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ORIGINAL ARTICLE

Efficacy of 'Five Ways to Well-being Program' in Promotion of Mental Wellbeing for Persons Admitted to Acute Psychiatric Service

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Abstract Promotion of wellbeing programs seldom described in psychiatric service locally. Through the Five Ways to Wellbeing program (NEF, 2008), including the actions to Connect, Be Active, Take Notice, Keep Learning and Give, clients were encouraged to make choices according to their wants and better their health. To document the applicability of the Five Ways to Wellbeing program in acute psychiatric settings. Prospective cohort analysis of patients admitted to In-patient Psychiatric wards within 12 months period. Clients are free to choose the seven sessions of intervention from topics of 'Five ways to wellbeing program' or 'Illness Management Recovery program'. Measurements include Pre- and post-intervention assessment of subjective well-being (C-SWEMWBS) and hope perception (Hope Scale), number of clinics visits and readmission rate 6 months post discharge. 623 admitted patients were recruited with 333 elected for Wellbeing Program. 79 within the group completed the five Ways of Wellbeing while the rest attended a mix of Wellbeing & Recovery program. The change of SWEMWBS score and Hope score is found correlated significantly with number of sessions of the Wellbeing Program attended, age, diagnostic group, onset years and employment status upon admission. The change of SWEMWBS score and the Hope score is significant across all participants of various diagnosis ($p < 0.05$). Stepwise regression confirmed five sessions of Five Ways to Wellbeing Program was strong predictor for change in SWEMWBS score (R = 0.169; Sig. = 0.001; F = 10.338)

and Hope score (R = 0.115; Sig. = 0.031, F = 4.702). Multivariate Test of between subject effect ($n = 357$) also showed significant mixed effect of Wellbeing and Hope scores on Clinic visits ($R^2 = 0.933$; $p = 0.000$; $F = 7.42$; power = 1, alpha = 0.025), and Readmission rate to psychiatric wards ($R^2 = 0.908$; $p = 0.000$; $F = 5.285$; power = 1; alpha = 0.025) within 6 month after discharge. The five ways of wellbeing program so developed has shown statistically effective in promotion of Mental Wellbeing state and personal Hope among the clients with severe mental illness during their acute admission phase. More extensive research on their protective effects on clinic visits and readmission in severe mental illness population is warranted.

Keywords Wellbeing · Acute psychiatry · Recovery · Illness management

Introduction

The understanding that everyone can benefit from improved mental health and wellbeing is wellknown. While acknowledging that many people living with mental health problems and illnesses, specialized services and supports are needed to help them from recover and achieve greater wellbeing [1]. It has becoming popular for nations to develop mental strategy or framework to work towards recovery and wellbeing for the high risk groups [2] and to the extent of whole population e.g. Canada [1]. In Hong Kong, the promotion of wellness programs for mild to moderate mood disorders in primary care settings or outpatient settings flourished in last few years where benefits were documented [3–6]. There is still a gap for people with severe mental illness or with frequent hospitalization to

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find a way to express their views on their own wellbeing status in clinical settings [7]. One approach to increasing wellbeing is to support personally relevant goal setting and goal striving activity [8].

The delivery of Illness Management Program as part of the Recovery Oriented Practice for Psychiatric hospitals was implemented locally for few years. However, promotion of wellbeing programs is not common in Severe Mental Illness population and seldom described in psychiatric service in past decades. Occupational Therapists, as member of the mental health workforce, emphasize meaningful life integration for their clients suffering from varieties of diagnosis like schizophrenia, bipolar disorder, major depression and adjustment disorders. They are utilizing several instruments to assess dysfunction and daily living problems, and recently developed culturally reliable measurements for evaluation of their interventions on client's wellbeing status [7]. Hence, in addition to the Illness Management Program, the Five Ways to Wellbeing packages was introduced, including the actions to *Connect, Be Active, Take Notice, Keep Learning* and *Give* [2]. Taking a new approach of therapy, clients were encouraged to shift from passive receivers to more active role to make choices of programs according to their wants and carry out weekly action plans to implement the 'Five Ways, during hospital stay. It is believed that to cultivate this attitude and virtues as early as in the acute admission stay period would be beneficial as majority of them, especially for those higher functioning groups of clients with depression and adjustment disorders, are usually discharged directly from hospital to community without going through extensive rehabilitation programs during hospital stay.

Objective

Hence, the objective of this study is to document the applicability of the Five Ways to Wellbeing program in acute psychiatric settings and explore the efficacy of the program among clients with psychotic and non-psychotic population according to DSM-V criteria.

Methodology

This is a prospective cohort analysis of patients admitted to In-patient Psychiatric wards of a local psychiatric hospitals within 12 months period. Upon admission, the clients were confirmed by case doctor on fitness to receive the interventions and referred. Baseline assessments were then performed by case therapist upon recruitment and consent by the client. Every client are invited to join the weekly sessions comprised of at least two sessions on recovery

concepts and remaining five more sessions by their selections either from Five Ways to Wellbeing program or Illness Management Program. Reassessments were performed again upon completion of seven sessions of interventions or on the date of discharge whichever is later. The program was delivered by therapists or care assistants after attended 2 days of training on the concept, content and coaching techniques in delivery of the program package.

Intervention

The Five Ways to Wellbeing are a set of evidence-based actions developed by New Economic Foundation from evidence gathered in the UK government's Foresight Project on Mental Capital and Wellbeing which promotes people's wellbeing. They are: Connect, Be Active, Take Notice, Keep Learning and Give. These activities are simple things individuals can do in their everyday lives. The Five Ways have been used by health organizations, schools and community projects across the UK and around the world to help people take action to improve their wellbeing. They've been used in lots of different ways, for example to get people to start thinking about wellbeing, to develop organizational strategy, to measure impact, to assess need, for staff development, and to help people to incorporate more wellbeing-promoting activities into their lives. In this study, the content of the five actions was translated into Chinese and culturally adapted to develop into a five sessions psychoeducational package (the Wellbeing Program), one session on one topic, inherent with slides for teaching and printed cards of weekly action plan under the selected theme given to clients for goal setting and recording the related activities of the week (Box 1).

The 'Illness Management Recovery Program' (the Recovery program) with the conventional psychoeducational topics under Recovery Model includes setting individual goals, instill hope, give choice, facilitate peer support and encourage active participation [9, 10]. Patients attended the mandatory two sessions in which they would learn the concept of recovery and set their own goals of recovery. Then they would choose the remaining sessions with different topics from wellbeing program or illness management program according to their preferences before their discharge from acute wards. Pre- and post-assessment of patients' subjective well-being, hope perception and understanding of illness management and recovery were conducted.

Participants

Recruited participants are those can read and write traditional Chinese with no significant or diagnosed cognitive

problems; and mentally stable for making consent for the study. The research proposal was ethically approved by Research Ethics Committees of Hospital Authority of HKSAR. All subjects are voluntary to participate in the study. Eligible candidates are required to complete the questionnaires. They have the right to withdraw from the study without any reasons and not affecting their conventional treatment.

Measurements

The Chinese Short Warwick Edinburgh Mental Wellbeing Scale (C-SWEMWBS) is an ordinal scale comprising seven positively phrased Likert-style items. Items cover a range of aspects of mental wellbeing including many which will be familiar from other popular scales. Responses in the form of a Likert scale comprise 'None of the above', 'Rarely', 'Some of the time', 'Often' and 'All of the time'. Scores ranges from 7 to 35, with a higher score reflecting a higher level of mental wellbeing. The scale was validated on people with severe mental illness in Hong Kong with good psychometric properties with Cronbach's alpha of 0.89 [7].

Hope scale is a 12-item measure of a respondent's level of hope. In particular the scale is divided into two subscales that comprise Synder's cognitive model of hope: Agency or goal directed energy and Pathway or planning to accomplish goals. Each item is answered using an eight point Likert-type scale ranging from Definitely False to Definitely True [11]. The Chinese validated Hope Scale by Ho et al. [12] is used in this study.

Data Collection

The recruited participants were interviewed by case therapists to complete the consent process and the database form. They were then given the Hope scale and C-SWEMWBS for self-completion. Other personal data including those related to their illness namely principal diagnosis, number of out-patient visits and readmission days in psychiatric beds 6 months after discharge were retrieved from electronic medical records afterwards. The number of additional sessions in Wellbeing Program & Illness management program attended is recorded.

Data Analysis

Descriptive statistics is used to show demographics, Means and Standard deviations of outcome measurements across variations of diagnosis and interventions intensity. Non-parametric Tests are used to determine significance of variations across groups. Spearman's rho correlation is calculated to show relationship among variables.

Multivariate analysis is used to explore relationship of mental wellbeing with readmissions and clinic visits, if any.

Results

Demographics

623 patients admitted during the study period were recruited for the Wellbeing and Recovery Program while 266 cases dropped out before discharge. Only 357 participants have completed the mandatory 2 sessions of Recovery Program and with further five sessions either on Five Wellbeing Program or the Recovery Program were being analyzed. Out of 357 participants, 144 (40.3 %) were female and 213 were male. 293 (82.1 %) were educated up to secondary level and 30 (8.4 %) were at tertiary level. 60 (16.8 %) were married and 246 (68.9 %) were single, the remaining 51 persons were either divorced or loss of spouse. Prior to their admission, 234 (65.5 %) were unemployed, while remaining are working as fulltime (23 %), 35 (9.8 %) of them were housewife and 6 (1.7 %) were students. They aged from 16 to 66 (mean 38.75; SD 11.62). They have their psychiatric history ranges from 0 to 49 years (mean 8.34; SD 9.57). They were categorized into 7 groups of diagnosis according to DSM-V where 252 (70.6 %) cases suffered from Schizophrenia or Psychosis or Delusional Disorder; 27 (7.6 %) with Bipolar affective disorder (BAD); 2 (0.6 %) case of Obsessive Compulsive Disorder, 36 (10.1 %) with Depression, 13 (3.6 %) with Adjustment Disorder, 4 (1.1 %) with Personality Disorder, and the 'Others' with 21 (5.9 %) suffered from Anorexia, Substance abuse, Mental Handicapped and Autism. After 6 months of discharge, 72 (20.2 %) of them including 50 cases with schizophrenia/psychosis/delusional disorder, 8 cases with BAD and 11 cases with depression; was readmitted to psychiatric wards at least once. Their visits to out-patient clinic was significantly different where non-psychotic group (Mean 1.176; SD 2.56) are paying less visits than the psychotic groups (Mean 1.83; SD 3.26; $p < 0.05$) post 6 months after discharge (Table 1).

Intervention Program

357 participants have attended at least 2 sessions of Recovery Program. 333 cases attended from 1 session (9.5 %) to 5 sessions (22.1 %) of Wellbeing Program. 24 of them did not choose any topic from the Wellbeing Program. 79 of them completed total 7 sessions of Wellbeing & Recovery program before discharge (Fig. 1).

In using Wilcoxon Signed Rank Test, pre and post intervention assessments of all participants showed a

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Table 1 Characteristics of all participants ($n = 357$)

Demographics	n (%)	Min	Max	Mean	SD
Sex					
Female	144 (40.3)				
Male	213 (59.7)				
Marital status					
Divorced/widow	51 (14.3)				
Married	60 (16.8)				
Single	246 (68.9)				
Education					
Primary or below	34 (9.6)				
Secondary	293 (82.1)				
Tertiary or above	30 (8.4)				
Work (before adm)					
Unemployed	234 (65.5)				
Gainful employed	82 (23)				
Vocational training/ student	6 (1.7)				
Others	35 (9.8)				
Diagnosis					
Schizophrenia/ psychosis/delusional disorder	252 (70.6)				
BAD	27 (7.6)				
Depression/anxiety disorder	36 (10.1)				
OCD	2 (6)				
Personality disorder	4 (1.1)				
Adjustment disorder	13 (3.6)				
Others	21 (5.9)				
Years with psychiatric illness	355	0	49	8.34	9.565
Age	357	15	66	38.75	11.62

significant different in Hope Scale (Mean 1.675; SD 10.423; $p = 0.000$) as well as the SWEMWBS (Mean 1.633; SD 4.124; $p = 0.000$). The participants in the psychotic group showed similar results with the non-psychotic groups. In the non-psychotic groups ($n = 103$), significant difference was found in the pre–post SWEMWBS score ($p = 0.000$) and Hope score ($p = 0.003$). In the psychotic group ($n = 252$) revealed significant difference in the pre–post SWEMWBS score ($p = 0.000$) and Hope score ($p = 0.028$). When comparing the absolute change of scoring, only SWEMWBS revealed significance ($p = 0.026$) between the psychotic and non-psychotic group with the non-psychotic group achieving better results (Table 2).

Within the group completed Recovery Program only ($n = 24$), significant improvement was shown in SWEMWBS ($p = 0.013$) but not in Hope Scale. For those who attended both programs, significant median of differences was found between pre–post assessments of SWEMWBS ($p = 0.000$) and Hope Scale ($p = 0.000$).

The change of SWEMWBS score and Hope score is found correlated significantly with number of sessions of the Wellbeing Program attended, age, diagnostic group, onset years and employment status upon admission. One way ANOVA for SWEMWBS score change revealed significant changes across number of sessions attended in the Wellbeing Program ($p = 0.012$; $F = 2.966$) and especially between groups of those attended the 7 sessions Wellbeing & Recovery Program ($n = 79$) and attended 7 sessions Recovery Program only ($n = 24$; $p = 0.049$ Mean diff = 2.65) in Post hoc analysis. Similar results also shown in Hope Scale where change of score is significant between participants of above 2 groups ($p = 0.023$; $F = 5.227$; Table 3).

For all participants, the between subject effect of Wellbeing Program was found significant in Multivariate Test on the SWEMWBS score ($R^2 = 0.088$; power = 0.999; alpha = 0.05) and Hope score ($R^2 = 0.057$; power = 0.932; alpha = 0.05) with co-variables of diagnosis, education level, onset years, and adjusted by age. Stepwise regression was then performed and confirmed the Wellbeing Program was the only strong predictor for change in SWEMWBS score (R = 0.169; Sig. = 0.001; $F = 10.338$) and Hope score (R = 0.115; Sig. = 0.031, $F = 4.702$; Table 4).

Relationship of Mental Wellbeing and Hope with Psychiatric Consultations and Readmission

Multivariate Test of between subject effect ($n = 357$) was performed. Pillai's Trace value showed the variables of diagnosis, onset years, mixed factor of Wellbeing and Hope scores change has significant effects on Clinic visits ($R^2 = 0.933$; $p = 0.000$; $F = 7.42$; Power = 1, alpha = 0.025), and Readmission rate to psychiatric wards ($R^2 = 0.908$; $p = 0.000$; $F = 5.285$; Power = 1; alpha = 0.025) within 6 month after discharge.

In the 'non-psychotic' groups, it was verified in Wilk's Lambda Test the positive effect of improvement in SWEMWBS score ($F = 3.416$; $p = 0.001$) and Hope score ($F = 2.387$; $p = 0.01$) in the Clinic visits and the Readmission Rate within 6 months after discharge. Test of between subject effect revealed the mixed factor of Wellbeing and Hope score contributed significantly on the overall model on Clinic visits ($F = 5.97$; Sig. 0.001; Partial N Sq. = 0.930; power = 0.994), and on Readmission rate to psychiatric wards ($F = 7.509$; Sig. 0.000; Partial N Sq. = 0.944; power = 0.999) within 6 months after discharge. Different pattern was shown in the 'psychotic' group where only improvement of Hope Score ($F = 1.799$,
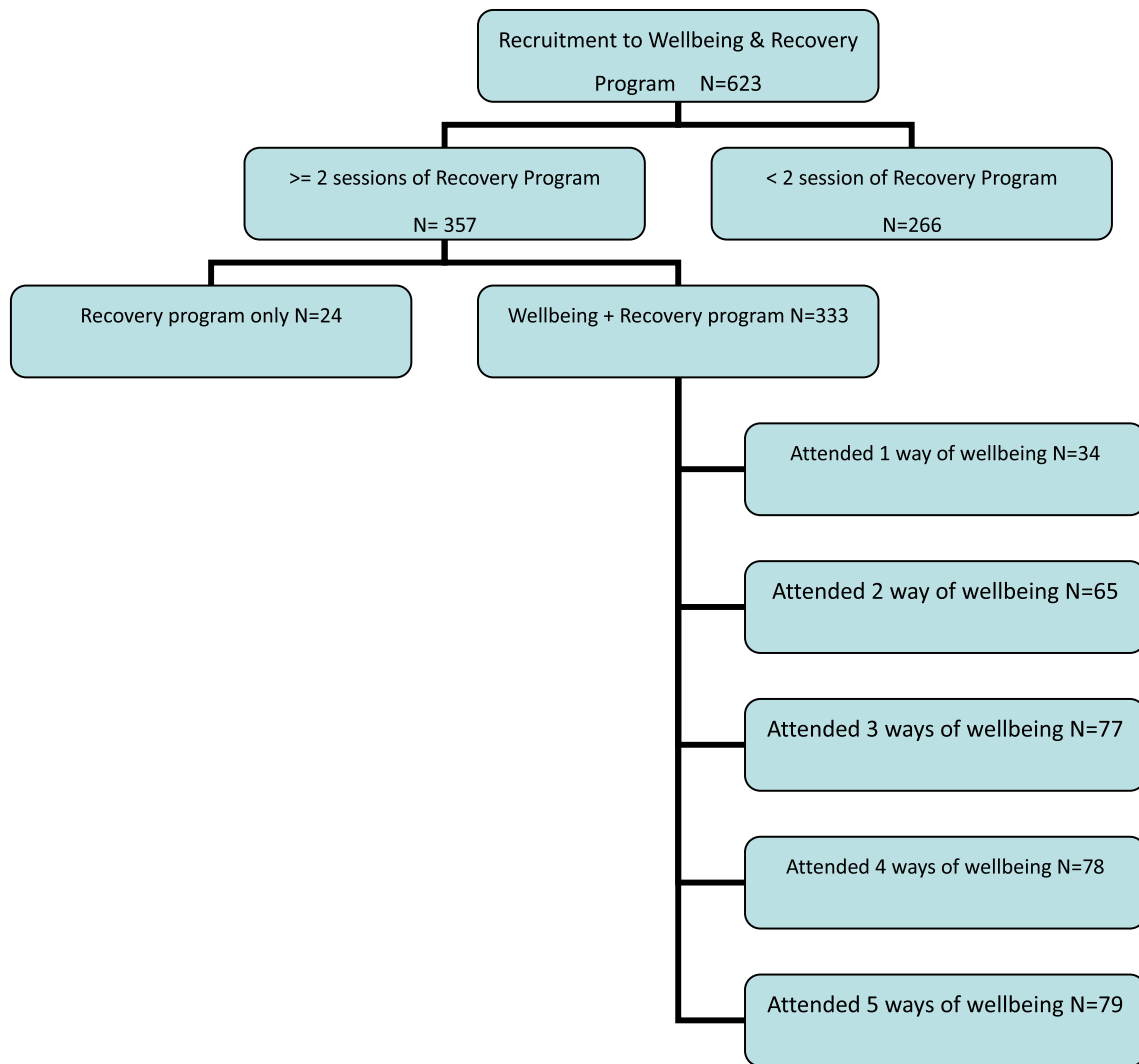
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Fig. 1 Flow of recruitment of participants

Table 2 Outcome measurements of all participants ($n = 357$)

Outcome	n (%)	Min	Max	Mean	SD	Median diff.	Sig. value
Readmission within 6 months post discharge	72 (20.2)						
Clinic visits within 6 month post discharge	356	0	19	1.635	3.0822		
Total session attended	357	3	7	5.59	1.0759		
Measures							
C-SWEMWBS pre	357	7	35	23.129	5.8937	1.675	0.000
C-SWEMWBS post	357	7	35	24.762	5.5685		
Hope pre	357	12	96	64.415	14.1235	1.633	0.000
Hope post	357	12	96	66.090	13.0553		

$p = 0.001$) was a significant factor for both dependent variables in Pillai's Trace Test. Tests of between subjects effects revealed a strong and significant mixed effect of change in SWEMWBS score and Hope score on the two dependent variables of Clinic visits ($F = 8.215$; Sig. 0.000; Partial N Sq. $= 0.917$; power $= 1$) and Readmission rate

Table 3 Spearman's rho (2-tailed) correlation tables among variables

	Wellbeing	Hope	5 Way	Recovery	Age	Diagnosis	Education	Work
Wellbeing								
Hope	0.163**							
5 Way	0.149**	0.007						
Recovery	0.027	0.067	0.664**					
Age	0.023	0.016	0.309**	0.168**				
Diagnosis	0.173**	0.063	0.137**	0.005	0.017			
Education	0.043	0.022	0.084	0.106*	0.177**	0.024		
Work	0.002	0.070	0.109*	0.082	0.018	0.135*	0.012	
Onset	0.086	0.059	0.143**	0.040	0.269**	0.137*	0.198**	0.161**

Remarks: wellbeing = change in wellbeing score; hope = change in Hope score; 5 ways = number of sessions in 5 ways program attended; recovery = number of sessions recovery program attended

* Sig < 0.05; ** sig < 0.01

($F = 7.219$; Sig. 0.000; Partial N Sq. = 0.907; power = 1) within 6 months post discharge (Table 5).

Discussion

It was not a conventional practice to implement therapeutic programs in promotion of Wellbeing for acute psychiatric patients on top of symptom management and medications locally. This is a pilot program to introduce the wellbeing promotion components in acute psychiatric settings. Although the methodology used in this study is not vigorous with controlled design, the findings are informative and extend the knowledge base in mental health practice. The Five Ways of Wellbeing Program so developed has shown statistically effective in promotion of Mental Wellbeing state and personal Hope among the clients with severe mental illness during their acute admission phase. While medication and psychological intervention remain the first line treatments, Wellbeing Program provides a juncture to clinical treatment that applies psycho-socio-behavioral principles to enhance physical and mental wellbeing [13, 14].

The Illness Management Program was evidenced to be effective in reducing risk of readmission, enhancing self-management and wellbeing of clients with severe mental illness [15, 16]. The Five Ways to Wellbeing program has provided a simple-minded agency, recapping basic

components in daily life: to learn, to connect, to appreciate, to participate and to give; and served the value of building 'Hope'; in addition to 'Wellbeing', as shown from this study. In addition to those evidenced in previous studies, that Wellbeing Program was effective not only in primary care programs for mild to moderate depression and adjustment disorders, but also to provide immediate positive effect in acute admission period of clients with severe mental illness. The responsiveness as shown above is encouraging. This may be due to the changes in the clients' self-management behavior and personal belief, also may affect their acceptance of community services provided after their discharge [17, 18]. The Wellbeing program was also applicable in the psychotic group of clients in a significantly manner which was different from results of another similar study by Schrank et al. [19] that no main effect on Wellbeing as measured by the same scale (WEMWBS) after 11 week group psychological intervention, although improvement in symptoms and depression was gained.

The causal relationship of attending the Wellbeing Program on the gain of SWEMWBS scores in all participants was inferred from the regression analysis above. It was the only strong predictor. It was also interesting as revealed in this study that the importance of introducing the 'Five Ways' together is needed to produce the best improvement, rather than any one of the component of the package,. This echoed with the original concept of the Five

Table 4 Stepwise regression analysis of dependent variables of 'change in Hope score' & 'change in Wellbeing score'

Dependent variables	Predictors	Model R	R^2	Adjusted R^2	SE of estimate	F	Sig.
Hope score	5 W prog. (excl. IMR, Dx., onset, age)	0.115	0.013	0.010	9.854	4.702	0.031
Wellbeing score	5 W prog (excl. IMR, Dx., onset, age)	0.169	0.029	0.026	3.853	10.336	0.001

Table 5 Multivariate test of between subjects effects of dependent variables 'Clinic visits' and 'Readmission' within 6 months for 'Psychotic group' and 'Non-psychotic group' of participants

Dependent variables	df	Mean square	F	Sig	Partial Eta squared	Observed power
Non-psychotic group[a]						
Corrected model						
Clinic visits*	84	2746.099	23.72	0.000	0.994	1.000
Readmission**	84	82.837	17.447	0.000	0.991	1.000
Intercept						
Clinic visits	1	257.715	2.226	0.160	0.146	0.187
Readmission	1	4.665	0.983	0.340	0.070	0.091
Hope score						
Clinic visits	32	325.962	2.816	0.025	0.874	0.795
Readmission	32	13.207	2.782	0.027	0.873	0.788
Wellbeing score						
Clinic visits	19	595.033	5.140	0.002	0.883	0.971
Readmission	19	11.272	2.374	0.058	0.776	0.640
Hope*wellbeing score						
Clinic visits	29	691.102	5.970	0.001	0.930	0.994
Readmission	29	35.653	7.509	0.000	0.944	0.999
Psychotic group[b]						
Corrected model						
Clinic visits	169	8244.362	13.767	0.000	0.970	1.000
Readmission	169	76.031	11.412	0.000	0.964	1.000
Intercept						
Clinic visits	1	2279.848	3.807	0.055	0.050	3.807
Readmission	1	1.073	0.161	0.689	0.002	0.161
Hope score						
Clinic visits	46	1369.334	2.287	0.001	0.594	0.999
Readmission	46	11.096	1.666	0.026	0.516	0.976
Wellbeing score						
Clinic visits	22	694.481	1.160	0.311	0.262	0.666
Readmission	22	10.648	1.598	0.071	0.328	0.857
Hope*wellbeing score						
Clinic visits	97	4919.573	8.215	0.000	0.917	1.000
Readmission	97	48.096	7.219	0.000	0.907	1.000

Weighted least square regression—weighted by age; alpha = 0.025

[a] * $R^2 = 0.992$; ** $R^2 = 0.986$

[b] * $R^2 = 0.966$; ** $R^2 = 0.964$

Ways that evidenced through the state-of-the-art research about mental capital and mental wellbeing through life [2]. It not only brought about positive effect in mental wellbeing, but also elevated the state of Hope among the participants.

Further controlled trials are necessary to confirm the postulation as reflected from the multivariate tests on the significant mixed effect of change in SWEMWBS score and Hope score on the 'number of clinic visits' and 'readmission rate due to psychiatry reasons' within 6 months post discharge. Wellbeing is made up of two key

elements: 'feeling good' and 'functioning well'. The Five Ways to Wellbeing program sets out five actions that promote wellbeing that it is not just a personal growth activity, but can be influenced by 'upstream' interventions [2] to promote the behaviors. Mental wellbeing and Hope are two closely related psychological virtues and presented consistent strong effect in illness management behavior both in psychotic and non-psychotic group in this study. Although the psychotic group presented with more outpatient visits and readmissions after 6 months post discharge, all the participants with higher gain in the

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Box 1 Five ways to wellbeing

Five themes	Values in life
1. '常連繫 Connect	1. 關懷身邊的人,成為生命中的支援與基石
	With the people around you. With family, friends, colleagues and neighbours. At home, work, school or in your local community. Think of these as the cornerstones of your life and invest time in developing them. Building these connections will support and enrich you every day
2. 常參與 Be Active	2. 有精神寄託,培養興趣
	Go for a walk or run. Step outside. Cycle. Play a game. Garden. Dance. Exercising makes you feel good. Most importantly, discover a physical activity you enjoy and that suits your level of mobility and fitness
3. 常細味 Take Notice	3. 欣賞自己和身邊的人和事
	Be curious. Catch sight of the beautiful. Remark on the unusual. Notice the changing seasons. Savour the moment, whether you are walking to work, eating lunch or talking to friends. Be aware of the world around you and what you are feeling. Reflecting on your experiences will help you appreciate what matters to you
4. 常學習 Keep Learning	4. 活到老, 學到老,保持好奇心
	Try something new. Rediscover an old interest. Sign up for that course. Take on a different responsibility at work. Fix a bike. Learn to play an instrument or how to cook your favourite food. Set a challenge you will enjoy achieving. Learning new things will make you more confident as well as being fun
5. 常施予 Give	5. 培養推己及人的態度
	Do something nice for a friend, or a stranger. Thank someone. Smile. Volunteer your time. Join a community group. Look out, as well as in. Seeing yourself, and your happiness, linked to the wider community can be incredibly rewarding and creates connections with the people around you

SWEMWBS and Hope scores had paid less consultation visits or readmissions in a highly consistent manner. Literature supports that both mental wellbeing and hope are stable virtues of a person, unlike momentary happiness, that lasts for a longer time and builds resilience [2]. Resilience is the capacity of people to confront and cope with life's challenges; to maintain their wellbeing in face of adversity; as well as building social capital [20]. There are growing evidence that Recovery of Mental Illness is strongly associated with better functioning, better mental health quality, higher wellbeing and personal growth in Bipolar Disorder [21, 22] and in Major Depression [23].

Promotion of recovery approach in psychiatric service in local hospitals has been flourishing since this century

started. Recovery is a personal journey of discovery. It involves making sense of and finding meaning in, what has happened, becoming an expert in ones' own self-care and building a new sense of self and purpose in life, discovering own resources and possibilities to pursue goals in life [24]. New forms of evidence resulted from positive psychology interventions as well as from synthesizing narratives about recovery from mental illness, which provide ecologically valid insights into the way to develop a purposeful and meaningful life [25–28]. More emphasis on the person's own goals and strengths will be needed, with integration of interventions which promote wellbeing into routine clinical practice [29]. For this to happen we are talking about a major transformation of services which involve thinking about differently about the skill mix and components of interventions we deliver as well as the care pathways. It requires the creation of health-oriented rather than illness-oriented services. Mental health workers will need new approaches to assessment and treatment if the goal is promoting wellbeing rather than treating illness only. This warrants for more extensive research on the protective effects of building Mental Wellbeing and Hope in affecting their illness management behavior e.g. clinic visits and readmission in severe mental illness population.

Limitations

This study has a number of limitations. The sample was collected in a single local hospital that the generalization of the results to the whole psychiatric population need further studies. Due to the limitations of program implementation, the design of study was not under a controlled environment. The results were subjected to numerous confounders that a more vigorous research design is needed to confirm the efficacy of the program in this population.

Conclusion

The Five Ways of Wellbeing Program so developed has shown statistically effective in promotion of Mental Wellbeing state and personal Hope among the clients with severe mental illness during their acute admission phase. It adds values on top of the conventional framework of recovery oriented practice in local psychiatric hospitals. The responsiveness is encouraging that warrant for more extensive research on the protective effects of these two potential significant factors affecting clinic visits and readmission in severe mental illness population.

Compliance with Ethical Standards

Conflict of interest All authors of this study was not funded by any sources or agency.

Ethical Approval All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards. Informed consent was obtained from all individual participants included in the study.

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