goals and in perceptions of needs between staff and clients is a normal phenomenon. This assumption has been described in the literature (Boydell & Everett, 1992; Elbeck & Fecteau, 1990; Prager & Tanaka, 1980). Luft, Smith & Kace (1978) even found differences in staff and clients' perspectives relative to desired treatment outcomes. One LSC staff member stated:

I think there is a big difference between what the consumer (client) needs and what the consumer wants. That is the problem. The consumer wants a job but the consumer is not prepared to put in the hard work required to get a job, which is getting to the living skills [centre] every morning at 9 o'clock, attending programmes, getting involved in the work programme, etc.... They are not willing to meet those things. They are like most people, they just want it to happen, a job.... This is the reality of the situation that the needs and the wants are totally different."

In both of the studies the discrepancy in perceptions of purposes and functions was quite obvious. Clients perceived the purposes and functions of the LSCs according to what they had received. They tended to express these perceptions in pragmatic terms. On the other hand, staff perceived the purposes and functions in terms of the goals that they wished the clients to achieve. They described the purposes in abstract, broad and idealistic terms. Perhaps, perceptions of outcomes may be similar; however, the language used to describe them is different. Thus, it appears that as long as the clients experience the service as meeting their needs, they will continue to attend LSCs. Clients have found ways to survive and gain benefits from the system.

The inadequacy in community mental health services has been highlighted in The Burdekin Report (Human Right and Equal Opportunity Commission Report, 1993). After clients are discharged from hospital, they still

require social support and structured time usage. These needs even become prominent for those clients with a long history of mental illness. Their abilities in problem solving and activating social networks have been diminished gradually through numerous relapses, exacerbation of negative symptoms, and hospitalisations that disrupt the continuity of their experiences in the community. Both studies indicated that clients perceived the LSCs as a place to make friends and to socialise. It seemed that they preferred to socialise with other clients. At the same time, they were receiving assistance in rebuilding their self–confidence and self esteem. They felt the staff were understanding and able to give support through a range of services, such as living skills training, education on mental illness, recreational activities, and counselling. Most of all, they found the LSCs to be the easiest identifiable and perhaps the only place in the community where they were accepted and did not need to worry about social stigma. The following comments from LSC clients illustrate this point:

> *[LSC offers] a variety of activities....You get self-esteem form doing a job and you get self–esteem from socialising, you get self-esteem from achieving, doing things, and just being with your friends....*

> *For me, if I didn't come here (LSC), I wouldn't see a soul because I live on my own....Mix with people, talk over our problems with others.*

> *....if I haven't had come to living skills [centre], I don't know how I would have ended up developing my life. I think that when living skills is not on, when they have the planning week, I found that I am a bit sort of lost. I have nothing to do.*

Although clients attended the LSCs and displayed high levels of satisfaction with the service, they also indicated that there was a need for future improvements. Besides more staffing, facilities and space, they suggested that the centres have a variety of programmes at different levels or requiring different functional abilities to meet specific needs. For example, one of the LSC clients wrote:

> *I think that living skills [centres] should cater to all levels of people's sickness and functioning. [It should] provide opportunity for all who attend to break away from the centre and enjoy a productive life or quality living. The focus should be on making the mental illness a small part of their lives so that they can get on with living.*

The LSC staff also appeared to be dissatisfied with the current situation and expect further improvement in services provided by the centres. This is reflected in the exploratory study and once again confirmed in the survey. Staff goals tended to be abstract and ideal, but clients expected concrete and practical benefits from the service. Examples of such client expectations were:

[We are able to] attend movies or theatres more often and interact with the community more.

We feel sanctuary or asylum in such institutions is important. This, as well as love, are/were very important in my recovery.

I would like to obtain employment through LSC.

It is not apparent as to whether or not the socio-economic and gender differences between staff and clients affected the discrepancies in perceptions between these two groups.

4.4 Further revelation from the qualitative data

In the survey, a significant proportion of staff felt that the LSCs were undervalued by other community mental health team staff. To illustrate this perception, the following two quotes, written by non-LSC staff, reflect some of the attitudes held by others toward LSCs:

> *The LSC in the local area tends to provide diversional activities and outings, which in my opinion is insufficient to do more towards improving the quality of life of person with mental illness....My impression is that LSCs are perceived as [maintenance] centres for clients who do not fit into the Commonwealth Rehabilitation Services, Skills Share Scheme and other work preparation programmes.*

> *LSCs are not client-centred, but group-centred. People do not have personal programmes, [treatment] goals or objectives. They are just put together as a group and minded for the day.*

In addition, the results of the survey revealed that the work experience in a LSC by staff was relatively short as compared to their years of experience in mental health, i.e. less than three years in the LSCs compared to nearly seven years of mental health experience. Only a small number of staff previously had worked in a LSC. This finding is consistent with the one in the exploratory study, where most of the staff had less than two years of work experience in the

centres. There appeared to be a high staff turnover rate in the centres. After leaving a centre, staff seemed to choose work in services other than LSCs. The high staff turnover or attrition rate may be a reflection of job dissatisfaction and burnout (Freudenberger, 1975; Maslach & Jackson, 1982). The following comments may help to understand the experience of the LSC staff:

> *Clients attending [are] not 'mentally ill' but 'brain damage[d]' clients, developmentally disabled, alcoholics, street people. [It is] hard to turn them away and they can influence those with mental illness.*

> *LSCs are not recognised enough by other services.*

The causes of high staff turnover were not explored adequately in this survey. However, the qualitative data shed some light on this issue. A staff member expressed the following feelings during an interview:

> *....I think some of them (referring persons or other community staff) thought that we had this really great job where we danced and sang and partied and generally had a real good time and they did the hard work. I think that we have demonstrated to them that they are the ones that are sort of having a good job partying, shooting around from client to client. We sometimes feel that they don't actually achieve anything and clients*

who are difficult are passed onto us because there is no where else for them to go.

The sense of job dissatisfaction among the LSC staff could be seen to be caused by factors generated from three major sources: staff, clients and the administrative hierarchy. These factors were grouped under the following common themes: discrepancy of goals between staff and clients; inability to meet client needs; inability to provide individual therapy; lack of appreciation and misconception of the LSCs by others; and, working in a small, confined space.

4.4.1 Discrepancy of goals between staff and clients

As discussed previously, the survey revealed that discrepancies existed not only in rehabilitation goals, but other identified areas described in **Section 4.2.3**. Consistently, the study findings indicated that the main reasons that clients use the LSCs were to socialise, meet other people and look forward to having some structure and routine in their daily life. Comments from the interviews include:

I don't come for the work programme. Personally, I come for companionship. I live alone...it gets terribly lonely when you are living by yourself.

On the one hand, staff understood the importance of providing opportunities for clients to socialise and meet each other. On the other hand, they were not content to work within this role and were eager to provide programmes to "rehabilitate" clients "into the community" through activities of daily living (self-care and grooming activities), and instrumental activities of daily living training (cooking and budgeting), therapeutic groups such as, expressive art, discussion and educational groups, etc., and supportive work programmes. The following quote is from a staff member who participated in the semi–structured interviews:

> *It (LSC) endeavours to do active rehabilitation rather than just a baby-sitting service. It provides groups that [include] a range of pre-vocational, leisure and therapy groups.*

This discrepancy of perceived purpose of the LSCs not only led to frustration among the staff, but it also led to self-doubt regarding their own professional competency and judgement.

> *We are trying to get those [discrepancies of goals] to meet up a bit more. However we have had experience here where we had run groups that we were perceiving to be therapeutic and clients did not attended and they didn't see them as necessary. Even though that was based on assessment of client needs: we asked the clients if that was something*

that we should be offering and we offered it and no one showed up so we are still having teething problems I guess.

Some of the staff persisted in implementing rehabilitation programmes that focused on integrating clients into the community and gaining productive employment; however participation in these programs was resisted by clients that has different goals. One of the client interviewees commented:

And I fought that, I did what I thought was right and they were doing what this particular person (the staff tried to 'encourage' her returning to productive employment) thought they were doing what they thought I was capable of and what they knew me as being capable of before, like when I was functioning in a workplace. I stood up for myself and painful as it was and may be disappointing as it was for them....maybe I don't want to loose my pension and maybe I don't want to loose my housing commission [flat], maybe I will one day, but it will be because I want to and because I want to get something out of work, not because anyone else is telling me to.

4.4.2 Inability to meet client needs

The problem of not being able to meet client needs was highlighted in the Human Rights and Equal Opportunity Commission (1993), (The Burdekin Report). Two shortcomings in the Living Skills Programmes were identified.

First, the programmes were not able to integrate the clients into local social, recreational, community or work activities. Secondly, the programmes were designed to meet the need of the most severely impaired clients. There were no alternatives for other clients who were less impaired.

This researcher observed that, perhaps to rectify the above situation, supportive work programmes were frequently implemented and seemed to be a common rehabilitation strategy in many LSCs for the higher functioning clients. These programmes were viewed as one of the important functions of the LSCs. It was a widely-held belief that work programmes were effective in providing work skills training for clients and had the potential for preparing them for competitive employment. It also was believed that the programmes helped clients to build up their own self-esteem by engaging in paid work. As one of the staff stated:

> *I guess also more and more a function of living skills centres is to provide supportive work, because it is not provided out in the community for people with mental illness and it is very important....[it is] a means for them [clients] to gain more work experience perhaps. I mean vocational training or the vocational area can consist of the correct assessment and then putting these people into whether it be an organisation outside of the centre or whether it be into our supportive work programme.*

Some clients also perceived supportive work programmes as beneficial. For example:

> *[The coffee shop (a self-initiated work programme) is] incorporated as part of the living skills [centre] and that is real good because people can go out and it is not easy work, it is hard work sort of thing and it is closer to the real world sort of thing. Any you get a larger wage and that is good too.*

> *Work programmes are good. You get paid for that, mop the floors, do the vacuuming and stuff like that. You get paid for that....it gets you motivated.*

Although some clients did not envision that they would be able to cope with competitive employment, they still highly regarded their experience in the supportive work program:

> *...but the work programmes for people who might have spend a long time in hospital and who never had opportunities to develop work skills.....and work programmes with the gardening and the company [a registered company to provide the supportive work] they have and you can do the paper run....and you earn a bit of money and you get self-esteem from that....Even if they don't go to open employment there is*

employment here that pays money and people can earn so much on the pension....without losing their pension. They can stay on their medication and they don't have to....go out into the open workforce.

However, it appeared that not every centre would be able to set up supportive work due to shortage of staff, space, and other resources. Some centres that called their programmes "work programmes" but were not as well organised as the others. The need for setting up supportive work programmes was reflected in staff's comments on further improvement during the semi–structured interviews:

We need to get a vocational officer, someone who is going to be able to set up a supportive work programme.

Oh, definitely a work programme. We need to begin to develop a co-op and our own work programme so that clients can get out of basically the rut they are in....I think there are lots of things, lots of areas where improvements can be made...in terms of space now we could do with a large room like for the work programme. We are having to look at getting, leasing a property in order to store our equipment, etc. It is like there is no space to expand....I think that there ought to be some supportive workshop set up that is available to all living skills [centres]

that really is more community based, not doing meat work like packaging and other nonsense that is mind dead work.

4.4.3 Inability to carry out individual therapy

In addition to affecting the establishment of work programmes, staff shortages also affected the staff's opportunities to provide individual therapy. Some of the staff interviewed saw the individual therapy, which included money management, cognitive-behavioural therapy and counselling, as an important part of their work in the LSCs.

.... Now then there are other more basic things like money management which doesn't really get done very well in a group situation because you really need to look at where the person's money is going and in a group situation they may not want to reveal that and not necessarily that they have to reveal that to me but it is better to do it individually. There is counselling involved too – mostly the clients have either experienced trauma or they are currently dealing with a lot of loss and dealing with why have I got schizophrenia for example and so on, perhaps individual sessions are appropriate there.

Interestingly, despite staff comments, money management, an instrumental activity of daily living skill, and cognitive-behavioural therapy traditionally are provided in group settings. Counselling also can be provided in

a group. In addition, there is the possibility that the LSC staff never received formal education or training in group work. Nevertheless, individual therapy is perceived by many mental health professionals as the most prestigious type of therapy. This may be the reason that staff associated it with more intrinsic rewards and job satisfaction. Psychiatrists, physicians, case managers, mobile treatment teams and crisis teams, who are seen as major players on the rehabilitation team, all are involved in individual therapy. Those who are involved in group work, which can be demanding both physically and mentally, often are poorly regarded by other community mental health staff and are seen as playing a relatively minor role in the rehabilitation process.

There also is an element of prestige associated with the type of clients that mental health professionals treat. The most desirable clients are those who are verbal, have a good potential for recovery, and have the cognitive ability to develop insight into their psychiatric problems. On the other end of the spectrum are the chronically mentally ill who exhibit negative symptoms, have limited verbal skills and whose potential for recovery is minimal.

On the other hand, some of the staff felt that there was not enough time or manpower to spend on individual therapy:

> *At the moment it is a bit tight, but it has always been something that I have wanted to do....I don't see the benefit of running a group when you cannot follow up with your client how they are going....Groups are*

great, but there are lots of things that you can't do. Unfortunately there is not a lot of time, our programme is really busy...

Thus, inability to carry out individual therapy contributes to feelings of frustration and job dissatisfaction among the staff.

Nevertheless, most of the clients who were interviewed saw the most important purposes of the LSC as providing a venue for them to meet friends and socialise, opportunities to talk to staff and other clients, and a structure for their daily life routines. Survey findings supported the perceptions identified through the interviews. The study findings also revealed that individual therapy was not a critical component of rehabilitation for every client.

The more I mix [with people] and get out [the house] the less I go to hospital.

4.4.4 Lack of appreciation and misconception of Living Skills Centres by other staff or referring agents.

LSC staff members described the misconception and lack of appreciation by other staff or referring agents in the following manner:

I think it [LSC] has been given very little priority by service directors...you can argue that mobile treatment teams are also in the business of rehabilitation and this is true. But they are not doing it in the same way that we are doing it. They don't have 20-30 clients to deal

with everyday. They deal with people in one's with breaks in between. While I think that we are at the coal face of the rehab[ilitation] process we are also the part of the service that is given the least credit in terms of being able to affect any changes in clients. We have been given very low priority. We have been forgotten about. We are kind of like a little back water, people don't take us very seriously.

On our referral forms we get a lot of socialisation, please socialise this person, activate this person. I guess I would say that probably doctors would perceive living skills as just providing a sort of day care service I would think. I think that would probably be a common perception of living skills [centre] that basically you send them to living skills [centre] to sort of take them off the streets and get them off your hands and keep them occupied.

One of the LSC staff made this strong comment, "I guess what we really need is to really know what we are all about and to keep the idea of rehabilitation and I think mental health team, like case managers do not provide rehabilitation, it is the living skills that are meant to provide it."

4.4.5 Working in a small confined space

As most of the programmes were carried out within the LSCs, which usually are housed in renovated three or four bedroom residential houses in the

community, space was a major concern. Insufficient space for expansion caused frustration among the staff. Lack of personal space for staff, as well as clients, increased tension and anxiety among them. Frequently the centre was crowded with 20 to 30 people at one time for six to seven hours a day, five days a week. There was limited space for staff to use for various programmes. There also was not enough individual space for either staff or clients to be alone. The space issue was described in the following interview:

> *I think that it [LSC] could be further improved by perhaps having more space....I think that staff have their own offices and I think that clients should have their own space as well. I think that if it was bigger and we had more very separate cottages with very distinct functions so that people could attend one or more simultaneously or at the different times if they wanted to attend one or the other that they would have the choice to move between them rather than just everybody sharing the same space together and all the roles overlapping and it becomes very confused.*

For some centres, a strategy for coping with space problems was to close the centre for various periods of time for a "Planning week" or "Staff report writing day", "Staff meeting day". However, this strategy was not received well by the clients:

....it [LSC] needs a bit more programmes....May be [opened] 5 days a week instead of 3

I think the hours of the centre could be improved a bit.....I think like the centre is opened from 10:30 to 3:00 four days a week and I think it could do to be opened a bit longer.....I think they should have some kind of a drop-in centre on the weekends.

Furthermore, a feeling of loss of general focus and direction for the LSC service also may be seen as a indication of confusion and self-doubt among the staff. As one staff member stated,

If you are neglected in that way in terms of administration, you tend be overlooked as well and no one seems to care very much or thinks very much.....so without much interest coming from the top you tend to get sort of anarchy at the bottom. People do what they want to do and people pursue pretty much what they think and there is no attempt to sort of sit down and consult with what is the best overall strategy. So you have no uniformity and you have no standardisation that is why I think we have been neglected in other words.

Similar comments were voiced by other LSC staff :

Well just from my opinion it looks like what is happening. [comment on whether LSC is losing its direction]. It started off when we had the psychosocial rehabilitation model which I think most of the centres were based on. Now centres, some are going purely to the vocational, some are going into this collaborative therapy, we are going into basically a bit of trying collaborative therapy, but at the moment we are into behavioural model, setting goals and so on. It seems like there are a few clues in people that are going in particular directions and we are losing the general focus.

What has constantly emerged [in the Life Skills Forum] is the fact that there is no effective way of working and that most people are unhappy with the model that they are using....This had led to this big move to Michael White['s Collaborative Therapy] because it requires much less paper work and structure so that is a big asset as far as most people are concerned. I think this unhappiness with the model is a big problem...

One of the staff members saw action from the administration as the way to overcome the problem of unclear direction and focus for the LSC services.

I think we need to get together with the executive of the mental health services and they need to sit down with staff of living skills centres and try and work out a philosophy and I think that is the only way we are

going to get - OK I accept that there are different client populations in different areas and that may create different needs in different areas but I still think that there needs to be some consultation process going on whereby we can sit down and work out some kind of general philosophy....I think that I guess the purpose of the Life Skills Forum was to do just that, but the Life Skills Forum is not attended by the executives of mental health services. It is only attended by staff of living skills centres. Once again it is this old bottom up top down thing which I find problematic we are not going to change things bottom up, I don't think so.

In addition, survey findings reveal that good staff-client relationships were perceived as the most important factor in assisting clients to achieve their own goals. It is obvious that a high staff turnover rate is detrimental to relationship building. Though clients did not complain about the high turnover rate, they were affected by the situation. One of the clients interviewed commented:

Well they (LSC staff) are going through a little bit of difficulty at the moment because they changing staff and you are getting new staff in....It takes a while for the staff to get settled in sort of thing and to really get into the swing of things. To get to know the clients and stuff like that

and for the clients to get to know them....It does [affect my progress] for a little while, but once I get settled in everything is OK.

Finally, although it may be a wish list, the improvements that the staff wanted to see for the LSCs may provide ideas to resolve the problem of job dissatisfaction and attrition. Identified improvements included a well-defined role and direction for the centres within the community mental health service; more specialised services to meet the needs of clients who have differing abilities and levels of functioning; and, more staff, facilities and space for the centres.

CHAPTER 5

Conclusion

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5.1 CONCLUSION

Living Skills Centres are part of the community mental health services. Their operation is based on the psychosocial rehabilitation framework which focuses on providing support to people with mental illness to enable them to achieve an optimal level of independent functioning in the community. The original aims of LSCs are to promote community adjustment and to prevent rehospitalisation.

The health care industry has undergone significant changes since the establishment of the first centre. Additionally, the literature on LSCs is limited. These factors prompted the researcher to examine this unique service. In order to explore and gain an understanding of issues associated with LSCs and to describe the general characteristics of the service in New South Wales, a research design of purposive survey, which combined semi-structured interviews and a questionnaire survey adopted. The purpose of the survey was to examine the perceptions of purposes and functions of LSCs from the perspectives of staff and clients.

Based on the findings from both the interviews and the survey, it was concluded that LSCs have played an important role within the community mental health service system, despite the fact that some of the staff felt the

service were being undervalued. It was found that LSCs provided services for rehabilitation purposes and maintaining the well-being of people with severe mental illness in a community-based environment. They also served as an outreach support service to help clients in the transition to community living, even though the transition process for some clients might take a long period of time.

Generally speaking, the perceived purposes and functions of LSCs, according to staff and clients, did not deviate extensively from the original aims of the LSC programme. The differences between clients' and staff perceptions were in the areas of description and priorities of those purposes and functions. Clients perceived the LSCs as meeting their needs for social support, recreation and constructive use of time. They believed that the LSC services had helped them in improving their quality of life in the community by:

1) gaining self-confidence and self-esteem;

2) providing opportunities to make friends and socialise; and,

3) having somewhere to go to spend time constructively.

Interestingly, the staff's, particularly those working in LSCs, perceptions of the purpose and functions were similar to the clients' perception. However, staff have other broad and abstract goals, such as provision of support and resources for clients to live in the community, and provision of opportunities to rebuild self-confidence and self-esteem. However, other members of community mental health team tended to perceive the LSCs serving a more limited function, i.e. provision of maintenance, social and diversional

programmes. They did not see the service as more important or even as important as other community mental health services.

Clients seemed to realise that their goals and reasons for attending the centres were different from the staff's goals. However, they still looked forward to attending the centres and expressed satisfaction with the service. Actually more clients than staff perceived the service as most important in improving their quality of life in the community. Possible reasons to explain this phenomenon include:

1) there inevitably are differences in focus and expectations for the service between clients and health professionals;
2) the other available community services do not meet client needs, particularly in the areas of social support and recreation; and,
3) clients prefer to socialise with people of similar background and with staff who understand their situations and illness.

Nevertheless, both clients and staff perceived the good relationship between each other in the Centres as the most important factor in assisting clients to achieve their goals in LSCs. Being allowed to set own goals for rehabilitation was another important factor that was valued by a significant number of clients and staff. Other contributing factors perceived by a great proportion of clients and staff were staff's motivation and dedication, case management within the centre, varieties of programmes, and client's own motivation.

Besides more staffing, facilities and space, future improvements of LSCs, as requested by clients, included having more specialised programmes to match their levels of ability and functioning. Although they agreed with clients on the latter recommendation, staff were more concerned about having a better defined role and direction for the LSC service within the community mental health service system. In the future, they also would like to have an improved working relationship and liaison with other community resources and services.

One particular phenomenon, which was not anticipated in the beginning of the study, was the sense of work dissatisfaction and burnout among the LSC staff. Actually, this situation was not difficult to understand when it was found that the staff had to cope with the following:

1) discrepancy of goals between staff and the clients;
2) inability to meet needs of the clients who had different levels of functioning;
3) inability to carry out individual interventions;
4) limited personal and work space; and,
5) lack of appreciation and misconception of LSC service by other mental health professionals.

When faced with these difficulties, it was inevitable that staff would develop feelings frustration and experience burnout The high staff turnover rate among the LSC staff probably can be attributed to these conditions.

Finally, as revealed in the study findings, LSCs continue to play a significant role in assisting people with mental illness to live in the community

and to enhance their quality of life. Thus, it is important to continue the service as well as increase its contributions and viability among the comprehensive mental health services.

5.2 LIMITATIONS OF THE STUDY

This study on Living Skills Centres is not without limitations. Regarding the survey, although the researcher attempted to select the LSCs randomly, in order for the findings to be generalisable to other LSCs, the responses did not turn out that way. There were poor responses from some of the selected centres, particularly those located in rural areas. Thus, the skewed responses might have distorted the results. Furthermore, the non-LSC subjects were recruited by convenience. This method of sample selection also reduced the generalisabilty of the findings. In addition, people's perceptions are likely to be influenced by experience and may change over time. Therefore, the findings only represent the perceptions of the subjects involved at the time of the survey. Another limitation of the study was that it only involved subjects who were capable of comprehending English and were present on the day of the interviews or when the survey was distributed.

An additional limitation was that there were too many items on the questionnaire and the items often overlapped, particularly in the areas of purposes and services. This might have caused some confusion among the subjects in understanding and selecting appropriate answers, particularly for clients who have a short attention span. On the other hand, asking several questions about an area of interest can serve to validate the responses. In addition, a significant number of clients, up to 25% at times, did not rank or had difficulties in ranking the items. This also might have distorted both the raw data and the data analysis.

Finally, this study also was intended to examine client satisfaction with the LSC service. The preferred method of participatory research, where clients are involved as co-researchers, was not able to be adopted by the researcher due to budget and time constraints. Although the researcher was independent to the LSCs and other community mental health services, the subjects' responses might have been biased, particulars those subjects who were given the questionnaire in person by the researcher.

5.3 RECOMMENDATIONS

The following recommendations for future improvements of the LSC service are based on the findings of the study and the literature review. They include staff empowerment, defining the service philosophy and directions, a three-tiered system of service provision, re-establishing the value of social and recreational programmes in psychiatric rehabilitation, and partnership in therapy.

5.3.1 *Staff empowerment*

The current health care system is highly politicised (Gardner, 1989). LSC staff need to use a political process to improve their sense of power and control over the working environment. Typically, health care professionals empower their clients to acquire better services and care through education and advocacy. Staff need to understand and evaluate the power structure of the health care system they work under and know their power base (Allison & Allison, 1984)

Another way to empower staff is to increase their knowledge base in the areas of rehabilitation, the health care system and community resources and networks. This can be accomplished formally through workshops, conferences, and other forms of continuing education. As one of the staff interviewees stated:

I think for living skills centres to be really effective then when someone starts a centre, if a particular centre is using cognitive behavioural methods, then that person should go away and do some sort of training course for ten days or two weeks or three weeks or however long it actually takes to learn this stuff properly before they actually come back and use it. And not have to pick it up piece meal from someone who hasn't learnt it either who has picked it up piece meal from someone else.

Another empowerment technique that would address one of the problems identified by staff, is the establishment of admission criteria, supported by well-reasoned rationales, for LSC clients and disseminating the criteria to the community mental health team and referring agencies.

5.3.2 *Defining the service philosophy and directions of Living Skills Centres*

Another problem identified by staff was the need for a better defined role and direction for the LSCs within the comprehensive mental health services. In the semi-structured interviews, staff expressed the need to examine the programs and even the name of the centres.

I think that it is a farce to teach living skills in a living skills centre, a farce, joke. Because if that is the emphasis on teaching, socialising or

therapy or relaxation or something else then I don't have a problem [same as] cooking or cleaning or whatever. But I think that living skills need to be in vivo and that living skills centres cannot provide that with the staffing levels and that we need to have more mobile treatment teams.

Living skills centre I think gives this connotation or.... people need living skills. I find that the majority of my clients, well not the majority, many of my clients well all of our clients, probably don't need living skills. Some do, some do need the basic living skills structure of doing very basic tasks but I don't like the name living skills. I never have.

I think that a number of other living skills centres have names of their own [Cottage or House or other generic name]. I think that is probably more appropriate, it is more adaptive to the immediate community in which you live, it is less stigmatising and I think to have some sort of name like that I think it is more readily accepted in the wider community. There is a facility up the road there called whatever and you can then develop a warm identity around that and hopefully some significant links with the community. Rather than a rather sterile and potentially stigmatising name like Living Skills Centre, which is very narrow in its connotation, depending on who is ringing you up....So I think there is a need to move from Living Skills Centre and have some

> *sort of name that links you more to the local community in which you live.*

The above quoted staff member had additional ideas on an appropriate name for the centres:

> *I think if you have something with psychiatric rehabilitation centre, I think that for me it evokes the images of the institution and rigid management guidelines that I think add to the stigmatising and I think the clients feel very comfortable with a house in suburbia....I think clients appreciate the lack of institutional sort of ethos, I think they are happy to come and have us in civilian clothes and be able to come in here and joining in a range of activities that are very much integrated with the local situation in which they live*

The initiative to begin a dialogue regarding service philosophy and directions for LSCs must come from the LSC staff, who may be the only people with a vested interest in this problem. Again, understanding and using the political system, that has the power to implement change in the mental health system, is critical to solving this problem. There is a resource in place that has the potential to support LSC staff in their efforts to implement change. The Life Skills Forum is a support group for LSCs and similar programmes. The aim of the Forum as expressed by one of the LSC staff interviewees is, "*I think*

perhaps for Livings Skills Centres as a whole we can all learn from one another and certainly where we have weaknesses other people have strengths and where we have strengths other people might have weaknesses. So I see the Forum has been a good way of cross pollinating."

In addition to providing mutual support, the Life Skills Forum can give individuals a sense of solidarity during the process of negotiating change. It is apparent that there are mutual advantages to clarifying the role of the LSCs. A clear service philosophy and operational model can provide direction and guidance for intervention planning, quality assurance and outcome evaluation. In addition, it will clarify the purpose and value of the LSCs to other agencies providing community mental health services.

5.3.3 *A three-tiered system of service provision*

It is generally agreed that clients are different and they have different needs at different times. The survey findings clearly indicated that some clients just need socialisation, others may need daily living skills training, and few need work programmes or any of these combinations. With limited resources and no clear priority, staff can easily find themselves unable to cope with the job demand which may be one of the causes of burnout (Maslach & Jackson, 1982).

The reason for that is explained by one of the staff interviewee:

> *I think that specific functions need to be outlined in this living skills centre, for example, we need to break up pre-vocational, leisure and therapy. I think the reason why we need to break that up is that it is confusing not only to the staff but to the clients. I think it places unrealistic expectations on lower functioning clients I think that there is an accidental yet still underlying and very ever present idea that good clients get jobs and bad clients don't. I think that could be broken up by separating pre-vocational from the rest of the service. I also think that it works the other way as well, that higher functioning clients that perhaps have come for therapy rather than socialising, just as an example, are forced to be in a low expectancy environment. I think that is equally as damaging to have a higher functioning client in a low expectancy environment as it is to have a low functioning client in a high expectancy group....There should be flexibility for clients to go between levels as one client can function at different level at different time.*

5.3.4 *Re-establishing the value of social and recreational programmes in psychiatric rehabilitation*

Very often, when staff provide rehabilitation to people with mental illness, consciously or unconsciously they are expecting some positive changes in the clients at the end of the intervention. This expectation may be due to the way health care professionals are trained. Working with clients who are verbal and capable of gaining insight into and changing their unproductive thinking

and behavior is far different than working with clients who are chronically mentally ill. With chronically mentally ill clients, there often is no resolution or "happy ending" for their problems. They will continue to require supportive services just as a person who is myopic will continue to need corrective lenses. Professionals working in mental health often devalue programmes, interventions, and activities that provide maintenance or support services.

It is important to note most of the clients in this study perceived the most important role of the LSCs as providing a venue for socialisation and making friends and opportunities to engage in activities which help them to establish daily routine. Thus, staff need to adjust their values and expectations according to what is valued and realistic for their clients. Psychosocial rehabilitation is a model of service provision designed to furnish the types of service, intervention and support that chronically mentally ill people need in order to live in the community. There are numerous studies documenting the effectiveness of these programmes. However, LSCs will not reach their potential for effective service delivery unless the staff and community mental health administrators "buy into" and support the concepts of the model they have selected.

5.3.5 *Partnership in therapy*

Often clients find it difficult to articulate what they need to function optimally in the community. Sometimes clients may not know what they want or need due either to the illness process (e.g. acute psychosis or cognitive impairment), or to insufficient information. Mental health professionals need to

empower clients through education and explanations of available options, so that clients can make informed decisions. Clients have the right to make decisions about their lives and staff have to accept these decisions and help them act on them. Since psychosocial rehabilitation supports client empowerment and participation, staff need to include clients in their centre-wide programme planning as well as individual treatment planning.

If the clients are unable to make decisions, as a result of cognitive impairments, staff can use the insights into cognitive disability identified by Allen, Earhardt, and Blue (1992) to structure the environment to meet clients' safety needs and support their level of cognitive functioning. They also can use themselves as a therapeutic tool (Mosey, 1986), which consists of staff's enthusiasm, flexibility, creativity and empathy, in engaging clients in the beginning stage of rehabilitation or the recovery process. As this is a partnership in therapy, both parties have the responsibility to make it work.

5.4 FUTURE RESEARCH ON LIVING SKILLS CENTRES

Although the study has provided some understanding about the perceptions of staff and clients on the LSC service, it also opens up more areas for further research. The need for further research was articulated by one of the LSC staff member, during an interview.

> *I think that we do need some research that would look at what different living skills centres are achieving in order to try to work out what method is the best method.*

Besides investigating the feasibility of the above recommendations, treatment and cost effectiveness of LSC are the two areas that need to be studied.

The results of the questionnaire survey might have been distorted due to the skewed responses as discussed in **section 4.1**. There was a possibility that those centres that responded were the better LSCs or perhaps the less busy ones. Therefore, a small postal survey would be useful to follow up to determine whether the demography, population and work rate of the other LSCs were comparable.

Further study also needs to be carried out on those potential subjects that were not involved in the survey, particularly those who did not attend LSCs. The questionnaire survey has identified some of the reasons why clients chose not to attend the centres, but they were not conclusive, as the number of subjects involved was small.

One of the limitations of the study is that clients who could not comprehend English had been excluded from the investigation. A significant number of them came from a culturally diverse background. The cultural and social factors that might have influenced the perception of the LSC service among the subjects had not been explored as this was not the focus of the study. However, this is certainly an important area to be addressed in future research as Australia is a multicultural society and how clients of ethnic background perceive the LSC service as well as the whole community mental health services will directly affect the effectiveness of these services in meeting their needs.

Furthermore, work dissatisfaction and burnout were found to exist among the LSC staff. There is a need to establish the relationship between and causal factors related to frequent staff turnover and job dissatisfaction.

The effectiveness of the programmes in preventing hospitalisation and improving clients' quality of life in the community is also an important area for further study. Finally, a similar survey of larger scale or with a more representative sample of LSCs would reveal findings that could be more generalisable.

To conclude, despite the above mentioned limitations, the study has helped to increase the knowledge on the LSC service and its benefits to clients. It also provides an in-depth understanding about the issues or phenomena exist in the service. LSC continues the momentum of community mental health movement and serves as an outreach support service to facilitate people with mental illness in the transition from hospital to independent community living. With further improvements, it can play a very important role within the mental health services and provide invaluable assistance to clients to live in the community as well as to enjoy a quality life.

~~~ The End ~~~
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APPENDICES

APPENDIX I: Questionnaire survey - Tables of results summary

1. *Living Skills Centres' staff and clients*

Table 1.1 The perceived improvements in client's quality of life in community according to LSC staff and clients

LSC	Staff N = 26	Client N = 50	Significant difference (*chi-square test*)
1. Able to make friends and socialise	**89% (23)**	**50% (25)**	***10.874, df=1, p<0.001***
2. Somewhere to go to spend time constructively	**85% (22)**	**52% (26)**	***7.819, df =1, p<0.01***
3. Able to learn skills to live in the community	77% (20)	34% (17)	*12.614, df=1, p<0.01*
4. Able to get help to prevent readmission to hospital	73% (19)	40% (20)	*7.491, df=1, p<0.01*
5. Able to get assistance and training for employment	42% (11)	26% (13)	*Insignificant*
6. Able to help the family/carer to cope with my mental illness	50% (13)	16% (8)	*9.888, df=1, p<0.01*
7. Able to help me to cope with my family/carer	50% (13)	20% (10)	*7.294, df=1, p<0.01*
8. Able to get assistance to live in group home	27% (7)	12% (6)	*Insignificant*
9. Able to comply taking medications	35% (9)	18% (9)	*Insignificant*
10. Able to learn how to manage symptoms	73% (19)	28% (14)	*14.147, df=1, p<0.001*
11. Able to gain self-confidence and self-esteem	**92% (24)**	48% (24)	*14.431, df=1, p<0.001*
12. Increase motivation to do things		2% (1)	
13. Increase life satisfaction		2% (1)	
14. Other		4% (2)	
15. Very little influence on my quality of life in the community		10% (5)	
16. I don't know	4% (1)	4% (2)	

* Percentage of subjects who chose this answer.

Table 1.2 The perceived purposes of Living Skills Centres according to LSC staff and clients

{Some of responses were a tick without giving a rank. This table displays frequency counts only}

LSC	Staff N = 26	Client N = 50	Kendall's tau-b values
1. Prevent hospitalisation	88% (23)	**72% (36)** ***8***	-0.346
2. Provide support and resource to live in the community	**96% (25)**	62% (31) ***7***	0.206
3. Assist and support family/carer to manage client's illness	85% (22)	44% (22) ***2***	0.000
4. Supervise daily medications	61% (16)	44% (22) ***2***	-0.415
5. A convenient venue for staff to monitor client's progress	69% (18)	58% (29) ***6***	-0.363
6. A place to engage in activities instead of being home alone or having no where to go	**96% (25)**	**80% (40)** ***8***	-0.484
7. A place for making friends and socialising	**96% (25)**	**72% (36)** ***8***	-0.321
8. Prepare for and assist in employment	85% (22)	46% (23) ***3***	-0.280
9. Provide opportunity to rebuild self-confidence and self-esteem	**100% (26)**	64% (32) ***8***	0.265
10. Rebuild one's natural character	4% (1)	2% (1) ***1***	
11. Education/ understanding illness	4% (1)	2% (1) ***1***	
12. Other	8% (2)	2% (1) ***1***	
13. I do not know		2% (1)	

* *Figure in italic and bold = Number of responses with no ranking given in that item.*

Table 1.3 Comparison of the first three ranking orders on the perceived purposes of Living Skills Centres between LSC staff and clients

LSC	**Staff N = 26**					**Client N = 50**				
Ranking	**n***	1	2	3	M	**n***	1	2	3	M
1. Prevent hospitalisation	23	13%	9%	22%	5	**28**	**50%**	**14%**	**14%**	**1.5**
2. Provide support and resources to live in the community	**25**	**56%**	**28%**		**1**	24	29%	17%	25%	2.5
3. Assist and support family/carer to manage client's illness	22	9%	9%	14%	5	20	15%		5%	5
4. Supervise daily medications	16				8	20	5%	5%	10%	6
6. A convenient venue for staff to monitor client's progress	18				7	23	4%	13%	4%	5.5
7. A place to engage in activities instead of being home alone or having no where to go	25	4%	12%	12%	4	**32**	**34%**	**13%**	**31%**	**3**
8. A place for making friends and socialising	25	12%	8%	8%	4	**28**	**39%**	**18%**	**7%**	**2**
9. Prepare for and assist in employment	22			9%	7	20	5%	10%	10%	6
10. Provide opportunities to rebuild self-confidence and self-esteem	**26**	**23%**	**23%**	**31%**	3	24	13%	13%	25%	3.25
11. Rebuild one's natural character	1		100%							
12. Education/ understanding illness	1									
13. Other	2		50%	50%	2.5					

* **n** is the total number of subjects who ranked the answer, i.e. excluding those who ticked the answer or made no response.

M = Median rank

Table 1.4 The perceived services of Living Skills Centres according to LSC staff and clients

{Some of responses were a tick without giving a rank. This table displays frequency counts only}

LSC	Staff N = 26	Client N = 50	Kendall's tau-b values
1. Supportive work programme and work skills training/Prevocational programme	73% (19)	**58% (29)** *7*	-0.414
2. Daily living skills training in the centre	85% (22)	**64% (32)** *6*	-0.122
3. In-vivo Daily living skills training	73% (19)	46% (23) *3*	-0.023
4. Assertive/social skills training	81% (21)	54% (27) *7*	-0.020
5. Provide opportunities to make friends and socialise	85% (22)	**66% (33)** *6*	-0.387
6. Provide opportunities for leisure activities	85% (22)	54% (27) *5*	-0.647
7. Provide programmes for client to spend time constructively during the day	85% (22)	54% (27) *3*	-0.082
8. Liaise with other community agents to assist me to live in the community	**92% (24)**	42% (21) *5*	0.020
9. Provide education on medications and symptoms management to client and family/carer	81% (21)	50% (25) *5*	-0.133
10. Provide opportunities for group discussion to share problems and set goals	**88% (23)**	54% (27) *6*	-0.111
11. Case management		8% (4) *1*	
12. Provide different level of activities to meet individual needs			
13. Support case management & client in goal setting and problem solving	8% (2)		
14. Other		2% (1) *1*	
15. I don't know			

** Figure in italic and bold = Number of responses with no ranking in that item.*

Table 1.5 Comparison of the first three ranking orders on the perceived services of Living skills Centres between LSC staff and clients

LSC	Staff N = 26					Client N = 50				
Ranking	n*	1	2	3	M	n*	1	2	3	M
1. Supportive work programme and work skills training/Prevocational programme	19	5%	21%	16%	7	22	55%	14%		**1.5**
2. Daily living skills training in the centre	**22**	**27 %**	**18 %**	**5%**	3.5	**26**	**27%**	**31 %**	**8%**	2
3. In-vivo Daily living skills training	19	11%	21%	11%	5	20	20%	10%	15%	4
4. Assertive/social skills training	21	5%	19%	19%	4	20	20%	5%	25%	3
5. Provide opportunities to make friends and socialise	22	14%		18%	5	**27**	**37%**	**11 %**	**22 %**	2
6. Provide opportunities for leisure activities	22	5%			7	22	23%	27%	14%	2
7. Provide programmes for client to spend time constructively during the day	22	18%	9%	14%	4	24	17%	13%	17%	4
8. Liaise with other community agents to assist me to live in the community	24	12%	4%	21%	4.5	16	25%	6%		5
9. Provide education on medications and symptoms management to client and family/carer	21	10%		5%	6	20	30%	10%		4
10. Provide opportunities for group discussion to share problems and set goals	23	9%	18%	13%	6	21	29%	5%		4
11. Case management						3	33%			8
12. Provide different level of activities to meet individual needs										
13. Support case management & client in goal setting and problem solving	2	100 %								

* **n** is the total number of subjects who had ranked the answer, i.e. excluding those who ticked the answer or made no response.

M = Median rank

Table 1.6 The perceived factors that assist clients to achieve their goals in Living Skills Centres according to LSC staff and clients

{Some of responses were a tick without giving a rank. This table shows frequency counts only}

LSC	**Staff** N = 26	**Client** N =50	**Kendall's tau-b values**
1. Good relationship with centre's staff	**96%** *2*	**74%** *9*	-0.252
2. Self motivation *[client's]*	73%	**60%** *5*	0.202
3. Adequate staffing and facilities	81% *1*	44% *5*	-0.286
4. Able to set own goals of rehabilitation	**85%** *1*	58% *6*	0.000
5. Staff motivation and dedication	**88%** *1*	56% *7*	-0.338
6. Good liaison between centre and other community agents	73% *1*	40% *2*	-0.102
7. Case manager assigned for each client in the centre	81% *1*	**60%** *7*	-0.222
8. Varieties of programmes and activities in the centre	**85%**	54% *5*	-0.149
9. Opportunities to practice learned skills outside the centre	73% *2*	44% *3*	-0.084
10. Case manager for overall management of client's rehabilitation	8%		
11. Develop clear goals of centre in collaboration with clients			
12. Other	4%	2% *1*	
13. I don't know		4% *1*	

* *Figure in italic and bold = Number of responses with no ranking given in that item.*

Table 1.7 Comparison of the first three ranking orders on perceived assisting factors between LSC staff and clients

LSC	**Staff** N = 26					**Client** N = 50				
Ranking	n*	1	2	3	**M**	n*	1	2	3	**M**
1. Good relationship with centre's staff	**23**	**30%**	9%	**22%**	3	**28**	**46%**	**18%**	**11%**	**2**
2. Self motivation	**19**	**47%**	**11%**	5%	2	**25**	**48%**	**12%**		3
3. Adequate staffing and facilities	20	10%	10%	5%	5	17	41%		12%	3.5
4. Able to set own goals of rehabilitation	**21**	**14%**	**24%**	**24%**	3	23	22%	17%	17%	**1**
5. Staff motivation and dedication	22	9%	18%	14%	5	21	38%	10%	19%	4
6. Good liaison between centre and other community agents	18		17%	6%	5	18	22%	11%	6%	7.5
7. Case manager assigned for each client in the centre	21	19%	10%	10%	4	23	43%		22%	2
8. Varieties of programmes and activities in the centre	22	8%	14%	14%	5	22	18%	18%	9%	4
9. Opportunities to practice learned skills outside the centre	14	14%		14%	6	19	26%	11%	5%	**1**
10. Case manager for overall management of client's rehabilitation	2			50%	3					
11. Develop clear goals of centre in collaboration with clients										
12. Other	1									

* **n** is the total number of subjects who had ranked the answer, i.e. excluding those who ticked the answer or made no response.

M = Median rank

Table 1.8 The perceived future improvements required for Living Skills Centres according to LSC staff and clients

{Some of responses were a tick without giving a rank. This table shows frequency counts only}

LSC	Staff N = 26	Client N = 50	Kendall's tau-b values
1. More staff	73% *1*	**52%** *2*	-0.038
2. More facilities and space	76% *1*	**52%** *2*	-0.338
3. Better informed about the centre prior attending	54%	28% *1*	-0.027
4. Better liaison with other community resources/ services	**81%** *2*	30% *1*	0.050
5. Better defined role and direction for the centre within the community mental health service	**81%** *1*	40% *1*	-0.017
6. More specialised services to meet the needs of clients of different level of ability/ functioning	**85%** *2*	**54%** *5*	0.055
7. Better access to public transports	35% *1*	34% *4*	-0.139
8. Have more activities	23% *2*	38% *3*	-0.333
9. Not to have too many activities	15%	24% *1*	-0.293
10. More autonomy to choose activities	42% *2*	32% *1*	-0.118
11. Change to a more appropriate name for the centre	15%	26%	-0.073
12. Abolish the centre and replace it with other service	11%	16% *1*	0.509
13. Providing help to be independence to live away from home			
14. Reorganise service based on community team rather than specialised services	4%		
15. Other		2%	
16. No further improvement required		16% *1*	
17. I don't know		6% *1*	

* *Figure in italic and bold = Number of responses with no ranking given in that item.*

Table 1.9 Comparison of the first three ranking orders on the perceived future improvements of Living Skills Centres between LSC staff and clients

LSC	**Staff N = 26**					**Client N =50**				
Ranking	n*	1	2	3	**M**	n*	1	2	3	**M**
1. More staff	**18**	**33%**	**11%**	**22%**	**3**	**24**	**67%**	**4%**	**4%**	**1**
2. More facilities and space	**19**	**26%**	**21%**	**16%**	**2.5**	**24**	**50%**	**33%**	**8%**	**1**
3. Better informed about the centre prior attending	14	7%	14%	14%	4.5	13	23%	15%	15%	3.5
4. Better liaison with other community resources/ services	19	5%	5%	37%	3	14	29%	14%	14%	3
5. Better defined role and direction for the centre within the community mental health service	**20**	**30%**	**30%**	**5%**	2	19	26%	26%	16%	3.25
6. More specialised services to meet the needs of clients of different level of ability/ functioning	**20**	**20%**	**35%**	**20%**	2	22	32%	5%	36%	3
7. Better access to public transports	8	12%	12%		7	13	15%	8%		5
8. Have more activities	6				9	16	6%	12%	12%	4
9. Not to have too many activities	4				11	11			9%	9
10. More autonomy to choose activities	9				5	15	13%		13%	4
11. Change to a more appropriate name for the centre	4	25%			6.5	13	8%	8%	23%	6
12. Abolish the centre and replace it with other service	3	33%			7	7				11
14. Reorganise service based on community team rather than specialised services	1									
15. Other						1	100%			
16. No further improvement required						7	86%		14%	
17. I don't know						2	100%			

* **n** is the total number of subjects who had ranked the answer, i.e. excluding those who ticked the answer or made no response.
M = median rank

Table 1.10 The perceived levels of importance of Living Skills Centres in improving client's quality of life according to LSC staff and clients

LSC	**Staff** **N = 26**	**Client** **N = 50**
Most Important	35% (9)	56% (28)
Just as important as other service	58% (15)	24% (13)
I'm not sure	4% (1)	10% (5)
Not as important as other service	4% (1)	
Not important at all		
No response		8% (4)

2. *Clients in Sydney's LSCs & those in Country LSCs*
(Excluding those "corrupted" responses)

Table 2.1 Sex distribution of clients of the randomly selected Living Skills Centres

CLIENTS	**RANDOMLY SELECTED LSC IN SYDNEY n = 37**	**RANDOMLY SELECTED LSC IN COUNTRY n = 11**
MALE	**29 (78%)**	**8 (73%)**
FEMALE	7 (19%)	3 (27%)
No response	1 (3%)	

Table 2.2 Age distribution of clients of the randomly selected Living Skills Centres

CLIENTS	**RANDOMLY SELECTED LSC IN SYDNEY**	**RANDOMLY SELECTED LSC IN COUNTRY**
Less than 21 years old		
21 - 30 years old	7 (19%)	2 (18%)
31 - 40 years old	**15 (41%)**	3 (27%)
41 - 50 years old	10 (27%)	**5 (45%)**
More than 50 years old	5 (14%)	1 (9%)
No response	1 (3%)	
Average Age	**38.4 years old S.D. = 9.5**	**41.1 years old S.D. = 9.4**

Table 2.3 Birth places of clients and their parents of the randomly selected Living Skills Centres

CLIENTS		RANDOMLY SELECTED LSC IN SYDNEY	RANDOMLY SELECTED LSC IN COUNTRY
FATHER	AUSTRALIA	**25 (68%)**	**6 (55%)**
	OVERSEAS	11 (29%)	4 (36%)
	No response	1 (3%)	1 (9%)
MOTHER	AUSTRALIA	**21 (57%)**	**8 (73%)**
	OVERSEAS	12 (32%)	3 (27%)
	No response	4 (10%)	
CLIENT	AUSTRALIA	**31 (84%)**	**8 (73%)**
	OVERSEAS	6 (16%)	3 (27%)

Table 2.4 Years of mental illness among clients of the randomly selected Living Skills Centres

CLIENTS	RANDOMLY SELECTED LSC IN SYDNEY	RANDOMLY SELECTED LSC IN COUNTRY
Less than 1 years ago	5% (2)	
1 - 5 years ago	5% (2)	27% (3)
6 - 10 years ago	24% (9)	36% (4)
11 - 15 years ago	21% (8)	9% (1)
16 - 20 years ago	16% (6)	
More than 20 years ago	17% (6)	18% (2)
No response	11% (4)	9% (1)
Mean	**13.2 years ago**	**10.8 years ago**

Table 2.5 Types of accommodation where clients of the randomly selected Living Skills Centres lived

CLIENTS	RANDOMLY SELECTED LSC IN SYDNEY	RANDOMLY SELECTED LSC IN COUNTRY
FAMILY	32% (12)	36% (4)
FRIEND	5% (2)	
GROUP HOME	8% (3)	27% (3)
ALONE	43% (16)	36% (4)
BOARDING HOUSE	3% (1)	
NURSING HOME	3% (1)	
HOSTEL	3% (1)	
OTHER	3% (1)	

Table 2.6 Previous Living Skills Centre experience among clients of the randomly selected Living Skills Centres

CLIENTS	RANDOMLY SELECTED LSC IN SYDNEY	RANDOMLY SELECTED LSC IN COUNTRY
YES	37% (14)	45% (5)
NO	63% (23)	55% (6)

Table 2.7 Days of attendance (per week) at Living Skills Centres among clients of the randomly selected Living Skills Centres

CLIENTS	RANDOMLY SELECTED LSC IN SYDNEY	RANDOMLY SELECTED LSC IN COUNTRY
1 day	5% (2)	82% (9)
2 days	11% (4)	
3 days	24% (9)	
4 days	24% (9)	
5 days	24% (9)	9% (1)
6 days		
7 days	3% (1)	
No response	8% (3)	9% (1)
Mean	**3.7 days** **S.D. = 1.32**	**1.4 days** **S.D. = 1.26**

Table 2.8 Perception of the discrepancy in goal setting between staff and clients as perceived by clients of the randomly selected centres

CLIENTS	RANDOMLY SELECTED LSC IN SYDNEY N = 37	RANDOMLY SELECTED LSC IN COUNTRY N = 11
All are different	24% (9)	18% (2)
Some are different	32% (12)	9% (1)
Very few are Different	14% (5)	18% (2)
No different	24% (9)	46% (5)
No response	5% (2)	9% (1)

Table 2.9 Referring agents' understanding of the purposes of Living Skills Centres as perceived by clients of the randomly selected centres

CLIENTS	RANDOMLY SELECTED LSC IN SYDNEY N = 37	RANDOMLY SELECTED LSC IN COUNTRY N = 11
Yes	**62% (23)**	100% (11)
No	8% (3)	
I am not sure	27% (10)	
No response	3% (1)	

Table 2.10 Reasons given for referring to Living Skills Centres as reported by clients of the randomly selected centres

CLIENTS	RANDOMLY SELECTED LSC IN SYDNEY N = 37	RANDOMLY SELECTED LSC IN COUNTRY N = 11
Yes	**65% (24)**	55% (6)
No	11% (4)	18% (2)
Can't remember	16% (6)	18% (2)
No response	8% (3)	9% (1)

(If YES, What were the reasons given for attending LSC?)

CLIENTS	RANDOMLY SELECTED LSC IN SYDNEY N = 24*	RANDOMLY SELECTED LSC IN COUNTRY N = 6*
1. Prevent readmission to hospital	54%	33%
2. Obtain training and support to live in the community	46%	33%
3. Obtain assistance in managing mental illness	**71%**	33%
4. Obtain medications	8%	
5. Make friends and socialise with other people	**67%**	**67%**
6. Have something to do, instead of being home alone or having no where to go during the day	**75%**	**50%**
7. Obtain training or assistance in finding job	29%	
8. Doctor's instruction / recommendation		
9. Other		
10. I can not remember	8%	17%

*** Number of client subjects who claimed that reasons were given when referred to LSC**

Table 2.11 Comparison of the perceived improvements in client's quality of life in community between Sydney and Country clients of the randomly selected centres

CLIENTS	RANDOMLY SELECTED LSC IN SYDNEY N = 37	RANDOMLY SELECTED LSC IN COUNTRY N = 11
1. Able to make friends and socialise	49%	**55%**
2. Somewhere to go to spend time constructively	**57%**	27%
3. Able to learn skills to live in the community	38%	27%
4. Able to get help to prevent readmission to hospital	41%	36%
5. Able to get assistance and training for employment	30%	9%
6. Able to help the family/carer to cope with my mental illness	19%	9%
7. Able to help me to cope with my family/carer	24%	9%
8. Able to get assistance to live in group home	14%	9%
9. Able to comply taking medications	24%	
10. Able to learn how to manage symptoms	27%	27%
11. Able to gain self-confidence and self-esteem	**51%**	36%
12. Increase motivation to do things	3%	
13. Increase life satisfaction	3%	
14. Other	5%	
15. Very little influence on my quality of life in the community	11%	9%
16. I don't know	5%	

* Percentage of target group subjects who had chosen this answer.

Table 2.12 Comparison of the ranking orders on the preferred methods of informing about the purposes of Living Skills Centres between Sydney and Country clients of the randomly selected centres

CLIENTS	**RANDOMLY SELECTED LSC IN SYDNEY N = 37**		**RANDOMLY SELECTED LSC IN COUNTRY N = 11**		**Kendall's tau-b values**
Ranking	**Median**	**Mode**	**Median**	**Mode**	
1. Received information pamphlets	6	6	5	5	0.119
2. A letter from the centre	4	6	3	3	-0.444
3. Visit the centre	2.5	2	**2**	**1**	-0.050
4. Trial period at the centre	3	1	4.75	6	0.316
5. Phone call from centre staff	2.5	1	3.25	1	0.129
6. Clear explanation by referring person/agent	**1.5**	**1**	3.25	1	0.233
7. Informed by relatives/friends	0	1			
8. Other	0	0		7	

Those responses which were a tick without a rank number have been replaced by the ranking values of **medians-of-nearby-points.**

Table 2.13 Comparison of the first three ranking orders on the perceived purposes of Living Skills Centres between Sydney and Country clients of the randomly selected centres

CLIENTS	RANDOMLY SELECTED LSC IN SYDNEY N = 37					RANDOMLY SELECTED LSC IN COUNTRY N = 11				
Ranking	**n***	1	2	3	**M**	**n***	1	2	3	**M**
1. Prevent hospitalisation	**20**	**55%**	**15%**	**20%**	**1**	7	29%	14%		3.5
2. Provide support and resources to live in the community	15	33%	27%	33%	2	8	25%			5
3. Assist and support family/carer to manage client's illness	12	17%	8%	8%	5	7	14%			6
4. Supervise daily medications	14	7%	7%	7%	4.5	6			17%	8.5
6. A convenient venue for staff to monitor client's progress	15	7%	7%	7%	5.25	7		29%		7
7. A place to engage in activities instead of being home alone or having no where to go	**22**	**36%**	**14%**	**27%**	**2**	**8**	**25%**	**13%**	**50%**	**3**
8. A place for making friends and socialising	18	39%	11%	11%	2	**8**	**50%**	**25%**		**1.5**
9. Prepare for and assist in employment	13		15%	8%	4.5	6	17%		17%	6
10. Provide opportunities to rebuild self-confidence and self-esteem	15	13%	7%	27%	3	7	14%	14%	14%	4

* **n** is the total number of subjects who ranked the answer, i.e. excluding those who ticked the answer or made no response.
M = Median rank

Table 2.14 Comparison of the first three ranking orders on the perceived services of Living Skills Centres between Sydney and Country clients of the randomly selected centres

CLIENTS	RANDOMLY SELECTED LSC IN SYDNEY N = 37					RANDOMLY SELECTED LSC IN COUNTRY N = 11				
Ranking	n*	1	2	3	M	n*	1	2	3	M
1. Supportive work programme and work skills training/Prevocational programme	**14**	**57%**	**14%**	**7%**	**1.5**	6	33%	17%		3.5
2. Daily living skills training in the centre	**16**	**44%**	**31%**	**6%**	**2**	7		43%	14%	3
3. In-vivo Daily living skills training	14	21%	14%	14%	3.5	5	20%		20%	6
4. Assertive/social skills training	12	25%	17%	8%	4	6	17%	33%	33%	3.5
5. Provide opportunities to make friends and socialise	**17**	**35%**	**18%**	**18%**	**2**	**8**	**50%**		**25%**	**2**
6. Provide opportunities for leisure activities	**15**	**27%**	**33%**	**20%**	**2**	6	17%	17%		5
7. Provide programmes for client to spend time constructively during the day	16	13%	19%	25%	3	6	33%			6
8. Liaise with other community agents to assist me to live in the community	12	25%	8%	17%	4	4	25%			6
9. Provide education on medications and symptoms management to client and family/carer	13	23%		23%	5	**6**	**50%**	**17%**		**1.5**
10. Provide opportunities for group discussion to share problems and set goals	14	36%			4.5	6	17%	17%		4.5
11. Case management	2	50%			4.5	1				0

* **n** is the total number of subjects who ranked the answer, i.e. excluding those who ticked the answer or made no response.

M = Median rank

Table 2.15 Comparison of the first three ranking orders on the perceived assisting factors between Sydney and Country clients of the randomly selected centres

CLIENTS	RANDOMLY SELECTED LSC IN SYDNEY N = 37					RANDOMLY SELECTED LSC IN COUNTRY N = 11				
Ranking	n*	1	2	3	**M**	n*	1	2	3	**M**
1. Good relationship with centre's staff	**20**	**45 %**	**15 %**	**15 %**	**1.5**	**6**	**50 %**	**33 %**		**1**
2. Self motivation	17	47%	18%		**2**	7	43%			4
3. Adequate staffing and facilities	12	50%		8%	3	5	20%		20%	4
4. Able to set own goals of rehabilitation	15	27%	13%	13%	3	**6**	**17 %**	**17 %**	**33 %**	**3**
5. Staff motivation and dedication	14	43%	7%	14%	2.5	**6**	**33 %**	**17 %**	**33 %**	**2**
6. Good liaison between centre and other community agents	13	23%	15%	8%	4	4	25%			4
7. Case manager assigned for each client in the centre	**18**	**44 %**		**22 %**	**3**	4	50%			**1**
8. Varieties of programmes and activities in the centre	14	21%	29%	7%	**2**	6	17%			5
9. Opportunities to practice learned skills outside the centre	13	31%		8%	4	5	20%	20%		4

* **n** is the total number of subjects who had ranked the answer, i.e. excluding those who had just ticked the answer or made no response.

M = Median rank

Table 2.16 Comparison of the first three ranking orders on the perceived future improvements of Living Skills Centres between Sydney and Country clients of the randomly selected centres

CLIENTS	RANDOMLY SELECTED LSC IN SYDNEY N = 37					RANDOMLY SELECTED LSC IN COUNTRY N = 11				
Ranking	n*	1	2	3	M	n*	1	2	3	M
1. More staff	**15**	**60 %**		**7%**	**1**	**7**	**86%**	**14%**		**1**
2. More facilities and space	**16**	**56 %**	**25 %**	**6%**	**1**	**6**	**33%**	**50%**	**17%**	**2**
3. Better informed about the centre prior attending	8	25%	13%	13%	3	5	20%	20%		4
4. Better liaison with other community resources/ services	10	30%	20%	10%	2.5	4	25%		25%	4
5. Better defined role and direction for the centre within the community mental health service	11	27%	27%	18%	2.25	7	29%	14%	14%	3
6. More specialised services to meet the needs of clients of different level of ability/ functioning	13	46%		38%	2.25	7	14%	14%	14%	3.75
7. Better access to public transports	9	11%	11%		5.5	4	25%			5
8. Have more activities	11		18%	9%	4.5	4	25%		25%	3.5
9. Not to have too many activities	7			14%	9	4				9
10. More autonomy to choose activities	10	10%		20%	4	4	25%			7
11. Change to a more appropriate name for the centre	9			22%	7	4	25%	25%	25%	2.5
12. Abolish the centre and replace it with other service	6				11	1				
13. Providing help to be independence to live away from home										
14. Reorganise service based on community team rather than specialised services										
15. Other	1	100 %								

* **n** is the total number of subjects who ranked the answer, i.e. excluding those who ticked the answer or made no response. **M = median rank**

Table 2.17 Comparison of the perceptions of the importance of Living Skills Centres in improving client's quality of life between Sydney and Country clients of the randomly selected centres

LSC	RANDOMLY SELECTED LSC IN SYDNEY N = 37	RANDOMLY SELECTED LSC IN COUNTRY N = 11
Most Important	**62% (23)**	**46% (5)**
Just as important as other service	24% (9)	36% (4)
I'm not sure	5% (2)	9% (1)
Not as important as other service		
Not important at all		
No response	8% (3)	9% (1)

3. *Subjects with LSC experience (past or current) and those with no LSC experience*

Table 3.1 Number of subjects

Subjects	**LSC experience**	**No LSC experience**
Staff	37% (30)	76% (25)
Client	63% (51)	24% (8)

Table 3.2 Sex distributions of subjects with and without Living Skills Centre experience

Subjects	**LSC experience N = 81**	**No LSC experience N = 33**	**TOTAL N = 114**
MALE	**56%**	**49%**	53% (61)
FEMALE	42%	51%	46% (52)
No response	1%		1% (1)

Table 3.3 Comparison of the perceived purposes of Living Skills Centres between subjects with and without LSC experience

{Some of responses were a tick without giving a rank.}

	LSC experience N = 81	**No LSC experience N = 33**	**Significant Difference (Chi-square test)**	**Kendall's tau-b values**
1. Prevent hospitalisation	75% *8*	76% *1*	20.304, df = 2, p < 0.01	0.462
2. Provide support and resources to live in the community	74% *7*	79% *1*	Insignificant at p < 0.05	0.099
3. Assist and support family/carer to manage client's illness	58% *2*	76% *1*	Insignificant at p < 0.05	0.088
4. Supervise daily medications	49% *2*	63%	Insignificant at p < 0.05	0.162
5. A convenient venue for staff to monitor client's progress	60% *6*	63%	Insignificant at p < 0.05	0.127
6. A place to engage in activities instead of being home alone or having no where to go	85% *8*	97% *1*	Insignificant at p < 0.05	-0.108
7. A place for making friends and socialising	81% *8*	81%	Insignificant at p < 0.05	-0.008
8. Prepare for and assist in employment	59% *3*	79% *1*	7.114, df = 2, p < 0.05	-0.264
9. Provide opportunities to rebuild self-confidence and self-esteem	77% *8*	88% *1*	Insignificant at p < 0.05	-0.222
10. Rebuild one's natural character	2% *1*	6%	Insignificant at p < 0.05	1
11. Education/ understanding illness	2% *1*			
12. Other	4% *1*	3%	Insignificant at p < 0.05	

** Figure in italic and bold = Number of responses with no ranking in that item.*

Table 3.4 Comparison of the first three ranking orders on the perceived purposes of Living Skills Centres between subjects with and without LSC experience

	LSC experience N = 81					No LSC experience N = 33				
Ranking	**n***	1	2	3	**M**	**n***	1	2	3	**M**
1. Prevent hospitalisation	**53**	**34%**	**18%**	17%	**3**	24	4%	4%	4%	6
2. Provide support and resource to live in the community	**53**	**42%**	**21%**	**15%**	**2**	**25**	**40%**	**16%**	**12%**	**2**
3. Assist and support family/carer to manage client's illness	45	11%	4%	9%	5	24	4%	4%	4%	5
4. Supervise daily medications	38	3%	3%	5%	8	21	5%	10%		8
6. A convenient venue for staff to monitor client's progress	43	2%	7%	2%	6	21		5%	5%	7
7. A place to engage in activities instead of being home alone or having no where to go	**61**	**42%**	**13%**	**42%**	**3**	**31**	**32%**	**6%**	**29%**	**3**
8. A place for making friends and socialising	**58**	**28%**	**14%**	**9%**	**3**	**27**	**22%**	**26%**	7%	3
9. Prepare for and assist in employment	45	2%	4%	9%	7	25	4%	8%	12%	5
10. Provide opportunities to rebuild self-confidence and self-esteem	**54**	**17%**	**20%**	**28%**	**3**	**28**	**29%**	**29%**	**29%**	**2**
11. Rebuild one's natural character	1		100%		0	2				0
12. Education/ understanding illness	1									
13. Other	2		50%	50%		1				

* **n** is the total number of subjects who ranked the answer, i.e. excluding those who ticked the answer or made no response.

M = Median rank

Table 3.5 Perceived services of Living Skills Centres according to subjects with and without LSC experience

{Some of responses were a tick without giving a rank. This table shows the frequency counts only}

	LSC experience N = 81	**No LSC experience N = 33**	**Kendall's tau-b values**
1. Supportive work programme and work skills training/Prevocational programme	63% *7*	**76%** *1*	0.063
2. Daily living skills training in the centre	69% *6*	**79%**	-0.058
3. In-vivo Daily living skills training	54% *3*	72%	0.086
4. Assertive/social skills training	63% *7*	72%	0.062
5. Provide opportunities to make friends and socialise	**74%** *6*	**81%**	0.066
6. Provide opportunities for leisure activities	67% *5*	**79%**	0.054
7. Provide programmes for client to spend time constructively during the day	67% *3*	**88%** *1*	-0.195
8. Liaise with other community agents to assist me to live in the community	59% *5*	**76%** *1*	0.313
9. Provide education on medications and symptoms management to client and family/carer	62% *5*	**79%** *1*	-0.217
10. Provide opportunities for group discussion to share problems and set goals	68% *6*	**84%**	-0.062
11. Case management	5% *1*	3%	-0.235
12. Provide different level of activities to meet individual needs	2%		
13. Support case management & client in goal setting and problem solving	4%		
14. I don't know	1% *1*	6%	0.352

* *Figure in italic and bold = Number of responses with no ranking given in that item.*

Table 3.6 Comparison of the first three ranking orders on the perceived services of Living Skills Centres between subjects with and without LSC experience

	LSC experience N = 81					No LSC experience N = 33				
Ranking	n*	1	2	3	M	n*	1	2	3	M
1. Supportive work programme and work skills training/Prevocational programme	**44**	**32%**	**18%**	**2%**	**2**	24	17%	21%	4%	3
2. Daily living skills training in the centre	**50**	**26%**	**24%**	**6%**	2.5	**26**	**38%**	**4%**	**19%**	3
3. In-vivo Daily living skills training	41	15%	17%	12%	4	24	13%	13%	4%	5
4. Assertive/social skills training	44	11%	11%	20%	4	24	13%	17%	8%	4
5. Provide opportunities to make friends and socialise	**54**	**24%**	**7%**	**20%**	**3**	27	11%	19%	11%	3.5
6. Provide opportunities for leisure activities	49	14%	12%	8%	4	26	12%	4%	23%	4.5
7. Provide programmes for client to spend time constructively during the day	51	18%	10%	14%	4	**28**	**32%**	**14%**	**14%**	4
8. Liaise with other community agents to assist me to live in the community	43	16%	7%	14%	4.5	24	13%		4%	5
9. Provide education on medications and symptoms management to client and family/carer	45	18%	4%	4%	5	25	8%	8%	4%	6
10. Provide opportunities for group discussion to share problems and set goals	49	18%	12%	8%	5	26	19%	15%	12%	4
11. Case management	3	33%			8	1			100%	5
12. Provide different level of activities to meet individual needs	1	100%			0					
13. Support case management & client in goal setting and problem solving	2	100%			1					
14. I don't know										

* **n** is the total number of subjects who ranked the answer, i.e. excluding those who ticked the answer or made no response.

M = Median rank

Table 3.7 Perceived factors that assist clients to achieve their goals in Living Skills Centres according to subjects with and without LSC experience.

{Some of responses were a tick without giving a rank. This table shows the frequency counts only}

	LSC experience N = 81	**No LSC experience N = 33**	**Kendall's tau-b values**
1. Good relationship with centre's staff	**81%** *11*	**85%** *1*	0.156
2. Self motivation *[client's]*	64% *5*	**79%** *1*	0.102
3. Adequate staffing and facilities	58% *6*	**76%** *1*	-0.040
4. Able to set own goals of rehabilitation	67% *7*	76%	0.007
5. Staff motivation and dedication	65% *8*	73%	0.020
6. Good liaison between centre and other community agents	51% *3*	70%	0.242
7. Case manager assigned for each client in the centre	68% *8*	73% *1*	0.153
8. Varieties of programmes and activities in the centre	65% *5*	**76%** *1*	0.037
9. Opportunities to practice learned skills outside the centre	54% *5*	73%	0.011
10. Case manager for overall management of client's rehabilitation	2%	3%	0.500
11. Develop clear goals of centre in collaboration with clients		3%	
12. Other	2% *1*		
13. I don't know	9%	6%	

* *Figure in italic and bold = Number of responses with no ranking given in that item.*

Table 3.8 Comparison of the first three ranking orders on the perceived assisting factors between subjects with and without LSC experience

	LSC experience N = 81					No LSC experience N = 33				
Ranking	n*	1	2	3	M	n*	1	2	3	M
1. Good relationship with centre's staff	**55**	**40%**	**13%**	**16%**	**2**	**27**	**26%**	**15%**	**15%**	**3**
2. Self motivation	**47**	**45%**	**17%**	**2%**	**2**	**25**	**32%**	**12%**	**12%**	**3**
3. Adequate staffing and facilities	41	22%	10%	10%	4	24	25%	4%	17%	4
4. Able to set own goals of rehabilitation	**47**	**21%**	**19%**	**19%**	**3**	**25**	**20%**	**16%**	**16%**	**3**
5. Staff motivation and dedication	**45**	**22%**	**13%**	**16%**	**3**	**24**	**13%**	**25%**	**13%**	**3.5**
6. Good liaison between centre and other community agents	38	11%	13%	5%	4.5	23	4%	9%	4%	6
7. Case manager assigned for each client in the centre	**47**	**30%**	**4%**	**19%**	**3**	23	4%	17%	13%	4.25
8. Varieties of programmes and activities in the centre	48	15%	15%	10%	4	24	21%	4%	4%	5
9. Opportunities to practice learned skills outside the centre	39	18%	5%	10%	4	24	17%	8%	17%	5.5
10. Case manager for overall management of client's rehabilitation	2			50%	3.5	1				0
11. Develop clear goals of centre in collaboration with clients						1	100%			0
12. Other	1				0					

* n is the total number of subjects who ranked the answer, i.e. excluding those who ticked the answer or made no response.
M = Median rank

Table 3.9 Perceived future improvements required for Living Skills Centres according to subjects with and without LSC experience

{Some of responses were a tick without giving a rank. This table shows the frequency counts only}

	LSC experience N = 81	**No LSC experience N = 33**	**Kendall's tau-b values**
1. More staff	59%	61%	0.138
2. More facilities and space	60%	55%	0.051
3. Better informed about the centre prior attending	38%	48%	0.060
4. Better liaison with other community resources/ services	48%	52%	0.110
5. Better defined role and direction for the centre within the community mental health service	56%	64%	-0.054
6. More specialised services to meet the needs of clients of different level of ability/ functioning	**65%**	**76%**	-0.059
7. Better access to public transports	35%	48%	-0.071
8. Have more activities	36%	39%	-0.109
9. Not to have too many activities	20%	24%	-0.047
10. More autonomy to choose activities	3%	45%	0.074
11. Change to a more appropriate name for the centre	25%	33%	0.087
12. Abolish the centre and replace it with other service	15%	27%	0.269
13. Providing help to be independence to live away from home			
14. Reorganise service based on community team rather than specialised services	1%		
15. Other	1%	9%	0.516
16. No further improvement required	7%	3%	0.181
17. I don't know	3%	15%	

** Figure in italic and bold = Number of responses with no ranking given in that item.*

Table 3.10 Comparison of the first three ranking orders on the perceived future improvements required for Living Skills Centres between subjects with and without LSC experience

	LSC experience N = 81					No LSC experience N = 33				
Ranking	n*	1	2	3	M	n*	1	2	3	M
1. More staff	**45**	**51 %**	7%	**11 %**	**1.5**	19	32%	5%	11%	3.5
2. More facilities and space	**46**	**39 %**	**38 %**	**11 %**	**2**	**17**	**35%**	**24%**	**18%**	**2**
3. Better informed about the centre prior attending	30	13%	13%	13%	4	15	13%	13%	20%	4
4. Better liaison with other community resources/ services	36	14%	11%	28%	3	17	6%	6%	35%	4
5. Better defined role and direction for the centre within the community mental health service	**43**	**28 %**	**26 %**	**12 %**	**2**	**20**	**40%**	**15%**	**20%**	**2**
6. More specialised services to meet the needs of clients of different level of ability/ functioning	**46**	**26 %**	**20 %**	**28 %**	**3**	**24**	**26%**	**33%**	**8%**	**2**
7. Better access to public transports	23	13%	9%		5.5	16	19%		13%	5.5
8. Have more activities	24	8%	8%	8%	5	12	33%			4.5
9. Not to have too many activities	15		7%		10	8	13%			10
10. More autonomy to choose activities	27	7%	4%	7%	5	15		13%	13%	6
11. Change to a more appropriate name for the centre	20	10%	10%	15%	6.5	11		18%	9%	8
12. Abolish the centre and replace it with other service	11	9%			10	9				12
13. Providing help to be independence to live away from home										
14. Reorganise service based on community team rather than specialised services	1				0					
15. Other	1	100 %			0	3	33%			6

* **n** is the total number of subjects who ranked the answer, i.e. excluding those who ticked the answer or made no response.
M = median rank

Table 3.11 The perceived levels of immportance of Living Skills Centres in improving client's quality of life according to subjects with and without LSC experience

	LSC experience N = 81	**No LSC experience N = 33**	**TOTAL N = 114**
Most Important	**51%**	27%	44% (50)
Just as important as other service	37%	**54%**	42% (48)
I'm not sure	5%	12%	7% (8)
Not as important as other service	3%		2% (2)
Not important at all		6%	2% (2)
No response	5%		4% (4)

APPENDIX II: Questions for the semi-structured interviews

(Staff)

1. Position

2. Date commenced working in the Living Skills Centre (LSC)

3. What purposes (in terms of goals) do you see are served by the LSC?

4. In your view, what are the functions (in terms of service provided) of LSC?

5. Do you think your clients understand those purposes and functions of LSC?

1---------------------------------------3---5

Absolutely no knowledge	Partially Understand	Fully understand

6. Who are your source of referral? Do you think they understand those purposes and functions of LSC?

7. In what ways the LSC has helped clients to live and remain in the community and prevent another admission to hosptial? How important are those things?

8. What are the further improvements required for the LSC to meet client needs?

9. What do you see are the factors that will help client achieve the programme's/their goals in the LSC?

10. Any comment you want to make re the LSC service or the questionnaire that is about to take place?

APPENDIX III: Questions for the semi-structured interviews

(Client)

1. Age

2. When was your first time in contact with hospital or community mental health service?

3. Date commenced attending the LSC.

4. Who did refer you to the LSC and for what reasons?

5. What do you see are the purposes of the LSC?

6. In your view, what are the functions of the LSC?

7. What are the things/programs/activities that you like most in LSC?

8. What are the things/programs/activities that you least like in LSC?

9. In what ways has the LSC helped you to live and remain in the community and prevent another admission to hospital? How important are those things?

10. What are the further improvements required for the LSC to meet your needs?

11. What do you see are the factors that will help you achieve your own goals or program goals in the LSC?

12. In what ways are you satisfied with the LSC programs?

13. 10-----------------------------------5-----------------------------------1
    Very satisfied Just satisfied Very dissatisfied

14. Any comment you want to make re the LSC service or the questionnaire survey that is about to take place.

APPENDIX IV : Questionnaire for Clients

A SURVEY ON SERVICES OF THE LIVING SKILLS CENTRE*

(CLIENT / CONSUMER)

***Living Skills Centre may also be known as "Rehabilitation Service", "Cottage". "House" or "Community Health Centre". It is a non-residential, community-based mental health service for persons with mental illness and their families or carers.**

OFFICIAL USE:
Centre Code:
Postcode:
Questionnaire Code:

Please indicate your response by ticking ( ) where appropriate unless otherwise specified.

1. a) Date of Birth

Month__________ Year ________

b) Gender

1. ( ) Male

2. ( ) Female

c) Where were your parents born ?

Father

1. ( ) Australia

2. ( ) Overseas

Mother

1. ( ) Australia

2. ( ) Overseas

d) Where were you born ?

1. ( ) Australia

2. ( ) Overseas

e) When did you first time require hospitalisation or community mental health service for your mental illness?

Year 19___ ___

f) Who do you live with ?

1. ( ) Family
2. ( ) Friend
3. ( ) Group Home
4. ( ) Alone
5. ( ) Other
(Please specify:_________________)

2. a) Did you attend any other Living Skills Centre in the past?

1. ( ) Yes
2. ( ) NO

b) Are you currently attending a Living Skills Centre?

1. ( ) Yes
2. ( ) No

If your answers to either Question 2a or Question 2b or both are YES, please continue to Question 3, otherwise, proceed to Question 4)

3. a) The date (month and year) you commenced attending any Living Skills Centre

Month______Year______

b) On average, when you started attending , how many days did you attend the centre's program in a week

____________Day(s) per week

c) Who referred you to the centre?

1. (   ) Case manager
2. (   ) Other member of the Community Mental Health Team
3. (   ) Staff of the Psychiatric Hospital
4. (   ) Your Psychiatrist
5. (   ) Your Family Doctor
6. (   ) Other
   Please specify:____________________)

d) Were you given the reasons for attending Living Skills Centre by the referring persons?

1. (   ) Yes
2. (   ) No
3. (   ) Can not remember

If YES, what were the reasons given? **(You may tick more than one)**

1. (   ) Prevent readmission to hospital
2. (   ) Obtain training and support to live in the community
3. (   ) Obtain assistance in managing mental illness
4. (   ) Obtain medications
5. (   ) Make friends and socialise with other people
6. (   ) Have something to do, instead of being home alone or having no where to go during the day
7. (   ) Obtain training or assistance in finding job
8. (   ) Other reason
   Please specify ____________________
   ____
9. (   ) I can not remember

e) Do you think the referring person understands the purposes of the Living Skills Centre?

1. ( ) Yes
2. ( ) No
3. ( ) I am not sure

f) Please indicate your preferred ways of being informed about the purposes of the Living Skills Centre before you agree to attend. **Rank your answer from 1 = most preferred to 6 = least preferred.**

1. ( ) Receive Information Pamphlets
2. ( ) A Letter from the centre
3. ( ) Visit the centre
4. ( ) Trial period at the Centre
5. ( ) Phone Call from centre staff
6. ( ) Clear explanation by referring person/agent
7. ( ) Other

Please Specify:______________________)

g) Do you find your own goals of attending the Living Skills Centre are different from the goals set by the staff ?

1. ( ) All the goals are different
2. ( ) Some of the goals are different
3. ( ) Very few goals are different
4. ( ) Non of the goals are different

h) Which is (was) the activity that you like **least** in the centre?

Please specify:______________________

i) Which is (was) the activity that you like **most** in the centre?

Please specify:______________________

j) All things considered, how satisfied are (were) you with the Living Skills Centre ?

1. ( ) Very Satisfied
2. ( ) Satisfied
3. ( ) Dissatisfied
4. ( ) Very dissatisfied

5. ( ) I am not sure

i) How has the Living Skills Centre helped to improve your quality of life in the community? **(You may tick more than one)**

1. ( ) Able to make friends and socialise
2. ( ) Some where to go to spend time constructively
3. ( ) Able to learn skills to live in the community

4. ( ) Able to get help to prevent re-admission to hospital
5. ( ) Able to get assistance and training for employment
6. ( ) Able to help the family/carer to cope with my mental illness
7. ( ) Able to help me to cope with my family/carer

8. ( ) Able to get assistance to live in group home
9. ( ) Able to comply taking medications

10. ( ) Able to learn how to manage symptoms
11. ( ) Able to gain self-confidence and self-esteem
12. ( ) Others
    Please specify:____________________
    ____

13. ( ) Very little influence on my quality of life in the community

14. ( ) I don't know

(Please continue from Question 5)

4. If you are not attending **AND** did not attend any Living Skills Centre in the past, what would be your MAIN reason for not attending ?

1. ( ) Never been referred
2. ( ) Not interested
3. ( ) Not sure about the purposes of Living Skills Centre

4. ( ) Not able to get to the centre
5. ( ) Don't like the programme
6. ( ) Don't like the staff working there

7. ( ) No Living Skills Centre in my area
8. ( ) Never been told such service exists
9. ( ) Other reason
Please specify:____________________)

5. In your view, what should be the purposes of the Living Skills Centre for persons with mental illness? **(Please RANK as many answers as you wish from 1, 2, 3 and so on... to indicate the degree of importance, " 1 " being the most important)**

1. ( ) Prevent hospitalisation
2. ( ) Provide support and resource to live in the community
3. ( ) Assist and support family/carer to manage client's mental illness

4. ( ) Supervise daily medications
5. ( ) A convenient venue for staff to monitor client's progress
6. ( ) A place to engage in activities, instead of being home alone or having nowhere to go

7. ( ) A place for making friends and socialising
8. ( ) Prepare for and assist in employment
9. ( ) Provide opportunity to rebuild self-confidence and self-esteem

10. ( ) Others
Please specify ____________________
____
____

11. ( ) I don't know

6. In your view, which should be the services provided by the Living Skills Centre ? **(Please RANK as many answers as you wish from 1, 2, 3 and so on... to indicate the degree of importance, "1" being the most important service)**

1. (   ) Supportive work programme and work skills training
2. (   ) Daily living skills training, such as cooking and budgeting, in the centre
3. (   ) Daily living skills training at where client lives

4. (   ) Assertive/Social skills training
5. (   ) Provide opportunity to make friends and socialise
6. (   ) Provide opportunity for leisure activities

7. (   ) Provide programmes for client to spend time constructively during the day
8. (   ) Liaise with other community agents/services to assist me to live in the community
9. (   ) Provide education on medications and symptoms management to client and family/ carer

10. (   ) Provide opportunity for group discussion to share problems and set goals

11. (   ) Others
Please Specify:______________________
____
____

12. (   ) I don't know

7. What do you need to help you achieving your goals in the Living Skills Centre? **(Please RANK as many answers as you wish from 1, 2, 3 and so on... to indicate the degree of importance, "1" being the most important factor)**

1. ( ) Good relationship with centre's staff
2. ( ) Self motivation
3. ( ) Adequate staffing and facilities
4. ( ) Able to set own goals of rehabilitation
5. ( ) Staff motivation and dedication
6. ( ) Good liaison between centre and other community agents/services
7. ( ) Case manager assigned for each client in the centre
8. ( ) Varieties of programmes and activities in the centre
9. ( ) Opportunities to practice learned skills outside the centre
10. ( ) Others
    Please specify:__________________
    ____
    ____
    ____
11. ( ) I don't know

8. In your opinion, what improvements are required by the Living Skills Centre to meet your needs? **(Please RANK as many answers as you wish from 1, 2, 3 and so on... to indicate the degree of importance, " 1" being the most important one)**

1. ( ) More staffing
2. ( ) More facilities and space
3. ( ) Better informed about the centre prior attending
4. ( ) Better liaison with other community resources/services
5. ( ) Better defined role and direction for the centre within community mental health service
6. ( ) More specialised services to meet the needs of clients of different level of ability/functioning
7. ( ) Better access to public transports
8. ( ) Have more activities
9. ( ) Not to have too many activities
10. ( ) More autonomy to choose activities
11. ( ) Change to a more appropriate name for the centre
12. ( ) Abolish the centre and replace it with other service (Please specify):__________________
13. ( ) Others Please specify:______________________
____
____
14. ( ) No further improvement required
15. ( ) I don't know

9. All things considered, how do you rate the importance of Living Skills centre in improving your quality of life in the community ?

1. ( ) Most important
2. ( ) Just as important as other services
3. ( ) Not as important as other services
4. ( ) Not important at all
5. ( ) I am not sure

10. Please comment on any aspects of the Living Skills Centre service that have not been covered above. (If insufficient space, please add extra page).

Please return the completed questionnaire and the signed consent form to the researcher or mail to (NO POSTAGE REQUIRED):

Freepost 20DCC
Matthew Yau
c/- School of Occupational Therapy
Faculty of Health Sciences
University of Sydney
East Street, LIDCOMBE NSW 2141

YOUR ASSISTANCE AND COOPERATION ARE VERY MUCH APPRECIATED

APPENDIX V : Questionnaire for Staff

A SURVEY ON SERVICES OF THE LIVING SKILLS CENTRE*

(STAFF)

***Living Skills Centre may also be known as "Rehabilitation Service", "Cottage", "House" or "Community Health Centre". It is a non-residential, community-based mental health service for persons with mental illness and their families or carers.**

OFFICIAL USE:
Centre Code:
Postcode:
Questionnaire Code:

Please indicate your response by ticking ( ) where appropriate unless otherwise specified

1. a) Profession

1. ( ) Nurse
2. ( ) Occupational Therapists
3. ( ) Psychiatrist/Registrar

4. ( ) Psychologist
5. ( ) Social Worker
6. ( ) Other
(Please specify:________________)

b) Gender

1. ( ) Male

2. ( ) Female

c) How long have you been working in the area of mental health/psychiatry?

________ Year(s)

d) Position

1. ( ) Team Leader/Director
2. ( ) Centre Co-ordinator/in-charge

3. ( ) Staff member of the team/centre
4. ( ) Other
(Please specify:________________)

2. Did you work in any other Living Skills Centre in the past?

1. ( ) Yes. For how long?

___________(years)

2. ( ) No

3. Are you currently working in a Living Skills Centre?

1. ( ) Yes. When did you start working in this centre?

Month_________ Year_________

2. ( ) No

If your answers to either Question 2 or Question 3 or both are YES, please proceed to Question 4, otherwise, carry on from Question 5)

4. a) Who is (was) the major referring agent of clients to the centre?

1. ( ) Community Mental Health Team
2. ( ) Psychiatric Hospital
3. ( ) Private Psychiatrist

4. ( ) Local General Practitioner
5. ( ) Other
Please specify:____________________)

b) Do you think the referring agents understand the purposes of the Centre?

1. ( ) Yes

2. ( ) No

If NO, what would be your preferred methods to advise them? **(Please rank answers from 1 to 5 according to your degree of preference, "1" being the most preferable method)**

1. ( ) Sending Information Pamphlets
2. ( ) Writing Letter
3. ( ) Regular Open Day

4. ( ) Attachment to the Centre for a period of time
5. ( ) Regular Phone Call
6. ( ) Other

(Please Specify:________________)

c) Do you think clients understand the purposes of the Living Skills Centre at the time when they are referred?

1. ( ) Yes
2. ( ) No

3. ( ) Partly understand
4. ( ) I am not sure

d) Do you think the services provided by the Living Skills Centre are valued by other staff of the community mental health team ?

1. ( ) Being valued more than any other services
2. ( ) Being valued as much as other services

3. ( ) Slightly being undervalued
4. ( ) Generally being undervalued

e) Do you find the goals that you set for your clients in Living Skills Centre are different from his/her own goals of attending the centre.

1. (   ) Always
2. (   ) sometimes
3. (   ) Rarely
4. (   ) Never

(Please continue to Question 5)

5. In your view, what should be the purposes of the Living Skills Centre for persons with mental illness? **(Please RANK as many answers as you wish from 1, 2, 3 and so on... to indicate the degree of importance, "1" being the most important purpose)**

1. (   ) Prevent hospitalisation
2. (   ) Provide support and resource to live in community
3. (   ) Assist and support family/carer to manage client's mental illness
4. (   ) Supervise daily medications
5. (   ) A convenient venue for staff to monitor client's progress
6. (   ) A place for clients to engage in activities, instead of being home alone or having nowhere to go
7. (   ) A place for making friends and socialisig
8. (   ) Prepare for and assist in employment
9. (   ) Provide opportunity for client to rebuild self-confidence and self- esteem
10. (   ) Others
    Please specify ____________________
    ____
11. (   ) I don't know

6. In your view, which should be the services provided by the Living Skills Centre ? **(Please RANK as many answers as you wish from 1, 2, 3 and so on... to indicate the degree of importance, "1" being the most important service)**

1. ( ) Supportive work programme and work skills training
2. ( ) Daily living skills training, such as cooking and budgeting, in the centre
3. ( ) Daily living skills training at where client lives
4. ( ) Assertive/Social skills training
5. ( ) Provide opportunity to make friends and socialise
6. ( ) Provide opportunity for leisure activities
7. ( ) Provide programmes for client to spend time constructively during the day
8. ( ) Liaise with other community agents/services to assist client to live in the community
9. ( ) Provide education on medications and symptoms management to client and carer
10. ( ) Provide opportunity for group discussion to share problems and set goals
11. ( ) Others
Please Specify:________________________
____
____
12. ( ) I don't know

7. In your experience or knowledge, how has the Living Skills Centre helped to improve client's quality of life in the community ? **(You may tick more than one)**

1. ( ) Able to make friends and socialise
2. ( ) Some where to go to spend time constructively
3. ( ) Able to learn skills to live in the community
4. ( ) Able to get help to prevent re-admission to hospital
5. ( ) Able to get assistance and training for employment
6. ( ) Able to help the family/carer to cope with client's mental illness
7. ( ) Able to help client to cope with his/her family/carer
8. ( ) Able to get assistance to live in group home
9. ( ) Able to comply taking medications
10. ( ) Able to learn how to manage symptoms
11. ( ) Able to gain self-confidence and self-esteem
12. ( ) Others
    Please specify:__________________
    ____
    ____
13. ( ) Very little influence on client's quality of life
14. ( ) I don't Know

8. What do you see are the factors that will help clients achieving their goals in the Living Skills Centre? **(Please RANK as many answers as you wish from 1, 2, 3 and so on... to indicate the degree of importance, " 1" being the most important factor)**

1. ( ) Good relationship with centre's staff
2. ( ) Self motivated
3. ( ) Adequate staffing and facilities
4. ( ) Able to set own goals of rehabilitation
5. ( ) Staff motivation and dedication
6. ( ) Good liaison between centre and other community agents/services
7. ( ) Case manager for each client in the centre
8. ( ) Varieties of programmes and activities in the centre
9. ( ) Opportunities to practice learned skills outside the centre
10. ( ) Others
    Please specify:_________________
    ____
    ____
    ____
11. ( ) I don't know

9. In your opinion, what improvements are required by the Living Skills Centre to meet client needs? **(Please RANK as many answers as you wish from 1, 2, 3 and so on... to indicate the degree of importance, "1" being the most important one)**

1. ( ) More staffing
2. ( ) More facilities and space
3. ( ) Cleint to be better informed about the centre prior attending

4. ( ) Better liaison with other community resources/services
5. ( ) Better defined role and direction for the centre within community mental health service
6. ( ) More specialised services to meet the needs of clients of different level of ability/functioning

7. ( ) Better access to public transports
8. ( ) Have more activities
9. ( ) Not to have too many activities

10. ( ) More autonomy for client to choose activities
11. ( ) Change to a more appropriate name for the centre
12. ( ) Abolish the centre and replace it with other service
(Please specify):_______________

13. ( ) Others
Please specify:__________________
____
____

14. ( ) No further improvement required

15. ( ) I don't know

10. All things considered, how do you rate the importance of Living Skills centre in improving the quality of life of person with mental illness in the community?

1. (   ) Most important
2. (   ) Just as important as other services
3. (   ) Not as important as other services
4. (   ) Not important at all
5. (   ) I am not sure

11. Please comment on any aspects of the Living Skills Centre service that have not been covered above. (if insufficient space, please add extra page.)

Please return the completed questionnaire and the signed consent form to the researcher or mail to (NO POSTAGE REQUIRED):

Freepost 20DCC
Matthew Yau
c/- School of Occupational Therapy
Faculty of Health Sciences
University of Sydney
East Street, LIDCOMBE NSW 2141

YOUR ASSISTANCE AND COOPERATION ARE VERY MUCH APPRECIATED

APPENDIX VI : Participant Consent Form

THE UNIVERSITY OF WOLLONGONG

HUMAN RESEARCH ETHICS COMMITTEE

PARTICIPANT CONSENT FORM

Research Title: **The perceived purposes and servicesof living skills centre according to staff and patients**

Researcher Name: **Matthew K. Yau**

This survey is being conducted as part of a Master of Science (Honours) degree in Mental Health supervised by Associate Professor Ross Harris in the Department of Public Health and Nutrition at the University of Wollongong. The researcher is also a lecturer in the School of Occupational Therapy, Faculty of Health Sciences, University of Sydney.

The aim of the research project is to find out the perceived purposes and services of the Living Skills Centres according to staff and clients who are currently attending the centres and those who are not. The researcher wants to find out to what extent the service has been perceived as helping clients to live in the community.

Your centre/service has been selected and you are invited to participate in this survey. The questionnaire will take about half an hour to complete. Your participation in this project is much appreciated. However, you are free to withdraw from the research at anytime without penalty.

Should you have any queries regarding the questionnaire, please do not hesitate to ask the researcher who is present on the day or phone (02)646-6213. If you have any enquires regarding the conduct of the research please contact the Secretary of the University of Wollongong Human Research Ethics Committee on (042) 213079.

* * * * * *

If you wish to take part in this research please read the Statement of Consent and sign below, then return this consent form and the completed questionnaire, as soon as you can, to the researcher or mail to (no stamp required):

Freepost 20DCC, Matthew Yau,
c/- School of Occupational Therapy, Faculty of Health Sciences,
University of Sydney, East Street,
LIDCOMBE, NSW, 2141

STATEMENT OF CONSENT

I do voluntarily agree to participate in the survey. I understand that though some personal data will be collected, I will not be identified in any report or publication. I also understand that the information generated from this study may help to expand knowledge of psychiatric rehabilitation and benefit myself and other service consumers and providers, and I consent for the data to be used in that manner.

Signed: ___________________________

Date: ___/___/___

APPENDIX VII: Interviewee's Release Form

INTERVIEWEE'S RELEASE FORM

I,____________________ of______________________________________ have granted permission to Matthew Yau to record interview as part of his research project on living skills centre with myself, on the following conditions:

1. That the interview will be transcribed; the transcripts can be edited; and that the recordings, transcripts and related materials will be held by Matthew Yau, School of Occupational Therapy, University of Sydney.

2. That I will receive a copy of the interview in **cassette form or as edited transcript** prior to its use in any publication or report.

3. That I have the right to correct errors in the record of interview prior to its use in any publication by Matthew Yau.

4. I assign all rights in the tape recording/s, transcript and other material deriving from the interview to Matthew Yau.

5. That Matthew Yau will permit bona fide researchers access to the interview material and control the use of the material in a responsible manner including maintenance of anonymity as required

6. Should any publication be written which incorporates any material from my interview, I **DO / DO NOT** *(cross out where inapplicable)* give permission for my name to be attributed to extracts from the transcript or recordings involving myself and the interviewer.

Signed________________________ Date / /

APPENDIX VIII: Thank you letter to the subjects in the exploratory study

Date

Dear,

I would like to extend my sincere thank to you for letting me to interview you in May/June, 1994, on issues related to the purposes and functions of Living Skills Centre. The interview has been transcribed. Please find attached a copy of edited transcript as well as the interviewee's release form for your record. Names and places that were mentioned in the interview have been disguised to maintain confidentiality and anonymity.

You may like to read it over and check for any errors, However, **please do not too concern** about the grammatical structure of your responses as further editing will be carried out should any quote be made from your speech.

Should you wish to make any corrections on the transcript, please kindly write on the copy and return to me by Friday, 26th August, 1994. If I do not hear from you by that date, I shall assume there is no change to be made.

Thank you once again for your cooperation and assistance. The information that I gained from the interview is invaluable and has provided me with few topics for further research in this area. I am currently analysing the interview data of yours and others' and the results will be published and presented in conference in the near future. If you have any further queries about the interview, please do not hesitate to contact me on phone: (02) 6466213.

Sincerely,

Matthew Yau

APPENDIX IX : Human Ethics Approval Application

THE UNIVERSITY OF WOLLONGONG

HUMAN EXPERIMENTATION ETHICS COMMITTEE

INITIAL APPLICATION FOR APPROVAL TO UNDERTAKE TEACHING OR RESEARCH INVOLVING HUMAN SUBJECTS

1. **Title of Project** The perceived purposes and functions of living skills centre according to staff and patients

2. **Centre/School/Department/Institution in which research will be conducted:** Selected living skills centres and community mental health centres in New South Wales

3. **Participants:**

Name	Position/Appointment	Qualification
Chief Investigator(s)		
Matthew Kwai-sang Yau	MSc(Hons) Candidate	BAppSc,MCom,OTR

Other participants

NIL

4. **Purpose of Project** *(please tick only one box)*

Staff Research:

Has an application been lodged for external support for this project? YES/NO *(delete one)*

Name of Organisation______________________________________

Student Research:

Course undertaken Master of Science (Honours) in Mental Health, Department of Public Health & Nutrition

Supervisor A/Professor Ross Harris

<u>5. Category of Experiments</u>

Please enter relevant experiment category(ies), to be used in this project: Category 1.2

6. Period of Clearance Requested: March 1994 - March 1995

7. Aims/Objectives of Project: 1. To investigate staff and client perception of the purposes and functions of the Living Skills Centre; 2. To investigate gaols established by staff for rehabilitation and the service received; 3. To identify client perceptions of the factors that will assist them to attain program goals in the Living Skills Centre; 4. To investigate improvement in community living as perceived by clients who attend the Living Skills Centre.

8. Brief description of aspects of experimental protocol utilising humans.

A cross-sectional survey by self-report questionnaire will be used. Participants will be asked to indicate their agreement of participation by completing the questionnaire and return to the researcher. To construct the questionnaire, a prior, informal semi-structured interview will be conducted with a small sample of staff and clients in the Living Skills Centres.

9. From what group(s) are the subjects to be drawn ?

A randomly selected Living Skills Centres will be approached for approval to conduct the survey among the staff and clients, who have been diagnosed as mentally ill. Staff and clients who are in the community, but do not attend Living Skills centres will be asked to participate in the same survey to act as the control group.

Method of recruiting subjects: Staff members and clients will be individually invited to participate by mail or in person.

10. <u>Subject Consent</u>

How does the project ensure that informed consent is freely obtained from the subject, or from the person who is legally responsible for the subject's welfare ?

Information sheet will be given to potential subjects. Participants will be asked to indicate their agreement of participation by completing the questionnaire and return to the researcher. The researcher will be available to be contacted via phone or in person for subjects to ask questions prior to their commitments.

<u>11. Confidentiality</u>

What measures will be taken to protect the privacy of individual subjects in terms of the test results and other confidential data obtained ?

No names will be used in reporting. No individually identifiable data will be disclosed in reports or publications.

12. Will subjects be paid for participation in the research ?
No.

13. Does the project involve the use of drugs? NO

If YES give details:____

14. How does the project deal with the following ethical issues?

14.1 Freedom to discontinue participation? Subjects may choose to discontinue participation by not filling in the questionnaire and/or not returning the completed questionnaire to the researcher

14.2 Deception (if any) NIL

15. Will any part of the experimental procedures described herein be placed on a film strip, movie film or video-tape, (excluding still photographs)? NO

For what purposes will the film or video-tape be used?

For what audience(s) will the film/tape be exhibited?

16. Does the project involve the use of invasive procedures (e.g. blood sampling) or the possibility of physical or mental stress?
NO

If YES give details____

17. Does this project involve obtaining information of a private nature from any Commonwealth Government Agency?

NO

18. If YES, which agency?____

Declaration

I, the undersigned, have read the current NH&MRC Statement on Human Experimentation and the relevant Supplementary Note to this Statement, and accept responsibility for the conduct of the experimental procedures detailed above in accordance with the principles contained in the Statement and any other condition laid down by the University of Wollongong's Human Experimentation Ethics Committee.

Chief Investigator's/s' signature/s __________Date

If the Chief Investigator is a student,

Supervisor's signature: _________________Date

Other participant's/s' signature/s:

______________________________Date

______________________________Date

Head of Unit's signature:

______________________________Date

The first named other participant will assume responsibility for the project in the absence of the Principal Investigator.

Completed forms to be returned: **Secretary,**
Human Experimentation Ethics Committee,
Office of Research and Postgraduate Studies.

APPENDIX X: A sample of Application for Ethics Approval for conducting the questionnaire survey in the selected health settings

xxxx HOSPITAL & COMMUNITY HEALTH SERVICES
and
XXX HOSPITAL & COMMUNITY HEALTH SERVICES

SUBMISSION OF RESEARCH PROTOCOL APPLICATION TO ETHICS COMMITTEE

1. **Title of Project** The perceived purposes and functions of living skills centre according to staff and clients

Participants:

Name	Position/Appointment	Qualification
Chief Investigator		
Matthew Kwai-sang Yau	MSc(Hons) Candidate University of Wollongong	BAppSc,MCom,OTR
Other participants		
NIL		

2. **Centre in which research will be conducted:**
X Cottage, Living Skills Centre, X Road, Y suburb

3. **Brief Description of the Study**
This study is being conducted as part of a Master of Science (Honours)degree in Mental Health supervised by Associate Professor Ross Harris in the Department of Public Health and Nutrition at the University of Wollongong. The investigator is also a lecturer in the School of Occupational Therapy, Faculty of Health Sciences, University of Sydney. This study is funded by the School Internal Research Grant.

A cross-sectional survey by self-report questionnaire will be used. Participants (staff and clients) will be asked to indicate their agreement of participation by completing the questionnaire and return to the researcher. Wicks Cottage is one of the Living Skills Centres in New South Wales being randomly selected and invited to participate in this survey.

4. **Purposes, Method and Value of the Study:**

The purposes of the study are: 1. To investigate staff and client perception of the purposes and functions of the Living Skills Centre; 2. To investigate gaols established by staff for rehabilitation and the service received; 3. To identify client perceptions of the factors that will assist them to attain program goals in the Living Skills Centre; 4. To investigate to what extent the service has been perceived as helping clients to live in the community.

The method of the Study: Participants are asked to indicate their agreement of participation by filling in a questionnaire, which will take no more than half an hour, and return to the investigator via freepost. (Please refer to the attached questionnaires).

The value of the Study: The investigator anticipate that the information generated from this study may enhance the service provided by the Living Skills Centres, and expand knowledge of psychiatric rehabilitation. There is currently insufficient literature on the functions and effectiveness of Living Skills Centre in rehabilitate people with mental illness.

5. **Procedures:**

The research procedures will not affect the normal care of the clients in the X Cottage. Once ethics approval is given by the Committee, a convenient time will be negotiated with the centre co-ordinator to conduct the questionnaire survey by myself, i.e. to explain the purposes of the study to potential participants, distribute questionnaires to those who are voluntary to participate and answer any queries at the scene.

6. **Studies Involving New Drugs:**

This study does not involve any use of drugs.

7. **Informed Consent:**

Please refer to attached **informed consent sheet.**

Informed consent sheet will be given to potential subjects. Participants will be asked to indicate their agreement of participation by completing the questionnaire and return to the researcher. The researcher will be available to be contacted via phone or in person for subjects to ask questions prior to their commitments.

8. **Operation Specimens**

No operation specimens involved in this study.

9. **Previous Studies:**
Please refer to attached detailed research protocol.

10. **Termination Criteria:**
Participants are free to choose whether to participate in the survey or not. They can also withdraw from it at any time or not returning the completed questionnaire to the investigator.

11. **Independent Monitoring**
Research procedures will be independently monitored by the centre co-ordinator and the Human Research Ethics Committee, University of Wollongong.

12. **a) Will subjects be paid for participation in the research ?** No.

b) Who will benefit from the information obtained ?

The investigator, to meet the requirements for the Master of Science (Honours) Degree.

The investigator also anticipate that the information generated from this study may enhance the service provided by the Living Skills Centres, and expand knowledge of psychiatric rehabilitation. There is currently insufficient literature on the functions and effectiveness of Living Skills Centre in rehabilitate people with mental illness.

c) Where will the information be used, stored or published?
Besides using the information to fulfil the master thesis, the investigator intends to disclose the findings through conference, workshop and/or publication in professional/mental health journals. The information will be stored on computer disks as well as in hard copy form, and will be kept in a secured place in the investigator's office.

13. **Protocols Involving use of Drugs and/or Radioactive Substances:**
This study does not involve the use of drugs and radioactive substances.

14. **Report of Project:**
The investigator agrees to inform the Committee of the conclusions drawn from this study when it is finished.

15. **Full Protocol:**
Please refer to the attached detailed research protocol.

Chief Investigator's signature __________ Date
Name in print: Matthew Kwai-Sang YAU

XXXX HOSPITAL & COMMUNITY HEALTH SERVICES
and
XXX HOSPITAL & COMMUNITY HEALTH SERVICES

CONSENT FORM TO PARTICIPATE IN A RESEARCH PROJECT

I,........................of ....Postcode.......

have been invited to participate in a research project entitled:

The perceived purposes and functions of living skills centre according to staff and clients

In relation to this project I have been informed of the following points:

1) The investigator is conducting this survey as part of a Master of Science (Honour) degree in Mental Health supervised by Associate Profession Ross Harris in the Department of Public Health & Nutrition at the University of Wollongong.

2) Approval has been given by the Ethics Committee of the XXXX Hospital & Community Health Services and XXX Hospital & Community Health Services.

3) The aim of the project is to find out the perceived purposes and functions of the Living Skills Centres according to staff and clients who are currently attending the centres and those who are not. The investigator wants to find out to what extent the service has been perceived as helping clients to live in the community.

4) The results which will be obtained may or may not be of direct benefit to my rehabilitation.

5) The procedure will involve me to indicate my agreement of participation by completing the questionnaire and return to the researcher by freepost at the researcher's cost. The researcher will be available to be contacted via phone (02)646-6213 or in person for me to ask questions prior to my commitment.

6) I can refuse to take part in this study or withdraw from it at any time without any penalty or effecting my medical care and rehabilitation.

7) Though some personal data will be collected, I will not be identified in any report or publication. The researcher agrees not to disclose my identity in any forms or circumstances without my prior approval.

page 2 of 2

After considering all these points I accept the invitation to participate in this survey.

SIGNATURE......................	SIGNATURE..................
of participant................ (please print name)	of Witness................. (please print name)
DATE..........................	DATE.......................

APPENDIX XI : <u>Letter of initial invitation for participation in the survey to the community mental health teams</u>

Date

Director
Community Mental health Service

Dear sir,

I need your help ! I am conducting a questionnaire survey of purposes and functions of Living Skills Centre. This survey is part of a Master of Science (Honours) degree in Mental Health supervised by Associate Professor Ross Harris in the Department of Public Health and Nutrition at the University of Wollongong. I am also a lecturer of the School of Occupational Therapy, Faculty of Health Sciences, University of Sydney. The research protocol of this study has been approved by the Human Research Ethics Committee, University of Wollongong. (Please refer to the attached)

The aim of the study is to find out the perceived purposes and functions of the Living Skills Centres according to staff and clients. The researcher wants to find out to what extent the service has helped clients to live in the community as comparing to those who do not use it.

Your team and your clients are invited to participate in this survey. In the next few weeks you will be receiving copies of the questionnaire designed to gather useful information regarding the perceived purposes and functions of living skills centre service. I would be grateful if you could kindly distribute the questionnaire to staff and clients, particular those who **do not** attend any living skills centre program. The questionnaire will not take more than half an hour to complete. The data from the survey will be used to more wisely evaluate the purposes and functions of Living Skills Centre to rehabilitate clients with mental illness and assist them living in the community. The results of this research study will be presented through publication and/or conference.

To assist persons with mental illness to living in the community should be of concern to all mental health professionals and consumers of the service. So that this study will most accurately reflect the opinions of all, I urgently request the participation from your team and your clients in this study by promptly returning the forthcoming questionnaire in the attached self-addressed envelop.

Should you have any queries, please do not hesitate to contact myself on phone (02) 646-6213. I thank you in advance for your time and cooperation.

Sincerely,
Matthew Yau

APPENDIX XII: Letter of initial invitation for participation in the survey to the Living Skills Centres

Date

Co-ordinator
Living Skills Centre

Dear sir/madam,

I need your help ! I am conducting a questionnaire survey of purposes and functions of Living Skills Centre. This survey is part of a Master of Science (Honours) degree in Mental Health supervised by Associate Professor Ross Harris in the Department of Public Health and Nutrition at the University of Wollongong. I am also a lecturer of the School of Occupational therapy, Faculty of Health Sciences, University of Sydney. The research protocol of this study has been approved by the Human Research Ethics Committee, University of Wollongong. (Please refer to the attached)

The aim of the study is to find out the perceived purposes and functions of the Living Skills Centres according to staff and clients. The researcher wants to find out to what extent the service has been preceived as helping clients to live in the community.

Your centre has been randomly selected from the membership list of the Life Skills Forum, N.S.W.. In the next few weeks I will contact you to confirm if your centre is willing to participate. Then, we can negotiate a date of convenience that I can bring to you, in person, the questionnaire. Staff and clients of the centre are invited to participate in this survey. The questionnaire will not take more than half an hour to complete. The data from the survey will be used to more wisely evaluate the purposes and functions of Living Skills Centre to rehabilitate clients with mental illness and assist them living in the community. The results of this research study will be presented through publication and/or conference. A copy of the results will be sent to you on request.

To assist persons with mental illness to living in the community should be of concern to all mental health professionals and consumers of the service. So that this study will most accurately reflect the opinions of all, I urgently request the participation from you and your centre.

Should you have any queries, please do not hesitate to contact myself on phone (02) 646-6213. I thank you in a
dvance for your time and cooperation.

Sincerely,

Matthew Yau

APPENDIX XIII: <u>Letter of introduction of the questionnaire survey</u>

Date

The Director/Centre Co-ordinator
Community Mental Health Service / Living Skills Centre

Dear Friend,

As you recall from my letter of 19th July, 1994, I am conducting a questionnaire survey on the perceived purposes and functions of Living Skills Centre according to staff and clients. I am now sending two sets of appropriate questionnaire to you - one for clients and another one for staff to fill in. I would be grateful if you could kindly distribute them to your staff (including yourself) and clients **who are currently attending / who are not currently attending** Living Skills Centre's programmes. If there are insufficient copies of questionnaire, please kindly inform me to send you more, or feel free to make photocopies as many as you require.

Since situations may differ greatly, and since I wish the results of the study to be as accurate as possible, I can not overemphasise the importance of receiving completed questionnaire from your staff and clients. In those instances in the questionnaire where no response category accurately reflects your centre/service situation, tick the best answer available and then qualify the response in the margin.

A NOTE OF CONFIDENTIALITY

> A vital concern of the Human Research Ethics Committee, University of Wollongong is the importance of the confidentiality in research. You may notice that codings are being used on the questionnaire. These codings will only be used to facilitate my recording and follow-up techniques, and to prevent your centre/service from receiving bothersome reminder letters. At no time will questionnaires be identified by respondent.

If you have any questions, please do not hesitate to contact myself on (02) 646-6213. At the completion of this research project, I shall be pleased to send you a copy of the results of this survey upon request. I appreciate your time and cooperation and look forward to receiving the completed questionnaires from your staff and clients..

Sincerely,

Matthew Yau

APPENDIX XIV: A reminder note

Dear

(Picture)

I have not received sufficient responses to the questionnaire on Living Skills Centre from your staff and clients. The only reasons I can think of are either the questionnaires have lost their way among your pile of paper works, or being eaten up by this big, fat, greedy pig. Certainly, they are good food for thought.

(Picture)

In the mean time, I am getting very depressed for not receiving your response that I start sipping a few drinks a day to cope with the disappointment. Please help ! Prevent me from becoming a maladjusted, traumatised alcoholic person with borderline personality disorder - it is always other people's fault for my failure.

Please send me your completed questionnaires in two weeks time. Encourage your staff and clients to do the same too. MANY THANKS!

If any questions or need more questionnaires, please call Matthew Yau
(02) 646-6213.