Self-determination in the context of personal recovery from mental illness: Exploration of a therapeutic recreation experience termed Recovery Camp

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Self-determination in the context of personal recovery from mental illness: Exploration of a therapeutic recreation experience termed Recovery Camp

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Abstract

**Background:** Self-determination has arisen as an area of importance in mental health care, as people with a mental illness report significantly low levels of this construct. Self-determination has been associated with positive health behaviours and personal recovery. As 1 in 4 people will experience a mental illness in their lifetime, it is crucial to explore methods of enhancing self-determination for people living with mental illness, and how this links to personal recovery.

**Methods:** Twenty-nine people with a lived experience of mental illness who attended a five-day therapeutic recreation initiative called Recovery Camp completed two self-report, Likert-scale questionnaires, measuring components of self-determination. Responses were collected pre-camp, post-camp, and at three-month follow-up, and were compared to a group of 26 people with a lived experience of mental illness who went about their lives ‘as usual.’ Fifteen Recovery Camp participants also participated in semi-structured interviews, exploring self-determination and personal recovery in the context of Recovery Camp. Member checking was conducted via a focus group of six participants.

**Findings:** Participants who attended Recovery Camp reported a statistically significant increase in autonomy, relatedness, perceived choice, and awareness of self post-camp, however the increase in autonomy was not maintained at three-month follow-up. Moreover, competence did not show significant change over time for either the Recovery Camp or comparison group. Analysis of interview and focus group findings using van Kaam’s psychophenomenological method of analysis explored self-determination and personal recovery in the context of Recovery Camp, and revealed key themes such as autonomy, competence, relatedness, confidence, and purpose. The most significant finding of the present
study, was the importance of relatedness for the personal recovery journey. Concepts of connectedness and relatedness were apparent across both interview and survey findings.

**Conclusion and implications for practice:** These findings underscore how participation in therapeutic recreation experiences such as Recovery Camp can foster the development of certain key components of self-determination among people living with a broad range of mental illnesses. Given the importance of self-determination to the personal recovery journey, it is important to consider therapeutic recreation for all individuals experiencing mental illness, across all mental health care contexts. Fostering social connection and relatedness should be at the forefront of any treatment or therapeutic approach for people living with mental illness.
Declaration of Originality

I, Ellie Karen Taylor, declare that this thesis submitted in fulfilment of the requirements for the award of Doctor of Philosophy, at the University of Wollongong, is wholly my own work unless otherwise referenced or acknowledged. This document has not been submitted for qualifications at any other academic institution.

Ellie Karen Taylor

12 July 2018
Dedication

This body of work is dedicated to my late grandfather, Kenneth James Evans – affectionately known as Poppy. Poppy instilled in me a passion to help others, and the courage to persevere, no matter the circumstances.

This is for you, Poppy.

“The most beautiful people we have known are those who have known defeat, known suffering, known struggle, known loss, and have found their way out of the depths. These persons have an appreciation, a sensitivity, and an understanding of life that fills them with compassion, gentleness, and a deep loving concern. Beautiful people do not just happen.”

Elisabeth Kübler-Ross
Acknowledgements

This thesis marks the end of my PhD journey. This journey was not travelled alone, but with the support of family, friends, supervisors, and colleagues. I would be remiss not to express my utmost appreciation, as this would not have been possible without them.

First and foremost, to my husband, Jeremy, you have been my rock and confidant every step of the way. When I thought it wasn’t possible, you motivated me to keep going. Your belief in me never wavered.

To my mum, and siblings, Aimee, Brittany, Geordie, and Jaimie, thank you for understanding my long absences spent in front of a computer busily writing. I so appreciate your ability to bring me back to reality and make me laugh.

To Ma and Poppy, though you are gone, you instilled in me morals and values that still guide me to this day. I can never thank you enough. You made me the person I am today.

To my great uncle, Terry, you make me believe anything is possible. Your support means more than I can convey in words.

To the people who took part in the study, you have truly left an imprint on my heart. I will always remember your stories, and I am forever grateful for your willingness to share them with me. Thank you for your openness and strength.

To my wonderful friends; you know you are. Thank you for cheering me on and always being there to lend an ear and an escape.

To my primary supervisor, Professor Lorna Moxham, thank you for encouraging me to undertake this PhD. I feel it has been an invaluable learning opportunity and I’m sincerely thankful for your support along the way. I’m certain that what I have learnt from you will stay with me for the rest of my career.
To my co-supervisor, Dr Dana Perlman, thank you for your enthusiasm and willingness to help. You have taught me a great deal, and your sense of humour has ensured that the process was never taken too seriously, and never became too overwhelming.

To those who I had the pleasure to work alongside on the Recovery Camp project (Renee, Caroline, Chris, Shawn, Anita, Stewart, Luke, Bridget, Kate, Rowena, and all the staff at YMCA Camp Yarramundi), it’s inspiring to see the impact you’re having on students and people living with mental illness. I admire your drive and I so appreciate your advice and pep talks.

Last but in no ways least, this thesis would not exist without the encouragement of the Global Challenges team at the University of Wollongong. You have instilled in me an appreciation for interdisciplinary research, and the importance of thinking outside the box to solve complex issues. Further, I would like to express my sincere thanks to the Faculty of Science, Medicine, and Health at the University of Wollongong for funding my attendance at the IAFOR Asian Conference on Psychology and the Behavioural Sciences in Kobe, Japan, where I was fortunate to present my research to an international audience in March 2018.
Publications and Presentations Arising from this Research

**Manuscripts**


**Presentations**


# Table of Contents

## Contents

Abstract

Declaration of Originality

Dedication

Acknowledgements

Publications and Presentations Arising from this Research

List of Figures

List of Tables

Glossary of Key Terms

Conventions used throughout this thesis

### CHAPTER ONE

Introduction

Research purpose and aims

Research questions

Rationale

Organisation of the thesis

Style and language

Chapter summary

### CHAPTER TWO

Background and Context

Introduction

The role of the researcher

Ontology and epistemology

*Section one: An overview of mental illness in adult populations*

Mental illness

Global impact of mental illness

Mental illness in the Australian context

Diagnosis of mental illness

Contributing factors

Impact on physical health

Social impact

The emergence of the consumer movement
CHAPTER THREE

Research Design ............................................................................................................. 53

Introduction ...................................................................................................................... 53

Research aims .................................................................................................................. 53

Section one: Methodology ............................................................................................... 54

Approach – mixed methods ............................................................................................. 54

Qualitative methodological approach ............................................................................ 55

Stages of data collection ................................................................................................. 57

Rationale for choice of methodology .............................................................................. 58

Section two: Methods ........................................................................................................ 59

Ethical considerations ....................................................................................................... 59

Recruitment ....................................................................................................................... 60

Data collection measures ................................................................................................. 62

Self-Determination Scale ............................................................................................... 62

Basic Need Satisfaction in Life Scale – Short Form ....................................................... 63

Interviews ......................................................................................................................... 64

Focus Group ..................................................................................................................... 66

Participants ....................................................................................................................... 67

Procedures ....................................................................................................................... 70

Data Analysis .................................................................................................................... 70
CHAPTER FOUR

Findings

Introduction

Section One: Quantitative Findings

Basic Need Satisfaction in Life Scale – Short Version

Self-Determination Scale

Section Two: Qualitative Findings

Self-determination

Connecting with and helping others (relatedness)

Making choices independently (autonomy)

‘Having a go’ and feeling successful (competence)

Confidence

Overcoming fear and stigma

Acceptance and balance

Purpose

Growth

Hope for the future

Chapter summary

CHAPTER FIVE

Discussion

Introduction

Section One: Quantitative Findings

Basic Need Satisfaction in Life Scale – Short form findings

Relatedness

Autonomy

Competence

Self-Determination Scale findings

Awareness of self
Section One: Understanding Perceived Choice

Perceived choice ................................................................................................. 107

Section Two: Qualitative Findings.......................................................................... 110

Self-determination .................................................................................................. 111
  Connecting with and helping others (relatedness) ........................................... 111
  Making choices independently (autonomy) .................................................. 115
  Having a go and feeling successful (competence) ........................................ 117

Confidence ............................................................................................................... 119
  Overcoming fear ............................................................................................... 119
  Overcoming stigma ......................................................................................... 122
  Acceptance ....................................................................................................... 124
  Balance ............................................................................................................. 125

Purpose .................................................................................................................... 127
  Growth ............................................................................................................... 128
  Hope for the future ............................................................................................ 129

Section Three: An Overarching Discussion of Findings....................................... 132

Chapter summary ................................................................................................. 139

CHAPTER SIX ........................................................................................................ 140

Conclusion ............................................................................................................. 140
  Key points ......................................................................................................... 141
  Contribution to knowledge ............................................................................... 142
  Implications and recommendations for further research ............................. 143
  Limitations ........................................................................................................ 145
  Personal reflection ............................................................................................. 147

REFERENCES ....................................................................................................... 151

APPENDIX 1: Recovery Camp Program May 2016 .............................................. 182

APPENDIX 2: Ethics Approval ................................................................................ 183

APPENDIX 3: Participant Information Sheets – Surveys & Interviews ................ 185

APPENDIX 4: Self-determination Questions to Guide Interviews ...................... 190

APPENDIX 5: Recovery Questions to Guide Interviews ....................................... 191

APPENDIX 6: Flyer .................................................................................................. 192
List of Figures

Figure 1. The five stages of personal recovery and their characteristics ................................................. 27
Figure 2. Glover (2012)'s Self Righting Star® .............................................................................................. 29
Figure 3. Department of Health (2013) requirements for recovery-oriented services (p. 17) .............. 35
Figure 4. The Self-Determination Continuum, adapted from Ryan & Deci (2000) .............................. 39
Figure 5. The Illawarra-Shoalhaven Region of New South Wales, Australia ......................................... 68
Figure 6. Structures and elements derived from interviews and focus groups using van Kaam’s (1969) psychophenomenological method of analysis ................................................................. 82
Figure 7. The structure of self-determination and its corresponding elements .......................................... 111
Figure 8. The structure of confidence and its corresponding elements ...................................................... 119
Figure 9. The structure of purpose and its corresponding elements ............................................................ 127
Figure 10. The convergence (social connection) of Glover’s (2012) concept of connectedness, Iwasaki et al.’s (2018) concept of a connected life, and the Self-Determination Theory (Deci & Ryan, 1985) need of relatedness .............................................................................................................. 137
List of Tables

Table 1. Recovery-oriented practice guideline themes: prevalence within international documents .................................................................................................................. 34
Table 2. Summary of Recovery Camp consumer-focused research .................................................. 50
Table 3. Demographics for the Recovery Camp and Comparison groups .................................. 68
Table 4. van Kaam’s (1969) psychophenomenological method of analysis stages and steps as they relate to the present study ........................................................................ 71
Table 5. Basic Need Satisfaction in Life - Short Form subscale responses for Recovery Camp and comparison groups .......................................................................................................................... 76
Table 6. Significance of between-group differences for Basic Need Satisfaction in Life - Short Form subscale responses .......................................................................................................................... 77
Table 7. Bonferroni pairwise comparisons for Basic Need Satisfaction in Life – Short Form subscale responses .......................................................................................................................... 78
Table 8. Self-Determination Scale subscale responses for Recovery Camp and comparison groups ........................................................................................................................................ 79
Table 9. Significance of between-group differences for Self-Determination Scale subscale responses .......................................................................................................................... 80
Table 10. Bonferroni pairwise comparisons for Self-Determination Scale subscale and total responses ........................................................................................................................................ 81
Table 11. Deci & Ryan's (1985) three key needs of Self-Determination Theory .................. 133
Table 12. Iwasaki et al.’s (2018) key elements of meaningful engagement with life, as influenced by engagement in leisure pursuits .................................................................................. 133
Table 13. Glover’s (2012) Self Righting Star® of Recovery polarities and descriptions .... 133
# Glossary of Key Terms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Term</th>
<th>Definition</th>
</tr>
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<tbody>
<tr>
<td>ANCOVA</td>
<td>Analysis of Covariance</td>
<td>Method of statistical analysis which evaluates treatment effect, while statistically controlling for the effects of another variable or other variables that are not of primary interest.</td>
</tr>
<tr>
<td>APA</td>
<td>American Psychiatric Association</td>
<td>The primary professional organisation of psychiatrists in the United States.</td>
</tr>
<tr>
<td>BNSL-S</td>
<td>Basic Need Satisfaction in Life Scale – Short Form</td>
<td>A Likert-scale, self-report questionnaire measuring the three key needs of Self-Determination Theory: autonomy, competence, and relatedness.</td>
</tr>
<tr>
<td>CAPIC</td>
<td>Campaign Against Psychiatric Injustice and Coercion</td>
<td>Australia’s first consumer organisation, developed by consumers who were treated poorly in Victoria’s mental health facilities.</td>
</tr>
<tr>
<td>DSM</td>
<td>Diagnostic and Statistical Manual</td>
<td>The handbook used by health care professionals, across many countries, to guide the diagnosis of mental illness.</td>
</tr>
<tr>
<td>ICD</td>
<td>International Classification of Diseases</td>
<td>The international standard diagnostic classification system for health management and clinical purposes, maintained by the World Health Organisation.</td>
</tr>
<tr>
<td>NCAG</td>
<td>National Community Advisory Group</td>
<td>A group that arose out of the First National Mental Health Strategy report and advocated for consumer rights.</td>
</tr>
<tr>
<td>SDT</td>
<td>Self-Determination Theory</td>
<td>A macro theory of human motivation and personality, developed by psychologists’ Ryan and Deci.</td>
</tr>
<tr>
<td>TR</td>
<td>Therapeutic Recreation</td>
<td>A therapeutic modality which utilises various interventions designed to challenge, remediate, and foster a sense of control, in pursuit of greater health and wellbeing.</td>
</tr>
<tr>
<td>YMCA</td>
<td>Young Men’s Christian Association</td>
<td>A welfare movement with branches all over the world.</td>
</tr>
</tbody>
</table>
Conventions used throughout this thesis

The following conventions are used in this thesis:

- $P = \text{participant}$
- *italic text* represents direct quotes from texts
- **bold italic text** represents direct quotations from study participants
- ‘single quotation marks’ are used for added emphasis

Throughout this thesis, I – the researcher – am referred to in the first person. When my viewpoint is being presented, the use of ‘I’ or ‘my’ will precede said viewpoint. Throughout this thesis, people with a lived experience of mental illness are referred to as ‘consumers.’ The term ‘mental illness’ in the present study is intended as an overarching term representing serious and enduring mental illness.
CHAPTER ONE

Introduction

This thesis offers an in-depth exploration of the experience of self-determination and personal recovery among people living with serious and enduring mental illness (consumers). These concepts were explored in the context of a therapeutic recreation (TR) initiative, termed Recovery Camp, where people living with mental illness were offered various opportunities to maximise self-determined behaviours. Consumers’ perspectives were at the forefront of this study, and their voices are privileged as the experts in this area. This is important as consumers are a group that have dealt with significant marginalisation and discrimination, and have rarely been offered the opportunity for their voices to be heard (Wahl, 2012).

The concept of recovery from mental illness has arisen time and again throughout my studies and my time working with people who have a lived experience of mental illness. It sparked my interest and encouraged me to delve deeper into different variations on the term, ‘recovery.’ I was surprised that there still appears to be some tensions around this term, despite the recovery-oriented approach being put forth as the gold standard for mental health care (Pinches, 2014). The more I read, the more I realised the concept of personal recovery was not as well understood within the sphere of mental health, compared to other forms of health care where clinical recovery – or a complete amelioration of symptoms – appeared to be the gold standard.

I wanted to better understand the concept of personal recovery from the perspective of those with lived experience. Consumers are the experts in the area of personal recovery and I
believe they should be treated as such. Further, I believe it was – and continues to be – important to understand how to best support their journey of personal recovery. In my reading, across the literature as well as policies and guidelines, the concept of self-determination arose. Self-determination can be defined as the propensity of an individual to act in a “self-directed, self-regulated, autonomous” way (Field, Martin, Miller, Ward, & Wehmeyer, 1998, p. 2), and will be discussed in-depth in Chapter Two.

The concept of self-determination may be influential in the personal recovery journey, in that recovery-oriented care typically addresses the basic needs espoused by Self-Determination Theory (Deci & Ryan, 1985; Mancini, 2008). Yet, I am not aware of any studies that have examined the two concepts concurrently among people living with mental illness. I was left wondering, do consumers who report high levels of self-determination also report positive steps toward their personal recovery journey? If so, how can we promote higher levels of self-determination among a group who typically report significantly low levels of this construct (Okon & Webb, 2014)?

In examining these concepts, I wanted to document the stories of people who live with mental illness. I chose to do this in the context of an uplifting, TR experience called Recovery Camp, as it is designed to promote elements of self-determination and is therefore appropriate for the present area of enquiry. I wanted to first determine whether the experience of attending Recovery Camp did indeed increase elements of self-determination. I then wanted to delve into the experience of self-determination and personal recovery, with the aim of adding to the body of knowledge on personal recovery and providing information that could be utilised by mental health services and policymakers.

A mixed methods approach was deemed most appropriate for this undertaking, to adequately address the complexities of the concepts under investigation. Quantitative self-
report surveys – completed by Recovery Camp participants and a ‘comparison’ cohort who went about their lives as usual – were utilised to quantitatively determine changes in self-determination over time (pre- and post-camp, and at three-month follow-up). Qualitative interviews and a focus group were important in ensuring that participants’ lived experiences were conveyed, and in building on the quantitative survey findings.

In analysing the qualitative data, van Kaam’s (1969) psychophenomenological method of analysis was utilised as it draws out the essence of an experience, from the perspective of those living it (Anderson & Eppard, 1998). This method of analysis ensured the participants’ voices could shine through, and their exact words are included throughout Chapters Four and Five. The resulting themes (or ‘structures’, as van Kaam terms them) are housed under the over-arching concept of personal recovery and convey what personal recovery means to the people who were interviewed and participated in a focus group.

Research purpose and aims

The purpose of this research was to contribute to the body of knowledge on personal recovery, filling an existing knowledge gap.

Thus, this study aims:

a) To explore how engagement in a therapeutic recreation initiative, termed Recovery Camp, can satisfy/support the motivational responses of consumers, and

b) To individually explore self-determined motivation and personal recovery, as well as the influence of self-determined motivation toward personal recovery in the context of Recovery Camp.
Research questions

The research questions for this study were:

a) Can participation in a TR initiative satisfy/support the motivational responses of people living with mental illness?

b) What do self-determination and personal recovery mean for people living with mental illness who attended Recovery Camp?

Rationale

This thesis was undertaken to explore the lived experience of people living with mental illness, as it relates to participation in a TR program called Recovery Camp. Given that many mental health policies, practices, and guidelines espouse the importance of recovery-oriented care and self-determination, it was important to explore what this means from the perspective of those experiencing said care. The concepts of personal recovery and self-determination have not been adequately explored in the literature to date. It is my hope that the findings derived from this research can be utilised to not only address a significant gap in the literature, but also inform future policies, practices, and guidelines, to best support the personal recovery needs of consumers. It should be noted that this research was completed as part of a battery of studies. At the time that I was completing this research, there were two other Doctor of Philosophy students studying different aspects of Recovery Camp.

Organisation of the thesis

This thesis consists of six chapters, each distinct but unified in piecing together the research undertaken. The present chapter – Chapter One – has introduced this area of enquiry, and outlined the research purpose, aims, questions, and rationale.
Chapter Two provides the context for this study, delving deep into the literature in the area of interest described above. The chapter consists of four sections. Section one provides an in-depth exploration of mental illness, including its background and proposed contributing factors. Section two explores the concept of personal recovery, including the movements, guidelines, and frameworks that have shaped this concept. An overview of Self-Determination Theory is provided in section three, including how self-determination relates to mental illness and personal recovery. Finally, section four describes Recovery Camp in detail.

Chapter Three comprehensively elucidates the research design, describing in-depth why a mixed methods approach was chosen and what it involved. Included are the ethical implications, participant demographics, and recruitment strategies. The surveys and interview/focus group strategies are also described in detail.

Chapter Four describes the findings as they relate to the research aims. This chapter is broken into two sections. Section one presents the quantitative survey findings, derived from statistical analyses. Section two presents the findings from analyses of 15 interviews and one focus group (with six participants) using van Kaam’s psychophenomenological method. The structures and elements derived from van Kaam’s approach are explored in detail.

Chapter Five is the discussion chapter, building on and explicating the findings as they relate to the literature. The discussion is paired with direct quotes from participants in seeking to make meaning of the findings. Findings are also compared to established frameworks in this area.

Finally, Chapter Six summarises how the purpose and aims of this study have been achieved. The ways in which the findings contribute new knowledge to the current body of
knowledge in this area are explored. Further, the practical implications for the findings are noted, in addition to recommendations for policy and practice. Areas for future research, and limitations, are discussed, followed by a final reflection.

**Style and language**

In this thesis, direct quotes have been used where possible, whilst ensuring that each participants’ confidentiality was protected. This made it possible for each individual’s lived experience – in their own words – to be adequately conveyed. As alluded to earlier, this is important for people living with mental illness who have long been silenced or ignored (Our Consumer Place, 2010).

**Chapter summary**

This chapter introduced the topic of this thesis, including the research questions, purpose, and aims. The way in which this thesis has been organised was also conveyed. The following chapter offers a detailed description of the background and context for the present study. This is achieved through an in-depth exploration of the literature on mental illness, including relevant policies and guidelines. Further, what is currently known about personal recovery will be explored, including its origins and influences. Self-Determination Theory will also be addressed in detail, and examined in the context of personal recovery and mental illness. Finally, Recovery Camp and existing research surrounding this experience will be described in detail.
CHAPTER TWO

Background and Context

Introduction

This chapter provides the background and context for the present study. Due to the length of this chapter, it has been broken into four sections, preceded first by an exploration of the ontology and epistemology; placing the research into context. Section one provides an in-depth examination of mental illness, including its background and proposed contributing factors. Further, the impact of mental illness in a national and international context is explored, including the various consequences at an individual and societal level.

The concept of personal recovery from mental illness is discussed in section two, including the movements, guidelines, and frameworks that have shaped this notion to date. Barriers to personal recovery are also explored. An explanation of Self-Determination Theory is provided in section three to further conceptualise the context of this research, including how self-determination relates to mental illness and personal recovery. A comprehensive literature review was undertaken, determining a paucity of research on self-determination and personal recovery, despite various policies and frameworks supporting the link between the two. Finally, in section four, Recovery Camp – a therapeutic recreation initiative – is discussed in detail, including research on this program to date.

Through a process of deep engagement with the literature, a knowledge gap was identified in the field of mental health research. The present study will address the knowledge gap by exploring personal recovery and self-determination in the context of Recovery Camp.
The role of the researcher

Lucas (2014) reminds us that, though a researcher may try to separate their opinions and beliefs from the research process, their ontological positions on human functioning and reality remain influential across all aspects of research. This includes everything from their choice of methodology to analysis. Further, researchers have their own epistemological views – that is, ‘ways of knowing’ – which are particularly influential with regard to methods of data collection and analysis (Slevitch, 2011). A researcher’s own beliefs ultimately guide their actions (Denzin & Lincoln, 2008). Heidegger – a renowned German scholar – rejected the concept of bracketing (McConnell-Henry, Chapman, & Francis, 2009). Bracketing refers to the notion of setting aside all preconceived ideas before exploring lived experience (Stumpf & Frieser, 2008). Heidigger contended that prior understanding actually improves interpretation and analysis; therefore, the researcher and their preconceived ideas are an integral component of the research process (McConnell et al., 2009).

Thus, it is imperative that the researcher critically examine their own ontological and epistemological views (Scotland, 2012). Guba and Lincoln (2005) referred to this process as ‘reflexivity’ and denoted that it is an important consideration across all aspects of research, including the choice to explore a certain research question. Once one examines their ontology and epistemology through reflexivity, they can decide upon a fitting research method and methodology, and understand the influence of their own position on the research question at hand.

Ontology and epistemology

The present study explored the concepts of self-determination and personal recovery among people living with mental illness. A constructivist-interpretivist ontology approach has been
adopted, as it acknowledges that there are various constructed, subjective realities, instead of a single true reality, as espoused in a positivist approach (Ponterotto, 2005). The constructivist-interpretivist approach denotes that reality is shaped by lived experience, social aspects of one’s surroundings, and an interaction between the participant and researcher (Ponterotto, 2005). This approach allows the researcher to explore aspects of mental illness from the perspective of those experiencing it.

My perspectives and pre-conceived notions of mental illness (including key concepts of self-determination and personal recovery) have some influence on the research process. My epistemological reality has been shaped by my studies, experience working with people who live with mental illness, and connections with family members who live with mental illness. Specifically, my worldview of mental illness has been shaped through experience as a Behaviour Therapist (working with a child with autism spectrum disorder) and Research Officer (working with adults who live with mental illness), and a close relationship with my grandfather, who had a lived experience of mental illness.

My grandfather – and his journey with major depression – sparked my interest in mental health as a young child. I knew little of his struggles then, but wanted to know more. I wanted to know how I could possibly help. Since his passing in 2003, I continued to learn of my grandfather’s story through my mother and grandmother, and garnered a greater understanding of his mental illness. My grandfather’s stories are evidence to me that personal recovery from mental illness is a genuine possibility, albeit an ongoing pathway.

My knowledge base surrounding mental illness was further developed through four years of undergraduate studies in psychology. I have continued to develop my epistemology through practical experience with children and adults living with mental illness. My ways of knowing evolve through ongoing direct engagement and research. My interpretation of the
present findings was, inevitably, informed by this background, and I remained conscious of this throughout the process.

My beliefs about mental illness are shaped not only by education and work experience, but also the emotional context of having witnessed the struggles of family members, and the carry-on effect to their caregivers. As such, I am of the opinion that mental health care is beneficial when it is recovery-oriented and strengths-based, valuing the unique lived experience of each individual. While I have witnessed some of the more difficult aspects of living with mental illness, I also firmly believe that people who live with mental illness can experience personal recovery, and lead meaningful lives.

Consequently, despite initial intentions to purely focus on this research from a quantitative perspective – based on my largely quantitative-focused undergraduate degree in psychology – a qualitative component was added to allow for the unique voice of each individual to come through. Throughout all aspects of this research, people who experience mental illness are at the forefront, as a recovery-oriented, strengths-based approach values their lived experience. It is their experience, and their story to tell. For this reason, wherever possible, I draw on research and theories/frameworks composed by people with a lived experience of mental illness.

While the aforementioned discussion provides insight into the reason for using a qualitative approach, a question that could be asked is why include a quantitative approach at all? Quantitative methods can be used to gather data directly from participants in a reliable, valid, and standardised format, with minimal influence from the researcher (Vogt, Gardner, & Haeffele, 2012). This format is common in mental health research, especially as current mental health diagnostic manuals utilise a classification systems, despite debate surrounding this approach (Kotov et al., 2011). Quantitative approaches are used in the field of health care...
research because they can capture and make sense of large population data, and provide a set of particular measures of impact through the significance of results (Bradley et al., 2009).

To ensure a more holistic approach – one that drew upon the strengths of both paradigms – the present study also utilised a quantitative approach to examine the influence of an intervention on self-reported self-determination. Further, this study was guided by Self-Determination Theory to ensure appropriate measures. Using a specific instrument to measure the key needs espoused by this theory is an approach that is common, and allows for comparison to similar studies (Deci & Ryan, 2000). Quantitative responses form a solid foundation of shared understanding, which can then be built on through qualitative approaches to elicit individual experiences (Terrell, 2012). Adapting a mixed methods approach has proven beneficial in addressing complex research questions and meeting the needs of health care professionals by providing a well-rounded, all-encompassing analysis of complex phenomena (Andrew & Halcomb, 2009).

Section one: An overview of mental illness in adult populations

Mental illness

The American Psychiatric Association (APA, 2015, p. 1) defines mental illnesses as “health conditions involving changes in thinking, emotion, or behaviour (or a combination of these). Mental illnesses are associated with distress and/or problems functioning in social, work, or family activities.” Colloquially, mental illness is sometimes referred to as a mental disorder. However, the term ‘mental illness’ will be used exclusively in this thesis. Mental illness is more acute than a mental health problem or mental health issue in which a persons feelings, thoughts, and behaviour are impacted, to a lesser degree (Lawrence & Kisely, 2010b). In
general, a mental health problem or issue can be alleviated through coping strategies and social support, whereas a mental illness is a clinical diagnosis which is more ‘serious’ and requires treatment from mental health professionals (Bruce & Raue, 2013). A mental illness is typically diagnosed using the Diagnostic and Statistical Manual of Mental Disorders (DSM) or the International Classification of Diseases (ICD) (Hyman, 2010).

Lawrence and Kisely (2010b) contend that mental illness be termed ‘serious’ and ‘enduring’ when the length and extent of disability have an even more pronounced effect on the consumer. Serious and enduring mental illnesses are those such as schizophrenia and schizoaffective disorder, and long-term, debilitating forms of depression, anxiety, bipolar, and personality disorders. They are defined as such due to the need for high levels of care, and the considerable disability produced, relative to other forms of mental illness (Patel & Prince, 2010). Disability in this instance affects most, if not all, areas of the consumers’ life, including social and physical impairment (Lawrence & Kisely, 2010a). The term ‘mental illness’ in the present study is intended as an overarching term representing these serious and enduring mental illnesses.

**Global impact of mental illness**

“No health without mental health.”

World Health Organization (2005)

The worldwide impact of mental illness is vast, surpassing that of cardiovascular disease and cancer (Vigo, Thornicroft, & Atun, 2016). The World Health Organization (WHO, 2017) states that the number of people living with mental illness is on the rise, arguing that population growth and increased life expectancy are key contributing factors. Two of the most common mental illnesses (Australian Bureau of Statistics [ABS], 2015) – depression
and anxiety – have become more prevalent in recent years. The WHO (2017) reported that in 2015, 4.4 percent of the global population reported living with depression – an increase of 18.4 percent over 10 years. Similarly, 3.6 percent of the global population reported living with an anxiety disorder – an increase of 14.9 percent.

The societal impact of mental illness is significant, particularly with consideration to the economic impact of inpatient services, medication, lost productivity, mortality, family impact, and the criminal justice system (Knapp, Mangalore, & Simon, 2004). Further, there is a profound human toll of mental illness, with significant loss to health and wellbeing compounded by the impact of stigma, a lack of opportunities in educational and social domains, and in many instances, the abuse of human rights (Patel, Flisher, Hetrick, & McGorry, 2007).

Globally, treatment of mental illness typically relies on mental health professionals delivering specialist care, however there are inadequate numbers of qualified mental health professionals across low, middle, and high-income countries, particularly in large countries with many remote locations (Patel, 2009). In countries such as Australia where mental health services are readily available, Insel (2009) asserts that it is still common for people not to receive care that is targeted to their presenting problem. Becker and Kleinman (2013) contend this is often due to an array of social and economic burdens, for example, stigma from family and friends, and a lack of monetary means. Cultural beliefs and practices also influence the way people express themselves and their symptoms, as well as their desire to seek assistance (Becker & Kleinman, 2013).

Another significant impact of mental illness is that of suicide. Across low-income countries, psychological autopsy studies – where the researcher collects all available information on the deceased by interviewing relatives, friends, and treating professionals –
have found that at least 90 percent of persons who die by suicide were living with mental illness at their time of death (Hawton & van Heeringen, 2009). Rates of suicide among people living with schizophrenia are particularly high, accounting for four to five percent of the population globally (Carlborg, Winnerbäck, Jönsson, Jokinen, & Nordström, 2010). This high rate of suicide is believed to correlate with hopelessness and a view that recovery is not possible (Pompili et al., 2009).

The above discussion clearly indicates that mental illness is a global issue that needs to be addressed effectively and promptly, across policy, practice, planning, and research. Wainberg et al. (2017) contend that, globally, mental health must become a mainstream concern, to the same extent as physical health. This is particularly important given the relationship between the two, with many physical illnesses increasing the risk for mental illness or mental health problems, and vice versa, as discussed later in this chapter. The process of making mental health a mainstream concern should encompass the development and evaluation of quality interventions, and a focus on mental health awareness and education in the broader community, across policy, planning, and the delivery of primary and secondary general health care in each individual country.

**Mental illness in the Australian context**

From the global perspective discussed above, it is clear that mental illness is a significant problem to be addressed worldwide. The present study took place in Australia, encompassing all the unique aspects of mental health care in this setting – from education, to regulation, policy, practice, and the tyranny of distance. This section serves to outline the distinct aspects of the Australian mental health landscape as they pertain to this study.

Pelling and Butler (2015) described the unique aspects of Australia’s diverse population. Encompassing immigrants from over 200 countries, as well as the nation’s first
people - Aboriginal and Torres Strait Islander peoples, Australia’s population in the latest census (September 2017) was 24,899 (ABS, 2018). Australia is a country that allows religious freedom, encompassing religions such as Christianity, Judaism, Islam, and Buddhism. Cultural and religious differences ought to be taken into consideration with respect to person-centred mental healthcare (Pelling & Butler, 2015).

The National Health Survey (ABS, 2015) is conducted every four to six years in Australia for the purpose of collecting information on the prevalence of health conditions, health risk factors, use of health services, and demographic characteristics. The latest survey identified that, in the period from 2014 to 2015, 4.0 million Australians (17.5%) reported experiencing a mental or behavioural condition. 15.8% of the population reported co-existing long-term mental and behavioural and physical health conditions. Anxiety disorders (11.2% of the population) and mood disorders (9.3%) were the most commonly reported. 5.1% of the population reported having both an anxiety and mood disorder. The prevalence of reported mental illness was greater among females than males (19.2% versus 15.8% of the population respectively). The survey also found employment rates were significantly lower in those with mental illness compared to those without a mental health problem or illness (60.7% versus 78.3%) (ABS, 2015).

A specialist mental health workforce is required to care for these individuals. The mental health workforce in Australia consists of a wide range of professionals, including psychologists, social workers, mental health nurses, counsellors, the consumer mental health workforce (e.g. peer workers), and psychiatrists. The process of diagnosis, as undertaken by some of the aforementioned professionals, is another consideration for the present study, and is described below.
Diagnosis of mental illness

Diagnostic approaches to mental illness, such as the DSM and ICD, are dynamic and constantly evolving. In the past, they were used to categorise, but over the years their use has evolved. Understanding the historical context of how diagnostic approaches to mental illness have evolved shapes our current understanding of mental illness, and helps guide appropriate treatments. As theoretical frameworks emerged (e.g. psychodynamic theory and behaviourism) in the late 19th and early 20th centuries, so too did the categorisation of mental illness (Jutras, 2017). In 1952, the first DSM was created, drawing on information from the WHO sixth edition of the ICD (APA, 2017) for the purpose of insurance funding. This first edition of the DSM espoused that mental illness should be classified on the basis of socio-environmental and biological causes (APA, 2017). By the 1970s, mental illness was defined by a consumers’ current or prior placement in state institutions (Schinnar, Rothbard, Kanter, & Jung, 1990). However, with the emergence of deinstitutionalisation and a shift to community-based treatment, the process of defining and diagnosing mental illness again evolved, as described below.

In the DSM, diagnoses were based on psychiatric symptoms, extent of functional disability, and duration of illness (Krauss & Slavinski, 1982). In 1980, the DSM-III did not include any mention of possible etiological causes of mental illness – a position maintained right through to the present edition (DSM-5), as the focus remained solely on diagnosis (APA, 2017). Around this time, the ICD-9 was published with no diagnostic criteria or multiaxial system, which was met with general dissatisfaction across medical professionals, leading to a modification (ICD-9-CM) (APA, 2017). In the late 1980s, it was recognised that mental illness was often episodic, with its associated variance in symptom severity and
duration and the seemingly unpredictable usage of mental health services, and this led to further changes (Schinnar et al., 1990).

The DSM-IV and the ICD-10 were developed in close consultation, resulting in greater congruence between the two, including similar wording (APA, 2017). The ICD-10 was published in 1992, and the DSM-IV was published in 1994, encompassing empirical evidence from the vast body of literature available on mental illness at that time. Further emphasis was placed on research with the development of the DSM-5, which was published in 2013 (APA, 2017). All research occurs within a particular context, and the aforementioned elucidation of how the diagnosis of mental illness has evolved over recent years sets the scene for the present study.

With ever-changing treatment options (e.g. pharmacotherapy and psychotherapy) and new discoveries emerging from various fields such as psychology, neuroscience, and genetics (e.g. environmental factors, biological markers, and genetic predispositions), the diagnosis of mental illness is a process that continues to evolve over time (Hyman, 2010). The APA (2016) has developed practice guidelines for the psychiatric evaluation of adults in an effort to improve diagnosis accuracy and determine the best option(s) for treatment. The guidelines state that diagnosis of mental illness is a complex process requiring an in-depth analysis of the consumers’ history of present illness, past psychiatric diagnoses, substance use history, medical history, family history, personal and social factors, and a mental status examination in which factors such as general appearance, mood, and hopelessness are taken into account. From there, treatment plans can be developed, with consideration toward potential benefits and harms. Lived experience perspectives on this process are elucidated in Section Two.

Despite the guidelines discussed above, classification systems, such as the DSM-5 and ICD-10, have proven controversial over the years. Some researchers question whether
mental illness can really fit within ‘neat’ categories (e.g. Horwitz & Wakefield, 2007; Hyman, 2010; Mataix-Cols, Pertusa, & Leckman, 2007; Stein et al., 2010). Hyman (2010) argued that human psychology and illness is too complex to contain in distinct classifications. Clinical use is the ultimate aim of manuals such as the DSM-5 and ICD-10. However, from a consumer perspective, a diagnosis is not always tantamount to appropriate treatment, leading many researchers and consumers to question how appropriate these approaches to diagnosis truly are (Corrigan, Druss, & Perlick, 2014). Further, clinical diagnosis can lead to an exacerbation of stigma surrounding mental illness, with many health professionals viewing consumers in terms of their diagnostic label, without consideration to their individual situation (Corrigan, 2007).

Hyman (2010) contends there is still a long way to go before definitive etiological and pathophysiological pathways underlying mental illness are empirically established and, as such, current classification is based on phenomenology and a subsequent ‘lumping’ together of symptom clusters. Consequently, diagnoses are regularly changing due to various factors such as trends, culture, and the influence of pharmaceutical companies (Patel & Prince, 2010), and comorbidity is common across DSM-5 and ICD-10 classifications. Further empirical evidence is required to address some of the shortfalls in current diagnostic manuals, with consideration to factors that contribute to mental illness.

**Contributing factors**

Factors that are thought to contribute toward mental illness have long been debated. Our Consumer Place (2010) – a provider of resources for mental health consumers – outlines how, within the consumer movement, there are many different approaches to understanding mental illness and its influences. Consumers have noted that the medical model – in which it is typically argued that mental illness is caused by a biochemical imbalance in the brain – is
incorrect, or does not account for all aspects of their story (Byrne, Happell, & Reid-Searl, 2016). Consumers have contended that mental illness is a ‘whole way of thinking’ which should be explored not in terms of symptoms, but instead as an experience that can be perceived as both positive and negative (Our Consumer Place, 2010). Research valuing the consumer perspective have demonstrated that many reject psychiatric diagnoses, as they appear to misrepresent their experience, perpetuate stigma, and disempower those who are labelled (Corrigan et al., 2014).

On the other hand, empirical evidence indicates that mental illness may be attributed to a combination of variables: genetic, biological, psychological trauma, and environmental (Cockerham, 2016). Evidence of heritability has arisen from studies showing diagnosis similarities within families, higher incidence among monozygotic (derived from a single ovum) compared to dizygotic twins, and adoption studies portraying greater similarities between biological relatives compared to adoptive relatives (Uher, 2009). From a biological perspective, population studies point to abnormalities in neurotransmitters – particularly for consumers living with schizophrenia – which is supported by brain studies (Angermeyer & Dietrich, 2006). Trauma is also implicated, with a recent increase in awareness and research surrounding the ill effects of trauma for both children and adults (Courtois & Gold, 2009). Relative to the general population, trauma is highly prevalent among people living with mental illness, and a trauma background has been linked to an increased need for mental healthcare (Grubaugh, Zinzow, Paul, Egede, & Frueh, 2011). In a similar vein, environmental factors – in particular stressors (e.g. Stockdale et al., 2007) and substance abuse (e.g. Fazel, Langstrom, Hjern, Grann, & Lichtenstein, 2009) – also appear to play a role in the development of mental illness. Despite a plethora of research across these areas, factors that contribute to mental illness is a hotly debated topic. Another area which is also frequently
researched and debated is the apparent impact of mental illness on physical health, which will now be explored.

**Impact on physical health**

People living with mental illness typically have poor physical health (Thornicroft, 2011), in addition to poor mental health, with research suggesting their mortality rate is two to three times greater than that of the general population (Holt & Peveler, 2010). In Italy, Carrà et al. (2014) compared the prevalence and correlates of metabolic syndrome – a collection of conditions which increase an individuals’ risk of heart disease, stroke, and diabetes – in inpatients with mental illness to a random selection of patients undergoing routine surgery. They found that people with mental illness were three times more likely to have metabolic syndrome than the random control group. Smoking and family history correlated strongly with metabolic syndrome across both groups. Holt and Mitchell (2015) reviewed the epidemiological association between mental illness and diabetes mellitus. They determined that people with mental illness are two to three times more likely to develop diabetes mellitus relative to the general population. Further, the consequences of diabetes are more profound and long-lasting in people living with mental illness, compared to people who did not have a diagnosed mental illness, and this included greater risk of death. Holt and Mitchell (2015) also purported that people living with mental illness typically receive poorer treatment for diabetes mellitus. Further still, people living with major depressive disorder and bipolar disorder are predisposed to accelerated atherosclerosis and early cardiovascular disease (Goldstein et al., 2015), and this appears particularly apparent when affective symptomatology is persistent over time (Fiedorowicz, 2014).

Many of the aforementioned problems can be attributed to health conditions such as obesity and hypertension, and behaviours such as smoking (De Hert et al., 2009).
Antipsychotic medications, in particular, can cause significant weight gain, further compounding health issues associated with serious mental illness (Newcomer, 2007; Usher, Park, & Foster, 2013). Lifestyle factors, such as a lack of treatment adherence across areas including hygiene and dental care (Nielsen, Munk-Jørgensen, Skadhede, & Correll, 2011), and poor diet (McElroy, 2009) also impact upon the physical health of consumers. In turn, these physical ailments can worsen psychological symptoms and stability, due for example to trauma and chronic pain, further impacting upon the overall wellbeing of the individual (De Hert et al., 2011). Despite the clear link between physical and mental health, efforts to bridge the historical divide – with concern to policy, practice, and treatment – between physical health and mental health have been lacklustre, with little progress in recent times (Becker & Kleinman, 2013).

Social impact

Another influence on consumers is their social environment. Consumers are often faced with disabling social situations, such as mistrust, stigma, and misunderstandings, when they attempt to seek help within the community and from mental health professionals (Henderson, Evans-Lacko, & Thornicroft, 2013). People living with mental illness also report fewer close social relationships, and those that are established are not necessarily supportive (Tew et al., 2012). A link between social factors and readmission has also been identified, particularly when friends and/or family are perceived as over-involved and highly emotional (Hooley, 2007). Similarly, social isolation can exacerbate symptom severity and call into question a person’s social identity (Malmberg-Heimonen, 2010). Consumers who enter the health system report being faced with coercion and paternalistic attitudes, which diminish their self-worth and self-determination (Hughes, Haywood, & Finlay, 2009). A sense of powerlessness...
and ‘social defeat’ often results (Tew, 2011). In order to further comprehend the experience of consumers, the emergence of the consumer movement will now be explored.

**The emergence of the consumer movement**

To fully understand how the consumer movement came to be, one must first understand the influence of the civil rights movement in the United States of America (USA), to encapsulate the events that motivated other marginalised groups to fight for their rights also.

> “The black revolution is much more than a struggle for the rights of Negroes. It is forcing America to face all its interrelated flaws – racism, poverty, militarism, and materialism. It is exposing evils that are rooted deeply in the whole structure of our society... and suggests that radical reconstruction of society is the real issue to be faced.”

*Martin Luther King Jr. (1960)*

**Defining figure of the civil rights movement**

Hall (2005) recounts how the civil rights movement, in the 1950s and 1960s, resulted in equal access to basic privileges and rights for African Americans in the USA. The movement consisted of negotiations, petitions, and nonviolent protests regarding discrimination across education, social segregation, and voting rights. The movement began with the 1954 Brown v. Board of Education decision, which saw the introduction of the Civil Rights Act of 1964 and the Voting Rights Act of 1965. Segregation was outlawed in public places, and racial discrimination was prohibited in employment settings. However, initial attempts to comply with the Brown verdict were met with violent protests (Hall, 2005).

Hall (2005) goes on to describe how, in the mid-1960s, African Americans were still ineligible to vote in the South, and attempts to change this were again met with violent resistance. Lawmakers were called to attention when voter-registration efforts took place in
Mississippi, which again drew much resistance, and a number of killings. In August 1965, the Voting Rights Act was introduced, and racial discrimination across the country was being targeted more than ever by civil rights activists. Out of this radical wing of the civil rights movement emerged Malcolm X. Despite controversy, this ‘black-power’ component of the moment did not garner support from most African Americans.

Further, Hall (2005) described how it was not until the late 1960s, following a multitude of legal cases, that segregation was outlawed in all schools. Schools were required to specifically promote the integration of African American with white schoolchildren and staff members. In 1968, the civil rights movement began to waver, however its legacy remains as it opened up various new opportunities for African Americans.

The civil rights movement formed the foundation for other marginalised groups to step forward. It was the impetus for the modern women’s right movement, the student movement, and the consumer movement (Simmons, 1981). Epstein (2013) recounts the development of the consumer movement in Australia and how this has profoundly influenced recovery-oriented practice and policy. The 1970s saw the development of Australia’s first consumer organisation – the Campaign Against Psychiatric Injustice and Coercion (CAPIC) in Victoria, a state of Australia. CAPIC was developed by consumers who were treated poorly in Victoria’s mental health institutions. It was dedicated to the demand of justice for consumers treated poorly through a variety of psychiatric practices, such as coercion, compulsory hospitalisation, and sexual assault by clinicians. Support from the wider community grew, given the political landscape of equal rights for marginalised populations. Eventually, the consumer organisation was backed by a large body of people embracing the fight for human rights. Social and economic changes in the 1980s, such as the privatisation of Australian universities and an increase in student and trade unions, resulted in the downfall of CAPIC and a further struggle in the fight for better treatment of consumers.
Further, Epstein (2013) described how, in the 1990s, the Australian national government finally recognised a need to explore the state of mental health services in Australia, following a large scale investigation into the state of public mental health services. The aim of the Australian government was to encourage the promotion of a consumer voice. In 1993, Brian Burdekin – the Australian Human Rights Commissioner from 1986 to 1994 – launched the Report of the National Inquiry into the Human Rights of People with Mental Illness, or the ‘Burdekin Report.’ The report revealed the lacklustre state of the public mental health care system in Australia and helped gain national funding for the first time.

“People affected by mental illness are clearly among the most vulnerable and disadvantaged in our community.

They suffer from widespread, systematic discrimination and are consistently denied the rights and services to which they are entitled.”

Burdekin (1993)

The Burdekin Report also determined that consumers and carers ought to be involved in policy and practice. A second report was released in 1993 – the First National Mental Health Strategy – by Labor Health Minister Brian Howe (Federal Government), with a push for radical change in mental health policies, advocating for the involvement of consumers and carers. This was tied to the establishment of the Federal Mental Health Branch.

Out of the First National Mental Health Strategy arose the National Community Advisory Group (NCAG) in 1993, consisting solely of consumers and carers. States and territories were asked to nominate a carer or consumer to chair the group. NCAG became influential in 1993 and persisted for seven years, advocating for consumer rights until the complexity of fighting for consumer rights led the group to dissipate. The issues surrounding
mental illness in both Australia and overseas were pervasive, and professionals and bureaucrats were unwilling to support the fight for consumer rights.

In the early 2000s, the emphasis of the consumer movement changed. While advocacy for adequate and humane treatment remained the core function, consumer employment in mental health services became a core aim of the movement. Epstein (2013) recounts that this was initially problematic, with little structure, consistency, and support. Relationships between consumer workers, and consumer recipients, became strained, with talk of high functioning versus low functioning, and important versus non-important. On the other hand, consumers were finally beginning to be seen as ‘experts’ by other mental health professionals and individual differences were recognised (Epstein, 2013).

Epstein (2013) contends that many consumer groups are now local, and come in various different forms: support groups (e.g. those run by carers or at private hospitals), advocacy groups (e.g. those demanding change), and peer groups (e.g. Hearing Voices Groups). The recent recovery-oriented focus across mental health treatment and support in Australia can be attributed in large part to the consumer movement, with involvement from many diverse groups (Pinches, 2014). Government recognition that these groups are important in the overall improvement of mental health services in Australia has started to grow. On the back of this recognition, consumer perspectives on personal recovery were explored, as described below.

Section two: Personal recovery from mental illness

Since the 1950s, mental health care has been embedded in a medical model, with a focus on ‘solving’ mental illness as a medical problem and striving for a clinical cure, instead of
focusing on individual capabilities and strengths (Hood & Carruthers, 2007). Since the establishment of the consumer movement in the 1970s, consumers have become more outspoken about their personal journeys as they live with, and learn to cope with, mental illness (Epstein, 2013). Notions of ‘personal recovery’ rather than clinical recovery have subsequently arisen across mental health services and policies worldwide (Mancini, 2008).

Personal recovery differs from clinical recovery, with a focus instead on concepts such as hope, sense of self, and personal accountability (Champ, 1998; Glover, 2012; Leamy, Bird, Le Boutillier, Williams, & Slade, 2011; Slade et al., 2014). Personal recovery can be defined as living a satisfying life despite the challenges of mental illness (Anthony, 1993). It is a journey unique to each individual (Slade, 2009b). Research in this area (e.g. Ochocka, Nelson, & Janzen, 2005; Piat et al., 2009; Yanos, Roe, & Lysaker, 2010) has focused on re-establishing a ‘lost’ identity due to the emergence of mental illness, and the journey or process of recovery itself (e.g. Picton et al., 2018). Yet, practices that are conducive to recovery-oriented care, such as valuing the uniqueness of each individual and encouraging choice, have received little focus across empirical studies (Mancini, 2008).

Consumer perspectives on personal recovery are broad-reaching, demonstrating the individual nature of the journey. This speaks to the notion that a ‘one size fits all’ approach is impractical within mental health services (Slade, 2009b). Most consumer perspectives on personal recovery contend that recovery is a process, not an outcome, whereby one sees beyond the challenges associated with their mental health (Glover, 2012). The process involves living a life of their own choosing, with the maintenance of autonomy and dignity, even if various symptoms remain (Davidson & Roe, 2007).

The literature surrounding personal recovery from mental illness suggests that the journey involves a series of distinct stages (e.g. Andresen, Caputi, & Oades, 2006; Davidson...
& Strauss, 1992; Glover, 2012; Pettie & Triolo, 1999; Pinches, 2014). Andresen et al. (2006) examined consumer accounts of mental health services in their process of formulating five overarching stages of personal recovery, which are outlined in Figure 1. However, the individual nature of the personal recovery journey dictates that stage models will not align with the journey of all consumers. Some will experience the process in a different order or may skip stages altogether.

**Figure 1.** The five stages of personal recovery and their characteristics (Andresen et al., 2006)

- **Moratorium**
  - Denial, hopelessness, withdrawal from social situations, low self-worth

- **Awareness**
  - Hope emerges, recovery possible, self-awareness increases

- **Preparation**
  - Decides to proceed towards recovery, engages with the community and learns about mental illness

- **Rebuilding**
  - Develops a new identity, sets goals and strives for them, establishes personal responsibility, deals with setbacks

- **Growth**
  - Illness management, feeling 'well,' hope for the future, self-confidence, self-determination
Glover’s Self Righting Star® of Recovery

Some of the shortcomings in Andresen et al.’s (2006) approach are addressed in Glover’s (2012) framework of recovery. Glover’s approach is based on her own lived experience of mental illness. As noted with regard to Andresen et al.’s (2006) model, the individualised nature of personal recovery proves to be a potential disadvantage when exploring this concept (Slade, 2009b). An established and widely-utilised framework of recovery, developed by Glover (2012), was employed to frame the current investigation, given the notion that each aspect is individual to each consumer and may occur in any order.

Helen Glover uses her lived experience of mental illness, as well as a background in social work and education, to describe the realities of recovery from mental illness. She has developed various large action learning projects, stemming from recovery-oriented approaches. Glover (2012) developed the Self Righting Star® (Figure 2) as a framework to assist mental health services in re-establishing methods of care in line with a recovery-oriented approach. The Self Righting Star® contains five ‘polarities’ which signify the key areas that people with a mental illness see as important to the recovery process. These are: Active Sense of Self, Hope, Ability to Respond/Take Control, Connectedness, and Discovery.
Figure 2. Glover’s (2012) Self Righting Star®

Glover (2012) describes each polarity as a shift from a previous, unsuccessful approach, to one which promotes recovery. The first polarity – Active Sense of Self – is described as the change from being a service user to re-identifying with one’s own strengths and positive characteristics. Hope highlights the movement from hopelessness to hope for the future. Ability to Respond/Take Control speaks to the shift from relying on others to promote recovery, to a belief that recovery is one’s own responsibility. Connectedness signifies a shift in identity – from viewing oneself as unwell and secluded, to actively participating in the community. Finally, Discovery involves a progression from alienation to the discovery of meaning and purpose, and all aspects of learning attached to that process. The Self Righting Star® framework encourages consumers to take an active role in re-establishing various key areas of their life, where the focus is on personal responsibility and control (Glover, 2012).

**Barriers to personal recovery**

**Stigma**

Perhaps one of the most problematic barriers to personal recovery from mental illness is stigma, despite significant increases in community understanding and improved treatment
options (Wahl, 2012). SANE Australia (2013a) – a national mental health charity supporting Australians living with mental illness – defines stigma as “the uninformed and negative attitudes held by many in the general community towards people with mental illness” (p. 1). Sociologist Erving Goffman (1963) explored stigma in his seminal work, Stigma: Notes on the Management of Spoiled Identity. People who experience stigma are said to constantly strive for an accepted social identity. Three types of stigma were identified by Goffman: stigma of character traits, physical stigma, and stigma of group identity. Stigma of character traits refers to features that are deemed unnatural, or due to inherent weakness. This is the type of stigma faced by people who live with mental illness.

People with mental illness report facing significant stigma, in the form of discrimination and prejudice, across most areas of their life – from renting a home (Nelson, 2010), to applying for work (Krupa, Kirsh, Cockburn, & Gewurtz, 2009), and even seeking support for their mental health (Overton & Medina, 2008). This has serious implications, limiting their ability to lead ‘ordinary’ lives, let alone accomplish recovery-related goals (Corrigan & Wassel, 2008). Stigma from the outside world is often paired with self-stigma, whereby the individual judges themselves to be incapable of living up to their own expectations and those imposed by societal norms (Overton & Medina, 2008). SANE Australia (2013b) describes self-stigma as something that occurs when a consumer accepts others’ judgements and negative views, internalising these perceptions. This can result in various damaging consequences, including self-hate and shame, which further limit the consumers’ ability to live independently and seek desired opportunities (SANE Australia, 2013b). This dynamic is complex, with research suggesting the issue may be improved through education and direct interaction with consumers (Moxham et al., 2016; Overton & Medina, 2008; Wahl, 2012). While it is of vast importance to explore better treatment options
for consumers, replacing stigma with encouragement and empowerment may have an even more profound impact on personal recovery (Wahl, 2012).

**Poverty**

Several studies have demonstrated a link between socioeconomic status and mental health, with the least privileged experiencing the most negative health outcomes (e.g. Jenkins et al., 2008; McLaughlin, Costello, Leblanc, Sampson, & Kessler, 2012; Ng, Muntaner, Chung, & Eaton, 2014; Tinghög, Hemmingsson, & Lundberg, 2007). The causal link is, as yet, unclear. Regardless, the evidence suggests that having insufficient resources – particularly monetary resources – can have a significant impact on the personal recovery journey. Poverty can significantly hinder inclusion in even the most basic educational, leisure, and social activities that promote wellbeing (Perese, 2007). It can also cause significant stress which increases symptom severity and often results in risk-taking behaviour (Wilton, 2004). It is not money itself that appears to be the problem, but access to opportunities that can be provided via monetary means.

**Victimisation**

People who live with mental illness are far more likely than the general population to experience victimisation in the form of abuse (verbal and/or physical), intimidation, neglect, theft, and rape (Hiday & Moloney, 2014; Teplin, McClelland, Abram, & Weiner, 2005). Many consumers who have been hospitalised in mental health facilities speak poorly of the experience, with staff members and other consumers contributing to a perception of danger and a lack of safety (Perese, 2007).

“I attended 2 mental health hospitals, experienced manic behaviours and then received a bipolar diagnosis. Things should not have been allowed to get as bad as they did. All because
of the stigmatising way I was spoken to and treated by the very professionals that are meant to be here to help and support us at the difficult times in our lives.”

Mental Health Commission of New South Wales (2014b)

Victimisation of consumers in the form of abuse, intimidation, stigmatisation, and neglect, can result in exacerbation of symptoms, increased incidence of hospitalisation, little to no sense of wellbeing, and a greater likelihood of being victimised again in the future (Teplin et al., 2005). This has serious implications for personal recovery. Safe, recovery-oriented care is crucial to overcoming these barriers.

**Recovery-oriented care**

Recovery-oriented, or recovery-focussed services, are those which promote an approach to mental health care that aligns with the attitudes and values espoused by the notion of recovery (Slade, 2009b). The Roadmap for National Mental Health Reform 2012-2022 – an Australian reform – denotes that a recovery-oriented approach “allows people flexibility, choice and control over their recovery pathway, and responds to each individual’s unique needs, circumstances, life-stage choices and preferences” (Council of Australian Governments, 2012, p. 1). Further, the National Framework for Recovery-Oriented Mental Health Services: Policy and Theory (Commonwealth of Australia, 2013) describe the approach as “…offering a transformative conceptual framework for practice, culture and service delivery in mental health service provision” (p. 3). They contend, “the lived experience and insights of people with mental health issues and their families are at the heart of recovery-oriented culture” (p. 3).

Research exploring recovery-oriented approaches and principles internationally has exposed various shared themes. Le Boutillier et al. (2011) qualitatively analysed 30
international recovery-oriented practice guidelines from six countries (the USA, England, Scotland, Republic of Ireland, Denmark, and New Zealand). The emergent themes, featured across the guidelines, are listed in Table 1. The themes speak to important factors such as respecting the individuality of each consumer, and encouraging their involvement in decision-making. Further, from an organisational perspective, a dedication to planning ahead and promoting quality improvement were identified. This interplay and shared vision between service user and service provider is integral to the recovery-oriented approach.
Table 1. Recovery-oriented practice guideline themes: prevalence within international documents

<table>
<thead>
<tr>
<th>Theme</th>
<th>Total</th>
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<tbody>
<tr>
<td><strong>Practice Domain #1: Promoting citizenship</strong></td>
<td></td>
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<tr>
<td>Seeing beyond “service user”</td>
<td>16</td>
</tr>
<tr>
<td>Service user rights</td>
<td>15</td>
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<tr>
<td>Social inclusion</td>
<td>23</td>
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<tr>
<td>Meaningful occupation</td>
<td>18</td>
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<tr>
<td><strong>Practice Domain #2: Organisational commitment</strong></td>
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<td>Recovery vision</td>
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<tr>
<td>Workplace support structures</td>
<td>13</td>
</tr>
<tr>
<td>Quality improvement</td>
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</tr>
<tr>
<td>Career pathway</td>
<td>13</td>
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<td>Workforce planning</td>
<td>21</td>
</tr>
<tr>
<td><strong>Practice Domain #3: Supporting personally defined recovery</strong></td>
<td></td>
</tr>
<tr>
<td>Individuality</td>
<td>13</td>
</tr>
<tr>
<td>Informed choice</td>
<td>23</td>
</tr>
<tr>
<td>Peer support</td>
<td>13</td>
</tr>
<tr>
<td>Strengths focus</td>
<td>12</td>
</tr>
<tr>
<td>Holistic approach</td>
<td>21</td>
</tr>
<tr>
<td><strong>Practice Domain #4: Working relationship</strong></td>
<td></td>
</tr>
<tr>
<td>Partnerships</td>
<td>21</td>
</tr>
<tr>
<td>Inspiring hope</td>
<td>20</td>
</tr>
</tbody>
</table>

(Le Boutillier, Leamy, Bird, Davidson, Williams & Slade, 2011, p. 1473)
The Department of Health (2013) in Australia’s National Framework for Recovery-Oriented Mental Health Services: Guide for Practitioners and Providers outlines the requirements for recovery-oriented service delivery and practice in Australia. Key requirements are listed in Figure 3. Emphasis is placed on including the consumer in the treatment process, encouraging autonomy, focusing on strengths, community reintegration, trauma recognition, and providing support as needed. In this respect, the Australian framework mirrors various aspects of the guideline themes espoused by Le Boutilier et al. (2011). The Australian framework also describes the various factors outside of mental health services that can impact on the ongoing recovery journey, including employment support, education, training, and a safe place to live. Particularly influential are family members, friends, and other community members who impact upon consumers in their home environment. “Most of a person’s recovery occurs at home” (Department of Health, 2013, p. 27). The following section goes on to describe how self-determination may also influence personal recovery.

Figure 3. Department of Health (2013) requirements for recovery-oriented services (p. 17)
Section three: Self-Determination Theory

Self-Determination Theory (SDT) is a theoretical framework that is useful in exploring personal recovery from mental illness. Self-determination can be defined as the propensity of an individual to act in a “self-directed, self-regulated, autonomous” way (Field et al., 1998, p. 2). SDT is a theoretical framework that has previously been used across numerous settings, including healthcare. Ng et al. (2012) conducted a meta-analysis of studies examining SDT in health care and health promotion settings. They found 184 independent data sets that supported a positive relationship between SDT needs and physical and mental health. Okon and Webb (2014) explored the influence of a psychosocial rehabilitation program that promoted self-determination and internal locus of control among twenty adults living with mental illness using a case study design (qualitative and quantitative) in the USA. Overall health, wellbeing, and connectedness were reportedly increased following participation in the program.

SDT, a macro theory of human motivation and personality, was originally developed by Edward L. Deci and Richard M. Ryan (1985) – psychologists immersed in human motivation research. They contend that this multifaceted theory can be used to explain human behaviour. Specifically, SDT is a framework that can be utilised to examine the impact of an individuals’ social environment on attitudes, motivations, behaviours, and beliefs (Deci & Ryan, 2000). SDT suggests that people possess an innate motive toward self-improvement through engagement in processes and behaviours that correspond to their overall development (Deci & Ryan, 2000). SDT posits that the more a person’s behaviour shifts from being extrinsically driven toward being autonomous and intrinsically motivated, the greater the likelihood they will participate in self-motivated behaviours that promote quality of life (Stone, Deci, & Ryan, 2009).
SDT (Deci & Ryan, 2008) posits that an individual’s motivation is influenced by three essential psychological needs: competence, autonomy, and relatedness. While the importance of self-determination to the overall wellbeing of individuals has been documented, people living with mental illness report significantly low levels of self-determination (Okon & Webb, 2014). The three needs espoused by SDT will now be explored.

Competence in relation to SDT refers to a feeling of success or optimal challenge (Deci & Ryan, 2008). The need to be competent drives individuals to build their skills base through challenges that are well-suited to their perceived capabilities, instilling a sense of confidence and efficacy in ones’ abilities (Ryan & Deci, 2004). Autonomy, as it relates to SDT, refers to a feeling of choice and control, where one acts with their own interests and values in mind (Deci & Ryan, 2008). Ryan and Deci (2004) contend that this concept is not synonymous with independence, in which external variables play no part. Instead, an individual can still act autonomously, in line with their own interests and values, even with the influence of external factors. Finally, relatedness is a perception of social connection and belongingness with others, and with the community as a whole (Deci & Ryan, 2008). Ryan and Deci (2004) argue that relatedness is an integral component of life – to be accepted by others, and to feel connected to them. This is not tied to a need for status or a tangible goal (e.g. sex), but instead the need to feel secure and included.

Deci and Ryan (2008) also make a distinction between autonomous motivation and controlled motivation. This distinction is central to SDT. Autonomous motivation encompasses intrinsic (internal demand or reward) and some forms of extrinsic (external demand or reward) motivation. Someone who is autonomously motivated will feel as though their actions are a product of their own choice and self-approval. On the other hand, controlled motivation first comprises external regulation, where behaviour is influenced by external factors such as reward and punishment. It also encompasses introjected regulation,
where behaviours are partly influenced by internal factors such as a desire for approval, or the belief that the behaviour will influence their self-esteem. Both forms of motivation have a distinct influence on behaviour. Conversely, amotivation involves a lack of motive and purposeful behaviour.

Self-determination is viewed on a continuum, as illustrated in Figure 4 (Ryan & Deci, 2000). Figure 4 shows each type of motivation across the self-determination continuum, including respective regulatory styles and corresponding outcomes. From left to right, Figure 4 illustrates the increasing degree to which each motivation is self-determined. Amotivation is depicted on the left and is followed, to the right, by five distinct types of motivated behaviours. There is a difference between how amotivation is conceptualised in SDT versus the mental health literature. Amotivation in SDT refers to a lack of intention to act (Ryan & Deci, 2000). Amotivation in the mental health literature refers to detachment, and a decreased interest in activities, and is often referred to as a ‘negative’ symptom of mental illness (Kaufman, McDonell, Cristofalo, & Ries, 2012). Here, the SDT version is utilised. Finally, in Figure 4, to the right is intrinsic motivation. Personal recovery can be linked to greater self-determination and intrinsic motivation, with outcomes including enjoyment and inherent satisfaction with life. This will be mapped against Glover’s (2012) Self Righting Star® as explored later in this chapter.
Figure 4. The Self-Determination Continuum, adapted from Ryan & Deci (2000)

Identified, integrated, and intrinsic forms of regulation can be combined to form an autonomous motivation composite. External regulation and introjected regulation can be combined to form a controlled motivation composite.

Ryan, Patrick, Deci, and Williams (2008) contend that satisfaction of the three essential psychological needs of competence, autonomy and relatedness can lead to improvements in mental health – notably, reduced symptoms of anxiety and depression, and greater reported quality of life. Ng et al. (2012) conducted a meta-analysis of 184 studies that utilised SDT in health care contexts. As a result of this meta-analysis, for research that examined mental health, as well as research that examined physical health, it was concluded that SDT is an appropriate conceptual framework with which to study health-related behaviours, including the precursors and outcomes of motivation. The apparent link between self-determination and mental illness also necessitates further exploration of the two concepts and how they are linked.
**Self-Determination Theory and personal recovery**

As discussed previously, personal recovery, in the context of mental illness, can be defined as living a satisfying life despite the challenges of mental illness (Slade, 2009b). Personal recovery is a goal for many people who live with mental illness, and has arisen as an area of importance in mental health care (Boardman, 2010). Mancini (2008) identified the need for an overarching theoretical or empirical framework to support the key notions of personal recovery from mental illness, suggesting that SDT overlaps, conceptually, with many ideas surrounding recovery. SDT can be used to clarify personal definitions of recovery. Indeed, practices and treatments that are referred to as recovery-oriented typically address the basic needs espoused by SDT: competence, autonomy and relatedness.

There is an association between some key needs of SDT and Glover’s (2012) polarities of personal recovery. While there is overlap and alignment between these concepts, they are not mutually aligned or exclusive. Competence – inclusive of feelings of success and optimal challenge – corresponds to Glover’s notion of rediscovering ones’ own strengths (Active Sense of Self). Relatedness – tied to social connection – relates to Glover’s notion of Connectedness within the community. Autonomy – a feeling of choice and control – promotes the exploration of meaning and purpose per Glover’s notions of Discovery and Ability to Respond/Take Control. Finally, Glover’s description of Hope can be viewed as an outcome of being self-determined.

The Department of Health (2013) in Australia’s National Framework for Recovery-Oriented Mental Health Services: Guide for Practitioners and Providers espouses that consumers’ self-determination is a critical factor in relation to successful treatment and personal recovery. Indeed, the principles of recovery emphasise choice and self-determination within medico-legal requirements and duty of care. It is argued that this must
include the reduction of seclusion, restraint, and coercion in mental health care. Piltch (2016), who has a lived experience of mental illness, described her personal recovery journey, outlining the critical role of renewed self-determination. She identified that five factors are crucial to developing self-determination and subsequently influencing personal recovery: 1) access to information about treatment options, 2) interpersonal support, 3) access to role models who have lived experience of personal recovery, 4) flexibility surrounding treatment options, and 5) involvement in personally meaningful activities. However, little research has been conducted as to how best to implement these strategies amongst clinicians, peers, and mentors. Very few programs or treatment options address the self-determination needs of consumers in an immersive and pragmatic sense. The present study goes some way to contributing to this void in the literature and to support the use of therapeutic recreation as an intervention.

SDT posits that the more a person’s behaviour shifts toward being autonomous and intrinsically motivated, the greater the likelihood they will participate in self-motivated behaviours that promote quality of life (Stone et al., 2009). The assumption, in relation to mental illness, is that greater self-determination will lead to freedom of choice toward behaviours and activities that promote personal recovery. This study explored this notion through an experience known as Recovery Camp.

Section four: Recovery Camp

Self-determination can be promoted through meaningful leisure pursuits. Iwasaki, Coyle, and Shank (2010) conducted an integrative review of the literature surrounding leisure and recreation as a context for active living, recovery, and wellbeing among people with a lived experience of mental illness. It was apparent that empirical research in this area was limited.
However, Iwasaki et al. (2010) were able to conclude that enjoyable and meaningful leisure promotes motivation, personal identity, positive emotions, social connectedness, effective coping strategies, human development, and physical and mental health.

Recovery Camp was developed as a meaningful, immersive program, and was the impetus for consumer’s renewal of self-determination in the present study. In turn, it was also a means through which the development of self-determination and the personal recovery journey could be explored empirically. Recovery Camp took place over five days and four nights at an established Young Men’s Christian Association (YMCA) recreation camp west of Sydney, New South Wales, Australia, called YMCA Camp Yarramundi. Recovery Camp has been an annual event since May 2013. In 2016, Recovery Camp was conducted twice – once in May, and then in October. The data examined in this thesis focuses on participants who attended Recovery Camp in May 2016. Undergraduate health students, people with a lived experience of mental illness, and staff members from the University of Wollongong attended Recovery Camp together.

Recovery Camp is strengths-based and recovery-oriented (Taylor et al., 2017). Mancini (2008) asserts that it is the sum total of a program – including therapeutic and non-therapeutic factors and activities – which contribute towards its efficacy in promoting personal recovery. Thus, all aspects of the Recovery Camp environment were considered in its development and planning. Cabin-based accommodation and shared meals ensured that camp activities and experiences relied on and fostered the development of therapeutic and collaborative relationships for all who attended. At the commencement of Recovery Camp, participants were split into three groups (approximately 20 people per group) to facilitate closer therapeutic relationships. Groups included a roughly equal mix of students and consumers, with at least one university staff member in each group, and a YMCA camp group facilitator (therapeutic recreation instructors trained in outdoor therapy). A large
portion of time was spent in the smaller groups, apart from shared group meals, and early-
morning and evening activities.

At Recovery Camp, undergraduate health students (predominately nursing students) are invited to learn from people with a lived experience of mental illness. Recovery Camp is considered an accredited clinical placement for Bachelor of Nursing students in Australia, however students were not the focus of the present study. As mentioned in Chapter 1, this study is part of a battery of studies, with other PhD students focusing on understanding the student experience of Recovery Camp.

Upon arrival at Recovery Camp, participants are allocated cabin accommodation by gender and, as mentioned previously, the larger group is divided into smaller groups of about 20 people. Groups (identified by a colour) stay together for the week and engage in therapeutic recreation activities together. This is a bonding experience, where participants are encouraged to be highly supportive of their other team members. Early morning and evening activities are conducted as one large group, and meals are also shared as one large group. Each smaller group included at least one registered mental health nurse, who was on hand to answer questions, provide mental health support, and supervise the interactions between consumers and undergraduate health students. The mental health nurse was also required to supervise nursing students who were undertaking their clinical placement. Group activities were purposefully designed to target physical, cognitive, and social domains of learning, and are described later in this chapter. Smaller groups included an equal balance of students (8 to 10 per group) and consumers (8 to 10 per group).
Recovery Camp is based on the principles of therapeutic recreation (TR) (e.g. autonomy, optimal health, and quality of life), which support the key needs of SDT (Dattilo, 2015). Intended to promote health and wellbeing – including mental health – TR utilises various interventions designed to challenge, remediate, and foster a sense of control (Carruthers & Hood, 2007). A goal of many TR, or leisure, activities is to elicit feelings of enjoyment and achievement. TR initiatives (e.g. pet therapy, horticultural therapy, cognitive retraining) value the uniqueness of each person. This approach speaks closely to the principles of personal recovery which are person-centred. For people living with mental illness who often feel they have very little control – over symptoms, stigma and more (Corrigan & Wassel, 2008) – TR can be an important opportunity to experience control and choice. Leisure has also been viewed as a protective factor against stress (Iwasaki et al., 2010).

*Meaningful engagement with life through leisure pursuits*

Recovery Camp is an example of a leisure pursuit. In addition to being grounded in SDT, Recovery Camp is also grounded in Iwasaki, Messina, and Hopper’s (2018) conceptual framework which identifies the key elements of leisure-induced meaningful engagement with life. Iwasaki et al.’s (2018) framework focuses on leisure pursuits, defined as an activity “freely chosen” (p. 30). The pursuit is meaningful and promotes active engagement towards growth and healing. Iwasaki et al.’s (2018) framework denotes that leisure pursuits help maintain five key elements which bring meaning to people’s lives:

1. **Joyful Life** – The promotion of a life that includes positive emotions, engagement, and meaning-making

2. **Connected Life** – The promotion of a life of meaning through holistic connectedness (e.g. social, spiritual, and cultural)
3. Discovered Life – The promotion of discovering one’s own unique talents and positive attributes

4. Composed Life - The promotion of a life in which one feels they are in control, and can make their own decisions

5. Empowered Life – The promotion of a life of stress-coping, emancipation, and inner strength

Iwasaki et al.’s (2018) framework is supported by prior research involving people who have a lived experience of mental illness (Iwasaki, Messina, Shank, & Coyle, 2015), in which they described the influence of leisure on the elements described above. The framework can be used in a broad sense (for people with and without disabilities), however for the purpose of the present study, the framework will be used to examine how a leisure experience (Recovery Camp) relates to elements of a more meaningful life (in alignment with personal recovery) for people with a lived experience of mental illness.

Self-determination and leisure

Various studies have been undertaken, demonstrating a link between leisure or TR and self-determination. Hill and Sibthorp (2006) examined a recreation camp in the USA for 60 adolescents with type I diabetes to establish the relationship between TR and self-determined behaviours. Participants completed self-report questionnaires, which revealed that the camp experience elicited increases in self-determined behaviours. Similar to people with type I diabetes, people who live with mental illness may partake in extensive behavioural management, and take responsibility for their medication where applicable, suggesting these findings may be transferable to this population. However, further research is required to confirm this link in adult consumer populations.
McGuire and McDonnell (2008) examined the relationship between leisure and self-determination in a group of 47 adolescents and young adults with intellectual disabilities in the USA (Utah). Involvement in leisure activities was monitored over a 2-week period. Responses on a self-report self-determination scale (Arc’s Self-Determination Scale) demonstrated that the greater time spent completing leisure activities, the higher the increases in reported overall, global self-determination. Their findings underscored the notion that self-determination can be boosted through specific leisure experiences, without having to explicitly teach skills. There is little to no evidence to support whether such an important impact would also be evident in an adult population with mental illness.

Snethen, McCormick, and Puymbroeck (2012) studied a TR-based intervention designed to increase community participation among eight adults living with schizophrenia in the USA. The program spanned 10 weeks and involved participation in interest-based recreation activities (e.g. activities of daily living, vocational assistance, counselling, medication support, financial assistance, and social and problem-solving skills) and support from a recreation therapist. Through semi-structured individual interviews, the authors found that participation in the intervention increased perceived competence and autonomy. However, the sample size was small, no follow-up was conducted, and participants with other mental health diagnoses were not invited to participate.

Similarly to other TR interventions, Recovery Camp focuses on individual strengths. Researchers have used various motivational models to explore TR interventions, such as the Self-Determination and Enjoyment Enhancement Model (Dattilo, Kleiber & Williams, 1998). Dattilo et al. (1998) assert that self-determination contributes to enjoyment in TR settings. Self-determination, in the context of leisure experiences, involves participants feeling that they are free to make choices and can choose the level at which they wish to participate. Recovery Camp offered this, inviting everyone to consider their goals, strengths, and physical
capabilities, and subsequently determine their own level of participation. For example, for some this meant climbing part or all the way to the top of the rock-climbing wall, while for others this meant assisting their fellow ‘campers’ in adjusting their harnesses and headgear, being on belay, and/or giving them positive encouragement. By creating an environment of this nature – which is responsive, informative, and fosters freedom of choice – the likelihood of participants becoming more self-determined was increased.

Recovery Camp provided the opportunity to engage in physically and mentally challenging activities (refer to Appendix 1 for the 2016 program), designed to appeal to a wide variety of individuals. Activities included a high ropes course, rock climbing, and a 14-metre high flying-fox/zipline, as well as a bush dance/hoedown, art and craft, daily Tai Chi (with a focus on balance), and initiative games. The activities offered participants many opportunities to work together in a collegiate and supportive manner, and engage in TR experiences designed to both challenge and remediate. YMCA camp staff members are trained TR professionals, and facilitated most of the activities, with the exception of a health education session run by a dietetics and exercise physiology student who received instruction from university staff prior to the session, a trivia night run by psychology students who also received instruction from university staff prior, daily Tai Chi run by a qualified instructor, and a bush dance run by an experienced musician.
Recovery Camp and Self-Determination Theory

The immediate social context of Recovery Camp aligns with SDT. SDT purports that motivation develops through the social and cultural environment (Chen & Jang, 2010). Social contexts or environments which support the key needs of SDT – autonomy, competence, and relatedness – are believed to support healthy motivational functioning (Ryan & Deci, 2004). In the context of Recovery Camp, this is inclusive of facilitator behaviours, social interactions amongst participants, and the various facets of activities – from the physical to the emotional.

The social context of Recovery Camp is autonomy supportive in that activities and facilitator behaviours are designed to facilitate self-regulation, choice, and control for those participating (Ryan & Deci, 2008). This is achieved by ensuring that all participants are aware that they can participate as little or as much as they wish, and verbal, positive
encouragement is imparted by facilitators and students regardless of the level of participation. Recovery Camp also has the potential to increase competence, as participants are supported to feel effective in their environment through numerous opportunities to demonstrate their capabilities. Again, no matter the level of participation, or the difficulty of the task, participants are verbally encouraged by facilitators, students, and other consumers, in an attempt to boost confidence. A wide variety of activities (e.g. mental, physical) ensures a greater likelihood that participants can feel competent in at least one undertaking at Recovery Camp. Finally, Recovery Camp supports relatedness. From the outset, participants are encouraged to interact with one another in a supportive fashion. Participants are purposely allocated into smaller groups, to encourage closer connections and belongingness. Student attendees are also encouraged to show care and support throughout activities.

**Recovery Camp: Knowledge gap**

As discussed, Recovery Camp is an experience that has the potential to assist consumers in their recovery pathway. However, this requires empirical evidence. To date, research surrounding Recovery Camp has focused on three participant groups: consumers, their carers/caregivers, and health students. Given the focus of the present study, the following section will explore Recovery Camp research that involved consumers only. Table 2 summarises key findings to date. Though various positive outcomes have arisen for consumers who attended Recovery Camp, how the experience influences their self-determination and personal recovery journey has yet to be explored in-depth and in combination.
### Table 2. Summary of Recovery Camp consumer-focused research

<table>
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<tr>
<th>Authors</th>
<th>Year</th>
<th>Key findings</th>
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| Moxham et al. | 2015 | - Individual participant expectations were examined using a purpose-designed quantitative Likert scale questionnaire.  
                |      | - Consumer expectations were met and exceeded, with themes including: overcoming challenges and stepping outside of one’s comfort zone.  
                |      | - Recovery Camp group \((n = 27)\) only                                                                                                     |
| Patterson et al. | 2016 | - The influence of Recovery Camp on the perceived control of participants was explored using a quantitative Likert scale questionnaire – the Perceived Control Across Domains Scale  
                |      | - Increased perceived control across areas such as substance use, personal cognition, and personal empowerment were identified post-camp.  
                |      | - Recovery Camp group \((n = 27)\) and comparison group \((n = 18)\)                                                                          |
| Taylor et al.  | 2017 | - Two aspects of self-determination – awareness of self and perceived choice – were explored using the Self-Determination Scale.  
                |      | - An increase in awareness of self and perceived choice was apparent immediately post-camp, however was only maintained for awareness of self at 3-month follow-up.  
                |      | - Recovery Camp group \((n = 28)\) and comparison group \((n = 23)\)                                                                         |
| Moxham et al.  | 2017 | - The types of goals set by consumers in the context of Recovery Camp were examined qualitatively. On a purpose-designed Likert scale, the extent to which the self-identified goals were attained post-camp was measured. |
Across the goals, four key themes emerged: connectedness, developing healthy habits, challenging oneself, and recovery. All goals were attained post-camp.

Recovery Camp group ($n = 27$) only

Consumers were interviewed about their subjective experience of Recovery Camp using a descriptive phenomenological approach.

Five key themes emerged: self-determination, participation, extending self, relationships, and positive change. The core essence of meaning was empowerment.

Recovery Camp group ($n = 5$) only

While self-determination has previously been explored to a minor extent in the context of Recovery Camp (e.g. Taylor et al., 2017), it was identified that the research only touched upon a small sub-section of SDT and that the concept actually required further exploration. In particular, measuring the three key psychological needs of SDT – autonomy, competence, and relatedness – provided a more in-depth examination, which is important because motivation occurs at multiple levels (Ryan & Deci, 2000). Further, a qualitative exploration of self-determination in the context of Recovery Camp added depth and greater understanding to quantitative findings, in that it helped identify which aspects of Recovery Camp increased or decreased reported self-determination.

Personal recovery is a concept that has not yet been touched upon within the literature surrounding Recovery Camp, and represents an important area of enquiry given its significance to consumers. This is particularly apparent in Moxham et al.’s (2017) finding that recovery-oriented goals were common amongst consumer participants at Recovery Camp. Moxham et al. (2017) asked consumers to list a series of goals pre-camp. Post-camp,
they rated (using a 10-point Likert scale), the degree to which each goal was achieved. The
majority of goals were achieved. After a thorough review of Recovery Camp research to date,
it is clear there is an area for future investigation: understanding the interplay between self-
determination and personal recovery in the Recovery Camp context. This will further
elucidate the efficacy of the Recovery Camp experience and how it can benefit consumers.

**Chapter summary**

The above chapter provided the background and context for the present study. The
researcher’s ontology and epistemology was detailed first, to place the research into context.
Adult mental illness was then explored in-depth, followed by a discussion of the concept of
personal recovery and its importance to mental health care. Next, an overview of SDT was
provided, including overlapping concepts between SDT and personal recovery. Finally, a TR
program – Recovery Camp – was explored in detail, as it relates to SDT and personal
recovery. This chapter will detail the methodology and methods used to explore the concepts
of self-determination and personal recovery.
CHAPTER THREE

Research Design

Introduction

This chapter outlines the methodology and methods used to explore self-determination and personal recovery from mental illness in the context of Recovery Camp. In order to investigate this, a mixed methods approach was used. Quantitative and qualitative approaches are outlined below. Due to the length of the chapter, it is divided into two sections. Section one describes the methodology used for the current study, and the rationale for why it was selected. Section two describes the methods used to conduct this study. This is inclusive of ethical considerations, methods for data collection (surveys, interviews, focus group), recruitment strategies, participant demographics, the setting, procedures, and data analysis techniques.

Research aims

This study aims to explore:

a) How engagement in a therapeutic recreation initiative, termed Recovery Camp, can satisfy/support the motivational responses of consumers, and

b) Self-determined motivation and personal recovery, as well as the influence of self-determined motivation toward personal recovery in the context of Recovery Camp.
Section one: Methodology

Approach – mixed methods

In order to explore self-determination in the context of personal recovery from mental illness, a mixed methods approach was used in the present study. Mixed methods studies emerged due to the recognition that one approach alone cannot adequately address the complexities of certain phenomena (Terrell, 2012). Mixed methods research typically involves the researcher combining quantitative and qualitative techniques, methods, and concepts into a single study (Johnson & Onwuegbuzie, 2004). In a practical sense, a key feature of mixed methods is the ‘mixing’ of the qualitative and quantitative components within the study – that is, interlinking both components to more fully explore all aspects of the research question (Zhang & Creswell, 2013). This expansive method of research uses various approaches to answer research questions, rather than limiting the researchers’ focus in their pursuit to answer the research question/s (Johnson & Onwuegbuzie, 2004).

There are several seminal methodologists who have written about mixed methods research, with particular attention devoted to the different types of mixed methods designs (Halcomb & Hickman, 2015). Tashakkori and Teddlie (2003) wrote the Handbook of Mixed Methods in Social and Behavioral Research – a seminal piece of work which described close to 40 varieties of mixed methods designs across the literature. Creswell, Plano Clark, et al. (2003) summarised the various different designs, from social science to education and health research. The present study utilised a sequential explanatory style, where qualitative data are collected to build upon quantitative findings. It has been argued that a disadvantage of sequential designs is that they are too lengthy, given that quantitative and qualitative data are collected one after the other (Halcomb & Andrew, 2009). Yet, the advantage is that one
approach can inform the other, which occurred in the present study, making for a full and rich
data set (Halcomb & Hickman, 2015).

Mixed methods research has successfully been applied to the study of health services
(O’Cathain, Murphy, & Nicholl, 2007b), including mental health (Hanson, Creswell, Clark,
Petska, & Creswell, 2005). O’Cathain et al. (2007b) assert that the recent popularity of the
mixed methods approach within health services research was driven by the recognition that
quantitative or qualitative approaches alone could not address the complexity of health care.
Mixed methods research can improve the reliability of findings and ensure that marginalised
groups are heard, and the development of one method (e.g. quantitative) can guide data
collection and/or analysis of the other (e.g. qualitative) (O’Cathain, Murphy, & Nicholl,
2007a). Mixed methods research encapsulates the strengths of both qualitative and
quantitative research, all the while lessening their weaknesses (Wisdom et al., 2012). Unlike
multi-method approaches, in which data is collected using multiple methods, a mixed
methods approach also has the benefit of combining qualitative and quantitative approaches
right from the planning stage through to data collection and interpretation of findings
(Halcomb & Hickman, 2015).

Quantitative and qualitative techniques were both used in the present study to explore
a therapeutic recreation (TR) program termed Recovery Camp. The research drew on the
lived experience of people living with mental illness (consumers). This necessarily privileges
the consumer position and voice – an integral and necessary approach when working with
people who have a mental illness (Gawith & Abrams, 2006).

**Qualitative methodological approach**

As this study sought to explore self-determination and personal recovery in the context of
mental illness, phenomenology was deemed an appropriate qualitative methodological
approach. A phenomenological approach enables the researcher to explore the finer details of an individual’s experience from their perspective, and the meaning they ascribe to this experience (Chadwick, 2007). Phenomenology is considered not only a research methodology, but also a philosophy, as originally developed by Edmund Husserl in his efforts to interpret human experience (van Manen, 1997).

Historically, there are a number of phases in phenomenology, including the Preparatory Phase, Germanic Phase, and French Phase. The Preparatory Phase was championed by Franz Bretano, a psychologist and philosopher who was committed to a scientific approach and focused on intentionality as something that could be studied (Harwood, 2010). The Germanic Phase was championed by Edmund Husserl and Martin Heidegger - a colleague and student of Husserl (von Zuben, 2011). The most significant point on which they differed was Heidegger saw the mind as inseparable from human existence (von Zuben, 2011). He believed that humans make our own choices and thus, determine our own destiny (Smith, 2011). Finally, the French Phase was championed by Gabriel Marcel, Jean-Paul Sartre, and Maurice Merleau-Ponty. This phrase was dominated by views that humans’ freedom of choice stems only from anguish (Jones, 2001).

In this study, I have adopted the philosophical position of Heidegger. Through use of Heidigger’s hermeneutic phenomenological approach, I recognise that I – as the researcher – bring pre-conceptions and pre-conceived judgements to the research process. Heidegger spoke of the dialogue between a person and their world, introducing the concept of “Dasein” or “Being there” (Groenewald, 2004). I agree with Heidegger’s position that humans make our own choices, and are not inseparable from the world around us. Hence my earlier discussion of how I have acquired knowledge within the world.
Amongst the various phenomenological research methods available, van Kaam’s (1969) psychophenomenological method was selected for the present study because this method is a four step, twelve stage approach that has previously been used to explore lived experience (Andersen & Eppard, 1998). van Kaam’s (1969) psychophenomenological method was developed following the recognition that empiricism had various limitations – notably, a lack of reliability – that needed to be addressed (Dowling, 2007). The aim of van Kaam’s (1969) approach is to seek the essence of an experience, from the perspective of those living it. This approach has previously been used to explore the lived experience of illness in its various forms (Pereira, 2012; Salmon, 2012). Anderson and Eppard (1998) have argued that van Kaam’s approach is suited to both small and large sample sizes. van Kaam’s (1969) psychophenomenological method is explained in more depth in section two of this chapter.

Stages of data collection

A two-stage approach was used for the present study:

- **Stage 1:** Participants with a lived experience of mental illness \( n = 29 \) who attended Recovery Camp, and participants with a lived experience of mental illness \( n = 26 \) who went about their lives ‘as usual’ (comparison group) were asked to complete a battery of surveys measuring their motivational responses using a pre, post and follow-up design.

- **Stage 2:** Post-Recovery Camp, qualitative measures were used to delve deeper in to the elements of Recovery Camp which influence the motivational elements and personal recovery of each participant. O’Cathain et al. (2007b) note that one method of research – in this case, qualitative – can be used to further explore the results of the other method (quantitative). This improves understanding of the concept under examination. Interviews
(within one month post-Recovery Camp) and a focus group (one year post-Recovery Camp) were undertaken.

It is important to define the level and type of self-determination being explored. For the present research, I explored self-determination at a global level using quantitative surveys. I also explored the contextual level, exploring the specifics of Recovery Camp via qualitative interviews and a focus group post-Recovery Camp.

**Rationale for choice of research approach**

A researcher ought to reflect upon their reasons for conducting research, how they go about the research process, and how they interpret findings (Guba & Lincoln, 2005). In this section, I refer to myself in the first person to clearly delineate my reflections from established theory.

Personal recovery from mental illness is unique to each individual (Topor, Borg, Di Girolamo, & Davidson, 2011). I was drawn to the intricacy of this notion, and wanted to explore it in a way that did justice to each individuals’ lived experience. I chose a mixed methods approach to allow for a broad examination that offered more than one channel for participants to express themselves. My intention was to study personal recovery and self-determination through the eyes of those who experience it day-to-day, introducing as little of my own values and beliefs as possible. I feel that the approach chosen necessarily privileges each individuals’ own, unique experience of personal recovery and self-determination. Further reflection will be included in the Discussion chapter.
Section two: Methods

Ethical considerations

Ethical approval for this study was obtained from the Human Research Ethics Committee (HREC) at the University of Wollongong, New South Wales, Australia (Appendix 2). Prior to the collection of data, participants were provided a participant information sheet (Appendix 3), which included a description of the study and the contact details of the research team members. It also included potential benefits and risks of participation. Participants provided written informed consent prior to participation. All responses remained confidential, with codes assigned to each participant, and all files (physical and electronic) stored securely in a locked location.

Given the survey, interview, and focus group questions were of a personal nature, there was a risk of participants experiencing distress, whether due to their current emotional state or their recollection of unpleasant experiences. Participant welfare was of utmost importance in the current study, and this was made clear to all participants by advising them that they did not have to respond to any questions that caused discomfort, and they could withdraw from the study at any time without consequence.

Every effort was made to minimise the risk of emotional harm. Participants were advised of services they could access should they experience any distress. As a psychology graduate, with some experience in mental health care, I possess the basic skills necessary to provide initial counselling if it was needed. However, no participants showed signs of distress throughout the interviews.

The Australian Government National Health and Medical Research Council’s (2007) National Statement on Ethical Conduct in Human Research states that people with a mental
illness “will assist in the design and review of research involving particularly vulnerable people.” In accordance with this, the Recovery Camp research team included a person with a lived experience of mental illness who had input into and provided feedback across all aspects of the research, and the Recovery Camp program, to ensure a truly recovery-oriented experience. Every effort was made to ensure all aspects of the research privileged the lived experience of each participant.

Recruitment

Recruitment for Recovery Camp (May 9th to 13th 2016) commenced in late January 2016. As this was the fourth time Recovery Camp had taken place, word of mouth – whereby past participants recommended the experience to their peers – accounted for approximately 25% of referrals. Advertising occurred through local mental health organisations through the use of a flyer (Appendix 6). This was distributed to mental health workers and, in some instances, directly to consumers. An information session was held at the University of Wollongong main campus six weeks prior to Recovery Camp. The information session was also advertised through a flyer distributed through local mental health organisations. Those who attended were given information about sleeping arrangements, meals, transport, and the purpose of this experience. They watched a video about YMCA Camp Yarramundi, which provided a visual demonstration of some of the activities that would be offered at Recovery Camp, and were invited to ask questions. Two consumers who attended Recovery Camp in 2015 also attended the information session in 2016 to speak about their experience and answer questions. This was organised in an attempt to further put potential participants at ease with regard to the experience.

Consumers who were interested in attending Recovery Camp were invited to call me, at which point I was able to determine their eligibility and respond to any questions or
concerns. At this stage, anyone who did not attend the information session was then provided the information they had missed. The phone call was for the purpose of registering the participant for Recovery Camp, but also to talk about the research. I advised participants that they would be invited to participate in some research as part of the experience. Participants were eligible to attend Recovery Camp if they were:

- 18+ years of age
- Diagnosed with a mental illness
- Stable in presentation – i.e. not hospitalised at the time they applied (this was again confirmed with each participant the week prior to Recovery Camp)
- Reasonably mobile (able to walk around the venue with ease)
- Able to independently manage their own medications
- Comfortable with shared cabin accommodation, split by gender
- Able to sleep without the use of a CPAP machine (due to a lack of power outlets in cabins).

Once eligibility was confirmed, participants were invited to register for Recovery Camp. If they chose to do so, they provided details such as their age, mental health diagnosis/es, gender, physical health conditions, and emergency contact details. Approximately one week prior to Recovery Camp, I called all participants to confirm their attendance and ensure they were still eligible to attend. One person dropped out two days prior to Recovery Camp, due to a physical ailment. A participant from the waitlist was invited to attend in their place.

As noted earlier, consumers who attended Recovery Camp were advised of the research prior to their attendance. Upon arrival at Recovery Camp, participants were asked to complete a series of surveys. I attended all 5 days and 4 nights of Recovery Camp in May
2016. Whilst there, I developed a therapeutic relationship with consumers. Therapeutic relationships were formed with participants to build rapport so as to ensure they felt comfortable and safe, and could respond to questions in an honest way. In addition to building rapport and establishing a therapeutic relationship, it was reiterated to participants at the start of each interview – and at the start of the focus group – that their responses would remain confidential. They were invited to respond openly and honestly, and also given the option to not respond to any given question if they felt uncomfortable or unable to respond truthfully.

For the comparison group, recruitment also occurred through local mental health facilities. I contacted the facilities prior, and visited at agreed times to talk to interested participants and complete the survey with them in person. For follow-up surveys, they were also given the option to complete the survey over the phone. ‘Usual care’ for these participants included usual, scheduled visits to their General Practitioner, and sometimes a psychologist, psychiatrist, and/or mental health nurse.

Data collection measures

Self-Determination Scale

The Self-Determination Scale (SDS) (Sheldon & Deci, 1996; Sheldon, 1995) is a short, 10-item scale. This survey was selected for the present study as it contains two five-item subscales: awareness of self (e.g. “My emotions sometimes seem alien to me”), and perceived choice (e.g. “I am free to do whatever I decide to do.”) These two forms of self-determination align with the key tenets of Recovery Camp and are areas of significance for people with a lived experience of mental illness. Participants were asked to specify which of two statements felt more true to them at the time of completion, on a Likert scale from 1 (“only A feels true”) to 5 (“only B feels true”). Subscale scores were calculated by reversing scores,
where applicable, and adding each item to determine the total. Higher scores reflect greater self-determination.

The SDS captures the key aspects of self-determination (Sheldon, 1995). Past research has successfully utilised this instrument to determine individual differences in self-determined behaviours (e.g. Sheldon, Ryan, & Reis, 1996). Further, the SDS has been shown to relate strongly to measures of wellbeing (Sheldon & Deci, 1996). The scale has good internal consistency ($\alpha = .85$ to $93$) and reasonable test-retest reliability ($r = .77$; 8-week period) (Sheldon & Deci, 1996).

**Basic Need Satisfaction in Life Scale – Short Form**

Accompanying the SDS in the present study was the short version of the Basic Need Satisfaction in Life Scale (i.e., the general scale; BNSL-S) – one of a series of scales housed under the overarching Basic Psychological Needs Scale (Deci & Ryan, 2000). The BNSL-S was selected as it measures the three key needs of self-determination: competence (e.g. “Often, I do not feel very competent”), autonomy (e.g. “I feel like I am free to decide for myself how to live my life”), and relatedness (e.g. “I get along with people I come into contact with.”) The short version contains nine items, with three items per need/subscale, measuring need satisfaction in general in one’s life. Participants responded to each item on a scale from 1 (not at all true) to 7 (very true). Subscale scores were calculated by reversing scores, where applicable, and adding each item to determine the total. The short form was used in the present study for brevity’s sake (Bowling, 2005).

The full 22-item version of the BNSL-S has successfully been used in studies with adults to examine certain behaviours and responses (e.g. Gagné, 2003; Kashdan, Julian, Merritt, & Uswatte, 2006). Good internal consistency has been demonstrated for the index of general need satisfaction (an average of the three subscales) ($\alpha = .89$) and the 22-item version
of the scale has shown predictive validity for prosocial behaviours (Gagné, 2003). La Guardia, Ryan, Couchman, and Deci (2000) successfully utilised the nine-item version of the BNS in their examination of within-person variation in security of attachment among 136 university undergraduates in the United States of America (USA). Participants rated the degree to which their basic needs were met in relation to specific relationships in their life – for example, with their mother, father, romantic partner, best friend, or roommate. Confirmatory factor analysis revealed the items were loaded on three factors (autonomy, competence, and relatedness) as anticipated. Chi-square analyses revealed that a three-factor model was significantly better than a one-factor or two-factor model. Reliabilities were good, ranging from .85 to .94.

**Interviews**

All interviews were conducted in a quiet space, free from distractions. The location was chosen by participants and was suitable for them. This is important for therapeutic communication, particularly for the present cohort, some of whom were experiencing positive symptoms of their illness such as auditory hallucinations, which can affect the clarity of communication. Interviews ranged in length from approximately 30 to 75 minutes, and I conducted every interview. The intent of having one researcher conduct all interviews was to ensure consistency across interviews and address inter-interviewer effects.

Participants were provided plenty of flexibility and time to describe their experiences in their own words, with predominately open-ended questions opening the conversations. Open-ended questions, as opposed to closed questions, seek to move beyond a simple response (e.g. “yes,” “no”) towards something longer and more meaningful. Open-ended questions are important for research interviews as they prompt the participant to think and reflect on the question at hand, increasing the likelihood that opinions and feelings will be expressed (Turner, 2010).
All interviews were semi-structured, enabling flexibility in my approach and the ability to seek further clarification as required (Berg, 2009). Interviews commenced with the following, short introduction, based on Trigwell’s (2000) approach:

“Thank you for giving me your time and agreeing to talk to me today. Before we begin, is it still OK with you that I record this interview in order for it to be transcribed later? This will be completely confidential, and the data will be stored in a safe and secure location.”

This was always followed by a grand tour question/statement: “Please tell me what personal recovery from mental illness means to you.” A general question regarding ‘enjoyment’ at Recovery Camp was also included, aligning with Dattilo et al.’s (1998) Self-Determination and Enjoyment Enhancement Model, and also serving the purpose of prompting participants to reflect on what they did at Recovery Camp: “At Recovery Camp, please explain to me which activities you got involved with.” Prompts then focused around the identified activities that evoked feelings of psychological involvement and sustained attention.

Other questions focused on the three key needs of self-determination: autonomy, competence and relatedness. Based on the direction of the participants’ responses, one question was selected from each category (Appendix 4). Further, in order to address elements of personal recovery, a series of questions were asked in accordance with Glover’s (2012) Star of Recovery model (Appendix 5). Probing statements were similar or identical to the following examples: e.g. “Please explain that further,” and “What do you mean by that?”

Every effort was made to ensure rapport was built and maintained with each participant. I attended Recovery Camp and engaged in activities with participants, allowing facilitation of rapport and building of trust. Efforts were made to ensure the participant felt at
ease prior to the ‘formal’ interview component (e.g. being nonjudgmental and friendly), and actively listening throughout the interview (e.g. restating comments, using the respondents own language.) Lang, Floyd, and Beine (2000) argue that active listening is an important skill, whereby the interviewer notices and explores subtle nuances provided by the participant. Instead of simply listening to the language the participant uses, active listening involves specifically hearing the intention behind the words. For the cohort in the present study, this was a particularly important consideration. Though the participants were not hospitalised at the time they participated in this component of the research, some were still experiencing various symptoms of mental illness. It was of vast importance that I heard and addressed subtle cues during their interviews, thereby respecting their stories, experiences and emotions.

**Focus Group**

A focus group was conducted in May 2017, to follow-up on participants one-year post-Recovery Camp. The purpose of the focus group was 1) to follow-up on participants to see whether there were any lasting benefits of Recovery Camp attendance, and 2) synthesised member checking. Long and Johnson (2004) contend that member checking increases the validity of results by reducing undue influences from the researcher such as overassessment of data. The focus group aimed to clarify my assessment of the data through direct consultation with participants. Participants were offered the opportunity to comment on the findings and confirm whether or not my interpretation was a true reflection of their beliefs and experiences. This was not a matter of memory, but instead a method of exploring the credibility of findings through the co-constructed lens of the participant (Birt, Scott, Cavers, Campbell & Walter, 2016). Thematic analysis of interview data revealed a series of themes (described in Chapter Four), which were then shared with the focus group and discussed. Ten participants who had participated in initial interviews were randomly selected to participate in
the focus group. Six said they were available and willing to participate. The focus group took place over 41 minutes in a quiet room, free from distractions. Participants were given the same consideration as outlined in the interviews section above (e.g. rapport building, open-ended questions, flexibility in responding.) Upon arrival, participants provided written, informed consent, and were then given a print-out of the themes derived from interview data. Each theme was discussed in order and each participant was invited to comment on each theme as much or as little as they chose. They also let me know if they felt I had captured what they had said in their initial interviews, validating the themes derived. No changes to themes were required as a result of focus group discussions.

**Participants**

Twenty-nine people with a diagnosed mental illness (44.8% female; 55.2% male) attended Recovery Camp from May 9th to 13th 2016. One participant dropped out on the morning of Recovery Camp as they were feeling unwell. All participants were from the Illawarra-Shoalhaven region of New South Wales (NSW), Australia, and all who attended Recovery Camp were invited to participate in the survey component of the present study. 100% of attendees participated in this component of the research. Participants ranged from 22 to 65 years ($M = 42.07, SD = 11.11$). Responses from the Recovery Camp group were compared to responses from a comparison group of 26 participants with a diagnosed mental illness who were asked to maintain their ‘usual’ routines (53.8% female; 46.2% male). Comparison group participants ranged from 18 to 65 years ($M = 45.42, SD = 10.69$), and completed the same survey within the same time frame. Reported diagnoses, which were similar across groups, included: major depressive disorder, schizophrenia, anxiety disorders, schizoaffective disorder, bipolar disorder, and borderline personality disorder. Demographics are summarised in Table 3.
Table 3. Demographics for the Recovery Camp and Comparison groups

<table>
<thead>
<tr>
<th></th>
<th>Recovery Camp (n = 29)</th>
<th>Comparison Group (n = 26)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of males</td>
<td>16</td>
<td>12</td>
</tr>
<tr>
<td>Number of females</td>
<td>13</td>
<td>14</td>
</tr>
<tr>
<td>Age range</td>
<td>22-65 years</td>
<td>18-65 years</td>
</tr>
<tr>
<td>Average age</td>
<td>$M = 42.07, SD = 11.11$</td>
<td>$M = 45.42, SD = 10.69$</td>
</tr>
</tbody>
</table>

The Illawarra-Shoalhaven region of NSW (shown in Figure 5) has a population of 456,724 (2011 census), and spans an area of 8,308km sq. This is a large region, and was therefore deemed an appropriately sized area from which to recruit participants for the purposes of this higher degree research project.

Figure 5. The Illawarra-Shoalhaven Region of New South Wales, Australia
For the interview component of the study, I initially asked 10 participants who attended Recovery Camp to be involved, all of whom agreed. These participants were selected for a number of reasons:

- I had developed a therapeutic relationship with the participants across the 5 days and 4 nights at Recovery Camp thus facilitating a sense of comfort and safety to enable honest, open dialogue, and

- The participants represented a diverse cohort of those who attended Recovery Camp, with a mix of different mental health diagnoses. This diversity was important, as the purpose of the present study was to look at mental illness broadly, instead of narrowing in on particular characteristics or symptoms.

Within qualitative research, the sample size is typically small because phenomena only need to appear once to be included in analysis (Ritchie et al., 2003). In terms of a phenomenological approach, Gonzalez (2009) suggested that the required sample size is guided by the amount of participants required to reveal all aspects of an experience. As such, sample sizes of less than twenty are common. Similarly, Creswell (2011) denotes that qualitative research requires only a few individuals.

It was determined, following analysis of the first ten interviews, that further interviews were appropriate to delve deeper into initial themes. A further five participants were selected, for the same reasons espoused previously.

Following analysis of interview themes, a focus group was held approximately one year post-Recovery Camp. Six participants were involved in the focus group, whose aim was member checking of the themes previously established through interviews. Again, participants with a variety of mental health diagnoses were involved, instead of the focus being just one symptom or diagnosis.
Interview and focus group participants ranged from 22 to 65 years (\( M = 43.33, \ SD = 10.71; \) 40% female). Reported diagnoses included: schizophrenia, depression, bipolar disorder, borderline personality disorder, and anxiety disorders (e.g. post-traumatic stress disorder).

**Procedures**

Upon arrival at Recovery Camp, participants were invited to complete a pre-intervention survey, which included the Self-Determination Scale and the Basic Need Satisfaction in Life General Scale – short form. Participants did so in a quiet area, free from distractions. To ensure the surveys were completed in an appropriate manner, the research team was present the whole time to answer and/or clarify any questions.

On the final day of Recovery Camp, participants were invited to complete a post-intervention survey, which was almost identical to that administered pre-Recovery Camp. The only difference was that demographic questions were not included again post-intervention. The same process as day one was followed.

Interviews were completed within three months post-Recovery Camp. Fifteen interviews were conducted (a purposive sample), either at participants’ homes or at a private location within the community (e.g. neighbourhood centre). Participants chose the venue for the interview. At three-month follow-up, Recovery Camp participants completed a follow-up questionnaire, which was again identical to those administered previously.

**Data Analysis**

**Quantitative data analysis**

SPSS (Version 21, SPSS, Chicago, IL, USA) was used to analyse quantitative data. All participants who attended Recovery Camp completed all three stages of the survey. For the
comparison group, one person withdrew from the study at three-month follow-up, stating they were too busy to take part. All data were removed for this person. Multiple random imputation was used to replace this missing data, as it lessens the likelihood of false-positive or false-negative findings, relative to other data replacement techniques (Peng, Stuart, & Allison, 2015).

Descriptive statistics were calculated for all pre-camp, post-camp and follow-up variables (i.e. autonomy, competence, relatedness, and self-determination). Four separate 2 x 3 (Group x Time) repeated measures Analyses of Covariance (ANCOVAs) were conducted with a Bonferroni adjustment, with the pre-camp scores as covariates. An ANCOVA was conducted to control for pre-camp differences between groups. Cronbach alpha reliabilities were calculated, and pairwise comparisons were used to explore the location of significant results.

**Qualitative data analysis**

van Kaam’s (1969) psychophenomenological method of analysis was used to analyse data in the present study. van Kaam’s method includes four overarching stages, inclusive of 12 key steps, which are outlined in Table 4, as they relate to the present study. van Kaam refers to themes as ‘structures’ and sub-themes as ‘elements.’

**Table 4.** van Kaam’s (1969) psychophenomenological method of analysis stages and steps as they relate to the present study

<table>
<thead>
<tr>
<th>Stage</th>
<th>Steps</th>
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<tbody>
<tr>
<td>ANALYSIS</td>
<td>1. Determine initial descriptions</td>
</tr>
<tr>
<td></td>
<td>➢ Carefully read each interview transcript in full</td>
</tr>
<tr>
<td></td>
<td>➢ Gain initial impression of each participant’s experience</td>
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<td></td>
<td>2. Initial grouping of structures</td>
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<tr>
<td></td>
<td>➢ Read each interview in full again</td>
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<td></td>
<td>➢ Identify possible structures</td>
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<td></td>
<td>➢ Retain original language of the participants</td>
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<tr>
<td></td>
<td>3. Reduction</td>
</tr>
<tr>
<td></td>
<td>➢ Remove repetitious statements</td>
</tr>
<tr>
<td></td>
<td>➢ Tally how many times a similar statement is repeated</td>
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</tbody>
</table>
|4. | Tentatively group related structures  
➢ Group compatible statements |
|5. | List statements  
➢ Using the participants’ own words, list compatible and incompatible statements  
➢ Show structures to supervisors (independent judges) for validation |
|6. | Reflection  
➢ Determine potential elements |
|7. | Determine potential structures (themes)  
➢ Draw together similar elements based on perceived compatibility  
➢ Evaluate any elements that may not seem relevant to the overarching structure |
|8. | Psychophenomenological situational reflection  
➢ Reflect on each element specifically as each participant worded it  
➢ Examine each element in turn to determine whether it captures the essence of experience |

**TRANSLATION**

<p>| | |</p>
<table>
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<tbody>
<tr>
<td>9.</td>
<td>Translate elements and structures into the language used in mental health literature</td>
</tr>
</tbody>
</table>

**TRANSPOSITION**

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|10. | Determine fidelity  
➢ Show final structures and elements to supervisors (independent judges) |

**PHENOMENOLOGICAL REFLECTION**

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</table>
|11. | Final identification  
➢ Integrate supervisors’ feedback into final analysis  
➢ If serious objections, repeat from step 1 |
|12. | State the limits of the analysis |

**Rigour in qualitative data analysis**

While reliability, validity, generalisability, and objectivity are key concerns for quantitative data, it is argued that these factors are not relevant to qualitative analysis (Sinkovics, Penz & Ghauri, 2008). Even so, Leech and Onwuegbuzie (2007) have contended that promoting trustworthiness and rigour in qualitative analysis is essential in maintaining the fidelity and strength of the data. Lincoln and Guba (1985) developed a set of evaluative criteria to determine the trustworthiness of qualitative data. The criteria encompasses: credibility, transferability, dependability, and confirmability.
Credibility

Credibility of the data refers to how ‘truthful’ it is, as compared to reality (Shenton, 2004). Lincoln and Guba (1985) argue that credibility can be ensured through well-established research methods, prolonged familiarity and engagement with the cohort, triangulation, and member checking. Triangulation typically involves the use of more than one data source, more than one researcher, and/or more than one method of analysis (Oliver-Hoyo & Allen, 2006). The present study utilised both quantitative and qualitative data sources. For qualitative data, member checking was conducted via focus groups. I worked closely with two supervisors – a mental health nursing researcher, and an education researcher – during the stages of analysis.

Transferability

Transferability of the data refers to the extent to which the conclusions can be applied to similar cohorts or situations. Shenton (2004) has argued that the results of a qualitative study must be understood within the particular context in which it was studied. This includes the time period, geographical location, number of participants, data collection methods, and participant restrictions. This study purposefully incorporated participants with a variety of mental health diagnoses, to improve transferability to a wider cohort. In addition, more than one data collection method was employed to ensure richness of data. However, the context must be considered. Participants were from one geographical region of New South Wales, Australia. They self-reported as ‘living well’ (not hospitalised) at the time they attended Recovery Camp. Further, the study took place in a distinct time period, between May 2016 and May 2017.

Confirmability

Confirmability of qualitative data is comparable to objectivity of quantitative data – that is, whether the conclusions drawn are due to the actual experiences of participants, as opposed
to the researchers’ own thoughts and opinions (Shenton, 2004). Again, triangulation is key in reducing the impact of potential investigator bias. In addition, the researcher must explore their own dispositions (Miles & Huberman, 1994). For this reason, I discussed my reasons for adopting the research methods outlined in this thesis and the weaknesses in each approach in Chapter Two. All efforts were made to privilege the lived experience of the participant over the researcher, through ongoing reflection, and the process of regular supervisory meetings allowed for biases to be identified and dealt with promptly throughout each stage of the research.

**Chapter summary**

The above chapter described the methodology and methods used in the present study to explore self-determination and personal recovery among people living with mental illness. First, the research design (mixed methods) was detailed, including the rationale for this approach. Second, the methods used to conduct the study were described in-depth. Ethical considerations and methods of data collection (surveys, interviews, focus group), preceded a description of recruitment strategies. Participant demographics were then conveyed, followed by the setting of the study (Recovery Camp), procedures for data collection, and the data analysis techniques utilised (quantitative and qualitative). This chapter will describe the findings derived from data analysis.
CHAPTER FOUR

Findings

Introduction

This chapter is divided into two sections to present the key findings of this research. The results of each method – quantitative and qualitative – are presented separately and discussed conjointly. Section one presents the quantitative survey findings, derived from statistical analyses of the Self-Determination Scale (SDS) (Sheldon & Deci, 1996; Sheldon, 1995) and the short version of the Basic Need Satisfaction in Life Scale (i.e., the general scale; BNSLS) (Deci & Ryan, 2000). Descriptive statistics and results of repeated measures Analyses of Covariance (ANCOVAs) are presented for each survey.

Section two presents the findings from analyses of 15 interviews and one focus group (with six participants) using van Kaam’s (1969) psychophenomenological method. These findings build upon the findings in Section One by further exploring self-determination, in the context of personal recovery from mental illness. The final ‘structures’ (the term used in van Kaam’s method to denote themes) are presented in this chapter, while a deeper exploration and discussion of their meaning is presented in Chapter Five. After careful reading and re-reading of each transcript, and after the fidelity of the findings was supported via cross-checking with an independent researcher, it was determined that interview and focus group quotes and structures should be interwoven to enhance the clarity of the findings. When a focus group quote is presented, this will be identified in the text. All other quotes are derived from interviews.
Section One: Quantitative Findings

Basic Need Satisfaction in Life Scale – Short Version

Descriptive statistics for the BNSL-S are presented in Table 5. Self-reported autonomy, competence, and relatedness were all captured pre-camp, post-camp, and at three-month follow-up across the Recovery Camp and comparison group.

Table 5. Basic Need Satisfaction in Life - Short Form subscale responses for Recovery Camp and comparison groups

<table>
<thead>
<tr>
<th></th>
<th>Recovery Camp (n = 29)</th>
<th>Comparison Group (n = 26)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
</tr>
<tr>
<td>Autonomy Pre-camp</td>
<td>4.83</td>
<td>0.99</td>
</tr>
<tr>
<td>Autonomy Post-camp</td>
<td>5.26</td>
<td>1.25</td>
</tr>
<tr>
<td>Autonomy Follow-up</td>
<td>4.79</td>
<td>1.16</td>
</tr>
<tr>
<td>Competence Pre-camp</td>
<td>4.31</td>
<td>0.83</td>
</tr>
<tr>
<td>Competence Post-camp</td>
<td>4.47</td>
<td>1.09</td>
</tr>
<tr>
<td>Competence Follow-up</td>
<td>4.35</td>
<td>1.22</td>
</tr>
<tr>
<td>Relatedness Pre-camp</td>
<td>4.85</td>
<td>1.22</td>
</tr>
<tr>
<td>Relatedness Post-camp</td>
<td>5.30</td>
<td>1.17</td>
</tr>
<tr>
<td>Relatedness Follow-up</td>
<td>5.26</td>
<td>1.09</td>
</tr>
</tbody>
</table>
Table 6 presents significance values for all dependent variables in this survey. There was a statistically significant between-group difference for relatedness and autonomy, but not competence.

Table 6. Significance of between-group differences for Basic Need Satisfaction in Life - Short Form subscale responses

<table>
<thead>
<tr>
<th></th>
<th>F</th>
<th>df</th>
<th>Error df</th>
<th>P</th>
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<tbody>
<tr>
<td>Autonomy</td>
<td>4.112</td>
<td>2</td>
<td>51</td>
<td>.022*</td>
</tr>
<tr>
<td>Competence</td>
<td>1.846</td>
<td>2</td>
<td>51</td>
<td>.168</td>
</tr>
<tr>
<td>Relatedness</td>
<td>8.375</td>
<td>2</td>
<td>51</td>
<td>.001*</td>
</tr>
</tbody>
</table>

Note. * Statistically significant (p <.05)
Table 7 shows the findings for the Bonferroni pairwise comparisons. There was a statistically significant difference between the two groups at Time 2 (post-camp) for autonomy; and a statistically significant difference between the two groups at Time 2 (post-camp) and Time 3 (follow-up) for relatedness. There were no significant differences for competence.

Table 7. Bonferroni pairwise comparisons for Basic Need Satisfaction in Life – Short Form subscale responses

<table>
<thead>
<tr>
<th>Subscale</th>
<th>(I)</th>
<th>(J)</th>
<th>Mean Diff. (I-J)</th>
<th>SE</th>
<th>Sig.</th>
<th>95% C.I.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Lower Bound</td>
</tr>
<tr>
<td><strong>Autonomy</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time 2 Camp Comparison</td>
<td>.983</td>
<td>.342</td>
<td>.006*</td>
<td></td>
<td></td>
<td>.295</td>
</tr>
<tr>
<td>Time 3 Camp Comparison</td>
<td>.377</td>
<td>.317</td>
<td>.240</td>
<td></td>
<td></td>
<td>-.260</td>
</tr>
<tr>
<td><strong>Competence</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time 2 Camp Comparison</td>
<td>.587</td>
<td>.322</td>
<td>.074</td>
<td></td>
<td></td>
<td>-.059</td>
</tr>
<tr>
<td>Time 3 Camp Comparison</td>
<td>.330</td>
<td>.334</td>
<td>.328</td>
<td></td>
<td></td>
<td>-.341</td>
</tr>
<tr>
<td><strong>Relatedness</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time 2 Camp Comparison</td>
<td>1.063</td>
<td>.303</td>
<td>.001*</td>
<td></td>
<td></td>
<td>.455</td>
</tr>
<tr>
<td>Time 3 Camp Comparison</td>
<td>.883</td>
<td>.275</td>
<td>.002*</td>
<td></td>
<td></td>
<td>.332</td>
</tr>
</tbody>
</table>

Note. * Statistically significant (p < .05); Mean Diff = mean difference; SE = standard error; CI = confidence interval
Self-Determination Scale

Descriptive statistics for the SDS are presented in Table 8. Self-reported awareness of self and perceived control were captured pre-camp, post-camp, and at three-month follow-up for the Recovery Camp and comparison group.

Table 8. Self-Determination Scale subscale responses for Recovery Camp and comparison groups

<table>
<thead>
<tr>
<th></th>
<th><strong>Recovery Camp</strong></th>
<th></th>
<th><strong>Comparison Group</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>M</strong></td>
<td><strong>SD</strong></td>
<td><strong>M</strong></td>
</tr>
<tr>
<td>Awareness of Self Pre-camp</td>
<td>17.55</td>
<td>3.75</td>
<td>16.21</td>
</tr>
<tr>
<td>Awareness of Self Post-camp</td>
<td>18.83</td>
<td>3.78</td>
<td>15.21</td>
</tr>
<tr>
<td>Awareness of Self Follow-up</td>
<td>18.61</td>
<td>3.78</td>
<td>15.59</td>
</tr>
<tr>
<td>Perceived Control Pre-camp</td>
<td>17.38</td>
<td>3.75</td>
<td>15.87</td>
</tr>
<tr>
<td>Perceived Control Post-camp</td>
<td>18.22</td>
<td>2.92</td>
<td>15.48</td>
</tr>
<tr>
<td>Perceived Control Follow-up</td>
<td>18.54</td>
<td>3.00</td>
<td>15.64</td>
</tr>
</tbody>
</table>
Table 9 presents significance values for all dependent variables in this survey. There was a statistically significant difference between groups for both awareness of self and perceived control.

Table 9. Significance of between-group differences for Self-Determination Scale subscale responses

<table>
<thead>
<tr>
<th></th>
<th>$F$</th>
<th>df</th>
<th>Error df</th>
<th>$p$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Awareness of Self</td>
<td>5.821</td>
<td>2</td>
<td>51</td>
<td>.005*</td>
</tr>
<tr>
<td>Perceived Control</td>
<td>4.078</td>
<td>2</td>
<td>51</td>
<td>.023*</td>
</tr>
</tbody>
</table>

* Statistically significant ($p < .05$)
Table 10 shows the findings for the Bonferroni pairwise comparisons. There was a statistically significant difference between groups at Time 2 (pre-camp) and Time 3 (post-camp) for awareness of self and perceived control.

**Table 10. Bonferroni pairwise comparisons for Self-Determination Scale subscale and total responses**

<table>
<thead>
<tr>
<th>Subscale</th>
<th>(I)</th>
<th>(J)</th>
<th>Mean Diff. (I-J)</th>
<th>SE</th>
<th>Sig.</th>
<th>95% C.I.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Lower Bound  Upper Bound</td>
</tr>
<tr>
<td><strong>Awareness of Self</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time 2</td>
<td>Camp</td>
<td>Comparison</td>
<td>2.70</td>
<td>.862</td>
<td>.003*</td>
<td>.970  4.430</td>
</tr>
<tr>
<td>Time 3</td>
<td>Camp</td>
<td>Comparison</td>
<td>2.124</td>
<td>.881</td>
<td>.020*</td>
<td>.355  3.892</td>
</tr>
<tr>
<td><strong>Perceived Control</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time 2</td>
<td>Camp</td>
<td>Comparison</td>
<td>1.663</td>
<td>.704</td>
<td>.022*</td>
<td>.250  3.076</td>
</tr>
<tr>
<td>Time 3</td>
<td>Camp</td>
<td>Comparison</td>
<td>1.967</td>
<td>.844</td>
<td>.024*</td>
<td>.272  3.661</td>
</tr>
</tbody>
</table>

*Statistically significant (p < .05); Mean Diff = mean difference; SE = standard error; CI = confidence interval*

The above statistics illustrated that various self-reported aspects of self-determination evolved over time for participants in the present study who attended Recovery Camp, compared to a group who went about their daily lives ‘as usual’.
Section Two: Qualitative Findings

The following findings were derived using van Kaam’s (1969) psychophenomenological method of analysis, and thus involved collaboration between myself and my supervisors (independent judges) to determine fidelity. van Kaam (1969) refers to themes as ‘structures’ and sub-themes as ‘elements.’ The interviews and focus groups explored the personal recovery journey of each participant. By using a highly systematised and reflective approach, the following structure was derived (Figure 6), consisting of a central theme (Recovery), three key structures within that theme (Self-Determination, Confidence, and Purpose), and several elements (sub-themes) that spoke to these structures. Findings will be separated into the three key structures of Self-Determination, Confidence, and Purpose.

Figure 6. Structures and elements derived from interviews and focus groups using van Kaam’s (1969) psychophenomenological method of analysis
Participants’ experiences emerged from the central focus on personal recovery and the question of what it means to them. Their participation in Recovery Camp was discussed in the context of their personal recovery journey, and this experience is therefore described numerous times throughout the analyses. Though participants did describe some overlap between structures, each structure is discussed separately to enhance clarity. Participants are identified using the numbers 1 to 15, and are referred to using gender-specific terminology where appropriate (e.g. “her,” “his”). No other demographic details are provided, to maintain confidentiality.

**Self-determination**

Self-determination was identified across interviews and the focus group as a key structure relating to recovery. It was explored in relation to the three key needs of relatedness, autonomy, and competence (Deci & Ryan, 2008).

*Connecting with and helping others (relatedness)*

In the context of personal recovery, the concept of connecting with and helping others arose as an area of importance. All participants described connecting with and helping people within community mental health groups, within their family and friendship circles, out on the streets, and at Recovery Camp. Twelve participants described how talking with others, and sharing their experiences, was and continued to be integral to their personal recovery journey. Two expressed that they were not communicating with people around them to the best of their ability yet, but described it as an important goal for their personal recovery. For all who discussed connecting with and helping others, there was a realisation that other people played a key role in the process of personal recovery.
Participant 11 spoke about how beneficial it is for him to connect with friends as his experience of mental illness has been ‘very lonely.’ He spoke about how he knows he is feeling ‘well’ when he calls his friends and makes an active attempt at organising outings.

*I don’t have a lot of friends, but the friends I’ve got are very loyal, and if I find I’m not in contact with them for any particular reason, it’s sort of an indicator that I’m not travelling very well. So, it’s sort of a guide… they contact me and say, “Come on, we’re going fishing.” And I go, “Oh, good. We’re going fishing…” When I’m travelling well, that’s when I ring people up.* (P11)

Participant 10 conveyed that he had ‘really recovered’ following participation in Recovery Camp, and felt the reason was largely because he was able to help students and other consumers.

*I helped out and supported everybody… Opening up and letting them [the students] know that there is [are] mental problems out there, and um, letting the students know what they’ve gotta know about becoming a psychiatrist or a nurse or something in the field. They’ve got to know about mental problems, and I can help them.* (P10)

Participant 3 described how ‘getting close to my family’ was what personal recovery meant for her, after many years of feeling disconnected from them. She also learnt to accept the physical, platonic touch of other people at Recovery Camp. She noted that this was significant for her in light of past experiences.

*If someone came up behind me and gave me a cuddle or something, I thought “…OK.” It was really hard. But, it didn’t… at first, it bothered me… but after a while I thought, “OK, I’m not in any danger. It’s OK.”*
So… and it was OK after that. You know, a few people came up and sort of wrapped their arms around me and things like that. (P3)

Two participants spoke about how their relationship with their significant other was transformed through their journey of mental illness. For both, it was an initial struggle. Participant 4 described how the ‘ongoing battle’ of mental illness was a strain on the relationship between her and her partner, but as her personal recovery journey progressed, she felt ‘very lucky’ to have ‘a very supportive partner.’

I think I’m more open. I’m willing to share my time a lot more… whereas, before, I closed myself away. I learnt to trust. Trust was a big thing for me. (P4)

Five participants said that navigating the social aspects of Recovery Camp were more challenging than the adventurous activities, such as the 15 metre/50 foot high giant swing. They saw overcoming this, and subsequently connecting with others, as a huge achievement that contributed to their personal recovery journey. Participants spoke about how they could then bring this confidence back into their day-to-day lives.

Making choices independently (autonomy)

Participants said that the ability to make their own choices, without having to rely on others, was something they had gained through their personal recovery journey (participants 4, 6, 7, 8, 10, 11, 12, 13). They each made the connection between the choices they made at Recovery Camp, and their ability to transfer those decision-making skills into their day-to-day living. Participants who spoke about this said that the acceptance they felt from others at Recovery Camp encouraged them to make their own choices and feel content with them.

If you couldn’t do something, the group wouldn’t care… Everyone was just like “oh yeah, you can’t do it, that’s fine.” I noticed I’ve never experienced
that before. Like, if you couldn’t do something before, it was “oh, you’re not good enough.” There’s pressure… But, you know what your limits are. If you can’t do something, you can’t do it. (P6)

Participant 11 recognised his own self-worth was important, and identified that he is able to take control of his own actions.

To know that I’ve got choices… because sometimes you get stuck with a mental health issue. It restricts your choice… That sort of stuff needs to be really smashed out of me, you know. I can do anything… I should be capable of anything I choose. (P11)

‘Having a go’ and feeling successful (competence)

Participants conveyed that the act of trying, and experiencing success, contributed in a positive way to their personal recovery journey. For ten participants, they noted that success did not necessarily mean ‘full’ completion of an activity, or ‘winning’ at the activity. The act of trying, in and of itself, was sufficient to instil a sense of achievement. Participant 8 said of his attempt to participate in rock climbing, ‘I succeeded in effort.’ He cited physical limitations (e.g. being overweight) as an impediment to climbing all the way to the top of the rock climbing wall. However, he conveyed that the notion of having challenged himself was beneficial for him.

It [Recovery Camp] challenged me to do new things… try new things. It challenged me to, um, not worry so much about what I’m not good at. (P8)

For Participant 12, many of the activities at Recovery Camp were a significant source of fear. She ‘didn’t want to miss out’ and ‘really wanted to do it,’ so she went on the giant swing. Despite feeling ‘freaked out’ by the experience, she felt a sense of success, and felt compelled to set a goal for the future.
I was so scared… But my challenge next time I go to camp is to do the flying fox. I need to do that… It [going on the giant swing] made me think that I can do anything. As long as I believe, I can do anything. (P12)

Five participants spoke about how it was their inherent enjoyment of an activity that encouraged them to participate and made them feel successful even if their level of ability felt less than those around them. Participant 14 said being ‘out having fun’ was important for her personal recovery journey, as it instilled in her a sense of normality. At Recovery Camp, it was the joy of the activities that made her feel successful.

When I first went, I thought I’d never be able to do it, like, um, say… the archery. Could not get it. I tried. But it was enjoyable… just out having fun… Just give it a go. I had fun. (P14)

Confidence

The words ‘confidence’ and ‘confident’ featured prominently across the interviews and focus group. When participants spoke of confidence, this was accompanied by four elements: overcoming fear, overcoming stigma, acceptance, and balance.

Overcoming fear and stigma

All participants spoke of the notion of overcoming barriers – in particular, fear and stigma – in their personal recovery journey. They spoke of fear related to activities at Recovery Camp, as well as the courage it took to attend Recovery Camp in the first place. Participant 2 described his fear of social interaction, and how hard it was for him to even say ‘yes’ to Recovery Camp. With relief, he spoke about how the benefit for him was being able to say he overcame his fear.
I look back at it and I think, “oh… I’ve done that now.” You know what I mean? Like, stuff like that, like… I’ve done that now… I got out there and done it. (P2)

Stigma was described by six participants as a barrier to personal recovery, in that negative judgements caused unexpected setbacks in their journey. Participant 10 spoke about the lack of understanding from others. Though he reported ‘I’m a lot better than I was 12 months ago’, he mentioned that he still feels most comfortable around those who have a similar ‘label’ to him, such as other consumers who also attended Recovery Camp.

When you’ve got a mental illness, it’s very difficult because a lot of people don’t understand stigma and medication and that. And there’s lots to go through, but I’ve got a label in my life. (P10, Focus Group)

Participant 6 noted that, when he was diagnosed, ‘everyone knew everything’ and ‘everyone’s got an opinion.’ However, the stigma he experienced left him feeling as though people could not understand what he was going through. He found that talking to the students at Recovery Camp was beneficial for his personal recovery journey in that it offered an opportunity for him to share his ‘lived experience’ and he felt accepted and not stigmatised.

Acceptance and balance
Most participants spoke about acceptance and balance going hand-in-hand through the journey of personal recovery (participants 3, 4, 5, 6, 7, 8, 10, 11, 15). With acceptance of their mental illness, came a realisation that they could balance the ‘good’ with the ‘bad.’ Participant 7 conversed in depth about accepting her illness, though appreciating that ‘it involves a lot of hard work… a lot of support.’ Balance, for her, meant being herself and doing ‘the things that I normally do’ after Recovery Camp. The acceptance and balance she felt at Recovery Camp, were linked to improvements in her social life.
I used to be really shy, but not anymore... I haven’t thought about getting
down or depressed or anything. Yeah. It’s been great. (P7)

Participant 15 noted that participation in Recovery Camp led to an increased
acceptance of their mental illness, and a subsequent increase in self-esteem.

I used to be by myself and I didn’t do the stuff that I liked to do. Then, since
camp, since I’ve been back here, it’s just opened up doorways. (P15)

Participant 15 started working again, two days a week, and went to social activities
‘for the first time in 12 years.’ He talked about how a sense of balance and harmony return to
his day-to-day life.

Six participants spoke about balance with regard to medication. Participant 8 defined
balance as being ‘fairly stable on medication.’ Participant 11 said he had not been
hospitalised for 9 months, due to a beneficial change in his medication and his attendance at
Recovery Camp.

My medication’s quite good at the moment, so… I’ve been on a lot of meds
for a lot of years now… I’m quite stable at the moment. It’s a big
improvement. It’s a good space to be in with the medications and stuff. (P11)

These participants also spoke of the side-effects of medication, and how, at times,
they had a negative impact on their recovery journey, both through physical discomfort and
the judgement of others. They suggested they did not experience this judgement from others
at Recovery Camp.
Purpose

All participants conveyed that recovery was an ongoing journey for them. As such, many felt that having a purpose was important as they moved forward. This related to two key areas: growth, and hope for the future.

Growth

Most participants described how growth in various areas of their life contributed toward their personal recovery. Participant 1 described how the process of growth for him meant ‘getting on with my life’ and ‘not letting my past problems sort of affect my life.’ He saw continuing his education – something that he felt encouraged to do after attending Recovery Camp – as a key area of growth that contributed towards the feeling that ‘life’s pretty good.’ Similarly, Participant 2 kept in contact with a friend from Recovery Camp, which was a significant area of growth for him given his fear of social interaction.

Participant 4 felt ‘totally empowered’ following Recovery Camp, and took various steps towards personal growth.

*When I got back [from Recovery Camp], I got a sports physiologist, and I go to the gym twice a week… I've also joined a local women’s group, and we do studies. I feel a lot more independent.* (P4)

Participant 5 described how she was striving to ‘be a better person’ in her personal recovery journey. She identified inner strength and ‘energy’ as something that she was working towards, and felt Recovery Camp invigorated her towards these goals. Similarly, Participant 13 said she had ‘matured a lot’ and could ‘stand up for myself more.’ She saw the experience of Recovery Camp as ‘a real eye-opener’ through which she ‘started doing some positive things’ after a period of grieving for a loved one.
Participant 8 spoke about how the activities at Recovery Camp encouraged growth.

*I think that just the responsibility we take, it equips us for the future, and uh… it does make us grow as well. I think when that big purpose comes along, uh… we’re more equipped to handle it. Everyone needs something to do. We need to be fulfilled… and to be happy.* (P8; Focus Group)

Participant 8 also described how he would achieve this growth and sense of purpose by trying to ‘improve socially,’ and suggested this was his biggest area of need.

**Hope for the future**

Various participants suggested that hope for the future was important for the process of personal recovery, and this hope encouraged them through difficult periods. Participant 10 said he felt ‘positive’ and that ‘a new beginning’ had emerged in his personal recovery journey, as a result of meeting new people at Recovery Camp. Through ‘learning about self-confidence’, he felt he was now ‘better than most people’ with regard to mental health, which was a far cry from previously ‘not talking to anybody.’

*I can’t change the past, but I can always change the future and have a better future.* (P10; Focus Group)

Participant 12 established various new goals following participation in Recovery Camp, and was hopeful that she would be successful in achieving them.

*It [Recovery Camp] made me think that I can do anything. As long as I believe, I can do anything. There’s hope out there for me somehow.* (P12)

This participant saw this as integral to her personal recovery journey, finding confidence and acceptance in having achieved things ‘that I never, ever thought I’d do.’
Participant 11 expressed that his personal recovery journey had been ‘from one extreme to the other’ and ‘it’s really hard to find balance in my mood.’ However, having a purpose meant he had hope for the future. In particular, talking to the nursing students at Recovery Camp gave him hope for the future of mental health care, which brought him comfort.

\textit{Being at Recovery Camp has been a really grounding experience. It's sort of, you know… talking to the nurses and stuff is a purpose right there. I've really enjoyed talking to the nurses. It's fantastic. Seeing where the future sits. The future of nursing is in good hands. Very good hands.} (P11; Focus Group)

In summary, this section conveyed in detail the qualitative findings of this study. Participants who attended Recovery Camp reported various positive benefits, including self-determination, confidence, and purpose.

\textbf{Chapter summary}

This chapter described the quantitative and qualitative findings of this mixed methods study. Quantitative findings revealed how various self-reported aspects of self-determination evolved over time for a group of people with mental illness who attended Recovery Camp, versus a group who went about their usual, day-to-day lives. This included a rise in awareness of self, perceived choice, and relatedness, post-camp and again at three-month follow-up. Qualitative findings, analysed using van Kaam’s psychophenomenological method, elucidated key structures and elements in the relationship between self-determination and personal recovery for people who live with mental illness that attended Recovery Camp. These structures and elements were supported by direct quotations from interviews and a focus group. Participants conveyed that attending Recovery Camp resulted in a positive
increase in important aspects of their life such as self-determination, confidence, and purpose. The significance of these findings, how they relate to one another, and how they correspond to established literature in this area will be explored in Chapter Five.
CHAPTER FIVE

Discussion

Introduction

This chapter explores the findings presented in Chapter Four in relation to relevant literature. The aims of this study were twofold:

a) To explore how engagement in a therapeutic recreation initiative, termed Recovery Camp, can satisfy/support the motivational responses of consumers, and

b) To individually explore self-determined motivation and personal recovery, as well as the influence of self-determined motivation toward personal recovery in the context of Recovery Camp.

In the present study, participants with a lived experience of serious and enduring mental illness reported an increase in various aspects of self-determination following participation in Recovery Camp. This included a rise in awareness of self, perceived choice, and relatedness, post-camp and again at three-month follow-up, relative to a comparison group of participants who went about their lives as usual.

Building on the quantitative findings, interview findings highlighted various themes, including an association between self-determination and personal recovery from mental illness for a sample of participants who attended Recovery Camp. All participants said Recovery Camp had an impact on their personal recovery journey. The final ‘structures’ (the term used in van Kaam’s method to denote themes) explored in Chapter Four included: self-determination, confidence, and purpose. Several ‘elements’ (sub-themes) were revealed
within these structures, and further enhance understanding of the structures. These structures and elements are discussed in this chapter. Quantitative (section one) and qualitative (section two) findings will first be discussed separately for clarity, in the context of existing literature. The findings will then be discussed in combination, using two theoretical frameworks (section three).

Section One: Quantitative Findings

Two reliable and valid self-report surveys were administered and analysed in the quantitative phase of this study, to explore how engagement in a therapeutic recreation (TR) initiative, termed Recovery Camp, can satisfy/support the motivational responses of consumers. Motivational responses were measured using the short version of the Basic Need Satisfaction in Life Scale (BNSL-S) (Deci & Ryan, 2000) and the Self-Determination Scale (SDS) (Sheldon & Deci, 1996; Sheldon, 1995). The BNSL-S measures the three key needs of SDT: autonomy, competence, and relatedness (Deci & Ryan, 2000). The SDS measures awareness of self and perceived choice, which align with the key needs of Self-Determination Theory and are areas of significance for people with mental illness (Taylor et al., 2017).

Basic Need Satisfaction in Life Scale – Short form findings

The BNSL-S measures the key needs of SDT. The BNSL-S, described in detail in Chapter Four, was administered (along with the SDS) pre- and post-Recovery Camp, and at three-month follow-up. Responses of people who attended Recovery Camp were compared to a cohort of people with a mental illness who went about their lives as usual (the comparison group). Thus, there were two cohorts for the quantitative component of this study. Analyses of covariance revealed that the participants who attended Recovery Camp reported
significantly higher relatedness post-camp and at three-month follow up. Participants also reported a significant increase in autonomy post-camp, however this was not maintained at three-month follow-up. There were no significant changes in competence. Each key need will be discussed in detail.

**Relatedness**

Relatedness is one of the three key needs of SDT. As described in Chapter Two, relatedness is a need for people to feel socially connected and experience belongingness with others, and with the community as a whole (Deci & Ryan, 2008). Ryan and Deci (2004) consider relatedness to be an integral component of life; people need to be accepted by others, and to feel connected to them. Many people who live with mental illness consider feelings of security and inclusion an important part of their personal recovery journey (Bonney & Stickley, 2008). The reality, however, is that many people who live with mental illness experience social isolation and stigma from the community at large, as well as family and friends (Malmberg-Heimonen, 2010). They report fewer close social relationships, and those that are established are not necessarily supportive (Tew et al., 2012; Topor et al., 2011; Yanos et al., 2010). Glover (2012) denotes that, when people living with mental illness actively participate in the community, and stop seeing themselves as secluded, they are taking steps toward personal recovery.

With regard to the intervention reported in this study, Recovery Camp is a TR initiative where people living with mental illness are offered opportunities to connect socially with their peers through structured, purposeful team-building activities designed to challenge participants in a safe and supportive context. This is achieved through the employment of trained TR specialists who facilitate smaller groups of no more than twenty participants. Activities are structured in that they start with a thorough briefing about the physical and emotional implications of the task, and end with a de-briefing and facilitated exploration of
physical and emotional issues that arose, and/or fears that were conquered. Participants are also informed to respect others, and engage in group and/or partner interactions as much as possible. The setting is designed to elicit conversation, build trust, and connect, given that activities require communication and listening to one another.

The notion that group-oriented TR programs can cultivate social connections is supported in the literature (e.g. Anderson & Heyne, 2012; Hutchinson, Bland, & Kleiber, 2008). For instance, Phinney and Moody’s (2011) qualitative exploration of a community-based TR group for 11 people living within the early stages of dementia determined that TR can fill an important gap in their lives. Interviews and observations revealed themes such as social connection and enjoyment within a group setting. Yet, little research to date has specifically explored whether this is also the case for people living with mental illness (Moxham et al., 2015).
Group activity at Recovery Camp (photography consent received)
The present finding – that participants who attended a five-day TR initiative reported greater relatedness following this experience, relative to a cohort that went about their lives as usual – supports the notion that such a program can cultivate social connections for people living with mental illness. Importantly, this can be maintained three months on. Despite returning to their usual lifestyles, participants who attended Recovery Camp reported improvements in relatedness that were significant compared to those who did not attend Recovery Camp. The five-day TR experience was a positive influence on their perceptions of social connection and belongingness. They were not only given a voice, but also actively listened to with empathy and care. Given that social isolation can exacerbate symptom severity and lower self-esteem (Malmberg-Heimonen, 2010), this is an important finding, suggesting an intensive experience like Recovery Camp can foster and maintain greater social connectedness among people living with mental illness. The potential reasons behind this are further explored in qualitative findings (section two).

The present findings support previous research by Allsop, Negley, and Sibthorp (2013) who explored the experience of 79 adolescents (11 to 22 years old) with chronic illness who participated in either a ‘normal’ week-long camp or a week-long camp based on the principles of TR in the United States of America (USA). The TR camp resulted in increases across social domains, including greater perception that they can complete a social task (social self-efficacy). Similarly, Dawson and Liddicoat (2009) explored the lived experience of 27 adults living with cerebral palsy who attended a week-long summer camp in the USA underpinned by the principles of both TR and self-determination. The case study approach revealed that participants felt respected by members of their community, and reported greater social connection and independence in dealing with stigma following participation in the camp. Though these papers focused on physical illness, they still demonstrate the ability of a TR initiative to promote social connection among adults living
with various forms of disability. Indeed, Relationships Motivation Theory (Deci & Ryan, 2014) – one of the six mini-theories contained within SDT – denotes that satisfaction of the need for relatedness is an important requirement for marginalised groups. People also require satisfaction of the need for autonomy and competence to ensure flourishing close relationships and overall wellbeing.

**Autonomy**

Autonomy is another key need described in SDT. As described in Chapter Two, autonomy (as it relates to SDT) refers to a feeling of choice and control, where one acts with their own interests and values in mind (Deci & Ryan, 2008). SDT posits that greater autonomy can lead to self-motivated behaviours that are beneficial for mental health and wellbeing (Stone et al., 2009). In this regard, this is a construct that is of benefit to consumers embarking on their personal recovery journey. If they can behave in ways that are autonomous – that is, with their own interests and values in mind – it is possible that they can make personally valuable improvements in their life.

Autonomy is not synonymous with independence, and a person may still act autonomously, despite the influence of the environment and people around them (Ryan & Deci, 2004). Participants who attended Recovery Camp reported a significant increase in autonomy post-camp, relative to the comparison group. However, this difference was not maintained at follow-up. There are a number of potential explanations for why this was not maintained. First, perhaps five-days were insufficient to instil lasting changes in autonomy. A short-term TR initiative can initially influence autonomy, but continued autonomy-supportive activities may be required to support sustained improvements in this construct over time. This requires further research.
Further, when participants returned to their ‘usual’ lifestyles, their circumstances and mental health treatment may not have been conducive to maintaining autonomy and making their own decisions. Duncan, Best, and Hagen (2009) systematically reviewed the literature and found that shared decision-making interventions were beneficial in fostering lasting autonomy for people with mental illness. A ‘shared’ decision concerns at least two people, and all information is shared. Decisions are agreed upon by all involved. Charles, Gafni, and Whelan (1997) contended that, for long-term health conditions, a shared decision-making model should involve “ongoing partnership between the clinical team (not just the clinician) and the patient [consumer]” (p. 25). The Mental Health Commission of New South Wales (2014a) denotes that collaborative care, where various providers partner with, communicate, and provide a holistic care plan and comprehensive client care, is crucial. If participants returned to their usual day-to-day lives and did not experience autonomy-support, shared decision making, or collaborative care, this may explain why autonomy was not maintained.

According to Mancini (2008), autonomy is the most critical element of recovery-oriented practice. People living with mental illness require autonomy to self-initiate healthy physical and mental behaviours, and continue to do so over time. However, there appears to be a double standard for people living with mental illness. Parsons (2008) described how the dignity of risk – the notion that every choice carries risk, but also the opportunity for growth – is an option rarely afforded to people with mental illness. Service providers and clinicians often take a protective stance, encouraging consumers to be autonomous, while simultaneously discouraging them from making potentially risky choices, when it is possible that those choices could result in significant learning and growth. Conversely, participants at Recovery Camp are encouraged to be autonomous and take risks in a safe and supportive setting. The findings of the present study suggest ongoing, genuine autonomy support is important in maintaining choice and control for people living with mental illness. Service
providers and clinicians should promote the dignity of risk, and assist consumers to make informed choices as they work toward their personal recovery goals.

Past research supports the notion that autonomy and goal-directedness can be promoted via leisure and/or TR interventions (Hood & Carruthers, 2007). Sylvester (2011) recognised that leisure and recreation can support various core capabilities for people with disabilities. In the case of autonomy, this can be promoted by helping participants build self-awareness and make their own choices. This was certainly the case in McGuire and McDonnell’s (2008) exploration of 47 adolescents (15 to 21 years old) with intellectual disabilities in the USA, and their involvement in recreation. Through a survey and document review of school files, it was determined that those who undertook more recreation activities, also reported greater autonomy. For an adult population – such as people living with dementia – leisure and recreation have the same effect. Genoe (2010) presented a research agenda and discussed how, for people living with dementia, leisure offers them a space “for resistance” (p. 303) – in the sense that they can resist stereotypes and dominant ideologies. Instead, they can feel autonomous, and make their own choices. These papers, in combination with the present findings, underscore the notion that TR initiatives and leisure pursuits can increase autonomy among marginalised groups. However, it is necessary to work with individuals to enhance their abilities to transfer their learnings about autonomy into their day-to-day lives.

**Competence**

Competence is the third key need of SDT. As outlined in Chapter Two, competence in relation to SDT refers to a feeling of success or optimal challenge (Deci & Ryan, 2008). Competence can motivate individuals to foster skills through challenges that suit their perceived capabilities, and can lead people to feel confident in their abilities and effective in their dealings with the environment around them (Ryan & Deci, 2004). Hood and Carruthers
(2007) argued that competence is important for people living with mental illness, as it can set the foundation for other skills to develop, and can help people remain optimistic when faced with adversity. Given that people with mental illness can face various challenges, such as poor physical health (Park, Foster, & Usher, 2017), social exclusion (Tew et al., 2012), and stigma (Moxham et al., 2016), this is an important consideration (Collins et al., 2011).

In the present study, participants reported no statistically significant change in competence, relative to the comparison group, following participation in Recovery Camp. Recovery Camp involved engagement in activities designed to challenge and remediate, as per the guiding principles of TR. However, competence is about challenging oneself based on an understanding of one’s own capabilities and strengths (Deci & Ryan, 1985). A five-day experience may be insufficient to develop a sense of competence in participants. Certainly, Recovery Camp included involvement in unique experiences (such as a giant swing, rock climbing, and orienteering), which were unlikely to already be a regular fixture in participants’ lives. Coming to terms with strengths and weaknesses in these activities could take time, and five days and four nights may have been an insufficient length of time.

The concept of time and its’ influence is supported by Snethen et al.’s (2012) findings, in which a 10-week TR intervention based in the USA increased perceived competence among ten participants living with schizophrenia. This was determined via therapists’ notes and semi-structured interview transcripts. Findings from Snethen et al.’s (2012) study suggest it may be the length of the program that is important in fostering competence long-term. It has also been argued that longer-term responsibilities, such as paid employment, instil a greater sense of competence in people living with mental illness, compared to singular pursuits (Blustein, 2008; Dunn, Wewiorski, & Rogers, 2008). Further, competence can be instilled through co-development of treatment plans and a person-centred approach to care – another longer-term approach (Cook et al., 2012).
A lack of change in competence may also be attributed to difficulty in transferring experiences of the Recovery Camp setting to one’s larger construct of self and life beyond the experience. Lysaker and DiMaggio (2014) have found that people who live with mental illness experience both cognitive and metacognitive challenges that may mediate the effect of experience on a sense of self as ‘competent.’ They suggest, for people living with schizophrenia in particular, that there is a need to develop interventions which not only foster the development of skills, but also assist people to form the kind of ideas about themselves and others that they require for the personal recovery journey. This was beyond the scope of Recovery Camp, but is an important consideration for future TR based interventions that focus on people living with mental illness.

While each psychological need is independent and important in its own right, the SDT model of change (Ryan et al., 2008) espouses that a sense of competence is fostered by autonomy. One must first perceive that they have choice and control, and that a challenge aligns with their perceived capabilities, before they can learn and develop new capabilities. According to SDT, autonomy and competence go hand in hand, and both are required to enact positive changes in health behaviour. Thus, opportunities for participants to realise their strengths and experience a sense of accomplishment, in a setting where they feel they have choice and control, are important considerations for TR programs and other mental health initiatives.

**Self-Determination Scale findings**

The SDS was administered pre- and post-Recovery Camp, and at three-month follow-up. Responses of participants who attended Recovery Camp were compared to a cohort of participants who went about their lives as usual (the comparison group). Analyses of covariance revealed that participants who attended Recovery Camp reported significantly
higher awareness of self and perceived choice post-camp, and this was maintained at three-month follow-up, relative to the comparison group.

**Awareness of self**

For people who live with mental illness, awareness of self is often lacking, in that they are often not aware of their own feelings and sense of self (Brevers et al., 2013). Yet, awareness of self is an aspect of daily living that can assist with personal recovery, as awareness of feelings and sense of self is an important step in addressing areas for growth (Buck et al., 2013). Ryan and Deci (2008) – who developed SDT – denote that, in the process of enhancing autonomy (one of the key needs of self-determination), the role of awareness is paramount. Deci and Ryan (1985) describe awareness in this context as a state where the individual is relaxed, but interested in their surroundings, without passing judgement or having an agenda (Deci & Ryan, 1985).

Awareness of self paves the way for the person with mental illness to explore their feelings and experiences in a relaxed, non-judgemental way, and work toward acknowledging and accepting these components of their life (Deci & Ryan, 2008). Deci and Ryan (1991) contend that it is through this process that coherence and harmony of the self can be achieved. Glover (2012) argues that one of the key aspects of personal recovery is moving toward an active sense of self. That is, moving from being a service user to re-identifying one's own strengths and sense of self.

In the present study, participants with a lived experience of mental illness who attended a five-day TR initiative – Recovery Camp – reported a significant rise in awareness of self post-camp, as measured by the SDS, and this was maintained at three-month follow-up. This was relative to a comparison group of participants living with a mental illness who reported no significant change in awareness of self over time. This finding is supported by
Taylor et al.’s (2017) research, and is significant in that it suggests participation in an intensive, five-day TR experience has the potential to foster and maintain awareness of self among people living with mental illness. Taylor et al. (2017) suggested this was due to the community-based and recovery-oriented nature of the therapeutic recreation experience.

The context of the Recovery Camp setting itself may have contributed to this positive shift in awareness of self. Past research has demonstrated that people experience greater awareness of self – often referred to in the literature as mindfulness – in settings that are autonomy-supportive (e.g. Brown & Ryan, 2003; Jõesaara, Heina, & Haggerb, 2012; Nix, Ryan, Manly, & Deci, 1999). Autonomy-supportive settings are those that encourage participants to make their own choices, and foster opportunities to take on challenges in line with their capabilities (Ryan & Deci, 2006). A modified version of Jang, Reeve, and Deci’s (2010) observational tool was utilised in past Recovery Camp research (Taylor et al., 2017) to determine whether the activities at Recovery Camp were conducted in an autonomy-supportive fashion. Participants were encouraged to physically attend each scheduled activity, but were ultimately given choice and control as to their level of participation. This meant that each individual could choose and control their own difficulty level. For example, for the rock climbing activity, some participants chose the ‘easier’ climbing wall, and only scaled a portion of it. This was still a significant feat for them, and they were able to feel challenged and supported. Other team members clapped and cheered for everyone, no matter their perceived level of achievement. In addition, facilitators purposely used flexible language, such as “you could try this,” and showed patience through their words and actions. Similar examples are presented in Section Two’s qualitative discussion.

The present findings align with the following studies which saw participants experience greater awareness of self in an autonomy-supportive setting. Awareness of self is often perceived as a pre-requisite for change, and this is supported in the following literature.
Maitland and Chalmers (2010) found that awareness of self was a pre-requisite for change among 19 participants undergoing cardiac rehabilitation in the United Kingdom. The researchers determined, via semi-structured interviews, that awareness of self brought about behavioural change for the participants in their study – for example, they developed healthier eating and exercise habits. This came about either from the participants’ own realisation that ‘problem’ behaviours were occurring, or from being told by a health professional that something needed to change. Similarly, Silva et al. (2010) found that a one-year weight management intervention based on SDT, and thus promoting autonomous forms of exercise, incited an increase in awareness of self among 239 women who participated in Portugal. Data from the study was obtained through administration of a self-report questionnaire. The increase in awareness of self corresponded to significant behavioural change one year on, such as higher levels of physical activity. Though both studies related to a physical – not mental – health issue, the results still suggest that a change in awareness of self has the potential to incite behavioural change.

**Perceived choice**

Further to awareness of self, perceived choice is also considered an aspect of daily living that can assist in the personal recovery journey (Buck et al., 2013). Ryan and Deci (2006) discussed the notion of choice. They noted that many researchers see choice as closely related to autonomy, which – in the context of SDT – refers to “regulation by the self” (p. 1557). Ryan and Deci (2006) argued that choice has a number of different meanings. On the one hand, a person can be presented with many options, and feel overwhelmed and frustrated, instead of autonomous. Conversely, a single choice may be presented, in which the person still experiences autonomy if they are supportive of that option. When choice is perceived as meaningful, self-determination can be facilitated. This is supported by qualitative findings in the present study, which are discussed in section two.
In the present study, participants with a lived experience of mental illness who attended the five-day Recovery Camp reported a significant increase in perceived choice post-camp, compared to pre-camp, and this was maintained at three-month follow-up. This was relative to a comparison group of participants who reported no change in perceived choice. Again, this is important as it suggests participation in an intensive, five-day therapeutic recreation experience has the potential to foster and maintain perceived choice.

Though Recovery Camp was deemed to be an experience within a setting that was autonomy-supportive, options for participants were not completely open. Participants followed a structured program, with set activities at set times. They were offered a choice as to whether they actively participated in each activity by ‘doing’ (e.g. climbing the rock wall), with the alternative being to sit and watch, show moral support, help with preparation for the activity, and/or cheer on others. The finding that participants experienced an increase in perceived choice, which was maintained at follow-up, demonstrates that structure can still result in positive improvements in aspects of self-determination for people living with mental illness.

The present findings are complementary but do not completely align with findings from a similar study. Taylor et al. (2017) explored data from a Recovery Camp held in 2014. They found that there was no significant difference in perceived choice between the two groups (Recovery Camp participants versus comparison group) at three-month follow-up. Taylor et al. (2017) argued that this may be due to the lifestyles that participants lead outside of the setting, where they may be limited by social isolation, and a lack of choices, competencies, and motivation. It is encouraging in the present study that participants did maintain a level of perceived choice at follow-up, as it indicates they may have brought some lessons from Recovery Camp into their day-to-day lives. In addition, relative to the 2014 camp, the 2016 camp explored in the present study purposefully incorporated more
opportunities for choice and autonomy-support for consumers, through a broader range of activities.

Encouraging choice is a cornerstone of recovery-oriented care policies (Mancini, 2008). For instance, the Roadmap for National Mental Health Reform 2012-2022 in Australia denotes that a recovery-oriented approach “allows people flexibility, choice and control over their recovery pathway, and responds to each individual’s unique needs, circumstances, life-stage choices and preferences” (Council of Australian Governments, 2012). Similarly, the Strategic Plan for Mental Health in NSW 2014-2024 states “our care relationships must celebrate and work to our strengths, not our ‘deficits’, and should be prepared to support us to take the important risks necessary for recovery. These relationships support a recovery embedded in hope and choice” (Mental Health Commission of New South Wales, 2014a). According to SDT, someone who perceives they can act in alignment with their own choice/s and self-approval is autonomously motivated, as opposed to acting on controlled motivation where behaviour is influenced by external factors such as reward and punishment, or amotivation which involves a lack of motive and purposeful behaviour (Deci & Ryan, 2008). As noted in Chapter Two, SDT posits that the more a person’s behaviour shifts from being extrinsically driven toward being autonomous or intrinsically driven, the greater likelihood they will be to participate in self-motivated behaviours that promote quality of life (Stone et al., 2009). The presence of choice as a key concept across recovery-oriented policies and SDT speaks to the importance of these findings to the overarching literature on personal recovery. This is discussed further in section two.

The quantitative section of this study revealed that participants with a lived experience of serious and enduring mental illness reported an increase in various aspects of self-determination following participation in a five-day TR program. This included a rise in awareness of self, perceived choice, and relatedness post-camp and again at three-month
follow-up, relative to a comparison group of participants who went about their lives as usual.

The qualitative section of this study will now be discussed in relation to the literature.

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**Section Two: Qualitative Findings**

As described in Chapter Three, individual interviews and a focus group were conducted to build on and more deeply explore the quantitative findings described in section one of this chapter. The aim was to explore self-determined motivation and personal recovery from mental illness, in the context of Recovery Camp. The systematised and reflective psychophenomenological approach, developed by van Kaam (1969) and explicated in Chapter Three and Four, was used to analyse the data. van Kaam (1969) uses the word ‘structure’ to denote themes in his method of analysis, and ‘element’ to denote sub-themes. Analyses consisted of a central concept (Personal Recovery), three structures (Self-Determination, Confidence, and Purpose), and several elements that spoke to these structures. As noted in Chapter Four, each structure and element represents the genuine essence of meaning of each person’s unique personal recovery journey, and provides insight into self-determination and personal recovery, as espoused in the study aims. Each sub-structure, and its various elements, will now be explored as they relate to existing literature.
Self-determination

Self-determination (Figure 7) arose as a key structure relating to the personal recovery journey of interview and focus group participants. Qualitative data collection built upon the quantitative component of this study, by specifically exploring the SDT concepts of relatedness, autonomy, and competence in more depth, and in the participants’ own words.

*Connecting with and helping others (relatedness)*

The first element, ‘connecting with and helping others,’ corresponds to the SDT concept of relatedness. This element captures the essence of meaning of participants’ experience of relatedness within the Recovery Camp setting, and within the community following participation in Recovery Camp. All participants indicated that Recovery Camp helped them feel more connected with the people around them.

People living with mental illness are likely to experience social difficulties (Malmberg-Heimonen, 2010). As discussed in Chapter Two, consumers are regularly faced with distrust, stigmatisation, and distressing misunderstandings within the community (Henderson et al., 2013). People living with mental illness report less close social relationships than people who do not have a mental illness (Tew et al., 2012). Though recovery-oriented services are purported to be the ‘norm’, the reality is that many people
living with mental illness who enter the health system are faced with coercion and paternalistic attitudes and behaviours, which are detrimental to their recovery journey (Drake & Whitley, 2014; Hughes et al., 2009). This can lead to poorer outcomes and symptom augmentation (Drake & Whitley, 2014).

Schon, Denhov, and Topor (2009) contend that social relationships play a key role in personal recovery from mental illness, as the journey takes place within a social context. Depending on the nature of such relationships, the relationships can either promote elements of personal recovery, or prove detrimental to the journey. Positive relationships are those in which the person is viewed as unique, and their abilities are recognised in addition to their disabilities. Positive relationships can form between the consumer and their family and/or friends, as well as between the consumer and health professionals (Topor et al., 2006).

Participants in the present study conveyed that a TR initiative – Recovery Camp – increased connections through verbal communication and physical touch, and in their life when they returned home. Participants spoke about the benefit of connecting with people in their assigned group at Recovery Camp, and the social relationships established through participation in this experience. One participant described how she was previously ‘so shy’, but connecting with others changed that and improved her verbal communication.

*A couple of nurses and stuff have come up and asked me about my mental illness, and I have shared my experience of mental illness, you know. Any other time, like, I was just too shy, but I’ve come out of my shell a lot more now.* (P14; focus group)

In accordance with the principles of TR, Recovery Camp is purposefully designed to be supportive of each person’s uniqueness, and to promote social connection amongst participants. When the relationships established within this setting were perceived as
supportive, the person was able to ‘let their guard down’ and participate fully in the activities at Recovery Camp and the social interactions available to them.

Similarly, participants spoke about the importance of relationships with family and friends once they returned home from Recovery Camp.

*I’m very lucky that I have a very supportive partner. He… we talk, and we talk all the time. So if I’m having a bad day or if he’s having a bad day, we very much support each other.* (P4)

The importance placed on relationships with family and friends underscores the significance of working on existing, supportive relationships, not just the development of new, positive relationships (Tew et al., 2012). Family and friends are important support systems for people living with mental illness, as they can encourage help-seeking and, when supportive, have been linked to decreased symptoms and protective factors (Stacy & Medina, 2008). Some people described how participation in Recovery Camp encouraged them to maintain relationships with their health professionals.

*I can see many benefits of me going to Recovery Camp. My focus now is to maintain my contacts. I’ve gotta maintain a healthy relationship with my psych and my GP. You know, you can’t say enough about those relationships.* (P11)

Participants also conveyed that helping others – and having the choice to do so – was an important social component of their participation in Recovery Camp. This included helping other consumers, as well as sharing their stories with student participants, which was perceived as helping them learn. This was regarded by participants as a positive influence on their recovery journey. Davidson, Bellamy, Guy, and Miller (2012) systematically reviewed the literature on peer support among people living with mental illness. Peer support, in its
various structured and unstructured forms, is valuable to people living with mental illness as it encourages sharing and the promotion of personal recovery. Peer support workers have a lived experience of mental illness and use their experience to assist others to gain confidence and hope (Repper & Carter, 2011). Recovery Camp did not entail a structured or formalised peer support program, but instead encouraged participants to build supportive relationships amongst themselves. In turn, participants spoke of gaining confidence in their abilities and their communication skills.

*It was full-on going away for a week with a whole group of people, but… just a little bit more confidence… and I just relaxed. You felt a little bit more sort of calm and a little bit sort of relaxed with the different people.* (P6)

Further, participants reported that sharing their stories with students made them feel as though they were contributing to the betterment of the mental health profession.

*I just want to thank the uni students who’ve come on the camp for us… They’re learning from us and getting hands-on experience with us through our stories. They can be better nurses.* (P10; focus group)

This sharing of stories aligns with Anghel and Ramon’s (2009) exploration of 18 consumers’ involvement in a social work undergraduate degree in England. Consumers who taught the students reported in interviews that the experience was positive, and made them realise that there is a need to develop mental health professional’s understanding of consumer’s difficulties from their perspective. Similarly, O’Reilly, Bell, and Chen (2012) explored the experience of 23 consumer instructors in Australia who provided education to health professional students. Through five focus groups using semi-structured interview guides, the researchers surmised that consumers became involved to raise awareness about
mental health and stigma. The consumer instructors reported benefitting personally from the experience, in that it empowered them and improved their confidence and social skills.

**Making choices independently (autonomy)**

Another benefit of Recovery Camp was revealed in the second element, ‘making choices independently,’ which corresponds to support for autonomy and an influence on self-determination. This element captures the essence of meaning of participants’ experience of making their own choices, without having to rely on others, within the Recovery Camp setting. Participants described how they were able to make decisions and take control of their actions within the Recovery Camp setting.

> Usually [outside of Recovery Camp], there’s pressure from people around you. “Why can’t you do it?” You always had to try and do it. But, you know what your limits are. They [people at Recovery Camp] cared enough not to sort of put that pressure on you. They didn’t put that extra pressure on you that you couldn’t do stuff. You made the decision. (P6)

Many people who live with mental illness have difficulty making decisions, particularly those decisions that may have a significant impact on their life (Slade, Amering, & Oades, 2008). Many consumers will avoid services, and subsequently do not receive the help they need (Slade et al., 2008).

Yanos et al. (2010) outlined how people who live with mental illness can develop an illness identity, defined as the perspectives and understandings a person has about living with their mental illness. The authors contend that a person’s illness identity can have a significant impact on their personal recovery. Indeed, self-stigma, whereby the individual judges themselves to be incapable of living up to their own expectations and those imposed by societal norms (Overton & Medina, 2008), often occurs. If an individual accepts an illness
identity in which they cannot make decisions, this can negatively affect important aspects of personal recovery such as hope and self-esteem. This illness identity can be brought about by the internalisation of stigmatising beliefs, such as the judgement that people with mental illness cannot make informed decisions about their own livelihood.

Participants in the present study stated that participation in Recovery Camp was the encouragement they needed to empower them to make their own choices.

*I actually found it [Recovery Camp] really, really good for my self-esteem and I felt empowered. I used to be by myself and I didn’t do the stuff that I liked to do. Then, since camp, since I’ve been back home, it’s just opened up doorways.* (P15)

Empowerment, for people with mental illness, can be defined as “the authority to exercise choices and make decisions that impact their lives and are educated and supported in so doing” (Slade et al., 2008, p. 130). Empowerment focuses not on compliance, but instead on people shaping their own behaviours in alignment with their own values, and is an important component of a recovery-oriented approach to mental health care (Slade, 2009a). The Mental Health Commission of New South Wales’ (2014a) Strategic Plan for Mental Health in NSW 2014-2024 denotes that health care should empower consumers to make their own choices. Indeed, participants in the present study suggested that their renewed belief in their capacity to make unrestricted decisions was an important aspect of personal recovery for them.

This element – making choices independently – showed a progression across participants. The progression was one of moving from low levels of self-determination, as is typically the case for people living with mental illness (Okon & Webb, 2014), to an increased, internal level of self-determination.
Having a go and feeling successful (competence)

The third element relating to personal recovery, ‘having a go and feeling successful’ corresponds to satisfaction of the need for competence, as espoused by SDT. This element captures the essence of meaning of participants’ experience of trying and succeeding in the Recovery Camp setting. This related to various aspects of the experience, from physically extending themselves in activities such as the giant swing, to increasing their efficacy to engage with others.

Borg et al. (2006) proposed that the personal recovery journey is supported by participation in personally meaningful activities, in which one feels they are important and valued. Part of this journey is the feeling of achievement accomplished through trying or ‘having a go.’ Borg et al. (2006) goes on to suggest that people living with mental illness have very few opportunities to experience success and achievement. As described in Chapter Two, the Australian Department of Health’s (2013) National Framework for Recovery-Oriented Mental Health Services outlines the various factors in a person’s life that can influence the personal recovery journey. Included in this list was employment, education, and training. In 2011-12, only 62% of Australians with a mental illness were employed, and this was a decrease of 2% since 2007-08 (Department of Health, 2013). Dunn et al. (2008) interviewed 23 individuals in various stages of personal recovery and found that employment enhanced self-esteem by promoting perceptions of competence and self-pride. For some, it is the only area of their life in which they feel valued because they do not find that they are valued by others in their life. Recovery Camp, like employment, is structured and provides opportunities to demonstrate success and experience achievement.

Parcesepe and Cabassa (2013) conducted a systematic literature review on public stigma of mental illness in the United States. They found that the public’s perception of
competence among people living with mental illness differed depending on the diagnosis. For instance, people living with schizophrenia and drug dependence were seen as less competent and in need of more coercive treatment, compared to people living with depression and alcohol use disorders. Stigma, in this regard, can be particularly damaging for people with more serious forms of mental illness, with little opportunities offered to feel competent.

Some people gain value through opportunities to feel physically competent. Participants in the present study noted how, despite some physical limitations (e.g. being overweight), they felt a sense of accomplishment in having ‘had a go’ at various activities at Recovery Camp.

*Even though my body is not strong, that doesn’t mean I didn’t get a hell of a lot out of camp. I went on the high flyer so that was great. I was just on a high, you know, because people were cheering me on… it just did so much for me… for my morale.* (P13)

The Recovery Camp setting invited participants to challenge themselves, in line with the principles of TR, through activities that were varied and designed to appeal to a broad range of capabilities. While some participants found the physical activities challenging, others challenged themselves by partaking in more social interactions, which was a fear for them to overcome. For example, for some participants, just sitting and having a chat over a shared meal was a challenge. Again, participants referred to the empowering nature of trying (‘having a go’) and succeeding at Recovery Camp.
Confidence

Confidence (Figure 8) arose as another key structure relating to the personal recovery journey of interview and focus group participants. As noted in Chapter Four, confidence in the context of personal recovery involves a belief that one can succeed (Slade, 2009a). Two elements were apparent within this structure: overcoming fear and stigma, and acceptance and balance. For ease of discussion, they have been broken into four sections below: overcoming fear, overcoming stigma, acceptance, and balance.

Overcoming fear

The first element, ‘overcoming fear’, related to participants’ experience of activities at Recovery Camp. Fear is something we all experience at various intensities and intervals. Yet, for many people living with serious mental illness, it can become a common fixture of their daily lives, often paired with a lack of support, difficulties expressing their needs, and self-neglect (Lawrence & Kisely, 2010a). Many symptoms of serious mental illness instil a sense of fear. For instance, Cáceda, Nemeroff, and Harvey (2014) noted that people who live with panic disorder – a form of anxiety disorder – live in fear of their next panic attack, given the uncertainty around when it will take place. This uncertainty is apparent for many other types of mental illness where the fear of public ridicule and negative perceptions are all too apparent, which is unsurprising given that people with mental illness, as a group, have long been devalued and portrayed in the media as people to be feared (Granello & Gibbs, 2016).
In line with the above studies, Thompson et al. (2008) explored the experience of people living with chronic mental illness using photovoice methodology in which participants took photos that represent what it is like to live with their illness. Each participant was subsequently interviewed for one hour. Results revealed that people living with mental illness often experience significant, daily fear and a need to feel safe. This is magnified for people who had previously been in abusive situations. The need to feel safe can be linked to SDT as one of the most basic human needs.

To illustrate the many aspects in which a person can experience fear, participants in the present study described how the very notion of reaching out and registering for Recovery Camp involved overcoming significant fears right from the beginning. One participant described how his fear revolved around social aspects of his life.

*That’s what I get scared of sometimes. Social interaction.* (P2)

Yet, he ‘pushed’ himself to register for Recovery Camp and, looking back, felt it helped him overcome his fear in so far as he gained a friend from the experience. Similarly, some participants found the activities at camp were initially a source of fear.

*I was able to do things that I was scared of [at Recovery Camp].

*Particularly the… the one that really sticks in my mind is that… that giant swing. That terrified me, but it was so fabulous. The feeling of accomplishment… Yeah, it was a really safe environment.* (P4)

The dignity of risk, as discussed previously in this chapter, was a component of the Recovery Camp experience. Participants were invited to make their own informed choices, in line with their goals for Recovery Camp. For some, this meant putting on a harness, and swinging from a 15 metre/50 foot high giant swing – an experience which stood out for many participants as it resulted in feelings of elation and achievement. Many conveyed that, if they
could take part in such a physically exhilarating and terrifying activity, ‘I can do anything.’ (P11)

While discussing their Recovery Camp experience, most participants also spoke of how it contrasted to their time in hospital settings, of which they were quite fearful.

*I get real anxious. I have panic attacks about things… A week ago, I got pain at the top of my lungs and it felt like a blood clot, and I was like… should I go to hospital? … I’m scared of hospitals. I’ve been into hospitals that many times, it’s become a fear for me… You’re wounded. You’re ‘damaged goods’ – that’s the term used.* (P1)

In contrast, participants indicated that the positive and encouraging people in the Recovery Camp setting enabled them to push through their fear and feel challenged, not scared.

Outside of TR settings, the general public often express fears regarding people with mental illness – a response perpetuated by stigmatising public perceptions and media coverage that suggest consumers are dangerous (to themselves and others) and unpredictable (Corrigan et al., 2014; Corrigan, Kuwabara, & O’Shaughnessy, 2009). Corrigan and Rao (2012) purport that these perceptions can be damaging to people living with mental illness, often resulting in self-stigma, whereby the individual internalises these perceptions of fear and other negative attitudes. Self-stigma has serious, negative implications not only for the person’s overall health, but also with respect to their decision to connect with others in their community and challenge themselves. This self-stigma, in addition to stigma from the general population, also emerged as an element across interviews. In the Recovery Camp setting, participants – whether students, consumers, or staff – are all treated as equal, negating the potential for self-stigma.
Overcoming stigma

The second element, ‘overcoming stigma,’ related to the negative judgements perceived by participants. This included how stigma caused setbacks in their personal recovery journey, and how Recovery Camp helped them deal with its impact. As discussed in Chapter Two, people with mental illness regularly face stigmatisation from those around them, including family and friends (Overton & Medina, 2008). This stigma occurs across many areas of their life, from renting a home (Nelson, 2010), to applying for work (Krupa et al., 2009), and seeking support (Overton & Medina, 2008). The negative implications are vast and can lead to serious impediments in the personal recovery journey (Corrigan & Wassel, 2008; Corrigan et al., 2014).

Iwasaki et al. (2010) contend that active living is important for the personal recovery journey. In particular, social leisure activities that encourage wellbeing (emotional and physical), and focus on the strengths of participants, as opposed to the deficits, can take the focus away from stigma. Indeed, participants in the present study described that, while they still have ‘a label in my life’, Recovery Camp encouraged them to focus on strengths and share their experience with peers. Further, having the opportunity to teach the students/future health professionals encouraged them to view their experiences – even those surrounding stigma – in a positive light.

They’re [students] learning from us and getting hands-on experience with us. Yeah. It’s really great what they do for us, and also they’re learning off us – what we’ve experienced with mental illness… I’m pleased that I helped out. (P14; focus group)
The notion that people in the community believed and appreciated their stories, was important for many participants. Participant 6 noted that his conversations with the students was something that helped him overcome some negative emotions surrounding stigma.

Viewing participants from a strengths-based perspective, as was the case at Recovery Camp, can pave the way for honest discourse surrounding stigma (Moxham et al., 2015). While it is difficult to mitigate stigma (Overton & Medina, 2008), it is important that people with a mental illness have an opportunity to express how it makes them feel. One participant described the pervasive, negative judgments of those around them.

*If you’ve got mental illness, people don’t look up to you. They think you’re dumb and stupid. I copped a lot in life for being slow. It’s why people ask questions I can’t answer, and then they pick on me because I can’t answer that question.* (P8)

He went on to describe how sharing these thoughts in a supportive setting – Recovery Camp – and having supportive experiences helped him cope with stigmatising attitudes and behaviours. Even something as simple as the students asking, ‘*what are you wearing tonight to keep warm?*’ He said, ‘*I like that. That cheers me up. I feel normal.*’ At Recovery Camp, students and staff were actively discouraged from speaking or behaving in a stigmatising way. For example, consumers were addressed by their names – not labels – and students did not know their diagnoses prior to attending Recovery Camp. They only found out if the consumer chose to tell them.

As noted earlier in this chapter, self-stigma is a significant issue for people living with mental illness. By internalising negative stereotypes, people with a mental illness can experience low self-esteem and a lack of hope for the future (Corrigan, Rafacz, & Rüsch, 2011). TR initiatives, such as Recovery Camp, offer an opportunity to reframe how people
see themselves, and are a means to regain confidence as described earlier in this chapter. Participants described how Recovery Camp participation led them to accept what they cannot change – including the perceptions of others.

**Acceptance**

The third element, ‘acceptance,’ related to participants’ acceptance of their diagnosis as an aspect of their personal recovery journey. Acceptance in this context can be defined as having positive regard for oneself (Carter & van Andel, 2011). Some people with a mental illness live in denial of what they are experiencing, and this can lead to social isolation and a lack of awareness as to the impact of their condition (Lysaker, Roe, & Yanos, 2007). Earlier in this chapter, illness identity – that is, the perspectives and understandings a person has about living with their mental illness – was discussed. Yanos et al. (2010) contend that acceptance of ones’ illness identity can lead to increased hope and self-esteem, and can decrease maladaptive coping strategies and symptom severity, and lower the risk of suicide.

Participants in the present study spoke about how Recovery Camp helped them to accept their mental health diagnosis, regardless of their varied capabilities. One participant spoke about how a lack of acceptance held her back from doing things she enjoyed in the past.

*I was just scared. I was just scared of feeling like I wasn’t going to be accepted. Acceptance is a big part [of personal recovery] for me… With my mental illness, I’ve never felt accepted in the family even.* (P3)

She spoke about how Recovery Camp encouraged her to feel more accepting of her illness, and suggested, *‘I'm not seeing black all the time.’* She attributed this to the support and lack of judgement from others – students and peers – when she did disclose her
diagnosis. This ignited a renewed sense of confidence in her ability to overcome the challenges she faced.

A significant and important component of many TR programs is the promotion of a climate of acceptance (Carter & van Andel, 2011). At Recovery Camp, this was achieved via active encouragement of warm and supportive interactions amongst peers, between consumers and health professionals, and in support of ones’ own goals. Trained TR professionals and the university facilitators ensured this was maintained throughout the week, at each activity, through structured introductions, support, and debriefing.

Hood and Caruthers (2007) contend that self-acceptance is particularly amenable to change using TR intervention. This has been the case in studies examining TR as a treatment for post-traumatic stress disorder (PTSD) amongst veterans. More recently, Dustin, Bricker, Arave, Wall, and West (2011) explored the experience of thirteen veterans with PTSD following participation in a four-day TR river trip. They found that participants expressed greater acceptance of their condition, and were able to put their lives into perspective. There is little to no research focusing on the influence of TR interventions on acceptance among people living with other forms of mental illness, suggesting an area for future research.

**Balance**

‘Balance’ was the fourth element revealed in interview findings. This element related to the importance of striking a balance – with regard to medication, and a return to ‘usual’ activities of daily living – in the personal recovery journey of participants. Medications prescribed for mental illness (e.g. antipsychotic medication) can elicit a number of side-effects (De Hert et al., 2011). This can include effects on appetite and food intake (e.g. Kluge et al., 2007), weight gain/obesity (e.g. Citrome & Vreeland, 2008), and metabolic syndrome (e.g. Correll, Frederickson, Kane, & Manu, 2008). Bellack et al. (2009) identified that medication
adherence can be lacklustre in people living with mental illness. They surveyed 41 medical professionals who suggested only 51-70% of consumers with schizophrenia or bipolar disorder take their prescribed medication. This was often associated with poor insight and illness awareness, and distress associated with side effects. They acknowledged that it was a complex and multi-determined issue, and required further exploration.

Participants in the present study spoke at length about medication, and identified that it was a key consideration for them, both in the Recovery Camp setting and beyond. They saw stability in medication as an important factor in their personal recovery. The ‘right’ medication – taken as directed – meant they could stay out of hospital, lessen ill judgements of others, and reduce physical and emotional discomfort. One participant affirmed, ‘I believe I am in recovery.’ When prompted to elaborate on why he felt that way, he suggested it related to medication.

*I’m fairly stable on medication, so I try new things. Um, so I’m excited about my life.* (P8)

Other participants referred to balance as a general feeling of stability, and a return to activities that were previously ‘normal’ for them.

*Sometimes when I feel like giving up and I’m a bit over life, I look at it a different way to balance it out, and I think to myself, that’s not very fair, you know? Things can be normal again.* (P14)

For one participant, regaining balance meant partaking in leisure activities that they used to enjoy, and utilising them as a coping strategy when his symptoms became overwhelming. As one example, he described how Recovery Camp helped him rekindle his interest in video games, and this helped lessen worrying and anxiety.
Edward, Welch, and Chater (2008) used descriptive phenomenological in-depth individual interviews to explore the phenomenon of resilience among eight people with mental illness. Resilience is regarded as the ability to bounce back from negative experiences, and is seen as an important antecedent for hope, faith, and humour which are important for personal recovery (Edward, 2007). Participants suggested that ‘striking a balance’ helped them to feel more resilient, in that they were able to self-regulate, monitor their mood shifts, and respect both their own opinions as well as the opinion of others. They also suggested that this was difficult, as there was some unpredictability to their illness, so every day was a struggle to maintain balance. The authors argued that looking at the world in terms of both potential difficulties and hope for the future was important in maintaining resilience and balance. This could then pave the way for personal recovery.

**Purpose**

*Figure 9. The structure of purpose and its corresponding elements*

Purpose (Figure 9) arose as another key structure relating to the personal recovery journey of interview and focus group participants. Kashdan and McKnight (2009) define purpose in life as a pivotal, self-proclaimed aim that corresponds to ones’ identity. They contend that having a purpose is the cornerstone for resilience and makes life more enjoyable (Glover, 2012). In the present study, purpose as an overarching structure related to two elements: growth, and hope for the future.
**Growth**

The first element, ‘growth,’ related to the prospect of personal growth, and how this gave participants something to work towards. As noted in Chapter Four, growth in this context refers to an emotional and/or psychological, positive shift, inclusive of personally valuable goals such as regaining independence (Passarelli, Hall, & Anderson, 2010). Twelve participants discussed this concept broadly, though it manifested itself in different ways for different people. For some it meant continuing their education, or increasing social interaction, while for others it meant making physical strides. One participant noted that, after participation in Recovery Camp, she threw away her walking stick. She noted this was a positive shift that helped her regain independence and empowerment through physical growth.

*I’d had a fall just before the camp, so I was actually using a stick to walk.*

*By the end of camp, with the exercise and everything, I could throw the stick away. So, that was huge.* (P4)

Growth is often discussed in the literature as it relates to well-being. Developmental perspectives on well-being emphasise growth and meaning making, and focus on human potential (Neugarten, 1973). Factors such as purpose in life, personal growth, and positive interpersonal connections are linked to both mental and physical well-being (Bonney & Stickley, 2008; Glover, 2012).

As conveyed in Chapter Two, consumers are often faced with life circumstances that cause distress, including poor physical health (Thornicroft, 2011), and unsupportive social networks (Henderson et al., 2013), which can further amplify psychological symptoms. However, as Weich et al. (2011) found in their Adult Psychiatric Morbidity Survey of people living with mental illness in England, people experiencing mental illness and psychological
distress can still experience growth and draw meaning from their experiences. This was
evident in the present study. Recovery Camp afforded participants the opportunity to engage
in strengths-based activities, which promoted personal growth through genuine, interpersonal
connections, peer support, and encouragement. One participant initially described
experiencing poor physical health, and many years of psychological distress. Yet, when she
was asked at Recovery Camp to provide support to her peers, this instilled considerable
confidence in her. She felt that it was the driving force for growth.

*It comes back to the confidence that I’ve got, because it was instilled in me
from being asked to help. I can’t really stress enough how much that meant.
It’s really strange, but it just meant everything. My whole world virtually
changed when that happened… I’d been so quiet prior to that. Now, I don’t
want to be on my own. I want to mix. I want to talk to people.* (P3)

Young, Green, and Estroff (2008) analysed data from a STARS (Study of Transitions
and Recovery Strategies) mixed-methods, longitudinal, exploratory study of personal
recovery among people living with serious mental illness. Interview analyses revealed an
association between personal growth and personal recovery. Participants described how
taking risks – even those that could lead to symptom exacerbation – were important in
achieving growth. This could mean new activities and/or responsibilities. This speaks to the
Recovery Camp setting in which the dignity of risk was encouraged, and resulted in many
participants experiencing personal growth and describing it as a positive step toward personal
recovery.

*Hope for the future*

Another positive step toward personal recovery was revealed in the second element, ‘hope for
the future.’ This related to the notion of hope and how it could help participants harness
strength and make strides toward personal recovery. As noted in Chapter Two, it has been established in the literature that hope is a key aspect of personal recovery (Champ, 1998; Glover, 2012; Leamy et al., 2011; Slade et al., 2014). Hope also underpins all aspects of self-determination as, without hope, there would be little to no growth in autonomy, competence, or relatedness. Glover (2012), who has a lived experience of mental illness, describes hope as the movement away from hopelessness toward a belief that one can successfully confront any future challenges that may arise.

Participants in the present study were asked what personal recovery means to them. It was identified that hope was a major factor in their personal recovery journey.

*Hope remains the paramount element in my recovery, because through effort and through resilience and through determination… these are all things I learnt on the camp… all those things are going to help me in the future, for sure.* (P8)

This aligns with Schrank and Slade’s (2007) review of the emergent concept of personal recovery in psychiatry, which revealed that the most important factors for personal recovery among consumers include hope, spirituality, purpose, symptom management, stigma, and connection with others. Shepherd, Boardman, and Slade (2008) argue that hope has the capacity to sustain motivation and build realistic expectations for a fulfilling future. They surmise that not everyone will remain constantly hopeful throughout the many challenges of living with mental illness, but the openness to keep trying to regain hope is an important part of personal recovery.

Hope can be inspired through relationships (Leamy et al., 2012), and this was also apparent in the words of participants in the present study. They described how meeting new people at Recovery Camp was *positive* and signalled *‘a new beginning’* (P10). In instances
where peers and family are not supportive, mental health professionals can provide ‘hope-inspiring’ relationships (Shepherd et al., 2008). Hobbs and Baker (2012), through analysis of semi-structured interviews with consumers, found that mental health professionals play a pivotal role in fostering hope for the future. Participants in the present study contended that this was essential for their personal recovery journey.

In line with this, Slade et al. (2008) argue that recovery-oriented interventions should include activities that promote hope and personal responsibility. TR interventions, while playing an important role in promoting enjoyment and fun, are also an important means to lift people’s spirits and restore hope (Hutchinson, LeBlanc, & Booth, 2006). Recovery Camp, underpinned by the principles of TR, challenged participants to harness hopefulness in undertaking each activity. TR facilitators used encouraging, person-centred language to promote participation to the best of each person’s ability, and ensured each person that they could overcome each challenge to the best of their ability. Participants spoke about how this approach encouraged them to feel, ‘I can do anything,’ and they were able to integrate that into their daily lives upon returning home.

In summary, van Kaam’s (1969) psychophenomenological method of analysis was used to analyse the qualitative data in this study. A central concept of Recovery was revealed, underpinned by three key structures (Self-Determination, Confidence, and Purpose), and several elements that informed these structures. The overarching analyses provided insight into the association between self-determination and personal recovery.
**Section Three: An Overarching Discussion of Findings**

In order to leverage the strength of a mixed methods approach, it is important to discuss the above findings from section one and two of this chapter in combination (Fetters, Curry, & Creswell, 2013). Looking at quantitative and qualitative findings in combination is particularly valuable for health care research, as it can provide greater insight than looking at either approach singularly (Curry et al., 2013). The present study explored a significant issue in mental health care – that is, how to satisfy/support the motivational responses of consumers, and how these motivational responses may or may not influence personal recovery from mental illness. By utilising a quantitative methodology to first address the magnitude of effect, then employing a qualitative methodology to explore the phenomenon from the individual’s perspective, the aforementioned issue was explored in depth.

As discussed in Chapter Two, this study draws on three frameworks as they relate to a TR experience known as Recovery Camp. The frameworks are:

- Self Determination Theory (SDT) (Deci & Ryan, 1985),
- Iwasaki et al.’s (2018) leisure-induced engagement theoretical framework, and
- Glover’s (2012) Self Righting Star® of Recovery

Tables 11 to 13 summarise the key elements of all frameworks, to realign the reader with the focus of each. Following the tables, I delve into the elements that are conceptually aligned.
Table 11. Deci & Ryan's (1985) three key needs of Self-Determination Theory

<table>
<thead>
<tr>
<th>Autonomy</th>
<th>Competence</th>
<th>Relatedness</th>
</tr>
</thead>
<tbody>
<tr>
<td>A feeling of choice and control, where one acts with their own interests and values in mind</td>
<td>A feeling of success or optimal challenge</td>
<td>A feeling of social connection and belongingness with others, and with the community as a whole</td>
</tr>
</tbody>
</table>

Table 12. Iwasaki et al.’s (2018) key elements of meaningful engagement with life, as influenced by engagement in leisure pursuits

<table>
<thead>
<tr>
<th>Joyful Life</th>
<th>Connected Life</th>
<th>Discovered Life</th>
<th>Composed Life</th>
<th>Empowered Life</th>
</tr>
</thead>
<tbody>
<tr>
<td>The promotion of a life that includes positive emotions, engagement, and meaning-making.</td>
<td>The promotion of a life of meaning through holistic connectedness (e.g. social, spiritual, and cultural).</td>
<td>The promotion of discovering one’s own unique talents and positive attributes.</td>
<td>The promotion of a life in which one feels they are in control, and can make their own decisions.</td>
<td>The promotion of a life of stress-coping, emancipation, and inner strength.</td>
</tr>
</tbody>
</table>

Table 13. Glover's (2012) Self Righting Star® of Recovery polarities and descriptions

<table>
<thead>
<tr>
<th>Active Sense of Self</th>
<th>Hope</th>
<th>Ability to Respond/Take Control</th>
<th>Connectedness</th>
<th>Discovery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Movement from being a service user to re-identifying one’s own strengths</td>
<td>Movement from hopelessness to hope for the future</td>
<td>Movement from relying on others to promote recovery, to a belief that recovery is one’s own responsibility</td>
<td>Movement from viewing oneself as unwell and secluded, to actively participating in the community</td>
<td>Movement from alienation to the discovery of meaning and purpose, and all aspects of learning within that process</td>
</tr>
</tbody>
</table>

The above frameworks elucidate the areas of self-determination, leisure (or TR), and personal recovery, making them particularly pertinent to the present study. The interview findings from the present study conceptually align with Glover’s (2012) Self Righting Star® of Recovery polarities in that participants used this opportunity to discuss their personal recovery journey. Glover’s (2012) framework is used in this discussion to frame participants’ experience of recovery, and highlight how the experience of Recovery Camp assisted participants to move from one frame of mind to another. This framework was selected as it
reflects a genuine lived experience of personal recovery, from the perspective of Helen Glover who has embarked on the journey herself.

Quantitative and qualitative findings will next be discussed in combination as they relate to the frameworks noted above. The three key needs espoused by SDT – autonomy, competence, and relatedness – will be used as headings below, given their prominence in the findings of this study.

**Autonomy**

Survey participants in the present study reported a significant increase in autonomy post-camp, at a ‘global’ level, however this was not maintained at three-month follow-up. This suggests there was something about Recovery Camp that resulted in an increase in autonomy, but something more was required to maintain autonomy over time. Interview participants underscored the importance of making choices independently, and suggested this new found autonomy (on a ‘contextual’ level) was something they were able to bring back into their daily lives post-camp. Participants also suggested that ‘having a purpose’ was important to their personal recovery. It encouraged participants to grow as a person, and look towards their wants and needs in the future.

Iwasaki et al.’s (2018) framework elucidates how our lives are made up of ‘restrictive’ domains of being, such as work and appointments, and leisure pursuits. Leisure – when compatible with the individual – can encourage feelings of liberation and freedom, in making choices, feeling autonomous, and living a life of meaning (‘composed life’). Iwasaki et al. (2018) draws on Iwasaki et al.’s (2015) research exploring the experience of personal recovery for people living with mental illness which underscored how leisure helped participants persevere with composure and confidence in the face of adversity. As described earlier in this chapter, interview participants in the present study discussed how participation
in Recovery Camp instilled in them a sense of choice and control (autonomy) over aspects of their lives that they found to be important.

Glover’s (2012) framework reflects the notion that people undertake considerable efforts to move from one state of being to another through their personal recovery journey. Glover’s concept with regard to possessing an ability to respond/take control, references the progression from others being in control, to the individual taking control and feeling more autonomous. Similarly, the concept of discovery references the progression from feeling alienated and marginalised, toward discovering for oneself what works for them, as an individual, and how they can find purpose and meaning.

Many health professionals assume that people living with mental illness cannot make responsible decisions (Slade et al., 2008) – a cornerstone of autonomy. Recovery Camp promoted the dignity of risk, encouraging participants to take control and discover their own purpose. This notion of personal responsibility and control is also supported by Andresen et al.’s (2006) model of recovery that was previously described in Chapter Two.

**Competence**

In the present study, analysis of the short version of the Basic Needs Satisfaction in Life General Scale (BNSL-S) revealed no significant rise in competence post-camp, yet interview participants spoke of competence gained from being at Recovery Camp. The BNSL-S was utilised to measure the three key needs of SDT on a ‘global’ scale. Competence, as framed by the BNSL-S, may have been discrepant with participants’ real-world view of competence in the Recovery Camp (‘contextual’) setting. Interview participants spoke of competence on a smaller, more specific scale – at Recovery Camp and within their small community structures.
Iwasaki et al.’s (2018) framework identifies the concept of a ‘discovered life,’ which also speaks to this notion of competence. Iwasaki et al. (2018) purported that leisure pursuits can encourage people to find and showcase their positive attributes and talents. This discovery contributes to the individual’s self-identity, in that it offers the opportunity to reframe how they see themselves, in a more competent way. It can also help them discover purpose and meaning in life. This was conveyed by participants in the present study, who saw success and optimal challenge at Recovery Camp, a TR experience, as the impetus for discovering or re-discovering their own positive attributes and abilities. This was something they said they brought back to their day-to-day lives post-camp.

This then links to Glover’s (2012) notion of active sense of self. As the personal recovery journey progresses, instead of remaining passive in the face of adversity and other situations that require decision-making, people living with mental illness feel a sense of strength and ownership over their abilities. This can be apparent amongst social circles where people may clarify what they need and want from key relationships in their life, and also in the context of mental health services. If the individual can competently advocate for their needs, theoretically they will receive more appropriate and targeted care. Indeed, Glover (2012) is a proponent of people taking an active role in their personal recovery and reclaiming responsibility for the trajectory of their future care in a competent and self-assured way.

**Relatedness**

Perhaps the most significant finding of the present study, is that of the importance of relatedness for the personal recovery journey. Connectedness (Glover, 2012), relatedness (Deci & Ryan, 1985), and a connected life (Iwasaki et al., 2018) were three concepts, closely
entwined, that were apparent across both interview and survey findings in the present study, as shown in Figure 10.

**Figure 10.** The convergence (social connection) of Glover's (2012) concept of connectedness, Iwasaki et al.’s (2018) concept of a connected life, and the Self-Determination Theory (Deci & Ryan, 1985) need of relatedness.

Self-Determination Theory denotes that relatedness is a perception of social connection and belongingness with others, including within the community as a whole (Deci & Ryan, 2008). Similarly, Iwasaki et al. (2018) discusses how a ‘connected life’ is one in which leisure, or TR, encourages positive interpersonal relationships and community involvement, and spiritual and cultural connectedness. Moreover, Glover (2012) describes connectedness as a movement from viewing oneself as secluded, to actively participating in the community. In support of all three frameworks above, the present survey findings revealed participants’ reported a significant increase in relatedness post-Recovery Camp, and this was maintained at follow-up. Further, every interview participant conveyed that social connection was paramount to their personal recovery journey.
Leisure pursuits (or TR) have been socially beneficial for a number of disadvantaged groups, including people with dementia (Phinney & Moody, 2011), people with spinal cord injuries (Chun & Lee, 2010), and immigrants (Mata-Codesal, Peperkamp, & Tiesler, 2015). Recovery Camp is a ‘judgement-free space’ where participants are encouraged to connect with one another and share their stories.

*I had so much fun. I met some really great people. Everyone was on the same page. There was no stigma. There was no judgement.* (P1)

While there was no pressure to connect with one another, all interview participants described taking this opportunity, and many developed lasting friendships. Glover (2012) describes how this process is beneficial because it moves people away from an identity of disability, toward ‘full’ community participation. This process is a transition away from the powerlessness often imposed on people with a mental illness, and is therefore an integral step in the personal recovery journey. The above discussion illustrates a convergence between self-determination, leisure (or TR), and personal recovery, given the relationship between SDT (Deci & Ryan, 1985), Iwasaki et al.’s (2018) leisure framework, and Glover’s (2012) Self Righting Star® of Recovery framework in the present study.
Chapter summary

This chapter explicated the findings described in the previous chapter by exploring them in-depth, then bringing them together in the context of established frameworks, including SDT (Deci & Ryan, 1985), Iwasaki et al.’s (2018) leisure framework, and the Self Righting Star® of Recovery framework. It addressed the aims of this research, by encapsulating a discussion of:

a) How Recovery Camp satisfied/supported the motivational responses of consumers, and

b) The meaning of self-determination and personal recovery as individual concepts, and as interconnecting concepts.

Participants who attended Recovery Camp reported that it did satisfy and support various motivational responses, such as awareness of self, perceived choice, and relatedness. The post-camp increase in these aspects of self-determination was maintained at three-month follow-up. Autonomy increased post-camp, however was not maintained at follow-up. Competence did not differ significantly from pre- to post-camp, as compared to a comparison group who went about their daily lives as usual. Qualitative findings highlighted parallels between aspects of self-determination and personal recovery. Participants did report that aspects of self-determination were a positive influence on their personal recovery journey, in addition to other influencing factors such as purpose and confidence.

The final chapter will summarise the findings of this study, as well as discuss limitations and areas for future research. Further, practical implications for the field of mental health care will be explored. Chapter Six will conclude with a final reflection.
CHAPTER SIX

Conclusion

The use of a mixed methods approach enabled the aims of the study to be achieved through a
detailed and comprehensive exploration of the research questions:

a) Can participation in a therapeutic recreation (TR) initiative (Recovery Camp)
satisfy/support the motivational responses of people living with mental illness?

b) What do self-determination and personal recovery mean for people living with mental
illness who attended Recovery Camp?

This is an important area of enquiry given the knowledge gap in this area. Very few
studies have explored whether involvement in TR activities can specifically develop the key
needs of self-determination for people living with serious and enduring mental illness. Past
studies have included people living with schizophrenia only and did not include participants
with other mental health diagnoses (Snethen et al., 2010). In addition, no follow-up was
conducted in prior research. Also, while the link between self-determination and personal
recovery has been explored in the literature (e.g. Mancini, 2008), this has not been studied in
people living with serious and enduring mental illness. No research has looked at the two
concurrently among this cohort. It is clear, therefore, that this thesis has contributed new
knowledge.

Chapter One introduced this area of enquiry, and outlined the research purpose, aims,
questions, and rationale. Chapter Two set the scene for this research, exploring existing
literature and elucidating the significant global impact of mental illness. This was followed
by Chapter Three in which the research design was explained in detail. The use of a mixed
methods approach involved an initial quantitative (survey) component, built upon via a qualitative component (15 interviews and 1 focus group). The findings of this approach were explored in Chapter Four. Chapter Five included a discussion of the quantitative and qualitative findings as they related to relevant literature, and brought the findings together using two theoretical frameworks. Direct quotes from participants were presented in Chapter Four and Five.

This chapter is the final chapter. It summarises the purpose and aims of this study, and the ways in which the findings contribute toward the current body of knowledge in this area. Practical implications are also explored. Finally, areas for future research, and limitations, are discussed, followed by a final reflection.

**Key points**

This research was born from a desire to explore the lived experience of people living with mental illness – to give them a voice and respect that they are the experts in this field.

Engaging service users in mental health research can boost their self-confidence by shedding light on their strengths and encouraging them to reclaim aspects of their life previously lost to illness (Schneider, 2010). This is important for consumers, given that – as a group – they have long been marginalised and stigmatised (Patel et al., 2007).

The participants in this study attended a TR experience called Recovery Camp. Participants self-reported on aspects of self-determination pre-camp, post-camp, and at three-month follow-up via their responses to two reliable and valid surveys. Their responses were compared to a comparison group who went about their lives ‘as usual.’ Fifteen Recovery Camp participants were later interviewed and generously offered their perspective on what personal recovery meant to them, and how this related to aspects of self-determination. Participants conveyed their worldview, tying their experiences at Recovery Camp to their
broader, ‘global’ perspective of experiencing mental illness and personal recovery from mental illness. Reflecting on participants’ words using van Kaam’s (1969) psychophenomenological approach to analysis ensured description and reduction of data, and the investigation of clear structures and elements, without compromising each individuals’ unique lived experience.

Through this process, it was revealed that some aspects of self-determination increased following participation in Recovery Camp – that is, autonomy, relatedness, perceived choice, and awareness of self. However, autonomy was not maintained at follow-up, and a change in competence was not statistically significant, relative to the comparison group. Further, an association between personal recovery and self-determination was apparent through interview findings. van Kaam’s (1969) psychophenomenological method of analysis revealed a central component (Recovery), three structures (Self-Determination, Confidence, and Purpose), and several elements that spoke to these structures.

The research exposed the intricacies of personal recovery, and the factors that influence the personal recovery journey. Elements of interview findings included the needs of Self-Determination Theory (SDT; autonomy, competence, and relatedness), overcoming fear and stigma, acceptance and balance, growth, and hope for the future. These elements strengthen the literature in this area by elucidating the meaning behind the personal recovery journey of people who live with mental illness, including clarification as to how self-determination influences this process, and how involvement in a TR experience can influence these concepts.

**Contribution to knowledge**

It is imperative that research is undertaken to clarify consumer perspectives on personal recovery, in order to ascertain what truly represents recovery-oriented care (Gawith &
Abrams, 2006; Onken, Dumont, Ridgway, Dornan, & Ralph, 2006). Yet, little research to date has privileged the consumer voice in this regard. The present study contributes to the gap in this area by discovering new knowledge. It did this through a comprehensive exploration of the concept of self-determination, which has been linked to personal recovery in the literature and in mental health policies (Mancini, 2008).

First, the notion that involvement in a five-day TR experience can develop certain key aspects of self-determination among consumers is significant. Consumers revealed that they felt more autonomous and connected, and felt more aware of themselves and better equipped to make choices, following Recovery Camp. Further, the present study shed light on how consumers perceive the personal recovery journey, and how self-determination informs this. This provides tangible evidence that self-determination should play a part in recovery-oriented practice and policies.

**Implications and recommendations for further research**

Mancini (2008) identified the need for an overarching theoretical or empirical framework to support the key aspects of personal recovery, and suggested that SDT overlaps, conceptually, with many ideas surrounding personal recovery. He recognised that practices and treatments we refer to as recovery-oriented typically address the basic needs espoused by SDT. Findings from the present study demonstrate a positive association between self-determination and personal recovery, thereby supporting Mancini’s (2008) work. This is an important consideration for mental health care. Developing self-determination is something the health care workforce should be undertaking whenever possible, to ensure consumers’ personal recovery journey is both supported and validated. Further, co-development of treatment plans is essential to increasing self-determination (Cook et al., 2012).
In line with this, quantitative findings from the present study also suggested that participation in a five-day TR experience does facilitate the development of certain key facets of self-determination, including relatedness, perceived choice, and awareness of self. The specific elements of Recovery Camp which facilitated this growth ought to be explored further. Similarly, quantitative findings revealed that autonomy increased post-camp, but this increase was not maintained at follow-up. The notion that a five-day TR experience may have been insufficient to instil lasting change in this area, and instead may require continued autonomy-supportive activities over time, should be explored in future research. Similarly, the reason/s why competence did not change following participation in Recovery Camp should also be explored. In the meantime, the delivery of mental health care should ascribe to the values espoused at Recovery Camp – that of strengths-based, recovery-oriented care that promotes the dignity of risk and encourages consumers to make informed choices as they work toward their goals for personal recovery. The new knowledge from this research demonstrates that TR experiences such as Recovery Camp should be one of the therapeutic options available to people in clinical practice settings. With regular involvement, increases in autonomy, competence, and relatedness may be even more pronounced.

In addition, qualitative analyses identified that stigma is a key issue for consumers, felt across the community but most notably in mental health care settings. At Recovery Camp, participants reported experiencing no ill judgement and spoke of this in positive terms. The mental health care workforce ought to be aware of their influence and take steps toward decreasing mental health stigmatisation. One way to achieve this could be the inclusion of TR initiatives, such as Recovery Camp, in the undergraduate health curriculum, and this should be explored in future research. Further, as acceptance and balance were identified as influential toward personal recovery for people living with mental illness, future research
should further explore how TR interventions influence acceptance and balance among people living with mental illness, as there is little to no research addressing this to date.

Finally, it should be considered that participants in the present study ranged quite considerably in age (22 to 65 years). Westerhof and Keyes (2010) indicated that older adults typically report greater autonomy than younger adults, yet less personal growth and purpose in life. They surveyed 1,340 Dutch adults between the ages of 18 and 87 years in their cross-sectional exploration of mental illness and mental health across the lifespan. Future research should consider how self-determination and personal recovery are perceived across different age groups, to ensure age-specific, targeted approaches to self-determination and personal recovery.

**Limitations**

All research has limitations, and the present study is no exception. The present study utilised self-report measures to quantify several key needs of self-determination. The potential for social desirability bias, whereby participants respond in a way they believe to be socially acceptable but not necessarily accurate, is a limitation in this respect (Krumpal, 2013). To help mitigate this, surveys were carefully selected to ensure the wording of questions/statements caused minimal discomfort, if any. The qualitative (interview and focus group) component of this research was designed to further alleviate potential bias and false reporting, as I was able to build rapport and trust prior and during, and participants were offered the opportunity to speak to other factors of their choosing, outside the rigidity of self-report measures.

The sample size was also relatively small and included participants from only one region of NSW, Australia (albeit spanning an area of 8,308km sq), somewhat limiting the generalisability of the findings. Yet, the intention of the present study was not to generalise.
The sample included all participants who attended Recovery Camp in May 2016, representing the entire cohort and including people with a broad range of mental health diagnoses. I acknowledge that, due to the small sample size, the power of quantitative analysis in the present study is low. I also acknowledge that, while the lived experience of those interviewed was genuinely conveyed to me, and I strictly adhered to van Kaam’s (1969) structured approach of analysis, different interpretations are possible. This does not negate from the validity and richness of the responses and experiences of those surveyed and interviewed in the present study.

The present study examined mental illness broadly, without regard to individual differences across diagnoses or clusters of diagnoses (e.g. anxiety disorders, mood disorders). Arguably, a limitation of this study is that the experience of personal recovery may well be different for people with schizophrenia compared to people with depression, for example. This is an area for future exploration. Regardless, I believe diversity in diagnoses is a strength of this study as the diagnostic criteria for mental illness can and does change quite regularly. This study took into account overall lived experience; all participants reported a serious and enduring level of impairment, which enabled them to constructively complete the survey and fully participate actively to answer the interview questions at hand.

The present study included a comparison group, who went about their daily lives ‘as usual.’ It is not clear whether an active comparison condition may have produced similar survey findings. For example, participants in the comparison group may have also reported increased relatedness if they were involved in a social group. Where possible, future research may include an active comparison group to determine whether a TR setting, such as Recovery Camp, increased aspects of self-determination above and beyond what might be seen in other, community programs.
Though not strictly a limitation, I acknowledge that personal recovery was only measured qualitatively in the present study, not quantitatively. Quantitative measures presently available were deemed inappropriately aligned with Glover’s (2012) model, and other similar models of recovery, which propose that personal recovery is a journey unique to each individual. Thus, interviews were used as the sole measure of personal recovery, given that participants were able to openly share their experience of personal recovery, without feeling restricted to particular survey questions and responses.

The global impact of mental illness is vast and far-reaching (WHO, 2017). Despite the above limitations, the present study contributed significantly to the current body of knowledge on mental health. A significant gap in the literature was addressed by exploring the hypothesis that greater self-determination leads to freedom of choice towards behaviours and activities that promote personal recovery from mental illness (Department of Health, 2013).

**Personal reflection**

I am honoured and humbled to have had the opportunity to listen to the experiences of people living with mental illness who participated in this study. To also have their permission to share their stories was both a privilege and a great responsibility. Throughout this process, at the forefront of my mind was a realisation of the importance of getting this ‘right.’ I wanted to accurately reflect the experiences that participants so generously shared, and I wanted to do justice to their stories, inclusive of all the emotions and feelings surrounding them. Unsurprisingly, given the prevailing marginalisation and ill-treatment of mental health consumers, some stories reflected negative and traumatic experiences, including stigmatisation and discrimination. I came to understand that personal recovery was an
ongoing journey, not without its ‘highs’ and ‘lows,’ and both must be conveyed to truly represent the whole story.

In building rapport and establishing trust with participants, I felt a connectedness to them, and found myself reflecting on my own pre-conceived ideas and values surrounding mental illness. I learned to truly listen, and not make undue assumptions or impose my own belief systems on others. Though I understood some aspects of mental illness, due to my studies and a close relationship with my grandfather who lived with depression, this experience gave me a great appreciation for the breadth and depth of symptoms and experiences across a variety of mental illnesses. Variation in symptom profiles and severity certainly existed even amongst people with identical diagnoses, which was not something I had fully appreciated previously.

Each consumer with whom I spoke showed immense gratitude for being invited to participate in this study. I did not expect that people would want to share their experience, understanding that stigma is still so prevalent even today. Yet, participants were eager to answer questions, and to convey their experience of mental illness and personal recovery. They seemed to take pride in being treated as the rightful experts in this area. I came to realise that lived experience narratives are of great value to people who live with mental illness. As mental health professionals, we would do well to recognise this and ensure that we approach care in a collaborative fashion, valuing the uniqueness and strength of each individual and their stories.

To conclude, undertaking this research has opened my eyes in many ways. The challenges of mental illness go far beyond what we see on the surface. Fear and stigma, a lack of hope for the future, and difficulty drawing meaning from life experiences, can be debilitating and lead people to feel vulnerable, isolated, and forgotten. If mental health
services are to be truly recovery-oriented, we need to implement programs and policies that foster self-determination, and that take into account the uniqueness of each person.
Above: Rock climbing at Recovery Camp (photography consent obtained)

Above: Team building activity at Recovery Camp (photography consent obtained)
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APPENDIX 1: Recovery Camp Program May 2016

Arrival - Camper briefing and camp orientation

1 Rock Climbing 1 Archery 1 Orienteering 1 High Ropes
2 Archery 2 Initiatives 2 High Ropes 2 Giant Swing
3 Initiatives 3 Rock Climbing 3 Giant Swing 3 Flying Fox

1.30pm Activity
1 Get to know you games 1 Alpine Rescue 1 Giant Swing 1 Flying Fox
2 Get to know you games 2 Rock Climbing 2 Flying Fox 2 Orienteering
3 Get to know you games 3 Alpine Rescue 3 Orienteering 3 High Ropes

3pm Afternoon Tea
1 Initiatives 1 Health Education 1 Tie Dye 1 Craft
2 Alpine Rescue 2 Tie Dye 2 Craft 2 Health Education
3 Archery 3 Craft 3 Health Education 3 Tie Dye

4.30pm Freetime

5.30pm Dinner

6.30pm Free Time

7.30pm Night Activity

Games

Trivia

Bush Dance

Campfire
APPENDIX 2: Ethics Approval

6 April 2016

Dear Professor Moxham,

Thank you for your response dated 1/04/15 to the HREC review of the application detailed below. I am pleased to advise that the application has been approved.

Ethics Number: HE16/060

Project Title: An evaluation of the Recovery Camp 2016

Researchers: Professor Lorra Moxham, Dr Susan Sumskis, Dr Renee Brighton, Mr Christopher Patterson, Dr Dana Perlman, Ms Ellie Taylor, Mr Stewart Alford, Ms Anita Cregan

Documents Approved:
- Initial Application (23/02/16)
- Response dated 01/04/16
- Mental Health Survey Invitation Flyer (Version 1, 01/04/16)
- Questionnaire (Version 1, 23/02/16)
- Participant Information Sheet, Volunteers at Camp (Version 2 – 1/04/15)
- Participant Information Sheet Volunteer Comparison Group (Version 2 – 1/04/15)
- Participant Information Sheet, Students at Camp (Version 2 – 1/04/15)
- Participant Information Sheet, Student Comparison Group (Version 2 – 1/04/15)
- Participant Information Sheet, Carers (Version 2 – 1/04/16)
- Consent Form for Volunteers at Camp (Version 2 – 01/04/16)
- Consent Form for Volunteers Comparison Group (Version 2 – 01/04/16)
- Consent Form for Student Comparison Group (Version 2 – 01/04/16)
- Consent Form for Students at Camp (Version 2 – 01/04/16)
- Consent Form for Carer Survey (Version 2 – 01/04/16)
- Frequently Asked Questions Sheet (Version 2, 01/04/16)
APPENDIX 2 (continued): Ethics Approval

Approval Date: 5 April 2016
Expiry Date: 4 April 2017

The HREC has reviewed the research proposal for compliance with the National Statement and approval of this project is conditional upon your continuing compliance with this document.

Approval by the HREC is for a twelve month period. Further extension will be considered on receipt of a progress report prior to expiry date. Continuing approval requires:

- The submission of a progress report annually and on completion of your project. The progress report template is available at http://www.uow.edu.au/research/ethics/human/index.html. This report must be completed, signed by the researchers and the appropriate Head of Unit, and returned to the Research Services Office prior to the expiry date.
- Approval by the HREC of any proposed changes to the protocol including changes to investigators involved
- Immediate report of serious or unexpected adverse effects on participants
- Immediate report of unforeseen events that might affect continued ethical acceptability of the project.

If you have any queries regarding the HREC review process, please contact the Ethics Unit on phone 4221 3368 or email rso-ethics@uow.edu.au.

Yours sincerely,

Associate Professor Melanie Randle
Chair, UOW & ISLHD Social Sciences
Human Research Ethics Committee

The University of Wollongong/ Illawarra and Shoalhaven Local Health Network District (ISLHD) Social Science HREC is constituted and functions in accordance with the NHMRC National Statement on Ethical Conduct in Human Research.
APPENDIX 3: Participant Information Sheets – Surveys & Interviews

Consumers at Recovery Camp

PARTICIPATION INFORMATION SHEET

TITLE: Evaluation of the Recovery Camp – VOLUNTEERS AT CAMP

PURPOSE OF THE RESEARCH: This is an invitation to participate in a study conducted by researchers in the School of Nursing (SN) and School of Education (SE). The purpose of the research is to investigate what it is like to be involved in the Recovery Camp.

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Stewart Alford Anita Cregan
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METHOD & DEMANDS ON PARTICIPANTS: If you choose to be included you will be asked to complete some surveys. There are no right or wrong answers. This is important to us as we are interested in what the Recovery Camp experience was like for you and whether this experience was of benefit to you. We will ask for five volunteers to complete an interview 3 months post-camp regarding their experiences at camp. This will be audio recorded. Your involvement in the study is voluntary and you may withdraw your participation from the study at any time by contacting Prof Moxham. The survey is completely confidential and will be stored securely in accordance with University of Wollongong policies and guidelines. If you choose not to participate in the study, there will be no effect on your relationship with the University of Wollongong, the School of Nursing or the School of Education. Please note that photographs will be taken at Recovery Camp.

POSSIBLE RISKS, INCONVENIENCES & DISCOMFORTS: Apart from about 30 minutes of your time for completion of the surveys (on three separate occasions) we can foresee no risks for you. If you do become distressed as a result of participating in this research, four members of the research team are mental health nurses so can spend time talking to you or help is available from Lifeline – PH: 13 11 14.

BENEFITS OF THE RESEARCH: This research will provide information regarding involvement in the Recovery Camp 2016 and how this may or may not benefit you. Findings from the study will be published in journal articles and presented as conference papers. You will not be identified in any part of the research.
ETHICS REVIEW & COMPLAINTS: This study has been reviewed by the Human Research Ethics Committee, of the University of Wollongong, reference no. HE16/060. If you have any concerns or complaints regarding the way this research has been conducted, you can contact the Ethics Officer on (02) 4221 3386 or email rso-ethics@uow.edu.au

Thank you for your interest in this study.
APPENDIX 3 (continued): Participant Information Sheets – Surveys & Interviews

PARTICIPATION INFORMATION SHEET

TITLE: Evaluation of the Recovery Camp – VOLUNTEER COMPARISON GROUP

PURPOSE OF THE RESEARCH: This is an invitation to participate in a study conducted by researchers in the School of Nursing (SN) and School of Education (SE). The purpose of the research is to investigate perceptions of those who attend the Recovery Camp, relative to those who do not attend.

INVESTIGATORS:
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Stewart Alford   Anita Cregan
PhD Student   Honours Student (SN)
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METHOD & DEMANDS ON PARTICIPANTS: If you choose to be included you will be asked to complete some surveys. There are no right or wrong answers. This is important to us as we are interested in aspects of your mental health. Your involvement in the study is voluntary and you may withdraw your participation from the study at any time by contacting Prof Moxham. The survey is completely confidential and will be stored securely in accordance with University of Wollongong policies and guidelines. If you choose not to participate in the study, there will be no effect on your relationship with the University of Wollongong, the School of Nursing or the School of Education.

POSSIBLE RISKS, INCONVENIENCES & DISCOMFORTS: Apart from about 30 minutes of your time for completion of the surveys (on three separate occasions) we can foresee no risks for you. If you do become distressed as a result of participating in this research, four members of the research team are mental health nurses so can spend time talking to you or help is available from Lifeline – PH: 13 11 14.

BENEFITS OF THE RESEARCH: This research will provide information regarding your mental health and how this relates to those who attend a program called Recovery Camp. Findings from the study will be published in journal articles and presented as conference papers. You will not be identified in any part of the research.

ETHICS REVIEW & COMPLAINTS: This study has been reviewed by the Human Research Ethics Committee, of the University of Wollongong, reference no. HE16/060. If you have any concerns or complaints regarding the way this research has been conducted, you can contact the Ethics Officer on (02) 4221 3386 or email rso-ethics@uow.edu.au

Thank you for your interest in this study
PARTICIPATION INFORMATION SHEET

TITLE: Evaluation of the Recovery Camp – FOCUS GROUPS (Investigator Taylor)

PURPOSE OF THE RESEARCH: This is an invitation to participate in a study conducted by researchers in the School of Nursing (SN) and School of Education (SE). The purpose of the research is to investigate what it is like to be involved in the Recovery Camp.

INVESTIGATORS:
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Luke Molloy
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METHOD & DEMANDS ON PARTICIPANTS: If you choose to be included you will be asked to be part of a focus group conducted by investigator Taylor (PhD student). Investigator Taylor will ask for up to twenty volunteers to complete a focus group at Recovery Camp. This will be audio recorded. Discussion topics may include: your mental illness, personal recovery, self-determination, and leisure. Your involvement in the study is voluntary and you may withdraw your participation from the study at any time by contacting Prof Moxham. The focus group is completely confidential and data will be stored securely in accordance with University of Wollongong policies and guidelines. If you choose not to participate in the study, there will be no effect on your relationship with the University of Wollongong, the School of Nursing or the School of Education.

POSSIBLE RISKS, INCONVENIENCES & DISCOMFORTS: Apart from approximately 30 to 75 minutes of your time for completion of the focus group, we can foresee minimal risks for you. If you do become distressed as a result of participating in this research, help is available from Lifeline – PH: 13 11 14.

BENEFITS OF THE RESEARCH: This research will provide information regarding involvement in the Recovery Camp and how this may or may not benefit you. Findings from the study will be published in journal articles and presented as conference papers. You will not be identified in any part of the research.
ETHICS REVIEW & COMPLAINTS: This study has been reviewed by the Human Research Ethics Committee, of the University of Wollongong, reference no. HE16/060. If you have any concerns or complaints regarding the way this research has been conducted, you can contact the Ethics Officer on (02) 4221 3386 or email rso-ethics@uow.edu.au

Thank you for your interest in this study.
APPENDIX 4: Self-determination Questions to Guide Interviews

Autonomy

Q1: “I would be interested to hear whether Recovery Camp has influenced how independent you feel in your day-to-day life.”

Q2: “Since returning from Recovery Camp, given all the decisions that you have to make in your day-to-day life, please explain to me how much control you have felt over these decisions.”

Competence

Q1: “Since returning from Recovery Camp, I would be interested in you telling me about your ability to deal with everyday aspects of your life.”

Q2: “Following Recovery Camp, please explain to me how you have approached difficult situations that have occurred.”

Relatedness

Q1: “We have been back from Recovery Camp now for about [time frame here]. I would be interested to hear how you have interacted with the people around you since then.”

Q2: “Since we got back from Recovery Camp, explain to me whether you have felt like you belonged in your community.”
APPENDIX 5: Recovery Questions to Guide Interviews

Active Sense of Self

“During Recovery Camp, you achieved many things [include examples if possible]. I’d be really interested to hear your opinion on what you believe contributed to these achievements.”

Hope

“In times of distress, sadness, worry, or other similar emotions, please explain to me how you have coped, since returning from Recovery Camp.”

Discovery

“Since Recovery Camp, I’m interested to know whether you have undertaken any self-learning or reflection surrounding the experience.”

Ability to Respond

This component of Glover’s (2012) model is covered by the ‘Competence’ questions above.

Connectedness

This component of Glover’s (2012) model is covered by the ‘Relatedness’ questions above.
APPENDIX 6: Flyer

The Recovery Camp

FAQ Sheet

Each year, the University of Wollongong offers people who live with a mental illness the opportunity to participate in the Recovery Camp. The camp is held over five fun-filled days at a recreation facility near Richmond, NSW. Participation in the camp is fully funded, including transport, shared cabin accommodation, meals and activities. No payment is required.

Frequently Asked Questions

Am I eligible to attend?
If you’re 18+ years of age, live with a mental illness, have reasonable mobility (some activities have 110kg weight restrictions), are comfortable with shared cabin accommodation (split by gender; single rooms are not available), and do not require a sleep machine (due to power outlet limitations), we’d love to hear from you.

When and where is it?
The camp runs from Monday morning to Friday afternoon, May 9-13, 2016, at YMCA Camp Yarramundi. You can view their facilities on their website: http://camping.ymcansw.org.au/camp-yarramundi

Participants will travel by bus to and from Wollongong or Oak Flats railway stations. All participants are required to stay until completion of the camp. (Unforeseen circumstances will be catered for.)

Who will be there?
We also invite University of Wollongong students to attend. Students are studying nursing and social sciences. Our aim is for students to have an immersive learning experience during which they can develop a greater appreciation and understanding of the lived experience of people who have a mental illness. Volunteers are encouraged to educate students on the experience of living with a mental illness. Five university academic staff members will also attend.

What do we do at Recovery Camp?
Volunteers and students will collaboratively participate in therapeutic recreation activities such as Tai Chi, initiative games, archery, a flying fox, rock climbing, camp fire story-telling, and more. Everyone is required to take part in each activity, but for some this may mean helping out instead of actively participating.

Whilst we can encourage participants to take any medications as necessary, we are unable to administer any medications in this setting. Therefore, prescribed medications need to be independently managed and Webster packs are one safe way for this to occur. Please also note that smoking facilities and opportunities to smoke are limited.

Feedback from a 2013 Camp Participant: “Once I got into the swing of the camp routine, I pushed myself and achieved more than I thought I ever could. This was the adventure of a lifetime.”
APPENDIX 6 (continued): Flyer

If you are managing well in your daily life and feel you would benefit from the opportunity to challenge yourself in the activities of the Recovery Camp, please get in contact with us. To have any questions answered, or to register to attend the camp, please contact Ellie Taylor, at elliejo@uow.edu.au or by phone on (02) 42 392 137 or 0498 215 700.