Hong Kong Journal of Mental Health
2018, *44(1)*, 17-32

Outcome Study on the Personal and Clinical Recovery of ICCMW Service Users in the Mental Health Association of Hong Kong

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Abstract

This study aims to evaluate the outcome of Integrated Community Centre for Mental Wellness (ICCMW) services of the Mental Health Association of Hong Kong (MHAHK) in terms of clinical and personal recovery. 78 service users from 3 ICCMWs were recruited. In the first part of the study, the pretest-posttest quasi-experimental approach was used to explore the participants' progress on clinical and personal recovery. In the second part, a qualitative study was conducted to explore the factors that are important to the clinical and personal recovery of ICCMW service users. Significant improvement in post-test scores on both clinical and personal recovery measures were found. The qualitative study identified five themes that were important to the participants' clinical and personal recovery, including home-likeness, recovery coaching, empathetic understanding, social support and social relationships, and assertive engagement. The results provided preliminary evidence on supporting resource allocation to ICCMW services and a further step towards evidence-based practice. They also provided valuable reference to the development of built-in mechanism in ongoing monitoring of outcome of the services.

Keywords: Recovery, Service evaluation, Mental wellness

Introduction

MHAHK operates Integrated Community Centres for Mental Wellness (ICCMW) in Kwun Tong and Tai Po districts as funded by the Social Welfare Department since 2010. ICCMW is an integrated centre that provides one-stop, district-based and accessible community support and social rehabilitation services ranging from early prevention to risk management for discharged mental patients, persons with mental health risks, their families/carers, and residents living in the serving district.

Operators of the ICCMWs are required to achieve the performance standards in accordance with the team size in the specified districts as listed in the Funding and Service Agreement by the Social Welfare Department. Yet, these performance standards focus on output

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only without measuring the outcomes. Outputs are the direct and measurable products of a program's activities or services, often expressed in terms of units such as hours, number of people or completed actions. Outcomes are the results or impact of these activities or services, often expressed in terms of an increase in understanding, improvements in desired health behaviors or attitudes of participants.

There are some local studies involving ICCMWs in data collection for various purposes, such as evaluating caregivers' burden, quality of life after discharge from ICCMW and facilitating strategic planning (Chiang et al., 2016; Lam, 2013; Ng, 2015). Limited well-published research studies have been carried out to formally evaluate the outcome of ICCMWs in systematic way.

Recovery as an expected service outcome

According to the Service Framework of Personalized Care of Adult with Severe Mental Illness in Hong Kong (HA & SWD, 2016), recovery is the common vision of service for people with Severe Mental Illness (SMI) in Hong Kong. The mission of the future service framework of personalized care for SMI adults in community, in line with the overall mental health services, is to facilitate the recovery of SMI patients by providing them and their families with personalized, holistic, timely and coordinated services that genuinely meet their medical, psychological and social needs. ICCMW is one of the major collaborating service units in the recovery journey of people with severe mental illness in Hong Kong, promoting recovery is undoubtedly a key service outcome.

Clinical Recovery and Personal Recovery – The interconnectedness

Dealing with symptoms is important to a lot of people and usually refers as clinical recovery (Slade et al., 2008). On the other hand, personal recovery is defined as "a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life even within the limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness" (Anthony, 1993).

The differences between clinical recovery and personal recovery have been discussed extensively in literature. Although a person with mental illness can experience one without the other, these two versions of recovery may be intertwined. Rather than just focusing on their differences, there are increasing acknowledgements of the interconnectedness of the two types of recovery as complementary and supportive to one another. Clinical and personal recovery should be considered as complementary and synergistic (Slade, 2009). The goal of mental health services is more explicitly the promotion and support of personal recovery, but clinical recovery has the value as one approach to support personal recovery (CSIP, RCPsych & SCIE, 2007).

It is also commonly agreed that an increased sense of wellbeing regardless of continuing symptoms can contribute to a reduction in those symptoms or in their severity (Davidson et al., 2006). Participants in a study of lived experience with psychosis also highlighted that symptom change as an indicator of their recovery and change in symptoms was often accompanied by alleviation of distress and personal change. (Wood et al., 2010).

A key objective of ICCMW is to support persons with mental health problems or suspected mental health problems living to improve their social adjustment capabilities, to prepare them to re-adjust to community living, and to help them to fully develop their social and vocational skills. Although clinical recovery with symptoms reduction would certainly have an impact on social

and community adjustment, it alone is not the whole. Community adjustment should incorporate the element of having meaningful life in which the concept of personal recovery has its position. The service of ICCMW is for promoting both clinical recovery on symptoms reduction, as well as personal recovery on seeking meaningful life. Thus, outcome measures for both aspects should be included in the outcome study of ICCMW services.

Indicators of clinical recovery

There is increasing evidence that the demarcation between anxiety and depressive symptoms and psychotic symptoms is not as clear as it seems. There is evidence that psychotic symptoms could be prevalent in anxiety disorders and depression. Also, high proportion of clinical levels of depression and anxiety symptoms are frequently encountered in the course of psychosis and are of considerable clinical importance. Such high association may be accounted by the neurological disturbances in emotional functioning and the social and functional impacts of the mental illnesses (Wigman et al., 2012). Among the service users of ICCMWs, many presented with active anxiety and depressive symptoms under various diagnoses, and they forms the major proportion of service users. Measuring anxiety and depressive symptoms would be a highly relevant evaluation of clinical recovery.

Indicators of personal recovery

According to Healthtalk Australia (2018), a consortium of researchers conducted qualitative research into experiences of health and illness. Personal recovery is regarded as living a meaningful life, as defined by the person with severe mental health problems. Personal recovery promotes the individual's health and wellbeing, including defining personal recovery goals, building self-esteem, self-confidence, resilience, the ability to maintain relationships, and having a sense of purpose. It should be noted that the indicators of personal recovery should be an account of the subjective experiences. Qualitative interview and psychometric outcome measures on the lived experiences of the person with mental illnesses are the usual methods of monitoring the progress in personal recovery.

Significance of the Study

The study serves as a pilot in evaluating the outcome of services of ICCMWs, in addition to the usual service output parameters which is required for accountability of the services to funding body.

The result of the study also provided valuable reference to the development of built-in mechanism in ongoing monitoring of outcome of the services and sheds lights on areas for further service improvement.

Objectives of the Study

1. Evaluate the outcomes for the services of ICCMW.
2. Explore the perceived factors contributing to the improvement of service users of ICCMW.

Research Questions

1. Does the services of ICCMWs of MHAHK facilitate the clinical and personal recovery of the service users?
2. What are the factors related to ICCMW services that are perceived by the recruited subjects to be important to their clinical and personal recovery?

Methodology

Research Design

The study adopts a mixed research design with pretest-posttest quasi-experimental design for research question 1 in part 1 of the study and qualitative explorative study design for the research question 2 in part 2 of the study.

Sampling

For research question 1, a total population sampling was applied to recruit all newly referred service users under case management services from the 3 ICCMWs operated by the Mental Health Association of Hong Kong.

A total of 95 subjects were recruited with informed consent for pre-test. Finally, 78 subjects (82.1%) were able to complete the post-test after 6-month from the pre-test. The reasons for the 17 subjects (17.9%) that dropout from the study included the following: being untraceable (5 subjects), withdrawal from the study (3 subjects), relapse of illness (2 subjects), exit from services (3 subjects), unavailable for post-test during data collection period (4 subjects). As the total number of dropout subjects was quite small, no Intention-to-Treat Analysis was carried out for consideration of the high likelihood of a Type II error skewing the results and decreasing the power of the analysis. Brief comparison of the demographic and outcome data of the dropout cases did not unveil marked differences from the successful completion group.

For the finally 78 subjects successfully recruited for both the pre-test and posttest measurement, it consisted of both male (28.2%) and female (71.8%). Most of them have a formal psychiatric diagnosis (66.7%), were in the age group of 30-59 (62.9%), living with family (78.2%) in public housing unit (57.7%) with senior secondary school education or above (66.6%) and not in competitive full time or part time employment (74.4%). Table 1 summarized the demographic characteristics of the recruited samples for the part 1 of the study.

For research question 2, a purposive sampling method was applied to maximize the representativeness of the recruited subjects for participation in the focus groups. The sample in Part 2 was recruited from the participants of Part 1. A total of 12 participants attended the focus groups. It consists of both male (16.7%) and female (83.3%). For the purpose to getting a representative sample, there was at least 1 subjects (i.e. 8.33%) in each major subgroups in terms of age groups, marital status, number of children, living status, housing types, education level, occupational status, sources of income, diagnostic groups, progress of the three measures (i.e. no change, deteriorated or improved). Table 2 summarized the demographic characteristics of the recruited samples for the part 2 of the study.

Data Collection and Analysis

Part 1

For Part 1 of the study, a set of 3 measuring tools would be applied. They are the traditional Chinese version of Patient Health Questionnaire (PHQ-9), the Generalized Anxiety Disorder Assessment (GAD-7) and the Chinese Version of Mental Health Recovery Measure (MHRM).

The PHQ-9 is a self-administered tool for screening, assessing and monitoring depression. It consists of 9 items that incorporate DSM-V depression criteria with other major leading depressive symptoms. The total score of PHQ-9 ranges from 0 to 27. Scores of 5, 10, 15, and 20 represents cut points for mild, moderate, moderately severe and severe depression. The diagnostic validity of PHQ-9 was established in studies involving 8 primary care and 7 obstetrical clinics. Using the threshold score of 10, PHQ-9 has a sensitivity of 88% and a specificity of 88% for major depressive disorder. Internal consistency of the PHQ-9 has been shown to be high (Kroenke et al., 2001).

The GAD-7 is a brief self-report tool primarily designed to screen and measure the severity for generalized anxiety disorder. It also has moderately good operating characteristics for panic disorder, social anxiety disorder and post-traumatic stress disorder. It consists of 7 items. The total score ranges from 0 to 21.

Table 1
Characteristics of the Recruited Subjects in Part 1 (N=78)

	Number	Percentage
Types of service users		
Known case	52	66.7
Suspected case	26	33.3
Gender		
Male	22	28.2
Female	56	71.8
Age		
15-29	15	19.2
30-49	25	32.1
50-59	24	30.8
60 or above	14	17.9
Marital status		
Single	34	43.6
Married	27	34.6
Cohabited	1	1.3
Divorced	13	16.7
widow/windower	3	3.8
Number of children		
0	38	48.7
1 – 2	34	43.6
3 – 4	5	6.4
5 or more	1	1.3
Living status		
Living alone	15	19.2
Living with family	61	78.2
Living in hostel	2	2.6
Housing types		
Public housing	45	57.7
Flat under Home Ownership Scheme	8	10.3
Rented room	2	2.6
Bed space	1	1.3
Private housing	21	26.9
Others	1	1.3
Education level		
No formal education	2	2.6
Primary school	12	15.4
Junior Secondary school	12	15.4
Senior Secondary school	32	41.0
Tertiary Education	20	25.6

Table 1
Characteristics of the Recruited Subjects in Part 1 (N=78) (Continued)

	Number	Percentage
Occupational status		
Full time open employment	17	21.8
Part-time open employment	3	3.8
Supported employment	1	1.3
Day hospital	1	1.3
Housewife	1	14.1
Retired	14	17.9
Student	6	7.7
Unemployed	25	32.1
Sources of Income		
Salary	20	25.6
CSSA	14	17.9
DA	4	5.1
Pension	1	1.3
Saving	11	14.1
Family support	28	35.9
Diagnostic groups		
Early Psychosis	2	2.6
Schizophrenia	9	11.5
Delusional disorders	1	1.3
Substance/medication induced psychotic disorders	1	1.3
Bipolar Disorder	4	5.1
Major Depressive Disorders	23	29.5
Anxiety Disorders	2	2.6
OC and related disorders	1	1.3
Trauma and Stress Related Disorders	6	7.7
Personality Disorders	1	1.3
Suspected mental health problems	26	33.3
Others	2	2.6
Dual Diagnosis		
With Dual Diagnosis	1	1.3
Without Dual Diagnosis	77	98.7
Other Disabilities		
Without other disabilities	76	97.4
With other disabilities	2	2.6

Table 2
Characteristics of the Focus Group Participants in Part 2 (N=12)

	Number	Percentage
Types of service users		
Known case	9	75.0
Suspected case	3	25.0
Gender		
Male	2	16.7
Female	10	83.3
Age		
15-29	1	8.3
30-49	4	33.3
50-59	4	33.3
60 or above	3	25.0
Marital status		
Single	6	50.0
Married	4	33.3
Divorced	2	16.7
Number of children		
0	7	58.3
1	2	16.7
2	3	25.0
Living status		
Living alone	2	16.7
Living with family	10	83.3
Housing types		
Public housing	4	33.3
Flat under Home Ownership Scheme	2	16.7
Rented room	1	8.3
Private housing	5	41.7
Education level		
Primary school	2	16.7
Junior Secondary school	2	16.7
Senior Secondary school	6	50.0
Tertiary Education	2	16.7

Table 2
Characteristics of the Focus Group Participants in Part 2 (N=12) (Continued)

	Number	Percentage
Occupational status		
Full time open employment	2	16.7
Part-time open employment	1	8.3
Day hospital	1	8.3
Housewife	1	8.3
Retired	3	25.0
Unemployed	4	33.3
Sources of Income		
Salary	3	25.0
CSSA	1	8.3
DA	1	8.3
Saving	3	25.0
Family support	4	33.3
Diagnostic groups		
Early Psychosis	1	8.3
Schizophrenia	3	25.0
Major Depressive Disorders	4	33.3
Trauma and Stress Related Disorders	1	8.3
Suspected mental health problems	1	25.0
Dual Diagnosis		
With Dual Diagnosis	0	0
Without Dual Diagnosis	12	100.0
Progress of PHQ9		
No change	1	8.3
Deteriorated	4	33.3
Improved	7	58.3
Progress of GAD7		
No change	2	16.7
Deteriorated	2	16.7
Improved	8	66.7
Progress of MHRM		
No change	4	33.3
Deteriorated	6	50.0
Improved	2	16.7

Scores of 5, 10, and 15 represent cut points for mild, moderate, and severe anxiety accordingly. For any anxiety disorder, a recommended cut point for further evaluation is a score of 10 or greater. Using the threshold score of 10, GAD-7 has a sensitivity of 89% and a specificity of 82% for generalized anxiety disorder. It is suggested that GAD-7 is a valid and efficient tool in clinical practice and research (Spitzer et al., 2006).

The Mental Health Recovery Measure (MHRM) is developed by Young and Bullock (2003). It is a self-report scale consists of 30 items covering eight recovery domains on overcoming stuckness, self-empowerment, learning and self-redefinition, basic functioning, overall well-being, spirituality, new potentials, and advocacy/quality of life. Higher scores represent higher self-reported level of recovery. Prior reliability tests have shown good internal consistency (Cronbach's α of .93 for the total score and .60 to .86 for subscales) and high test–retest reliability (r = .92 for 1-week, and r = .91 for 2-week test–retest reliability) (Ye et al., 2013). Good convergent validity was demonstrated as measured by the relationship between the MHRM and other conceptually related measures, such as empowerment, resiliency, and living skills (Andresen et al., 2010). The convergent validity values have been found to be moderate to high, ranging from r=.57 to r=.75 (Bodine, 2013).

Recruited subjects of Part 1 were arranged to evaluate for pretest data and posttest data from the intake (i.e. the time started their ICCMW services) and 6 months after receiving the services respectively. Paired sample t-test and Wilcoxon signed ranks test were both applied in testing the difference between the pre-test and post-test data for the three outcome measures. Wilcoxon signed ranks test was applied in additional the paired t-test because the assumption of normal distribution for the data sets were not supported with the results of Kolmogorov-Smirnov test, Shapiro-Wilk test.

Part 2

For Part 2 of the study, two focus group interviews were organized 7-8 months after receiving ICCMW services with a structured interview protocol in exploring the factors related to ICCMW services that are perceived by the recruited subjects to be important to their clinical and personal recovery.

The audio-recording of the focus groups were transcribed for identification of themes on factors related to ICCMW services that are perceived by the recruited subjects to be important to their clinical and personal recovery. The transcripts were first reviewed by the 5 researchers in group for identification of initial themes. The initial identified themes were then further reviewed individually by researchers with efforts to establish links with existing theories from available literature to ensure the quality of the coding process.

Results

For question 1

Depressive Symptoms for clinical recovery

The results of paired samples t-test indicated that there was a significant reduction of depressive symptoms of the recruited subjects as measured by PHQ-9 for pre-test (M=10.63, SD=5.99) and post-test (M=7.71, SD=5.33); $t(77)=4.85$, $p < .001$.

The results of Wilcoxon signed rank test gave the same indication ($Z=4.397$, $p < .001$).

Anxiety Symptoms for clinical recovery

The results of paired samples t-test indicated that there was a significant reduction of anxiety symptoms of the recruited subjects as measured by GAD-7 for pre-test (M=9.50, SD=5.90) and post-test (M=6.69, SD=5.21); $t(77)=4.32$, $p < .001$.

The results of Wilcoxon signed rank test gave the same indication (Z=4.038, $p < .001$).

Personal Recovery

The results of paired samples t-test indicated that there was a statistical significant improvement in level of personal recovery of the recruited subjects as measured by MHRM for pre-test (M=102.73, SD=16.21) and post-test (M=105.67, SD=15.70); $t(77)= -1.762$, $p = 0.041$.

The results of Wilcoxon signed rank test gave the same indication (Z=-1.686, p=0.046).

For question 2

Five themes were identified to represent the factors related to ICCMW services that are perceived by the recruited subjects to be important to their clinical and personal recovery. They are home-likeness, recovery coaching, empathetic understanding, social support and social relationships, and assertive engagement.

Home-likeness

The participants shared that the ICCMWs they are attending provided them with a home-like feeling that included not only a comfortable environment and adequate facilities, but also the caring, sharing and interaction with the members and staff that make them feel like a home.

As one participant said,

“我只不過係覺得(ICCMW)有個家嘅感覺咋！我嘅需要咪就話好似個家囉！唔… 起碼呢度返嚟都有電視機睇，坐得舒服啲呀！住喺劏房係好辛苦！”

“通常都係你哋嗰個擺設，都係好似屋企咁上下嘅！ ……而呢一度嘅中心，係更加似一個家多啲囉！ (對於一個住劏房嘅人，有一撻地方有個家嘅感覺) 好重要！”

“飲湯煲湯係好緊要！呢邊啲湯始終同出邊有啲唔同！有啲似家嘅感覺！”

Another participant also highlighted,

“我入到呢度我覺得個環境好舒服，真係好舒服……我有時唔開心落黎坐響呢個中心睇下電視，你地啲員工同朋友都好似好親切咁樣。”

“你地對我地既性質係好似一個家庭咁樣關心我地。”

“黎呢度參與，又幾好喎，煮左啲野，排好晒，啲朋友又圍圈…… 做果個好開心，食個果仲開心。又可以係度食啦，又可以係度傾偈，其他果啲中心係無呢啲，即係唔係話貪食而係一種分享。”

According to (Amore et al., 2011), there are three domains constituting a home, namely the physical domain (which implies physical adequacy), the social domain (which refers to privacy and ability to enjoy social relations), and the legal domain (which indicates exclusive possession, security of occupation and legal title). Service users of ICCMWs are provided with the membership to enjoy the physical space and facilities of the center. They also experience social connections there. While it is suggested that built environment, household and neighborhood quality are associated with psychological distress (Wong et al., 2016), the home-like feelings cultivated by the ICCMWs could have a positive impact on members’ mental health.

Recovery Coaching

Coaching refers to facilitate the individual to answer his or her problems within them, to unlock his or her potential. It is to “learn to silence that inner voice and allow their instincts, or their subconscious, to take over” (Gallwey, 1974). When talked about recovery coaching, Skiffington and Zeus (2003) stated that contemporary coaching is inspired by Carl Rogers, that is about humanistic psychology and has philosophical roots in constructivism and existentialism. Researches also commented that the coaching relationship is important (Lai & McDowall, 2014), that coaches’ attributes have a significant influence on the effectiveness of coaching. De Haan (2008) also highlighted the quality of the

coaching relationship would be important for cultivating a positive coaching result.

In view of that, coaching as a holistic approach on how one makes meaning and seeks improvement for his or her life, enhances recovery of service users. It is non-directive, focus on hope and unique in terms of how one define his or her life. Whitmore (2002) also mentioned that coaching is about promoting awareness, responsibility and self-belief, further stated it matches the principles of recovery. As from Roberts (2007), supporting personal recovery is the common purpose of mental health services, life coaching could be a key feature for future development of social services (Bora et al., 2010).

One participant stated,

"…可能會帶俾我嘅目標囉! 即係可以響呢個目標行囉咁! 如果行到呢個目標呢，就梗係好啲啦! 就唔係一個好實際嘅幫忙，係一個目標，係帶我點樣去行呢個目標，或者初時唔好諗到咁遠，少少都得!"

"每人個目標唔同，要做嘅嘢都唔同。呢個係一般正常生活所必須嘅，可能我以前就係失咗為自己定立目標個方向…俾咗個一個希望，一個嘗試嘅信心，我會識得定位自己係去到邊一個階段。"

Another participant shared,

"因為我覺得真係……先唔好講呢度嘅服務，或者職員係點，我淨係講個服務當中已經比到一種方向囉，因為嚟咗呢度，我就話俾自己聽，自己接受緊治療，咁如果你知道自己接受緊治療，你就會開始諗下：「啊! 我係應該做啲乜嘢，可以令到我康復得到? 做啲乜嘢，令我快啲康復啊?」當你開始諗呢啲嘢嘅時候，你先會繼續去explore更加多resources同埋道路囉!"

It is in fact in line with the focus in recovery-oriented practice in ICCMW as stated in our strategic planning meeting which highlighted the importance of recovery. We can also find in users' dialogue during the qualitative study of this research on intervention outcome that the case workers had applied recovery coaching in their contacts with users and this has also been perceived important by them. They mentioned the case workers would explore directions with them, let them think about their own solutions; respect the uniqueness of different people's needs; give them hope and confidence for the future they are facing; and let them know they can do something about themselves to make recovery possible.

Empathetic Understanding

Participants in the focus groups mentioned that very often, their circumstances, feelings and needs are not being understood by people in their social circle, they shared that they could be empathetically understood by the case workers of the ICCMW service.

As one participant said,

"朋友多數都會用佢地嘅自己角度話俾你聽，你嘅情況係點，但係有無實質? 因為佢無呢個病，佢唔係咁清楚，但係姑娘見嘅野多，變左知道我地嘅需要，睇到我地自己個病係點樣或者有啲咩需要……佢俾到我啲信心，咁我咪自己思考，慢慢諗。"

Another participant shared,

"如果我將呢啲野話俾我最親啲人聽，唔知人點諗……我同我個社工講，我個社工唔會咁諗我，我覺得呢樣好欣慰。"

Cited one participant's words,

"就算我同哥哥女朋友講野或者傾番，但係感覺上都係唔係好理解點解你會唔做野同匿埋，但係佢地(中心社工)受過一啲嘅專業嘅知識，知道左個病原來係咁嘅，佢就掉番轉頭話我聽，你地個情況係會咁樣架，可能會匿埋自己，所以對自己信心大左……我走番出黎做野或其他方面有更多信心。"

As defined by Carl Rogers, "The state of empathy, or being empathic, is to perceive the internal frame of reference of another with accuracy, and with the emotional components and meanings which pertain thereto, as if one were the other person, but without ever losing the 'as if' condition" (1959, p. 210). Rogers (1957)

proposed that a continuous effort by the therapist to empathically understand the client is the most basic condition for therapeutic change to occur. This empathetic attitude, as communicated by the therapists to the clients, foster client's self-acceptance as well as a more adequate perception of oneself and one's life situation (Greenberg et al., 2003). Just as the participants in the focus groups revealed, the empathetic understanding they perceived from the ICCMW workers made them feel being understood, comforted, and increased their self-confidence to go through the recovery journey.

Social Support and Social Relationships

The participants in the focus groups mentioned that they became more contented, more confident, less lonely and less indulged in negative thoughts after they joined the various social activities in the ICCMWs, which create opportunities for them to make new friends, to acquaint with peers and to have meaningful daytime engagement.

Extracted from their sharing,

"(引致正面改變的因素是)因為恆健坊提供活動令我認識更多朋友，開朗咗。"

"即係參加左啲班，同人地互動，個人開心咗、開朗咗。"

"我開心同人分享，同人分享係一個好大嘅樂趣。"

"興趣小組活動令我覺得心情愉快，參加左多啲活動，識多啲朋友，無之前咁孤獨。"

"我知道多左其他同我有同樣經歷嘅人，有多啲鼓勵。"

"我加入左青年組，多左啲人可以識到，覺得可以增加到自己信心去認識新朋友。"

"返嚟做嘢(參與日間訓練) 咁咪冇時間亂諗嘢囉！"

"(如果沒有ICCMW) 我會成日喺屋企，會諗啲好唔開心嘅嘢囉！"

"ICCMW讓我更積極參與社交活動。多了社交活動，更有信心與人溝通。"

"同人傾計，所以增加左自信。"

As proposed by Davidson (2003) and Topor et al. (2006), one of the decisive factors in the recovery journey for mental health service users is social support from professionals, others suffering from mental health issues and their families, as well as friends. People reported that greater informal social support is more likely to help them recover from psychotic symptoms (Calsyn & Winter, 2002). Social contacts or social relationships become an influential in their recovery, including their mental health and psychological wellbeing (Andersson, 1998). However, feelings of loneliness are greater and social network size is smaller among mental health service users than in the general population (Lauder et al., 2004; Palumbo et al., 2015).

As told by the participants, occupational engagement or activities, participating in meaningful activities organized by ICCMW, and peer relationships can cultivate their self-confidence, self-identity, and individual growth. Occupational arrangements and participation in meaningful activities are regarded as a way of temporarily helping mental health service users who are leaving psychiatry hospitals when they are idling at home or do not have a job. Second, peer relationships involve qualities of understanding, acceptance, and mutuality due to the shared experiences in going through hardship among mental health service users (Mead & MacNeil, 2006). Relationships not only provide encouragement and hope to achieve recovery (Spaniol et al., 2002) but also shape mental health service users' confidence and identities (Tew et al., 2011). They can offer and receive support when they come in contact and connect with other people. Such continuing social interaction can develop an optimistic aspect of life and other people (Whitley et al., 2008).

During this process, mental health service users can redefine or reconstruct themselves through social relationships. The facilitative, "familial feeling" or "home-like" environment provided by ICCMW can serve as a safe place to promote their social functioning, social skills and social support, also facilitate their personal growth and the building or rebuilding of socialization and meaningful relationships. All these factors have a positive impact on their mental health (Kawachi et al., 2005).

Assertive Engagement

Focus groups' participants shared that their caseworkers took active roles to approach them and to follow their recovery progress. Such assertive engagement made them felt being cared for and being supported. They mentioned that the caseworkers would contact them proactively, regularly and continuously, and also arrange flexible visits to them, in particular, during their difficulty times in the recovery journey.

Quoted one participant said,

"(中心)姑娘會成日打電話俾我，睇下我有咩需要，或者有咩事發生，轉變呀，所以佢真係幫到我。"

Another participant shared,

"早一輪，七月佢都知我唔開心，話我好似都冇落黎，做咩你唔落黎，唔開心呀？我話係呀我唔開心，好啦我過幾日上你屋企探下你啦，我就將我啲野講，我話我個女嫁唔開心，又係咁傾一輪……"

One more participant pointed out,

"我就覺得佢地社工會主動去搵我地，呢個好好，因為有時自己都唔知原來係需要有人支持，可能已經做得幾好，即係佢會打電話搵我地，真係去關心我地。"

The importance of assertive practice has been highlighted in research on community support for people with mental illness. Assertive practice demands the care practitioners to actively look for the patients, actively help them to find solutions and actively work with support systems (Stein & Test, 1978; Bond et al., 2001; Drukker et al., 2011). Flexibility is also a key element in assertive engagement as identified from a recent qualitative study on assertive community treatment (George et al., 2016). Flexible approach allows service providers to adapt to changes in client needs in service provision. As reported by the participants, these practices are also reflected in the case intervention approaches of the caseworkers in the ICCMWs.

Discussion

This is the first pilot study to evaluate the outcome of ICCMW services in terms of clinical and personal recovery. The statistically significant improvement in post-test scores on both clinical and personal recovery measures after 6-month of ICCMW services (including case management as the core component) provides preliminary evidence on supporting resource allocation to ICCMW Services and a further step towards evidence-based practice.

Besides, the selected psychometric measures and the study protocol also provide useful references for further development of built-in system for ongoing outcome data collection in ICCMWs.

The qualitative part of the current study although quite small in scale, actually provides meaningful information for ICCMW services provider to understand the important elements of the services as perceived to be important to the services users. It sheds light to the focuses of further service development and staff training. It should be recognized as a demonstration of recovery-oriented practice in

service outcome evaluation with client as the centre, while recovery coaching as one of the identified themes in the qualitative analysis also provides support for the need of recovery-oriented practice in ICCMW service provision.

This study with its pilot nature and time limitation has rooms for further improvement. First, the sample size is relative small which did not allow for some further analyses, such as subgroup analysis with different psychiatric diagnostic group, intention-to-treat analysis or further advance statistical procedure such as regression analysis for prediction of outcome. Second, the current pre-test and post-test quasi-experimental study design did not control for the effect of the potential extraneous variables contributing to bias in result interpretation. Third, the application of focus groups for qualitative data collection was tried, we did not arrange follow-up interviews for further confirmation of emerging themes or achievement of data saturation.

Acknowledgement

The authors would like to thank Mr. Keith Wong and Dr. K.K. Law of the Hong Kong Council of Social Service for their valuable support in this study.

摘要

精神健康綜合社區中心服務使用者的復元狀況研究

本研究旨在了解服務使用者接受精神健康綜合社區中心服務6個月後，在個人及臨床復元上的進展，研究結果顯示服務使用者的臨床抑鬱及焦慮徵狀有明顯減少，個人復元程度亦有明顯提升。服務使用者並指出五個他們認為與中心服務相關而有助促進他們復元的主要元素，包括：家的感覺、能夠被理解、復元為本的指導、社交支持及主動接觸。

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