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Effectiveness of a Recovery Program for Chinese Psychiatric Inpatients

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Abstract
This study is a retrospective evaluation study for a 63 Chinese clients with schizophrenia, bipolar affective disorder, depression and adjustment disorder in recovery program. This study is going to note genders' specific response to the recovery program and to identify predictors for their length of hospital stay. All recruited subjects would participate in a three-week recovery program. A series of goal setting training, psycho-education and empowerment activities, and therapeutic group sharing were included. Clients' level of hope, mental-well-being, and ability in recovery and illness management would be assessed by Chinese Hope Scale (CHS), Chinese Short Warwick-Edinburgh Mental Well-being Scale (CSWEMWBS) and Chinese Illness Management and Recovery Scale (CIMRS). Subjects showed improvement in generating routes to recovery goals, enhanced capacity in initiating and maintaining the actions to reach their recovery goals. Moreover, clients showed significant improvement noted in seeking social support. Genders showed their specific characteristics in their pattern of recovery.
Key words: Recovery, Well-being, Illness Management

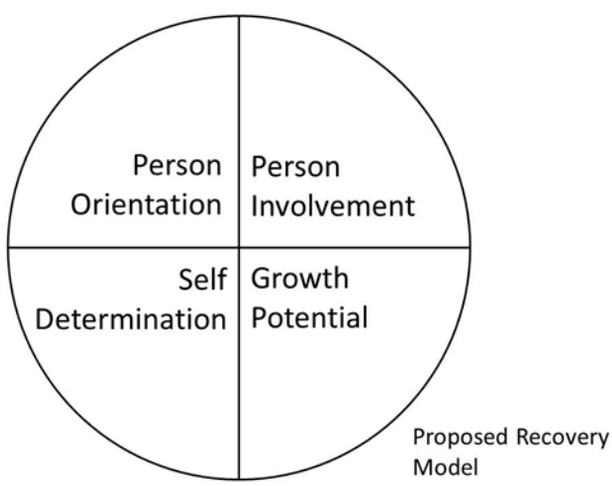
Introduction:

In late 1900s, psychiatric care was largely based on medical model which focused on medical model (Campbell-Orde et al., 2005), relapse prevention (Anthony et al., 2002),and to maintain clients level of functioning (Frese et al., 2001). It has been emphasized that each individual's journey to recovery is a personal process, as well as being related to an individual's community and society; alike the model by Repper & Perkins (2006) which focused on social inclusion in relation to recovery. With further reference to the work of Campell-Orde and colleagues on 2005, the later recovery model was developed with the input from clients whom diagnosed with different mental illness. They highlighted what supported or blocked them from living with their illnesses and the later development of recovery model focuses more on client's daily life and peer support rather than treatment. In early 2000's , Frese and his colleagues further developed their recovery model which scrutinize on individual's recovery journey with the person deciding what he or she needs to recover (Frese et al, 2001). Davidson, O'Conell, Tondora, Styron and Kangas (2006) further suggested the concept of "recovery in",

which means the client lives in a safe, dignified manner in the community with the accommodations and supports that he or she needs. Since then, mental health practitioners moved to the development of recovery–oriented systems and recovery had become a guiding force in developing mental health policy and practice in foreign countries (Davidson et al., 2006).

This study adopted the values of recovery by Farkas, Gagner, Anthony and Chamberlin on 2005 as shown in Figure 1.This model of recovery was renowned by conceptualizing recovery-oriented mental health programs to both providing direction to those involved in program implementation of evidence based mental health practices, as well as providing a stimulus for further development of recovery program. (Farkas, 2007; Farkas & Anthony, 2010). These values had been shown to be evidence based and been well studied for years (Rogers & Farkas, 2008; Slade et al., 2014; Lyman et al., 2014). These values included considerations in person orientation, person involvement, self-determination and growth potential (Farkas et al., 2005). Firstly, in person orientation focuses on client as a whole with strengths. Secondly, person involvement focuses on the unique characteristics of each client while developing his/her own expectation in recovery. Thirdly, self-determination focuses on assisting client to make informed choices and to gain or accept responsibility for their own choices. Fourthly, growth potential focuses on client's capacity to grow and to improve functioning. The purpose of this retrospective evaluation was to investigate outcomes for a group of clients who participated in a recovery-based occupational therapy program.

Figure 1 - Proposed Recovery Model



Methodology

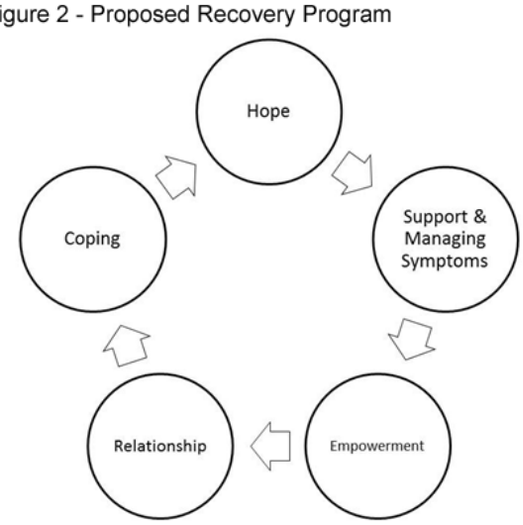
From May 2015 to July 2015, 63 in-patients joined the three weeks program of recovery activities, which were held for sixty minutes, five mornings a week. These groups were conducted by registered occupational therapist, therapy assistants and patient care workers. Groups were held on occupational therapy department. Occupational therapists assess, monitor and treat clients by providing treatments in our inpatient unit. As part of a multidisciplinary team, occupational therapists collaborate to educate clients, their family and also communities. Occupational therapists believe that recovery from mental illness is possible, but the process takes place in a series of small steps. Clients need knowledge, skills and coping strategies to help relieve their symptoms and manage stress to rejoin their uniqueness in the community.

Our designed recovery program aimed to promote successful recovery through proper goal setting, positive thinking, taking control and empowering their life and life role rebuilding through a series of education and discussion modules. This program included five elements as therapeutic modules as shown in Figure 2. Firstly,

in the module of "Hope", client would have increased positive thinking and with feelings of healing and hope. Moreover, this is to increase trust in self and others through therapeutic activities. Secondly, in "Support and Managing Symptoms" module, client would understand how to manage symptoms and advise on healthy lifestyle changes to help prevent relapse. Thirdly, in the module of "Empowerment", clients would develop confidence by problem-solving, goal setting and focusing on own strengths, to discuss stigma, to improve social skills, assertiveness and self-awareness. Fourthly, in the module of "Relationships", clients would learn how to improve tolerance, anger management and communication skills. Activities include exploring emotions, communication, anger and conflict. Fifthly, in "Coping", client would develop personal coping strategies for self-management and stress reduction; cope with feelings of depression, anxiety, frustration and anger. Moreover, to assist client to recognize distorted thinking. Concepts of cognitive behavioral therapy were woven through the program. The group leader could choose from a variety of optional activities of recovery and illness management as considered to be appropriate. Sequence of programmed sessional activities and lessons bellows were modified according to the progress of patients as needed. Concepts to be delivered to patients in the treatment program including:

- Session A. Identification of hope and development of faith
- Session B. Enhance personal responsibility and productivity
- Session C. Promote self-management and autonomy
- Session D. Importance peer support and community life
- Session E. Frustration tolerance building and to learn forgiveness
- Session F. Social acceptance and enhance self-awareness
- Session G. Adaptability and capacity to change
- Session H. Situational applicability

Figure 2 - Proposed Recovery Program



Outcome measures

Chinese Hope Scale (CHS) It is a 12-item measure of a client's level of hope. Snyder et al (1991) defined hope is defined as a cognitive set that is based on a reciprocally-derived sense of successful agency (goal directed determination) and pathways (planning to meet goals). It is divided into two subscales that comprise Snyder's cognitive model of hope (Snyder et al., 1991): (1) Agency (i.e., goal-directed energy) and (2) Pathways (i.e., planning to accomplish goals). Of the 12 items, 4 (Items 1,4,6 and 8) make up the Agency subscale and 4 (Items 2,9,10 and 12) make up the Pathways subscale. The remaining 4 items are fillers. Each item is

answered using an 8-point Likert-type scale ranging from Definitely False to Definitely True. It is internally consistent with Cronbach' alpha = .81with $p < .001$ for agency factors, and Cronbach's alpha, 0.82 with $p < .001$ for pathway factors (Snyder et al., 1991), yet the agency and pathways subscales are factorially identifiable as subcomponents of the overall measure, which accounted for 67.2% of the variance. The four agency items load principally on one factor and the four pathways items load principally on another.

Chinese Short Warwick-Edinburgh Mental Well-being Scale (CSWEMWBS) The SWEMWBS is measure for mental wellbeing of clients. Responses in the form of a Likert scale included 'none of the time' (scored 1), 'rarely' (2),'some of the time' (3), 'often' (4), and 'all of the time' (5). Scores ranged from 7 to 35, with a high score reflecting a high level of mental wellbeing. The scale was validated, with good content validity, moderately high correlations with other mental health scales and lower correlations with other scales measuring overall health. The C-SWEMWBS by research team of Ng on 2014, was cross-culturally adapted from the original English version. The C-SWEMWBS is a short 7-item questionnaire C-SWEMWBS showed good internal consistency (Cronbach's alpha, 0.89) and the principal components factor analysis identified a single component (eigenvalues, 4.28; 61.1% variance), which was consistent with that of English version (Ng et al., 2014). Scores of CSWEMWBS were positively correlated with the scores of WHO5 ($r = 0.49$; $p < 0.001$), suggesting it came with good concurrent validity (Ng et al., 2014).

Chinese Illness Management and Recovery Scale (CIMRS) IMRS have been developed to assess the clients' progress towards recovery and better illness management (Mueser et al., 2005). It contains 15-items to capture different aspects of recovery, such as knowledge about mental illness, social support, treatment adherence, relapse prevention planning, coping efficacy, and substance abuse and dependence. Previous research has established good internal consistency, test–retest reliability and convergent validity for the IMRS among clients with severe mental illness (Hasson-Ohayon, 2008). This scale was translated into Chinese by a group of local experts in the field of psychiatric rehabilitation.

All these instruments would be used to document patients' condition immediate before the implementation and after their completion of recovery-based rehabilitation training.

Data Analysis

Descriptive statistics were applied to the demographics, number of previous admissions and their primary diagnosis, T-test analysis would be used to measure if there would be any mean difference before and after the recovery program. Moreover, t-test would be used to compare genders' responses in the program. ANOVA analysis would be employed to assess if there would be any difference in variance among different diagnostic groups.

Results

Convenient sampling strategy would be used to recruit subjects for the present study. The participants had to fulfill several selection criteria: 1) Aged between 18 and 60 years old, 2) In-patient status in a regional psychiatric hospital, 3) Are ethnic Chinese who can read and understand Chinese. With consideration on smoothness of program and discussion running, patients cannot read and understand Chinese would be excluded in this study. All selected subjects would be screened by an occupational therapist whom had properly understood the content to the recovery program.

In order for the subjects to be prepared to voluntarily participate they were first be informed as to what the purpose of the study was, from whom they could access further information about the researchers and/or the study, how their anonymity would be maintained, how findings would be disseminated, information, if appropriate, about benefits, and a reiteration that participation was voluntary. The potential for harm in this study was considered to be minimal. In order to maintain confidentiality all subjects' names were be changed and let-

ters were assigned to each participant. Extreme care was taken in the maintaining a secure database and in the reporting of findings in order to preserve the confidentiality of the data collected, as what had been suggested in literature (Neuman, 2003).

A convenient sample of 63 clients was recruited, and the demographic information was shown in Table 1

Table 1 Demographic Information

Gender Female : 25 Male : 38	**Living** With Family : 41 Alone : 14 Hostel : 5 Others : 3
Martial Status Single: 42 Married : 11 Divorced / Widowed : 8	**Occupation Status (before admission)** Unemployed : 46 Gainfully employed : 12 Vocational Training : 6
Martial Status Single: 42 Married : 11 Divorced / Widowed : 8	**Years of Onset** New Onset : 7 Onset less than 2 years : 18 Onset btwn 2 to 5 years : 10 Onset more than 5 years : 28
Educational Level Primary : 6 Secondary : 46 Tertiary and above : 10	**Primary Diagnosis** Gp 1 – Schizophrenia / Psychosis / Delusional Disorder : 38 Gp 2 – Bipolar Affective Disorder : 12 Gp 3-Depression : 10 Gp 4- Adj. Disorder : 3

Assessment on Mental Well-being

Clients' mental well-being was measured by the Chinese-SWEMWBS. The raw score was displayed in Table 2. Among the whole study population, in t-test analysis, there was significant difference in the Chinese SWEMWBS before and after recovery program ($t = 2.15$, $p < .05$). There was significant difference noted in "feeling relaxed" ($t = 2.23$, $p < .01$), "dealing with problems well" ($t = 2.34$, $p < .05$), "feeling close to other people" ($t = 2.32$, $p < .05$), "able to make up my own mind about things" ($t = 1.89$, $p < .05$). Specifically, in male subjects, among the measures by the CSWEMWBS There was significant difference in the item "I've been feeling close to other people" ($t = 2.63$, $p < .05$) when individual items were investigated. In female subjects, interestingly, there were significant difference in the item "I've been feeling relaxed" ($t = 3.67$, $p < .001$), "I've been dealing with problems well" ($t = 2.19$, $p < .05$), and "I've been feeling close to other people" ($t = 2.53$, $p < .05$) when individual items were investigated. There was no significant difference in CSWEMWBS and the seven subscales among four different diagnostic groups.

Assessment on Level of Hope

Clients' level of hope was measured by the Chinese Hope Scale as shown in Table 2. There was significant difference noted in "I energetically pursue my goals" ($t = 1.23$, $p < .05$), "my past experience have prepared me for my future" ($t = 1.65$, $p < .05$), "I've been pretty successful in life" ($t = 2.23$, $p < .01$) and "I meet the goals that I set for myself" ($t = 2.56$, $p < .01$)

Table 2. T-test analysis for CSWEMWBS, Chinese Hope Scale and Illness Management & Recovery Scale (N= 63)

Variables	Subscales	Before		After		*t*
		M	*SD*	*M*	*SD*	
CSWEMWBS	Feeling optimistic about the future	3.24	.92	3.39	.91	1.25
	Feeling Useful	3.40	.97	3.48	.94	0.89
	Feeling Relaxed	3.00	.91	3.34	.85	2.23**
	Dealing with Problems Well	3.15	.92	3.34	.97	2.34*
	Thinking Clearly	3.54	.92	3.50	.97	0.25
	Feeling Close to Other People	3.23	.99	3.63	.96	2.32*
	Able to Make up My Own Mind about Things	3.18	.97	3.37	.98	1.89 *
Chinese Hope Scale	I can think of many ways to get out of a jam	5.94	1.56	5.81	1.57	0.63
	I energetically pursue my goals	5.92	1.90	6.11	1.51	1.23*
	I feel tired most of the time	5.11	2.23	4.48	1.99	0.23
	There are lots of ways around any problem	6.10	1.70	6.20	1.68	0.13
	I am easily downed in an argument	4.65	2.04	4.70	1.87	0.08
	I can think of many ways to get the things in life that are most important to me	5.71	1.59	5.00	2.00	0.62

	I worry about my health	5.89	1.67	5.93	1.56	0.56
	Even when others get discouraged, I know I can find a way to solve the problem	5.89	1.67	5.93	1.56	0.25
	My past experiences have prepared me for my future	6.16	1.71	6.38	1.58	1.65 *
	I've been pretty successful in life	4.63	1.92	5.10	1.88	2.23 **
	I usually find myself worrying about something	5.56	1.68	5.27	1.02	0.56
	I meet the goals that I set for myself	5.08	1.82	5.47	1.23	2.56**
Illness Management and Recovery Scale (IMR)	1. Progress towards personal goals	2.50	1.01	2.74	1.13	1.98*
	2. Knowledge	2.89	1.21	3.44	1.11	3.72*
	3. Involvement of family and friends in my mental health treatment	3.18	1.23	3.49	1.12	2.08*
	4. Contact with people outside of my family	2.77	1.12	2.72	1.05	0.56
	5. Time in Structured Roles	2.48	.78	2.37	.72	0.34
	6. Symptom distress	3.10	1.08	3.15	1.12	0.25
	7. Impairment of functioning	2.95	1.11	3.08	1.08	0.65
	8. Relapse Prevention Planning	2.89	1.12	3.15	1.02	2.30*

9. Relapse of Symptoms	3.02	1.02	2.89	1.02	0.86
10. Psychiatric Hospitalizations	3.71	1.12	3.60	1.02	0.56
11. Coping	3.48	0.81	3.60	0.79	0.89
12. Involvement with self-help Activities	2.85	0.56	3.34	0.76	3.58*
13. Using Medication Effectively	4.00	0.89	4.53	0.89	3.14*
14. Functioning affected by alcohol use	4.02	1.02	4.15	0.89	0.65
15. Functioning affected by drug use	4.13	0.25	4.03	0.59	0.23

*$p < .05$, **$p < .01$, ***$p < .001$

When female subjects were analyzed, there was significant difference between before and after treatment program in both Pathway subscale ($t = 2.63$, $p < .05$) and Agency subscale ($t = 2.89$, $p < .05$) of the Hope Scale. Nevertheless, in male subjects, there was significant difference in Pathway subscale ($t = 2.92$, $p < .05$) but not in Agency subscale ($p > .05$) when measures between before and after treatment program. Male participants note to have significant higher pathways thinking than females ($t = 3.42$, $p < .001$). Moreover, there are no significant difference in the both Pathway subscale ($F = 1.49$, $p > .05$) and Agency subscale ($F = .202$, $p > .05$) among different diagnostic groups.

Assessment on Illness Management

Clients' illness management and recovery was measured by Illness Management and Recovery Scale as shown in Table 2. In the whole study population, there were significant difference in "progress towards personal goals" ($t = 1.98$, $p < .05$), "knowledge" ($t = 3.72$, $p < .001$), "Involvement of family and friends in my mental health treatment" ($t = 2.08$, $p < .05$), "Relapse Prevention Planning" ($t = 2.30$, $p < .05$), "Involvement with self-help activities" ($t = 3.58$, $p < .001$), "Use of Medication Effectively" ($t = 3.14$, $p < .01$).

Male clients seem with less improvement in their illness management and recovery. There were significant difference in "knowledge" ($t = 2.14$, $p < .01$) and "Involvement with self-help activities" ($t = 2.51$, $p < .05$). Nevertheless, female clients showed better response in their illness management and recovery, as shown in "knowledge" ($t = 2.14$, $p < .05$), "Involvement of family and friends in my mental health treatment" ($t = 2.22$, p

< .05), “Symptom distress” (t = 2.21, p < .05), “Relapse Prevention Planning” (t = 2.30, p < .05), “Coping” (t = 3.67, p < .01), “Involvement with self-help activities” (t = 3.58, p < .001), “Use of Medication Effectively” (t = 3.14, p < .01).

There was no significant difference among different diagnostic group in the IMR, except in “Time in Structured Role” (p < .05), in which, the group of schizophrenic clients showed lesser time in doing activities for or with another person.

Predictors of Recovery

A regression analysis was conducted to predict clients’ length of stay with those recovery measures as shown in Table 3. The regression model was able to predict a significant proportion of variance in intention of helping (R^2 = .32). Agency subscales in the Chinese Hope Scale contributed significantly to the regression model (β = .21), while the feeling of getting closer to other people contributed (β = .09), feeling relaxed (β = .11), dealing with problems well (β = .09) in CSWEMWBS showed their significance. Moreover, the involvement of family and friends in recovery (β = .09) and increased in knowledge of recovery (β = .12) showed significant contribution in Illness Management and Recovery

Table 3. Prediction of LOS from Recovery Factors (N = 63)

Predictor Variables	*B*	*SE*	β	*t*
Hope Scale				
Agency Subscale	6.62	.3.1	.21	2.2 *
Illness Management and Recovery				
Involvement of Family & Friends	5.47	3.21	.09	1.26*
Increase knowledge in Recovery	2.45	.81	.12	1.58 *
CSWEMWBS				
Feel closer to other people	1.45	.72	.09	.89*
Feel Relaxed	4.34	2.07	.11	.92*
Deals with Problem	3.45	1.04	.09	.78*

Note. *p < .05, **p < .01, ***p < .001 [R^2 = .32]

Discussion

This study is a retrospective evaluation study for a group of in-patient clients who participated in a recovery-based occupational therapy program. There were a number of positive changes noted in our clients throughout and after this recovery program.

Firstly, there is significantly positive change noted in identifying and getting social support from clients in our study. It is worth to note that there is significant improvement noted in getting involvement from their family and friend. This was reflected from the significant difference noted in clients’ self-reported illness management and well-being measure. These positive changes could be attributed by their social network re-activation and more social inclusion, as suggested from findings of Perry and Pescosolido on 2015. Interestingly, female clients showed significant awareness in getting social support from their trusted one than male. This phenomenon could be rectified by the study of Davidson on 2003 that male would adopt their recovery journey by involving in a limited social network than female (Repper & Perkins, 2006). Genders specificity in their social collection and getting social support was underscored from this recovery program.

Secondly, after the recovery program, both genders showed their enhancement in knowledge and information acquisition in recovery. It partially reflected the effectiveness of psycho-education as an effective media in promoting the concept of recovery for our Chinese Hong Kong population. These findings also shared by previous researches like the one by Petersen et al on 2015. Moreover, another study conducted by Mueser on 2002

found that psycho-education would increase individuals' insight into illness and affected sociability. It was believed that recovery strategies were acquired through knowledge and skills obtained in relationships with therapist, therapy assistants, and other clients with their own experience of mental illness.

Thirdly, clients felt more relaxed throughout and after the recovery program. This could be attributed by their acquisition of knowledge in their illness management and strategies in relapse prevention. Moreover, this therapeutic group interaction can enhance their communication between each other in a relaxed but therapeutic environment. A number of coping strategies could be role-played and shared through an error-free and criticism free trial among clients. Furthermore, it is interesting to note that female clients showed better outcome in coping and dealing with problems well after this recovery program. On the other hand, male clients would more likely to accept direct knowledge and instructions by officials (Fitzgerald, 2010). These finding further echoed to the work by Schön, U.K. (2010), which showed that female would be more effective in learning coping strategies than male (Schön, 2010).

Fourthly, it is worthy pointing out that female showed significant change in both pathway thinking and agency thinking in the hope scale measure. However, male showed only significant change in pathway thinking. This phenomenon could be explained by the work by Snyder et al (1991). In their study, they hypothesized that both agentic and pathways thinking are necessary for higher levels of hopeful thought (i.e. they are additive). On the other hand, they can reciprocally interact (i.e. they iterate in the thoughts of people as they entertain their goals). Although agentic and pathways thinking are related, they are not synonymous. Therefore, they refer to differing aspects of the goal directed thinking process. This can justify female and male adopt different perspective in formulating their recovery and illness management strategies. Male would have enhanced ability to generate routes to his recovery goals. Apart from the enhance ability in male, female clients would have enhanced capacity for initiating and maintaining the actions necessary to reach a goal.

Our findings echoed the work by Schön (2010) that female showed to be an advantage in the recovery process than male. The recovery of female clients would be facilitated by emotionally supportive social relationships with others who listened to them, and who understood and showed engagement. The male recovery process is under the influence by gender constructions both in terms of societal gender expectations and in terms of the men 'doing gender' in their strategies to control the illness (Harding, 1986).

Finally, there is significant difference of clients with schizophrenia than other groups of clients in "Time in Structured Role" as the measure of illness management and recovery. This could be attributed by the fundamental difference in pre-morbid life roles of our clients as shown in previous study (Fitzgerald, 2010). Pre-morbid life role is considered as a crucial but missed parameter that was missed to address in this study, nevertheless, this is worth to be considered for further study. Moreover, factors like early onset of illness, the predominant negative symptoms and limitation in social skills development of clients with schizophrenia would further impede their use of time in structured role.

Conclusion

Recovery is a common theme in rehabilitation for clients with mental illness nowadays. Recovery is considered as a journey in clients' life, with ups and downs. This study is the pioneer study in showing the effectiveness of a recovery-based occupational therapy program for in-patients in a regional psychiatric hospital. Through the recruitment of 63 clients with diagnosis groups of schizophrenia, bipolar affective disorder, depression and adjustment disorder, their mental well-being and progress towards recovery and illness management were assessed. After a series of planned recovery program in psycho-education program and therapeutic group sharing, clients showed their enhanced knowledge in recovery, enhanced ability to generate routes to recovery goals, enhanced capacity in initiating and maintaining the actions that necessary to reach their recovery goals. Female subjects showed more positive changes than male subjects in getting social involvement in their

recovery than male subjects. Results provide new insights into gender as an important factor in understanding recovery processes and in providing care to facilitate these processes. Further studies with larger samples from more diversify populations are suggested for generalization of the results. Moreover, the study period would be too short follow up if exploring outcome, more like post-review evaluation without insight into how long the positive effect can sustain

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