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The Impact of Deinstitutionalization of Mental Health Services on Recovery Process among Depressive Patients in Gaza Strip

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Dedication

I dedicate this work to

my parents,

my wife,

my brothers,

my children (Reema, Ghazil and Ahmed)

and my friends

who have shown unconditional love and support from the

beginning to the end.

Declaration

I certify that this thesis submitted for the degree of Master is the result of my own research, except where otherwise acknowledged, and this thesis (or any part of the same) has not been submitted for a higher degree to any other university or institution.

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Abstract:

The overall aim of this study is to understand the impact of deinstitutionalization "community based treatment" versus hospital based treatment on recovery process among depressive patients in Gaza Strip in order to find the most effective way for achieving recovery among depressive patients. Descriptive, cross-sectional design was used, focused on distributed questionnaires. This questionnaire was used to collect the required data in order to achieve the objectives of the study . Which included 383 mentally ill patients, (245) male and (138) female with confirmed diagnosis of depression, who were treated in the local governmental community based treatment and EL-Nasser psychiatric hospital in Gaza Strip during 2009-2010, they participated voluntarily in this study. The sample was 120 participants, and it was as the following 80 patients from governmental community mental health centers and 40 patients from EL-Nasser psychiatric hospital, so the sample was 2:1. Questionnaires were distributed to the research sample with response rate 86%, validity and reliability of the instrument were tested and the total instrument reliability test (Cronbach's Alpha) was 0.91. The major findings of this study was as the following: The level of recovery for depressive patients in EL-Nasser psychiatric hospital was 42.88 %, while the level of recovery for depressive patients in Gaza governmental community mental health clinics was 73.29%, and (P- value equal or less than 0.05), the study revealed that there were significant differences on the opinion of the respondent about all fields of recovery scale at significant level $\alpha = 0.05$ and the differences in favor of Gaza governmental community mental health clinics. There were significant differences about the impact of deinstitutionalization of mental health services on recovery process among depressive patients in Gaza Strip due to marital status at significant level $\alpha = 0.05$ in favor of " single ", which can be clarified because of lack of social relationships and responsibilities that keep them need less concentrated support and economical costs. There were statistical differences about the impact of deinstitutionalization of mental health services on recovery process among depressive patients in Gaza Strip due to period of treatment at significant level $\alpha = 0.05$ in favor of "6 months-1 year", that appears that more acute cases can achieve recovery in early diagnosis with more optimal treatment methods. There were significant differences about the impact of deinstitutionalization of mental health services on recovery process among depressive patients in Gaza Strip due to place for treatment at significant level $\alpha = 0.05$, and the difference in favor of Gaza governmental community mental health clinics, showed that community based treatment can achieve much better results for depressive patients that may return to many factors as, acceptance to community based treatment is more likable and preferable than in hospital based treatment with more social interaction and communication away from social isolation and exclusion. The study recommended that it's important to focus our attention on mental health care provided for those patients to relieve their suffering and make better health care provision for them. Community based treatment can achieve great level of recovery for depressive patients and enhance social interaction and communication rather than hospital based treatment.

ملخص عن الدراسة باللغة العربية

أثر العلاج خارج نطاق المستشفيات "من خلال عيادات الصحة النفسية والمجتمعية" على عملية التعافي لدى مرضى الاكتئاب في قطاع غزة

الهدف العام لهذه الدراسة هو فهم تأثير العلاج خارج نطاق المستشفيات "من خلال عيادات الصحة النفسية المجتمعية" على عملية التعافي لدى مرضى الاكتئاب في قطاع غزة، من أجل إيجاد أكثر طريقة فعالة لتحقيق عملية التعافي لدى مرضى الاكتئاب، أجريت الدراسة على شكل دراسة وصفية علي عينة مكونة من ١٢٠ شخص بالغ لديه الاكتئاب، يتلقون العلاج في عيادات الصحة النفسية المجتمعة الحكومية ومستشفى الطب النفسي بغزة، ومسجلين في سجل ٢٠٠٩-٢٠١٠، حيث يتكون مجتمع الدراسة من ٣٨٣ مريض لديهم اكتئاب، ٢٤٥ ذكور و ١٣٨ إناث يتلقون العلاج في عيادات الصحة النفسية والمجتمعية ومستشفى الطب النفسي، وقد كانت عينة الدراسة ٨٠ حالة من عيادات الصحة النفسية والمجتمعية و٤٠ حالة من مستشفى الطب النفسي بغزة، وبعد أخذ الموافقة علي المشاركة في الدراسة، حيث بلغت نسبة تجاوب المرضى مع الدراسة ٨٦%، ولقد تمتع مقياس الدراسة بدرجة ثبات عالية بلغت ٠.٩١ حسب مقياس (Cronbach's Alpha) .

تم تعبئة الاستبيانات عن طريق إجراء مقابلات وجهًا لوجه متضمنة البيانات الشخصية وإستبانة التعافي، وتم إدخال البيانات وتحليلها باستخدام الحزمة الإحصائية للعلوم الاجتماعية النسخة(١٤)، وكانت نتائج الدراسة على النحو التالي: مستوى التعافي للمرضي في مستشفى الطب النفسي ٤٢.٨٨%، بينما مستوى التعافي للمرضى في عيادات الصحة النفسية والمجتمعية ٧٣.٢٩%، حيث تفيد أنه توجد فروق ذات دلالة إحصائية عند مستوى الدلالة α = ٠.٠٥ حول مستوى التعافي، والفروق لصالح مرضى الاكتئاب في عيادات الصحة النفسية والمجتمعية، توجد فروق ذات دلالة إحصائية عند مستوى الدلالة α = ٠.٠٥ بين المرضى في الحالة الاجتماعية لصالح الأفراد، وأنه توجد فروق ذات دلالة إحصائية عند مستوى الدلالة α = ٠.٠٥ بين المرضى في فترة العلاج لصالح ٦شهور – سنة، وتوجد فروق ذات دلالة إحصائية عند مستوى الدلالة α = ٠.٠٥ بين المرضى في مكان تلقى العلاج لصالح عيادات الصحة النفسية والمجتمعية، حيث أثبتت الدراسة أن العلاج والمتابعة من خلال عيادات الصحة النفسية والمجتمعية يحقق نتائج أفضل وأحسن لدى مرضى الاكتئاب وذلك يمكن أن يعود لعدة عوامل، التقبل للعلاج النفسي في عيادات الصحة النفسية والمجتمعية أكثر من العلاج في مستشفى الطب النفسي، وتعمل على تحسين التواصل والتفاعل الاجتماعي، بعيداً عن العزلة الاجتماعية والانطوائية. وقد أوصت الدراسة على أهمية الاهتمام بخدمات الصحة النفسية والمجتمعية والرعاية المقدمة للمرضى النفسيين لتخفيف معاناتهم وتقديم أفضل خدمات صحية مجتمعية، وأن العلاج من خلال عيادات الصحة النفسية والمجتمعية يحقق مستوى عال من التعافي لدى مرضى الاكتئاب، حيث أكدت نتائج الدراسة علي أهمية تحسين خدمات الصحة النفسية المجتمعية و تطويرها لتحسين مستوي التعافي بين المرضي النفسيين.

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List of Abbreviations:

ACT	Assertive community treatment
APA	American psychiatric association
CFA	Confirmatory factor analysis
CIDI	Composite international diagnostic interview
CMHS	Center for mental health services
CPMC	California pacific medical center
DD-NOS	Depressive disorder not otherwise specified
DSM-IV	Diagnostic and statistic manual of mental disorder 4th edition
DSM-IV-TR	Diagnostic and statistic manual of mental disorder-revised
ECT	Electroconvulsive therapy
EEG	Electroencephalography
EFA	Exploratory factor analysis
FGDs	Focus group discussions
FDA	Food and drug administration
GAS	Global assessment scale
GCMHP	Gaza community mental health program
GHQ	General health questionnaire
HIV	Human immunodeficiency virus
HoNOS	Health of the nation outcome scales
HRSD	Hamilton rating scale for depression
ICD-10	International classification of diseases-10th edition
K-S test	Kolmogorov and Smirnov
MAOIs	Monoamine oxidase inhibitors
MHRM	Mental health recovery measure
NIMH	National institute for mental health
NIMHE	National institute for mental health in England
PTSD	Post-traumatic stress disorder
RAS	Recovery assessment scale
RBD	Recurrent brief depression
SAD	Seasonal affective disorder

SAS-SR	Social adjustment scale-self report
SMI	Severe mental illness
SNRIs	Serotonin norepinephrine re-uptake inhibitors
SOFAS	Social and occupational functioning assessment scale
SPSS	The statistical package for social science
SSDI	Social security disability insurance
SSIs	Semi-structured interviews
SSDI	Social security disability insurance
TCAs	Tricyclic antidepressants
TCL	Training in community living
UNRWA	The United Nation for relief & work agency
VNS	Vagal nerve stimulation
WHO	The world health organization
WMR	Wellness management and recovery

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Chapter 1

Introduction

Chapter 1

1.1 Introduction:

Gaza strip has a beautiful sense in its life, where people living in great nature that is located near to the blue sea which is full of dynamic life, that encourages their people to work more and go on their lives that appears full of energy and make them develop themselves to come continuously to reach other developed countries, their people try to face all difficulties and political issues that tries to hold their steps, In spite of that, our scientists, researchers and experts continue their efforts to develop more and keep life more pretty.

Mental disorders are responsible for about 12-15% of the world's total disability-more than cardiovascular diseases, and twice as much as cancer. Their impact on daily life is even more extensive, accounting for more than 30% of all years lived with disability (Murray and Lopez, 2005).

There has been a debate between those who favour providing mental health treatment and care in hospitals, and those who prefer providing it in community settings, primarily or even exclusively. A third alternative is to utilize both community services and hospital care. In this balanced care model, the focus is in providing services in normal community settings close to the population served, while hospital stays are as brief as possible, promptly arranged and used only when necessary.

According to the global view the mental disorder is expected to increase in 2020, especially depression which was projected to rank second in the world as a cause of disability by 2020 (healthy people, 2010).

73% of patients visiting primary care clinics in Gaza Strip have psychiatric symptoms consistent with psychiatric disorders. The prevalence of mental health problems among females was higher (76,8%) than males (67%) (GCMHP, 2003).

Services created by governmental and non-governmental organizations in these contexts are a drop in the ocean compare with what is needed. So, it's important to focus our attention on mental health care provided for those patients, to relieve their suffering and make better health care provision for them, and this study aims to identify the most appropriate type of mental health care provided for mentally ill patients in Gaza Strip and to compare between the effects of community based treatment and hospital based treatment on achieving recovery among depressive patients in Gaza Strip.

Near East consulting, 2006 conducted a survey in occupied Palestinian territory and showed that, the recent socio-economic and political situation in the occupied Palestinian territory has undoubtedly affected the morale of the Palestinian population as more than ¾th of the Palestinian population is suffering from severe "depression" as 55% of the Palestinian population are very depressed and 22% depressed. These percentages point to an increase of 21% in just one year (from 56% to 77%). Meanwhile, 11% of Palestinians are on the borderline of a "depression", and the remaining 13% are either contented (9%) or very contented (4%). "Depression" rates in the Gaza Strip resemble those of the entire occupied Palestinian territory as 87% of Gaza Strip residents are either very depressed (66%) or depressed (21%) in

comparison to the West Bank were less than half of Palestinians are very depressed (48%) and 23% are depressed.(Near East consulting, 2006).

In this our area- Gaza strip- siege with most of its types are assignment strongly which affect negatively monitory economically and psychologically on our people in Gaza Strip. Siege as language is monopolizing and limiting needs through deconstructed behavior or dealing. Siege means obstacles and punishment in various ways on people, countries, group of people, or communities and companies done by powerful countries for their own and properties. The siege had strong impact on Palestinian children in Gaza strip that they were complaining of various emotional and behavioral problems that encounter them and their parents(Abu Hein, 2008).

The Gaza strip has turned into a huge prison with no access to the outside world. Israel has subjected Gaza strip to a series of collective punishment measures, the main of which is imposed strict siege on the movement of people and goods. The suffocating siege imposed on Gaza strip is leading to disastrous consequences to the physical and mental health of the citizens. The serious consequences of the blockade are on the psychological, social, and the Palestinian society, where they lead to increased rates of mental disorders in general terms commonly depression, anxiety and psychological disorders caused by physical psychological reasons, as well as contribute to satisfactory setbacks widely among psychopaths.(Qouta & Kassab, 2008).

The current siege provokes the previous traumas making people re-experience the negative feelings that they have previously encountered and passed through. The effects of the siege and blockade on the Palestinian family have different effects 99% found the prices highly risen compared to previously situations, 87% social relation ceased, where psychological symptoms that most commonly 23% neurological, 17.2% quickly and harassment by initiation, 14% feeling malaise, and 16.2% transitional feature of anger (Thabet, 2008).

Thabet et. al. (2008) in a study aimed to investigate the impact of the siege of Gaza strip on the Palestinian feelings of anger and anger state in relation to psychological symptoms. They found that the most common impact of siege of Gaza items was: prices were sharply increased (97.67%). The results showed that female reported more summarization, obsessive compulsive disorder, and phobic and anxiety. Also, Palestinians who live in camps reported more psychological problems, depression symptoms, anxiety, and hostility. However, psychosis symptoms were more common in people who live in villages than in camps or cities. People with who reported high siege scores were correlated positively with high psychopathology including anxiety and depression (Thabet, 2008).

Mental illness can strike anyone at anytime. Behavioral disorders do not discriminate. They strike men and women in about equal proportions. They affect people of all ages, races, ethnic groups and socioeconomic classes.

Economical Cost:

• Mental illnesses impose a multibillion dollar burden on the economy each year. Total economic costs amounted to 147.8 billion in 1990. More than 31 percent of those costs- 46.6 billion are for anxiety disorders (Rice and Miller, 1993)

• Direct cost-expenditures for professional health care for persons who experience mental disorders, including care in mental specialty institutions, hospitals and nursing homes, physician and other professional services, and prescription drugs- accounted for $67 billion, or 11.4 percent, of all personal health care expenditures in 1990 (Rice and Miller, 1993)

• Depression costs the U.S. economy 31.3 billion for indirect costs such as decreased productivity and lost work days, and 12.4 billion in direct costs, such as medication and physician time (NMHA, 2000).

• Major Depression is the 2nd leading cause of disability worldwide (NIMH, 1999; WHO, 1998)

• 73% of professional, ranging from nurses and administrators to lawyers, with serious mental illnesses are able to achieve full time employment in various fields (Boston University, 1999).

1.2 Background
Gaza Strip

Geographical characteristics:

Gaza Strip is located in the Middle East. It has a 51 kilometers border with Israel, and an 11 km border with Egypt, near the city of Rafah. Khan Yunis is located 7 kilometers (4 mi) northeast of Rafah, and several towns around Deir EL-Balah are located along the coast between it and Gaza City. Beit Lahia and Beit Hanoun are located to the north and northeast of Gaza City, respectively. The Gush Katif block of Israeli localities used to exist on the sand dunes adjacent to Rafah and Khan Yunis, along the southwestern edge of the 40 kilometers (25 mi) Mediterranean coastline. Gaza strip has a temperate climate, with mild winters, and dry, hot summers subject to drought. The terrain is flat or rolling, with dunes near the coast. The highest point is Abu 'Awdah (Joz Abu 'Auda), at 105 meters (344 ft) above sea level. Natural resources include arable land (about a third of the strip is irrigated), and recently discovered natural gas. Environmental issues include desertification; salination of fresh water; sewage treatment; water-borne disease; soil degradation; and depletion and contamination of underground water resources. The Strip currently holds the oldest known remains of a man-made bonfire, and some of the world's oldest dated human skeletons. It occupies territory similar to that of ancient Philistia, and is occasionally known by that name. It consist of five governorates, Rafah, Khanyounis, North Gaza, Gaza city and Deer El-Balah. (wikipedia.org, 2010)

Demographics:

In 2007 approximately 1.4 million Palestinians live in the Gaza Strip, of whom almost 1.0 million are UN-registered refugees. The majority of the Palestinians are descendants of refugees who were driven from or left their homes during the 1948 Arab-Israeli War. The Strip's population has continued to increase since that time, one of the main reasons being a total fertility rate of more than 5 children per woman. In a ranking by total fertility rate, this places Gaza 30th of 222 regions and above all non-African countries except Afghanistan and Yemen. The vast majority of the populations are Sunni Muslims, with an estimated 2,000 to 3,000 Christians. In December 2007, Israel permitted 400 Gaza Christians to travel through Israel to Bethlehem for Christmas. Even though they were restricted by travel permits, many Christian families took the opportunity to settle in the West Bank, despite the illegality. One of the largest foreign communities in the Gaza Strip was the approximately 500 women from the former Soviet Union. During the Soviet era, the Communist Party subsidized university studies for thousands of students from Yemen, Egypt, Syria and the territories. Some of them got married during their studies and brought their Russian and Ukrainian spouses back home. However, over half of them were able to leave the Strip via the Erez crossing to Amman within days of Hamas's takeover. From there they have flown back to Eastern Europe. (wikipedia.org, 2010).

Economy:

The economy of the Gaza Strip is severely limited by high population density, limited land access, strict internal and external security controls, and the effects of Israeli military destruction of capital, and restrictions on labour and trade access across the border. Per capita income was estimated at 3,100 US$ in 2009, a position of 164th in the world. Eighty percent of the population is below the poverty line according to a 2007 estimate (wikipedia.org, 2010).

Health:

A study carried out by Johns Hopkins University (U.S.) and Al-Quds University (in Abu Dis) for CARE International in late 2002 revealed very high levels of dietary deficiency among the Palestinian population. The study found that 17.5% of children aged 6–59 months suffered from chronic malnutrition. 53% of women of reproductive age and 44% of children were found to be anemic. In the aftermath of the Israeli withdrawal of August and September 2005, the health care system in Gaza continues to face severe challenges. After the Hamas takeover of the Gaza Strip the health conditions in Gaza Strip faces new challenges. World Health Organization (WHO) expressed its concerns about the consequences of the Palestinian internal political fragmentation; the socioeconomic decline; military actions; and the physical, psychological and economic isolation on the health of the population in Gaza. Gazans who desire medical care in Israeli hospitals must apply for a medical visa permit. In 2007, State of Israel granted 7,176 permits and denied 1,627. Following the war, Gaza has witnessed increasing epidemics of health problems. At the Al Shifa hospital a constant increase in the percentage of children born with birth defects of about 60% was witnessed when the period of July to September 2008 was compared to the same period in 2009. Local doctors point the finger at radioactive munition and white phosphorus used by Israel during the Gaza war. Dr. Mohammed Abu Shaban, director of the Blood Tumors Department in Al-Rantisy Hospital in Gaza has witnessed an increase in the number of cases of blood cancer. In March 2010 the department had seen 55 cases so far for that year, compared to the 20 to 25 cases normally seen in an entire year (wikipedia.org, 2010).

Religion:

Adherents of Islam makes up 99.3 percent of the population and 0.7 percent of the population are Christian (wikipedia.org, 2010).

Transportation and communication:

The Gaza Strip has a small, poorly developed road network. It also had a single standard gauge railway line running the entire length of the Strip from north to south along its center; however, it is abandoned, in disrepair, and little trackage remains. (wikipedia.org, 2010)

1.3 Problem statement:

Deinstitutionalization of mental health services is a new system in the mental health field that was applied in different western and European countries, America, United kingdom and Canada, and there was attitude from the Ministry of health and the World health organization in Gaza strip to apply this system in the mental health field. So, this study is important to prove that whether deinstitutionalization of mental health services has effectiveness and merits on achieving recovery among depressive patients or not.

1.4 Significance of the study:

This study was done to clarify the nature of the relationship between type of treatment received and incidence of patients achieved recovery, It also helps mental health personnel (psychiatrists, doctors, nurses, social workers and psychologists) to give more attention on community based treatment and recovery process, shows the importance to coordinate the efforts of various mental health services, whether governmental, nongovernmental or private, and to ensure that the interfaces between them function properly and demonstrates that community based mental health services generally cost the same as the hospital based services they replace.

1.5 Overall aim of study:

To understand the impact of deinstitutionalization "community based treatment" versus hospital based treatment on recovery process among depressive patients in Gaza Strip.

1.6 Objectives:

- To identify the relationship between community based treatment and achievement of recovery process.

- To find the effects of community based treatment on developing recovery.

- To know the possible factors contribute to the achievement of recovery process.

- To explore some demographic variables affect on recovery process.

- To establish baseline information in Gaza strip to enable further needed research studies on recovery and deinstitutionalization.

- To conclude recommendations for mental health providers for achieving recovery.

1.7 Research questions:

- **Is** there a relationship between community based treatment "deinstitutionalization" and achievement of recovery process among depressive patients in Gaza Strip?

- **What** are the possible factors contribute to the achievement of recovery process?

- **Which** research studies are needed in Gaza Strip for recovery and deinstitutionalization?

- **What** are the recommendations for mental health providers for achieving recovery?

- **What** is the reliable information required for the development of appropriate recovery process?

Chapter 2

Conceptual Framework

Chapter 2

2.1 Introduction:

In this chapter the researcher viewed the theoretical framework, Also, the researcher will show the literature reviews in four main axes, the first axis is about mental health services, the second axis is about recovery model, the third axis is about theories of depression, and the fourth axis is about some sociodemographic variables and its effects on recovery.

2.2 Mental health in Palestine:

History of mental health in Palestine:

Health sector of the West Bank and Gaza Strip was managed in the past by the Israeli Civil Administration after the occupation of 1967, and the health sector had been neglected in full, and the distribution of services and facilities and the lack of attention and the general supervision and performance are generally deficient and incomplete results, and that mental health has suffered from fragmentation in the previous period and lack of regulation and follow-up, there was also different providers of health services (government, UNRWA, and non-governmental, or private) each of them has its own without guidance or cooperation(Palestinian Ministry of health, 2000).

In the Gaza Strip during the Israeli occupation, crossed the mental health services psychiatric hospital in Gaza City since 1980, and was the only hospital and contains 32 beds and has an outpatient clinic and one working 4 days a week and two days dealing with all patients with epilepsy in the sector of children and adults as the number of undecided daily average of 200 references to psychological or epilepsy, outpatient clinics and other psychological work one day a week in the city of Khan Younis and management of these services is very small crew of 3 doctors and 3 specialists, psychologists, social workers, 14 nurses, and EEG technicians, and a pharmacist, and a number of administrative workers, amounting to proportion of the family concern in the Hospital about 80-90%(Palestinian Ministry of health, 2000).

Since most of the population who continue to suffer long years of occupation, some of them suffering from persecution and oppression or trauma, injury, disability or deprivation and remoteness and deportation, imprisonment or siege or orphaned because of the martyrdom of one of the parents, desperately in need of psychiatric care because of the potential vulnerability is not rated size of effects psychologically, and remained on the monthly statistics and research is limited according to the event, where the Ministry of Health, according to a national plan, the attempt to develop a system of mental health work of the Department of Community Mental Health, but attached to primary care, which led to the division of mental health among primary care and hospital management, although the fact that the correct orientation based on the mental health community-based and best in the field of mental health, for coordination with providers of different health services to these areas (government, agency, non-governmental institutions, or private) and providers of health services,

primary care and hospitals, and community participation by providing service mental health of the Palestinians need a more comprehensive and fill the required services, which will reflect positively to the performance and the achievement of individuals and society, and fight stigma and the development of the entire country, There is still the need for Palestinians to integrated mental health without fragmentation, especially as the security situation and political augur well for further trauma and psychological suffering, and also non-economic and social stability augurs well for greater psychological pressure, the most recent siege on the Gaza Strip and all the people in the Gaza Strip are victims of instability in the military and security situation and socio-economic to the Palestinians that hold onto generation after generation, the generation of British occupation, then the generation of refugees, and then generation of the Israeli occupation and collective punishment and the siege(Palestinian Ministry of health, 2000).

The majority of those who are psychologically affected by Palestinian groups of vulnerable children, who were not 50% of the total population, women, and older senators, who make up 25% of the population, the majority of Palestinians are suffering from stress and stress disorders and post-traumatic stress(GCMHP, 2000).

In 2008, construction began on the public administration community mental health decision of the Minister of the Palestinian Health Dr. Bassem Naim, for the integration of service and without resellers and comprehensive services based on community-based and three community services department and the Department of Rehabilitation and the Department of Training and Development, covering all the inhabitants of the Gaza Strip(WHO, MOH, 2009).

Have been set up 6 centers for mental health community covered in each province center, but two in the Gaza strip because of the large number of the population, with the first center was established early 1995 in EL-Surani clinic in EL-Shegaeah for people in eastern Gaza city, the second one was established in 1996, in the southern region in Khan Younis Gasser Aqha apartment, and the third place in the middle area in 2005 and the fourth one in the province Rafah in 2006, the fifth in the North province in 2008, and the sixth clinic in the psychiatric hospital for population in the west of Gaza city in 2008(WHO, MOH, 2009).

Effects of the Intifada:

The Palestinian population has lived through several consecutive wars (1948, 1956, and 1967) and long periods of unrest. The first of the two Intifadas (Uprising of the Palestinian people against Israeli occupation) started in December 1987. The continuing effects of occupation have caused a great deal of suffering and worsening economic conditions for both refugee and nonrefugee populations(Steering committee on mental health, February 2004).

Coupled with increased levels of tension and unrest, by 2003, economic hardship has reached an unprecedented level for this region. This has been attributed to a variety of factors including the adverse effects of the Gulf crisis, restrictions on movement of the population and extended curfews. Per capita gross domestic product declined by half between the beginning of the Intifada and July 1990(Steering committee on mental health, February 2004).

The present Intifada, the Al-Acqsa Intifada, has left many Palestinians unable to work. According to Miftah (Palestinian Initiative for the Promotion of Global Dialogue) the unemployment rate in the West Bank and Gaza Strip, was estimated at 53% with a 47% decrease in per capita income. The percentage of Palestinians now living below the poverty line is 64%. This contrasts with 21.1% of the population living below the poverty line prior to the beginning of the Al-Acqsa Intifada in September 2000. More recent reports have estimated the unemployment rate in 2003 to be as high as 70%(Steering committee on mental health, February 2004).

In the Ministry of Health Annual Report on *'The Status of Health in Palestine, 2001'* it is reported that around 20% of crops in Gaza have been flattened for security reasons. 320,000 olive and other trees have also been destroyed. As agriculture represents a significant proportion (as high as 60%) of the local economy, this is likely to have a significant impact on livelihoods of the population affected (Palestinian Ministry of health, 2001).

The ongoing conflict has had a detrimental effect on the community, communications and transport infrastructure in Palestine. 36,000 people have had their homes either destroyed or partially destroyed; there are severe restrictions on travel and movement with approximately 120 Israeli checkpoints throughout the West Bank and Gaza, making travel between some towns and cities virtually impossible. These factors have also had a significant impact on the ability of people to access many health services(Steering committee on mental health, February 2004).

It has been noted that a high percentage of Palestinian children experience mental and behavioral problems and this has been linked to the prolonged conflict (Steering committee on mental health, February 2004).

According to Abu Hein et. al. (1993) and other data high proportions of Palestinian children had been tear gassed, 42% had been beaten, 19% detained or had their house raided(Abu Hein et. al., 1993).

Thabet et. al. (1998) found that 21.5% of the 9-13 year-old children in the Gaza Strip showed anxiety problems. In a longitudinal study of children aged 7-13 years, 11% reported moderate to severe post-traumatic reactions and parents rated 21% of children with mental health problems(Thabet et. al., 1998).

2.3 Conceptual framework:

In this part the researcher will view the theoretical framework in four broad categories, the first is about deinstitutionalization of mental health services, the second is about the recovery model, where the third axis is about depression, and the fourth one is about some sociodemographic data, as shown in the following figure.

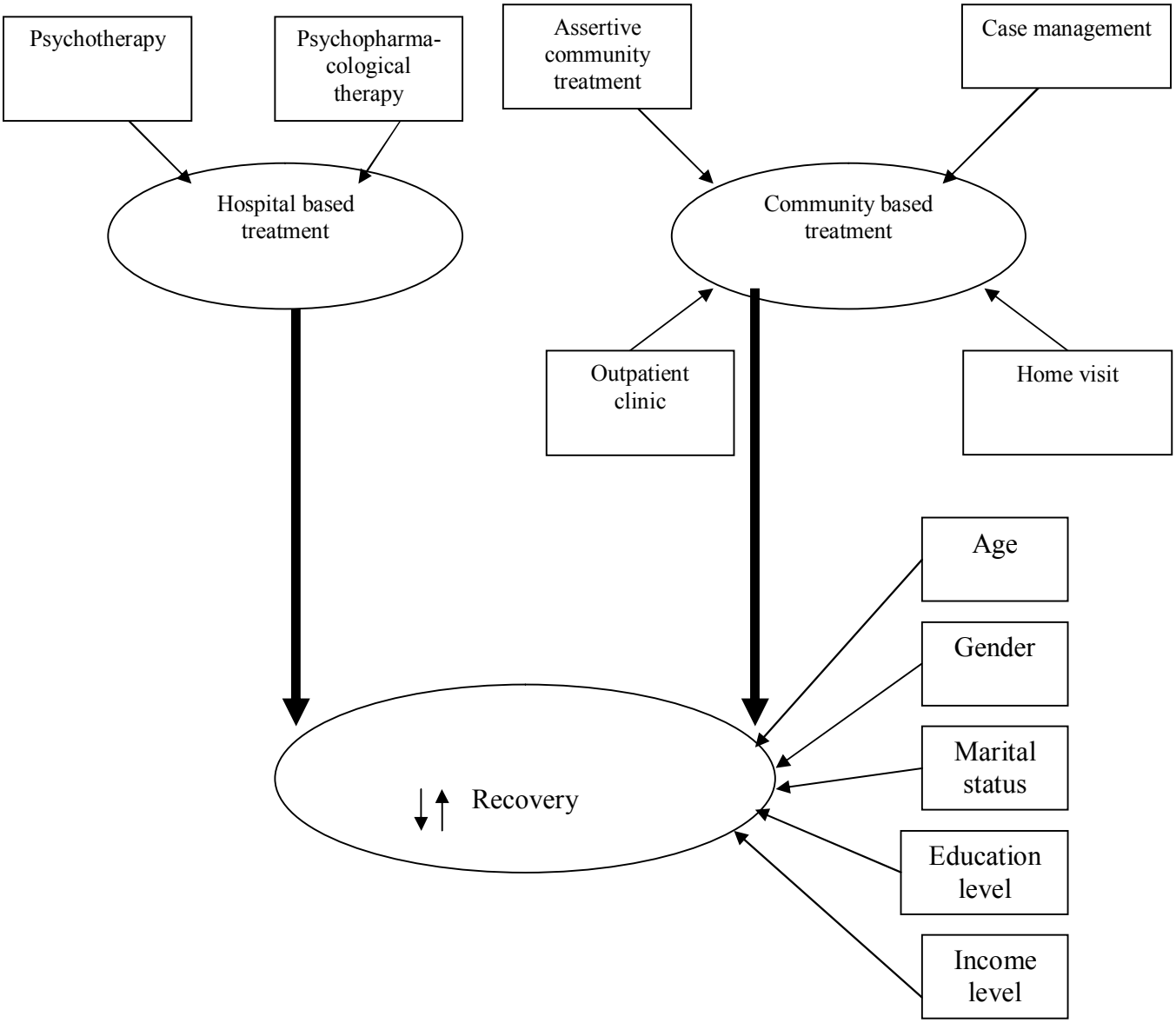

Figure 2.1
Community based treatment and hospital based treatment and their components

The researcher developed this model that clarifies the relationship between the independent variable "community based treatment" and its parts and the dependent variable "recovery process", and shows some sociodemographic variables that affect on recovery process, Also, showing the "hospital based treatment" and their parts .

2.4 Definitions:

Theoretical definition:

Deinstitutionalization "Community based treatment": At the patient level, it refers to the transfer of a patient hospitalized for extended periods of time to community setting. At the mental health care system level, it refers to a shift in the focus of care from long-term institution to the community, accompanied by discharging long-term patients and avoiding unnecessary admissions(Stuart, 2008).

Operational definition:

Before beginning the study, the researcher will clarify and define the variables that under the study. The independent variable is (community based treatment), and the dependent variable is (recovery process).

Community based treatment: means that the attitude of the world to focus on mental health services provided in community mental health clinics, and reducing inpatient mental health services provided through hospital based treatment.

Theoretical definition:

Recovery: is a journey of healing and transformation enabling a person with mental health problem to live a meaningful life in the community of his or her choice while striving to achieve his or her potential (US department of health and human services, 2004:1).

Operational definition:

Recovery process: means living satisfying hopeful life for depressive patients, and adaptation with their mental illness, that will be measured by Mental Health Recovery Measure (MHRM) questionnaire(Young & Bullock, 2003).

Theoretical definition:

Depression:

The key symptoms are depressed mood and loss of interest or pleasure in all or most of the activities.

Diagnosis: presence of five or more of the following symptoms at the same period which is not less than two weeks conditional by depressed mood or anhedonia should be one of them:

- Depressed mood most of the day, everyday "nearly".
- Noticeable decrease of interest or loss of pleasure toward most of the daily activities "nearly" everyday and most of the day.
- Significant weight loss or gain or change in appetite.
- Insomnia or hypersomnia daily "nearly".
- Psychomotor agitation or retardation daily "nearly".
- Exhaustion or loss of energy daily "nearly".
- Diminished ability to think, concentrate or make decision.
- Feelings of self-worthlessness, guilty feeling "inappropriate" which may become as delusion daily "nearly".
- Recurrent thought of death "including thoughts of suicide" (DSM4, 2004).

Operational definition:

Depressive patients: patients with confirmed diagnosis of depression for at least six months duration, who are treated in governmental community mental health centers, and other patients with confirmed diagnosis of depression that are treated in EL-Nasser psychiatric hospital.
Eligibility criteria for depressive patients:

- Gender: male and female.

- Age: 20-50 years old.

- Confirmed diagnosis of major depression according to DSM4, for at least six months duration.

- Determined social level, economical level.

- Depressive patients in Gaza governmental community mental health clinics and

depressive patients in EL-Nasser psychiatric hospital.

Sociodemographic variables:
Age:

Date of birth and date of event, age at time of event (years, months, days) (Connecticut department of public health, policy on collecting sociodemographic data, 2008).
Depressive patients aged from 20-50 years old.

Gender:
Sex of persons, male or female.

Marital status:

The marital status is the civil status of each individual in relation to the marriage laws or customs of the country, i.e. never married, married, widowed and not remarried, divorced and not remarried, married but legally separated. (Demographic and population statistics, 2001).
So, available social statuses are, Married, Single, Divorced or Widowed.

Educational level:

Level of education**,** which represents a broad section of the education "ladder", that is, the progression from very elementary to more complicated learning experience, embracing all fields and programme groups that may occur at that particular stage of the progression.(Demographic and population statistics, 2001).
This was presented in this study's questionnaire as, primary, preparatory, secondary or university.

Income level:

The amount of money or its equivalent received during a period of time in exchange for labor or services, from the sale of goods or property, or as profit from financial investments. (the American Heritage Dictionary of the English Language, 2000).

This was presented in this study's questionnaire as Less than 500 NIS, from 500-1000 NIS, from1000-1500 NIS, from 1500-2000 NIS, from 2000-2500 NIS or more than 2500 NIS.

Chapter 3
Literature review

Chapter 3

Literature review:

3.1Introduction:

This chapter consists of two parts, the first part is the literature review about depression, community based treatment and recovery, the second part about previous studies which related to this study subjects. Also the researcher will sum up some concepts of previous research that will let us understand and analyze the questions at issue.

Previous research in the field is extensive from the international point of view. Most of researches came from United States and United Kingdom; this could be related to the early implementation of policies on community based approach in the field in these countries.

3.2 Deinstitutionalization of mental health services:

The goal of the mental health delivery system is to help people who have experienced psychiatric illness live successful and productive lives in the community and to ensure that consumers and families have access to timely and accurate information that promotes learning, self-care management, and health. Started that successfully transforming the mental health service delivery system rests on two principles:

1. Services and treatments must be consumer and family centered.
2. Care must focus on increasing consumers' ability to successfully cope with life's challenges, on facilitating recovery, and on building resilience.

The report goes on to say that evidence shows that offering a full range of community-based alternatives is more effective than hospitalization and emergency department (ED) treatment, (Stuart, 2008).

Many psychiatric nurses work in community-based settings, where they assume a broad range of responsibilities and engage in a variety of tasks and interventions (Kudless and White, 2007). In these settings they work with interdisciplinary teams and focus on prevention, care management, and recovery. Nurses at both the basic and advanced levels of education practice in the community where they engage with consumers and family members, empowering them to make decisions about their care. Consumers have noted that community mental health nurses increase their access to care, engage in positive relationships with them, and help them meet their health care needs (Elsom et al, 2007).

Deinstitutionalization:

At the patient level, deinstitutionalization refers to the transfer of a patient hospitalized for extended periods of time a community setting. At the mental health care system level, it refers to a shift in the focus of care from long-term institution to the community, accompanied by discharging long-term patients and avoiding unnecessary admissions.

In reviewing the failures of this early attempt to move patients into community care, mental health experts agree that the following problems contributed to the lack of success:

- Poor coordination between state hospitals and community mental health centers.
- Underestimation of the support systems needed to enable people with mental illness to live in the community.
- Lack of knowledge about psychiatric rehabilitation.
- Shortage of professional trained to work this population in the community, (Stuart, 2008).

3.2.1 The history of deinstitutionalization:

The history of deinstitutionalization falls into several stages as policies and objectives have changed over time. The early focus was on moving individuals out of state public mental hospitals and from 1955 to 1980, the resident population in those facilities fell from 559,000 to 154,000. Only later was there a focus on improving and expanding the range of services and supports for those now in the community, in recognition that medical treatment was insufficient to ensure community tenure. In the 1990's whole institutions began to close in significant numbers and there was a greater emphasis on rights that secured community integration – such as access to housing and jobs. However, overall progress was extremely slow and resources for community care were a major issue. Not until 1993 were more state-controlled mental health dollars allocated to community care than to the state institutions. In addition, while promising models of community care were tried, they were rarely fully evaluated and even more rarely incorporated into standard practice. The history of deinstitutionalization began with high hopes and by 2000; our understanding of how to do it had solidified. But it was too late for many. Looking back it is possible to see the mistakes, and a primary problem was that mental health policymakers overlooked the difficulty of finding resources to meet the needs of a marginalized group of people living in scattered sites in the community. Multiple funding streams were uncoordinated. Even when needs were eventually recognized it was difficult to braid together a comprehensive service package (Koyangi, 2007).

History of Deinstitutionalization:

1961 Joint Commission report Action for Mental Health
1963 John F. Kennedy's Message to Congress
1963 Mental Retardation Facilities and Community Mental Health Center Construction Act enacted
1965 Community Mental Health Centers Construction Amendments authorizing staffing funds for CMHCs 1965 Medicaid and Medicare enacted
1971 Wyatt v. Stickney case decided regarding obligations for treatment of those involuntarily hospitalized 1972 Supplemental Security Income program enacted
1977 Commission on Mental Health established by President Jimmy Carter
1975 Community Support Program established by the National Institute for Mental Health
1980 Mental Health Systems Act enacted
1980 Publication of National Plan for the Chronically Mentally Ill
1981 Mental Health Systems Act repealed and community mental health centers program replaced by block grant Supreme Court rules SSI/SSDI benefit rules must be revised
1988 Fair Housing Act amended to include persons with disabilities
1990 Americans with Disabilities Act enacted
1999 Surgeon General's Report on Mental Health
2003 President's New Freedom Commission on Mental Health Report (Koyangi, 2007)

The history of deinstitutionalization began with high hopes that modern medications and modern treatments could assure people with serious mental illness a successful life in the community. By 2000, our understanding of how to do that had solidified, but it was too late for many. Times had changed. Resources had not flowed as expected. The arrays of programs that support people with mental illness in the community were not controlled by policymakers who fully understood mental health. (Koyangi, 2007).

3.2.2 Systems model of care:

A systems model of community mental health operates on the philosophy that all aspects of a person's life need to be cared for – basic human needs, physical health needs, and needs for psychiatric treatment and rehabilitation – if a person is to live successfully in the community. The focus is on developing a comprehensive system of care and coordinating needed services into and integrated package for persons with severe and disabling mental illnesses(Stuart, 2008).

3.2.2.1 Case Management:

In implementing these systems, case management became the primary means for ensuring that the components were available to every person with a chronic mental illness who needed them. Components of a community support system include patient identification and outreach, mental health treatment, crisis response services, health and dental care, housing, income support and entitlement, peer support, family and community support, rehabilitation services, and protection and advocacy(Stuart, 2008).

Case management involves linking the service system to the consumer and coordinating the service components so that the consumer can achieve successful community living. It focuses on problem solving to provide continuity of services and overcome problems of rigid systems, fragmented services, poor use of resources, and problems of inaccessibility(Stuart, 2008).

The six activities of case management are as follows:

1. Identification and outreach
2. Assessment
3. Service planning
4. Linkage with needed services
5. Monitoring service delivery
6. Advocacy (Stuart, 2008)

3.2.2.2 Assertive Community Treatment:

Assertive Community Treatment (ACT) was developed in Wisconsin in the early 1970s as a program originally called Training in Community Living (TCL). It was created as a way to organize outpatient mental health services for patients who were leaving large state mental hospitals and were at risk for rehospitalization. ACT is a service delivery model, not a case management program. It was designed for people with the most challenging and persistent problems. The goal of ACT is recovery through community treatment and habituation. ACT uses an interdisciplinary, team-oriented approach that typically includes 10 to 12 professionals (nurses, psychiatrists, social workers, activity therapists) who meet regularly to plan individualized care for a shared caseload of about 120 patients. Teams may include a person with a mental illness or a family member of a person with a mental illness. More than 75% of staff time is spent in the field providing direct treatment and rehabilitation. Psychiatric nurses are typically integral members of the ACT treatment team In effect, ACT programs function as a community-based "Hospital without walls," providing a high-intensity program of clinical support and treatment (Stuart, 2008)

3.2.2.3 Psychiatric home visits:

Definition:

A professional face to face contact made by the profession to the client or family to provide necessary health care or data collection activities and to further attain an objective of the health agency.

Home psychiatric care is available to a broad segment of the population. Factors contributing to the development of this treatment setting include the following:

- Continued trend of deinstitutionalization.
- Growth of managed care, which focuses on cost, outcomes, and earlier hospital discharges.
- Advocacy by consumer groups to find less restrictive and more humane ways of delivering care to people with mental illness (Stuart, 2008)

The advantages of home care in relation to inpatient treatment involve its ability to serve as the following:

- An alternative to hospitalization by maintaining a patient in the community
- A facilitator of an impending hospital admission through preadmission assessment.
- An enhancement of inpatient treatment plan
- A way to shorten inpatient stays while keeping the patient engaged in active treatment.
- A part of the discharge planning process by assessing potential problems and issues.

Examples of other gains obtained by psychiatric home care include its outreach capacity and emphasis on patient participation, responsibility, autonomy, and satisfaction.(Stuart, 2008)

Context of Home Care:

Psychiatric home care nursing provides unique challenges and opportunities to the nurse. In an inpatient clinic or office setting, the provider has the control and power that come with ownership. The patient is a guest, and the nurse is the host. In the home setting the nurse is the guest and the patient sets the rules. This raises four key issues for the nurse:
Cultural competence, flexibility in boundary setting, trust, and safety. (Stuart, 2008)

Psychiatric Nursing Activities:

Nursing interventions in the home include assessment, teaching, medication management, administration of parenteral injections, venipuncture for laboratory analysis, and skilled management of the care plan. All these interventions are recognized as reimbursable skilled nursing services by Medicare.
Psychiatric home care nurses provide many other skilled nursing services. They act as case mangers, coordinating an array of services, including physical therapy, occupational therapy, social work, and community services, such as home-delivered meals, home visitors, and home health aides. They collaborate with all the patient's health care providers and often facilitate communication among members of the multidisciplinary team(Stuart, 2008).

Purpose of home visits:

Home visits are an effective means of confirming household circumstances such as residence and household composition. They are also an excellent opportunity to review family self-sufficiency plans, assess supportive service needs, and discuss other client rights and responsibilities. (Department of health and social services, division of public assistance, 2007)

Components of a home visit:

1. Planning:

– The plan is the essential tool in achieving precise and appropriate application of psychiatric home intervention.

2. Implementation:

– The psychiatric nurse and family are partners in restoring, performing positive family health behavior.

Phases of approach:

a. socialization phase:

b. working / professional phase:

- apply problem solving techniques, plan with family to resolve health problem situation.

c. Summary phase:

- Documentation of significant findings.

3. **Evaluation.** (Magpantay**,** 2006)

3.2.2.4 Psychiatric outpatient clinic:

People seek mental health assistance for a variety of reasons; for themselves or their families; for home or work relationship issues; for feeling uncomfortable or on edge; for personal tragedy, long-lasting discouragement, or depression; for child or teen behavior or discipline issues, and many other reasons. Often, behavioral and emotional concerns can cast a shadow on everyday life, creating additional problems that may, in time, get worse without help. Psychiatric outpatient clinic offer a wide range of behavioral health services to ensure that our patients and community have access to help when they need it. The Mental Health Clinic is available for persons of all ages offering affordable, comprehensive, and easily accessible behavioral health care. Many behavioral health care options exist. This diversity of treatment choices allows us the opportunity to provide individualized care for each person or family. Finding the right treatment option is your first step on the path to feeling better and doing better(California pacific medical center, 2011).

The Outpatient Mental Health Clinic offers a full spectrum of mental health services for adults, teens, and children:

- Individual Psychotherapy
- Family and Couples Therapy
- Group Therapy
- Medication Evaluation and Consultation
- Psychological Testing (California pacific medical center, 2011).

The second part:

The second part from this chapter will discuss the recovery; it covers the definitions, components, and the relationship between recovery and deinstitutionalization of mental health services.

Introduction:

Any illness may involve significant changes in a personal level of functioning. People who have been seriously ill are more likely to have problems resuming their usual life and activities. The goal of health care should be to promote an optimal level of wellness and full recovery from the illness when ever possible(Sundeen, 2009:199).

3.3 Definitions of Recovery:

According to Webster's Dictionary (1984) The formal definition of the word recovery means "to get back: regain" or "to restore (oneself) to a normal state (Onken and others, 2002:7).

According to Anthony (1993) recovery has been defined as a person with serious mental illness living a satisfying life within the constraints of his/her mental illness, and he said recovery is a continuing, deeply personal, individual effort that leads to growth, discovery and the change of attitudes, values, goals and perhaps roles. (Potokar, 2008:27)

Anthony (1993) defined recovery as a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by the illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness(Potokar, 2008)

Blanch (1993) said that recovery involves hope, courage, adaptation, coping, self esteem, confidence, a sense of control or free will (Ralph, 2000:8).

Spaniol and others (1994) recovery is the process by which people with psychiatric disability rebuild and further develop these important personal, social, environmental, and spiritual connections, and confront the devastating effects of stigma through personal empowerment. Recovery is the process of adjusting one's attitudes, feelings, perceptions, beliefs, roles, and goals in life. It is a process of self-discovery, self-renewal, and transformation (Johnson, 2000:6)

Deegan (1996) said that the goal of recovery is not to become normal. The goal is to embrace the human vocation of becoming more deeply, more fully human (Roberts and Wolfson, 2004:37).

According to Demasi (1996) recovery includes physical and mental health, and economic and interpersonal well-being (Ralph, 2000:8).

Chamberlin (1997) said that "One of the elements that make recovery possible is the regaining of one's belief in oneself (Ralph, 2000:7).

Mental health recovery is a journey of healing and transformation enabling a person with mental health problem to live a meaningful life in the community of his or her choice while striving to achieve his or her potential (US department of health and human services, 2004:1).

Andresen et al (2003) there are several meanings of the recovery concept which developed from the consumer movement These definitions presumably fall along a continuum: the medical model definition, the rehabilitative model definition, and the empowerment model definition According to the medical model, mental illness is viewed as a disease and recovery occurs when an individual is "cured", when he or she returns to their former health state prior to the onset of their mental illness (Hupp, 2008:13).

Corrigan & Phelan (2004) said this definition, also called clinical recovery, syndromal recovery, or remission, the main focus is the absence of symptoms and the overcoming of disabilities (Hupp, 2008:14).

According to Andresen et al (2003) the second definition along this recovery continuum is the rehabilitative model, which states that mental illness is incurable, but the individual is often able to return to some resemblance of their former mental health state(Hupp, 2008).

Andresen et. al. (2003) The final definition along this continuum is the empowerment model. According to this concept of recovery, there are no biological bases for which a person's mental illness develops; rather, mental illness is caused by extreme emotional distress, and it is a combination of empowerment, understanding, and hope that will lead a person to recovery (Hupp, 2008:14).

Andresen et al (2003) defined psychological recovery as the establishment of a fulfilling, meaningful life and a positive sense of identity founded on hopefulness and self-determination" Psychological recovery differs from the aforementioned, and has been found to be most compatible with consumer beliefs, because it makes no statement about the cause of mental illness, the necessity of medication, does not define recovery by roles valued by society, or define whether the illness is still present during recovery, It actually allows for the presence of symptoms and ongoing management of the illness in the midst of recovery(Hupp, 2008:15).

Markowitz (2001) said that the recovery process is involve symptom control, dealing with discrimination and stigma by society, regaining a positive sense of self, and attempting to lead a satisfying and productive life (Hupp, 2008:15).

The concept of recovery values include maximization of 1) each patient's autonomy based on that patient's desires and capabilities, 2) patient's dignity and self respect, 3) patient's acceptance and integration into full community life, and 4) resumption of normal development. The concept of recovery focuses on increasing the patient's ability to successfully cope with life's challenges, and to successfully manage their symptoms. The application of the concept of recovery requires a commitment to a broad range of necessary services and should not be used to justify a retraction of resources. The concept of recovery is predicated on a partnership

between psychiatrist, other practitioners, and patient in the construction and direction of all services aimed at maximizing hope and quality of life. (APA, 2005:1).

3.3.1 History:

In general medicine and psychiatry, recovery has long been used to refer to the end of a particular experience or episode of illness. The broader concept of "recovery" as a general philosophy and model was first popularized in regard to recovery from substance abuse/drug addiction, for example within twelve-step programs. Application of recovery model concepts to psychiatric disorders is comparatively recent. By consensus the main impetus for the development came from the Consumer/Survivor/Ex-Patient Movement, a grassroots self-help and advocacy initiative, particularly within the United States during the late 1980s and early 1990s. The professional literature, starting with the psychiatric rehabilitation movement in particular, began to incorporate the concept from the early 1990s in the United States, followed by New Zealand and more recently across nearly all countries within the "First World". Similar approaches developed around the same time, without necessarily using the term recovery, in Italy, the Netherlands and the UK. Developments were fueled by a number of long term outcome studies of people with "major mental illnesses" in populations from virtually every continent, including landmark cross national studies by the World Health Organization from the 1970s and 1990s, showing unexpectedly high rates of complete or partial recovery, with exact statistics varying by region and the criteria used. The cumulative impact of personal stories or testimony of recovery has also been a powerful force behind the development of recovery approaches and policies. A key issue became how service consumers could maintain the ownership and authenticity of recovery concepts while also supporting them in professional policy and practice. Increasingly, recovery became both a subject of mental health services research and a term emblematic of many of the goals of the Consumer/Survivor/Ex-Patient Movement. The concept of recovery was often defined and applied differently by consumers/survivors and professionals. Specific policy and clinical strategies were developed to implement recovery principles although key questions remained(Wikipedia, 2011).

3.3.2 Concepts of recovery:

Variation:

There is some variation in how recovery is conceptualized within models. Professionalized clinical approaches tend to focus on improvement, in particular symptoms and functions, and on the role of treatments; consumer/survivor models tend to put more emphasis on peer support, empowerment and real-world personal experience. Recovery can be seen in terms of a social model of disability rather than a medical model of disability, and there may be differences in the degree of acceptance of diagnostic "labels" and treatments. In psychiatric rehabilitation, the concept of recovery may be used to refer primarily to managing symptoms, reducing psychosocial disability, and improving role performance. A review of the psychiatric literature suggested authors are rarely explicit about which concept they are

employing; the reviewers called "rehabilitation" perspectives those which focused on life and meaning within the context of supposedly enduring disability, and "clinical" those which focused on observable remission of symptoms and restoration of functioning. A consensus statement on mental health recovery from US agencies, that involved some consumer input, defined recovery as a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential. Ten fundamental components were elucidated, all assuming that the person continues to be a "consumer" or to have a "mental disability". From the perspective of psychiatric rehabilitation services, a number of qualities of recovery have been suggested: recovery can occur without professional intervention; recovery requires people who believe in and stand by the person in recovery; a recovery vision is not a function of theories about the cause of psychiatric conditions; recovery can occur even if symptoms reoccur; recovery changes the frequency and duration of symptoms; recovery from the consequences of a psychiatric condition are often far more difficult than from the symptoms; recovery is not linear; recovery takes place as a series of small steps; recovery does not mean the person was never really psychiatrically disabled; recovery focuses on wellness not illness; recovery should focus on consumer choice. For many, "recovery" has a political as well as personal implication—where to recover is to find meaning, to challenge prejudice (including diagnostic "labels" in some cases), perhaps to be a "bad" non-compliant patient and refuse to accept the indoctrination of the system, to reclaim a chosen life and place within society, and to validate the self. Recovery can thus be viewed as one manifestation of empowerment. (Wikipedia, 2011).

Concerns:

Some concerns have been raised about recovery models, including that recovery is an old concept, that a focus on recovery adds to the burden of already stretched providers, that recovery must involve cure, that recovery happens to very few people, that recovery represents an irresponsible fad, that recovery happens only after and as a result of active treatment, that recovery-oriented care can only be implemented through the addition of new resources, that recovery-oriented care is neither reimbursable nor evidence based, that recovery-oriented care devalues the role of professional intervention, and that recovery-oriented care increases providers' exposure to risk and liability. There have also been tensions between recovery models and particular "evidence-based practice" models in the transformation of US mental health services based on the recommendations of the New Freedom Commission on Mental Health. The New Freedom Commission's emphasis on the recovery model has been interpreted by some critics as saying that everyone can fully recover through sheer will power, and therefore as giving false hope to those judged unable to recover and implicitly blaming those people judged unable to recover. However, the critics have themselves been charged with undermining consumer rights and failing to recognize that the model is intended to support a person in their personal journey rather than expecting a given outcome, and that it relates to social and political support and empowerment as well as the individual(Wikipedia, 2011).

Assessments:

The data-collection systems and terminology used by services and funders are typically incompatible with recovery frameworks, so methods of adapting IT resources or paper forms have been developed. It has also been pointed out that the Diagnostic and Statistical Manual of Mental Disorders (and to some extent any system of categorical classification of mental disorders) uses criteria, definitions and terminology that are inconsistent with a recovery model, and therefore does not promote a culture in which people can improve and recover. It has been suggested that the DSM-V requires greater sensitivity to cultural issues and gender; needs to recognize the need for others to change as well as just those singled out for a diagnosis of disorder; and that it needs to adopt a dimensional approach to assessment that better captures individuality and does not erroneously imply excess psychopathology or chronicity. A number of standardized questionnaires and assessments have been developed to try to assess aspects of the recovery journey. These include the Milestones of Recovery (MOR) Scale, Recovery Enhancing Environment (REE) measure, the Recovery Measurement Tool (RMT) and the Recovery Oriented System Indicators (ROSI) Measure, the Stages of Recovery Instrument (STORI), and numerous related instruments(Wikipedia, 2011).

3.3.3 Elements of recovery:

According to Wikipedia, 2011, It has been emphasized that each individual's journey to recovery is a deeply personal process, as well as being related to an individual's community and society. A number of features have been proposed as often being core elements, however:

Hope:

Finding and nurturing hope has been described as a key to recovery. It is said to include not just optimism but a sustainable belief in oneself and a willingness to persevere through uncertainty and setbacks. Hope may start at a certain turning point, or emerge gradually as a small and fragile feeling, and may fluctuate with despair. It is said to involve trusting, and risking disappointment, failure and further hurt(Wikipedia, 2011).

Secure base:

Appropriate housing, a sufficient income, freedom from violence, and adequate access to health care have also been proposed. It has been suggested that home is where recovery may begin but that housing services and the "continuum of care concept" have failed to flexibly involve people and build on their personal visions and strengths, instead "placing" and "reinstitutionalizing" them(Wikipedia, 2011).

Self:

Recovery of a durable sense of self (if it had been lost or taken away) has been proposed as an important element. A research review suggested that people sometimes achieve this by "positive withdrawal"—regulating social involvement and negotiating public space in order to only move towards others in a way that feels safe yet meaningful; and nurturing personal psychological space that allows room for developing understanding and a broad sense of self, interests, spirituality, etc. It was suggested that the process is usually greatly facilitated by experiences of interpersonal acceptance, mutuality, and a sense of social belonging; and is often challenging in the face of the typical barrage of overt and covert negative messages that come from the broader social context(Wikipedia, 2011).

Supportive relationships:

A common aspect of recovery is said to be the presence of others who believe in the person's potential to recover, and who stand by them. While mental health professionals can offer a particular limited kind of relationship and help foster hope, relationships with friends, family and the community are said to often be of wider and longer-term importance. Others who have experienced similar difficulties, who may be on a journey of recovery, can be of particular importance. Those who share the same values and outlooks more generally (not just in the area of mental health) may also be particularly important. It is said that one-way relationships based on being helped can actually be devaluing, and that reciprocal relationships and mutual support networks can be of more value to self-esteem and recovery(Wikipedia, 2011).

Empowerment and Inclusion:

Empowerment and self-determination are said to be important to recovery, including having self control. This can mean developing the confidence for independent assertive decision making and help-seeking. Achieving social inclusion may require support and may require challenging stigma and prejudice about mental distress/disorder/difference. It may also require recovering unpracticed social skills or making up for gaps in work history(Wikipedia, 2011).

Coping strategies:

The development of personal coping strategies (including self-management or self-help) is said to be an important element. This can involve making use of medication or psychotherapy if the consumer is fully informed and listened to, including about adverse effects and about which methods fit with the consumer's life and their journey of recovery. Developing coping and problem solving skills to manage individual traits and problem issues (which may or may not be seen as symptoms of mental disorder) may require a person becoming their own expert, in order to identify key stress points and possible crisis points, and to understand and develop personal ways of responding and coping(Wikipedia, 2011).

Meaning:

Developing a sense of meaning and overall purpose is said to be important for sustaining the recovery process. This may involve recovering or developing a social or work role. It may also involve renewing, finding or developing a guiding philosophy, religion, politics or culture. From a postmodern perspective, this can be seen as developing a narrative.(Wikipedia, 2011)

3.3.3 National policies and implementation:

United States and Canada:

The New Freedom Commission on Mental Health has proposed to transform the mental health system in the US by shifting the paradigm of care from traditional medical psychiatric treatment toward the concept of recovery, and the American Psychiatric Association has endorsed a recovery model from a psychiatric services perspective. The US Department of Health and Human Services reports developing national and state initiatives to empower consumers and support recovery, with specific committees planning to launch nationwide pro-recovery, anti-stigma education campaigns; develop and synthesize recovery policies; train consumers in carrying out evaluations of mental health systems; and help further the development of peer-run services. Mental Health service directors and planners are providing guidance to help state services implement recovery approaches. Some US states, such as California, Wisconsin and Ohio, already report redesigning their mental health systems to stress recovery model values like hope, healing, empowerment, social connectedness, human rights, and recovery-oriented services. At least some parts of the Canadian Mental Health Association, such as the Ontario region, have adopted recovery as a guiding principle for reforming and developing the mental health system(Wikipedia, 2011).

New Zealand and Australia:

Since 1998, all mental health services in New Zealand have been required by government policy to use a recovery approach and mental health professionals are expected to demonstrate competence in the recovery model. Australia's National Mental Health Plan 2003-2008 states that services should adopt a recovery orientation although there is variation between Australian states and territories in the level of knowledge, commitment and implementation.(Wikipedia, 2011).

UK and Ireland:

In 2005, the National Institute for Mental Health in England (NIMHE) endorsed a recovery model as a possible guiding principle of mental health service provision and public education. The National Health Service is implementing a recovery approach in at least some regions, and has developed a new professional role of Support Time and Recovery Worker. A leading independent charity issued a 2008 policy paper proposing that the recovery approach is an idea "whose time has come". The Scottish Executive has included the promotion and support of recovery as one of its four key mental health aims and funded a Scottish Recovery Network to facilitate this. A 2006 review of nursing in Scotland recommended a recovery approach as the model for mental health nursing care and intervention. The Mental Health Commission of Ireland reports that its guiding documents place the service user at the core and emphasize an individual's personal journey towards recovery.(Wikipedia, 2011).

3.4 Depression:

The third part of the this chapter discusses the depression in general. It covers Theories of Depression, causes, classification and treatment of depression.

Introduction:

Depressive disorders are common, with a prevalence of 5-10% in primary care settings. They rank fourth as causes of disability worldwide, and it has been projected that they may rank second by the year 2020 (Semple and Smith, 2009).

Normal mood: every person experiences from time to time a change in his mood, which is related to everyday life events. This is considered normal as long as it is appropriate to the event. Mood is considered abnormal when it is excessively depressible or related out of proportion to the life experience.

Mood disorders (affective disorders): are a group of disorders characterized by disturbance in regulation of emotion, ranging from intense elation or irritability to severe depression., These disorders often result in personal suffering, family distress, interpersonal and occupational impairment, an untold social costs (Alhajar; 2005:45).

3.4.1 Theories of Depression:

The researcher will view in this study 5 etiological theories for depression (Biological, Psychoanalytic, behavioral, interpersonal, and cognitive).

All theories relating to the etiologies of mood disorders, whether biological, psychological or social, are hypotheses. No theory is fully explanatory and they only offer partial guidance, or support and specific nursing interventions.

Life events:

Varcarolis (2002) said that life events are psychosocial stressors and interactions that are very distressing or traumatic for an individual and significant life events cause stress, which results in depression or mania(Elder et.al, 2005:245).

Learned helplessness:

Stuart (2001) defines Learned helplessness as is 'both a behavioral state and a personality trait of one who believes that control has been lost over the environment'. Learned helplessness also relates to hopelessness and powerlessness—that is, the inability to escape an intolerable situation leads to the ultimate mode of adaptation: subjugation and acceptance(Elder et.al, 2005:244).

Gender:

Horsfall (1994) said Researchers have noted that the emotional dependence, over-responsibility, passivity, non-expression of anger, and low self-esteem associated with depression, are considered 'normal' female characteristics in some families and cultures (Elder et.al, 2005:244).

Fontaine (2003) said When daughters are socialized to be subservient and comply with family customs in ways that boys do not have to, then teenage girls (the age when female rates of depression increase) and young women are unable to gain autonomy and feel in charge of their lives, and feelings of hopelessness and

depression can ensue. 'Rigid expectations about gender roles continue to linger [after teenage years] and contribute to higher rates of depression among women (Elder et.al, 2005:244).

Cognitive factors:

Stuart (2001) describes This model posits as people become depressed because their thinking is negatively distorted Cognitions are disturbed in depressed people; however, this may be a consequence, not a cause. Depressive thinking involves the triad of negative views of self, others and the world; it is pessimistic and clients often overgeneralization, catastrophise, and think superstitiously and dichotomously (viewing everything as either black or white) (Elder et.al, 2005:245).

Biological Theory:

Neurotransmitter involvement:

Varcarolis (2002) indicates There is much evidence to support the view that depression is a biologically heterogeneous disorder. This indicates that many neurotransmitters are implicated and the mechanisms of their interactions are not fully understood. Neurotransmitter dysregulation may result from environmental stressors, drug use, some medical conditions and/or an inherited vulnerability. Keltner & Warren (2003) describe three neurotransmitters that have attracted most medical research attention in relation to mood disorders are the catecholamines, serotonin, norepinephrine and dopamine. Also, acetylcholine and gamma-aminobutyric acid are likely to have modulating effects on those biogenic amines(Elder et.al, 2005:244).

According to Varcarolis (2002) It is known that stressful events overtax norepinephrine, serotonin and acetylcholine systems and lead to depletion of these neurotransmitters**,** Serotonin is an important regulator of sleep, appetite and libido; and decreased levels may account for lowered energy levels, concentration difficulties and the inability to feel pleasure**.** Keltner & Warren (2003) conclude that to conceptualize depression as a decreased level of serotonin and norepinephrine (Elder et.al, 2005:245).

Neuroendocrine influences:

According to Thase (2000) Hormonal fluctuations are being studied in relation to depression. Mood disturbances have been documented in people with endocrine disorders such as those of the thyroid, adrenal, parathyroid, and pituitary. Elevated glucocorticoid activity is associated with the stress response, and evidence of increased cortisol secretion is apparent in about 40% of clients with depression with the highest rates found among older clients. Postpartum hormone alterations precipitate mood disorders such as postpartum depression and psychosis. About 5% to 10% of people with depression have thyroid dysfunction, notably an elevated thyroid-stimulating hormone. This problem must be corrected with thyroid treatment or treatment for the mood disorder will be affected adversely (Videbeck, 2003:334).

Psychoanalytic theory of depression:

Depression may be intertwined with self-criticism. Sigmund Freud wrote that the "super-ego becomes over-severe, abuses the poor ego, humiliates it and ill-treats it, threatens it with the direst punishments". Freud argued that objective loss, as occurs through death or a romantic break-up, could result in subjective loss as well, when the depressed subject has identified with the object of its affection through an unconscious, narcissistic process called the libidinal cathexis of the ego. Such loss results in "a profoundly painful dejection, cessation of interest in the outside world, loss of the capacity to love, inhibition of all activity, and a lowering of self-regarding feelings" that is more severe than mourning. "In mourning 'it is the world that has become poor and empty; in [depression] it is the ego itself." (Barlow, 1999).

Behavioral theory of depression:

Jacobson, et al (1960) considers The predominant behavioral theory of depression postulates that major life stressors can result in a depressive episode because they disrupt normal behavior reinforcement patterns. Originating from an operant conditioning paradigm, this theory views depression as the consequence of a lack of or decrease in the efficiency of positively reinforced behavior and perhaps overt punishment for behavioral initiation. This may be a result of a decrease in the availability of reinforcing events, one's personal skills to act on the environment, the impact of certain types of events, or a combination of these. In addition, the mobilization of support from family and other social networks may result in a negative feedback loop of social reinforcement for depressive behaviors (e.g., social withdrawal, positive social reinforcement for withdrawal, further withdrawal). In other words, in times of major stress from unexpected events, people may experience a low rate of positive reinforcement for mood-enhancing behavior and a higher rate of positive reinforcement for depressive behavior(Davidson et.al., 2004:168).

Interpersonal theory of depression:

Miller (2001) said the interpersonal theory of depression is based on theories emanating from the interpersonal school of psychiatry and empirical data related to attachment theory and social roles. Interpersonal psychotherapy, developed by Klerman et. al. is a focused, short-term, time-limited therapy that emphasizes the current interpersonal relations of the depressed patient. A large body of research has documented the importance of interpersonal factors, including strained or critical personal relationships, in the onset of depressive symptoms and major depression in young and middle-aged adults. Vulnerability factors—such as early maternal loss, lack of a confiding relationship, responsibility for the care of several young children at home, and unemployment—can interact with life stressors to increase the risk of depression. For older adults, the factors are often health problems, changes in relationships with a spouse or adult children due to the transition to a care-giving or care-needing role, the death of a significant other, or a change in the availability or quality of social relationships with older friends because of their own health-related life changes (Miller, et al. 2001).

Cognitive Theory:
The cognitive theory of depression developed by Beck (1963)
Cognitive triad, that formed negative thoughts about self, future and world.

Descriptive Features of Depression:

Beck postulated several cognitive concomitants of depression. All depressed people are said to show a cognitive triad: automatic (i.e., repetitive, unintended, and not easily controllable) thoughts reflecting themes of loss and revealing negative views of the self, the world, and the future. This triad is alleged to characterize all depressions, regardless of clinical subtype (e.g., endogenous or reactive). Moreover, the degree of negative thinking is believed to relate directly to the severity of other depressive symptoms.

Beck said it is important to clarify what is not being said in this description, namely that the cognitive triad causes depression: "It seems unwarranted to assert that 'cognitions cause depression.' Such statements would be akin to saying that 'delusions cause psychosis.

The non causal status of cognitions in cognitive theory is often misunderstood; we see two main reasons for this confusion. First, Beck's (1987) usage of the term cognitions may not be universally shared. Others may consider dysfunctional beliefs, which play a causal role in the theory, to be cognitions. Second, Beck's use of the term primacy, which is not intended to connote causality, may be confusing: "As an initial step in understanding a baffling condition such as depression, we can attempt to arrange the various phenomena into some kind of understandable sequence" (Haaga et. al., 1991:215).

According to cognitive theory, depression results from specific cognitive distortions present in persons susceptible to depression. Those distortions, referred to as depressogenic schemata, are cognitive templates that perceive both internal and external data in ways that are altered by early experiences. Aaron Beck postulated a cognitive triad of depression that consists of (1) views about the self a negative self-precept; (2) about the environment a tendency to experience the world as hostile and demanding, and (3) about the future the expectation of suffering and failure (Sadock et al, 2007: 535).

The researcher see that these theories can affect on the incidence of depression and that may can result in increasing ability to cause depression and there is no specific theory.

Several testable hypotheses have been derived from the descriptive account of depressive cognition, including the following:

1. Negativity. Depressed persons' thoughts are more negative than are those of non depressed people.
2. Exclusivity. Negative cognitions are pervasive in depression, positive ones subject to "automatic exclusion". That is, among depressed people we can expect to find "a decrement in positive ideas and recollections almost to the point of expunging any personally favorable evaluations.
3. Triad. Depressed people think more negatively about themselves, the world, and the future than do non depressed people.

4. Automaticity. These negative cognitions are repetitive, unintended, and not readily controllable.
5. Universality. The cognitive triad characterizes all subtypes of depression.
6. Necessity. All depressed people show the triad.
7. Specificity. Although negativity may be common to all emotional disorders, depressive cognitions are specific in that they involve perceiving final and definite loss (e.g., that a negative situation is hopeless).
8. Association with non cognitive symptoms. The degree of negative cognitions is associated with the severity of non cognitive symptoms of depression.
9. Information-processing biases or distortions. Depressive cognitions often reflect information-processing biases such as selective memory for negative material, or even distortions of reality (Haaga et al, 1991:216).

Causal Elements of Cognitive Theory:

Cognitive theory holds that non endogenous unipolar depression results from the interaction of (a) dysfunctional belief(s) about the significance of certain kinds of experience; (b) high subjective valuation of the importance of the experience (stemming in principle from the individual's personality mode); and (c) occurrence of an apt stressor (viewed as important and impinging on cognitive vulnerability (Haaga et al, 1991:216).

The hypotheses about causal aspects of cognitive theory include the following:

1. Stability. Dysfunctional beliefs should be stable (albeit varying in degree of accessibility) before, during, and after a depressive episode.
2. Subjective valuation. Event valuations can be predicted from personality modes.
3. Onset. Initial episodes of non endogenous unipolar depression can be predicted by the interaction of dysfunctional beliefs, event valuations, and vulnerability-congruent negative events.
4. Recurrence. Subsequent episodes of non endogenous depression are predictable in the same way as are initial ones (Haaga et al, 1991:217).

According to Gabbard (2000) Many psychodynamic theories about the cause of mood disorders seemed to “blame the victim” and his or her family.

Freud looked at the self-depreciation of people with depression and attributed that self-reproach to anger turned inward related to either a real or perceived loss. Feeling abandoned by this loss, people became angry while both loving and hating the lost object**.** The psychodynamic understanding of depression defined by Sigmund Freud and expanded by Karl Abraham is known as the classic view of depression. That theory involves four key points: (1) disturbances in the infant mother relationship during the oral phase (the first 10 to 18 months of life) predispose to subsequent vulnerability to depression; (2) depression can be linked to real or imagined object loss; (3) introjection of the departed objects is a defense mechanism invoked to deal with the distress connected with the object's loss; and (4) because the lost object is regarded with a mixture of love and hate, feelings of anger are directed inward at the self (Sadock et al, 2007: 534).

Bibring believed that one's ego (or self) aspired to be ideal (that is, good and loving, superior or strong), and that to be loved and worthy, one must achieve these high standards.

Depression results when, in reality, the person was not able to achieve these ideals all the time.

Jacobson compared the state of depression to a situation in which the ego is a powerless, helpless child victimized by the superego, much like a powerful and sadistic mother who takes delight in torturing the child.

Meyer viewed depression as a reaction to a distressing life experience such as an event with psychic causality.

Horney believed that children raised by rejecting or unloving parents were prone to feelings of insecurity and loneliness, making them susceptible to depression and helplessness.

Beck saw depression as resulting from specific cognitive distortions in susceptible people (Videbeck, 2003:334).

3.4.2 Epidemiology:

2% of the general population develops a mood disorder.
21% of women and 13% of men develop major depression. Ratio M: F ≈ 1:2
Age of onset for major depression disorder ≈ 25
Depression occurs more frequently in lower socioeconomic groups.
Bipolar disorders occur more frequently in higher socioeconomic groups.
Age of onset of bipolar disorder ≈ 20
Prevalence of bipolar disorder ≈ 1%. Ratio M: F ≈ 2:3 (Gournay, 2009: 80).

WHO estimates that depression will become the second most important cause of disability worldwide (after ischemic heart disease) by 2020. Major depressive disorder affects 1 in 20 people during their lifetime.
Both major depression and dysthymia seem to be more common in women.

Depressive illness is strongly associated with physical disease. Up to a third of physically ill patients attending hospital has depressive symptoms. Depression is even more common in patients with:

- Life threatening or chronic physical illness
- Unpleasant and demanding treatment
- Low social support and other adverse social circumstances
- Personal or family history of depression or other psychological vulnerability
- Alcoholism and substance misuse
- Drug treatments that cause depression as a side effect, such as antihypertensive, corticosteroids, and chemotherapy agents. (Peveler et.al., 2003 :10)

Course:

Much is known about the time course of major depression. Symptoms of major depression usually arise within days or weeks and prodromal symptoms may include anxiety symptoms and mild depressive symptoms, which can be present for weeks to months. Duration of the depressive episode is variable. Most patients recover within 1-2 years, some will have a second depressive episode or a partial remission or become chronically depressed. Up to 15% of the patients with severe major depression may commit suicide. a new recurrent episode will arise in half of the patients after a first episode of major depression and this risk increases even further after more depressive episodes. Recurrent depression is mostly seen in younger persons (Kaptien, 2008:12).

What is depression?

Everyone occasionally feels blue or sad, but these feelings are usually fleeting and pass within a couple of days. When a person has a depressive disorder, it interferes with daily life, normal functioning, and causes pain for both the person with the disorder and those who care about him or her. Depression is a common but serious illness, and most that experience it need treatment to get better.

- Many people with a depressive illness never seek treatment. But the vast majority, even those with the most severe depression, can get better with treatment. Intensive research into the illness has resulted in the development of medications, psychotherapies, and other methods to treat people with this disabling disorder.
- Depression is a set of feelings of sadness, loss of pleasure, helplessness, and hopelessness that persist over time, for at least 2 weeks. Depression can be associated with alcohol and other drug abuse and can lead to school failure as well as suicide attempts (National Institutes of Health, 2009:3).

3.4.3 Causes and risk factors:

Some medical illnesses have a specific biological or chemical cause, making treatment, like a medication or surgery, more straightforward. Depression is more complicated. It is not just a result of a chemical imbalance, and is not simply cured with medication. What makes depression so difficult to treat is what seems like depression may actually be something else. If you are stuck in a dead end job and feel hopeless and helpless, for example, the best treatment might be finding another job which challenges you more. And if you are new to an area and feeling lonely and sad, the best treatment might be finding new friends at work or through a hobby. In those cases, the depression is situational and is remedied by changing the situation. (EL-Buhaisi, 2010:22).

Elkin (1999) said Clinical depression is thought to be caused by a combination of biological, psychological and social factors. There are certain risk factors that may make you more vulnerable. Learning what the risk factors are and making lifestyle changes might help reduce the risk of developing depression.

- **Genetics.** If you have family members who have suffered from depression, you may have a greater risk of developing depression yourself, although there is currently no direct gene that has been found to cause depression.
- **Early childhood trauma or abuse.** Emotional trauma and abuse has a powerful effect on the psyche. If you had traumatic early life experiences, you may be more at risk to develop depression during or after a stressful life event.
- **Loneliness and lack of social support.** A key risk factor for depression is isolation and loneliness. Lack of support, whether it is family, friends or colleagues, makes coping with stress all the more difficult. Having marital and relationship problems can also make you feel alone and frustrated.
- **Recent stressful or traumatic life experiences.** Some events, like losing a loved one, are clearly stressful and cause enormous disruption and strain in our lives. However, anything that causes change can be a stressful life experience, even if it is normally considered a happy event such as a big work promotion, a wedding or childbirth.
- **Alcohol and drugs.** Alcohol and drugs can cause strong depression symptoms on their own. They can also make you more vulnerable to depression even if you decide to stop using them. Some people try to treat themselves with alcohol and drugs to self medicate, but this only worsens the problem.
- **Finances and employment.** Financial strain can be an enormous stressor. Struggling to pay the bills or mortgage, or suddenly becoming unemployed, is a very stressful life event. Being unemployed can be a blow to self confidence and can be a very difficult adjustment, especially for men.
- **Health problems or chronic pain.** Health problems and chronic pain may reduce your mobility, your ability to work or your spare time. They can chip away at supportive relationships and make you feel hopeless and frustrated. (Elkin, 1999).

There is no single cause of depression. There are many reasons why a woman may become depressed:

- Genetics (family history) – If a woman has a family history of depression, she may be more at risk of developing it herself. However, depression may also occur in women who don't have a family history of depression.
- Chemical imbalance – The brains of people with depression look different than those who don't have depression. Also, the parts of the brain that manage your mood, thoughts, sleep, appetite, and behavior don't have the right balance of chemicals.
- Hormonal factors – Menstrual cycle changes, pregnancy, miscarriage, postpartum period, perimenopause, and menopause may all cause a woman to develop depression.
- Stress – Stressful life events such as trauma, loss of a loved one, a bad relationship, work responsibilities, caring for children and aging parents, abuse, and poverty may trigger depression in some people.
- Medical illness – Dealing with serious medical illnesses like stroke, heart attack, or cancer can lead to depression (Roca, 2010:2).

3.4.4 Classification of depressive disorders:

There are several forms of depressive disorders. The most common are major depressive disorder and dysthymic disorder.

- **Major depressive disorder** Major depressive disorder. Also called major depression, this is a combination of symptoms that hurt a person's ability to work, sleep, study, eat, and enjoy hobbies. Major depression is disabling and prevents a person from functioning normally. An episode of major depression may occur only once in a person's lifetime, but more often, it recurs throughout a person's life. (Roca, 2010:1).

- **Atypical depression:** is characterized by mood reactivity (ability to react to positive stimuli) and significant weight gain increased appetite, hypersomnia, a sensation of heaviness in limbs (leaden paralysis), and significant social impairment as a consequence of hypersensitivity to perceived interpersonal rejection (National Institutes of Health, 2009:4).

Some forms of depressive disorder exhibit slightly different characteristics than those described above, or they may develop under unique circumstances. However, not all scientists agree on how to characterize and define these forms of depression. They include:

- Psychotic depression, which occurs when a severe depressive illness is accompanied by some form of psychosis, such as a break with reality, hallucinations, and delusions.

- Postpartum depression, which is diagnosed if a new mother has a major depressive episode within one month after delivery (Roca, 2010:1).

- Melancholic depression**:** is characterized by a loss of pleasure in most or all activities, a failure of reactivity to pleasurable stimuli, a worsening of symptoms in the morning hours, early morning waking, psychomotor, retardation, excessive weight loss, excessive guilt.

- Catatonic depression: is a rare and severe form of major depression involving disturbances motor behavior, stupor, immobile.
- Seasonal affective disorder (SAD), which is characterized by the onset of a depressive illness during the winter months, when there is less natural sunlight. The depression generally lifts during spring and summer. SAD may be effectively treated with light therapy, but nearly half of those with SAD do not respond to light therapy alone. Antidepressant medication and psychotherapy can reduce SAD symptoms, either alone or in combination with light therapy (National Institutes of Health, 2009:4).

Seasonal affective disorder (SAD**),** which is a depression during the winter months, when there is less natural sunlight.

- **Dysthymic disorder**, also called dysthymia, is characterized by long-term (two years or longer) but less severe symptoms that may not disable a person but can prevent one from functioning normally or feeling well. People with dysthymia may also experience one or more episodes of major depression during their life times. this kind of depression lasts for a long time (two years or longer). The symptoms are less severe than major depression but can prevent you from living normally or feeling well. (Roca, 2010:1).

- **Depressive Disorder Not Otherwise Specified** (DD-NOS) is designated by the code 311 for depressive disorders that are impairing but do not fit any of the officially specified diagnoses. APA (2000) said According to the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) DD-NOS encompasses "any depressive disorder that does not meet the criteria for a specific disorder." It includes the research diagnoses of Recurrent brief depression, and Minor Depressive Disorder listed below.

- **Recurrent brief depression** (RBD), distinguished from Major Depressive Disorder primarily by differences in duration. People with RBD have depressive episodes about once per month, with individual episodes lasting less than two weeks and typically less than 2–3 days. Diagnosis of RBD requires that the episodes occur over the span of at least one year and, in female patients, independently of the menstrual cycle. People with clinical depression can develop RBD, and vice versa, and both illnesses have similar risks.
- **Minor depression** which refers to a depression that does not meet full criteria for major depression but in which at least two symptoms are present for two weeks (EL-Buhaisi, 2010:25).

Occurrence of Depression:

According to the WHO (2001), 450 million people in the world currently suffer from some form of mental or brain disorder, including alcohol and substance misuse. Within this huge number, 121 million people suffer from depression, and more than 800, 000 people die by suicide each year, with young people accounting for well over half of these. Projections from 1990 to 2020 suggest that, in future, the proportion of the global burden of all disease accounted for by mental and brain disorders will increase to 15% (Ghodse, 2003:1).

3.4.5 DSM-IV criteria for Major depressive episode:

A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.
Note: Do not include symptoms that are clearly due to a general medical condition, or mood-incongruent delusions or hallucinations.

1. Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful). **Note:** In children and adolescents, can be irritable mood
2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others)
3. Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. **Note:** In children, consider failure to make expected weight gains.
4. Insomnia or hypersomnia nearly every day
5. Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)
6. Fatigue or loss of energy nearly every day
7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)
8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)
9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

B. The symptoms do not meet criteria for a mixed episode.
C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
D. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism).

The symptoms are not better accounted for by bereavement, i.e., after the loss of a loved one, the symptoms persist for longer than 2 months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation. (Sadock et al, 2007: 536).

Major depressive disorder is a condition involving seriously depressed mood and other symptoms defined by the DSM-IV criteria. Symptoms of major depressive disorder affect all aspects of a person's bodily systems and interfere significantly with a range of daily living activities, with noticeable changes in behavior, cognition, communication, mood and physical functioning.

Elder et.al (2000) said **Behavioral changes** in depression include social and emotional withdrawal and markedly decreased interest in, and pleasure from, previously enjoyable activities. The person is often less effective in areas of work or family relations. Fontaine (2003)said **Cognitive changes** in The depressed person becomes increasingly egocentric— that is, they focus on self to the degree that other people's needs are beyond their awareness. Classically, the person's thoughts about self, others and the world become increasingly negative. The person thinks of them self as incompetent, faulty, unlovable and a failure—these are examples of

catastrophic thinking or catastrophising and inappropriate guilt. Keltner & Warren (2003) describe **Communication changes** Commonly; depressed people's communication mirrors the narrowing and repetitive focus of their thoughts. Negative self-absorption in combination with insufficient energy and interest in others means they are unlikely to initiate a conversation, and when asked a question may take a long time to answer, and give a short reply (Elder et.al, 2005:235).

Mood changes For major depression, the mood has to have been significantly lower than usual for at least two weeks'". Sadness, anguish and misery, along with a feeling of separation from others, and feelings of hopelessness and powerlessness, constitute the pain of depression. Many depressed clients cry a lot. These feelings of sadness and hopelessness and the behaviors they give rise to, such as crying and looking dejected, are referred to as affect. Affect is the observable behaviors associated with changes in a person's mood (Elder et.al, 2005:236).

According to Choi et. al. (2002) **Alterations in physical functioning**, Sleep disturbances, particularly insomnia, are common concomitants of depression. Fatigue'" is frequently associated with depression: it seems that the depressed mood, disturbed sleep and negative thinking deplete the person's energy levels. Sexual desire diminishes. The person's appetite for food is disturbed, usually decreasing, with a subsequent loss of weight and constipation. Very depressed people may experience psychomotor disturbances"", such as psychomotor retardation. Some people do not notice, or mention, their low mood as their distress is expressed via pain or other symptoms across a range of body systems). (Elder et.al, 2005:236).

3.4.6 Mental status examination for depression:

General Description:

Generalized psychomotor retardation is the most common symptom of depression, although psychomotor agitation is also seen, especially in older patients. Hand-wringing and hair-pulling are the most common symptoms of agitation. Classically, a depressed patient has a stooped posture, no spontaneous movements, and a downcast, averted gaze On clinical examination, depressed patients exhibiting gross symptoms of psychomotor retardation may appear identical to patients with catatonic schizophrenia. This fact is recognized in DSM-IV by the inclusion of the symptom qualifier with catatonic features for some mood disorders.

Mood, Affect, and Feelings:

Depressed mood and he sees the world through dark glasses**,** Depression is the key symptom, although about 50 percent of patients deny depressive feelings and do not appear to be particularly depressed. Family members or employers often bring or send these patients for treatment because of social withdrawal and generally decreased activity.

Speech:

Slow, monotonous, answers in brief. Many depressed patients have decreased rate and volume of speech; they respond to questions with single words and exhibit delayed responses to questions. The examiner may literally have to wait 2 or 3 minutes for a response to a question.

Perceptual Disturbances:

Depressed patients with delusions or hallucinations are said to have a major depressive episode with psychotic features. Even in the absence of delusions or hallucinations, some clinicians use the term psychotic depression for grossly regressed depressed patients mute, not bathing, soiling. Such patients are probably better described as having catatonic features.

Delusions and hallucinations that are consistent with a depressed mood are said to be mood congruent. Mood-congruent delusions in a depressed person include those of guilt, sinfulness, worthlessness, poverty, failure, persecution, and terminal (Sadock et al, 2007: 545).

Thought:

Depressed patients customarily have negative views of the world and of themselves. Their thought content often includes nondelusional ruminations about loss, guilt, suicide, and death. About 10 percent of all depressed patients have marked symptoms of a thought disorder, usually thought blocking and profound poverty of content.

process:

Thinking is slow and difficult; the patient may take along time to answer a question.

Sensorium and Cognition:

Orientation:

Most depressed patients are oriented to person, place, and time, although some may not have sufficient energy or interest to answer questions about these subjects during an interview.

Memory:

About 50 to 75 percent of all depressed patients have a cognitive impairment, sometimes referred to as depressive pseudodementia. Such patients commonly complain of impaired concentration and forgetfulness

.

Judgment/Insight:

Depressed patients emphasize their symptoms, they are said to have excessive insight into their condition.

Judgment is best assessed by reviewing patients' actions in the recent past and their behavior during the interview. Depressed patients' description of their disorder is often hyperbolic; they overemphasize their symptoms, their disorder, and their life problems. It is difficult to convince such patients that improvement is possible**.**

Reliability:

In interviews and conversations, depressed patients overemphasize the bad and minimize the good. A common clinical mistake is to unquestioningly believe a depressed patient who states that a previous trial of antidepressant medications did not work. Such statements may be false, and they require confirmation from another source. Psychiatrists should not view patients' misinformation as an intentional fabrication; the admission of any hopeful information may be impossible for a person in a depressed state of mind.

Impulse control:

About 10 to 15 percent of all depressed patients commit suicide, and about two thirds have suicidal ideation. Depressed patients with psychotic features occasionally consider killing a person as a result of their delusional systems, but the most severely depressed patients often lack the motivation or the energy to act in an impulsive or violent way. Patients with depressive disorders are at increased risk of suicide as they begin to improve and regain the energy needed to plan and carry out a suicide (paradoxical suicide). (Sadock et al, 2007: 546).

3.4.7 Management:

The main aims of treatment are to improve mood and quality of life, reduce the risk of medical complications, improve compliance with and outcome of physical treatment, and facilitate the "appropriate" use of healthcare resources. The development of a treatment plan depends on systematic assessment that should, whenever possible, not only involve the patients but also their partners or other key family members. (Peveler et al, 2003:1)

Hospitalization:

The first and most critical decision a physician must make is whether to hospitalize a patient or attempt outpatient treatment. Clear indications for hospitalization are the risk of suicide or homicide, a patient's grossly reduced ability to get food and shelter, and the need for diagnostic procedures. A history of rapidly progressing symptoms and the rupture of a patient's usual support systems are also indications for hospitalization (Sadock et al, 2007: 551).

Psychopharmacology:

Researchers believe that levels of neurotransmitters, especially norepinephrine and serotonin, are decreased in depression. Evidence is increasing that antidepressant therapy should continue for longer than the 3 to 6 months originally believed necessary. Fewer relapses occur in people with depression who receive 18 to 24 months of antidepressant therapy. As a rule, antidepressants should be tapered before being discontinued. Major categories of antidepressants include tricyclic antidepressants (TCAs), monoamine oxidase inhibitors (MAOIs), selective serotonin reuptake inhibitors (SSRIs), and atypical anti-depressants. Serotonin norepinephrine re-uptake inhibitors. (SNRIs). (Videbeck, 2003:341).

Other medical treatment and psychotherapy:

Electroconvulsive Therapy: Psychiatrists may use electroconvulsive therapy (ECT) to treat depression in select groups such as clients who do not respond to antidepressants or those who experience intolerable side effects at therapeutic doses (particularly true for older adults). In addition, pregnant women can safely have ECT with no harm to the fetus. Clients who are actively suicidal may be given ECT if there is concern for their safety while waiting weeks for the full effects of antidepressant medication. According to Challiner & Griffiths (2000) ECT involves application of electrodes to the head of the client to deliver an electrical impulse to the brain; this causes a seizure. It is believed that the shock stimulates brain chemistry to correct the chemical imbalance of depression; Studies regarding the efficacy of ECT are as divided as the opinions about its use. Some studies report that ECT is as effective as medication for depression, while other studies report only short-term improvement.

Likewise, some studies report that side effects of ECT are short-lived, while others report they are serious and long-term (Videbeck, 2003:334).

Psychotherapy:

Cognitive behavioral therapy, interpersonal therapy, and problem solving have all been shown to be effective for treating depression (Peveler et al, 2003:13).

Rush (2000) considers a combination of psychotherapy and medications the most effective treatment for depressive disorders. There is no one specific type of therapy that is better for the treatment of depression. The goals of combined therapy are symptom remission; psychosocial restoration; prevention of relapse or recurrence; reduced secondary consequences such as marital discord or occupational difficulties; and increasing treatment compliance(Videbeck, 2003:334).

Interpersonal therapy:

Interpersonal therapy, developed by Gerald Klerman, focuses on one or two of a patient's current interpersonal problems. This therapy is based on two assumptions. First, current interpersonal problems are likely to have their roots in early dysfunctional relationships. Second, current interpersonal problems are likely to be involved in precipitating or perpetuating the current depressive symptoms. The interpersonal therapy program usually consists of 12 to 16 weekly sessions and is characterized by an active therapeutic approach. Intrapsychic phenomena, such as defense mechanisms and internal conflicts, are not addressed. Discrete behaviors such as lack of assertiveness, impaired social skills, and distorted thinking may be addressed but only in the context of their meaning in, or their effect on, interpersonal relationships (Sadock et al, 2007: 553).

Behavioral therapy:

Behavioral therapy seeks to increase the frequency of the client's positively reinforcing interactions with the environment and to decrease negative interactions. It also may focus on improving social skills (Videbeck, 2003:334).

Behavioral therapy is based on the hypothesis that maladaptive behavioral patterns result in a person's receiving little positive feedback and perhaps outright rejection from society. By addressing maladaptive behaviors in therapy, patients learn to function in the world in such a way that they receive positive reinforcement**.**

Cognitive therapy:

Cognitive therapy, originally developed by Aaron Beck, focuses on the cognitive distortions postulated to be present in major depressive disorder. Such distortions include selective attention to the negative aspects of circumstances and unrealistically morbid inferences about consequences, Studies have shown that cognitive therapy is effective in the treatment of major depressive disorder. Most studies found that cognitive therapy is equal in efficacy to pharmacotherapy and is associated with fewer adverse effects and better follow-up than pharmacotherapy. Some of the best controlled studies have indicated that the combination of cognitive therapy and pharmacotherapy is more efficacious than either therapy alone, although other studies have not found that additive effect (Sadock et al, 2007: 553).

According to Rush (2000) Cognitive therapy focuses on how the person thinks about the self, others, and the future and interprets his or her experiences. This model focuses on the person's distorted thinking that in turn influences feelings, behavior, and functional abilities (Videbeck, 2003:334).

Family therapy:

Family therapy is not generally viewed as a primary therapy for the treatment of major depressive disorder, but increasing evidence indicates that helping a patient with a mood disorder to reduce and cope with stress can lessen the chance of a relapse. Family therapy is indicated if the disorder jeopardizes a patient's marriage or family functioning or if the mood disorder is promoted or maintained by the family situation (Sadock et al, 2007: 555).

It is recommended if there is a relation between the symptoms with patient and reaction with his family. Also it tests the role of patient in his family and how the family affects on continuity of depression condition or not.

Social therapy:

Helping the patient socially and solving his social problems and establishing appropriate environmental changes to decrease his suffering **(**Alhajjar, 2005::78**).**

Vagal Nerve Stimulation:

Experimental stimulation of the vagus nerve in several studies designed for the treatment of epilepsy found that patients showed improved mood. This observation led to the use of left vagal nerve stimulation (VNS) using an electronic device implanted in the skin, similar to a cardiac pacemaker. Preliminary studies have shown that a number of patients with chronic, recurrent major depressive disorder went into remission when treated with VNS. The mechanism of action of VNS to account for improvement is unknown. The vagus nerve connects to the enteric nervous system and, when stimulated, may cause release of peptides that act as neurotransmitters (Sadock et al, 2007: 555).

3.3 Previous studies:

The researcher shows previous studies into two main parts, the first part is about deinstitutionalization of mental health services, where the second part about recovery process.

Deinstitutionalization and attitudes toward mental illness in Jamaica: a qualitative study.

Frederick W. Hickling et. al. (2011) did this qualitative study discussing deinstitutionalization and attitudes toward mental illness in Jamaica. Objective: To consider whether or not deinstitutionalization and the integration of community mental health care with primary health care services have reduced stigma toward mental illness in Jamaica. Methods: A qualitative study of 20 focus groups, with a total of 159 participants grouped by shared sociodemographic traits. Results were analyzed using ATLAS.ti software. Results. Participant narratives showed that stigma had transitioned from negative to positive, from avoidance and fear of violent behavior during the period of deinstitutionalization to feelings of compassion and kindness as community mental health services were integrated with Jamaica's primary health care system. The Bellevue Mental Hospital and homelessness were identified as major causes of stigma. Conclusions. Attitudes toward the mentally ill have improved and stigma has decreased since the increase of community involvement with the mentally ill. This reduction in stigma seems to be a result of the rigorous deinstitutionalization process and the development of a robust community mental health service in Jamaica.

Assessing the efficacy of a modified assertive community-based treatment programme in a developing country.

Ulla A Botha et. al. (2010), did this study that discussed A number of recently published randomized controlled trials conducted in developed countries have reported no advantage for assertive interventions over standard care models. One possible explanation could be that so-called "standard care" has become more comprehensive in recent years, incorporating some of the salient aspects of assertive models in its modus operandi. The study represents the first randomized controlled trial assessing the effect of a modified assertive treatment service on readmission rates and other measures of outcome in a developing country. Methods: High frequency service users were randomized into an intervention ($n = 34$) and a control ($n = 26$) group. The control group received standard community care and the active group an assertive intervention based on a modified version of the international model of assertive community treatment. Study visits were conducted at baseline and 12 months with demographic and illness information collected at visit 1 and readmission rates documented at study end. Symptomatology and functioning were measured at both visits using the WHO-QOL. Results: At 12 month follow-up subjects receiving the assertive intervention had significantly lower total PANSS ($p = 0.02$) as well as positive ($p < 0.01$) and general psychopathology ($p = 0.01$) subscales' scores. The mean SOFAS score was also significantly higher ($p = 0.02$) and the mean number of psychiatric admissions significantly lower ($p < 0.01$) in the intervention group. Conclusion: The results indicate that assertive interventions in a developing setting where standard community mental services are often under resourced can produce significant outcomes. Furthermore, these interventions need not be as expensive and

comprehensive as international, first-world models in order to reduce inpatient days, improve psychopathology and overall levels of functioning in patients with severe mental illness.

Scaling up community-based services and improving quality of care in the state psychiatric hospitals: the way forward for Ghana.

B Akpalu, C Lund, V Doku, A Ofori-Atta, A Osei, K Ae-Ngibise, D Awenva, S Cooper, AJ Flisher (2010), performed this research that talking about scaling up community based services and improving quality of care in psychiatric hospitals in Ghana. Objective: This research aims to explore the options available for developing community-based care and improving the quality of care in psychiatric hospitals in Ghana. Method: Quantitative and qualitative data both was collected in a cross-sectional survey. Quantitative data were collected using the WHO Assessment Instrument for Mental Health Systems (WHOAIMS) version 2.2. The WHO-AIMS is a questionnaire designed to assess national mental health systems. Semi-structured interviews (SSIs) and focus group discussions (FGDs) were conducted with a cross-section of stakeholders including health professionals, researchers, policy makers, politicians, users and carers. The SSIs and FGDs were recorded digitally and transcribed verbatim. Apriori and emergent themes were coded and analyzed with NVivo version 7.0, using a framework analysis. Results: Psychiatric hospitals in Ghana have a mean bed occupancy rate of 155%. Most respondents were of the view that the state psychiatric hospitals were very congested, substantially compromising quality of care. They also noted that the community psychiatric system was lacking human and material resources. Suggestions for addressing these difficulties included committing adequate resources to community psychiatric services, using psychiatric hospitals only as referral facilities, relapse prevention programmes, strengthening psychosocial services, adopting more precise diagnoses and the development of a policy on long-stay patients. Conclusion: There is an urgent need to build a credible system of community-based care and improve the quality of care in psychiatric hospitals in Ghana.

A situation analysis of mental health services and legislation in Ghana: challenges for transformation.

A Ofori-Atta, UM Read and C Lund (2010), did this research study that analyze the situation of mental health services and legislation in Ghana. Objective: To conduct a situation analysis of the status of mental health care in Ghana and to propose options for scaling up the provision of mental health care. Method: A survey of the existing mental health system in Ghana was conducted using the WHO Assessment Instrument for Mental Health Systems. Documentary analysis was undertaken of mental health legislation, utilizing the WHO Legislation checklists. Semi-structured interviews and focus group discussions were conducted with a broad range of mental health stakeholders (n=122) at the national, regional and district levels. Results: There are shortfalls in the provision of mental health care including insufficient numbers of mental health professionals, aging infrastructure, widespread stigma, inadequate funding and an inequitable geographical distribution of services. Conclusion: Community-based services need to be delivered in the primary care setting to provide accessible and humane mental health care. There is an urgent need for legislation reform, to improve mental health care delivery and protect human rights.

- The role of the Wellness Management and Recovery (WMR) Program in promoting mental health recovery.

Michael O'Rourke (2009) did this study which clarifies that Mental health recovery has gained increasing attention as it relates to the conceptualization and treatment of those individuals experiencing severe mental illness, such as schizophrenia, major depression, and manic-depressive illness. Despite "recovery" serving as a guiding vision for the implementation and practice of mental health service delivery (Anthony, 1993), the concept itself continues to evolve. The problem statement: What is The Role of the Wellness Management and Recovery (WMR) Program in Promoting Mental Health Recovery? The procedures and methods: The model that emerged from the qualitative data, based on a sample N=7 consumers of mental health services, consisted of 3 primary themes characterizing the components of recovery: Growth, Group Content & Process, and Overcoming Prejudice & Stigma. Furthermore, the inter-relationships between themes and the sub-categories contained within provided a model of the process of recovery or how it took place for consumers. Of particular importance for many consumers were the aspects of group atmosphere, a sense of belonging, equality, and having fun. Of secondary importance in the present study was the assessment of group change (N=291) from Pre- to Post-Treatment in the areas of mental health recovery, empowerment, quality of life, and symptoms distress. Results are indicative of significant group change across time, with small to medium effect sizes found (Cohen's *d*= .21 - .59). Results and conclusions: The present study not only provides further data supporting recovery in general, but details the specific process of recovery within the context of an evolving evidence-based practice (i.e., WMR). Implications for clinical practice as well as a change in mindset or philosophy when it comes to the treatment and conceptualization of those experiencing severe mental illness are discussed.

- Initiation of Assertive Community Treatment Among Veterans With Serious Mental Illness: Client and Program Factors.

John F. McCarthy, Marcia Valenstein, Lisa Dixon, Stephanie Visnic, Frederic C. Blow, and Eric Slade (2009), did this study to ensure equitable access to mental health services is a national priority. The authors examined assertive community treatment (ACT) services initiation in the Veterans Affairs (VA) health system among program-eligible patients. The problem statement: Initiation of Assertive Community Treatment among Veterans with serious mental illness: client and program factors. The procedures and methods: The VA's National Psychosis Registry included 6,540 patients who met program eligibility criteria (mental illness diagnosis and prior hospitalization) in fiscal year (FY) 2003 (FY 2003) and had not received VA ACT services in FY 2001–FY 2003. Receipt of VA ACT services during FY 2004 was assessed with generalized estimating equations. Independent variables included age, gender, race and ethnicity, marital status, service-connected disability benefits, substance use disorder, psychiatric inpatient days in FY 2003, distance to the nearest facility with a VA ACT team, presence of an onsite team at the facility where the last VA psychiatric hospitalization occurred, and number of open slots with the nearest ACT team. Results and conclusions: A total of 452 of the eligible patients (7%) received VA ACT services in FY 2004. In multivariate analyses, older age was associated with reduced odds of receiving ACT services (odds ratio [OR] =.92 per five years); being female (OR=1.86) and having schizophrenia (OR=1.64) were positively associated with ACT services initiation. Individuals living farther from ACT sites were less likely to receive ACT services (OR=.95 per ten miles). The

marginal effects of distance were most substantial in the first 30 miles and beyond 100 miles. Most patients who were eligible for yet not already receiving VA ACT services went without these services in FY 2004. Geographic distance limited services initiation. Focused efforts are needed to enhance ACT services initiation and delivery, particularly for individuals in remote locations. (*Psychiatric Services* 60:196–201, 2009).

Psychiatric deinstitutionalization in BC: Negative consequences and possible solutions.

Alison Read (2009) performed this study and talking about the negative consequences and possible solutions that result from psychiatric deinstitutionalization.

Over the past half century, psychiatric deinstitutionalization has resulted in the movement of patients from hospitals to community care, supplemented by hospital beds for acute cases. Deinstitutionalization aims to empower mentally ill people and increase their autonomy. In British Columbia, thousands of psychiatric patients at Riverview Hospital have been transferred to the community since the 1990s. Although many patients benefit from community integration, some may experience negative effects. Funds saved by this trend have not been allocated to provide necessary supports to mentally ill people in the community. Negative consequences:

Due to a deficiency in mental health resources, this population is at risk for homelessness, drug abuse, incarceration in jail, and suicide. An understanding of these issues is required to propose effective solutions. In particular, there needs to be an increase in supportive housing and long-term care facilities for individuals with chronic mental health issues. Conclusion: Research suggests the mentally ill population is at risk of homelessness, drug abuse, jail time, and suicide. In the wake of deinstitutionalization, it is vital that these patients possess community support to maintain wellbeing. Possible solutions include increased supportive housing, long-term care, and an urgent response center. As a society, we have an obligation to address these problems and provide needed medical care to people living with a mental illness.

- Gail W. Stuart(2008), wrote about community based treatment, The goal of the mental health delivery system is to help people who have experienced a psychiatric illness live successful and productive lives in the community and to ensure that consumers and families have access to timely and accurate information that promotes learning, self-care management, and health. Started that successfully transforming the mental health service delivery system rests on two principles:

1. Services and treatments must be consumer and family centered.
2. care must focus on increasing consumer's ability to successfully cope with life's challenges, on facilitating recovery, and on building resilience.

- Recovery- and Community-Based Mental Health Services in the Slovak Republic: A Pilot Study on the Implications for Hospitalization and Inpatient Length-of-Stay for Individuals with Severe and Persistent Mental Illness.

Jenny K. Hyun, Petr Nawka, Soo Hyang Kang, Teh-wei Hu, and Joan Bloom (2008), performed this study to assess the impact of community mental health service interventions (i.e., case management, sheltered housing, and psychiatric rehabilitation services) on the probability of hospitalization, 30-day re-hospitalization, and inpatient lengths-of-stay for individuals with severe and persistent mental illness. The problem statement: What is impact of community mental health service interventions (i.e., case management, sheltered housing, and psychiatric rehabilitation services) on the probability of hospitalization, 30-day re-hospitalization, and inpatient lengths-of-stay for individuals with severe and persistent mental illness? The procedures and methods: Using a natural experiment design on a five-year, longitudinal cohort, generalized estimating equation models are used to compare 757 individuals who were hospitalized at the psychiatric hospital in Michalovce in 2001 to 46 individuals who received some type of community mental health service intervention between 2001 and 2005. Results: Although community service interventions did not have a statistically significant effect on the probability of hospitalization, the interventions were associated with significantly decreased probabilities of 30-day re-hospitalization and inpatient lengths-of-stay. Conclusions: Findings support the continuing policy initiative of building deinstitutionalized, community-based mental health systems in Eastern European countries.

Evaluation of the rehabilitation process in Greek Community Residential homes: resettlement from Greek psychiatric hospitals.

Stelios F. Stylianidis (2008) performed this study to evaluate the rehabilitation process in Greek community residential homes on the patients' level of social functioning. Objective: The aim of the study is to evaluate the impact of transfer of care from the psychiatric hospital to community residential homes on the patients' level of social functioning, one year after discharge. Method: A repeated measures design was employed in order to compare 73 patient's level of functioning one week before the transfer to the psychiatric hospital and one year later in community residential homes. A Personal data and psychiatric history form was used as well as the Scale of Rehabilitation Evaluation of Baker and Hall (1984). Descriptive statistics and One-Way ANOVA were used to analyze the data. Results: A statistically significant improvement was noted in the rehabilitation and social functioning status of the patients ($p<0.01$). Conclusions: Specific interventions developed in the community residential homes seems to have positive impact in many domains of social function of chronic psychiatric patients.

- Outcome of community-based rehabilitation program for people with mental illness who are considered difficult to treat.

Angelo Barbato, Barbara D'Avanzo, Maria Frova, Antonino Guerrini and Mauro Tettamanti, (2007) did This observational study investigated the outcomes of a community-based rehabilitation program. Significance of the study: That was designed to enhance social functioning, social inclusion, and well-being of people with mental illness who were considered treatment failures by psychiatric professionals in Italy. The procedures and methods: 144 patients who entered the

program, 131 started the program and 109 completed either 12 or 18 months of treatment. Illness severity was assessed by the Health of the Nation Outcome Scales (HoNOS) and social functioning by the Social and Occupational Functioning Assessment Scale (SOFAS). The results and conclusions: On the HoNOS, 33% of patients showed reliable change. On the SOFAS, 27% showed reliable change, although the change was substantial for few patients. Over time, patients showed moderate but significant improvements on the HoNOS and SOFAS. The HoNOS subscales concerning interpersonal relationships and social inclusion showed significant change. Very isolated people with mental illness gained some advantages from this rehabilitation program that was based on a close relationship with a key worker; however, the program duration may have been inadequate to produce substantial changes. Our findings warrant further research based on controlled studies.

- Deinstitutionalization and new models of care: early impacts on client satisfaction, wellbeing, recovery and stigma, in two acute mental health units for older people.
Luana Passalacqua (2007), did this study that aimed to elicit and compare consumers' and cares' perspectives on the acute aged care facilities at Glenside campus (Rosewood) and the new purpose built facility at the Repatriation general hospital (ward 18) in terms of satisfaction, stigma, recovery and wellbeing. Methods: Eight consumers from Rosewood and 5 consumers from ward 18 participated in an interview process which employed a mixed method approach, using quantitative measures and a semi-structured open-ended interview format. Tow cares from Rosewood completed quantitative and qualitative questionnaires. Qualitative interviewing was used to elicit information about the experiences of consumers and their carers in relation to experiences on the wards, perception of stigma, recovery and service satisfaction. Formal content analysis using inductive thematic analysis techniques was employed. Quantitative data was analyzed using descriptive statistics. Results: Quantitative findings indicated that there were no significant differences between consumers on Rosewood or ward 18 in relation to outcome measures.
Qualitative findings supported these results. Conclusions: Future evaluation research should take into account limitations of the current research when evaluating services to determine if mainstreaming services results in improved care, adherence to the recovery model and reduced stigma. Additional, more robust research is required to support the present findings.

- Common mental disorders among Arab-Israelis: Findings from the Israel national health survey.
Itzhak Levav et. al. (2007) performed this study talking about common mental disorders among Arab-Israelis. Objectives: Psychiatric epidemiological data on Arab populations are generally scanty. This community based survey, a component of the World Health Organization's 27-country study, explored the prevalence rates of anxiety and mood disorders, emotional distress and help-seeking practices among Arab-Israelis, and compared them with those found among Jewish-Israelis. Methods:
Close to 5,000 non-institutionalized individuals were interviewed with the WHO/Composite International Diagnostic Interview (CIDI) to determine the prevalence rates of selected psychiatric diagnoses, and with the 12 item General Health Questionnaire (GHQ) to measure emotional distress. The schedule included other items, e.g., socio-demographic variables and help-seeking practices. Results: Arab-Israelis, in contrast to Jewish-Israelis, had higher mean GHQ-12 scores and lower self-appraisal of mental health. Twelve-month prevalence rates for any anxiety

or affective disorder were not significantly higher among Arab-Israelis. Among respondents with diagnosed disorders, rates of help-seeking from specialized health services were lower among Arab-Israelis than among Jewish-Israelis. Intention to consult was elicited from both groups when the disorders were accompanied by higher distress scores. Conclusion: Despite major health gains, the social stresses impacting the Arab-Israeli minority may explain both the higher emotional distress and lower self-appraisal of mental health. However, no impact was observed of social causation factors on the rates of common mental disorders in the Arab-Israeli group. Cultural factors, including the definition of disorders and stigma and a lesser availability of culturally-tailored services, could account for the marked treatment gap.

- New programs in the old asylum: the deinstitutionalization of long-term psychiatric hospital patients in Argentina.

Erica Dillon (2006) performed this study that focuses on some changes taking place in a centenary psychiatric hospital in Buenos Aires province: the *externación* of long-term psychiatric patients through new programs planned and run from inside the institution by health professionals compromised in making a change in the old asylum. Research questions: Can long-term inpatients with serious mental illness such as schizophrenia leave the asylum and integrate in the society having a recovered life? Do the new externación programs make this possible? What is the place of the psychiatric hospital in the process of *externación*? Objectives: to analyze the achievements, difficulties, and problems of the *externación* programs in light of the ex-patients' experiences of deinstitutionalization, the particular socio-politic and economic context of Argentina, and the deinstitutionalization process in the United States and other countries. The researcher wanted to show whether people diagnosed with serious mental illness who have been long-term psychiatric inpatients can leave the Hospital, deinstitutionalize from the negative aspects of mental institutions, and integrate in the community having made a successful recovery. Methodology: it describes the ex-patients' experiences of life inside the institution, going through the *externación* process, and living outside in the community. These experiences provide insider perspectives to analyze the new programs and also the place of the psychiatric hospital in ex-patients' lives in the community, an ethnographic methodology, which is primarily qualitative, based on the techniques of participant observation and conversational interviews. The researcher did not use formal structured interviews.

Conclusion: The *externación* programs (Psychosocial Rehabilitation Center, Day Hospital, and Pre-Discharge House), are not projects designed from the health authorities or even from the Hospital authorities. They have been planned and implemented by health professionals, It would be needed is a higher politization of the deinstitutionalization movement to create more social conscience and acceptance of people with psychiatric conditions living as citizens and being able to share their psychiatric world with the outside one without stigma, making available for them to have a normal life in a wider conception of normality. What is important is not that ex-patients maintain themselves far from the institution, and avoid seeing other ex-patients; what is important is their construction of a new identity from where to relate with others not as passive powerless receptors but as persons with self-esteem, own projects, and determination that makes use of the institution instead of being managed by it. As the researcher see it, having a partner and being the partner of another person, no matter if he/she is a patient, expatient, or someone outside the psychiatric

circle, gives patients and ex-patients a social role, a valued role difficult to find for many "normal" people, and it is a big step towards their recovery.

Potential of human rights standards for deinstitutionalization of mental health services in Russia: a comparative legal analysis.
Dmitri Bartenev et. al. (2005) performed this comparative analytical study talking about human rights standards for deinstitutionalization of mental health services. Objectives: to 1. review international and foreign legal instruments designed to strengthen the individual's position in mental health care by promoting its delivery in the least restrictive settings. 2. give an overview of mental health care reforms aimed at bringing national policies in conformity with international human rights standards in terms of fostering social inclusion of the mentally disabled through deinstitutionalization. 3. Identify possible benefits and applicability of the gained results to reforming Russian legislation in the field of mental health within the framework of providing mental health treatment in the most integrated setting appropriate (provide policy recommendations). Method: performed comparative legal analytical study between hospital based treatment and community based treatment and focused attention on human rights standards for deinstitutionalization. Recommendations: Promote culture of respect for human rights values in mental health care at all the levels: policymakers, mental health administrators, care providers, mental health professionals. A greater emphasis must be placed on equality of rights and the right to social inclusion. Establishing community-based services should be regarded as a priority in mental health care. A comprehensive action plan should be developed to promote deinstitutionalization of mental health care. Set up effective procedures for monitoring human rights and quality assessment in mental health care.

- Examining the factor structure of the recovery assessment scale.
Patrick W. Corrigan, Mark Salver, Ruth O. Ralph, Yvette Songster, and Lorraine Keck (2004), did this study that follows up on earlier research examining the factor structure of a measure of recovery from serious mental illness. Exactly 1,824 persons with serious mental illness who were participating in the baseline interview for a multistate study on consumer-operated services completed the Recovery Assessment Scale (RAS) plus measures representing hope, meaning of life, quality of life, symptoms, and empowerment. Methods: Data from this study were obtained during baseline assessment of participants in the Consumer- Operated Services Project (Campbell et al., submitted). This Center for Mental Health Services (CMHS)-funded multisite study examined the impact of consumer services on people with serious mental illness; criteria for the definition of consumers included a DSM-IV (APA 1994) Axis I diagnosis consistent with a serious mental illness such as schizophrenia, bipolar disorder, or major depression and a significant functional disability that resulted from the mental illness. People with primary diagnoses of substance abuse were excluded. Proxies that represented significant functional disability included receipt of Social Security Disability Insurance (SSDI); two or more state hospitalizations; or self-reported interference with housing, employment, or social support. Measures: Research participants were administered several interview-based measures before entering the Consumer-Operated Services Project. Data reported in this article include the RAS and measures of symptoms and psychosocial functioning. Participants completed the RAS (Giffort et al. 1995), a 41-item scale on which respondents described themselves using a five-point agreement scale (5 = strongly

agree; 1 = strongly disagree). Sample items include "I have a desire to succeed" and "I can handle it if I get sick again." A previous study of the scale showed overall scores to have satisfactory reliability and validity (Corrigan at al. 1999). Results: Two analytic steps were completed to determine reliable factors that compose the RAS. First, an exploratory factor analysis (EFA) was completed on RAS items on a random half of the sample. The factor structure that emerged from this analysis was then cross-validated on the remaining half of the sample using confirmatory factor analysis (CFA). Conclusion: This study extends previous measurement development efforts with the RAS. Recovery has been a challenging construct to conceptualize because it seems to consist of, and be related to, so many constructs, including hope, empowerment, meaning of life, and quality of life, all of which were examined in this study. Overall, the RAS appears to have solid psychometric and conceptual features that likely make it useful in mental health services research. However, additional efforts to examine the measure's construct validity, especially clearer evidence of convergence and divergence from other constructs, would greatly add to confidence in using the RAS to assess recovery. Part of this effort might include examining how recovery changes over time.

- Prediction of outcome from the Dartmouth assertive community treatment fidelity scale.

Gary R. Bond, PhD, and Michelle P. Salyers (2004), performed this study that predicts the outcome from the Dartmouth assertive community treatment fidelity. Background:

Assertive community treatment (ACT) is an intensive and comprehensive treatment for clients with severe mental illness (SMI) who do not readily benefit from clinic-based services. Monitoring the implementation of such programs is critical, because better-implemented programs have been found to be effective in improving client outcomes. Objective: Tested the hypothesis that fidelity to the ACT model would be positively correlated with improved client outcomes, as measured by reduction in psychiatric hospital use. Methods: A scale measuring fidelity of program implementation, the Dartmouth ACT Scale, was examined in 10 newly formed ACT teams. Using the team as the unit of measure, the mean reduction in state hospital days for a 1-year period before and after program admission was calculated. Mean effect size in reduction in hospital days was used as the outcome measure in a correlational design. Results: Pre/post comparisons showed a 43% reduction in hospital days for 317 clients ($t=8.61$, $P<.001$). The Pearson correlation between DACTS fidelity and reduction of state hospital days was .49, $P=.08$, one-tailed. Conclusion: Several possible reasons are offered for why the study hypothesis was not confirmed. However, even if predictive validity of the Dartmouth ACT Scale is limited, it continues to be a useful tool for program monitoring and for providing corrective feedback.

- A systematic review of the effectiveness of community-based mental health outreach services for older adults.

Aricca D. Van Citters and Stephen J. Bartels (2004) did This review that evaluates the evidence base for the effectiveness of outreach services for older adults with mental illness in noninstitutional community settings. Objectives: Psychiatric outreach services that provide mental health assessment and treatment to older adults in their homes or communities are widely promoted as improving access and outcomes for older adults. However, a systematic review of the efficacy of these services has not

been done. This review evaluates the evidence base for the effectiveness of outreach services for older adults with mental illness in noninstitutional community settings. End points of interest include the ability of the outreach program to increase access to mental health services and improve psychiatric outcomes. Methods: MEDLINE, CINAHL, PsycINFO, and Web-of-Science databases were searched for articles in English that were indexed through May 2004. Studies were included if they evaluated face-to-face psychiatric services provided to adults aged 65 and older with mental illness and if they were randomized controlled trials, quasi-experimental outcome studies, uncontrolled cohort studies, or comparisons of two or more interventions. Articles were excluded that evaluated interventions that were provided in institutional settings or that focused on persons with dementia or their caregivers. Results: Fourteen studies matched all the inclusion criteria. Two studies (one controlled prospective study and one study that used a comparison group) found support for the use of gatekeepers—nontraditional referral sources—in identifying socially isolated older adults with mental illness. Twelve studies (five randomized controlled trials, one quasi-experimental study, and six uncontrolled cohort studies) found that home and community-based treatment of psychiatric symptoms were associated with improved or maintained psychiatric status. All randomized controlled trials reported improved depressive symptoms, and one reported improved overall psychiatric symptoms. Conclusions: Limited data supported the effectiveness of outreach services in identifying isolated older adults with mental illness. A more substantial evidence base indicated that home-based mental health treatment is effective in improving psychiatric symptoms. Studies are needed that apply more rigorous methods evaluating the efficacy of case identification models and subsequent treatment for older persons with a variety of psychiatric diagnoses.

The effect of deinstitutionalization on the longitudinal continuity of mental health care in the Netherlands.

Y.J. Pijl and S. Sytema (2004) did this study to evaluate the effects of Dutch model for deinstitutionalizing mental health care. Background: Deinstitutionalization has been accompanied by a decreasing continuity of care in a number of countries. This study evaluates the effects of the Dutch model for deinstitutionalizing mental health care. Methods: Details of users and their use of community- and hospital-based services between 1990 and 1999 were retrieved from the Groningen case register. The time between discharge from the hospital and the first subsequent community-based contact was the primary indicator for changes in continuity of care. Results: The total proportion of discharges from hospital-based mental health care followed within 6 months by community-based care increased by 11% due to the improved availability of day treatment and home treatment. In terms of median survival time, aftercare in the years 1998/1999 was delivered more than twice as fast as in the years 1990/1991. Conclusions: Study results supported the hypothesis in Dutch deinstitutionalization policy that the continuity of mental health care would benefit as to its longitudinal dimension.

After the 1995 Swedish Mental Health Care Reform and deinstitutionalization: a follow up study of a group of severely mentally ill.

Hans Arvidsson (2004) did this study to follow up a sample of severely mentally ill persons after the 1995 Swedish mental health care reform and deinstitutionalization. Aims: The overall aim of this thesis was to follow up a sample of severely mentally ill persons after the 1995 Swedish mental health care reform and to assess if the

observed changes were in accord with the aims of the reform. Methods: In 1995/96, 602 persons were surveyed and identified as severely mentally ill in a defined area of Sweden. In 2000/2001, 828 persons were surveyed using the same method. The surveyed persons were interviewed and their needs were assessed on both occasions. Study I involved the 378 persons surveyed on both occasions. The results of interviews and assessments of needs from the two occasions were compared. In Study II, the results of the interviews and need assessment in 1995/96 and in 2000/2001 were compared. The subset of the group surveyed in 2000/2001 that also was surveyed in 1995/96 (n=378) was compared to the group that was "new" in 2000/2001 (n=450). In study III the persons surveyed in 1995/96 but not in 2000/2001 (n=224) were investigated with respect to recovery. A small sample also participated in an interview particularly focusing on recovery. Study IV was a case register study, assessing the quantity of psychiatric care delivered during the period 1994-2003.
Results: In general, the results were in accord with the aims of the reform. The number of met needs had increased and the number of unmet needs had decreased. Furthermore, efforts by psychiatric care and social services had increased for the target group of the reform. The objectives of the reform thus seemed to have been effectuated. There seemed to have been a change in the interpretation and application of the concept severely mentally ill between 1995/96 and 2000/2001. It appeared that the threshold for applying the concept had been lowered on the second survey. Only 14 % were considered to have recovered from being severely mentally ill between the two surveys. Conclusions: The findings were in accord with the aims of the reform. Why then is the reform commonly considered a failure in the public debate? The main argument for dubbing the reform a failure may be the fact that the severely mentally ill as a group are still very underprivileged and that they are clearly not afforded opportunities equal to those enjoyed by society at large.

Spontaneous recovery from depression in women: a qualitative study of vulnerabilities, strengths and resources.
S. Naeem et. al. (2004), performed this study that clarify there is spontaneous recovery from depression in women and discuss vulnerabilities, strengths and resources. Objective: To gain insight into the perceived vulnerability and restitution factors for anxiety/or depression. Methods: Focus group discussion of seven married women recovered spontaneously from anxiety and/or depression, belonging to a lower middle class semi-urban community of Karachi. Results: Poverty, unemployment, abuse and on going difficulties were perceived as risk factors for depression, A reliable social support system, positive thinking approach, faith, prayers, and experiencing a "turning point" event were reported as factors that promoted recovery from anxiety and/or depression. Conclusion: Individual vulnerabilities, strengths and resources can have an important role in recovery from anxiety and/or depression in women.

- Exploring recovery from the perspective of people with Psychiatric disabilities.
Sharon L. Young and David S. Ensing (2003), did this study that Explores recovery from the perspective of people with psychiatric disabilities. Overcoming `stuckness' during the initiation of the recovery process; Regaining of what was lost and moving forward; Improvement of the quality of life. Purpose of study: The purpose of the current study was to explore the meaning of the recovery process from the perspective of mental health consumers. Methods: Seven semi-structured, qualitative interviews and two focus group discussions were carried out with a total of 18 people, and

grounded theory analysis was used to identify common, underlying components of the recovery process. A model of the recovery process was developed, which included the higher order categories that recovery is a process of 1) overcoming "stuckness," 2) discovering and fostering self-empowerment, 3) learning and self-redefinition, 4) returning to basic functioning, and 5) improving quality of life. The relationship between the current model and the existing literature on the recovery process is discussed. Results: Although each recovery process follows its own unique path (Anthony, 1993), the results of this study indicated that there are some general aspects of recovery that typify the process for many consumers. The higher order categories which emerged from the data are that recovery is a process of 1) overcoming "stuckness," 2) discovering and fostering self-empowerment, 3) learning and self-redefinition, 4) returning to basic functioning, and 5) improving quality of life. For a more detailed overview of the recovery process as described by participants.

Predictors of early recovery from major depression among persons admitted to community-based clinics.

Barnett S. Meyers et. al. (2002) did this observational study clarifying predictors of early recovery from major depression among persons admitted to community based clinics. Background: Twenty years have elapsed since the National Institute of Mental Health Collaborative Depression Study reported on the early course and treatment of major depression within the mental health sector. Using similar methods, an observational study was conducted to assess relationships between initial depression severity, personality dysfunction and other baseline characteristics, subsequent treatment, and 3-month outcomes among persons admitted to public and voluntary sector outpatient clinics, including 1 academic program. Methods: A 2-stage sampling technique was used to recruit subjects (N=165) diagnosed by the Structured Clinical Interview for DSM-IV, Patient Version, as having a major depression episode. Sociodemographic and clinical characteristics were assessed at admission. Data on treatment and outcome were obtained at 3 months using structured instruments from the Longitudinal Interview Follow-up Evaluation. Logistic regression was used to assess hypothesized predictors of early recovery. Analyses were carried out in the total sample and after dichotomizing subjects by baseline depression severity. Results: Fifty (30.3%) of the 165 subjects met recovery criteria. Less than half of the subjects (45%) met criteria for adequate pharmacotherapy. Less severe depression, having received adequate antidepressant treatment, female sex, and being married independently predicted early recovery. In the more depressed subgroup, early recovery was associated with female sex. Among less severely depressed subjects, high personality dysfunction scores and being married were significant predictors. Conclusions: Initial depression severity and receiving adequate pharmacotherapy predict early recovery in individuals with major depression seeking outpatient treatment. A minority of persons receive intensive antidepressant treatment. Less severe personality dysfunction and being married predicts early recovery among persons with less severe depression.

Working toward recovery in new Hampshire: A study of modernized vocational rehabilitation from the viewpoint of the consumer.

Keith A. Young (2001) did this study and took the viewpoints of the consumers about modernized vocational rehabilitation applied with them. Objective: Following the passage of the ADA and the Rehabilitation Amendments of 1992, vocational rehabilitation services offered by New Hampshire community mental health centers

have striven collectively to streamline the efficiency of their interventions. Evolved versions of the two most frequently utilized modalities are compared, by measuring vocational satisfaction as it is rated by the perspective of the consumer. Both methods are found to be highly effective, but differ greatly in the nature of their impact and applicability. The strengths and weaknesses of each are identified in the context of psychiatric rehabilitation, and implications are presented for further research. Method: The participants of this study were consumers of a community mental health center, who as the result of a referral process by an interdisciplinary team were identified as individuals who requested and were considered to be clinically appropriate for a sheltered vocational experience. A second sample of comparable size was also identified who received strictly supported employment vocational services in the community, and who served as a contrast group. The Minnesota Satisfaction Questionnaire (short form) (Minnesota, 1977) is an assessment tool that defines and measures the key dimensions of satisfaction with a vocational experience (Carlos, 1999), and was chosen to be the primary measurement tool for this study. serves as the quasi-independent variable for this study. For the purpose of the project, vocational satisfaction was operationally defined consistently by all instruments as it is defined in the Minnesota Satisfaction Questionnaire (short form). Results: The hypothesis of this study was that the satisfaction level of the consumer with a vocational experience would be positively affected by the services offered from both a nontraditional sheltered workshop and conceptually evolved supported employment services from a community mental health center. The results of the study present significant differences in the nature of their individual impacts. Conclusion: Research in general on vocational programs in the area of community mental health has been relatively sparse. When considering the combination of the most effective theories that have taken place, along with limitations that have been addressed and modified, and the evolution of community-based and sheltered services to a consumer-focused, recovery-oriented mission, it becomes apparent that we have been provided with an entirely new and different range of possibilities for research and continued development. This study intended to evaluate, to a limited degree, the progress that has been made thus far, in a state that has gained a reputation for keeping “ahead of the game” in providing the most advanced quality service to those individuals with disabilities and an interest in vocational success.

Getting ready for recovery: Reconciling mandatory treatment with the recovery vision.

Mark R. Munetz & Frederick J. Frese (2001), performed this study that clarify that with individuals whose psychotic illness substantially impairs decision making, mandatory treatment may offer the best hope of getting well enough for recovery to be possible. It is essential; however, that any program involving involuntary community treatment involves recovering individuals who have themselves experienced a serious mental illness. The authors propose the use of a consumer-run guardianship program and a capacity review panel as two possible ways to achieve such participation. Conclusion: It is increasingly clear that serious mental disorders like schizophrenia are brain disorders, best understood in a biopsychosocial context. While some individuals may recover from such disorders without pharmacologic treatment, this appears to be unusual. There are far more people who repeatedly get ill and deteriorate over time because of persistent refusal to accept treatment. Mental health professionals need to increase their skills to develop working alliances with such individuals to help them accept treatment willingly. At the same time, as some

(but by no means all) consumers acknowledge (Frese, 1997), a means to provide treatment over the affected person's objection is necessary to give those people an opportunity to become well enough to begin the recovery process. It is hoped that as consumers continue to do well, there will be less attention paid to the struggle for treatment compliance and more attention paid to skill building, independent living, and other aspects of recovery. It is hoped that over time consumers will come to accept their illness in some fashion and regain decision-making capacity.

Moving assertive community treatment into standard practice.
Susan D. Phillips et. al. (2001) performed this study to describe the assertive community treatment model of comprehensive community-based psychiatric care for persons with severe mental illness and discusses issues pertaining to implementation of the model. Objectives: to describe the assertive community treatment model of comprehensive community-based psychiatric care for persons with severe mental illness. Method: The assertive community treatment model has been the subject of more than 25 randomized controlled trials. Results: Research has shown that this type of program is effective in reducing hospitalization, is no more expensive than traditional care, and is more satisfactory to consumers and their families than standard care. Conclusions: Since the inception of assertive community treatment nearly 30 years ago, research has repeatedly demonstrated that it reduces hospitalization, increases housing stability, and improves the quality of life for those individuals with severe mental illness who experience the most intractable symptoms and experience the greatest impairment as a result of mental illness; This model of delivering integrated, community-based treatment, support, and rehabilitation services has been adapted to a variety of settings, circumstances, and populations. Although research shows that greater adherence to a group of core principles produces better outcomes, the relationship between specific structural aspects of assertive community treatment programs and outcomes is not always clear. When this model is being implemented, thoughtful consideration should be given to research on assertive community treatment programs and local conditions. Issues that should be considered include adequate funding, monitoring of fidelity, adaptation of policies and procedures to accommodate the model, and adequate training of professional staff. Tools that provide practical information on how to address issues related to implementing the assertive community treatment model will be available in the near future.

Symptomatic recovery and social functioning in major depression.
Furukawa TA (2001) performed this study talking about symptomatic recovery and social functioning in major depression. Objective: To determine whether social functional recovery proceeds, runs in parallel with, or lags behind symptomatic recovery from major depressive episodes. Method: Psychiatric out-patients or in-patients aged 18 years or over, diagnosed with unipolar major depressive disorder according to DSM-IV, and who had received no antidepressant medication in the preceding 3 months were identified at 23 collaborating centers from all over Japan (n=95). They were rated with the 17-item Hamilton Rating Scale for Depression (HRSD) and the Global Assessment Scale (GAS) monthly, and with the Social Adjustment Scale-Self Report (SAS-SR) 6-monthly. Remission was defined as 7 or less on the HRSD and recovery as 2 or more consecutive months of remission. Results: The GAS ratings showed continuous amelioration from baseline to remission, remission to recovery, and after sustained recovery. The same trends were observed for SAS-SR scores. Conclusion: We can expect further amelioration in

social adjustment after symptomatic remission and recovery of major depressive episodes.

The impact of closing a State psychiatric hospital on the County Mental Health System and its clients.

Edna Kamis-Gould et. al. (1999) performed this study showing the impact of closing a state psychiatric hospital. Objective: This three-year study examined the impact of closing a state psychiatric hospital in 1991 on service utilization patterns and related costs for clients with and without serious mental illness. Methods: The cohort consisted of all individuals discharged from state hospitals and those diverted from inpatient to community services and enrolled in the unified systems project, a state-county initiative to build up the service capacity of the community system. The size of the cohort grew from 1,533 enrollees to 2,240 over the three years. Information on the types, amounts, and cost of all services received by each enrollee was compiled from multiple administrative databases, beginning two years before enrollment and for up to three years after. The data were analyzed to reveal patterns of and changes in service utilization and related costs. Results: Replacement of most inpatient services with residential and ambulatory services resulted in significant cost reduction. For project enrollees, a 94 percent reduction in state hospital services resulted in cost savings of more than $45 million during the three-year evaluation period. These savings more than offset the funds used to expand community services. Overall, the net savings to the system for mental health services for this group was $3.4 million over three years. Conclusions: The hospital closure and infusion of funds into community services produced desired growth of those services. The project reduced reliance on state psychiatric hospitalization and demonstrated that persons with serious mental illness can be effectively treated and maintained in the community.

3.4 Summary of previous studies:

All of the literature reviews that the researcher found during searching supported the research hypothesis and give the same results that the researcher expected before getting the research results, in which it seems to be justifiable and discusses a relationship that looks to be realistic.

Lack of local studies that discussed community based treatment and its effects on recovery process among depressive patients, what made the present study mainly depends on foreign studies. The researcher found most of previous studies which related to community based treatment aimed to enhance social functioning, social inclusion, and well-being of people with mental illness who were considered treatment failures by psychiatric professionals in Italy, clarify the impact of community mental health service interventions (i.e., case management, sheltered housing, and psychiatric rehabilitation services) on the probability of hospitalization, 30-day re-hospitalization, and inpatient lengths-of-stay for individuals with severe and persistent mental illness, Test the hypothesis that fidelity to the ACT model would be positively correlated with improved client outcomes, as measured by reduction in psychiatric hospital use, to explore the options available for developing community-based care and improving the quality of care in psychiatric hospitals in Ghana, consider whether or not deinstitutionalization and the integration of community mental health care with primary health care services have reduced stigma toward mental illness in Jamaica, evaluates the effects of the Dutch model for deinstitutionalizing mental health care and describe the assertive community treatment model of comprehensive community-based psychiatric care for persons with severe mental illness.

The researcher found most of previous studies which related to recovery process clarifies that Mental health recovery has gained increasing attention as it relates to the conceptualization and treatment of those individuals experiencing severe mental illness, such as schizophrenia, major depression, and manic-depressive illness, clarify there is spontaneous recovery from depression in women and discuss vulnerabilities, strengths and resources, clarifying predictors of early recovery from major depression among persons admitted to community based clinics and determine whether social functional recovery precedes, runs in parallel with, or lags behind symptomatic recovery from major depressive episodes.
Some of the researchers used tools as questionnaires, interviews, closed ended questions and observations.

The researcher took advantages of these previous studies and used it to develop questionnaire, select study design, write the conceptual framework, definition of terms, and discussion. Finally, most of previous studies related to this study, the researcher found the results of previous studies as the following:

Improvements in interpersonal relationships and social inclusion.

Significantly decreased probabilities of 30-day re-hospitalization and inpatient lengths-of-stay.

Support the continuing policy initiative of building deinstitutionalized, community-based mental health systems.

Focused efforts are needed to enhance assertive community treatment services initiation and delivery.

Build a credible system of community-based care and improve the quality of care in psychiatric hospitals.

Improve psychopathology and overall levels of functioning in patients with severe mental illness.

Attitudes toward mental illness have improved and stigma has decreased and has positive impact in many domains of social function of chronic psychiatric patients.

Individual vulnerabilities, strengths and resources can have an important role in recovery from anxiety and/or depression, recovery process can be achieved successfully for depressive patients when appropriate services of treatment used.

Chapter 4
Methodology

Chapter 4

4.1 Introduction:

This chapter describes the methodology that was used in this research. The adopted methodology to accomplish this study used the following techniques: the information about the research design, research population, questionnaire design, statistical data analysis, content validity, pilot study and ethical consideration.

4.2 Study design:

The design that was used in this study is a descriptive, cross sectional design, which tries to answer the study's questions about the relationship between community based treatment "deinstitutionalization" and achieving recovery among depressive patients in Gaza governorates and other possible factors contributing to the development of recovery. This method was selected because it can be performed quickly and cheaply and for more ethical considerations.

The first phase of the research thesis included identifying and defining the problems and establishment objective of the study and development research plan.

The second phase of the research included a summary of the comprehensive literature review. Literatures on claim management were reviewed.

The third phase of the research included a field survey which was conducted with the **impact of deinstitutionalization of mental health services on recovery process among depressive patients in Gaza Strip**

The fourth phase of the research focused on the modification of the questionnaire design, through distributing the questionnaire to pilot study, The purpose of the pilot study was to test and prove that the questionnaire questions are clear to be answered in a way that help to achieve the target of the study. The questionnaire was modified based on the results of the pilot study.

The fifth phase of the research focused on distributing questionnaire. This questionnaire was used to collect the required data in order to achieve the research objective.

The sixth phase of the research was data analysis and discussion. Statistical Package for the Social Sciences, (SPSS) was used to perform the required analysis. The final phase includes the conclusions and recommendations.
One hundred and fourty questionnaires were distributed to the research population and **one hundred and twenty** questionnaires were received.

Figure 4.1 shows the methodology flowchart, which leads to achieve the research objective.

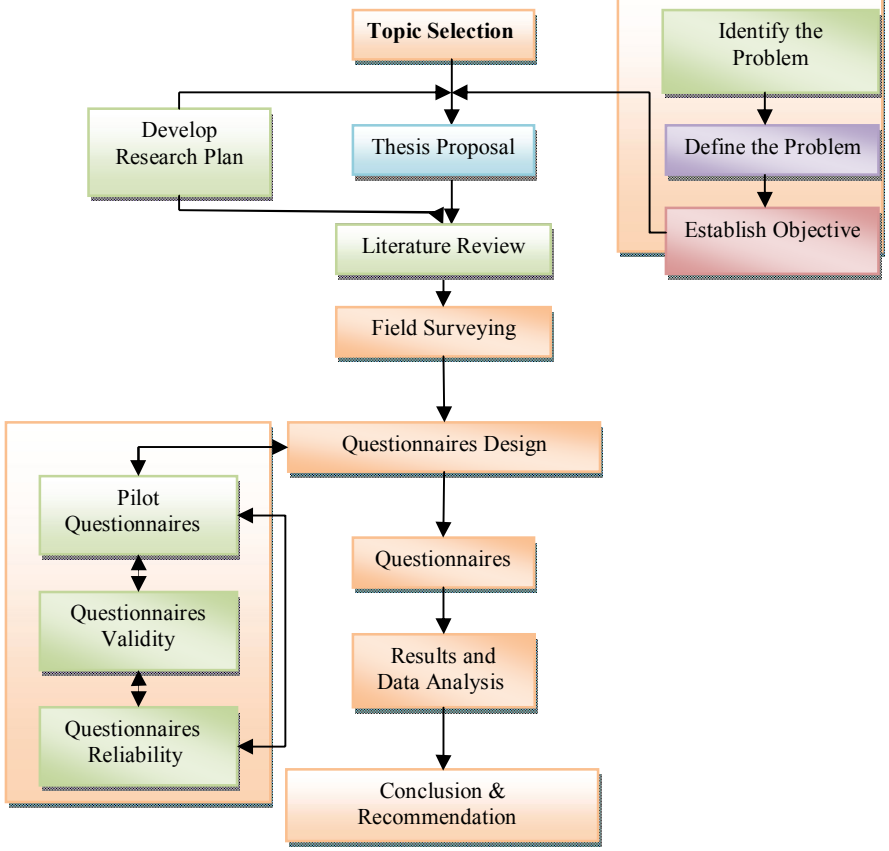

Figure (1) illustrates the methodology flow chart.

4.3 Population of study:

Population of study is defined as a group of individuals (or a group of organizations) with some common defining characteristic that the researcher can identify and study (Creswell, 2008:152). The population consisted of all depressive patients who were treated in governmental mental health centers in Gaza strip and they are nearly 383 patients, 245 male and 138 female.

4.4 Sample and sampling technique:

The sample is defined as a subgroup of the target population that the researcher plans to study for generalizing who are representative of the entire population (Creswell, 2008:152). This is a cross-sectional study which included 383 mentally ill patients with confirmed diagnosis of depression (men and women) aged >= 20 year of age, who were treated in the local governmental community based treatment in Gaza Strip during 2009-2010, they participated voluntarily in this study. The sample was selected through accidental sampling = 140 participants. **and 140 questionnaires** were distributed to the research sample and **one hundred and twenty** questionnaires were received, while there were 20 questionnaires not received due to refuse, some not available patient, and some of the cannot reach them, and it were as the following 80 patients from community mental health centers and 40 patients from EL-Nasser psychiatric hospital, So the sample was 2:1.

4.5 Data Collection Methodology:

In order to collect the needed data for this research, the researcher used the secondary resources in collecting data such as books, journals, statistics and web pages, in addition to preliminary resources that not available in secondary resources through distributing questionnaires on study population in order to get their opinions about the impact of deinstitutionalization of mental health services on recovery process among depressive patients in Gaza Strip. Research methodology depended on the analysis of data on the use of descriptive analysis, which depended on the poll and use the main program (SPSS). The researcher found that the most appropriate methods for this study were to do an interview with subjects of the selected sample which is considered one of the self report methods, and preferred to use focused interview with semistructured self report technique.

4.6 Research instruments:

Questionnaire design and content:

The researcher used Mental Health Recovery Measure (MHRM) questionnaire (Young & Bullock, 2003), as an instrument "Likert scale" in data collection, the researcher applied great changes and modifications on it, and translated it by two official translation institutions for confirmed validity and reliability. The questionnaire was provided with a covering letter explaining the purpose of the study, the way of responding, the aim of the research and the security of the information in order to encourage a high response. The questionnaire included multiple choice questions: which used widely in the questionnaire, the variety in these questions aims first to meet the research objectives, and to collect all the necessary data that can support the discussion, results and recommendations in the research.

The sections in the questionnaire verified the objectives in this research related to the **impact of deinstitutionalization of mental health services on recovery process among depressive patients in Gaza Strip** as the following:

Table 4.1 illustrates the questionnaire contents

Number	Domains	Items
First	• Hope.	Questions from 1-5.
Second	• Will and determination.	Questions from 6-10.
Third	• Feeling of value.	Questions from 11-15.
Fourth	• Safety and security.	Questions from 16-20.
Fifth	• The positive approach.	Questions from 21-25.
Sixth	• Self efficiency.	Questions from 26-30.

And all questions follow likert scale as the following:

Level	Strongly disagree	disagree	Not sure	Agree	Strongly agree
Scale	1	2	3	4	5

4.7 Period of study:

From May 2011 to June 2012.

4.8 Setting of study:

Gaza governmental community mental health clinics and EL-Nasser psychiatric hospital.

4.9 Eligibility criteria:

Patients who participated in this study met the following criteria:

(Inclusion criteria):

- male and female
- 20—50years old.
- Confirmed diagnosis of major depression according by DSM4 by psychiatrists.
- All depressive patients treated in governmental community mental health clinics at 2009-2010.

(Exclusion criteria)

- Less than 20 and more than 50years old.
- Depressive patients not followed by governmental community mental health clinics.

4.10 Research control:

- The researcher made the condition during data collection as similar as possible for all subjects.
- The researcher made control of external factors as:

Environment: The researcher chose one place for all patients.

The time: The researcher conducted data at limited time from 8---11 am, 3 days in a week for at least one month.

Communication: The researcher collected data alone, and explained and clarified questions and informed the study purpose to all participants at the same time and the level.

4.11 Pilot study:

The researcher performed pretest questionnaires for 5% of the selected population"30 subjects" that ensured efficacy of the questionnaires and treated any errors presented, and checked for any needed modifications. A pilot study for the questionnaire was conducted before collecting the results of the sample. It provided a trial run for the questionnaire, which involved testing the wordings of question, identifying ambiguous questions, testing the techniques that used to collect data, and measuring the effectiveness of standard invitation to respondents.

4.11.1 Validity of the questionnaire:

The researcher defined the validity of an instrument as a determination of the extent to which the instrument actually reflects the abstract construct being examined (Creswell, 2008:169)."Validity refers to the degree to which an instrument measures what it is supposed to be measuring". High validity is the absence of systematic errors in the measuring instrument. When an instrument is valid; it truly reflects the concept it is supposed to measure. Achieving good validity required the care in the research design and sample selection. The amended questionnaire was checked by the supervisors and Five expertises in the tendering and bidding environments to evaluate the procedure of questions and the method of analyzing the results. The expertises agreed that the questionnaire was valid and suitable enough to measure the purpose that the questionnaire designed for.

4.11.2 Content validity of the questionnaire:

It is the extent to which the questions on the instrument and the scores from these questions are representative of all the possible questions that a researcher could ask about the content or skills (Creswell, 2008:172). Content validity test was conducted by consulting five expertises, to evaluate and identify whether the questions agreed with the scope of the items and the extent to which these items reflect the concept of the research problem and to evaluate that the instrument used is valid statistically and that the questionnaire was designed well enough to provide relations and tests between variables. The expertises agreed that the questionnaire was valid and suitable enough to measure the concept of interest with some amendments.

4.11.3 Statistical validity of the questionnaire:

To insure the validity of the questionnaire, two statistical tests were applied. The first test is Criterion-related validity test (Pearson test) which measures the correlation coefficient between each item in the field and the whole field. The second test is structure validity test (Pearson test) that used to test the validity of the questionnaire structure by testing the validity of each field and the validity of the whole questionnaire. It measures the correlation coefficient between one filed and all the fields of the questionnaire that have the same level of similar scale.

4.11.4 Criterion related validity:

1) Internal consistency:

Internal consistency of the questionnaire was measured by a scouting sample, which consisted of **thirty** questionnaires, through measuring the correlation coefficients between each paragraph in one field and the whole filed. Tables No.'s (4.2-4.3) below show the correlation coefficient and p-value for each field items. As show in the table the p- Values are less than 0.05 or 0.01,so the correlation coefficients of this field are significant at $\alpha = 0.01$ or $\alpha = 0.05$, so it can be said that the paragraphs of this field are consistent and valid to be measured what it was set for, and the pilot study were excluded because of some changes and modifications were applied.

Table (4.2), The correlation coefficient between each paragraph in the field and the whole field

No.	Statement	Pearson coefficient	p-value
	Hope		
1	I work hard towards my mental health recovery.	0.538	0.006
2	Even though there are hard days, things are improving for me.	0.789	0.000
3	I ask for help when I am not feeling well.	0.758	0.000
4	I take risks to move forward with my recovery.	0.762	0.000
5	I believe in myself.	0.705	0.000
	Will and determination		
6	I have control over my mental health problems.	0.629	0.001
7	I am in control of my life.	0.793	0.000
8	I socialize and make friends.	0.534	0.006
9	Every day is a new opportunity for learning.	0.895	0.000
10	I still grow and change in positive ways despite my mental health problems.	0.844	0.000
	Feeling of value		
11	Even though I may still have problems, I value myself as a person of worth.	0.784	0.000
12	I understand myself and have a good sense of who I am.	0.902	0.000
13	I eat nutritious meals everyday.	0.560	0.004
14	I go out and participate in enjoyable activities every week.	0.556	0.004
15	I make the effort to get to know other people.	0.627	0.001
	Safety and security		
16	I am comfortable with my use of prescribed medications.	0.829	0.000
17	I feel good about myself.	0.879	0.000
18	The way I think about things helps me to achieve my goals.	0.863	0.000
19	My life is pretty normal.	0.707	0.000
20	I feel at peace with myself.	0.837	0.000
	The positive approach		
21	I maintain a positive attitude for weeks at a time.	0.887	0.000
22	My quality of life will get better in the future.	0.847	0.000
23	Every day that I get up, I do something productive.	0.735	0.000
24	I am making progress towards my goals.	0.820	0.000
25	When I am feeling low, my religious faith or spirituality helps me feel better.	0.899	0.000
	Self efficiency		
26	My religious faith or spirituality supports my recovery.	0.787	0.000
27	I advocate for the rights of myself and others with mental health problems.	0.689	0.000
28	I engage or I work other activities that enrich myself and the world around me.	0.646	0.000
29	I cope effectively with stigma associated with having A mental health problem.	0.832	0.000
30	I have enough money to spend on extra things or activities that enrich my life.	0.519	0.008

4.11.5 Validity of the questionnaire:

Validity is the second statistical test that used to test the validity of the questionnaire structure by testing the validity of each field and the validity of the whole questionnaire. It measured the correlation coefficient between one filed and all the fields of the questionnaire that have the same level of liker scale.

As shown in table No. (4.3), the significance values are less than 0.05 or 0.01, so the correlation coefficients of all the fields are significant at $\alpha = 0.01$ or $\alpha = 0.05$, so it can be said that the fields are valid to be measured what it was set for to achieve the main aim of the study.

Table No. (4.3)
Validity of the questionnaire

Number	section	Pearson correlation coefficient	p-value
Factors of recovery scale	Hope	0.900	0.000
	Will and determination	0.930	0.000
	Feeling of value	0.874	0.000
	Safety and security	0.929	0.000
	The positive approach	0.914	0.000
	Self efficiency	0.934	0.000

4.11.6 Reliability of the Research:

Reliability means that scores from an instrument are stable and consistent. Scores should be nearly the same when researchers administer the instrument multiple times at different times. Also, scores need to be consistent. When an individual answers certain questions one way, the individual should be consistently answer closely related questions in the same way (Creswell, 2008:169). Reliability of an instrument is the degree of consistency with which it measures the attribute it is supposed to be measuring. The test is repeated to the same sample of people on two occasions and then compares the scores obtained by computing a reliability coefficient. For the most purposes reliability coefficient above 0.7 are considered satisfactory. Period of two weeks to a month is recommended between two tests Due to complicated conditions that the contractors is facing at the time being, it was too difficult to ask them to responds to our questionnaire twice within short period. The statistician's explained that, overcoming the distribution of the questionnaire twice to measure the reliability can be achieved by using Cronbach's Alpha coefficient and Half split method through the SPSS software.

4.11.7 Half split method:

This method depends on finding Pearson correlation coefficient between the means of odd rank questions and even rank questions of each field of the questionnaire. Then, correcting the Pearson correlation coefficients can be done by using Spearman Brown correlation coefficient of correction. The corrected correlation coefficient (consistency coefficient) was computed according to the following equation:

Consistency coefficient = 2r/(r+1), where r is the Pearson correlation coefficient. The normal range of corrected correlation coefficient 2r/(r+1) is between 0.0 and + 1.0 As shown in Table No.(4.4), all the corrected correlation coefficients values are between 0.865 and 0.925 and the general reliability for all items equal 0.892, and the significant (α) is less than 0.05 so all the corrected correlation coefficients are significance at α = 0.05. It can be said that according to the Half Split method, the dispute causes group are reliable.

Table (4.4)
Split-half coefficient method

	section	person-correlation	Spearman-Brown Coefficient	p-value
Factors of recovery scale	Hope	0.821	0.902	0.000
	Will and determination	0.799	0.888	0.000
	Feeling of value	0.762	0.865	0.000
	Safety and security	0.860	0.925	0.000
	The positive approach	0.814	0.897	0.000
	Self efficiency	0.788	0.882	0.000
	Total	**0.807**	**0.893**	**0.000**

4.11.8 Cronbach's coefficient alpha:

This method is used to measure the reliability of the questionnaire between each field and the mean of the whole fields of the questionnaire. The normal range of Cronbach's coefficient alpha value between 0.0 and + 1.0, and the higher values reflects a higher degree of internal consistency. As shown in Table No. (4.5) the Cronbach's coefficient alpha was calculated for the first field of the causes of claims, the second field of common procedures and the third field of the Particular claims. The results were in the range from 0.882 and 0.941, and the general reliability for all items equal 0.917. This range is considered high; the result ensures the reliability of the questionnaire.

Table (4.5)

Reliability for Cronbach's Alpha

Number	section	Cronbach's Alpha
Factors of recovery scale	Hope	0.922
	Will and determination	0.900
	Feeling of value	0.882
	Safety and security	0.935
	The positive approach	0.941
	Self efficiency	0.928
	Total	**0.917**

4.11.9 Statistical Manipulation:

To achieve the research goal, researcher used the statistical package for the Social Science (SPSS) for Manipulating and analyzing the data.

***Statistical methods are as follows:**

1- Frequencies and Percentile

2- Cronbach- Alpha Test for measuring reliability of the items of the questionnaires

3- Person correlation coefficients for measuring validity of the items of the questionnaires.

4- Spearman –Brown Coefficient

5-Relative importance Index formula

6-One sample t test

7-Independent samples t test

8-One way ANOVA test

4.12 Ethical considerations:

- The participants agreed to participate in the research study, so the researcher got a consent form to be signed from each participant because every one is free to accept or refuse participation.

- The researcher brought also, administrative agreement from the general director of mental health in Gaza strip.

4.13 Statistical analysis:

The collected data processed and analyzed under the supervision of the academic supervisor and the statisticians. Data entered by SPSS computer program for data entry and analysis, with correlational coefficient, one way ANOVA and t-test.

Chapter 5

Data Analysis and Results

Chapter 5

5.1 Introduction:

In this chapter the researcher clarified the main results of the study after data collection and analysis by using statistical tools of sample of 120 subjects. The researcher used SPSS program for data entry and analysis. The researcher used many statistical tests like descriptive statistics, frequencies, percentage, mean, standard deviation. In addition to differences between study variables using t- independent test and one- way ANOVA test.

5.2 Sociodemographic data:

The following tables illustrated the properties of the samples:

Personal data :

1- Age:

Table No.(5.1) show that 13.3% from the sample ages "25-less than 30 years " , and 36.7% from the sample ages "30-less than 40 years " , and 50.0% from the sample ages " 40 years or more " .

Table No. (5.1)
Age

Age	Frequency	Percentages
25-less than 30 years	16	13.3
30-less than 40 years	44	36.7
40 years or more	60	50.0
Total	120	100.0

2- Gender:

Table No.(5.2) show that 75.0% from the sample are " male " , and 25.0% from the sample are " Female "

Table No. (5.2)
Gender

Gender	Frequency	Percentages
Male	90	75.0
Female	30	25.0
Total	120	100.0

3- Address:

Table No.(5.3) show that 5.0 % from the sample from " Northern governorate " , and 30.0% from the sample from " Gaza governorate " , and 36.7% from the sample from " Mid-area governorate " , and 28.3% from the sample from " Khanyounis governorate " .

Table No. (5.3)
Address

Address	Frequency	Percentages
Northern governorate	6	5.0
Gaza governorate	36	30.0
Mid-area governorate	44	36.7
Khanyounis governorate	34	28.3
Total	120	100.0

4- Marital status:

Table No.(5.4) show that 11.7% from the sample are " Married " , and 70.0% from the sample are " Single " , and 6.7% from the sample are " Divorced " , and 11.7% from the sample are " Widowed " .

Table No. (5.4)
Marital status

Marital status	Frequency	Percentages
Married	14	11.7
Single	84	70.0
Divorced	8	6.7
Widowed	14	11.7
Total	120	100.0

5- Educational level:

Table No.(5.5) show that 35.0 % from the sample the educational level are " Primary " , and 22.5% from the sample the educational level are " preparatory " , and 25.8% from the sample the educational level are " secondary " , and 16.7% from the sample the educational level are " university " .

Table No. (5.5)
Educational level

Educational level	Frequency	Percentages
primary	42	35.0
preparatory	27	22.5
secondary	31	25.8
university	20	16.7
Total	120	100.0

6- Economical level:

A- family income sources:

Table No.(5.6.1) show that 54.2% from the sample the family income sources are "Social affairs", and 18.3% from the sample the family income sources are "person's work", and 11.7% from the sample the family income sources are "wife's work", and 2.5% from the sample the family income sources are "husband's work", and 1.7% from the sample the family income sources are "son's work", and 11.7% from the sample the family income sources are "Ranching".

Table No. (5.6.1)
family income sources

family income sources	Frequency	Percentages
social affairs	65	54.2
person' s work	22	18.3
wife's work	14	11.7
husband's work	3	2.5
son' s work	2	1.7
agricultural land	٠	٠.٠
ranching	14	11.7
another work	٠	٠.٠
Total	120	100.0

B- Value of monthly income:

Table No.(5.6.2) show that 69.2% from the sample the value of monthly income are " Less than 500 NIS ", and 15.8 % from the sample the value of monthly income are " from 500-1000 NIS ", and 9.2% from the sample the value of monthly income are "from1000-1500 NIS", and 1.7% from the sample the value of monthly income are "from 1500-2000 NIS", and 2.5% from the sample the value of monthly income are "from 2000-2500 NIS", and 1.6% from the sample the value of monthly income are "more than 2500 NIS".

Table No. (5.6.2)
value of monthly income

value of monthly income	Frequency	Percentages
Less than 500 NIS	83	69.2
from 500-1000 NIS	19	15.8
from1000-1500 NIS	11	9.2
from 1500-2000 NIS	2	1.7
from 2000-2500 NIS	3	2.5
more than 2500 NIS	2	1.6
Total	120	100.0

7- History of psychiatric disease:

A. period of treatment and follow up:

Table No.(5.7.1) show that 8.3% from the sample the period of treatment are " 3-6 months " , and 34.2% from the sample the period of treatment are "6 months-1 year", and 29.2 % from the sample the period of treatment are "1-3 years " , and 28.3% from the sample the period of treatment are "3 years and more " .

Table No. (5.7.1)
period of treatment and follow up from

period of treatment and follow up from	Frequency	Percentages
3-6 months	10	8.3
6 months-1 year	41	34.2
1-3 years	35	29.2
3 years and more	34	28.3
Total	120	100.0

B- Place for treatment and follow up:

Table No. (5.7.2) show that 33.3 % from the sample the Place for treatment follow EL-Nasser psychiatric hospital, and 66.7% from the sample the Place for treatment follow Gaza governmental community mental health clinics.

Table No. (5.7.2)
Place for treatment and follow up

Place for treatment and follow up	Frequency	Percentages
EL-Nasser psychiatric hospital	40	33.3
Gaza governmental community mental health clinics	80	66.7
Total	120	100.0

5.3 Descriptive analysis of the study:

One Sample K-S Test:

One Sample K-S test was used to identify if the data follow normal distribution or not, this test is considered necessary in case answering research questions as most parametric Test stipulate data to be normality distributed and this test used when the size of the sample are greater than 50, (Creswell, 2008).

Results test as shown in table (5.8), clarifies that the calculated p-value is greater than the significant level which is equal 0.05 (p-value. > 0.05), this in turn denotes that data follows normal distribution, and so parametric Tests must be used.

Table (5.8)
One Sample K-S

Domains	Items No.	Statistic	P-value
Hope	5	0.940	0.340
Will and determination	5	0.919	0.367
Feeling of value	5	1.248	0.089
Safety and security	5	0.630	0.822
The positive approach	5	1.065	0.207
Self efficiency	5	0.998	0.272
Total	**30**	0.803	0.539

5.4 Discussion and interpretation of each domain's items:

First domain: Hope

The researcher used an independent samples t test to test if there is a difference on the opinion of the respondent about **Hope** and the results shown in Table No. (5.9) as follows:

EL-Nasser psychiatric hospital:

The highest item " I work hard towards my mental health recovery " with the weight mean equal " 60.0%" and the lowest item " I believe in myself " with weight mean equal "39.50% ".

Gaza governmental community mental health clinics:

The highest item " I ask for help when I am not feeling well " with the weight mean equal " 90.0%" and the lowest item "I believe in myself " with weight mean equal " 66.25% ".

Table (5.9)

Mean, weight mean, standard deviation, t-value and p-value for **hope**.

No.	statement	EL-Nasser psychiatric hospital			Gaza governmental community mental health clinics			t-value	P-value
		Mean	standard deviation	Weight mean	Mean	standard deviation	Weight mean		
1	I work hard towards my mental health recovery.	3.00	1.281	60.00	4.09	0.783	81.75	-5.754	0.000
2	Even though there are hard days, things are improving for me.	2.08	0.971	41.50	3.78	0.826	75.50	-10.012	0.000
3	I ask for help when I am not feeling well.	2.30	1.381	46.00	4.50	0.827	90.00	-10.891	0.000
4	I take risks to move forward with my recovery.	2.38	1.334	47.50	4.00	0.616	80.00	-9.144	0.000
5	I believe in myself	1.98	1.074	39.50	3.31	1.051	66.25	-6.526	0.000
	TOTAL	2.35	0.926	46.90	3.94	0.434	78.70	-12.833	0.000

Critical value of t at df "118" and significance level 0.05 equal 1.98

For general the results for all items of the domain show that the following:

For EL-Nasser psychiatric hospital the average mean equal 2.35 and the weight mean equal 46.90 % , and for Gaza governmental community mental health clinics the average mean equal 3.94 and the weight mean equal 78.70 %, and the value of t test equal 12.833 which is greater than the critical value which is equal 1.98 and the p- value equal 0.000 which is less than 0.05, that means there is a difference on the opinion of the respondent about Hope at significant level $\alpha = 0.05$, and the differences in favor of Gaza governmental community mental health clinics.

Second domain: will and determination

The researcher used an independent samples t test to test if there is a difference on the opinion of the respondent about **Will and determination** and the results shown in Table No. (5.10) as follows:

EL-Nasser psychiatric hospital:

The highest item " Every day is a new opportunity for learning " with the weight mean equal "47.00 %" and the lowest item " I have control over my mental health problems " with weight mean equal " 35.0%.

Gaza governmental community mental health clinics:

The highest item " Every day is a new opportunity for learning " with the weight mean equal "77.5 %" and the lowest item " I socialize and make friends " with weight mean equal "61.0% ".

Table (5.10) Mean, weight mean, standard deviation, t-value and p-value for will and determination.

No.	statement	EL-Nasser psychiatric hospital			Gaza governmental community mental health clinics			t-value	P-value
		Mean	standard deviation	Weight mean	Mean	standard deviation	Weight mean		
1	I have control over my mental health problems.	1.75	0.742	35.00	3.46	1.018	69.25	-9.448	0.000
2	I am in control of my life.	1.83	0.813	36.50	3.63	0.973	72.50	-10.071	0.000
3	I socialize and make friends.	2.25	1.006	45.00	3.05	1.292	61.00	-3.429	0.001
4	Every day is a new opportunity for learning.	2.35	1.122	47.00	3.88	0.560	77.50	-9.955	0.000
5	I still grow and change in positive ways despite my mental health problems.	1.95	0.932	39.00	3.74	0.670	74.75	-12.037	0.000
	TOTAL	2.03	0.722	40.50	3.55	0.633	71.00	-11.866	0.000

Critical value of t at df "118" and significance level 0.05 equal 1.98

For general the results for all items of the domain show that the following:

For EL-Nasser psychiatric hospital the average mean equal 2.03 and the weight mean equal 40.50 % , and for Gaza governmental community mental health clinics the average mean equal 3.55 and the weight mean equal 71.0 %, and the value of t test equal 11.866 which is greater than the critical value which is equal 1.98 and the p- value equal 0.000 which is less than 0.05, that means there is a difference on the opinion of the respondent about Will and determination at significant level $\alpha = 0.05$ and the differences in favor of Gaza governmental community mental health clinics.

Third domain: Feeling of value

The researcher used an independent samples t test to test if there is a difference on the opinion of the respondent about **Feeling of value** and the results shown in Table No. (5.11) as follows:

- **EL-Nasser psychiatric hospital**:

The highest item " Even though I may still have problems, I value myself as a person of worth " with the weight mean equal " 44.0%" and the lowest item " I go out and participate in enjoyable activities every week. " with weight mean equal "36.5%".

- **Gaza governmental community mental health clinics**:

The highest item " Even though I may still have problems, I value myself as a person of worth. " with the weight mean equal "77.75%" and the lowest item " I eat nutritious meals every day " with weight mean equal "49.75 %".

Table (5.11)
Mean, weight mean, standard deviation, t-value and p-value for feeling of value

No.	statement	EL-Nasser psychiatric hospital			Gaza governmental community mental health clinics			t-value	P-value
		Mean	standard deviation	Weight mean	Mean	standard deviation	Weight mean		
1	Even though I may still have problems, I value myself as a person of worth.	2.20	0.939	44.00	3.89	0.636	77.75	-11.618	0.000
2	I understand myself and have a good sense of who I am.	1.93	0.888	38.50	3.89	0.551	77.75	-14.876	0.000
3	I eat nutritious meals every day.	1.93	1.185	38.50	2.49	0.981	49.75	-2.759	0.007
4	I go out and participate in enjoyable activities every week.	1.83	0.844	36.50	3.23	1.147	64.50	-6.843	0.000
5	I make the effort to get to know other people.	2.00	1.109	40.00	2.98	1.180	59.50	-4.352	0.000
	TOTAL	1.98	0.790	39.50	3.29	0.575	65.85	-10.401	0.000

Critical value of t at df "118" and significance level 0.05 equal 1.98

For general the results for all items of the domain show that the following:

For EL-Nasser psychiatric hospital the average mean equal 1.98 and the weight mean equal 39.50 %, and for Gaza governmental community mental health clinics the average mean equal 3.29 and the weight mean equal 65.85 %, and the value of t test equal 10.401 which is greater than the critical value which is equal 1.98 and the p- value equal 0.000 which is less than 0.05, that means there is a difference on the opinion of the respondent about Feeling of value at significant level $\alpha = 0.05$ and the differences in favor of Gaza governmental community mental health clinics.

Fourth domain: Safety and security

The researcher used an independent samples t test to test if there is a difference on the opinion of the respondent about **Safety and security** and the results shown in Table No. (5.12) as follows:

- **EL-Nasser psychiatric hospital**

The highest item " I am comfortable with my use of prescribed medications" with the weight mean equal "61.50 %" and the lowest item " My life is pretty normal " with weight mean equal "33.5% ".

- **Gaza governmental community mental health clinics**

The highest item " I am comfortable with my use of prescribed medications " with the weight mean equal "90.25 %" and the lowest item " My life is pretty normal " with weight mean equal "51.25% ".

Table (5.12)
Mean, weight mean, standard deviation, t-value and p-value for safety and security

No.	statement	EL-Nasser psychiatric hospital			Gaza governmental community mental health clinics			t-value	P-value
		Mean	standard deviation	Weight mean	Mean	standard deviation	Weight mean		
1	I am comfortable with my use of prescribed medications.	3.08	1.289	61.50	4.51	0.693	90.25	-7.955	0.000
2	I feel good about myself.	1.98	0.768	39.50	3.95	0.475	79.00	-17.350	0.000
3	The way I think about things helps me to achieve my goals.	1.70	0.723	34.00	3.78	0.573	75.50	-17.097	0.000
4	My life is pretty normal.	1.68	0.764	33.50	2.56	0.979	51.25	-5.017	0.000
5	I feel at peace with myself.	1.70	0.992	34.00	3.71	0.814	74.25	-11.848	0.000
	TOTAL	2.03	0.680	40.50	3.70	0.492	74.05	-15.442	0.000

Critical value of t at df "118" and significance level 0.05 equal 1.98

For general the results for all items of the domain show that the following:

For EL-Nasser psychiatric hospital the average mean equal 2.03 and the weight mean equal 40.50 % , and for Gaza governmental community mental health clinics the average mean equal 3.70 and the weight mean equal 74.05 %, and the value of t test equal 15.442 which is greater than the critical value which is equal 1.98 and the p- value equal 0.000 which is less than 0.05, that means there is a difference on the opinion of the respondent about Safety and security at significant level $\alpha = 0.05$ and the differences in favor of Gaza governmental community mental health clinics.

Fifth domain: The positive approach

The researcher used an independent samples t test to test if there is a difference on the opinion of the respondent about **The positive approach** and the results shown in Table No. (5.13) as follows:

- **EL-Nasser psychiatric hospital**

The highest item " When I am feeling low, my religious faith or spirituality helps me feel better" with the weight mean equal "62.50%" and the lowest item " I am making progress towards my goals. " with weight mean equal "36.0% ".

- **Gaza governmental community mental health clinics**

The highest item " When I am feeling low, my religious faith or spirituality helps me feel better " with the weight mean equal 95.75" %" and the lowest item " Every day that I get up, I do something productive " with weight mean equal "71.5%".

Table (5.13)

Mean, weight mean, standard deviation, t-value and p-value for the positive approach

No.	statement	EL-Nasser psychiatric hospital			Gaza governmental community mental health clinics			t-value	P-value
		Mean	standard deviation	Weight mean	Mean	standard deviation	Weight mean		
1	I maintain a positive attitude for weeks at a time.	2.23	1.025	44.50	3.79	0.589	75.75	-10.601	0.000
2	My quality of life will get better in the future.	2.30	1.203	46.00	3.79	0.688	75.75	-8.616	0.000
3	Every day that I get up, I do something productive.	1.93	0.859	38.50	3.58	0.868	71.50	-9.848	0.000
4	I am making progress towards my goals.	1.80	0.687	36.00	3.80	0.736	76.00	-14.341	0.000
5	When I am feeling low, my religious faith or spiritual-ity helps me feel better.	3.13	1.436	62.50	4.79	0.520	95.75	-9.245	0.000
	TOTAL	2.28	0.724	45.50	3.95	0.550	78.95	-14.087	0.000

Critical value of t at df "118" and significance level 0.05 equal 1.98

For general the results for all items of the domain show that the following:

For EL-Nasser psychiatric hospital the average mean equal 2.28 and the weight mean equal 45.5 % , and for Gaza governmental community mental health clinics the average mean equal 3.95 and the weight mean equal 78.95 %, and the value of t test equal 14.087 which is greater than the critical value which is equal 1.98 and the p- value equal 0.000 which is less than 0.05, that means there is a difference on the opinion of the respondent about The positive approach at significant level $\alpha = 0.05$ and the differences in favor of Gaza governmental community mental health clinics.

Sixth domain: Self efficiency

The researcher used independent samples t test to test if there is a difference on the opinion of the respondent about **Self efficiency** and the results shown in Table No. (5.14) as follows:

- **EL-Nasser psychiatric hospital**:

The highest item "My religious faith or spirituality supports my recovery "with the weight mean equal "69.5 %" and the lowest item "I cope effectively with stigma associated with having a mental health problem." with weight mean equal "32.5% ".

- **Gaza governmental community mental health clinics**: The highest item " My religious faith or spirituality supports my recovery " with the weight mean equal "96.5 %" and the lowest item " I have enough money to spend on extra things or activities that enrich my life " with weight mean equal " 41.5%".

Table (5.14)

Mean, weight mean, standard deviation, t-value and p-value for self efficiency.

No.	statement	EL-Nasser psychiatric hospital			Gaza governmental community mental health clinics			t-value	P-value
		Mean	standard deviation	Weight mean	Mean	standard deviation	Weight mean		
1	My religious faith or spirituality supports my recovery.	3.48	1.281	69.50	4.83	0.382	96.50	-8.714	0.000
2	I advocate for the rights of myself and others with mental health problems.	2.48	1.062	49.50	3.85	0.658	77.00	-8.724	0.000
3	I engage or I work other activities that enrich myself and the world around me.	1.85	0.834	37.00	3.16	1.037	63.25	-6.957	0.000
4	I cope effectively with stigma associated with having a mental health problem.	1.63	0.925	32.50	3.89	0.477	77.75	-17.709	0.000
5	I have enough money to spend on extra things or activities that enrich my life	1.68	0.997	33.50	2.08	0.808	41.50	-2.361	0.020
	TOTAL	2.22	0.614	44.40	3.56	0.445	71.20	-13.647	0.000

Critical value of t at df "118" and significance level 0.05 equal 1.98

For general the results for all items of the domain show that the following:

For EL-Nasser psychiatric hospital the average mean equal 2.22 and the weight mean equal 44.40 % , and for Gaza governmental community mental health clinics the average mean equal 3.56 and the weight mean equal 71.20 %, and the value of t test equal 13.647 which is greater than the critical value which is equal 1.98 and the p- value equal 0.000 which is less than 0.05, that means there is a difference on the opinion of the respondent about Self efficiency at significant level $\alpha = 0.05$ and the differences in favor of Gaza governmental community mental health clinics.

For all factors:

The researcher used an independent samples t test to test if there is difference on the opinion of the respondent about all **fields of Recovery scale** and the results in Table No. (5.15) show the following:

For EL-Nasser psychiatric hospital the average mean equal 2.14 and the weight mean equal 42.88 % , and for Gaza governmental community mental health clinics the average mean equal 3.66 and the weight mean equal 73.29%, and the value of t test equal 15.703 which is greater than the critical value which is equal 1.98 and the p- value equal 0.000 which is less than 0.05, that means there are significant differences on the opinion of the respondent about all fields of Recovery scale at significant level $\alpha = 0.05$ and the differences in favor of Gaza governmental community mental health clinics.

Table (5.15)
Mean, weight mean, standard deviation, t-value and p-value for all fields of recovery scale

No.	Factor	EL-Nasser psychiatric hospital			Gaza governmental community mental health clinics			t-value	P-value
		Mean	standard deviation	Weight mean	Mean	standard deviation	Weight mean		
1	Hope	2.35	0.926	46.90	3.94	0.434	78.70	-12.833	0.000
2	Will and determination	2.03	0.722	40.50	3.55	0.633	71.00	-11.866	0.000
3	Feeling of value	1.98	0.790	39.50	3.29	0.575	65.85	-10.401	0.000
4	Safety and security	2.03	0.680	40.50	3.70	0.492	74.05	-15.442	0.000
5	The positive approach	2.28	0.724	45.50	3.95	0.550	78.95	-14.087	0.000
6	Self efficiency	2.22	0.614	44.40	3.56	0.445	71.20	-13.647	0.000
	TOTAL	2.14	0.626	42.88	3.66	0.425	73.29	-15.703	0.000

Critical value of t at df "118" and significance level 0.05 equal 1.98

There are no statistical differences about the impact of deinstitutionalization of mental health services on recovery process among depressive patients in Gaza Strip due to **age** at significant level $\alpha = 0.05$.

There are no differences about the impact of deinstitutionalization of mental health services on recovery process among depressive patients in Gaza Strip due to **Gender** at significant level $\alpha = 0.05$.

There is differences between " Northern governorate ", and " Gaza governorate " in favor of " Gaza governorate ", and between " Northern governorate ",and " Khanyounis governorate " in favor of " Khanyounis governorate ".

There are statistical differences about the impact of deinstitutionalization of mental health services on recovery process among depressive patients in Gaza Strip due to **Marital status** at significant level $\alpha = 0.05$. show that the differences between "Single ", and "Widowed" in favor of "Single ".

There are no statistical differences about the impact of deinstitutionalization of mental health services on recovery process among depressive patients in Gaza Strip due to **Educational level** at significant level $\alpha = 0.05$.

There are no statistical differences about the impact of deinstitutionalization of mental health services on recovery process among depressive patients in Gaza Strip due to **family income sources** at significant level $\alpha = 0.05$.

There are no statistical differences about the impact of deinstitutionalization of mental health services on recovery process among depressive patients in Gaza Strip due to **value of monthly income** at significant level $\alpha = 0.05$.

There are statistical differences about the impact of deinstitutionalization of mental health services on recovery process among depressive patients in Gaza Strip due to period of treatment at significant level $\alpha = 0.05$, show that the differences between " 6 months-1 year " ,and " 3 years and more " in favor of "6 months-1 year".

There are statistical differences about the impact of deinstitutionalization of mental health services on recovery process among depressive patients in Gaza Strip due to **Place for treatment** at significant level $\alpha = 0.05$. And the difference in favor of Gaza governmental community mental health clinics.

5.5 Statistical analysis for research's questions:

1. Are there significant differences about the impact of deinstitutionalization of mental health services on recovery process among depressive patients in Gaza Strip due to (**Age** ,**Gender, Address**, **Marital status, Educational level**, **Family income sources, Value of monthly income, Period of treatment, Place for treatment**) at significant level α =0.05?

And this question divided into sub-questions as the following:

Are there significant differences about the impact of deinstitutionalization of mental health services on recovery process among depressive patients in Gaza Strip due to **age** at significant level $\alpha = 0.05$?

To answer the question the researcher used the one way ANOVA and the result illustrated in table no.(5.16) which show that the p-value equal 0.884 which is greater than 0.05 and the value of F test equal 0.124 which is less than the value of critical value which is equal 3.07 , that's means There are not statistical differences about the impact of deinstitutionalization of mental health services on recovery process among depressive patients in Gaza Strip due to age at significant level $\alpha = 0.05$.

Table No. (5.16)

One way ANOVA test for difference in point of view up to the impact of deinstitutionalization of mental health services on recovery process among depressive patients in Gaza Strip due to **age**

Field	Source	Sum of Squares	df	Mean Square	F value	Sig.(P-Value)
The impact of deinstitutionalization of mental health services on recovery process among depressive patients in Gaza Strip	Between Groups	0.192	2	0.096	0.124	0.884
	Within Groups	90.952	117	0.777		
	Total	91.144	119			

Critical value of F at df "2,117" and significance level 0.05 equal 3.07

Are there significant differences about the impact of deinstitutionalization of mental health services on recovery process among depressive patients in Gaza Strip due to **Gender** at significant level α =0.05?

To answer the question the researcher used the Independent Samples Test and the result illustrated in table no.(5.17) which show that the p-value equal 0.462 which is greater than 0.05 and the absolute value of T test equal 0.737 which is less than the value of critical value which is equal 1.98, that's means there are no differences about the impact of deinstitutionalization of mental health services on recovery process among depressive patients in Gaza Strip due to **Gender** at significant level $\alpha = 0.05$.

Table No. (5.17)

Independent Samples Test for difference in point of view up the impact of deinstitutionalization of mental health services on recovery process among depressive patients in Gaza Strip due to **Gender**

Field	Gender	N	Mean	Std. Deviation	T	P-value
the impact of deinstitutionalization of mental health services on recovery process among depressive patients in Gaza Strip	**Male**	90	3.124	0.850	-0.737	0.462
	Female	30	3.260	0.956		

Critical value of t at df "118" and significance level 0.05 equal 1.98

Are there significant differences about the impact of deinstitutionalization of mental health services on recovery process among depressive patients in Gaza Strip due to **Address** at significant level α =0.05?

To answer the question the researcher used the one way ANOVA and the result illustrated in table no.(5.18) which show that the p-value equal 0.000 which is less than 0.05 and the value of F test equal 6.942 which is greater than the value of critical value which is equal 2.68 , that's means There are a statistical differences about the impact of deinstitutionalization of mental health services on recovery process among depressive patients in Gaza Strip due to Address at significant level $\alpha = 0.05$ .and from Scheffe Multiple Comparisons test table No.(5.19) show that the differences between " Northern governorate ", and " Gaza governorate " in favor of " Gaza governorate ", and between " Northern governorate ",and " Khanyounis governorate " in favor of " Khanyounis governorate ".

Table No. (5.18)

One way ANOVA test for difference in point of view up to the impact of deinstitutionalization of mental health services on recovery process among depressive patients in Gaza Strip due to **Address**

Field	Source	Sum of Squares	df	Mean Square	F value	Sig.(P-Value)
The impact of deinstitutionalization of mental health services on recovery process among depressive patients in Gaza Strip	Between Groups	13.873	3	4.624	6.942	0.000
	Within Groups	77.270	116	0.666		
	Total	91.144	119			

Critical value of F at df "3,116" and significance level 0.05 equal 2.68

Table No. (5.19)
Scheffe Multiple Comparisons due to Address

Address	Northern governorate	Gaza governorate	Mid-area governorate	Khanyounis governorate
Northern governorate		-0.938	-1.337*	-1.442*
Gaza governorate	0.938		-0.399	-0.504
Mid-area governorate	1.337*	0.399		-0.105
Khanyounis governorate	1.442*	0.504	0.105	

Are there significant differences about the impact of deinstitutionalization of mental health services on recovery process among depressive patients in Gaza Strip due to **Marital status,** at significant level α =0.05?

To answer the question the researcher used the one way ANOVA and the result illustrated in table no.(5.20) which show that the p-value equal 0.000 which is less than 0.05 and the value of F test equal 9.108 which is greater than the value of critical value which is equal 2.68, that's means There are a statistical differences about the impact of deinstitutionalization of mental health services on recovery process among depressive patients in Gaza Strip due to **Marital status** at significant level $\alpha = 0.05$. and from Scheffe Multiple Comparisons test table No. (5.21) show that the differences between "Single ", and "Widowed" in favor of "Single ".

Table No. (5.20)
One way ANOVA test for difference in point of view up to the impact of deinstitutionalization of mental health services on recovery process among depressive patients in Gaza Strip due to **Marital status**

Field	Source	Sum of Squares	df	Mean Square	F value	Sig.(P-Value)
The impact of deinstitutionalization of mental health services on recovery process among depressive patients in Gaza Strip	Between Groups	17.376	3	5.792	9.108	0.000
	Within Groups	73.768	116	0.636		
	Total	91.144	119			

Critical value of F at df "3,116" and significance level 0.05 equal 2.68

Table No. (5.21)
Scheffe Multiple Comparisons due to Marital status

Marital status	Married	Single	Divorced	Widowed
Married		-0.649	-0.325	0.443
Single	0.649		0.324	1.092*
Divorced	0.325	-0.324		0.768
Widowed	-0.443	-1.092*	-0.768	

Are there significant differences about the impact of deinstitutionalization of mental health services on recovery process among depressive patients in Gaza Strip due to **Educational level** at significant level α =0.05?

To answer the question the researcher used the one way ANOVA and the result illustrated in table no.(5.22) which show that the p-value equal 0.082which is greater than 0.05 and the value of F test equal 2.285 which is less than the value of critical value which is equal 2.68, that's means There are no statistical differences about the impact of deinstitutionalization of mental health services on recovery process among depressive patients in Gaza Strip due to **Educational level** at significant level $\alpha = 0.05$.

Table No. (5.22)
One way ANOVA test for difference in point of view up to the impact of deinstitutionalization of mental health services on recovery process among depressive patients in Gaza Strip due to **Educational level**

Field	Source	Sum of Squares	df	Mean Square	F value	Sig.(P-Value)
The impact of deinstitutionalization of mental health services on recovery process among depressive patients in Gaza Strip	Between Groups	5.086	3	1.695	2.285	0.082
	Within Groups	86.058	116	0.742		
	Total	91.144	119			

Critical value of F at df "3,116" and significance level 0.05 equal 2.68

Are there significant differences about the **impact of deinstitutionalization of mental health services on recovery process among depressive patients in Gaza Strip** due to family income sources at significant level α =0.05?

To answer the question the researcher used the one way ANOVA and the result illustrated in table no.(5.23) which show that the p-value equal 0.070 which is greater than 0.05 and the value of F test equal 2.103 which is less than the value of critical value which is 2.29 means There are not statistical differences about the impact of deinstitutionalization of mental health services on recovery process among depressive patients in Gaza Strip due to family income sources at significant level $\alpha = 0.05$.

Table No. (5.23)

One way ANOVA test for difference in point of view up to the impact of deinstitutionalization of mental health services on recovery process among depressive patients in Gaza Strip due to **family income sources**

Field	Source	Sum of Squares	df	Mean Square	F value	Sig.(P-Value)
The impact of deinstitutionalization of mental health services on recovery process among depressive patients in Gaza Strip	Between Groups	7.698	5	1.540	2.103	0.070
	Within Groups	83.446	114	0.732		
	Total	91.144	119			

Critical value of F at df "5,114" and significance level 0.05 equal 2.29

Are there significant differences about the impact of deinstitutionalization of mental health services on recovery process among depressive patients in Gaza Strip due to **value of monthly income** at significant level α =0.05?

To answer the question the researcher used the one way ANOVA and the result illustrated in table no.(5.24) which show that the p-value equal 0.146 which is greater than 0.05 and the value of F test equal 1.676 which is less than the value of critical value which is equal 2.29, that's means There are not statistical differences about the impact of deinstitutionalization of mental health services on recovery process among depressive patients in Gaza Strip due to value of monthly income at significant level $\alpha = 0.05$.

Table No. (5.24)

One way ANOVA test for difference in point of view up to the impact of deinstitutionalization of mental health services on recovery process among depressive patients in Gaza Strip due to **value of monthly income**

Field	Source	Sum of Squares	df	Mean Square	F value	Sig.(P-Value)
The impact of deinstitutionalization of mental health services on recovery process among depressive patients in Gaza Strip	Between Groups	6.242	5	1.248	1.676	0.146
	Within Groups	84.902	114	0.745		
	Total	91.144	119			

Critical value of F at df "5,114" and significance level 0.05 equal 2.29

Are there significant differences about the impact of deinstitutionalization of mental health services on recovery process among depressive patients in Gaza Strip due to **period of treatment** at significant level α =0.05?

To answer the question the researcher used the one way ANOVA and the result illustrated in table no.(5.25) which show that the p-value equal 0.000 which is less than 0.05 and the value of F test equal9.325 is greater than the value of critical value which is equal 2.68, that's means There are a statistical differences about the impact of deinstitutionalization of mental health services on recovery process among depressive patients in Gaza Strip due to period of treatment at significant level $\alpha = 0.05$. and from Scheffe Multiple Comparisons test table No.(5.26) show that the differences between " 6 months-1 year " ,and " 3 years and more " in favor of "6 months-1 year".

Table No. (5.25)

One way ANOVA test for difference in point of view up to the impact of deinstitutionalization of mental health services on recovery process among depressive patients in Gaza Strip due to **period of treatment**

Field	Source	Sum of Squares	df	Mean Square	F value	Sig.(P-Value)
The impact of deinstitutionalization of mental health services on recovery process among depressive patients in Gaza Strip	Between Groups	17.710	3	5.903	9.325	0.000
	Within Groups	73.434	116	0.633		
	Total	91.144	119			

Critical value of F at df "3,116" and significance level 0.05 equal 2.68

Table No. (5.26)
Scheffe Multiple Comparisons due to period of treatment

Period of treatment	3-6 months	6 months-1 year	1-3 years	3 years and more
3-6 months		-0.649	-0.325	0.443
6 months-1 year	0.649		0.324	1.092*
1-3 years	0.325	-0.324		0.768
3 years and more	-0.443	-1.092*	-0.768	

Are there significant differences about the impact of deinstitutionalization of mental health services on recovery process among depressive patients in Gaza Strip due to **Place for treatment** at significant level $\alpha = 0.05$?

To answer the question the researcher used the Independent Samples Test and the result illustrated in table no.(5.27) which show that the p-value equal 0.000 which is less than 0.05 and the absolute value of T test equal 15.703 which is greater than the value of critical value which is equal 1.98, that's means there are a statistical differences about the **impact of deinstitutionalization of mental health services on recovery process among depressive patients in Gaza Strip** due to Place for treatment at significant level $\alpha = 0.05$. And the difference in favor of Gaza governmental community mental health clinics.

Table No. (5.27)
Independent Samples Test for difference in point of view up the impact of deinstitutionalization of mental health services on recovery process among depressive patients in Gaza Strip due to **Place for treatment**

Field	Place for treatment	N	Mean	Std. Deviation	T	P-value
The impact of deinstitutionalization of mental health services on recovery process among depressive patients in Gaza Strip	**EL-Nasser psychiatric hospital**	40	2.144	0.626	-15.703	0.000
	Gaza governmental community mental health clinics	80	3.665	0.425		

Critical value of t at df "118" and significance level 0.05 equal 1.98

Chapter 6

Discussion, Conclusion and Recommendations

Chapter 6

6.1 Introduction:

This chapter introduced the main results that achieved in the previous one and its discussion on the light of the previous studies. Furthermore, it's important here to clarify the results and its relation with other studies that may be helpful in supporting our finding. However, the researcher will put on the hand some of implications and recommendations regarding to community based treatment "deinstitutionalization", recovery and hospital based treatment among depressive patients that are likely to be in consideration in the application of the future planning. Also, recommendations for further research will be provided on the basis of the results of the current study.

6.2 Analysis of the sample's characteristics:

According to the personal data of the sample, the researcher found that 13.3% from the sample ages"25-less than 30 years", and 36.7% from the sample ages "30-less than 40 years", and 50.0% from the sample ages "40 years or more", and that can be referred to different factors like increase of responsibilities, deterioration of general health, decrease of body abilities, increase size of family members and unemployment related to low level of health.

75.0% from the sample are "male", and 25.0% from the sample are "female", and that may returned to increase of responsibilities upon men, cultural factors that keep female not searching for mental health treatment, political issues that can affect on men more than women, and unemployment.

Address of the sample was distributed normally, and there is no any specified area in Gaza strip that have high level of depression.

11.7% from the sample are " Married ", and 70.0% from the sample are "Single ", and 6.7% from the sample are " Divorced ", and 11.7% from the sample are " Widowed ", the researcher found that high percentage of the cases are single persons, that can returned to lack of social relationships and responsibilities that keep them need less concentrated support and economical costs, cultural factors that keep stigma from mental illness and weak of strength mechanisms.

35.0 % from the sample the educational level are " Primary " , and 22.5% from the sample the educational level are " preparatory " , and 25.8% from the sample the educational level are " secondary " , and 16.7% from the sample the educational level are " university ", the researcher notified that depressive patients can be increased among persons with low level of education rather than high educational level, that can have appropriate defense mechanisms and more acceptance to mental illness with appropriate dealing.

54.2% from the sample the family income sources are "Social affairs", and 18.3% from the sample the family income sources are "person's work", and 11.7% from the sample the family income sources are "wife's work", and 2.5% from the sample the family income sources are "husband's work", and 1.7% from the sample

the family income sources are "son's work", and 11.7% from the sample the family income sources are "Ranching", 69.2% from the sample the value of monthly income are " Less than 500 NIS ", and 15.8 % from the sample the value of monthly income are " from 500-1000 NIS ", and 9.2% from the sample the value of monthly income are "from1000-1500 NIS", and 1.7% from the sample the value of monthly income are "from 1500-2000 NIS", and 2.5% from the sample the value of monthly income are "from 2000-2500 NIS", and 1.6% from the sample the value of monthly income are "more than 2500 NIS", that appeared to income level can affect on mental health, stability, ability to satisfy requirements of life's needs and provision of personal needs.

8.3% from the sample the period of treatment are " 3-6 months " , and 34.2% from the sample the period of treatment are "6 months-1 year", and 29.2 % from the sample the period of treatment are "1-3 years ", and 28.3% from the sample the period of treatment are "3 years and more ", in acute cases recovery can achieved more successfully.

6.3 Mental health recovery measure:

6.3.1 Hope:

For general the results for all items of the field show the following:

For EL-Nasser psychiatric hospital the average mean equal 2.35 and the weight mean equal 46.90 % , and for Gaza governmental community mental health clinics the average mean equal 3.94 and the weight mean equal 78.70 %, and the value of t test equal 12.833 which is greater than the critical value which is equal 1.98 and the p- value equal 0.000 which is less than 0.05, that means there is a difference on the opinion of the respondent about Hope at significant level $\alpha = 0.05$, and the differences in favor of Gaza governmental community mental health clinics.

6.3.2 Will and determination:

For general the results for all items of the field show the following:

For EL-Nasser psychiatric hospital the average mean equal 2.03 and the weight mean equal 40.50 % , and for Gaza governmental community mental health clinics the average mean equal 3.55 and the weight mean equal 71.0 %, and the value of t test equal 11.866 which is greater than the critical value which is equal 1.98 and the p- value equal 0.000 which is less than 0.05, that means there is a difference on the opinion of the respondent about Will and determination at significant level $\alpha = 0.05$ and the differences in favor of Gaza governmental community mental health clinics.

6.3.3 Feeling of value:

For general the results for all items of the field show the following:

For EL-Nasser psychiatric hospital the average mean equal 1.98 and the weight mean equal 39.50 %, and for Gaza governmental community mental health clinics the average mean equal 3.29 and the weight mean equal 65.85 %, and the value of t test equal 10.401 which is greater than the critical value which is equal 1.98 and the p- value equal 0.000 which is less than 0.05, that means there is a difference on the

opinion of the respondent about Feeling of value at significant level $\alpha = 0.05$ and the differences in favor of Gaza governmental community mental health clinics.

6.3.4 Safety and security:

For general the results for all items of the field show that the following:

For EL-Nasser psychiatric hospital the average mean equal 2.03 and the weight mean equal 40.50 % , and for Gaza governmental community mental health clinics the average mean equal 3.70 and the weight mean equal 74.05 %, and the value of t test equal 15.442 which is greater than the critical value which is equal 1.98 and the p- value equal 0.000 which is less than 0.05, that means there is a difference on the opinion of the respondent about Safety and security at significant level $\alpha = 0.05$ and the differences in favor of Gaza governmental community mental health clinics.

6.3.5 The positive approach:

For general the results for all items of the field show that the following:

For EL-Nasser psychiatric hospital the average mean equal 2.28 and the weight mean equal 45.5 % , and for Gaza governmental community mental health clinics the average mean equal 3.95 and the weight mean equal 78.95 %, and the value of t test equal 14.087 which is greater than the critical value which is equal 1.98 and the p- value equal 0.000 which is less than 0.05, that means there is a difference on the opinion of the respondent about The positive approach at significant level $\alpha = 0.05$ and the differences in favor of Gaza governmental community mental health clinics.

6.3.6 Self efficiency:

For general the results for all items of the field show that the following:

For EL-Nasser psychiatric hospital the average mean equal 2.22 and the weight mean equal 44.40 % , and for Gaza governmental community mental health clinics the average mean equal 3.56 and the weight mean equal 71.20 %, and the value of t test equal 13.647 which is greater than the critical value which is equal 1.98 and the p- value equal 0.000 which is less than 0.05, that means there is a difference on the opinion of the respondent about Self efficiency at significant level $\alpha = 0.05$ and the differences in favor of Gaza governmental community mental health clinics.

For all factors:

It appears in all items of mental health recovery measure there are significant differences on the opinion of the respondent about all fields of recovery scale at significant level $\alpha = 0.05$ and the differences in favor of Gaza governmental community mental health clinics.

6.4 Discussion:

For all fields of recovery scale the results are For EL-Nasser psychiatric hospital the average mean equal 2.14 and the weight mean equal 42.88 % , and for Gaza governmental community mental health clinics the average mean equal 3.66 and the weight mean equal 73.29%, and the value of t test equal 15.703 which is greater than the critical value which is equal 1.98 and the p- value equal 0.000 which is less than 0.05, that means there is difference on the opinion of the respondent about all fields of Recovery scale at significant level $\alpha = 0.05$ and the differences in favor of Gaza governmental community mental health clinics, and those results are congruent with the results of Jenny K. Hyun et.al. (2008) study that clarified that Although community service interventions did not have a statistically significant effect on the probability of hospitalization, the interventions were associated with significantly decreased probabilities of 30-day re-hospitalization and inpatient lengths-of-stay. This showed in conclusions that findings support the continuing policy initiative of building deinstitutionalized, community-based mental health systems in Eastern European countries.

The study of Angelo Barbato et.al. (2007), found that On the HoNOS, 33% of patients showed reliable change. On the SOFAS, 27% showed reliable change, although the change was substantial for few patients. Over time, patients showed moderate but significant improvements on the HoNOS and SOFAS. The HoNOS subscales concerning interpersonal relationships and social inclusion showed significant change. Very isolated people with mental illness gained some advantages from this rehabilitation program that was based on a close relationship with a key worker; however, the program duration may have been inadequate to produce substantial changes.

The study of Michael O'Rourke (2009), appeared that Results are indicative of significant group change across time, with small to medium effect sizes found (Cohen's *d*= .21 - .59). Results and conclusions: The present study not only provides further data supporting recovery in general, but details the specific process of recovery within the context of an evolving evidence-based practice (i.e., WMR). Implications for clinical practice as well as a change in mindset or philosophy when it comes to the treatment and conceptualization of those experiencing severe mental illness are discussed.

The study of John F. McCarthy et.al. (2009) showed that A total of 452 of the eligible patients (7%) received VA ACT services in FY 2004. In multivariate analyses, older age was associated with reduced odds of receiving ACT services (odds ratio [OR] =.92 per five years); being female (OR=1.86) and having schizophrenia (OR=1.64) were positively associated with ACT services initiation. Individuals living farther from ACT sites were less likely to receive ACT services (OR=.95 per ten miles). The marginal effects of distance were most substantial in the first 30 miles and beyond 100 miles. Most patients who were eligible for yet not already receiving VA ACT services went without these services in FY 2004. Geographic distance limited services initiation. Focused efforts are needed to enhance ACT services initiation and delivery, particularly for individuals in remote locations.

The study of Luana Passalacqua (2007), found that Quantitative findings indicated that there were no significant differences between consumers on Rosewood or ward 18 in relation to outcome measures. Qualitative findings supported these results.

The results of this study also agree with the results of Erica Dillon (2006) study that showed that The *externación* programs (Psychosocial Rehabilitation Center, Day Hospital, and Pre-Discharge House), are not projects designed from the health authorities or even from the Hospital authorities. They have been planned and implemented by health professionals, It would be needed is a higher politization of the deinstitutionalization movement to create more social conscience and acceptance of people with psychiatric conditions living as citizens and being able to share their psychiatric world with the outside one without stigma, making available for them to have a normal life in a wider conception of normality. What is important is not that ex-patients maintain themselves far from the institution, and avoid seeing other ex-patients; what is important is their construction of a new identity from where to relate with others not as passive powerless receptors but as persons with self-esteem, own projects, and determination that makes use of the institution instead of being managed by it. As the researcher see it, having a partner and being the partner of another person, no matter if he/she is a patient, expatient, or someone outside the psychiatric circle, gives patients and ex-patients a social role, a valued role difficult to find for many "normal" people, and it is a big step towards their recovery.

The study of Patrick W. Corrigan (2004) appeared that Data reported in this article include the RAS and measures of symptoms and psychosocial functioning. Participants completed the RAS (Giffort et al. 1995), a 41-item scale on which respondents described themselves using a five-point agreement scale (5 = strongly agree; 1 = strongly disagree). Sample items include "I have a desire to succeed" and "I can handle it if I get sick again." A previous study of the scale showed overall scores to have satisfactory reliability and validity (Corrigan at al. 1999). Results: Two analytic steps were completed to determine reliable factors that compose the RAS. First, an exploratory factor analysis (EFA) was completed on RAS items on a random half of the sample. The factor structure that emerged from this analysis was then cross-validated on the remaining half of the sample using confirmatory factor analysis (CFA).

The findings of the study of Sharon L. Young and David S. Ensing (2003), showed that although each recovery process follows its own unique path (Anthony, 1993), the results of this study indicated that there are some general aspects of recovery that typify the process for many consumers. The higher order categories which emerged from the data are that recovery is a process of 1) overcoming "stuckness," 2) discovering and fostering self-empowerment, 3) learning and self-redefinition, 4) returning to basic functioning, and 5) improving quality of life. For a more detailed overview of the recovery process as described by participants, that go with the findings of the study and support upon working on the recovery model for mentally ill patients.

The study of Aricca D. Van Citters and Stephen J. Bartels (2004) appeared that fourteen studies matched all the inclusion criteria. Two studies (one controlled prospective study and one study that used a comparison group) found support for the use of gatekeepers—nontraditional referral sources—in identifying socially isolated older adults with mental illness. Twelve studies (five randomized controlled trials,

one quasi-experimental study, and six uncontrolled cohort studies) found that home and community-based treatment of psychiatric symptoms were associated with improved or maintained psychiatric status. All randomized controlled trials reported improved depressive symptoms, and one reported improved overall psychiatric symptoms, which are going in agreement for the findings of the study.

The study of B Akpalu et.al. (2010) showed that Psychiatric hospitals in Ghana have a mean bed occupancy rate of 155%. Most respondents were of the view that the state psychiatric hospitals were very congested, substantially compromising quality of care. They also noted that the community psychiatric system was lacking human and material resources. Suggestions for addressing these difficulties included committing adequate resources to community psychiatric services, using psychiatric hospitals only as referral facilities, relapse prevention programmes, strengthening psychosocial services, adopting more precise diagnoses and the development of a policy on long-stay patients, and there is an urgent need to build a credible system of community-based care and improve the quality of care in psychiatric hospitals in Ghana, that going with the findings of the study on supporting and focusing attention on community based treatment.

The study of A Ofori-Atta et.al. (2010), clarified that there are shortfalls in the provision of mental health care including insufficient numbers of mental health professionals, aging infrastructure, widespread stigma, inadequate funding and an inequitable geographical distribution of services, and Community-based services need to be delivered in the primary care setting to provide accessible and humane mental health care. There is an urgent need for legislation reform, to improve mental health care delivery and protect human rights, that agree with the findings of the study on supporting and focusing attention on community based treatment.

The study of Ulla A Botha et. al. (2010), showed that at 12 month follow-up subjects receiving the assertive intervention had significantly lower total PANSS ($p = 0.02$) as well as positive ($p < 0.01$) and general psychopathology ($p = 0.01$) subscales' scores. The mean SOFAS score was also significantly higher ($p = 0.02$) and the mean number of psychiatric admissions significantly lower ($p < 0.01$) in the intervention group. Conclusion: The results indicate that assertive interventions in a developing setting where standard community mental services are often under resourced can produce significant outcomes. Furthermore, these interventions need not be as expensive and comprehensive as international, first-world models in order to reduce inpatient days, improve psychopathology and overall levels of functioning in patients with severe mental illness, Also, these results support the results of the study that there is need on working on community based treatment and reducing inpatient days, that will work on improving levels of functioning in patients with severe mental illness.

The study of Frederick W. Hickling et. al. (2011), appeared that Participant narratives showed that stigma had transitioned from negative to positive, from avoidance and fear of violent behavior during the period of deinstitutionalization to feelings of compassion and kindness as community mental health services were integrated with Jamaica's primary health care system. The Bellevue Mental Hospital and homelessness were identified as major causes of stigma, and Attitudes toward the mentally ill have improved and stigma has decreased since the increase of community involvement with the mentally ill. This reduction in stigma seems to be a result of the

rigorous deinstitutionalization process and the development of a robust community mental health service in Jamaica that showed congruency with the results by which through community based treatment level of stigma will be reduced and acceptance for treatment will be approved from the patients.

The study of Dmitri Bartenev et. al. (2005), performed comparative legal analytical study between hospital based treatment and community based treatment and focused attention on human rights standards for deinstitutionalization, showed that there is need t Promote culture of respect for human rights values in mental health care at all the levels: policymakers, mental health administrators, care providers, mental health professionals and A greater emphasis must be placed on equality of rights and the right to social inclusion. Establishing community-based services should be regarded as a priority in mental health care. A comprehensive action plan should be developed to promote deinstitutionalization of mental health care. Set up effective procedures for monitoring human rights and quality assessment in mental health care, these results of study go in agreement with the results of study on need for developing community based treatment and improvements.

The study of Y.J. Pijl and S. Sytema (2004) showed that the total proportion of discharges from hospital-based mental health care followed within 6 months by community-based care increased by 11% due to the improved availability of day treatment and home treatment. In terms of median survival time, aftercare in the years 1998/1999 was delivered more than twice as fast as in the years 1990/1991, these results support the results of study on keeping concentration on community based treatment and recovery model among mentally ill patients.

The study of Susan D. Phillips et. al.(2001), Research has shown that assertive community treatment model of program is effective in reducing hospitalization, is no more expensive than traditional care, and is more satisfactory to consumers and their families than standard care and Since the inception of assertive community treatment nearly 30 years ago, research has repeatedly demonstrated that it reduces hospitalization, increases housing stability, and improves the quality of life for those individuals with severe mental illness who experience the most intractable symptoms and experience the greatest impairment as a result of mental illness; This model of delivering integrated, community-based treatment, support, and rehabilitation services has been adapted to a variety of settings, circumstances, and populations, these findings agree with the results of the study on the effective of community based treatment and its effects on reducing hospitalization and its cost effectiveness.

The study of Edna Kamis-Gould et. al. (1999), found that Replacement of most inpatient services with residential and ambulatory services resulted in significant cost reduction. For project enrollees, a 94 percent reduction in state hospital services resulted in cost savings of more than $45 million during the three-year evaluation period. These savings more than offset the funds used to expand community services. Overall, the net savings to the system for mental health services for this group was $3.4 million over three years and the hospital closure and infusion of funds into community services produced desired growth of those services. The project reduced reliance on state psychiatric hospitalization and demonstrated that persons with serious mental illness can be effectively treated and maintained in the community, these results are going positively with the results of the study on the great benefits of community based treatment that can be achieved and recovery can be maintained.

The study of S. Naeem et. al. (2004), appeared that Poverty, unemployment, abuse and on going difficulties were perceived as risk factors for depression, A reliable social support system, positive thinking approach, faith, prayers, and experiencing a "turning point" event were reported as factors that promoted recovery from anxiety and/or depression and that Individual vulnerabilities, strengths and resources can have an important role in recovery from anxiety and/or depression in women, these results go in deep agreement for the reality of achieving recovery among depressive patients and supporting the results of the study and showing some factors that may enhance recovery and treatment.

The study of Barnett S. Meyers et. al. (2002), showed that Fifty (30.3%) of the 165 subjects met recovery criteria. Less than half of the subjects (45%) met criteria for adequate pharmacotherapy. Less severe depression, having received adequate antidepressant treatment, female sex, and being married independently predicted early recovery. In the more depressed subgroup, early recovery was associated with female sex. Among less severely depressed subjects, high personality dysfunction scores and being married were significant predictors and Initial depression severity and receiving adequate pharmacotherapy predict early recovery in individuals with major depression seeking outpatient treatment. A minority of persons receive intensive antidepressant treatment. Less severe personality dysfunction and being married predicts early recovery among persons with less severe depression, these findings are congruent with the research's results on ability for achieving recovery among depressive patients and acceptance for community based treatment are more preferable than hospital based treatment.

The study of Furukawa TA (2001) appeared that The Global Assessment Scale (GAS) ratings showed continuous amelioration from baseline to remission, remission to recovery, and after sustained recovery. The same trends were observed for the Social Adjustment Scale-Self Report (SAS-SR) scores, these results congruent with results in which recover model can be applicable for depressive patients and focusing on community based treatment.

The researcher used an independent samples t test to test if there is difference on the opinion of the respondent about all fields of Recovery scale For EL-Nasser psychiatric hospital the average mean equal 2.14 and the weight mean equal 42.88 % , and for Gaza governmental community mental health clinics the average mean equal 3.66 and the weight mean equal 73.29%, and the value of t test equal 15.703 which is greater than the critical value which is equal 1.98 and the p- value equal 0.000 which is less than 0.05, that means there were significant differences on the opinion of the respondent about all fields of Recovery scale at significant level $\alpha = 0.05$ and the differences in favor of Gaza governmental community mental health clinics.

The results of study appears that there were significant differences about the impact of deinstitutionalization of mental health services on recovery process among depressive patients in Gaza Strip due to (age, Gender, Address, Marital status, Education level, family income sources, value of monthly income, period of treatment, Place for treatment) at significant level $\alpha = 0.05$, which was as the following:

There were not statistical differences about the impact of deinstitutionalization of mental health services on recovery process among depressive patients in Gaza Strip due to age at significant level $\alpha = 0.05$, which means that recovery process from mental illness can be achieved at any point of age.

There were no differences about the impact of deinstitutionalization of mental health services on recovery process among depressive patients in Gaza Strip due to Gender at significant level $\alpha = 0.05$, which presents that male and female patients of depression have the ability to achieve recovery.

There were statistical differences about the impact of deinstitutionalization of mental health services on recovery process among depressive patients in Gaza Strip due to Marital status at significant level $\alpha = 0.05$, show that the differences between " Single ", and " Widowed " in favor of " Single ", which can be clarified because of lack of social interaction and support, that keep them weaker and need concentrated support.

There were no statistical differences about the impact of deinstitutionalization of mental health services on recovery process among depressive patients in Gaza Strip due to Educational level at significant level $\alpha = 0.05$.

There were not statistical differences about the impact of deinstitutionalization of mental health services on recovery process among depressive patients in Gaza Strip due to family income sources at significant level $\alpha = 0.05$.

There were not statistical differences about the impact of deinstitutionalization of mental health services on recovery process among depressive patients in Gaza Strip due to value of monthly income at significant level $\alpha = 0.05$.

There were statistical differences about the impact of deinstitutionalization of mental health services on recovery process among depressive patients in Gaza Strip due to period of treatment at significant level $\alpha = 0.05$, show that the differences between " 6 months-1 year ", and " 3 years and more " in favor of "6 months-1 year", that appears that more acute cases can be achieved recovery in early diagnosis with more optimal treatment methods.

There were statistical differences about the impact of deinstitutionalization of mental health services on recovery process among depressive patients in Gaza Strip due to Place for treatment at significant level $\alpha = 0.05$. And the difference in favor of Gaza governmental community mental health clinics, that show that community based treatment can achieve much better results for depressive patients that may return to many factors as, acceptance to community based treatment is more likable and preferable, less stigma can be noted than in hospital based treatment, more social interaction and communication than in hospital based treatment, away from social isolation and exclusion.

6.5 Conclusion:

Great findings of the study were appeared from the results as it highlights on concentrating our efforts on the following:

- Community based treatment achieve great level of recovery for depressive patients rather than hospital based treatment.
- In current study, some sociodemographic variables seems to be markedly affect on achieving recovery.
- The findings highlight the importance of community based treatment services with the use of new models of treatment.
- The findings show that acceptance to community based treatment is more likable and preferable; less stigma can be noted than in hospital based treatment.
- Community based treatment can enhance social interaction and communication more than hospital based treatment.

From the results of the study it appears that the recovery achievement by community based treatment can be much better gained with these services than hospital based treatment that may returned to many causes as acceptance for treatment in community based services is more preferable than hospital based treatment, stigma to hospital based treatment is greater than community based treatment services, and the results showed that patients undergoing treatment in hospital based treatment without continuous follow up in community based treatment will get remission and deteriorate in their mental health, so, it's important to focus our attention on community based treatment and reducing hospitalization for mentally ill patients and keep that for acute cases and aggressive patients who need closed observation for not raising there social problems like social isolation, ineffective communication, and social phobia. So, its necessary to develop community mental health services with using new models of treatment and concentrate attention on recovery model that will lead to good improvement in mental health, the researcher thinks that the present study is more comprehensive than the other studies on the review section as it covers and measures the effects of community based treatment on recovery process.

6.6 Limitations of the study:

There are a number of limitations are predicted to apply the study:

Difficulty finding literature reviews talking on the same topic in local, Arab countries and even in the Middle East.

No availability of documented statistics in mental health system about incidence and prevalence of mentally ill patients.

Continuous cutting off electricity affects the readiness of the research.

Little journals and books are available about mental health in Gaza Strip.

No availability of suitable places in community mental health clinics for doing interviews with the patients.

Applying on non probability sample.

6.7 Recommendations:

Practical recommendations:

- It's important to focus our attention on mental health care provided for those patients, to relieve their suffering and make better health care provision for them.

- Developing community based treatment models under professional framework.

- Providing training courses for mental health care provided related to community based rearmament modalities.

- Good coordination between hospitals and community based treatment centers.

- General health education about mental illnesses.

- Well- established community based treatment centers.

- Providing of community based treatment centers with multidisciplinary team with cooperative and coordinated work.

- Increasing number of qualified personnel and experts.

- Encouraging wide range of physical, rehabilitative, social and psychiatric services.

Researchable recommendations:

- Future evaluation research should take into account limitations of the current research when evaluating services to determine if mainstreaming services results in improved care, adherence to the recovery model.

- Additional, more robust research is required to support the present findings.

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Annexes

Annex 1
Participation letter

This Questionnaire aims to collect necessary data for the research about:

"Effects of deinstitutionalization of mental health services on recovery among depressive patients in Gaza Governorates."

Seeking your generous cooperation in filling up this Questionnaire which is a part of my research study of master degree in community mental health, nursing science.

your opinion would be very effective towards this successful study which will enhance community mental health services.

The Questionnaire contains five choices of answers (strongly agree, agree, not sure, disagree, strongly disagree). So please try to choose the accurate one. If you accept to join this study, you have the right to withdraw from the study at any time.

However: your answers will be respected and confidentiality will be taken in consideration, as it will be used for the study purposes only. You don't have to write your name.

The researcher clarifies the following:

(Recovery scale):

- The questions from 1-7 are the information and personal data, in the opposite of each question there are five choices to choose from, put (x) in the appropriate square. And the recovery scale divides into six domains:
- Hope. Questions from 1-5.
- Will and determination. Questions from 6-10.
- Feeling of value. Questions from 11-15.
- Safety and security. Questions from 16-20.
- The positive approach. Questions from 21-25.
- Self efficiency. Questions from 26-30.

Thanks for your participation

Annex 2
Questionnaire

Date: / / 2012. Number----------
(For the researcher only)

Personal information:

Please put (x) in the appropriate square:

7- Age: ----------years.

8- Gender: ☐ male ☐ female

9- Address:
☐ Northern governorate ☐ Gaza governorate ☐ Mid-area governorate
☐ Khanyounis governorate ☐ Rafah governorate

10- Marital status:
☐ Married ☐ Single ☐ Divorced ☐ Widowed

11- Education level:
☐ Primary ☐ preparatory ☐ secondary ☐ university

12- Economic level
A- family income sources:

☐ Social affairs ☐ person's work ☐ wife's work ☐ husband's work
☐ son's work ☐ agricultural land ☐ Ranching ☐ another work.

B- value of monthly income:

☐ Less than 500 NIS ☐ from 500-1000 NIS ☐ from1000-1500 NIS
☐ from 1500-2000 NIS ☐ from 2000-2500 NIS ☐ more than 2500 NIS

7- History of psychiatric disease:
A- period of treatment and follow up from:
☐ 3-6 months ☐ 6 months-1 year ☐ 1-3 years ☐ 3 years and more.

B- Place for treatment and follow up:
☐ Psychiatric hospital. ☐ Governmental community mental health clinic

☐ Other private institutions ☐ psychiatric hospital and governmental community mental health clinic.

Nu	Statement	Strongly agree	Agree	Not sure	Disagree	Strongly disagree
	Hope					
1	I work hard towards my mental health recovery.					
2	Even though there are hard days, things are improving for me.					
3	I ask for help when I am not feeling well.					
4	I take risks to move forward with my recovery.					
5	I believe in myself.					
	Will and determination					
6	I have control over my mental health problems.					
7	I am in control of my life.					
8	I socialize and make friends.					
9	Every day is a new opportunity for learning.					
10	I still grow and change in positive ways despite my mental health problems.					
	Feeling of value					
11	Even though I may still have problems, I value myself as a person of worth.					
12	I understand myself and have a good sense of who I am.					
13	I eat nutritious meals everyday.					
14	I go out and participate in enjoyable activities every week.					
15	I make the effort to get to know other people.					

Nu	Statement	Strongly agree	Agree	Not sure	Disagree	Strongly disagree
	Safety and security					
16	I am comfortable with my use of prescribed medications.					
17	I feel good about myself.					
18	The way I think about things helps me to achieve my goals.					
19	My life is pretty normal.					
20	I feel at peace with myself.					
	The positive approach					
21	I maintain a positive attitude for weeks at a time.					
22	My quality of life will get better in the future.					
23	Every day that I get up, I do something productive.					
24	I am making progress towards my goals.					
25	When I am feeling low, my religious faith or spirituality helps me feel better.					
	Self efficiency					
26	My religious faith or spirituality supports my recovery.					
27	I advocate for the rights of myself and others with mental health problems.					
28	I engage or I work other activities that enrich myself and the world around me.					
29	I cope effectively with stigma associated with having a mental health problem.					
30	I have enough money to spend on extra things or activities that enrich my life.					

Thank you for completing this measure

Annex 3
Participation letter in Arabic

بسم الله الرحمن الرحيم

تهدف هده الإستبانة إلي جمع البيانات اللازمة لدراسة حول **مقياس التعافي بين مرضى الاكتئاب في محافظات غزة.**

أرجو التكرم بالتعاون في تعبئة هده الاستبانة والتي هي جزء من دراستي للحصول علي درجة الماجستير في الصحة النفسية المجتمعية–علوم التمريض.

كما سيكون لأرائكم بالغ الأثر في نجاح هده الدراسة وما يترتب عليها من تحسين في خدمات الصحة النفسية المجتمعية .

الإستبانة تحتوي علي خمسة خيارات للإجابة فحاول اختيار مدي التعافي الذي يصف شعورك بدقة، إذا وافقت علي المشاركة في البحث فيبقي لك الحق في الانسحاب من البحث متي شئت، علما بأن إجابتك ستحترم وستعامل بسرية تامة، وستستخدم لأغراض البحث العلمي فقط، ولا داعي لذكر اسمك.

شكرا لتعاونكم

الباحث/ باسم محمد بكير.

يشكر لكم الباحث موافقتكم على المشاركة ويود أن يوضح ما يلي:-

(إستبانة التعافي)

- الأسئلة من ١-٧هي المعلومات و البيانات الشخصية، يتم الإجابة بوضع علامة (×) في المربع المناسب.
- الأسئلة من ١-١٠صممت للتعر ف عليأمل وا إرادة المريض وعزيمته في التعافي من المرض النفسي، يوجد مقابل كل سؤال خمس خيارات يتم وضع العلامة في المربع المناسب.
- الأسئلة من ١١-٢٠ صممت للتعرف على مدى شعور المريض بقيمته ومدى الأمن والطمأنينة لديه، حيث يوجد مقابل كل سؤال خمس خيارات يتم وضع العلامة في المربع المناسب.
- الأسئلة من ٢١-٣٠ صممت للتعرف على توجه المريض وكفاءته الذاتية، حيث يوجد مقابل كل سؤال خمس خيارات يتم وضع العلامة في المربع المناسب.

شكرا لكم على المشاركة

Annex 4
الاستبانة باللغة العربية

الباحث/ باسم محمد بكير.

التاريخ: / / ٢٠١٢ الرقم ----------

(خاص بالباحث)

البيانات الشخصية

من فضلك ضع علامة (×) في المربع المناسب لك.

١-العمر.....سنة.

٢-الجنس: ☐ ذكر ☐ أنثى.

٣-العنوان

☐ محافظة الشمال ☐ محافظة غزة ☐ محافظة الوسطى ☐ محافظة خان يونس ☐ محافظة رفح.

٤-الحالة الاجتماعية:

☐ أعزب/ آنسة ☐ متزوج/ ة ☐ أرمل/ ة ☐ مطلق/ ة.

٥- المستوى التعليمي:

☐ ابتدائي ☐ إعدادي ☐ ثانوي ☐ جامعي.

٦- المستوى الاقتصادي:

أ. مصادر دخل الأسرة:

☐ . شئون اجتماعية ☐ عمل الشخص نفسه ☐ عمل الزوج/ ة ☐ عمل الأولاد ☐ أراضي زراعية

☐ تربية المواشي والأغنام ☐ أعمال أخرى.

ب. قيمة الدخل الشهري:

☐ اقل من ٥٠٠ شيقل ☐ من ٥٠٠-١٠٠٠شيقل ☐ من ١٠٠٠-١٥٠٠شيقل ☐ من ١٥٠٠-٢٠٠٠ شيقل ☐ من ٢٠٠٠-٢٥٠٠ شيقل ☐ أكثر من ٢٥٠٠ شيقل.

٧- التاريخ المرضي:

أ.فترة العلاج والمتابعة من:

☐ ٣-٦شهور ☐ ٦شهور-١سنة ☐ ١-٣سنوات ☐ ٣سنوات فأكثر.

ب- مكان تلقي العلاج والمتابعة:

☐ مستشفى الطب النفسي ☐ عيادة الصحة النفسية والمجتمعية الحكومية.

☐ مؤسسات خاصة ☐ مستشفى الطب النفسي وعيادة الصحة النفسية والمجتمعية الحكومية.

استبانه التعافي:ويعرف إجرائياً بأنه الاستشفاء من المرض وأعراضه والتي يصاب بها الفرد، ويتضمن أمله ونظرته للمستقبل، ثم عزمه وا ٍرادته في قراراته المتعلقة بعقله وسلوكه وانفعاله، ثم شعوره بقيمة ذاته وقيمة شخصه وما يملك من إمكانات وقدرات ويقاس التعافي بالدرجة الكلية للمقياس المعد لذلك.

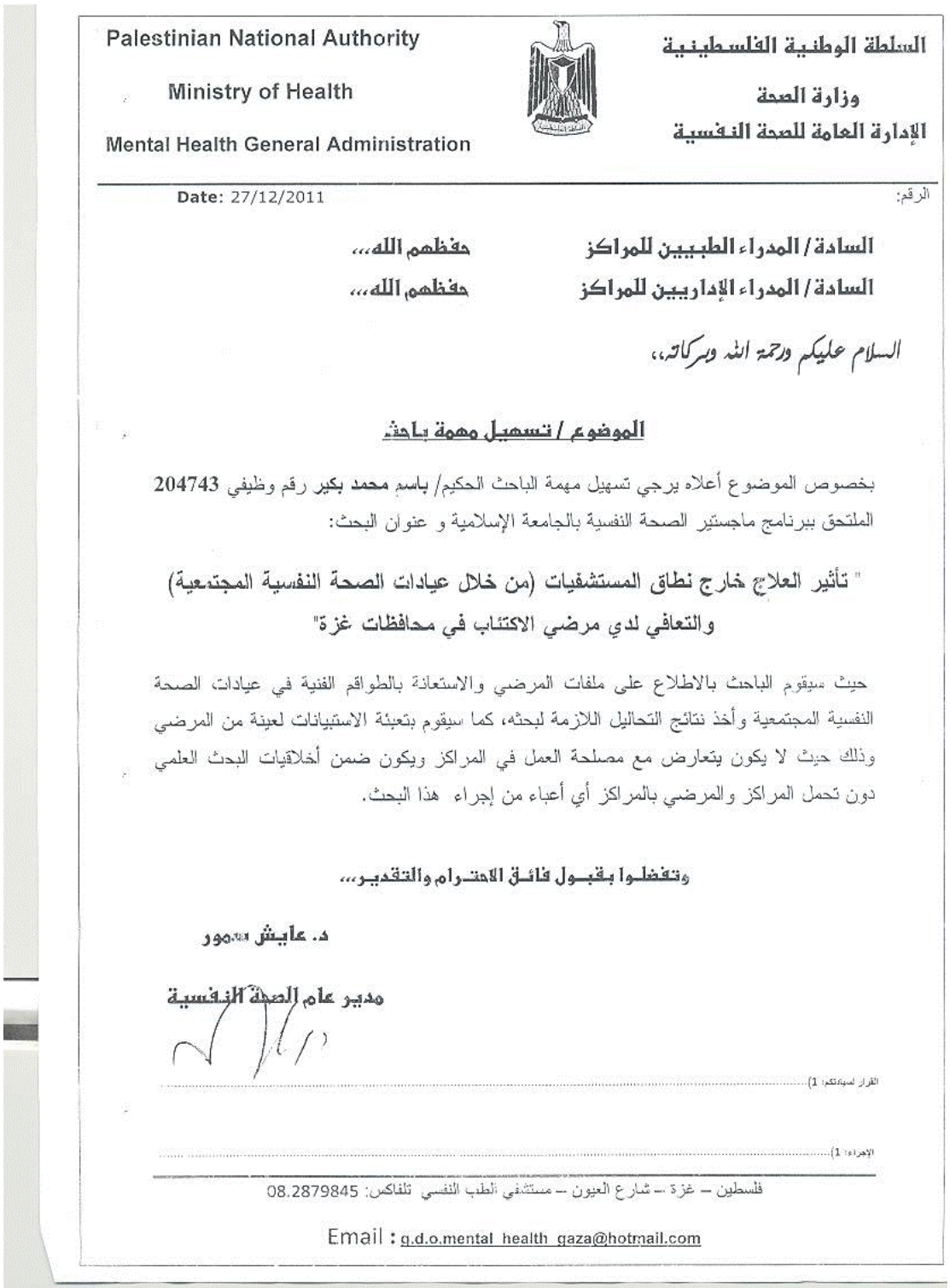
الرقم	العبارة	موافق بشدة	موافق	لا أعرف	غير موافق	غير موافق بشدة
	الأمل					
١	آمل أن أعمل بجد من أجل الوصول لعملية التعافي من ناحية الصحة النفسية.					
٢	على الرغم من وجود أيام صعبة، ولكن الأمور تتحسن.					
٣	أطلب المساعدة من الآخرين عندما تسوء حالتي النفسية.					
٤	أتمنى مواجهة الصعاب من أجل المضي في عملية التعافي.					
٥	أنا أثق بنفسي.					
	الإرادة والعزيمة					
٦	لدي القدرة للتحكم بمشاكلي النفسية.					
٧	أنا مسيطر على أمور حياتي.					
٨	أنا اجتماعي ولدي القدرة على كسب الأصدقاء.					
٩	كل يوم يمر يعتبر فرصة جديدة للتعلم.					
١٠	مازلت أتكيف وأتغير بشكل ايجابي على الرغم من مشاكلي النفسية.					
	الشعور بالقيمة					
١١	على الرغم من أنه مازال لدي مشاكل نفسية، لكني أقدر نفسي كشخص ذي قيمة.					
١٢	استطيع فهم نفسي ولدي إحساس جيد بمن أكون.					
١٣	أتناول وجبات مغذية ومفيدة كل يوم.					
١٤	أخرج من البيت وأمارس بعض النشاطات الممتعة كل أسبوع.					
١٥	كسب الناس ومعرفتهم ذو قيمة عندي.					

اقلب الصفحة

الرقم	العبارة	موافق بشدة	موافق	لا أعرف	غير موافق	غير موافق بشدة
	الأمن والطمأنينة					
١٦	أشعر بأني مرتاح مع استخدامي للعلاج الموصوف.					
١٧	أنا أشعر بشكل جيد.					
١٨	الطريقة التي أفكر بها عن الأشياء من حولي تساعدني في تحقيق أهدافي.					
١٩	حياتي جميلة وطبيعية.					
٢٠	أشعر بسلام مع نفسي.					
	التوجه الإيجابي					
٢١	أحافظ على توجهات إيجابية للأسابيع المقبلة في وقت ما.					
٢٢	جودتي في الحياة ستكون أفضل في المستقبل.					
٢٣	كل يوم استيقظ فيه من النوم، أفعل شيئاً ايجابياً .					
٢٤	نظرتي إيجابية نحو تحقيق أهدافي.					
٢٥	عندما تسوء حالتي، معتقداتي الدينية وإيماني يجعلاني أشعر بشكل أفضل.					
	الكفاءة الذاتية					
٢٦	إيماني ومعتقداتي الدينية تدعمان عملية التعافي.					
٢٧	أدافع عن حقوقي الشخصية وحقوق الأشخاص الآخرين الذين لديهم مشاكل نفسية.					
٢٨	أشارك وأعمل نشاطات أخرى تنفعني وتنفع العالم من حولي.					
٢٩	أتعامل بكفاءة وفاعلية مع وصمة المرض.					
٣٠	لدي مال كاف لكي أنفقه على أشياء أخرى إضافية ونشاطات في حياتي.					

تمت بحمد الله.

Annex 5
Permission letter



Palestinian National Authority
Ministry of Health
Mental Health General Administration

السلطة الوطنية الفلسطينية
وزارة الصحة
الإدارة العامة للصحة النفسية

Date: 27/12/2011 الرقم:

السادة / المدراء الطبيين للمراكز حفظهم الله،،،
السادة / المدراء الإداريين للمراكز حفظهم الله،،،

السلام عليكم ورحمة الله وبركاته،،

الموضوع / تسهيل مهمة باحث

بخصوص الموضوع أعلاه يرجي تسهيل مهمة الباحث الحكيم/ **باسم محمد بكير** رقم وظيفي **204743** الملتحق ببرنامج ماجستير الصحة النفسية بالجامعة الإسلامية و عنوان البحث:

" تأثير العلاج خارج نطاق المستشفيات (من خلال عيادات الصحة النفسية المجتمعية) والتعافي لدي مرضي الاكتئاب في محافظات غزة"

حيث سيقوم الباحث بالاطلاع على ملفات المرضي والاستعانة بالطواقم الفنية في عيادات الصحة النفسية المجتمعية وأخذ نتائج التحاليل اللازمة لبحثه، كما سيقوم بتعبئة الاستبيانات لعينة من المرضي وذلك حيث لا يكون يتعارض مع مصلحة العمل في المراكز ويكون ضمن أخلاقيات البحث العلمي دون تحمل المراكز والمرضي بالمراكز أي أعباء من إجراء هذا البحث.

وتفضلوا بقبول فائق الاحترام والتقدير،،،

د. عايش نمور

مدير عام الصحة النفسية

القرار لسيادتكم: 1)

الإجراء: 1)

فلسطين – غزة – شارع العيون – مستشفي الطب النفسي تلفاكس: 08.2879845

Email : g.d.o.mental_health_gaza@hotmail.com

Annex 6

List of arbitrators:

1- Ayesh Samour. General Director of Mental Health.

2- Abed El-karim Radwan. Dean of Nursing College.

3- Hikmy El-roomy. Psychiatrist M.O.H.

4- Habib El-Hawajry. Chief of Psychologists.

5- Nabil Dokhan. Dr. in Education Faculty at IUGAZA.

Annex 7
Location Map of the Gaza