



Hopes and Wishes of Clients with Mentally Illness in Hong Kong

Daniel W. L. Lai¹ · K. C. Chan² · G. D. Daoust³ · X. J. Xie⁴

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Abstract

Recovery is a progressive process involving support to people with mental illness to take control of their life through the enhancement of motivation, self-drive, and responsibility. Drawing on qualitative interviews with 61 patients with mental illness aged between 40 and 75 in the community or residential settings, this study examined the wishes and hopes of clients who were in recovery. Participants described wishes and hopes for autonomy and independence in finances, accommodation, and health; stable housing or accommodation; meaningful occupation or employment; ‘giving back’ to society by serving others; intimate relationships; and gaining back ‘lost time.’ Wishes and hopes were motivating factors contributing to physical, mental, and social health over time, motivating clients with mental illness to live happily. To foster recovery, mental health practitioners should consider the identification and fulfilment of wishes and hopes in health and social care programs for this unique client group.

Keywords Mental illness · Recovery · Wish · Hope · Mental health · Aging

Introduction

Recovery processes can be lengthy and challenging for clients with mental illness due to bio-medical difficulties and socio-cultural stereotypes encountered. With accessible psychotropic drugs and heightened humanistic views toward support, the life expectancy of mental patients has been on

the rise. Growing old with mental illness is a reality facing many clients.

The Recovery Model of Mental Illness

In the late 20th century, increasing opposition to governmental and institutional authority led to the promotion of different perspectives and approaches to mental illness, including the recovery model (Jacob 2015). Clinical perspectives regarding recovery focus on the reduction of symptoms and restoration of full functioning, while personal recovery perspectives focus on holistic well-being and development (Rayner et al. 2018). In the recovery model, recovery is a progressive process involving ‘ups and downs’, with the provision of support for people with mental illness to take control of their life (Jacob 2015). The recovery model emphasizes personal control over one’s life by enhancing motivation, self-drive, and individual responsibility. To foster recovery, it is important to promote a supportive and enabling environment for people with mental illness and improve their desire and self-management skills to reconnect to the community.

When fostering personal recovery, it is important to examine factors in the environments surrounding people with mental illness, including both resources and hindrances.

✉ Daniel W. L. Lai
daniel_lai@hkbu.edu.hk

K. C. Chan
kcchan@swk.cuhk.edu.hk

G. D. Daoust
G.Daoust@sussex.ac.uk

X. J. Xie
xiexjing@gmail.com

¹ Faculty of Social Sciences, Hong Kong Baptist University, Room 1325, 13/F Academic and Administration Building, Baptist University Road Campus, Hong Kong, China

² Department of Social Work, The Chinese University of Hong Kong, Hong Kong, China

³ Department of International Relations, The University of Sussex, Brighton, UK

⁴ International Social Service Hong Kong Branch, 130 Hennessy Rd, Wan Chai, Hong Kong, China

Drawing on components from ecological system theory, Rayner et al. (2018) outline a model synthesizing factors in social environments that impact recovery. These include factors at the personal (personal attitudes, perspectives, and awareness), systemic (social or geographic factors with immediate impacts on individuals), and macro (wider social, political, and technological forces) levels.

Grounded upon the strengths perspective to identifying and sustaining environmental and personal resources for maintaining an independent life, Slade et al. (2014) identify three categories of interventions for personal recovery: support networks providing peer support and mental health triad to encourage mental patients to become proactive and participatory; fostering self-management through wellness recovery action planning tools and teaching self-management strategies; and supporting full citizenship by providing recovery education, employment, and housing. Frost et al. (2017) identify three factors contributing to recovery: remediation of functioning (initial treatment and recovery planning to initiate hope), collaborative restoration of skills (rebuilding personal, interpersonal, and daily coping skills and competence), and active community reconnection (providing chances for community participation).

Recovery of People with Mental Illness in Hong Kong

Hong Kong has a high reputation as a global city that embraces a vibrant lifestyle and international community due to its unique British colonial history and geographic location. For people in recovery from mental illness in Hong Kong, the diverse social, economic, and political factors also create diverse challenges. Chinese culture plays an important role in mental healthcare services in Hong Kong. The Chinese culture poses many challenges to implementing the types of recovery-oriented practices developed over the last two decades in the West. As noted by Davidson and Tse (2014), a variety of challenges that policymakers, system leaders, practitioners, family members, and persons with mental illnesses themselves may face in attempting to transform care in Hong Kong. The Chinese culture and family values emphasize a collectivist approach in which family is a significant component. This context aligns with the non-linear path of mental health recovery that would often involve the hard work from the individual and the family. (Davidson and Tse 2014).

The mental health services and the application of the recovery concept in Hong Kong focus on users' participation. It identifies the importance of more coordinated efforts, which are needed to establish the organizational support and policy framework so that sustainable and evidence-based service provision can be achieved. (Tse et al. 2012). Even though Hong Kong's mental health services have become

more recovery-oriented, the context, meaning, and process of which is highly individualized. The inadequacy in vocational and education training, as well as options, is a major concern among service users. The mental health services in Hong Kong are thus encouraged to highlight the importance of involving family and caregivers as integral members of the recovery movement. (Tsoi et al. 2014).

Although it is hard to argue that the stigma against people with mental illness is more severe among the Chinese culture than among people of other cultural backgrounds, it is an undeniable fact that many Chinese people have difficulty expressing their mental health needs. People with mental illness are adversely affected by the social stigma attached to mental illness in Chinese culture. In particular, shame, guilt, and the loss of face associated with mental illness stigma among Chinese harm Chinese people with mental illness. People in recovery from mental health illnesses may be deterred from seeking rehabilitation services and mental health treatment (Lam et al. 2010). The consequences of unable to seek professional are negative impacts on their work and family life, which would eventually lead to other social problems such as unemployment, poverty, and social isolation.

The high demand for mental health services in Hong Kong has resulted in a shortage of mental health professionals both in the public and private healthcare sectors, and a long waiting time for people with mental health illness to access mental healthcare in time (Tse 2020; Ng 2020). Moreover, the cost of mental health services is another financial burden for the people in recovery. Social stigma at the workplace is one reason for the high unemployment rate among people with mental illness. With limited or unstable income, many people in recovery have difficulty handling extra costs related to accessing mental health services. The worries of their financial burden may further affect their mental health status (Food and Health Bureau 2020).

Hope and Mental Illness Recovery

“Mental health recovery is a journey of healing and transformation, enabling a person with a mental health problem to live a meaningful life... while striving to achieve his or her full potential” (SAMSHA 2006). Hope is a critical element in the recovery process for people with mental illness (Oles et al. 2015; Acharya and Agius 2017; Hayes et al. 2017) and a key component in the Substance Abuse and Mental Health Services Administration's (SAMSHA 2012) definition of recovery. Hayes et al. (2017) define hope as “expectation or desire for positive events in the future”. Acharya and Agius (2017) emphasize the subjective nature of hope, noting that for some people, hope involves gathering resources and ability to improve one's current situation, while others define hope as a

desire to fully recover. Others define hope in terms of cognitions that involve self-motivation and making plans to achieve goals (Oles et al. 2015). Although different terms and concepts are used to define hope, hope generally involves aspects of positive thinking or imaginations of the future that can and will possibly happen.

Hope can help people with mental illness achieve recovery in several ways. First, hope can promote patient activation, which refers to knowledge, skills and confidence in handling illness and has a positive relationship with medication adherence, disease self-management, quality of life, and physical and mental health (Oles et al. 2015). Second, hope can support other dimensions of recovery. The ‘Recovery Star’ identifies 10 areas to achieve recovery: managing mental health, physical health and self-care, living skills, social networks, work, relationship, addictive behaviour, responsibilities, identity and self-esteem, and trust and hope (Acharya and Agius 2017). Hope guides and motivates people to seek changes in these areas. This is similar to the ‘hope’ component of the SAMSHA Recovery Model. In a systematic review of literature on recovery, hope was among the three most frequently identified components (Ellison et al. 2018). Third, hope can promote positivism and personal growth, which are helpful for personal recovery (Tang 2019). Fourth, hope is considered a counterforce against depression (Ellison et al. 2018; Russinova 1999). In these ways, hope can promote the development of multiple interconnecting factors that contribute to personal recovery for people with mental illness. Hope, however, does not always work as a facilitator for personal recovery because it is greatly influenced by one’s personal environment. Due to a lack of adequate and appropriate support from the family and/or experiences of discrimination, people with mental illness might feel that hope can lead to disappointment and feelings of powerlessness, which hinders recovery (Tang 2019).

Research Objectives and Questions

This study examines the wishes and hopes of clients with mental illness in recovery. While many clients have been in the mental health rehabilitation system for years, their aging process is more recent, and some have sensed and experienced functional deterioration associated with aging. However, little was revealed regarding the hopes and wishes of this group of clients. Two research questions were addressed: (1) What are the hopes and wishes of older clients with mental illness as they grow old? (2) How do hopes and wishes influence their recovery?

Design and Methods

Research Design, Data Collection, and Analysis

The data for this paper came from a larger study, from which some findings on the meanings of aging have previously been published (Lai et al. 2020). While these two papers share the same methods and data, they address different research questions. Data were collected using a qualitative narrative interview approach, which aims to facilitate the understanding of participants’ experiences, perspectives, and behaviours, particularly those of ‘unheard’ populations, based on personal stories which can represent their lives (Anderson and Kirkpatrick 2016). These stories might involve broad accounts of past events or more ‘tightly bounded’ accounts. They provide narratives of experiences rather than general descriptions (Riessman 2008). The meanings of these experiences and events are co-constructed through conversation between interviewers and respondents (Gubrium and Holstein 2002). Narrative interviews provide a means of organizing and assigning meanings to experiences, shaping identities and actions, enhancing coping and resilience, and challenging dominant narratives. This type of interview has been used in previous research with aging populations (Phoenix et al. 2010; Randall et al. 2015).

Data were collected through individual narrative interviews, a process suggested by Bauer (1996). Each interview lasted for about 30 to 40 min. In the interviews, the participants were generally asked unstructured questions that focused on the meanings of being older and the ‘pros and cons’ of becoming older with mental illness, perspectives and approaches to preparing for aging, and challenges and barriers associated with preparing for aging. Interviews were conducted by pairs of social workers and master-level social work students with training through role-playing and other exercises. The interview participants included 61 adults aged 40 and older, as thinking about and planning for aging and later life can begin before age 50, and age-related health problems that are common among older adults are also common among individuals with mental illness (due to dietary and lifestyle factors). Participants were service users of the New Life Psychiatric Rehabilitation Association, and had previously been clinically diagnosed with a mental illness before being referred to mental health care or support services. Participants emotionally, mentally, and verbally capable of communicating were recruited to join the study via the invitation by the social workers in the service units. Our sample reflected the different age and gender distribution of the Association’s service users. Either written or verbal informed consent was obtained according to the approved ethics review protocol.

The participants consisted of 30 men and 31 women. Over half (33; 54%) were aged 50 years or older, and the rest were aged 40 to 49. Twenty-five (41%) lived in the community, 22 (36%) lived in a halfway house, and 14 (23%) lived in residential housing. Two-thirds of participants had junior or senior secondary education (66%), while 14 (23%) had primary education, five (8%) had tertiary or university education, and one had no schooling. Thirty-eight (62%) had previous employment experience, while 21 (34%) had none. Only 18 (30%) were currently employed, including 10 in open employment and eight in supported employment. One was retired, one was a housewife at the home, while 40 (66%) were not currently employed.

The majority of participants (43; 71%) had schizophrenia, schizoaffective disorder, or paranoid schizophrenia. Ten (16%) reported depression, three (5%) had bipolar affective disorder, two (3%) had delusional disorder, and one had anxiety disorder or unstable/low mood due to poor health. Five (8%) had multiple mental health diagnoses. Thirty-one participants (51%) reported diagnosed physical health problems. With respect to length of illness, 13 participants had experienced their illness for 10 years or less, 21 for 11 to 20 years, 14 for 21 to 30 years, seven for 31 to 40 years, and four for 41 to 50 years. When identifying the type of mental health services received, halfway houses and sheltered workshops were each identified by 16 participants, while 15 identified community services and 14 identified residential services.

For data analysis, the interviews were audio-recorded with participants' consent and verbatim transcribed by the third author, while the first author was involved in cross-checking the accuracy of the transcripts. We used thematic analysis, which is an appropriate approach for narrative interviews and other qualitative research data (Anderson and Kirkpatrick 2016; Braun and Clarke 2014). Our analysis involved examining the ways in which narratives and stories were constructed by participants, the meanings ascribed to experiences, and their contexts (Riessman 2008). Initial coding of initial codes and themes was performed by the first and third authors independently, with the second and fourth authors served the role of cross-validating the themes emerged from the coding process. Codes, categories, and themes were examined through a 'bottom up' approach, starting from the narratives (Anderson and Kirkpatrick 2016). Key concepts, events, examples, and details provided by participants were analyzed to identify specific categories related to the research questions. This approach facilitated analysis of narratives that were presented in segments or with limited elaboration due to participants' communication challenges (associated with mental symptoms and cognitive difficulties). The study was approved by the Survey and Behavioural Research Ethics Committee, Faculty of Social Science, The Chinese University of Hong Kong. All

participants were informed about the study nature and provided either verbal or written consent.

Results

Wishes and hopes are key motivating factors to maintain physical, mental, and social health over time. Common wishes and hopes among most of the participants included living as a 'normal' person and returning to society. Hopes and wishes were also related to finances, interpersonal relationships, and self-enhancement, which served as motivating factors for clients with mental illness to live happily at their respective life stages.

Independence and Autonomy

In previous research, people with mental illness conceptualized recovery in terms of enhancing autonomy, agency, and sense of control in life (Cruce et al. 2012; Lysaker and Leonhardt 2012; Piat et al. 2009; Song and Hsu 2011). Their conception of recovery includes making life decisions, feeling ownership over one's actions, and a sense of self, competency, and purpose (Lysaker and Leonhardt 2012; Song and Hsu 2011) as well as autonomy regarding decision-making about health care preferences (Wright-Berryman and Kim 2016).

Independence, or not having to rely on others, was an overarching wish for participants in this study, disregarding their age and gender. As one described, "I do not want to bother others when I get old... For everything, let it be". Others discussed autonomy and independence in relation to finances and accommodation, as described in the sections below. Participants also discussed autonomy and independence in relation to health, including healthy lifestyles, good nutrition, and regular physical activities. Autonomy and independence influenced mobility, engagement in leisure activities, expectations of independence, and avoiding 'burdening' their children or family members.

Many participants wished to avoid relying on formal services. As one said, "I want to gain acknowledgement from others and hope to contribute to society... I am trying not to use too many government resources and to rely on myself". When discussing finances, some participants desired to live independently and not to rely on the government or NGOs through, for example, financial subsidies. Others felt that receiving subsidies would enable them to get rid of financial burden and that they could not have a good standard of living without assistance. However, to avoid dependence on services, other sources of social support (outside of formal services) might be necessary. This illustrates a key tension: participants wanted to maintain independence, but they also

described the importance of social support, which was necessary to avoid depending on formal services.

Having an Accommodation

Previous studies identified housing as crucial to recovery and wellbeing for individuals with mental illness, including health, functioning, community participation, and quality of life (Browne and Hemsley 2010; Kloos and Shah 2009; Weiner et al. 2010). People with mental illness may prefer independent or supported housing, which can contribute to independence and autonomy (Tsai et al. 2010; Weiner et al. 2010). However, they may face significant housing-related challenges, including a lack of money to pay for housing, difficulty managing paperwork, lack of affordable accommodation, poor housing quality, and stigma and discrimination from housing managers or agents (Browne and Hemsley 2010; Kloos and Shah 2009; Tsai et al. 2010).

Most of the participants, disregard their age and gender, in this study wished to have stable housing or accommodation and to live independently. They discussed places to live, people with whom they wanted to live, and preferences for private versus public housing. Having accommodation meant not only having a place to reside but also having a place of one's own. As one participant from the older age group of 65 and older shared, "The most important thing for elderly people is to have our own flats". Participants provided different reasons for their wishes for having a place of one's own, including a desire not to be looked down upon, to maintain independence, and to develop or maintain intimate relationships—a particularly important sign of recovery for participants. As one mid age participant said, "I can have a girlfriend only if I have my own flat... I need to have a room, then I could date a girl... I like a girl who is also a volunteer as me... but I cannot let her know that I am still living in the halfway house... I hope I will have my own flat after I move out, or I can live in public housing. Then I can have a girlfriend".

For participants, both for the mid age or older age groups, challenges associated with accommodation and independent living included fear of living on their own without support, and a desire to live with family members or in places with support (such as elderly service centres). For some, access to independent accommodation was linked to employment, another perceived sign of recovery. One older participant explained that the most important thing for older people was to have one's own flat, but felt this was impossible due to financial affordability: "It's impossible to save money to buy a flat... I will buy the lottery weekly, to see if there's a chance to win the prize".

Having Meaningful Employment

Employment and income can be central to recovery for people with mental illness (Seeman 2009; Topor et al. 2011), contributing to health and social wellbeing (Kukla et al. 2012). The 'meaningfulness' of one's work can be critically important, involving feelings of normality, acceptance, belonging, and fulfilment, and providing a sense of daily structure and identity (Leufstadius et al. 2009). However, individuals with mental illness often experience discrimination when seeking employment and during employment (Corbiere et al. 2011; Hipes et al. 2016; Seeman 2009; Thornicroft et al. 2009). The discrimination is generally linked to employers' concerns about employees' performance, reliability, behaviour, workplace interactions, and safety (Seeman 2009). Employment opportunities for people with mental illness can be expanded through workplace accommodations (e.g. flexible scheduling, modified job duties) (McDowell and Fossey 2015; Modini et al. 2016).

Participants, mainly the mid age ones, wished for a meaningful occupation or employment and discussed the importance of career goals. As for the older participants, issues related to employment were not shared much, probably due to their age being closer to retirement. In addition to providing a source of income and stability, having employment was associated with a meaningful role and occupation in life, social engagement, motivation, positive thinking, and self-regard. As one participant explained, "I enjoy working in the sheltered workshop. It's fun to work here and I feel my life is meaningful". Finding a job served as a significant part of the recovery process as it provided a way to maintain contact with society. One participant noted, "I enjoy working in the sheltered workshop. I enjoy staying with my colleagues. We eat together, have afternoon tea together, chat together". On a broader level, employment was viewed as a way to change social stigma attached to mental illness as it could acknowledge individuals' independence and contributions to society.

Employment was related to earning a higher salary, which enabled participants to meet additional goals such as engaging in leisure activities and saving money, an important aspect of recovery. One participant explained, "I can buy things I like to eat, and can enjoy films at the cinema... I enjoy watching films". As another reported, "I want to earn more money... Saving money in this way makes my future safer and I feel happier when considering the future".

Participants who wished to work identified challenges to meaningful occupation or employment. Low energy levels affected people's motivation and work activities, including motivation and capacity to find employment. As one mid age participant said, "I want to find a job, to feel more contact with society, but my health is poor... since I have taken many medicines. I am getting old". Another participant

noted, “It is not easy to find a job. I really want a job, but I’m very tired... I worry... that I will relapse under work pressure... and I will be fired again”. Ambivalence about wanting to find a job due to worries about not being able to keep a job was a common concern. Others, particularly the older participants, expressed challenges associated with moving from sheltered to ‘open’ employment. They were accustomed to working in sheltered workshops and thus they felt reluctant or unable to gain ‘open’ employment outside the sheltered environment.

‘Giving Back’ to Society

In previous research, a desire to help others and to give back to society is identified as an important part of recovery for people with mental illness (Bromley et al. 2013; Firmin et al. 2015; Song and Hsu 2011). This can provide a sense of pleasure, positive engagement and contributions, and a sense that one can help others despite their illness (Bromley et al. 2013; Song and Hsu 2011). It also contributes to illness management, hope, and quality of life (Firmin et al. 2015).

Some participants described a desire to ‘give back’ to society and some people from different age groups reported a slight different approach. As one mid age participant explained, “I have received help before... so I want to give back to society and help others”. Another participant echoed this: “The society supported me through CSSA... so I always participate in voluntary activities to give back to society... as a helper in the elderly home.”. A third participant who was at an older age reflected, “I’m aged now, but I can face it. I am disabled [with a mental illness], but... I hope I can continue to give back to the society, and not only wait for society to support me through welfare”. They gained happiness through serving others and social engagement. Re-integration via giving back to society served as a key component of recovery.

Some participants mentioned volunteer work as a way of helping and engaging with other people and providing a connection to society. One mid age participant explained, “Helping others is helping myself... Sometimes I go out to have home-visits with older adults on Saturdays”. Another described their specific wish to support other older people: “Being a volunteer now is a preparation for my future... I would also like to establish an elderly home and hire older adults as workers... I want to give back to society and help others... That’s my dream! I can hire my friends from our sheltered workshop at my elderly home. Then they could do things that are meaningful”.

Intimate Relationships

In previous studies, romantic, intimate, and/or sexual relationships are identified as important in promoting recovery and wellbeing for people with mental illness (Boucher et al. 2016; Davison and Huntington 2010; McCann 2010; Werner 2012), providing a source of attention, affection, companionship, trust, care, and support (Boucher et al. 2016; McCann 2010). However, people with mental illness may experience stigma and discrimination in intimate or sexual relationships and challenges due to limited social networks, financial strain, and effects of mental illness (Boucher et al. 2016; McCann 2010; Thornicroft et al. 2009; Wainberg et al. 2016). They may lack sexual health information and their needs for intimate relationships and sexual health tend to be overlooked by mental health professionals (Davison and Huntington 2010; Hughes 2016; McCann 2010).

Some participants, particularly the younger participants, expressed a desire for intimate relationships in which they could love and be loved. The desire for intimate relationships was connected with that for a ‘normal’ life and one’s own place. Participants described their desire for intimate relationships in terms of mutual affection and having someone with whom to grow old. As one participant said, “I hope to have a partner who can accompany me, and I won’t feel bored when I am older”. Another explained, “I hope to get married after 10 years. Then I can live with my husband... We will love each other”.

New Interests, Knowledge, and Skills

In previous research, individuals with mental illness conceptualized recovery in terms of returning to their ‘old’ self as well as moving forward in life (Piat et al. 2009; Provencher and Keyes 2011). This involved processes of gaining knowledge and building on talents and strengths (Provencher and Keyes 2011; Topor et al. 2011). Daytime and leisure activities are identified as important aspects of recovery for people with mental illness (Iwasaki et al. 2014; Werner 2012). They can provide a sense of meaning, connection, freedom, and autonomy as well as support people to cope with stress and achieve active living, a sense of belonging, and social engagement (Iwasaki et al. 2014; Townley et al. 2009).

There is a desire to gain back ‘lost time’ by discovering strengths and new talents. Many mid age participants described the importance of acquiring, renewing, and engaging in interests and hobbies, which were associated with life enjoyment, social engagement, self-achievement,

learning new things, connecting the past, and preparations for future life. Some participants described a desire to travel. As one explained, “I want to travel in Europe! I have never been there before. And I want to visit some places I have not been to... like Jiuzhaigou Valley... [and] Kenting (Taiwan)”. According to another participant, “The best life for me is to have friends and families, to sleep early, get enough rest, and have the opportunity to go travelling”. Others shared the importance of career goals and academic upgrading in accessing employment and achieving broader goals of self-esteem, self-enhancement, and self-actualization.

Discussion

Recovery is a lengthy process and that it is important not to over-emphasize expectations of a symptom-free life. Dealing with the symptoms of mental illness, side effects of drugs, and socio-cultural stereotypes and discrimination can be a lonely and frustrating battle for many clients in their recovery process. Based on current population trends, people with mental illness are living longer. In other words, aging would impact their lived experiences and processes of discovery. Despite these challenges, this study highlights the importance of hopes and wishes in driving, supporting, and facilitating clients with mental illness along the path of recovery. Participants’ various hopes and wishes reflected a personal understanding of recovery based on holistic well-being and development (Rayner et al. 2018). Their hopes and wishes covered many domains, including mental and physical health, life skills, work, relationships, and identity and self-esteem (Acharya and Agius 2017), reflecting both tangible and intangible aspects. Similar to many people without mental illness, clients with mental illness in this study shared a common concern over tangible needs, notably accommodation, meaningful employment, and financial resources. Participants also emphasized the importance of intangible needs, such as autonomy, developing intimacy, giving back to society, and pursuing interests and self-enhancement.

Participants’ conceptualizations of recovery and possibilities for fulfilling hopes and wishes echoed the ecological model of recovery (Rayner et al. 2018). They discussed personal-level factors such as individual health, awareness of options, and personal desires, along with systemic and macro-level factors, such as financial resources, social networks, and discrimination in housing and employment. Participants’ narratives also highlighted the interrelatedness of various hopes and wishes. For example, hopes and wishes associated with health were directly linked to possibilities for meaningful employment. Employment is key to accessing financial resources, which could support

independent accommodation. And independent accommodation was considered crucial to intimate relationships.

This study illustrates how hopes and wishes serve as motivating factors for clients with mental illness to maintain a healthy lifestyle and habits over time as part of their recovery. Participants discussed the importance of being physically, mentally, and socially healthy over time. As they aged, their sense of vulnerability appeared to increase, leading to a realisation of the importance of maintaining good health in fulfilling hopes and wishes associated with independence and autonomy, employment, accommodation, societal contributions, intimate relationships, and self-enhancement. A desire to achieve these aims motivated participants to take different actions, such as participating in sheltered employment and volunteer work and developing new knowledge and skills.

These findings point to the need for mental health practitioners to identify and fulfil wishes and hopes in health and social care programs for aging mental health clients. As previous literature on recovery (Frost et al. 2017; Slade et al. 2014) suggests, practices should focus on recovery action planning, facilitating and strengthening support networks and community participation, self-management strategies and coping skills, and support for employment and housing. Creative intervention approaches such as logotherapy could support clients to find meanings in life—and wishes and hopes are indicators of and pathways toward making life meanings. The use of arts-based interventions such as art therapy and music therapy could also allow clients to further explore their wishes and empower them to make such wishes. Mental health practitioners working with clients with mental illness should actively identify hopes and wishes and facilitate sharing of dreams and strategies among clients. Efforts should be guided by a holistic understanding of recovery that recognizes autonomy and self-esteem, knowledge development, meaningful occupation, and belonging and love (including intimate relationships) as common human needs shared by clients with mental illness. Mental health practitioners should also actively address the ways in which aging processes affect clients’ hopes and wishes and their possibilities for fulfilling those hopes and wishes, given that clients may feel increasingly lonely or vulnerable due to feelings of dependence on others as they age.

To enable clients’ achievement of tangible and intangible hopes and wishes, support is needed to facilitate their access to accommodation, meaningful employment, volunteer opportunities, and peer networks so that clients with mental illness may gradually engage in transition into ‘recovery mode.’ These efforts align with a sense of choice and autonomy, for example, that with respect to the type of accommodation and employment. Practitioners should reflect on options to facilitate clients’ transitions from dependence to

independence as wishes and hopes may not be immediately achievable in the short term.

The challenges faced by clients with mental illness are often long-term challenges. The long process of recovery could be facilitated through mini-step transitions—from supported accommodation to independent accommodation, from sheltered to ‘open’ employment, or from volunteer to paid opportunities. This approach would align with clients’ wishes for basic changes upon which further changes can be anchored. Providing space and opportunities for clients to come together to share their hopes and wishes in a context of peer support could help them develop actions and realistic pathways to the fulfilment of hopes and wishes. Mental health practitioners need to pay more attention to aspects of contexts and environments that can facilitate or limit the fulfilment of hopes and wishes. More efforts are needed to provide support for finances and housing among clients with mental illness as well as to address social stigma and discrimination that limit their access to meaningful employment and independent accommodation.

As a qualitative narrative study, the goal of this study was not about generalization. The authorship team understands the limitations of this study. By collecting data from clients of one organization in one Asian city, the generalization power of the findings is hampered. However, the narrative interviews have served to uncover stories and experience of the participants. The findings have provided knowledge on the multiple perspectives held by the participants. As indicated in the discussion, the findings have shown similarity in previous research results on people with mental illness in other jurisdictions. This has illustrated the contribution of this study to provide reference to gaining in-depth understanding toward the recovery process of the people with mental illness. While the findings have echoed previous literature on recovery (Acharya and Agius 2017; Rayner et al. 2018), further research to compare the differences due to variations in socio-cultural and economic contexts of the clients in other jurisdictions such as other Western and Asian societies would be meaningful to enhancing our global understanding of the mental health recovery.

Finally, the recent social and political unrest in Hong Kong as well as the global Covid-19 pandemic have posed additional challenges to the mental health of people in recovery. The unprecedented social unrest created vivid scenes of conflicts or experiences of physical violence. The trust between families and friends shrunk because of their different political views. For those with mental health illness, the newsfeed or physical exposure to violent and chaotic street scenes may trigger traumatic flashbacks and PTSD (post-traumatic stress symptoms). The challenging political factor in Hong Kong creates a mental health tsunami that adds further mental and emotional burden to people who have mental illnesses. (Ng 2020).

During the pandemic, due to lockdown, social distancing, and prolonged quarantine, mental health of many people has been negatively affected (Panchal et al. 2020). The pandemic triggered isolation in social life and disruptions in daily activities may result in aggravated experience of loneliness, disconnectedness, and helplessness, which have a significant negative impact on mental health status, particularly the various vulnerable groups and those which psychiatric disabilities (Tse 2020). To what extent these emerging societal and global health circumstances have impacted the hopes and wishes of people in recovery is subject to further investigation by researchers in future studies. The impact of the “new normal” after the pandemic particularly has created new forms of lifestyles and daily living patterns that may require additional efforts of people in recovery to adapt. The need for new approaches of delivering services or programs for facilitating recovery in the new normal era should be a key direction for mental health professionals and policy makers to further contemplate.

Author Contributions DWLL was principal investigator of the study, conceptualized and designed the study, identified recruitment sources, provided training the interviewers, coordinated data collection, led and supervised data analysis, drafted parts of the paper and critically reviewed the paper. KCC was co-investigator of the study, co-designed the study, coordinated recruitment and data collection, oversaw data collection, involved in discussion of the results, critically reviewed the draft and provided inputs. XJX involved in data collection, data analysis, and organizing the results for paper development. GDD organized research findings and drafted parts of the paper. All authors read and approved the final manuscript.

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Compliance with Ethical Standards

Conflict of interest The authors declare that they have no conflict of interest.

Ethical Approval This study was approved by the Survey and Behavioural Research Ethics (SBRE) Committee, Faculty of Social Science, The Chinese University of Hong Kong. The study was approved based upon project title “Meanings of Aging of People Living with Mental Illness: Implications to promoting healthy aging practices.” All participants have been informed about the content of the study, the risks as well as the content of the interview may be used for the publication. This study has obtained either informed written or verbal consent from all participants.

Consent to Participate All participants have been informed about the content of the study as well as the risks.

Consent to Publish Participants have signed the consent to participate in the interview and known that the content of the interview would be used for publication.

References

- Acharya, T., & Agius, M. (2017). The importance of hope against other factors in the recovery of mental illness. *Psychiatry Danubina*, 29(Suppl 3), 619–622.
- Anderson, C., & Kirkpatrick, S. (2016). Narrative interviewing. *International Journal of Clinical Pharmacy*, 38(3), 631–634.
- Bauer, M. (1996). The narrative interview: Comments on a technique for qualitative data. Papers in Social Research Methods Qualitative Series No. 1. London School of Economics and Political Science Methodology Institute.
- Boucher, M. E., Groleau, D., & Whitley, R. (2016). Recovery and severe mental illness: The role of romantic relationships, intimacy, and sexuality. *Psychiatric Rehabilitation Journal*, 39(2), 180.
- Braun, V., & Clarke, V. (2014). What can “thematic analysis” offer health and wellbeing researchers? *International Journal of Qualitative Studies on Health and Well-Being*, 9, 26152. <https://doi.org/10.3402/qhw.v9.26152>.
- Bromley, E., Gabrielian, S., Brekke, B., Pahwa, R., Daly, K. A., Brekke, J. S., & Braslow, J. T. (2013). Experiencing community: Perspectives of individuals diagnosed as having serious mental illness. *Psychiatric Services*, 64(7), 672–679.
- Browne, G., & Hemsley, M. (2010). Housing and living with a mental illness: Exploring carers’ views. *International Journal of Mental Health Nursing*, 19(1), 22–29.
- Corbiere, M., Zaniboni, S., Lecomte, T., Bond, G., Gilles, P. Y., Lesage, A., & Goldner, E. (2011). Job acquisition for people with severe mental illness enrolled in supported employment programs: A theoretically grounded empirical study. *Journal of Occupational Rehabilitation*, 21(3), 342–354.
- Cruce, G., Öjehagen, A., & Nordström, M. (2012). Recovery-promoting care as experienced by persons with severe mental illness and substance misuse. *International Journal of Mental Health and Addiction*, 10(5), 660–669.
- Davidson, L., & Tse, S. (2014). What will it take for recovery to flourish in Hong Kong? *East Asian Archives of Psychiatry*, 24(3), 110–116.
- Davison, J., & Huntington, A. (2010). “Out of sight”: Sexuality and women with enduring mental illness. *International Journal of Mental Health Nursing*, 19(4), 240–249.
- Ellison, M. L., Belanger, L. K., Niles, B. L., Evans, L. C., & Bauer, M. S. (2018). Explication and definition of mental health recovery: A systematic review. *Administration and Policy in Mental Health and Mental Health Services Research*, 45(1), 91–102.
- Firmin, R. L., Luther, L., Lysaker, P. H., & Salyers, M. P. (2015). Self-initiated helping behaviors and recovery in severe mental illness: Implications for work, volunteerism, and peer support. *Psychiatric Rehabilitation Journal*, 38(4), 336.
- Frost, B. G., Tirupati, S., Johnston, S., Turrell, M., Lewin, T. J., Sly, K. A., & Conrad, A. M. (2017). An Integrated Recovery-oriented Model (IRM) for mental health services: Evolution and challenges. *BMC Psychiatry*, 17(1), 22.
- Hayes, L., Herrman, H., Castle, D., & Harvey, C. (2017). Hope, recovery and symptoms: The importance of hope for people living with severe mental illness. *Australasian Psychiatry*, 25(6), 583–587.
- Hipes, C., Lucas, J., Phelan, J. C., & White, R. C. (2016). The stigma of mental illness in the labor market. *Social Science Research*, 56, 16–25.
- Hughes, E. (2016). The sexual health and relationship needs of people with severe mental illness. *Journal of Psychiatric and Mental Health Nursing*, 23(5), 338–343.
- Iwasaki, Y., Coyle, C., Shank, J., Messina, E., Porter, H., Salzer, M., ... & Ryan, A. (2014). Role of leisure in recovery from mental illness. *American Journal of Psychiatric Rehabilitation*, 17(2), 147–165.
- Jacob, K. S. (2015). Recovery model of mental illness: A complementary approach to psychiatric care. *Indian Journal of Psychological Medicine*, 37(2), 117.
- Kloos, B., & Shah, S. (2009). A social ecological approach to investigating relationships between housing and adaptive functioning for persons with serious mental illness. *American Journal of Community Psychology*, 44(3–4), 316–326.
- Kukla, M., Bond, G. R., & Xie, H. (2012). A prospective investigation of work and nonvocational outcomes in adults with severe mental illness. *The Journal of Nervous and Mental Disease*, 200(3), 214–222.
- Lai, D., Chan, K. C., Xie, X. J., & Daoust, G. D. (2020). The experience of growing old in chronic mental health patients. *Aging & Mental Health*, 24(9), 1514–1522. <https://doi.org/10.1080/13607863.2019.1609903>.
- Lam, C., Tsang, H., Corrigan, P., Lee, Y., Angell, B., Shi, K., et al. (2010). Chinese lay theory and mental illness stigma: Implications for research and practices. *Journal of Rehabilitation*, 76(1), 35–40.
- Leufstadius, C., Eklund, M., & Erlandsson, L. K. (2009). Meaningfulness in work—Experiences among employed individuals with persistent mental illness. *Work*, 34(1), 21–32.
- Lysaker, P. H., & Leonhardt, B. L. (2012). Agency: its nature and role in recovery from severe mental illness. *World Psychiatry*, 11(3), 165.
- McCann, E. (2010). Investigating mental health service user views regarding sexual and relationship issues. *Journal of Psychiatric and Mental Health Nursing*, 17(3), 251–259.
- McDowell, C., & Fossey, E. (2015). Workplace accommodations for people with mental illness: A scoping review. *Journal of Occupational Rehabilitation*, 25(1), 197–206.
- Modini, M., Tan, L., Brinchmann, B., Wang, M. J., Killackey, E., Glozier, N., ... & Harvey, S. B. (2016). Supported employment for people with severe mental illness: Systematic review and meta-analysis of the international evidence. *The British Journal of Psychiatry*, 209(1), 14–22.
- Ng, R. M. K. (2020). *Mental Health Crisis in Hong Kong*. Retrieved from: <https://www.psychiatristimes.com/view/mental-health-h-crisis-hong-kong>.
- Oles, S. K., Fukui, S., Rand, K. L., & Salyers, M. P. (2015). The relationship between hope and patient activation in consumers with schizophrenia: Results from longitudinal analyses. *Psychiatry Research*, 228(3), 272–276.
- Panchal, N., Kamal, R., Orgera, K., Cox, C., Garfield, R., Hamel, L., Munana, G., & Chidambaram, P. (2020). The implications of COVID-19 for mental health and substance use. Retrieved from: <https://www.kff.org/coronavirus-covid-19/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use/>.
- Phoenix, C., Smith, B., & Sparkes, A. C. (2010). Narrative analysis in aging studies: A typology for consideration. *Journal of Aging Studies*, 24(1), 1–11.
- Piat, M., Sabetti, J., Couture, A., Sylvestre, J., Provencher, H., Botschner, J., & Stayner, D. (2009). What does recovery mean for me? Perspectives of Canadian mental health consumers. *Psychiatric Rehabilitation Journal*, 32(3), 199.
- Provencher, H. L., & Keyes, C. L. (2011). Complete mental health recovery: Bridging mental illness with positive mental health. *Journal of Public Mental Health*, 10, 57–69.
- Randall, W., Baldwin, C., McKenzie-Mohr, S., McKim, E., & Furlong, D. (2015). Narrative and resilience: A comparative analysis of how older adults story their lives. *Journal of Aging Studies*, 34, 155–161.
- Rayner, S., Thielking, M., & Lough, R. (2018). A new paradigm of youth recovery: Implications for youth mental health service provision. *Australian Journal of Psychology*, 70(4), 330–340.

- Riessman, C.K. (2008). *Narrative methods for the human sciences*. CA, USA: SAGE Publications.
- Russinova, Z. (1999). Providers' hope-inspiring competence as a factor optimizing psychiatric rehabilitation. *Journal of Rehabilitation, 65*, 50–57.
- Seeman, M. V. (2009). Employment discrimination against schizophrenia. *Psychiatric Quarterly, 80*(1), 9–16.
- Slade, M., Amering, M., Farkas, M., Hamilton, B., O'Hagan, M., Panther, G., ... & Whitley, R. (2014). Uses and abuses of recovery: Implementing recovery-oriented practices in mental health systems. *World Psychiatry, 13*(1), 12–20.
- Song, L. Y., & Hsu, S. T. (2011). The development of the Stages of Recovery Scale for persons with persistent mental illness. *Research on Social Work Practice, 21*(5), 572–581.
- Substance Abuse and Mental Health Services Administration [SAMHSA]. (2006). *National consensus statement on mental health recovery*. US Department of Health Human Services: Rockville.
- Substance Abuse and Mental Health Services Administration [SAMHSA]. (2012). SAMHSA's working definition of recovery. Retrieved from <https://store.samhsa.gov/shin/content/PEP12-RECDEF/PEP12-RECDEF.pdf>.
- Tang, L. (2019). Recovery hope and agency: The meaning of hope amongst Chinese users of mental health services in the UK. *The British Journal of Social Work, 49*(2), 282–299.
- Thornicroft, G., Brohan, E., Rose, D., Sartorius, N., Leese, M., & INDIGO Study Group. (2009). Global pattern of experienced and anticipated discrimination against people with schizophrenia: a cross-sectional survey. *The Lancet, 373*(9661), 408–415.
- Topor, A., Borg, M., Di Girolamo, S., & Davidson, L. (2011). Not just an individual journey: Social aspects of recovery. *International Journal of Social Psychiatry, 57*(1), 90–99.
- Townley, G., Kloos, B., & Wright, P. A. (2009). Understanding the experience of place: Expanding methods to conceptualize and measure community integration of persons with serious mental illness. *Health & Place, 15*(2), 520–531.
- Tsai, J., Bond, G. R., Salyers, M. P., Godfrey, J. L., & Davis, K. E. (2010). Housing preferences and choices among adults with mental illness and substance use disorders: A qualitative study. *Community Mental Health Journal, 46*(4), 381–388.
- Tse, S. (2020). *To soften the mental health impact of coronavirus, Hong Kong must take better care of the vulnerable*. Retrieved from: <https://www.scmp.com/comment/opinion/article/3083457/soften-mental-health-impact-coronavirus-hong-kong-must-take-better>.
- Tse, S., Cheung, E., Kan, A., Ng, R., & Yau, S. (2012). Recovery in Hong Kong: Service user participation in mental health services. *International Review of Psychiatry (Abingdon, England), 24*(1), 40–47. <https://doi.org/10.3109/09540261.2011.646244>.
- Tsoi, E., Lo, I., Chan, C., Siu, K., & Tse, S. (2014). How recovery oriented are mental health services in Hong Kong? Snapshots of service users' perspectives. *Asian Pacific Journal of Social Work and Development. https://doi.org/10.1080/02185385.2014.885211*.
- Wainberg, M. L., Cournos, F., Wall, M. M., Norcini Pala, A., Mann, C. G., Pinto, D., ... & McKinnon, K. (2016). Mental illness sexual stigma: Implications for health and recovery. *Psychiatric Rehabilitation Journal, 39*(2), 90.
- Weiner, A., Roe, D., Mashlach-Eizenberg, M., Baloush-Kleinman, V., Maoz, H., & Yanos, P. T. (2010). Housing model for persons with serious mental illness moderates the relation between loneliness and quality of life. *Community Mental Health Journal, 46*(4), 389–397.
- Werner, S. (2012). Needs assessment of individuals with serious mental illness: Can it help in promoting recovery? *Community Mental Health Journal, 48*(5), 568–573.
- Wright-Berryman, J. L., & Kim, H. W. (2016). Physical health decision-making autonomy preferences for adults with severe mental illness in integrated care. *Journal of Social Service Research, 42*(3), 281–294.

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