Hong Kong Journal of Mental Health
2024, *50(2),* 68-75

Recovery Self-Assessment in the Integrated Community Centres for Mental Wellness of The Mental Health Association of Hong Kong

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Abstract

This paper examines the outcome of the recovery-oriented practices implemented in the Integrated Community Centre for Mental Wellness (ICCMW) of The Mental Health Association of Hong Kong (MHAHK). The Chinese Service User version of Recovery Self-Assessment (CRSA-SU) and Recovery Self-Assessment (RSA) were employed to collect the observations and experiences of service users, service providers, and service administrators. 503 questionnaires were received. The scores of service users, providers, and administrators were 4.12, 3.91, and 3.90, respectively, which showed a satisfactory level of attainment regarding the implementation of recovery-oriented practices in ICCMWs. The domain of 'Invite' was ranked the highest among the 3 types of respondents. There was also a consistency of the lowest rating in the domain of 'Involvement' among the 3 groups. The results tended to reflect the consensus of some recovery-related value in ICCMWs among staff in different positions, which demonstrated the significance of the ongoing recovery-oriented practices and training. On the other hand, the participation of service users in the service planning, unit operation, and service evaluation, as well as the role model effect of Peer Support Workers were suggested to be further strengthened.

Keywords: recovery self-assessment, recovery-oriented practice

Introduction

Recovery-oriented practices (ROP) have been implemented in the Integrated Community Centres for Mental Wellness (ICCMWs) of The Mental Health Association of Hong Kong (MHAHK) since their launching in 2010. A systematic review of ROP of MHAHK ICCMWs has been conducted in recent years and affirmed that the journey of implementing ROP has already gone through its Engaging Stage and Development Stage and comes into the Transformation Stage after a decade of dedicated efforts (Lee et al., 2018). A working group on Recovery Strategic Planning has been formed in MHAHK with members comprised of management officers and clinical leaders of ICCMWs. Guided by 5 principles, namely 'commitment, consolidation of experience, evidence-based research, promotion & staff training, and daily operation', ROP continues to flourish in ICCMWs of MHAHK and contributes to the local recovery movement.

As described by Shepherd, Boardman and Burns (2009), organization in the Transformation Stage fully realizes its vision to achieve significant changes at all levels and makes continuous effort to collaborate with other parties in promoting positive mental health and wellbeing. In MHAHK, a remarkable attainment of promoting recovery with collaboration of other stakeholders was the establishment of Mindset College in 2017. The College was the first educational platform to provide recovery-oriented training and

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courses on mental health and self-management in Hong Kong. Promising results were elicited from the students, peer trainers and professional trainers (Chan, 2020). After the completion of the Mindset College in 2023, MHAHK endeavors to continue applying the concept and approach of co-production in its ICCMWs to support persons-in-recovery to develop their potentials and pursue life goals.

Closely related to Mindset College was the Peer Support Service which was first introduced in 2012 with the support from MINDSET. Peer Support Service became regularly subvented by the Social Welfare Department since 2016. MHAHK has been operating the Peer Support Service for more than a decade. The uniqueness of the roles of Peer Support Workers to share their live experience and to design and lead recovery-themed activities is highly valued in our ICCMWs and recognized by both staff and service users.

Moreover, ICCMWs of MHAHK continue to develop staff training themed on mental health recovery, including the Strength-based Cognitive Behavioral Therapy and Expanded Coming Out Proud Project, both of which involved the collaboration with local tertiary institutes and ICCMWs' social workers and peer support workers. There is also the year-round Strength-based Case Management Training, which aims to further polish case managers' core competencies to deliver a strength-based approach. Likewise, orientation workshops on recovery are regularly held for new staff of ICCMWs to enrich their knowledge and skills in implementing recovery-oriented practices in daily work. All these trainings manifested the non-stop efforts to cultivate a strong recovery-based mentality of the staff team.

Evidence supported that the implementation of recovery-oriented services could increase the satisfaction of customers towards the services delivered to them (Ahuja & William, 2005; Linhorst & Eckert, 2002). Two evidence-based research studies conducted in the ICCMWs of MHAHK upheld the importance of ROP in enhancing service users' personal recovery (Lee et al., 2018; Yu et al., 2019). Furthermore, it is suggested that service users' involvement in the planning and evaluating recovery-oriented service is imperative (Chao et al., 2019). The essential elements of recovery, such as hope, respect, choice, and self-determination could be put forward in a consumer-driven approach. As such, the present study aims to actively involve the service users of ICCMWs to evaluate MHAHK ICCMWs' recovery orientation service and its outcome by completing the Chinese Service User version of Recovery Self-Assessment (CRSA-SU).

The CRSA-SU has been validated in the hospital-based mental health services in Hong Kong (Chao et al., 2019). The Recovery Self-Assessment (RSA) is regarded as a quality assessment instrument of recovery practice as its items are directly relevant to recovery orientation, are appropriately validated, easy to administer, applicable to the local context, and include a consumer perspective (O'Connell et al., 2005). It is internationally well-known and has been translated and applied in non-English speaking countries (Rosenberg et al., 2015; Ye et al., 2013). Countries like the US and Australia suggest adopting RSA as a regular evaluation of recovery services. In addition, the RSA Revised version (RSA-R) is developed into 4 parallel versions to collect feedback from different types of stakeholders, namely persons-in-recovery, family caregivers, service providers, and service administrators, making the evaluation more comprehensive. Apart from service users, the present study also included all service providers and administrators of MHAHK ICCMWs to complete the RSA-R with the following objectives:

- To evaluate the recovery-oriented practices in ICCWMs of MHAHK
- To assess the strengths and weaknesses of ICCMWs in the implementation of recovery-oriented practices
- To facilitate the planning of promoting recovery-oriented practices in MHAHK

Ethical approval for this study was obtained from the Sub-committee of the Integrated Community Centre for Mental Wellness of MHAHK.

Method

Participants

Invitations were sent to all current members and staff of four ICCMWs operated by MHAHK from February to April 2022. A total of 503 questionnaires were received, of which 401 were from persons-in-recovery, 93 were from service providers, and 9 were from administrators. The gender distribution of the persons-in-recovery respondents was 25.7% male and 74.3% female.

Measurement

The Recovery Self-Assessment (RSA) was

adopted. It is a widely recognized and well-validated instrument used to assess recovery-oriented services globally. The RSA evaluates recovery-oriented practices from the perspectives of administrators, direct service providers, and persons-in-recovery. The RSA-R, a revised version of the instrument, includes specific measures for each group: 36 items for administrators, 32 items for persons-in-recovery, and 32 items for providers (O'Connell et al., 2007). The present study utilized these three parallel versions of the RSA-R:

- Person-in-recovery: Chinese version (with permission from Kwai Chung Hospital)

- Provider: Available in both English and a Chinese version translated by the survey working group

- Administrator: Available in English

The self-report survey comprises items reflecting practices associated with the conceptual domains of recovery. Respondents rate the degree to which the centre engages in recovery-oriented practices using a 5-point Likert scale, ranging from 1 (strongly disagree) to 5 (strongly agree), with an additional option of N/A (not applicable). Higher scores indicate greater agreement with the represented recovery-oriented practices.

The RSA-R consists of six empirically derived subscales (O'Connell et al., 2007):

1. Life Goals: Assesses how much staff help with the development and pursuit of individually defined life goals, such as employment and education.

2. Involvement: Evaluates the involvement of persons in recovery in the development and provision of programs/services, staff training, and advisory board/management meetings.

3. Diversity of Treatment Options: Measures the availability of linkages to peer mentors and support, a variety of treatment options, and assistance with becoming involved in non-mental health activities.

4. Choice: Determines the extent to which service users have access to their treatment records, whether staff refrain from using coercive measures to influence choice, and the degree to which staff respect the choices of service users.

5. Individually Tailored Services: Assesses the extent to which services are tailored to individual needs, cultures, and interests, and focus on building community connections.

6. Invite: Evaluates the extent to which the staff and physical space of the facility make users feel invited, comfortable, and dignified.

Results

A total of 503 questionnaires were collected from all four participating ICCMWs. Of these, 403 were from persons-in-recovery, 93 were from service providers, and 9 were from site administrators. Table 1 shows a breakdown by site for these numbers.

Table 1.
Number and Type of Questionnaires Collected from Each ICCMW Sites

Type of Questionnaire	KTC	KTN	KTS	TP	Total
User	103	94	69	135	401
Provider	26	24	12	31	93
Administrator	3	1	1	4	9

Note. KTC refers to Amity Place (Kwun Tong Central), KTN refers to Amity Place (Kwun Tong North), KTS refers to Jockey Club Amity Place (Kwun Tong South), and TP refers to Jockey Club Amity Place (Tai Po).

Service User Statistics

The ICCMW users who participated in this study came from diverse backgrounds. Their reported age ranges from 16 to 65, the mean age was 43.4 (SD=15.6). Among the user participants, 25.7% (N=103) were male, and 74.3% (N=298) were female; 39.7% (N=159) received high school education and another 32.2% (N=129) received tertiary education. Their most common reported diagnosis was

depression (46.3%), followed by psychotic disorder (28.1%) and anxiety disorder (16.0%). The survey also collected their length of service received at the ICCMW, the most common group received service between 3 months to 1 year (31.7%), followed by 3-5 years (25.4%) and 1-2 years (19.0%).

For the RSA-R service user questionnaire, there were six subscales including one new subscale (Invite), which was added to the revised version of the questionnaire. We calculated the mean scores for each subscale as well as the summary score across all questions. The highest subscale score was Invite (4.40, SD=0.66), and the lowest subscale score was Involvement (3.87, SD=0.85). The mean summary score for the user questionnaire was 4.12 (SD=0.63). See Table 2 for the sites' breakdown and overall subscale and summary scores.

Table 2.
Service User Questionnaire Subscale and Summary Scores by ICCMW Sites

Service User Subscale Scores	KTC	KTN	KTS	TP	Overall	SD
Life Goals	4.21	4.07	4.17	4.27	4.19	0.62
Involvement	3.92	3.75	3.77	4.03	3.87	0.85
Diversity of Tx Options	4.09	3.87	3.71	4.04	3.95	0.82
Choice	4.04	3.94	3.96	4.09	4.02	0.69
Individually Tailored Services	4.15	4.06	4.01	4.20	4.12	0.72
Invite	4.44	4.29	4.45	4.42	4.40	0.66
RSA-R Summary Score	4.15	3.99	4.09	4.22	4.12	0.63

Note. KTC refers to Amity Place (Kwun Tong Central), KTN refers to Amity Place (Kwun Tong North), KTS refers to Jockey Club Amity Place (Kwun Tong South), and TP refers to Jockey Club Amity Place (Tai Po).

To further identify specific preferences from service users, we also examined the highest-rated and lowest-rated questions from the user questionnaires.

The top three highest-rated questions were (scores from high to low):

- Q6 "Staff do not use threats, bribes, or other forms of pressure to get me to do what they want." (Mean score 4.58)
- Q1 "Staff welcome me and help me feel comfortable in this program." (Mean score 4.49)
- Q10 "Staff listen to me and respect my decisions about my treatment and care." (Mean score 4.48)

The bottom three lowest-rated questions were (scores from low to high):

- Q4 "I can change my clinician or case manager if I want to." (Mean score 3.11)
- Q25 "I am encouraged to attend agency advisory boards and/or management meetings if I want." (Mean score 3.68)
- Q5 "I can easily access my treatment records if I want to." (Mean score 3.74)
- Also tied at third place was Q20 "Staff introduce me to people in recovery who can serve as role models or mentors." (Mean score 3.74)

Statistical analyses were conducted on the user survey results to see if there were significant differences on the summary or subscale scores between users from different sites and demographic backgrounds. For site differences, one-way multivariate analysis of variance (MANOVA) was conducted on all the subscale scores as well as the summary score. For demographic differences, t-test was used to compare the summary scores between genders, Pearson coefficient (r) was used to calculate the summary score's correlation with age, and analyses of variance (ANOVA) were used to compare summary scores of participants from different education, work status, and service duration categories. Using a p-value cutoff of 0.05, the null hypothesis could not be rejected for all the above-mentioned tests. In other words, no significant difference between sites and users with different demographic backgrounds could be suggested.

Service Provider Statistics

A total of 93 service provider questionnaires were submitted by front-line staff at the Centres, including social workers, clinical psychologists, occupational therapists, nurses, and rehabilitation workers. The RSA-R provider questionnaire asked the same questions as the service user questionnaire, except for minor wording changes to describe the questions from the staff's perspective. Mean scores for the six subscales and the summary score were calculated similarly to the user questionnaires. Similar to the user questionnaire findings, the highest subscale score in the provider questionnaire was also Invite (4.23, SD=0.67), and the lowest subscale score was also Involvement (3.73, SD=0.66). The mean summary score for the provider questionnaire was 3.91 (SD=0.55). Two tail t-test suggested a significant difference between the provider summary scores and the user summary scores (p=0.0016). See Table 3 for the sites' breakdown and overall subscale and summary scores for the provider questionnaires.

Table 3.
Service Provider Questionnaire Subscale and Summary Scores by ICCMW Sites

Service Provider Subscale Scores	KTC	KTN	KTS	TP	Overall	SD
Life Goals	3.85	3.88	3.92	4.08	3.94	0.57
Involvement	3.73	3.59	3.76	3.83	3.73	0.66
Diversity of TX Options	3.94	3.78	3.89	4.12	3.95	0.66
Choice	4.00	3.81	3.93	3.98	3.94	0.59
Individually Tailored Services	3.76	3.73	3.73	3.94	3.81	0.62
Invite	4.06	4.13	3.95	4.56	4.23	0.67
RSA-R Summary Score	3.85	3.82	3.87	4.04	3.91	0.55

Note. KTC refers to Amity Place (Kwun Tong Central), KTN refers to Amity Place (Kwun Tong North), KTS refers to Jockey Club Amity Place (Kwun Tong South), and TP refers to Jockey Club Amity Place (Tai Po).

The top three highest-rated questions picked by providers were (scores from high to low):

- Q6 "Staff do not use threats, bribes, or other forms of pressure to influence the behavior of program participants." (Mean score 4.59)
- Q16 "Staff help program participants to develop and plan for life goals beyond managing symptoms or staying stable (e.g., employment, education, physical fitness, connecting with family and friends, hobbies)." (Mean score 4.30)
- Q1 "Staff make a concerted effort to welcome people in recovery and help them to feel comfortable in this program." (Mean score 4.27)

The bottom three lowest-rated questions were (scores from low to high):

- Q4 "Program participants can change their clinician or case manager if they wish." (Mean score 3.25)
- Q5 "Program participants can easily access their treatment records if they wish." (Mean score 3.27)
- Q30 "Staff at this program regularly attend trainings on cultural competency." (Mean score 3.28)

Statistical analyses were also conducted on the provider survey results to see if there were significant differences on the summary or subscale scores between different sites. Analyses of variance (ANOVA) was used and using a p-value cutoff of 0.05, the null hypothesis could not be rejected for all but one test. Results suggested that service providers from the Tai Po Centre rated significantly higher on the invite scale than providers from other centres (p=0.0065).

Administrator Statistics

A total of 9 administrator questionnaires were collected. Given the small sample size and that some centres only have one respondent in the administrator survey, cross-centre qualitative analysis was not conducted. The mean factor scores were: Life Goals 3.98 (SD=0.28), Involvement 3.78 (SD=0.64), Diversity of Treatment Options 3.82 (SD=0.37), Choice 3.95 (SD=0.37), Individually Tailored Services 3.83 (SD=0.28), Invite 4.17 (SD=0.25),

and the mean summary score was 3.90 (SD=0.28). A comparison of factor and summary scores between users, service providers, and administrators is shown in Figure 1. Following the same trend as user and provider responses, administrators also rated Invite as the highest factor and Involvement the lowest. While the mean scores from administrators were numerically lower than those from the users, two tail t-test conducted on the summary scores did not suggest any significant difference using a p-value cutoff of 0.05.

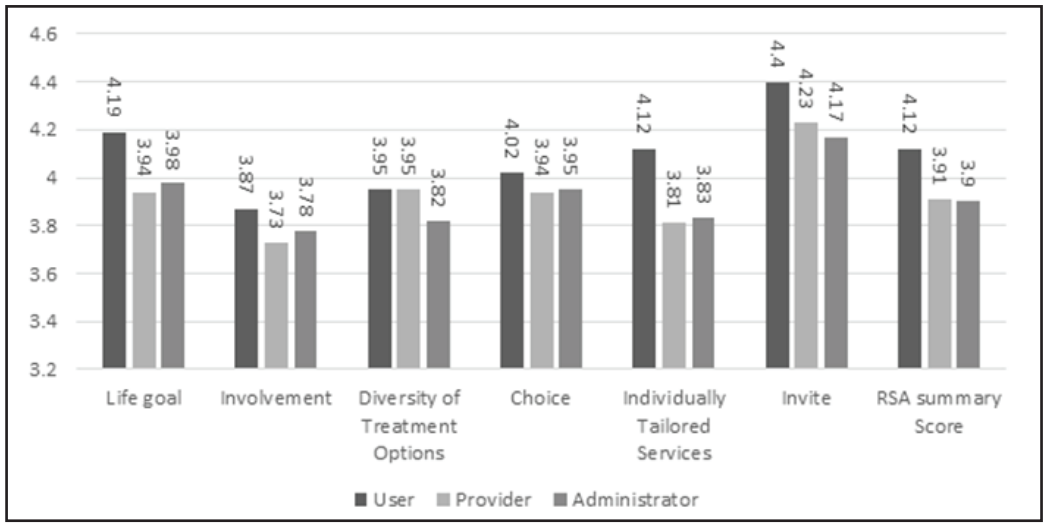

Figure 1: Factor and Summary Scores by Service Users, Service Providers and Administrators

The highest-rated question picked by administrators was:

- Q6 "Staff do not use threats, bribes, or other forms of pressure to influence the behavior of program participants." (Mean score 4.78)

This was followed by 3 questions that gained the same second highest rating:

- Q27 "Progress made towards an individual's own personal goals is tracked regularly." (Mean score 4.56)
- Q33 "This agency provides formal opportunities for people in recovery, family members, service providers, and administrators to learn about recovery" (Mean score 4.56)
- Q34 "This agency provides structured educational activities to the community about mental illness and addictions." (Mean score 4.56)

The bottom two lowest-rated questions were:

- Q4 "Program participants can change their clinician or case manager they wish." (Mean score 2.63)
- Q25 "People in recovery are encouraged to attend agency advisory boards and management meetings." (Mean score 2.89)

These were followed by three questions that gained the same third lowest rating:

- Q15 "Staff offer participants opportunities to discuss their sexual needs and interests when they wish." (Mean score 3.00)
- Q30 "Staff at this program regularly attend trainings on cultural competency." (Mean score 3.00)
- Q32 "Agency staff are diverse in terms of culture, ethnicity, lifestyle, and interests." (Mean score 3.00)

Discussion

This present study highlights several strengths in the implementation of recovery-oriented practices within ICCMWs of MHAHK. Notably, the summary score for persons-in-recovery was high, averaging 4.12 out of 5, reflecting positive perceptions among service users. Among the highest scores across service users, providers, and administrators was

the statement, "Staff does not use threats, bribes, or other forms of pressure to influence the behavior of program participants," indicating a strong shared organizational value against coercion and pressure., Additionally, the statement "Staff welcome me and help me feel comfortable in this program" ranked among the top five for both service users and providers, showcasing a welcoming and comfortable environment fostered by staff across various positions. This pervasive recovery mentality among professional and non-professional staff is highly commendable. The significance of these ongoing recovery-oriented practices is evident, and it is crucial to emphasize the inheritance of these positive practices and mentalities in preparation for potential staff turnover.

However, the research also identified areas for improvement. One notable weakness is the limited participation of service users in service planning, unit operation, and service evaluation. Enhancing interactions between service users and Peer Support Workers (PSWs) could further demonstrate the role model effect of PSWs, potentially leading to better recovery outcomes. Interestingly, service users' scores on the five lowest-rated questions were still higher than those from providers and administrators, suggesting possible discrepancies in perspectives. Some of these issues may be attributed to cultural differences and inherent service limitations. For instance, the consistency among service users, providers, and administrators regarding the ability to change case workers upon request indicates an area needing attention. Similarly, ensuring easier access to treatment records is another area for potential improvement to align with recovery-oriented practices.

Implications

To enhance the participation of service users, it is crucial to further increase their involvement in various organizational processes. These include providing opportunities for service users to play enhanced roles in meetings, such as member meetings, and establishing focus groups focused on service development and unit operation. Building groundwork for empowerment is essential. With the formation of self-directed groups, which have already been launched in some of our ICCMWs and will be extended to all centres, service users can express their views regarding unit policies, service planning, and daily operations.

Besides, as implied by the present study results, strengthening the role model effect of PSWs is of vital importance. Promoting collaboration between colleagues and PSWs through regular work sharing can enhance the visibility and impact of PSWs. While encouraging 'co-production' initiatives between colleagues and PSWs can further integrate PSWs' unique perspectives into the service framework, facilitating themed sharing sessions between PSWs and service users can foster deeper understanding and connection that promote mutual recovery.

Finally, to ensure the sustainability of recovery-oriented practices in the MHAHK, regular training and sharing sessions for staff at all levels should be carried out. Continuous evaluations and assessments of these practices manifest the commitment of the MHAHK to elevate the recovery paradigm.

Limitations

This study has several limitations that should be considered. Firstly, the use of convenient sampling may limit the generalizability of the findings, as this method may not adequately represent the broader population. Secondly, the questionnaire used for the provider version was self-translated, which could introduce biases or inaccuracies in how questions were interpreted and answered. Moreover, the perception of caregivers was not obtained, restricting the comprehensive understanding of the service impact from multiple perspectives. These limitations suggest future research should aim for more rigorous sampling methods, utilize professionally translated questionnaires, and include caregiver perceptions to provide a more holistic evaluation.

Conclusion

Affirmed by the encouraging results of the present study, MHAHK will continue adhering to the guiding principles of recovery to flourish recovery-oriented practice in different service units and at all levels of service provisions, visioning for an all-rounded and sustainable organizational culture to support persons with mental health concerns.

摘要

香港心理衞生會精神健康綜合社區中心復元為本服務自我評量

本研究旨在檢視本會精神健康綜合社區中心推動復元為本工作的成效。透過復元自我評量表了解服務使用者、服務提供者及服務管理人員對復元為本服務的觀察及經驗。從503 份收回的問卷顯示，服務使用者、服務

提供者及服務管理人員的整體分數分別為4.12、3.91 及 3.90，反映復元為本的推動工作具有成效。當中「邀請」範疇的分數於服務使用者、服務提供者及服務管理人員中皆為最高；同時，「參與」範疇亦一致地於三種對象中評分最低。調查結果反映了本會精神健康綜合社區中心的職員不論職位皆於復元取得一致的價值觀，同時亦顯示了本會一直推動復元為本工作的重要性。另一方面，服務使用者於服務策劃、單位運作及服務評估方面的參與，與及朋輩支援工作員的模範效果方面可進一步提升。

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